GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Ethiopia Case Study

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Group Disclaimer

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Acronyms and Abbreviations

CJSC	Central Joint Steering Committee
CRDA	Christian Relief and Development Association
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccine and Immunization
GFATM	Global Fund for TB, HIV/AIDS and Malaria
HEP	Health Extension Program
HEW	Health Extension Worker
HPN	Health Population and Nutrition
HSDP	Health Sector Development Program
HSS	Health Systems Strengthening
IHP	International Health Partnership
IRC	Independent Review Committee
IRT	Integrated Refresher Training
ITN	Impregnated Treated Net
JCCC	Joint Core Coordinating Committee
JFA	Joint Financing Agreement
JSI	John Snow Inc
MDGPF	Millennium Development Goals Performance Fund
MTR	Mid Term Review
PASDEP	Program for Accelerated and Sustainable Development to End Poverty
PBS	Protecting Basic Services
PEPFAR	Presidents Emergency Program for AIDS Response
PFSA	Pharmaceutical Fund and Supply Agency
PMU	Program Management Unit
WoRHO	Woreda Health Office

Executive Summary

The purpose of this report is to evaluate how sound Ethiopia's HSS processes were, how far GAVI principles have been adopted during design, and implementation and monitoring processes and what would have been the case without HSS Funding (the counterfactual).

Ethiopia developed a prioritized and costed strategic plan, the Health Sector Development Program III (HSDP III) in consultation with, and endorsed by, major stakeholders in 2005. As a country with a decade of experience in SWAPs and one of the pilot counties for alignment and harmonization, Ethiopia has been working to develop one plan, one monitoring framework and governance structure in the health sector. Furthermore the government at all levels, not only in the FMOH (Federal Ministry of Health) but at also at Cabinet level, has a clear vision on what the health sector should do and a commitment to meet the MDG goals. Though there was progress at a technical level on moving towards implementing the aid effectiveness agenda, the election problem of 2005 stalled this momentum as many development partners withheld their budget support. This period coincided with the establishment of the GAVI HSS window.

The application was developed by the direction of Joint Core Coordinating Committee (JCCC), made up of government and DPs (development partners), through a joint team that worked on the proposal for review by the stakeholders and approval by JCCC and Central Joint Steering Committee (CJSC). A visit by the GAVI Secretariat when the proposal writing process was initiated created more understanding between GAVI Secretariat and in country stakeholders and helped the GAVI Board to consider Ethiopia's HSS proposal as a special case. The IRC comments were not particularly difficult to respond to and were easily incorporated. Resubmission was therefore possible within two months. Following approval of the proposal the only requirement for the country to access funding was the submission of the 2006 Annual Performance Report (APR). It should be noted that the allocation of GAVI HSS to Ethiopia was greater than what would have been allowed under the HSS normal allocation formula i.e. $5 per newborn. After meeting these conditions, disbursement was made immediately on a frontloaded basis as per Ethiopia's request. Though the HSS funding will end of 2010, all GAVI HSS funds have now been disbursed to the country.

Development partners and government have been pushing for the implementation of the aid effectiveness agenda, consistent with GAVI values. The team's evaluation and discussions with all stakeholders including the JCCC indicate that the country position in terms of alignment and harmonization is improving not least because of GAVI HSS and International health partnership

(IHP+) initiatives. With the exception of sustainability, to which it might have contributed negatively, GAVI HSS's contribution has been positive in most of the aid effectiveness components (see table 1). The findings of this evaluation documented that GAVI HSS window funding is not only aligned with government systems in terms of planning, budgeting, and financial management but has also helped the FMOH to jump start the harmonization of funding in the health sector by helping to create the MDG PF. Its management of funding is so flexible that whenever additional resources are available from other sources for areas that HSS is funding, JCCC is able to reallocate resources to other underfunded areas within the proposal. Stakeholders commended this flexibility and its effect on reducing the transaction costs of reprogramming as one its strong features. This demonstrates counties like Ethiopia do have ability to reprogram global resources through an in country shared decision mechanism without prior approval with due regard to overall programme objectives and frameworks. Other strong aspects of GAVI HSS are its additionality and catalytic effect. It has not only helped to mobilize resources from other donors and government but also at community level. One region has managed to construct 40 health posts by ensuring additional community contribution to the construction cost. This is another example of catalytic impact at community level/additionality. On the other hand, the increasing government and donor financing, and innovative financing mechanisms (both social and community based health insurance schemes that are put in place) are likely to contribute only over the medium and long term. Unless finance is available through donors during the interim the large expansion in infrastructure and services contributed to by GAVI HSS might not be sustained.

The evaluation team used a scoring system to review the progress of aid effectiveness agendas (GAVI values) through a scoring system ranging from 1-5; 5 being excellent and 0 means no progress at all. We discussed these scoring systems with JCCC on whether the scoring reflects actual reality and consensus was reached.

Table 1 Preliminary findings on implementation of GAVI Values

Country ownership	Position of country	GAVI contribution
Policies and practise reflect the general in-country understandings of proper health policy direction	5	0
Governance capacity to implement agreed policies and strategies	4	+
Effective M&E that feeds back into strategic processes for constant re-evaluation and improvement	4	+

Alignment	Position of country	GAVI contribution
Partners alignment to strategic priorities	4	+
Partners alignment to government processes and systems	3	+

Harmonisation	Position of country	GAVI contribution
A functioning system of consultations to allow all stakeholders a say in strategic matters and thus making it possible to live with agreed plans	3.5	0
Transparency in relations between stakeholders	3	+
Active measures from all stakeholders to reduce transaction burden	3	++

Additionality	Position of country	GAVI contribution
External aid resources complementary to country efforts to reach critical levels of funding	5	+
Absence of tactical anticipatory reductions of country resources to health expecting aid to compensate.	5	+

Catalytic effect	Position of country	GAVI contribution
Marginal benefit of aid additional resources high	5	+

Innovative	Position of country	GAVI contribution
Supportive to trying out new technologies and new solutions for provision and demand generation.	3	0

Inclusiveness	Position of country	GAVI contribution
Strategic development processes open to all stakeholders	4	+
Systems for provision open for user influence	1	0
Non-discriminatory practises in provision of services and demand generation	5	0
Services are equitably accessed (geographic and financial)	3	+

Sustainability	Position of country	GAVI contribution
Sustainability of benefits after HSS evaluation	3	-

Most of the outputs expected to be delivered through HSS support are on track. The health extension program has managed to cover all rural communities and GAVI HSS's contribution to improving the quality of their skills through apprenticeship training and support by skilled supervisors has been significant. Most of the health centre and health post construction activities are on track though the number of these units constructed might fall short of what was planned in the proposal due to the increasing price of construction materials. The procurement of equipment for these health facilities has been carried out and delivery is expected to be completed in the next few months. All the equipment necessary for management strengthening below the woreda level (HMIS equipment and transport vehicles for supervision) were procured and distributed. However, delays have been experienced in health centre construction, HMIS scaling up and IMNCI training.

In terms of outcomes, DPT 3 coverage, vitamin A supplementation and de-worming have exceeded proposal targets. The rest of the indicators have improved but not reached their HSS target. This can be explained partly by the fact that the health facility construction is slower than planned and this affected the pace at which access has been expanded. It is reasonable to assume that GAVI HSS support has contributed to these results. The full impact of any improvements made though upstream health intervention on infant, child and maternal mortality can only be known when the next DHS results are available.

One of the central themes of this evaluation has been the counterfactual; i.e. what would have happened if there had been no GAVI HSS support. Health stakeholders (JCCC, development partners and government), in Ethiopia perceive that an absence of GAVI HSS would have considerably reduced the chances of reaching MDG 4 and 5 through a number of effects. The

positive push for further reform of the aid architecture provided by GAVI HSS would have been dearly missed and commitment to health both within the Government of Ethiopia and its allied development partners may also have been reduced. The outcomes and outputs would have been reduced due to the lower scale of support (GAVI HSS funded about 8% of the funding gap under scenario one); The health extension program might have not been implemented as fast as it is now and the quality of the service could have been reduced. Further, other development partners might have not put their additional money into the sector at that critical point in time (due to election problems) and the catalytic effect of HSS funding on increased mobilization of resources from domestic and some external sources (DPs who were not willing to put their funding on such efforts are being part of financing activities that HSS is financing now) would have been lost. The development of the MDG performance fund (the pooled account for the health sector) could have been delayed; the credibility of the country system to be used to channel aid resources could not have been established and finally, feasibility of an in-country resource approval process (JCCC) would not have been tested and demonstrated.

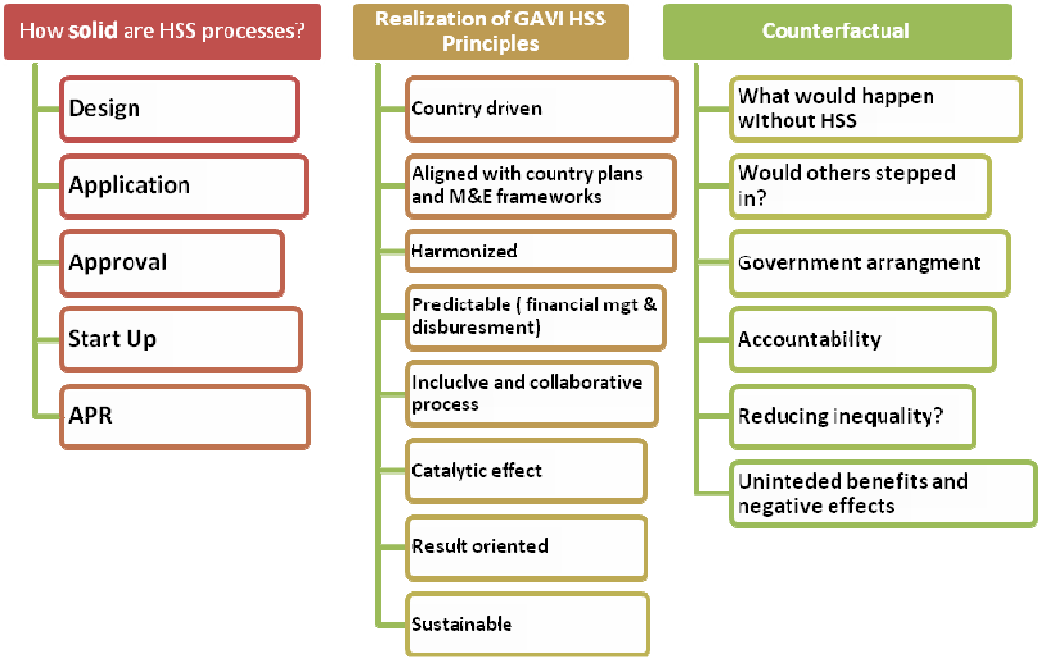
1. Introduction

GAVI HSS provided a total of $76.5m to support the strengthening of the Ethiopian health system (equivalent to about $1 per capita and about 8% of the projected gaps of HSDP III under scenario 1).

The preliminary findings of this case study are a result of a literature review and in-depth interviews of the policy makers, implementers and partners working at the national level. A JSI/ Indevelop Tracking Study is ongoing and its results were not available to the evaluation team. This evaluation did not visit the field to review what has been implemented at regional and Woreda levels to avoid further transaction costs given that the tracking study team is undertaking a field survey.

The case study closely follows the global methodology developed for this evaluation and tried to answer the three critical questions exploring how sound the HSS processes are, how far GAVI principles have been adopted during design, and implementation and monitoring processes and what would have been the case without HSS Funding (the counterfactual).

Figure 1 Global conceptual framework for HSS evaluation



The information for this case study on Ethiopia was obtained through a review of all relevant policy, programmatic and evaluation reports carried out in the sector for the last five years; a review of the GAVI HSS proposal, APR reports and other GAVI related guidelines and assessment reports carried out at the global level; and responses obtained from interviews with the various stakeholders involved in the design, implementation and management of overall health systems strengthening within the country. We would like to acknowledge the contribution Dr Tedros Adhanom, Minister for Health in Ethiopia. We would also like to acknowledge the contribution of JCCC members, individually and collectively, not only for their provision of their responses to our interviews but also for their critical input to our evaluation of the implementation of GAVI principles.

This case study has its limitations. The team did not carry out field visits and was unable to incorporate findings from the tracking study. Finally, we were not able to attribute successes, or lack of it, to GAVI HSS as there are many partners funding similar activities.

2. Ethiopia: The Baseline

The HSS proposal was drafted in 2006 and submitted for approval in 2007. The Ethiopian Demographic and Health Survey was published in September 2006 (covering 2000 to 2005). This report summarizes this Survey[1] as it was used as a baseline before the approval of the HSS proposal. Overall, the DHS documented that has been progress since the 1990s and much faster since 2000 in many of the indicators, however most are below the required growth to reach the MDG targets.

2.1 Child Health

In 2005, one in every 13 Ethiopian children died before reaching age one, while another one in eight did not reach their fifth birthday. Infant mortality has declined by 19% over the past 15 years from 95 deaths per 1,000 live births to 77. Under-five mortality has reduced by 25% from 166 deaths per 1,000 live births to 123. The corresponding declines in neonatal and post-neonatal mortality over the 15-year period are 15% and 22% respectively. Mortality is consistently lower in urban areas than in rural areas. Male children experience higher mortality than their female counterparts and the gender difference is especially pronounced for infant mortality. Some regions are doing better than others.

When it comes to outcome indicators, the coverage for the first dose of DPT was 58% but only 32% go on to receive the third dose of DPT; a clear sign of weak health systems in the country. Polio coverage was higher than DPT coverage at 72%. 13% of children under-five showed symptoms of acute respiratory infection (ARI). Only 6% of households in Ethiopia own a mosquito net, with 3% of households owning an insecticide-treated net (ITN). Only 2% of children under-five slept under a net, while less than 2% slept under an ever-treated net and under an ITN. 18% of children under age five had diarrhea, and 6% had diarrhea with blood.

Breastfeeding is nearly universal in Ethiopia with a median duration of 25.8 months. Exclusive breastfeeding, on the other hand, is relatively short, with a median duration of 2.1 months and, only around one in three children age 4-5 months is exclusively breastfed. The level of malnutrition is significant with nearly one in two (47%) Ethiopian children under five years of age stunted (short for their age), 11% wasted (thin for their height) and 38% underweight.

[1] Central Statistical Agency,2006, Ethiopian Demographic and Health Survey, Addis Ababa, Ethiopia

Table 2 Progress between 2000 and 2005 in health impact indicators

	2000	2005	Average decline per year
Under -5 mortality rate	166	123	8.6
Infant Mortality Rate	97	77	4
Stunting (height for age)	52	47	1

Source: Central Statistical Agency, 2006, Ethiopian Demographic and Health Survey, Addis Ababa, Ethiopia

2.2 Maternal Health

In 2005, only 28% of mothers received antenatal care from health professionals. There was little improvement in the percentage of mothers who received antenatal care from a health professional in the five years between the 2000 and 2005 surveys. Only one in three women was protected against neonatal tetanus. The percentage of women who received two or more tetanus injections during pregnancy for the last birth increased from 17% in 2000 to 28% in 2005. An overwhelming majority (94%) of births was delivered at home and only 5% of births were delivered in a public facility and 1% in a private facility. While 90% mothers received no postnatal care at all, only 5% of mothers received postnatal care within the critical first two days after delivery.

2.3 Policy framework and its linkage with the proposal

Ethiopia has been implementing the Health Sector Development Program (HSDP) over the last ten years and is currently in its third phase (since 2005/6). HSDP III set the priorities and targets for the health sector to be achieved in 2010. HSDP III is the health component of the Programme of Accelerated and Sustainable Development to End Poverty (PASDEP)-Ethiopia's PRSP document. As the targets and resource requirements of HSDP III form the basis for the health section of PASDEP, this ensures policy coherence between the national and the health sector frameworks.

Table 3 Summary of Focuses, outcomes and targets of HSDP III

Focus areas	Outcome	Vehicles	Bloodlines
Maternal Health	MMR 871 to 600 CPR >60%	HP: 13,635 HC: 3200 HEW: 30,000 HO: 5000 GP QA	HMIS Logistic system Finance system Harmonization
Child Health	U5MR 123/1000 to 85/1000 IMR 77/1000 to 45/1000 Immunization >85%		
HIV/TB	To maintain the prevalence of HIV at 3.5; Reach every household ART 263,000		
Malaria	20 million ITNs		

Source: FMOH, 2005, HSDP III, page xxi.

The main strategies[2] designed to achieve the maternal and child health include:

- Vigorous implementation of the Health Extension Program (HEP);
- improving the quality of health care through provision of adequate resources, implementation of the two-way referral system, enhancing the capacity of the HEWs for detection, referral and follow up of patents, and strengthen secondary and tertiary hospitals and referral laboratories; improving the numbers, skills, distribution and management of health workers;
- ensuring planned training of health managers in adequate numbers and appropriate skills;
- mobilizing adequate financial resources, ensuring efficient utilization, and strengthening sustainable financing mechanism;
- improving health information system and the capacity for effective monitoring and evaluation; and improving logistics management.

The priority areas where the government set targets for has been creating universal access to basic health services through the implementation HEP and setting up of fully functional health posts and health centers as per the national standard during this phase of HSDP.

[2] FMOH, 2005, Health sector Development program III, page xxi.

3 The HSS Application and Review Process

3.1 Initiation and Design

Ethiopia's experience of HSS design at the country level, its review by the IRC and its consequent approval by the board has been relatively smooth. The visit of the GAVI Secretariat in March 2006 and its subsequent decision to consider Ethiopia as a special case have contributed to this. Ethiopia started the preparation of the HSS proposal just three months after the Board's decision to establish HSS, i.e. March 2006. The visit of Julian Lob-Levyt provided the necessary impetus to the process. With the invitation of the Minister of Health, GAVI coordinated a mission from 13-16 March 2006 with the Global Fund (UNICEF, WHO and USAID also joined the mission) to assess the potential for scaling up health services in line with the post-High Level Forum (HLF) harmonization agenda. GAVI and Global Fund both had a strong interest in coordinating around scaling up health systems.

Box 1: Justification for considering Ethiopia a special case

It is proposed that Ethiopia should be provided the opportunity to apply for support in the first half of 2006. The team found out that the country has systems in place for strategic planning, monitoring and evaluation of the health sector and has shown key improvements in immunization coverage and child health indicators over recent years. There is an effective national health coordination mechanism in place which oversees a health sector review process. A costed health sector development plan (HSDP3) with a detailed plan for scaling up health service delivery was finalized and endorsed by major health partners in October 2005. A national Child Survival Strategic plan that addresses 90% of child mortality has been prepared and is being implemented. There are however significant funding gaps in the rapid scale up plan to achieve the Millennium Development Goals. There is a risk of a delay in release of funds for programme implementation due to political challenges the country is facing. The GAVI Alliance can facilitate the expansion of services by providing flexible GAVI HSS support on a timely basis though channels endorsed by the country and its development partners.

Source: GAVI Health Systems Strengthening Task Team (HSS TT) Minutes of 2nd Face to Face Meeting, 13 – 14 September 2006, Geneva, Page 4

Initially a team was put in place to draft the write-up and a budget for the HSS proposal and a draft was ready by June 2006. After going through one round of reviews on this initial draft, another team was formed consisting of MOH, WHO (chief writer), UNICEF, USAID, Tulane University (funded by PEPFAR) and a DFID consultant to finalize the proposal. The absence of the proposal guidelines from GAVI Secretariat at that time was a challenge for the writing team. Development partners were involved in the write-up process through discussions related to

health systems barriers and mechanisms for addressing them with the writing team. They were also engaged through discussing and approving the proposal at various coordination fora (Joint Core Coordinating Committee (JCCC), Health Population and Nutrition (HPN) donor consultative meeting and Central Joint Steering Committee (CJSC).[3]

Table 4 List of stakeholders participated in the design of HSS

Areas of support	Organizations
Proposal design and management	Relevant Government depts., WB, WHO, UNICEF, USAID, CIDA and Save the Children (US)
Proposal management	Regional Health Bureaus, MOH. Other agencies: USAID, DFID, Health, Population & Nutrition Donor group provide oversight
Proposal implementation	GTZ, UN agencies, Regional Health Bureaus

Source: FMOH, 2006, HSS proposal

As shown in the above table there was only one NGO involved in the development of the proposal, Save the Children USA. CRDA, as a coordination umbrella of NGOs, was part of the CJSC decision making process. The involvement of other NGOs and civil society during HSS proposal development seems to have been limited. The proposal did benefit from an informal review of the GAVI Alliance Secretariat during the write up process. It was submitted to the GAVI Secretariat on 3 November 2006.

3.2 Proposal Review and Dialogue with GAVI

The proposal was reviewed[4] by the IRC in about 10 days. The Committee, in principle, approved the proposal worth of $76.5m subject to adequate clarification on the following issues:

a) It noted the need to revise the section on monitoring by including baseline data and data sources, and aligning the impact targets with those in the larger HSDP III. It further requested an explanation on how the monitoring will be conducted (frequency and which department will be responsible);

b) The proposal was for the period 2006/7 – 2009/10 (i.e., four years), but the budget was for a period of five years. The Committee recommended to Ethiopia to adopt one of the following alternatives: Reduce budget to four years or extend the plan to five years, or

[3] GAVI Health Systems Strengthening Task Team (HSS TT) Minutes of 2nd Face to Face Meeting, 13 – 14 September 2006, Geneva, Page 4

4 Proposals need to meet the following requirements: intervention critical for raising immunization coverage, level and nature of support makes a difference, be integrated into the national plans, progress can be monitored and be endorsed by MOF and in-country partners.

maintain the plan and budget as presented in the proposal with the understanding that the country will not be eligible for any additional support until after the five-year period.

c) There was a need to clarify the account into which HSS funds should be deposited, the pooled "MDG Performance Package Fund Account" against "Ministry of Health Yellow Fever Vaccines".

d) Finally, the Committee urged the country to involve the CJSC in the process of technical support function and in confirming its support for the proposal, in response and reply to the above clarifications[5.]

This provisional approval with clarification of Ethiopia's HSS proposal made it one of the first five proposal approved among the fifteen reviewed by IRC in November 2006.[6] The Secretariat approved the proposal within 20 days of the submission of the proposal.

The country took about two months to provide clarification to the IRC. Its clarification was sent on 15 January 2007.[7] The clarification note stated that:

- All relevant targets were aligned to HSDP III targets,
- All available baseline indicators (impact from DHS and outcome from HMIS) were filled and when such indicators were not available, the proposal factored in plans to establish them during the start up process ; and
- The CJSC opted to adopt the third option provided by the IRC regarding alignment of budget framework with the HSDP III: i.e., the funding would be for 2007-2010 in order to meet HSDP III targets, but the country would not be eligible for funding until the end of five years.

The clarification provided by the country to issues raised by the IRC was found to be satisfactory and the approval of the proposal was obtained from the Secretariat on 1st March 2007. The letter clearly stated that the support will be subjected to strict performance monitoring and requested the government to provide the APR 2006 to enable it carry out first disbursement of HSS support.

5 GAVI Alliance Secretariat, Letter to the FMOH Ethiopia, 24 November 2006
6 GAVI Alliance Secretariat, GAVI Alliance and Fund Board Meeting, 11-12 May 2007.
7 Ethiopia's Letter to GAVI Alliance Secretariat, 15th January 2007

Table 5 Approved Funding for HSS support

Annual Disbursements as Requested in the Proposal					
2006/2007	2007/2008	2008/2009	2009/2010	2010/2011	Total
$23,733,500	$32,106,000	$12,629,500	$8,025,500	$0	$76,494,500

Source: GAVI Alliance Secretariat letter to FMOH dated March First 2007.

3.3 Success Factors during Development of proposals

There were some success factors behind the development and endorsement of Ethiopia's GAVI HSS proposal. The most important ones are related to strategic preparedness of the country at that point in time and the existence of a committed and proactive leadership and management that mobilized partners to meet the targets the country set for itself.

Strategic preparedness

Existence of strategic vision and prioritized and costed program

The country has developed its PRSP (Programme for Accelerated Sustainable Development to End Poverty (PASDEP)) in mid 2005 and one chapter of this document was the Health Sector Development Programme, HSDP III. This health sector strategic plan was well prioritized and costed showing the main health priorities with their targets, implementation strategies and activities as well as the projected financial resources required, available and gaps using three scenarios. The plan was developed with the participation of regions and development partners and enjoyed wide ownership by in-country stakeholders. The analysis of financing gaps by area of intervention demonstrated that *health systems* was the one that was most severely underfinanced. The GAVI HSS window was established at a time when filling this huge financing gap was top on the agenda for both government and development partners.

Existence of sector wide framework

Ethiopia, as one of the countries that has been implementing sector wide approaches, has a functioning health sector coordination framework that allows development partners and government to take shared decisions. The participatory approach used in GAVI HSS design was another area of strength in the design process; in terms of promoting collaborative work between the government and development partners. As soon as the news of the GAVI HSS funding mechanism was announced, FMOH-HPN Donors Group met to set a technical team composed of FMOH and development partners to write the proposal. Team members were drawn from the Planning and Programming Department, UNICEF, WHO, and USAID. The fact

that the financing gaps for the realization of the HSDP III had already been identified made it considerably easier to develop a proposal for GAVI.

Once the draft proposal was on the table, it was reviewed in country and finalized using the existing governance structure in the health sector. The Joint Core Coordinating Committee took the responsibility of overseeing the relevance and technical soundness of the proposal at all stages. The FMOH-HPN Donors Group Joint Consultative Forum was used to obtain comments and feedbacks from the wider donor group in the health sector. The FMOH-RHBs (Regional Health Bureaus)) Joint Steering Committee reviewed the proposal, with the specific aim of making sure it reflected the prevailing gaps at grassroots levels. The Central Joint Steering Committee (the health sector Coordination Body), which is the highest level coordination and decision-making body in the health sector made the final decision to submit to GAVI. In general, existing fora were used to oversee and monitor the implementation of GAVI HSS in Ethiopia which is a hallmark of significant step towards harmonization and alignment.

Proactive and committed leadership

The leadership and management of the health sector envisaged clearly saw the need to strengthen health systems in order to provide access to health to the majority of the rural population. When the call for HSS was made, the Minister took a bold decision to invite the GAVI Alliance Secretariat to assess country preparedness. This assessment resulted in Ethiopia being treated as a special case. Ethiopia's funding approval – although it only meets only about 8% of its funding gap under the lower scenario - is by far the largest HSS approval to-date and only two out of 45 other countries managed to secure more than just 50% of Ethiopian HSS funding (DRC and Nigeria). The allocation to Ethiopia was greater than would have been allowed under the HSS allocation formula i.e. $5 per newborn. This is a result of the proactive engagement of the leadership of the FMOH.

The commitment of the leadership to get things done in GAVI HSS continued during implementation. The Minister closely monitors the implementation of three major health programmes on a weekly basis: GAVI HSS, Protecting Basic Services and the Global Fund. The management and leadership were able to mobilize additional funding from other partners (PEPFAR for instance) and government resources to ensure that the targets set are achieved in areas which GAVI HSS has been funding. The Minister also leads a committee on a weekly

basis to fast track the liquidation funds[8] by regions. There is visible commitment for getting activities done at the right time and with minimum cost.

3.4 Weaknesses in HSS Proposal

Upstream definition of HSS and maternal health

The primary objective of the health systems strengthening in Ethiopia is to expand access to health services through the expansion of primary health care. This involves the training and deployment of two health extension workers (trained for one year) in every Kebele and the expansion of health posts and health centres to provide facility-based services. This is expected to contribute to the provision of primary services to the large number of people who, to date, have not been reached by facility-based health services.

The objective of GAVI HSS is to achieve and sustain increased immunization coverage, through strengthening the capacity of the health system to provide immunization and other health services (with a focus on child and maternal health). By focusing on overall access constraints, the HSS proposal for Ethiopia seems to overlook many other interventions (see paragraph below) that are critical to achieve the MDG goals for maternal health. Responses from our interviews suggested that this seems a missed opportunity for the country to incorporate some interventions in this area. The fact that GAVI HSS stressed the need to justify the health systems strengthening interventions in terms of removing bottlenecks of increased immunization is reported to have contributed to limiting the scope of the proposal. A recent assessment shows that almost 70% of hospitals and 90% of health centers are understaffed with midwives; furthermore, half of the hospitals do not have obstetricians and 73% of the district hospitals do not undertake caesarean sections. Comprehensive emergency obstetric and new born care is available in only 79 health facilities out of the 623 health centers and 114 hospitals in the country. The referral system remains weak. The removal of these bottlenecks would have attracted more mothers to deliver in health facilities instead of at home, and could have provided the health systems that would allow access to children for immunization early. Addressing these additional problems of Ethiopia's health system would have costed more or reduced other HSS interventions planned.

The new health centres supported under GAVI HSS are going to have basic obstetric care services, but it will take some time to upgrade 30% of the new health centres to provide comprehensive emergency obstetric care. Training of health officers on emergency obstetric

[8] Liquidation here is defined as submitting statement of expenditures with supporting financial statements to help spending is recognized in the accounting records.

care has begun. The opportunity of establishing functional health centres that provide Comprehensive Emergency Obstetric care during the GAVI HSS strengthening phase therefore does constitute missed opportunity. The MTR report recommended that there should be increased financing in this area if Ethiopia is to achieve MDG targets.[9]

Sustainability of high level of expansion

The country's health system is expanding rapidly in terms of deployment of health extension workers and expansion of health facilities. Such an expansion has implications for training and deployment of health workforce, the allocation of resources for running these facilities and their maintenance cost. The proposal is silent about sustainability and the IRC has not picked up on the issue to date.

The required health extension workers are now in place (see following sections) and their salary is already borne by the government budget. The sustainability issue in this regard is to make sure that the attrition of health extension workers is offset through training additional staff (considering that they are young women, the attrition rate could rise in the future as high as 15-20%[10]). This does not seem an insurmountable challenge.

Ethiopia is at the critical phase of trying to translate the investment in health infrastructure into service outcomes as all the on-going facility construction activities are completed, equipped, manned and provided with a running budget. Already more than 75% of the health resources at sub-national level are allocated to salary costs. With the proposed expansion, the wage burden of the additional human resources and the recurrent budget implications are likely to increase in the coming years. Though the country is trying to implement various health financing reforms (retention, social health insurance and community-based health insurance), these reforms are not likely to provide the necessary financial leverage for the health sector in the short and medium term. Government and donor financing are going to remain the major sources of funding until sustainable domestic sources of health financing are established. The extension of Protecting Basis Services phase 2 programme will significantly contribute to the availability of resources in the sector at sub-national level in the short term; the adequacy of which depends on the overall resource framework provided to sub-national levels, as well as the ability of the sector at regional and woreda levels to negotiate for increased resources vis-a vis other sectors.

[9] FMOH, 2008, HSDP MTR final Report
[10] This is just authors estimation based on more general experience

The evaluation team would like to note that HSS has contributed to an increased capacity to the health sector but fails to provide adequate mechanism to sustain the benefits that it has created. It might be necessary in this regard to chart out a mechanism to address this critical gap.

4 Implementation and GAVI principles and Values

4.1 Country Owned[11] and Driven proposal

As described above the HSS proposal is a subset of the sector development programme, HSDP III, the priorities of which are government driven. The HSS proposal mainly provides additional funds for two government flagship programmes - the health extension programme and the expansion and equipment of facilities. Rapid implementation and relatively high absorption of resources (see section on HSS spending) reflects the political as well as technical importance attached to these activities. The health extension programme is the 'hardware' of the Ethiopian primary health care service provision, which is now able to fully cover the agrarian rural areas of the country and is a major strategy in PASDEP; endorsed in 2005. The need to construct and equip health posts and health centres was identified as early as 2004. As all interventions included in the HSS proposal were defined before the conceptualization of HSS itself, Ethiopia's HSS proposal was entirely country driven, supported by technical inputs from partners but with little use made of consultants.

Yes, but public sector dominated as the role of NGOs and civil society in health service delivery is limited

The proposal focuses entirely on supply side interventions. Demand side financing has not been incorporated into HSS interventions in Ethiopia although the anticipated impact of the health extension programme, which aims to improve the demand for and utilization of services should not be underestimated. With the expansion of the HEP, some services like vaccination and delivery services are coming closer to the community. The house to house follow up of the HEW (health extension workers) on model households is expected to contribute to the uptake of some services.

On a general note, the functionality of the health sector governance system has been weakened by the existence of multiple coordination mechanisms (one for Global Fund) and the less frequent meetings of the CJSC because of the inability to set a proper agenda. One important note here is that the ownership is mainly on the part of public sector actors as the role of other

[11] In our view a country can and should fertilize ideas obtained from external sources and adopt it to its conditions. It should not there fore mean a country monopoly of ideas on strategic interventions for reaching the MDG and improving aid effectiveness. Country driven is a much seem to better reflect the process of development.

service providers is marginal compared to other countries.

4.2 Alignment with National Plans and Systems and Harmonization

The GAVI HSS support to Ethiopia is a project for the GAVI Alliance but it is part of the strategy to finance the funding gap for HSDP III for Ethiopia. The strategies, targets, monitoring framework, the coordination and management process of the GAVI HSS implementation are fully aligned with the government/sector processes. The only exception to this rule is that GAVI requires a separate progress report to check project deliverables and ensure reduced fiduciary risk.

Yes with the reservation of the use of APRs and some process indicators outside the nationally agreed framework

The GAVI HSS was the first to agree to channel funding through the FMOH's preferred modality; the MDG Performance Fund, as outlined in the HSDP III. It has influenced the behaviour of other donors to fast track their efforts towards more alignment to government systems in spite of higher level political challenges faced in the country. Seven development partners (DFID, Irish Aid, Italian Cooperation, Spanish Development Cooperation, UNICEF, UNFPA and World Bank) have signed-up to channel part of their resources through this fund. It also tested the feasibility of the government's financial management system to support pooled funding arrangements. The IHP+ initiative has galvanized government and development partners to work towards more alignment and harmonization. This led to the development of, and signature of, both the IHP road map and its Compact by some development partners and government. To translate the agreements included in the compact into operationalizing the pooled funding, the MDG PF performance was appraised[12] by an independent team to assess whether it could be used as an expanded pooling mechanism. The team concluded that the basic requirements for expanding the pool exist, but provided recommendations and action plans to strengthen some of these systems. This culminated in the signing of the JFA in 2009 with additional resourcing of about $100 million. The GAVI initiated MDG PF, with an enhanced push from IHP+ initiative, has now become the basis for which the recently signed Joint Financing Agreement[13] was initiated. We can therefore conclude that the GAVI HSS window

[12] The MDG PF was appraised in terms of its programming, financial management, procurement, social inclusion and institutional arrangement. Please refer the appraisal reports 2008.
[13] Based on the experience of the GAVI model, with some strengthening measures a Joint Financing Agreement was signed in 2009 by FMOH and seven development partners.

funding is not only aligned to government systems in terms of planning, budgeting and financial management but that it has also helped the FMOH to jump-start harmonization of funding in the health sector by helping to create the MDG PF. It has also supported the institutionalization of the Woreda based bottom up planning process.

Table 5 Characteristics of the MDG PF to which GAVI HSS funds are channeled

Dimension	Satisfied?	Comments
On plan	Yes	MDG Fund activities are part of HSDP-III and annual woreda core plans and follows government planning calendar
On budget	Yes	Activities are part of the core budget
On parliament	Yes	Fund has been gazetted as part of annual appropriation at national level
On Treasury	No	Channel 2 used – funds are disbursed directly to Federal Ministry of Health and not through the Ministry of finance and economic development
On accounting	Yes	FMOH follows standard GOE accounting procedures in the treatment of MDG transactions
On audit	Partial	Current arrangements allow for appointment of External Auditor by FMOH – however, appointment has not been made,
On report	Yes	MDG activities reported alongside other core HSDP-III activities.

Source: MDG appraisal report: financial management, 2008, page 14.

GAVI is expected to move to full alignment to government system as it pledged to do so in the IHP+ meeting this year:

> *In 2009, GAVI will further its initiatives to align processes with country-level plans and objectives by piloting a new approach to funding and monitoring in a number of IHP+ countries, starting with Ethiopia and Mozambique. This builds on GAVI's earlier decision to provide financial support for strengthening Ethiopia's health service capacity through Ethiopia's MDG Performance Fund. The GAVI Board committed to support the IHP+ in October 2008 and will monitor progress through 2009*[14].

On the negative side, GAVI Secretariat is still receiving annual APRs from GOE which follows a project type approach. The government, while acknowledging it implies some transaction cost, would like to use this reporting as a mechanism for ensuring follow up of implementation and would like to continue until the HMIS scale up is completed. Since the MDG PF Joint Financing Agreement has come out with a harmonized financial and performance reporting format that is

[14] IHP Ministerial statements, February 2009

aligned to government reporting system and formats, what remains for better alignment from GAVI HSS is, therefore, to adopt these formats instead of using its APR. In this regard, the team fully concurs with the issue paper 'performance funding for GAVI Alliance HSS financing' which states that:

> *It might be difficult for countries to provide reports on how GAVI funds have been spent. In this case the country can submit its Joint Annual Review report (or equivalent) to show progress in the health sector. …This obviously presents fiduciary risk that will have to be born by the GAVI Alliance, which can be justified if oversight mechanisms are put in place at country level. Also considering the long term nature required to bring lasting improvements to health systems this risk might be worth taking*[15]

It is, however, important that country annual performance and joint review mission reports should present the contribution of the most important health programmes (e.g. GAVI HSS, PBS and Global Fund) to help GHIs (global health initiatives)) discharge their accountability responsibilities as well. Given the momentum towards more harmonization and alignment, it is expected that HSS will fit into the full MDG proposed implementation modality (JFA) signed by development partners.

The above statements need to be seen in light of the fact that alignment and harmonization is a process. In this regard, the health service delivery in Ethiopia is dominated by the public sector and alignment of NGOs and private sector to sector strategies is far behind other countries, not least because of the lack of efficient networking of NGOs and private sector to engage in this process[16]. The support provided by DPs to NGOs is not aligned either. The time taken to strengthen some of the systems required to ensure reduce fiduciary risk by the government continue to be the reason for some DPs to not fully align to government systems.

While progress is being made, significant external funders (PEPFAR and Global Fund) remain outside the pool. Though encouraging signs have been recently seen from the US related organizations on information sharing, transparency on funding for some donors and most NGOs remains a challenge.

[15] GAVI, Issue paper for performance based for GAVI Alliance HSS financing, P 3.
[16] FMOH, 2008, HSDP III MTR Report

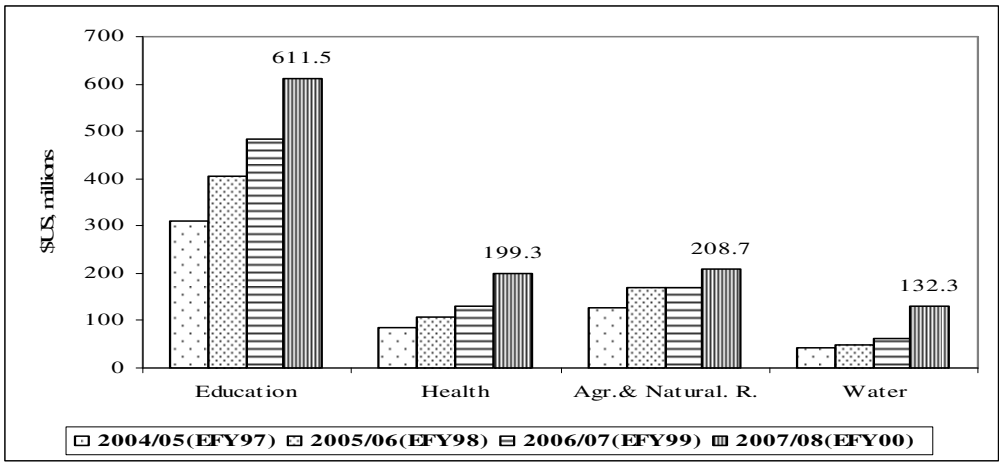
4.3 Additionality and Catalytic Effect

GAVI HSS support is almost certainly additional to government and development partners financing for health. Financing figures do not show any anticipation or displacement effect on the part of government or donors. Rather, GAVI support seems to have had a catalytic effect. Some DP interviewees responded that HSS funding was instrumental in influencing their decision to commit more funding to the health sector.

Yes, but the recent inflation reducing its real value

Government allocation has increased both at the Federal and regional levels, though not at the rate envisaged in the government's own plan. HSDP III aimed to double the share of health in government expenditure by the end of the programme period. In practice, it managed to increase the share from 6% in 2006 to around 7.5% in 2007. Regions have committed more funds for the construction of health centres. Furthermore, regions have allocated increasing resources for service delivery at the sub-national level from the block grants allocated to them as reflected in table 6.

Table 6 Regional Spending on Basic Services, in millions of USD



Source, World Bank, 2009, Project Appraisal Document, page 6.

In addition, PEPFAR has provided funding for 144 health centres. The PBS component II has been used to equip and furnish health posts over the last two years. Procurement of medical equipment for 850 health centers and 7000 health posts worth $24.9 million is underway and requests for procurement of equipment for a further 1100 health centers worth $18.6 million is

under review by the World Bank through the PBS funding[17]. PBS's component one is assisting the availability of additional funding through block grants at facility level for improved quality of care. Development partners that signed the JFA under the MDG Performance Package Fund committed to finance similar activities worth around $100 million in 2009. One can therefore say GAVI and Global Fund investment in strengthening selected health system components have assisted the mobilization of additional funding both from domestic and external sources.

Another interesting issue is that various development partners are funding similar activities to GAVI HSS, showing that they complement GAVI HSS strengthening efforts. The following are some examples of such complementarily, and possibly additionality. In the health extension programme the main contributors providing direct and major support to the HEP are; (1) the GOE (salaries HEWs, construction, supervision), (2) GAVI (health system strengthening and HEW capacity building), (3) Global Fund (equipment), (4) PBS (logistics master plan, equipment), (5) USAID (HEWs and VCHWs training) and (6) UNICEF (health post kits support, RT, HEP website development). In addition, a substantial number of Development Partners also provide indirect support to the HEP through the HSDP III programmatic areas[18] and through several NGOs and special programmes[19] [20]. Of the total 1391 health centers to constructed through external funding, The FMOH has managed to mobilize funding to 212 Health centers from GAVI, 144 from PEPFAR and the remaining 1035 from GFTAM. PEPFAR committed to provide USD 2 billion over 5 years to national health workforce strategies in four countries engaged in the IHP+ - Mozambique, Ethiopia, Kenya and Zambia[21] though the share of each country and actual country programmable amount is not known.

Obtaining the overall health financing information has continued to be a challenge. The following table summarizes the total health sector financing from various sources from two types of sources of data.

[17] FMOH/WB, Joint review and Implementation Support Mission, November 10 – 12, 2008, Aide Memoire, page 27.
[18] The programmatic areas include: (1) child health (EPI and IMNCI), (2) malaria, (3) HIV/ AIDS and TB, (4) maternal health, (5) nutrition, (6) water, sanitation and hygiene and (7) health systems Strengthening (including HEP)
[19] DFID provides support to; (1) Merlin (malaria, nutrition, and EPI), (2) PSI (malaria), (3) DKT (HIV/AIDS and reproductive health) and Action Aid (HIV/AIDS). The European Commission channels part of its support through; (1) Save the Children Fund, AMREF and SOS (health financing) and German Red Cross, Care UK, Christian Aid, Interaide (HIV/AIDS). USAID supports the NGOs; (1) The Carter Centre (training of health officers) and (2) Pathfinder International (maternal and child health, reproductive health, post abortion care, adolescent sexual health, HIV/AIDS/STI). USAID supports the ACCESS programme (survival of mothers and newborn children) and the ESHE programme.
[20] FMOH, HSDP III Mid-Term Review Report, 2008
[21] IHP SURG, IHP+ update for H8, p 2.

Table 7 Trends in health sector financing by major sources in Million USD

Year	Source from OECD database				Calculated from Resource Mapping 2008				
	Bilateral	Multilateral	GF	Total	Bilateral	Multilateral	GHIs	Total	
2002	33	8	0	41					
2003	70	5	28	103					
2004	42	7	0	49					
2005	50	9	25	84	70.5	34.6	28.8	183	
2006	77	8	74	160	50.6	76.7	108.9	320	
2007	66	38	21	125	108.9	113.3	77	311	

Source, Abebe (2009), draft report, Efficiencies of Aid Channels in Ethiopia, page 9

As can be discerned from the above paragraphs, GAVI and Global Fund funds, that are being managed by FMOH, has given the Ministry leverage to negotiate with regional and woreda levels to allocate budget for another health centre for each one put up by these funds. This is an innovative approach that has increased commitment to mobilize additional resource allocation from domestic sources at sub national levels[22]. In this regard, the FMOH has been able to mobilize funding for construction of 1391 health centers from partners and regions, and expects regions to mobilize funds from the Regional and Woreda Councils for 1166 health centers, of which only 411 health centres remain unfunded. Progress is being made in implementing this agreement as shown in table 8.

[22] FMOH, 2008, HSDP Mid-Term Review Report, page 99.

Table 8 The status and source of financing of the construction activities

	Constructed up to (EFY 2000)	Budget allocated for 2001 EFY	Status of implementation in 2001 EFY				Source of funding
			Sites selection	Contract signed	Construction started	Constructing completed	
FMOH*		1391	1201	1010	880	237	Mobilized from 212 from GAVI; 144 from PEPFAR; and the remaining from GFTAM
RHBs		1166	706	631	628	154	Government resources
Total		2557	1907	1641	1508		

*because of the escalating construction prices the allocated fund from the various sources might not be able to finance the completion of the number of health centers constructed.

Source: FMOH, 2001 EFY nine months report, Amharic, April 2009.

4.4 Predictability and flexibility of funding

One of the major strength of GAVI HSS in Ethiopia is its predictability and flexibility. GAVI has disbursed all of its approved funding - $76.5 million as per the approved schedule. This form of funding is unique in the Ethiopian context.

Table 9 The disbursement of HSS funding to FMOH

	Disbursement Date	Disbursed Amount in USD
First Disbursement	12/4/2007	23733388
Second Disbursement	24/09/2007	32105953
Third Disbursement	24/10/2008	12629196
Fourth disbursement	15/03/2009	8,025,938
Total		76,494,475

Another strong area is the flexibility in the use of funds within the overall framework of the HSS proposal with the approval of the Joint Core Coordinating Committee. According to the

information generated from our reviews, re-programming of activities has been made for two reasons: Escalating construction prices and the availability of financing, either from regions and/or other partners. Whenever additional resources are available from other sources for areas that HSS is funding, JCCC reallocates resources to other underfunded areas within the proposal. Stakeholders commended this flexibility and its effect on reducing the transaction costs of reprogramming as one its strong features. This also makes it unique in the Ethiopian setting for allowing significant global resources to be reprogrammed through an in-country shared decision mechanism without prior approval. However, the JCCC itself acknowledges that the process of reprogramming is affected by the lack of information on the overall resource landscape of the sector. While the JCCC have all the information on GAVI HSS funding and its activities, they do not have information of Global Fund, PBS and other sources of funding and their activities and this might have made the basis for reprogramming less solid.

Inclusiveness

The development of the HSDP III has involved most of the health stakeholders. Development partners and FMOH discussed its strategies and targets. The regional health bureaus were consulted in the development process through their bi-monthly meetings. The lower levels are also involved in the annual planning process every year. Parliament has endorsed PASDEP, the PRSP programme, in which HSDP III is chapter. It also debates the achievement and challenges of the health sector for a day each year.

The limitation in this regard is the involvement of the NGOs and civil society. This is mainly because of two reasons. Firstly, since health services are dominated by the public sector, the strategies are mostly inward looking, focusing only on strengthening the efficiency and effectiveness of public health delivery. Secondly, the private sector (be it for or not-for profit) has a very weak network to coordinate and engage with government. The role of patients in influencing strategies is also weak.

Development partners are involved in the development of the HSS proposal. The lower levels are involved in setting the annual targets for HSS as part of their annual plan.

Yes but limited in the participation of NGOs and private sector

Sustainability

As described in the preceding section, sustainability is an issue that does not seem to be well addressed in the HSS interventions. The recurrent and human resource implications of the health service facility expansion are enormous and cannot realistically be financed through domestic resource mobilization alone. Currently more than 75% of resources are allocated to health at lower levels for salary. The implication of more than 2000 new health centres in terms of recurrent cost will be substantial. Since HSDP IV will shift resources from investment to recurrent expenditure (as targets for facility expansion will be met in HSDP III), and since the current trend of increasing the proportion of health expenditure to total government expenditure continues (from 6% in 2005/06 to about 8% in 2008), there will be some room to accommodate the increasing financial resource requirement of the sector. Innovative financing mechanisms (both social and community-based health insurance schemes) are likely contribute only over the medium and long term. Unless finance is available through donors during the interim the large expansion in infrastructure and services contributed to by GAVI HSS might not be sustained.

No, the human and recurrent cost implication does not seem well considered

Table 10 Summary the implementation of GAVI principles and reasons for implementation

No	GAVI Principles and Values	Implemented because of on going country initiatives	Contributed to Fast track systemic improvements	Remarks
1	Country driven	Integrated into the country owned and driven program defined a year a go by the government and country stakeholder		
2	Alignment to country's planning, budgeting and monitoring framework	It followed an in-country developed harmonization manual and the planning and monitoring framework		It required a APR report out side the sector wide agreements
3	Harmonized		Contributed to establishment of the FMOH's preferred modality of aid: The MDG PF.	GAVI has been the only financier channeling its resources to this account since 2007. Seven more DPs have signed to join in 2009.
4	Predictable financial management and disbursement		The most predictable financing in Ethiopia, including its front loading. All approved resources are disbursed to the country.	
5	Catalytic effect		Contributed to providing government to have resources to come up with the concept of 'matching health centre' and negotiate with regional health bureaus for more resources. Other partners have also joined the bandwagon since then (PEPFAR and GFTAM)	
6	Result oriented			
7	Inclusiveness			Yes but limited in the participation of NGOs and private sector
8	Sustainable			The in-country resource mobilization effort alone might not be able to sustain the demand that will be created for more resources by HSS outputs.

5. Is HSS on track to achieve its objectives

5.1 Objectives of the HSS in Ethiopia

According to the proposal, GAVI HSS[23] will contribute to the full implementation of scenario one of HSDP3 which includes: (i) the establishment of 16,250 Health posts, the human resources, equipment, drugs, vaccines, consumables and recurrent funds required to ensure access to quality promotional, preventative and a limited set of basic curative care services (malaria, diarrheal diseases, pneumonia) to 100 % of communities; (ii) the construction of 253 health centres and the upgrade of 1,457 health stations to health centers to ensure access to full primary health care services including basic emergency obstetrical care to 80% of the population. The activities identified as critical to ensure increased access and utilization of quality health services that are proposed for GAVI HSS support fit into three groups:

a) **In the area of health workforce**, the main interventions planned were integrated refresher courses for Health Extension Workers and strengthening apprenticeship for Health Extension Worker trainees;

b) **In the area of supply distribution and maintenance systems** the main activities were the upgrading of 321 health stations to health centers, equipping of 321 health centers (50 type A, 271 Type B), construction of 100 Health posts in regions with very low access to Health services (Somali, Afar, Gambella, Ben-Shangul Gumuz), equipping 6620 Health posts, and support for the initial implementation of the Master Plan for Logistics of Essential Health Commodities; and

c) **In the area of organization and management capacity** the activities were strengthening of Woreda Health Office personnel for management and supportive supervision: Refresher courses (IRT) and technical assistance, transport equipment for 109 Woreda Health offices and IT support for 100 woredas and Monitoring and Evaluation.

5.2 Outputs Produced by HSS support

Health work force mobilization and distribution

The country has been able to train and deploy all the health extension workers (30193) in the agrarian areas of the country, with the support of many partners including GAVI. There is full

[23] FMOH, 2006, GAVI HSS proposal

coverage of rural agrarian areas with two extension workers per Kebele as planned in HSDP III and the GAVI HSS proposal. Of these, it was planned that about 9175 health extension workers will be provided with refresher training up to the end of this Ethiopian fiscal year 97% (or 8941) of the planned target of 9175 was achieved. About 5000 urban health extension workers are now under training. GAVI support was instrumental in getting the refresher training programme started. Another important outcome of HEP is the training and graduation of 2,107,494 model households after taking 106 hours of training by health extension workers. These households are believed to have achieved behavioral change to take care of their own health through better household practices and seeking care when needed. When additional resources come into the sector from other sources, the funds allocated from GAVI for training were reprogrammed towards construction with the approval of JCCC.

Two important factors would have improved the effectiveness of services delivered by health extension workers: The provision of comprehensive treatment for fever (including for pneumonia) and for diarrhea for children; and accelerating the clean deliveries by health extension workers. The first is not included in the HEP program package while the second is constrained as it contradicts the WHO standard for clean and safe delivery.

Though data on attrition of HEWs is not available at national level, some evidence suggests that this may be a challenge in the coming years. Anecdotal evidence collected during the HSDP III MTR in 2008 estimated that the attrition rate in Dire Dawa region was 14% while it was only 1.3% in SNNPR. Reasons for their turnover included unwillingness to stay in a rural area, re-settlement to other areas and search for better employment opportunities. In some other regions, a considerable number of HEWs were also on maternity leave (28%), which impacted negatively on the functioning of the health posts. The MTR recommended an assessment of the level of attrition in order to estimate and train new HEWs to replace the HEWs that have left their job. In addition, it recommended that temporary replacements should be made available to cover HEWs on maternity leave. If the average attrition rate is 10% per year, training 3,000 new HEWs is required on an annual basis. This implies that a number of Technical and Vocational Educational Training Schools (TVETs) have to remain functional[24].

Another activity supported by HSS was the training of health workers on IMNCI. The planned revision of guidelines, development of in-service and pre-service modules, booklets and handbooks took place with 3500 and 4500 copies printed respectively. It was also planned to train 4050 health workers on IMNCI up to the end of 2008/09, to provide integrated refresher

[24] FMOH, HSDP III MTR, 2008.

training for 5580 woreda and health management teams. 1410 were trained on IMNCI and 3893 on integrated refresher training, given the performance rate of 35 and 70% respectively. So far 82% of health centers do have trained personnel on IMNCI. However, the extent to which the trained health personnel are functioning as per the guidelines are yet to be assessed and this has become the bottleneck for further training and allocation of the resources to this activity. The turnover of staff trained in IMNCI within and outside the health facility also contributed to weak performance IMNCI activities.

5.3 Supply Distribution and maintenance system for PHC drugs, equipment and infrastructure

Health centre and health post construction

One of the major activities planned under GAVI HSS was constructing /upgrading 212 health centres and, constructing 100 health posts. So far, and with the support of other partners, 287 health centers have been completed and handed over; while contracts have been signed for another 1010, of which 880 are under construction.

GAVI HSS kick-started this phenomenal expansion of primary health care. It was the first partner willing to invest a significant part of its resources in construction. The plan to initially construct over 500 through all sources of financing new health centres (or upgraded health posts and clinics), offering OPD, BEmONC and 10 bed in-patient facilities, placed a high demand on the limited administrative and technical resources in the health system, resulting in the outsourcing of the management of the construction of HC to GTZ. GTZ was recruited to provide implementation support. The experience of GTZ was unsatisfactory and a year ago the FMOH established an embedded PMU within the government structures to take over this role. The PMU is now pursuing the construction of another 891 health centers, bringing the total donor financed health centers to 1391. Though the degree of effectiveness varies from region to region, the PMU managed to ensure that beneficiary communities monitor progress and quality of construction on a daily basis. The effect of this massive investment in construction has also brought about another development within the institutional arrangement of the FMOH. Through the recently concluded Business Process Re-engineering[25], the federal MOH has established a Directorate for Public Health Infrastructure.

[25] Business Process Re-engineering is a process that assesses the procedural; structural and capacity constraints and redesign the government structure alone process rather than functional lines. FMOH is restructured based on the outcome of this process

Regarding the construction of health posts, 70 health posts are constructed in the four regions supported by GAVI HSS[26]. While three of the four regions managed to construct only ten health posts instead of 25, one region has managed to construct 40 health posts by ensuring additional community contribution to the construction cost. This is another example of catalytic impact at community level/additionality. The lack of sufficient progress in constructing the necessary number of health posts in some regions is related to the lack of adequate resources and the erosion of its value due to escalating construction materials costs in the country. The limited availability of building materials in the arid and semi-arid areas, further impacts negatively on the communities' ability to construct health posts. The provision of local materials (e.g. cement, nails, and iron sheet) is a pre-condition of receiving matching support from the Woreda health office, the GOE and NGOs in the pastoralist areas (either financial or material).[27]

Other causes of delay of the construction of health centres include difficulty in accessing remote areas; a limited pool of competent building contractors; the rapidly increasing cost of commodities, particularly cement and steel. The JCCC is reprogramming the funds that are allocated for other areas into this component to ensure that most of the infrastructure is in place by the end of HSDP III. As can be seen from table 8 above, budget is allocated to cover the investment cost of 2557 health centers, about three times as many as the available health centers in the country.

Equipment of health centers and health posts

GAVI HSS is expected to contribute significantly to the procurement of equipment for both health centers and health posts. HSS plans to provide funding to fully equip 7340 health posts and 300 health centres. The procurement of health post kits was carried out through UNICEF. So far 3670 health post kits have been procured and distributed, while the remaining 3670 are being distributed. The procurement of equipment for 300 health centres is being carried out by the PFSA (Pharmaceutical Fund and Supply Agency). A letter of credit was signed and consignments of goods are expected to reach the country in the next three to four months. It is expected that the procurement and distribution of health centre equipment will be completed in 2009. This activity seems to be on schedule.

[26] MOH, 2009, APR 2008
[27] FMOH, HSDP III MTR report

5.4 Organization and management of health services at district level and below

Support to the PFSA

The planned activity in this sub-theme was to support the implementation of the Logistics Master Plan. In the process of implementation, the USAID project (Commodity Management and Supply Chain project) was able to finance some of the activities that were included in the GAVI HSS Plan. Consequently, the HSS funding has been reprogrammed to contribute towards strengthening the storage capacity of PFSA by financing the construction of a warehouse within the PFSA compound. The design of the store was financed by PEPFAR and the tender for construction is currently open. PFSA is also using these funds in a catalytic manner as it assisted (i) in influencing CMSC rent for the warehouse on the understanding that there will be constructed warehouses later and (ii) enabling PEPFAR to construct steel framed warehouses once the foundations were financed through GAVI HSS.

Strengthening HMIS

The health management information system was redefined and re-engineered to make it more efficient and effective. Its implementation so far is not progressing as planned because of the huge financial requirement. When the GAVI HSS Project plan was formulated the Re-engineering of HMIS was in process the cost of scaling up was not fully known. The training of hospital level staff on HMIS tools was completed. The electronic family folder that will be used as the basis for collecting and updating all information at the household level has been designed and pilot tested in Dire Dawa region. Training for health centre staff is ongoing. Resources allocated for IT equipment for 109 woredas were able to finance the procurement for 180 woredas without reducing quantity.

There are a number of challenges in the implementation of this important reform. The scaling up of the reformed HMIS requires the employment of a number of information officers at regional and facility levels, which for the time being, has become the major challenge for the bigger regions to finance. It also requires huge financial resources for IT equipment. According to stakeholders the speed with which the HMIS is scaled up is rather slow and the participation of stakeholders in the implementation process is weak, compared to its design phase. The country is still collecting information from the reformed and old HMIS systems that are running in parallel. The weaknesses that were identified in terms of quality, timeliness and reliability of information during the design phase are still valid today and will remain until the redesigned HMIS system is scaled up nationwide.

Table 11 Summary of HSS annual plan and its achievement by HSS activities

	HSS activities	HSS plan				HSS achievement				Comments on the Achievements as compared to the plan	Degree of Achievement
		2006/07	2007/08	2008/09	Total	2006/07	2007/08	2008/09	Total		
1	Health worker mobilization, distribution and motivation										
1a	Intergraded HEW IRT training	4950	13250	3425	21625		24571	5622	30193	Realized	140%
1b	Support to HEW apprenticeship	0	5750	3425	9175			2275	8941		97%
1c	Training of HC staff on integrated management of neonatal childhood illnesses	1350	1350	1350	4050		656	754	1410	Supportive supervision on and assessment of the impact of training delayed further training	35%
1d	Intergraded refresher training of Woreda and health centre management team	1860	1860	1860	5580			1974	3893		70%
2	Supply Distribution and maintenance system for PHC drugs, equipment and infrastructure										
2a	Upgrading Health stations to health centre (construction)	35	71	71	177					GTZ over paid and re-programming has to be done before last	0%

	HSS activities	HSS plan				HSS achievement				Comments on the Achievements as compared to the plan	Degree of Achievement
		2006/07	2007/08	2008/09	Total	2006/07	2007/08	2008/09	Total		
										disbursement is made.	
	Equipping Type A HC	10	10	10	30		353	300*		In process	?
	Equipping Type B HC	45	90	90	225						0%
2b	HP construction				100				76*	On process in the four regions. Best example Benishangul	76%
2c	Equipping health posts				7340		2069	3670	3	Another 50% are being delivered currently	100%
3	Organization and management of health services at district level and below										
3a	Strengthening M&E										
	Procurement of computers, printers and UPSs for Woredas				109			109	109		100%
	Roll out of HMIS										
	Annual regional HEP review	1	1	1	4		1	1	1		100%

	HSS activities	HSS plan				HSS achievement				Comments on the Achievements as compared to the plan	Degree of Achievement
		2006/07	2007/08	2008/09	Total	2006/07	2007/08	2008/09	Total		
3b	Procurement of vehicles				109				134.00	Additional 25 vehicles were procured with the remains fund with programming approval of the JCCC	123%
	Support to initiate implementation of the health commodity supply system									PFSA requested the reprogramming c this fund towards construction of hubs. JCCC has approved this reprogramming	

HSS Spending

GAVI has disbursed all the funding that it has approved to the country for HSS including the recently approved CSO support. Overall, GAVI has disbursed a total of $76.5 million in four tranches for HSS, the latest of which was in March 2009. From the analysis of the proposal and the approval letter, the funding is released not only as per schedule but using the principle of front-loading to ensure the funding obtains the advantage of scale in bulk procurement. Ethiopia is one of few countries that requested and was granted this front-loading of resources. GAVI support is more predictable than any other source of funding for health in Ethiopia at the moment. This funding is planned to be used for four years, including for the following financial year. The status of disbursement for GAVI and within the country as well as actual expenditure is presented in the table 12. Of these total disbursements, 51.5% have been spent, and 36.5% have been transferred to the implementing agencies for implementation.

Table 12 Liquidation of disbursement by various HSS implementing units

Financial categories		
Disbursement from GAVI		**701,139,717**
Total Expenditures		
Regions	67,477,745	
GTZ	185,952,216	
UNICEF	73,900,808	
UNDP	23,251,544	
MOH	7,472,435	
Ethiopian pediatric Institutions	3,276,000	
Total	**361,330,748**	**339,808,970**
Regions*	57,157,488	
GTZ	-	
UNICEF	118,500,282	
UNDP	-	
MOH		
Ethiopian pediatric Institutions	-	
PFSA	80,276,976	
Total	**255,934,745**	**83,874,224**

Source, Finance and Supplies Directorate

Of the total resources disbursed to the implementing units of GAVI HSS, the financial returns (statement of expenditures with their supporting documents) of about 65% of the total disbursement remains to be submitted. While about 49% of invoices to be collected are due to the slow/late procurement process of UNICEF, the major concern is ensuring the liquidation of funds released and spent at regional levels; accounting for about 16% of the un-liquidated fund. From these non-liquidated funds, the three large regions (Amhara, Oromiya and SNNPR) account for close to 75% (see table 13). The major reasons for not submitting invoices and their supportive documents are a lack of financial management capacity at the Woreda finance bureau levels and the ineffectiveness of the pool financial management system. Woreda Finance and Development offices serve a number of sectors. Even if it is cost effective in centrally serving several sector offices, the pooled financial system is operationally organized across functional structures rather than being process-oriented. It often lacks transparency and causes additional transaction costs.

Table 13 Distribution of non-liquidated funds by region

Region	Not liquidated fund	%
Harari	1,155	0.0%
Addis Ababa	119,605	0.6%
Dire Dawa	156,268	0.7%
Gambella	740,513	3.4%
Afar	972,326	4.5%
Somali	972,951	4.5%
Tigray	983,914	4.6%
Benishangul Gumuz	1,783,873	8.3%
Oromiya	3,297,349	15.3%
SNNPR	5,134,799	23.8%
Amhara	7,433,007	34.4%
Total	21,595,760	100.0%

Source: Finance and Supplies Directorate

Major efforts are underway in the regions to increase the submission of financial statements (invoices) with their supportive evidences. There is close ongoing monitoring by the political leadership both at the federal and regional levels (weekly at the federal level and monthly with regions) to ensure funds are accounted for. Accountants are sent to the regions to collect

statement of expenditures (SOEs). The FMOH is also undertaking a study to know the process bottlenecks in the accounting of funds using the pooled system and to come out with a liquidation business process reengineering that might require the approval of Ministry of Finance and Economic Development and the Council of Ministers.

The main conclusion in terms of spending is that all the resources approved for Ethiopia have been disbursed. Of these about 51.5% were spent and accounted for, 36.5% is under implementation and the remaining is yet to be accounted. While liquidation of resources is an issue at the moment, the commitment of the FMOH to get into the root cause of delays provides confidence that these resources will be accounted for.

Health Outcomes

The HSS interventions in Ethiopia have been targeting wider and upstream health systems issues that affect immunization but also other health services. There has been progress since 2005/06 (HSDP III) in improving the health outcomes in this country. Many health outcome indicators in the health sector have improved since the HSS funding initiated. The extent of improvement however varies from service to service. DPT 3 coverage, vitamin A supplementation and de-worming have recorded achievements better than the targets outlined in the HSS proposal. The rest of the indicators have improved but did not reach the targets set for them in the proposal. It is reasonable to believe that GAVI HSS has substantially contributed to the results obtained; however, the methodology for this evaluation does not allow attribution of results to the particular efforts of GAVI.

The full impact of these improved health outcomes on infant, child and maternal mortality can only be known when the next DHS results are released. The impact of GAVI HSS interventions – as well as support from other partners and from Government itself – contribution to improving health impacts will take time to appear and even more to measure them.

Table 13 Comparison of HSS outcome targets and current level of achievement

Outcome indicators	Baseline in 2005	Target of HSS by 2008/9	Current status
Pentavalent (DPT3) coverage(from 69% baseline 2005)	69%	80%	81%
Measles coverage (from 59% baseline 2005)	59%	75%	72%
% of children 6-12months having rec. Vit. A last 6 months	91%	60%	94%
% of children12-59 months rec. Albendazole last 6 months	92%	60%	100%
% of children with Diarrhea receiving ORT/ORS at HP level		50%	
% of deliveries with skilled birth attendant or trained HEW		40%	23%
% of children treated with the IMNCI protocol at HC level		40%	31%

Source: FMOH, various publications, including GAVI HSS proposal, APR reports and health and health related indicators.

The improvements noted above should not obscure the fact that present levels of services and development outcomes are still low and that Ethiopia is below the Sub-Saharan average for several indicators. In spite of progress in expanding services, progress is not always even as disparities persist across gender, income groups, and Regions, and differential performance exists in different sectors.

The recently concluded PBS programme, phase 2 appraisal document, suggests that the challenge in meeting MDG targets are threefold: Sustaining the momentum built; complementing broad-based efforts with targeted interventions to bridge the “last mile”; and accelerating efforts where performance lags behind the required rates of improvement. It recommends that expansion of service delivery needs be sustained and supplemented by improvements in the efficiency and quality of services.

One of the main requirements in this regard is that financing for services increases at a pace commensurate with needs. Yet, despite resources at decentralized levels in Ethiopia increased in recent years, the latest analysis shows per capita spending on basic services (education, health and water) at the sub-national level (regional level and below) was only about USD13.7 in 2007/08, showing a high financing gap in these services to reach the MDGs (USD2.1 billion in basic services over FY2009-2011).[28] The uncertain macroeconomic environment over the last

[28] WB, Protecting Basic Services phase II, PAD, 2008.

two years, together with the global economic downturn, will affect the availability of resources (both domestic and aid) for expanding basic services in Ethiopia[29.]

SUMMARY: overall the country seems to be on track in the implementation of HSS. A number of points are worth highlighting:

- There are delays in some of the activities of the HSS, particularly construction. The outputs planed under HSS are likely to be realized in the remaining implementation period. The level of commitment by the leadership and management of the health sector to get the bottlenecks removed provides confidence for such a conclusion;
- while utilization of financial resources is sound, challenges of submitting financial returns (invoices) remain. The effort that is being made by the sector is likely to address the question of outstanding balances that still need to be accounted for.

The impact of the HSS in terms of contributing to reduced child and maternal mortality rates and the extent to which Ethiopia is on track to achieve MDGs can only be know when the next DHS is released.

[29] Ibid.

6 Is HSS in Ethiopia worth doing? The counterfactual analysis

As described in the preceding sections, the interventions that GAVI HSS supported are health systems issues that have so far been the major bottlenecks to provide accessible and quality health services in the country. Indeed the interventions indentified for financing through GAVI HSS will help to ensure an accelerated effort (on the part of the country) to meet the MDG goals; including those related to child health and immunization.

The GAVI HSS funding has helped to bridge some of the funding gaps to reach the unreached areas through expansion of primary health care. The interventions selected for HSS funding are relevant and will contribute to the country's effort to meet the MDG goals. Indeed, the health expansion achieved or being implemented with this big scale and high speed, in tandem with other sources of funding, will contribute in the coming years to the likely improvement of health outcomes. The team concluded from the preceding analysis that the GAVI HSS was worth doing. Had GAVI HSS funding not been available:

- The achievement obtained so far would have been reduced because of the scale of the support (about 8% of the funding gap).
- Other development partners might have not put their money into the sector as that critical point in time (election problems).
- The involvement of GAVI HSS on increasing access through construction and equipment has had a catalytic effect for domestic and even partner funding. Those who were not willing to finance such efforts before are now joined through these efforts.
- The health extension programme might have not been implemented as fast as it is now and the quality of the service may have been reduced.
- The development of the MDG performance fund (the pooled account for the health sector) may have been delayed even further.
- The credibility of the country system to be used to channel aid resources may not have been established. Furthermore, the role of an in-country resource approval process (JCCC) would not have been demonstrated.

6.1 Suggestions for improvement

- The country is instituting sector monitoring frameworks for tracking progress in the health sector. The use of sector annual performance and JRM reports instead of the GAVI APR will not only strengthen the country systems but also will reduce transaction costs. However as Ethiopia moves to sector monitoring frameworks, it may be necessary to ensure that these reports reflect the contribution of HSS in terms of activities and funding. It is important that GAVI follow through what it has initiated in the form of MDG PF and fully align with its financial management and activity reporting.

- Currently the GAVI Alliance is funding the health sector through three modes: (ISS, HSS and civil society). Stakeholders in Ethiopia suggested that GAVI should work towards bringing all the three funding arrangements together and form a wider health systems funding modality.

- GAVI's strength in the Ethiopian case has been its ability to fund the perceived needs of the health sector as identified by counties. Its future support should be built around more trust and analysis of the country's strategy and programme. The application process should reduce as much as possible the competition for funds and assist countries to meet the gaps in their strategic plans. As far as possible GHIs should avoid dictating terms to in-country stakeholders on what and what should not be done.

- In the event that a global health fund is established by merging GAVI and GFATM HSS components, it will be necessary to use GAVI values and principles to guide any future design. The use of systems outside government and its independent validation system together with its separate governance structure makes the Global Fund's mode of financing less attractive as it has more transactions cost. The use of government preferred aid modalities should be respected.

Annex 1 Interview List

No.	Name	Responsibility
1	Dr Tedros Adhanom	Minster of Health, FMOH
2	Dr Nejimudin Kedir	Director General, Planning, policy and Resource Mobilization
3	Mr Rick	Head , program management unit for construction
4	Ato Wodnwossen Ayele	Deputy Director, Pharmaceuticals Fund and Supply Agency
5	Kiros	Deputy Director, Policy , planning and monitoring
6	Anchin Alu	Director, finance , procurement and supplies
7	Roman Tesfaye	Director, Resource Mobilization
8	Ato Noah Elias	Focal Person, GAVI HSS
9	Partners	
10	Vivian Van Steirteghem ..	Deputy Rep, UNICEF
11	Chris Gaukler	Consultant Economist, Human Development, world Bank
12	Ethiopian Pediatric Society	IMNCI training
13	JCCC	Group interview with membership of the JCCC

Annex 2 List of Documents reviewed

Abebe Alebachew, (2009), Efficiencies of Aid Channels in Ethiopia, as part of the HLSP report to NORAD.

Central Statistical Agency, 2006, Ethiopian Demographic and Health Survey, Addis Ababa, Ethiopia.

FMOH, 2005, Health Sector Development Program III.
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FMOH 2007a, Ethiopia's Letter to GAVI Secretariate, 15th January.

FMOH 2007b, GAVI Annual Performance Report.

FMOH 2008a, HSDP Mid Term Report, final Report.
FMOH 2008b, GAVI Annual Performance Report.

FMOH 2008c, MDG Appraisal Consolidated Report.

FMOH 2009, 2001 EFY nine months report, Amharic, April 2009.

GAVI Alliance Secretariat, 2007, Minutes of GAVI Alliance and Fund Board Meeting, 11-12 May.

GAVI Alliance Secretariat, 2006a, Letter to the FMOH Ethiopia, 24 November.
GAVI alliance 2006b, Update on Health systems Strengthening, Alliance and Fund Joint EC meeting – 23 March .
GAVI Secretariat 2006c, GAVI Health Systems Strengthening Task Team (HSS TT) Minutes of 2nd Face to Face Meeting, 13 – 14 September 2006, Geneva.

WHO, IHP Ministerial statements, February 2009.

World Bank 2008a, Protecting Basic Services Phase II, Project Appraisal Document, 2008.

World Bank, 2008b, PBS Joint Review and Implementation Support Mission, November 10 – 12, 2008, Aide Memoire.

Annex 3 Summary of Methodology

The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be **complemented by the results of 6 on-going GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.

Annex 4 Typology of areas for HSS support

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA ($50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	*Internal process*	IRC-HSS
IRC recommendations	*Internal process*	IRC-HSS
Decision on proposals	*Internal process*	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring