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Health Systems Strengthening Tracking Study
GAVI RFP-003-08

Ethiopia Country Case Study

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Acronyms

ACIPH	Addis Continental Institute of Public Health
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARM	Annual Review Meeting
ART	Anti Retroviral Therapy
ARV	Anti-retroviral
BCG	Bacillus Caulmette Guerin
BEOC	Basic and Emergency Obstetric Care
BOF	Bureau of Finance
BOFED	Bureau of Finance and Economic Development
CBOs	Community-based Organizations
CHAs	Community Health Agents
CHWs	Community Health Workers
CJSC	Central Joint Steering Committee
CSA	Central Statistical Authority
CSOs	Civil Society Organizations
CSRP	Civil Service Reform Program
DOTS	Directly Observed Treatment Short Course
DPT	Diphtheria, Pertussis and Tetanus Vaccine
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic and Health Survey 2000
EFY	Ethiopian Fiscal Year
EHSP	Essential Health Service Package
EOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
ESHE	Essential Services for Health in Ethiopia
EU	European Union
FBOs	Faith Based Organizations
FGOE	Federal Government of Ethiopia
FMoH	Federal Ministry of Health
FY	Financial or Fiscal Year
GAVI	Global Alliance for Vaccines and Immunization

GC	Gregorian Calendar
GDP	Gross Domestic Product
GFATM	Global Fund Against AIDS, Tuberculosis and Malaria
GNP	Gross National Product
GOE	Government of Ethiopia
HCs	Health Centers
HCSS	Health Commodities Supply System
HEP	Health Extension Programme
HEW	Health Extension Workers
HF	Health Facility
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPs	Health Posts
HRD	Human Resource Development
HSDP	Health Sector Development Programme
HS	Health Stations
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Committee
IMCI	Integrated Management of Childhood Illnesses
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Nets
JCCC	Joint Core Coordinating Committee
JCM	Joint Consultative Meeting (FMoH and HPN group)
JRM	Joint Review Mission
JSI	John Snow Incorporated
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MOFED	Ministry of Finance and Economic Development
MTR	Mid Term Review
NGOs	Non Governmental Organizations
NHA	National Health Accounts
NNT	Neonatal Tetanus

PPF-GD	Policy , Programming and Finance General Directorate
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
RED	Reaching Every District
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
RTCs	Regional Training Centers
SNNPR	Southern Nations Nationalities and Peoples Region
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WorHO	Woreda Health Offices
ZHD	Zonal Health Department

Executive Summary

The Global Alliance for Vaccines and Immunization (GAVI) was launched in 2000 to increase immunization coverage and reverse widening global disparities in access to vaccines. The partnership includes governments in industrialized and developing countries, the United Nations Children's Fund (UNICEF), World Health Organization (WHO), World Bank, non-governmental organizations (NGOs), foundations, vaccine manufacturers, and public health and research institutions working together to achieve common immunization goals. Health systems strengthening (HSS) grants are a relatively new addition to GAVI's funding portfolio. The GAVI Alliance created this new funding window in 2005 based on a multi-country study that identified system-wide barriers to higher immunization coverage. Currently, a total of US $800 million is available from GAVI for HSS to help countries address difficult health systems issues such as management and supervision; health information systems; health financing; infrastructure and transportation; and health workforce numbers, motivation and training.

The GAVI Secretariat, along with its inter-agency HSS Task Team, sought an interim assessment of the HSS application and early implementation experience, with a focus on how countries are planning, budgeting and implementing their programs. With this purpose, GAVI awarded JSI Research and Training, Inc. (JSI) a contract to work with its partner organization in Sweden, InDevelop-IPM, to jointly implement the tracking study. The HSS tracking study was designed to provide real-time evidence from the country level regarding the technical, managerial, and policy processes of GAVI HSS grant implementation. The tracking study spanned a period of 13 months (August 2008 to September 2009) and produced Case Studies in six HSS-recipient countries. One of those countries is Ethiopia.

With a population of 73.9 million, Ethiopia is the second most populous country in Africa. Its annual growth rate is 2.6 percent, and its population increases annually by 2 million persons. Located in the Horn of Africa, Ethiopia is one of the least urbanized countries in the world, with 84 percent of its population living in rural areas. The gross national income per capita stands at US $220—far below the sub-Saharan average of US $952. Nearly 4 out of 10 (39 percent) Ethiopians live below the international poverty line of US $1.25 per day.

Ethiopia's health status is poor relative to other low-income countries, including those in Sub-Saharan Africa. While under-five mortality rates are consistently declining, they remain high, with most recent survey estimates placing under-five mortality at 123 deaths per 1,000 live births. Levels of DPT3 coverage have shown a steady increase, with current coverage reaching 73 percent of the targeted population (surviving infants). However, regional disparities are wide, with the Somali and Gambella regions reporting DPT3 coverage rates of 15 percent and 35 percent, respectively.

Against this background, the GAVI Alliance has supported the immunization program in Ethiopia since 2001, with total support equaling US $401,100,819. GAVI support is provided to the Expanded Program on Immunization (EPI), which is run by the Ministry of Health (MoH) in collaboration with WHO, UNICEF and other partners, and is implemented by health bureaus located in each of Ethiopia's nine regions. The EPI program seeks to increase DPT3 and measles coverage to 95 percent by 2009. By 2007, 32 percent of woredas (or districts) reported DPT3 coverage greater than 80 percent as a result of implementing two approaches: Reaching Every District and Sustainable Out-reach Services.

The Government of Ethiopia (the Government or GOE) submitted an initial GAVI HSS proposal on 30 October 2006. The Independent Review Committee (IRC) reviewed and approved it with clarifications. Based on the recommendations of the IRC, the GAVI Alliance Board approved the country proposal on 1 March 2007. GAVI

released the first tranche of HSS funding, totaling US $23.7 million, only eight weeks later (4 April 2007). For Ethiopia, the entire period between GAVI HSS proposal submission and the receipt of the first tranche of funds was only seven months.

The Addis Continental Institute of Public Health (ACIPH), working under contract with JSI, Inc., conducted this study with the following objectives:

- Assess the progress and underlying factors in the management, coordination and financial mechanisms that support HSS implementation at the federal, regional and woreda levels.
- Assess the status of the implementation with particular focus on the performance measures included in the Federal Ministry of Health (FMoH) application for HSS funds.

Phase 1 Methodology

During Phase 1, three members of the HSS Tracking Study core team made an initial assessment visit to Ethiopia (10-21 November 2008). Using a semi-structured interview guide, the Study Team conducted 25 interviews with individuals who were either involved in the HSS application process or knowledgeable of its implementation or of HSS efforts in Ethiopia generally. In addition, the team conducted an extensive review of documents on Ethiopia's health system strengthening efforts.

Phase 2 Methodology

In Phase 2, a range of study methods was utilized. Given the time and resources available, three regions and two woredas within each region were selected as primary study areas, purposively using regional-level selection criteria, including population size, GAVI HSS funding amounts, and absorption and liquidation capacity. The Amhara and Oromia regions were selected based on population size and significant funding received from the HSS GAVI. The Afar region was selected as representative of the emerging regions and for its role in the construction of health posts using GAVI-HSS funding.

In each region, the ACIPH research team, together with experts from the region, selected zones and woredas using criteria described in the Case Study. In each woreda, the main health center and its satellite health posts were included in the study. A team of three experts collected data in each study unit, using document and record reviews, interviews of key informants, and observation of health facilities. The team spent one week in each selected woreda. Across the three regions, 43 individuals at various levels were interviewed. Facility observations were conducted in 6 health centers and 20 health posts. The field work was conducted from mid-April to mid-May 2009.

Ethiopia has a very dynamic environment in regard to health systems strengthening, harmonization and alignment, and health reform. FMoH efforts include:

- implementing the Business Processes Re-Engineering (BPR),
- initiating a new pooled-funding mechanism called the Millennium Development Goals Performance Fund (MDG-PF),
- becoming involved in an International Health Partnership Compact with development partners,
- adapting the Protecting Basic Services model in partnership with the World Bank, and
- initiating a Joint Financing Agreement (JFA), which will, in effect, spark fuller use of the MDG-PF and other available resources for health development.

These and other significant efforts—such as the changing mandate for the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) in regards to HSS—set the stage for the discussion of HSS and GAVI's role in Ethiopia.

Ethiopia's overall HSS efforts are guided by the national Health Sector Strategic Plan (HSDP-III) being implemented from 2003/04 to 2009/10. A major element of that Plan is reaching all rural kebeles with the Health Extension Program (HEP), an initiative designed to deliver health promotion, immunization and other disease-prevention measures, and a limited set of high-impact curative interventions.

At the core of the HEP is an outreach program intent on posting two Health Extension Workers (HEWs) and constructing and equipping a health post in each kebele. The Mid-Term Review (MTR) of the HSDP-III found that HEP was making substantial progress towards achieving these results, notably:

- By the end of the Ethiopian Fiscal Year 2000, there were 11,000 health posts in place against the HSDP-II target of 15,000, representing 73 percent coverage. With construction work continuing, the MTR team concluded that the target is likely achievable by the end of HSDP-III.
- HEP aims to train and place a total of 30,000 HEWs to ensure two HEWs per health post. The MTR found 82 percent achievement of this target, with 24,500 HEWs trained and deployed. The target is expected to be met by the completion of HSDP-II.

HEWs are recruited locally, trained for one year, formally employed and salaried through woreda budgets. They offer key technical services, such as immunization and family planning. The MTR concluded that there are strong indications that HEP has contributed to improved health-seeking behavior although the data required to substantiate this finding are still being generated.

Governance and funding

Governance of the HSDP-III is guided by a Harmonization Manual, which includes a Code of Conduct developed in 2005 and signed by 14 development partners. At the highest level, the governance structure for HSDP-III is the Joint Government-Donor Steering Committee (CJSC), the top policy-making body in health, which oversees and coordinates HSDP-III implementation. The Policy, Planning and Finance General Directorate (PPF-GD) of the FMoH serves as the secretariat to the CJSC. A Joint Core Coordinating Committee (JCCC) serves as a functional, technical arm of the Joint Consultative Forum of FMoH/HPN and the Health Sector Development Programme Secretariat.

> "We see GAVI HSS support as an important breakthrough in improving aid effectiveness, thereby enabling us to achieve greater improvements in health outcomes per dollar of aid that we received from all sources."
>
> -Ethiopia HSS Proposal

Cost estimates and scenarios[1] for HSDP-III were prepared using the Marginal Budgeting for Bottlenecks method and tools. Over its life, Scenario 1 of HSDP-III is estimated to cost US $2.26 billion. The projected finance gap for Scenario 1 is US $562 million, or 25 percent of the total. The MTR notes that global health initiatives such as GAVI and the Global Fund have become significant contributors and that these funds are being used by the FMoH to catalyze increased regional and woreda allocations to health through a "matching agreement" for the construction of new health facilities.

Several channels exist for the funding of the Ethiopian health sector through Government and donor sources. These channels, which vary by characteristics, represent for FMoH a fragmented approach to financing the health sector, with each bringing a varying degree of flexibility and predictability.

[1] The HSDP-III strategy lays out three costing scenarios, each with differing levels of population coverage and scenarios for the achievement of MDGs.

Within these funding streams is the relatively new MDG-PF. Established in 2005, MDG-PF is a pooled fund managed by the FMoH following established Government procedures to ensure transparency and accountability. To date, the MDG-PF has supported the HEP, maternal health programs and technical assistance. Until early 2009, the MDG-PF operated with one participating donor: the GAVI health systems strengthening grant awarded in 2007. In April 2009, the Government and seven development partners[2] signed a new Joint Financing Agreement, which will substantially expand the use of the MDG-PF.

Looking forward, the MTR recommended that the Government seek to consolidate the successful gains made in the expansion of health services at the kebele level and that it focus on implementation capacity at the woreda level, which was deemed to be weak, thereby affecting service delivery. The MTR team pointed to the "unprecedented facility expansion of health posts and centers and the staggering numbers of HEWs that are being trained and deployed in the sector" and advised that increased attention be placed on the associated budgetary requirements for operational costs, which the MTR felt were not fully addressed.

Processes and content

The Ethiopia country proposal was developed through a well-coordinated process by the FMoH and its development partners. The GAVI HSS proposal was developed immediately after a thorough consultative process used for developing the HSDP-III. The HSDP III development process—which involved all departments of the FMoH, all levels of the health system, development partners, and an umbrella organization of civil society organizations (CSOs) and NGOs—identified health sector priorities and key gaps. The GAVI HSS proposal development benefited from that process immensely and used similar procedures in finalizing the proposal, which was approved by the existing coordinating bodies, comprising broad membership from the Government, development partners and CSOs, and endorsed by the JCCC.

One respondent called the HSS proposal "the first and best document of this type."

Stakeholders involved in the process were remarkably consistent in their praise for the GAVI HSS proposal development, calling it Government-led, participatory and focused on key priority gaps in the health system. At the central level, almost every respondent mentioned the flexibility of the GAVI Alliance in terms of its support to health systems.

Recognizing the need to greatly increase access and utilization by health services to improve primary health care coverage, the proposal sought to rehabilitate and expand existing facilities and ensure they are staffed by appropriately trained and motivated personnel with access to regular supplies of vaccines and drugs and to effective technical and administrative support. In accordance with this objective, the proposal outlined an allocation of resources by GAVI HSS themes (Table 1).

The largest activities under these themes are (a) upgrading health stations to health centers and (b) equipping health posts. These two account for 50 percent of all GAVI HSS funding in Ethiopia. The proposal's approach to these priority areas was to capitalize on existing mechanisms through FMoH contracting. Accordingly, the GAVI HSS funds in Ethiopia are used at the central level (approximately 77 percent of all HSS funds) primarily to coordinate and manage the procurement of equipment, supplies, and facility construction on behalf of the woredas/regions. The remaining funds (23 percent) are distributed to regions according to an established equity formula used to allocate health sector funds.

As the support is designed to assist the overall performance of the Ethiopian Health System and activities were aligned with HSDP priorities, the GAVI HSS did not consider targeting specific geographic areas.

[2] The Department for International Development (DFID, UK), The Spanish Development Cooperation, Irish Aid, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank and the World Health Organization.

Costs and allocation

The total approved value of the GAVI HSS grant is US $76.49 million. The unit costs established for the GAVI HSS funding proposal are consistent with the costing assumptions used for the HSDP-III and were linked to costing scenarios generated for the HSDP-III.

Executive Summary Table 1: Executive Summary: Allocation of the GAVI HSS Funds by Themes, Ethiopia

	GAVI HSS themes	% of total budget
1	Health workforce mobilization, distribution and motivation	18%
2	Supply, distribution and maintenance for PHC drugs, equipment and infrastructure	62%
3	Organization and management of health services at district level and below	20%

The proposal allocated the majority of HSS resources for capital investment (including basic equipment and construction) in anticipation that recurrent costs (maintenance, salaries and operating costs) would be covered through Government budgetary sources, along with pooled funds available through the Protecting Basic Services (PBS) grant. In addition, as a goal of the HSDP-III, the Government is expected to increase its overall allocation to the health sector by 60 percent.

The GAVI HSS proposal specified that funds would flow through the MDG-PF and, once received in the FMoH, would be disbursed through the following means:

- FMoH contracts for goods and services would be delivered at regional, zonal and woreda levels. Contracts were to be developed with Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (GTZ, German society for technical cooperation), UNICEF, and the Ethiopia Paediatric Society.
- FMoH funds would be transferred to other federal-level units and agencies. Recipients include Pharmaceutical & Medical Supplies Import & Wholesaler Share (PHARMID) and the Health Extension Program of the FMoH.
- Funds would be transferred to the regional health bureau for transfer to the zones and woredas.

CJSC has overall responsibility for approving annual plans, budgets and quarterly progress reports for use of the GAVI HSS funding. PPF-GD provides management and oversight of the fund and its activities. The proposal specified that two additional staff, a program manager and an accountant, would be required in PPF-GD to perform these functions.

Indicators

The proposal included a set of indicators to be monitored:

- HSS inputs,
- HSS outputs and activities,
- outcomes - capacity of the system,
- outcomes - impact on immunization, and maternal, newborn and child (MNC) interventions, and
- impact on child mortality.

For the inputs and outputs, indicators are presented for each of the three theme areas. The proposal provides neither definition of indicators, information on the frequency of collection or reporting nor where baseline

data are available. The IRC review of the Ethiopia proposal noted that the monitoring framework was "slightly weak," with some baselines and data sources missing. This is due to the fact that during the proposal development it was difficult to use the HSDP-III indicators as the Health Management Information System had not yet been scaled up. Therefore, the FMoH and its partners decided to select indicators other than those in the HSDP-III.

Strengths and weaknesses

The primary strength of the GAVI HSS proposal lies in its close alignment with the on-going HSDP-III. By working within a well-defined and agreed-upon set of objectives and priority activities, the GAVI HSS funds as proposed had the potential for rapid start-up and implementation. The alignment of budget and financial mechanisms is also notable, with the GAVI HSS proposal utilizing the same budgeting assumptions and scenarios as the HSDP-III and channeling monies through the nascent MDG-PF.

The most notable weakness in the proposal was the monitoring and evaluation (M&E) plan. In fact, there was no M&E plan per se; rather, there was a listing of indicators with likely data sources and targets. The proposal does, however, include a sound framework for the indicators presented with inputs, outputs, outcomes (for systems as well as populations) and impact. Many of the indicators have good face validity (e.g., these variables reflect key elements of the approach and priority activities). It should be noted that the FMoH Health Information System has been under revision for some time, and the proposal was limited in its ability to draw on existing HIS and routinely generated data.

With the majority of HSS funds expended at the FMoH level, management and coordination at the central level is fundamental. In accordance with the proposal, the HSS fund is managed and overseen by the PPF-GD of the FMoH, which also provides monitoring and facilitating implementation and ensures the timely release of funds and guidance on the implementation process. The PPF-GD is responsible for managing the new Global Fund Round 8 multi-million dollar grant, as well as the newly awarded GAVI CSO grant. Implementation to date has closely followed established procedures for procurement, budgeting and reporting at the FMoH.

The regular meetings of the JCCC considered a range of issues related to the implementation of the HSDP-III. The JCCC has the authority to review and approve any request for re-programming (from both the federal and regional levels) as well as to review the Annual Progress Report to GAVI. Although the FMoH immunization program and the immunization ICC are not directly engaged in HSS management and coordination, membership of the JCCC and ICC overlap.

At the regional level, an estimated 23 percent of all GAVI HSS monies are planned and disbursed, including funds for training of HEWs, capacity development for woreda health officers, and annual HEP reviews. In accordance with standard procedures, the FMoH, with CJSC approval, allocates the GAVI HSS funds to the regions based on the national equity formula, which includes population size, absorption/liquidation capacity, implementation capacity, and infrastructure and disease burden.

Funding at regional and local levels

> "The problem we faced did not happen during the integration [of the HSS funds]; rather it is on clearing/closing of the budget. The problem is on the utilization."
>
> --Zonal health bureau manager

GAVI HSS funds are transferred from FMoH to regional health bureaus (RHBs) and from RHBs to zonal health bureaus (ZHBs), with notification provided through transfer letters specifying activities and associated budgets. The RHBs take responsibility for organizing integrated refresher training of HEWs, Integrated Management of Newborn and Child Illness (IMNCI) training for health center staff, health post construction, annual HEP review meetings, and monitoring and evaluation. RHBs report very little difficulty in integrating the GAVI HS funds into their annual work plans as the objectives and activities are so consistent. According to RHB and ZHB managers, the major

difficulties with the use of HSS funds is fully utilizing the funding provided during the plan period and liquidating (expenditure reporting) the funds.

At the woreda level, GAVI HSS inputs are provided primarily as in-kind goods and services. According to the RHB managers interviewed, these arrangements are made due to the limited capacity of the woredas to plan, budget and account for activities. Further, woreda health offices (WorHOs) vary in their level of engagement in GAVI-funded activities. In the Amhara and Oromiya regions, the WorHO staff had a role in planning, recruiting and sending HEWs for the training and follow-up of health facility upgrades. In the case of the Afar RHB, because the woredas do not have the capacity to implement GAVI HSS activities, the fund has not been channelled to the woreda. The GAVI HSS money is pooled at the regional level, and all planned activities are performed through the RHB on behalf of the woredas.

Planning processes

Departments at FMoH—such as the Family Health Department, Health Promotion and Disease Prevention Department, Health Extension Department and PPF-GD—prepare annual work plans for their respective divisions; these plans are consolidated by PPF-GD and submitted to the CJSC. The entire planning process is completed by the end of June in preparation for the beginning of the Ethiopian fiscal year on 8 July.

The planning at the regional, zonal and woreda levels is based on the resource mapping exercise and an indicative plan prepared at the federal level and fed down to the regions, zones and woredas. The indicative plan provides a framework within which these units prepare their own more detailed core activity plan which, in turn, feeds into a consolidated national health sector core annual plan.

Funding mechanisms

The FMoH makes its annual funds request to GAVI with the submission of the Annual Progress Report. To date, four tranches of funding have been received[3]. In 2007, the FMoH requested forward funding to allow for several large-scale procurements. By contracting through existing mechanisms, the GAVI HSS funds were rapidly disbursed in Ethiopia: Within the first two years of the grant, 73 percent of all funds were disbursed.

Executive Summary Table 2: Disbursement of GAVI HSS funds, Ethiopia, 2007-2010

Year	Percent disbursed annually	Cumulative disbursed
2007	31%	31%
2008	42%	73%
2009	17%	90%
2010	10%	100%

Source: Annual Progress Reports 2006-2008

For that portion of the grant expended at the regional level, the FMoH disburses the HSS funds to the region's bank accounts and notifies the RHB through a letter of transfer, specifying both the total amount available to the RHB as well as allocation by activity. In the case of the ZHBs, the RHB sends a transfer letter in much the same manner as the FMoH sends the notifications to the region. In the three regions included in the Case Study, HSS funds were not disbursed to the woreda but rather programmed on behalf of the woreda by either the RHB or the ZHB.

In the regions and zones, GAVI HSS funds may arrive "off-cycle," that is after an annual plan is prepared and is being implemented. However, the types of activities funded under HSS are consistent enough with these on-going programs that they can be readily integrated. Regional and zonal health officers see the GAVI HSS monies and activities as fully consistent with and integrated into their health programs. However, these same officers would prefer that the funds be fully incorporated into the annual plans and budgeted accordingly. Some managers cited difficulties in clearing the

[3] The four tranches were received on 4 April 2007, 24 September 2007, 15 October 2007, and 10 March 2009.

funding in time (prior to the implementation period) because of the "off-cycle" nature of its arrival. Difficulties emerge when GAVI HSS funds arrive close to the end of the fiscal year. In some interviews, the RHBs reported that the HSS funds were released but the transfer letters were delayed. Many RHB and ZHB respondents cited delays in the liquidation (expenditure reporting) of the HSS funds because of limited human resources in the finance area, which is compounded by high staff turnover.

The Study Team has been informed by the PPF-GD that the FMoH recognizes the problem of expenditure reporting and is taking steps to resolve it, including regular meetings to review expenditure patterns described below. A longer-term solution comes in the form of a web-based accounting system that promotes transparency, accountability, timely utilization of funds, and timely reporting. That system is under development with external assistance.

Finally, the study respondents also indicated that the work force often complain about the use of regular Government per diem rates for GAVI HSS activities. It is reportedly difficult to motivate health workers because of the low per diem provided, for example, for attending training sessions.

Data related to the HEP and GAVI HSS investments are generated primarily through activity reports. Respondents described a process of aggregating numbers about immunization, integrated refresher training, medical supply, supportive supervision, etc. Respondents did not report on the use of key indicators or systematic data collection. According to most managers, a single report is prepared without separating reporting by donor. Reporting to GAVI is focused primarily on measures related to the number of HEWs who have completed IRT, health stations upgraded and health posts equipped.

Focus on results

A number of steps are being taken to focus on results and improve performance across all levels. PPF-GD staff travel to the regions on a regular basis to review performance and address management issues. When regions have significantly lagging performance, the FMoH sends a letter to spark discussion on performance. In one example, such a letter resulted in a RHB assessing their remaining budget and activities and then requesting a re-programming of funds. In that case, monies that had been allocated for training could not be utilized as other donors had already covered the training expenses. In general, requests for re-programming of funds are submitted to the PPF-GD and brought to the JCCC for consideration.

Recognizing that there were problems with the liquidation of accounts, the FMoH started a series of weekly management meetings on this issue several months ago. The meetings considered liquidation issues for both the Global Fund grants as well as for GAVI HSS. The meetings have reportedly helped with the liquidation patterns for other donors as well.

At the RHBs and ZHBs, managers described a number of mechanisms to ensure that activities were being carried out, including review meetings and supervisory visits using checklists. According to interview respondents, supervisory visits appear to be done on an ad hoc rather than on a regularly scheduled basis, with lack of transportation cited as a factor.

Performance against targets

At the activity level, the Ethiopian HSS grant has achieved almost all targets set out in the proposal. By bringing services closer to the community, the large-scale training and deployment of HEWs, construction and equipping of health posts, and upgrading of health stations have the potential to bring about significant improvements in coverage and the use of proven interventions. Managers interviewed at the regional, zonal and woreda levels expressed certainty that these activities were already contributing to improved health status.

If the HEWs are able to operate effectively from the health posts—with needed vaccines, drugs, and other commodities and with the technical support of the health center or WorHO—then improved immunization coverage seems assured. Indeed, evidence is beginning to emerge that the HEP, through the HEWs, is having the intended effect of increasing service use and improving health behaviors.

If increased immunization coverage is to be examined as an outcome of the GAVI HSS investment, then the routine data sources used to generate these estimates need to be improved**.** An assessment of the Health Management Information System (HMIS) Business Process Re-engineering found that the availability and quality of immunization records were very poor. These data quality issues could negatively impact the ability of the FMoH and its development partners to accurately determine changes in coverage.

The Study Team concluded that the GAVI HSS funding provided to Ethiopia has had important effects on the expansion of primary care services through the HEP as well as on the donor landscape in Ethiopia. Overall, the program supported through the HSS funding will meet some, but not all, of its targets in key performance areas. Significant gaps observed by the Study Team are not specific to GAVI HSS funding but rather pertain more broadly to the implementation of the HEP and the HSDP-III in Ethiopia. The experience in Ethiopia can inform the GAVI Alliance on several successful practices and lessons learned in an ambitious, large-scale HSS program.

The team also found that the capacity for HSS implementation varies widely across regions and levels. At the national level, the FMoH developed and submitted a strong proposal developed with its development partners and drawing entirely on the HSDP-III. Stakeholders involved in the process expressed satisfaction with both the process and the outcome of the application. There was no delay in disbursement from the GAVI Alliance Board once funding was approved. In order to streamline implementation, the FMoH chose to channel these monies through existing mechanisms (GTZ for construction, and UNICEF for procurement and equipping of health posts), which allowed for this rapid disbursement. Indeed, within the first two years, 73 percent of the grant monies were disbursed. Expenditure of HSS funds is concentrated at the FMoH, with about 77 percent of funds spent at the FMoH for implementing activities at the woreda level.

Despite a very small number of individuals working on GAVI HSS, the country's capacity to implement at the national level is quite strong. The management of the HSS grant demonstrates a results-oriented focus, and several methods to spur improved performance are being used. The JCCC, through its active engagement in GAVI HSS oversight, plays an important technical support role.

Perhaps the main weakness in GAVI-HSS appears in the area of monitoring and evaluation. The performance measures included in the country proposal have not been made operational. The performance measurement approach has not been adequately articulated in the country proposal nor has the GAVI Alliance encouraged its implementation. Another issue which emerges for further consideration is the inclusiveness of HSS grant development, management and coordination. The FMoH reports that efforts are being made to engage NGOs and the private sector in GAVI HSS programming. The ability of the NGO community to extend the reach and reinforce the HEP program seems apparent. This situation may change more favorably with the newly awarded GAVI CSO grant being managed "in-house" at PPF-GD, along with the GAVI HSS grant (as well as the newly signed Global Fund Round 8 grant).

At the sub-national level, a different picture of capacity to implement emerges. At the regional level, several important activities have progressed according to plan (IRT for HEWs, HEW apprenticeships and management training for WorHO). Regional and zonal managers are able to integrate GAVI HSS activities into their work plans because of common objectives and agreed-upon priority activities. However, interviews with 43 individuals across three regions revealed surprising consistency in the challenges encountered. Many of these challenges are not specific to the GAVI HSS funding; they also apply to the HEP component of the HSDP-III.

However, several commonly voiced challenges are specific to the GAVI funding. Regional and zonal managers consistently report that:

- GAVI HSS funds arrive "off-cycle," that is, out of sync with the fiscal year planning.
- Liquidation problems are wide-spread in part due to overburdened finance staff and low capacity at the woreda level.

Other challenges described in the interviews pertain more broadly to the HEP:

- Inadequate supervision of activities due to lack of transportation.
- Lack of adequate technical and administrative capacity at the woreda.
- Problems with the cold chain (spare parts and/or kerosene for refrigerators) and vaccines kept at health centers. (A number of HEWs interviewed complained that vaccines storage at the health centers was an inconvenience for the community.)

A complete set of recommendations is found in the Case Study. The Study Team has identified a core set of priority recommendations for country policy and program decision-makers, as follows:

- Sustain the participatory process and ensure the involvement of stakeholders not included previously at the national and regional levels to provide a coordinated approach to oversight and information sharing on the HEP roll-out.
- Give priority attention to the monitoring and evaluation of the HEP. The FMoH is encouraged to convene an M&E summit to determine the set of actors currently engaged in monitoring or evaluating HEP, with details of their activities, methods and sites. The purpose of the summit would be to consolidate information on existing M&E efforts. It may well be that development partner investments in M&E provide a solid evidence base for evaluating the HEP. With additional coordination and systematic data capture, this could be a cost-effective approach for outcome and impact evaluation.
- Give high-level attention to needed supportive supervision for the HEWs, guided by standard operating procedures at all levels. Integrated Supportive Supervision (ISS) (a system whereby a health center-based nurse is solely responsible for supervising five health posts) requires simple problem-solving tools for the supervisor and HEWs to use together. There is ample opportunity to pilot-test different types of approaches and materials to determine their relative effect.
- Strengthen efforts to encourage greater involvement of the civil society and private sectors in the health sector development initiatives since CSOs play a key role in strengthening the health system in the country.

I. Introduction

a). GAVI Health systems strengthening funding: background

The GAVI Alliance was launched in 2000 to increase immunization coverage and reverse widening global disparities in access to vaccines. Governments in industrialized and developing countries, UNICEF, WHO, the World Bank, non-governmental organizations, foundations, vaccine manufacturers, and public health and research institutions work together as partners in the Alliance to achieve common immunization goals, in recognition that only through a strong and united effort can much higher levels of support for global immunization be generated.

Health systems strengthening (HSS) grants are a relatively new addition to GAVI's funding portfolio. The GAVI Alliance created this new funding window in 2005, based on a multi-country study that identified system-wide barriers to higher immunization coverage. In late 2005 the GAVI Alliance Board made new HSS support available to all GAVI-eligible countries. Currently, US $800 million is available from GAVI for HSS to help countries overcome system-wide barriers that constrain productivity and progress in providing immunization and other child and maternal health services. By December 2008, 45 of the 72 countries eligible for GAVI HSS funding have had their applications approved. These approved HSS applications have an associated financial commitment of US $532 million.

The purpose of GAVI HSS is to address those bottlenecks and system-wide barriers that impede progress in improving and sustaining high immunization coverage and the delivery of other maternal and child health care interventions. This innovative use of funds for health systems strengthening makes it possible for recipient countries to address difficult health system issues such as management and supervision; health information systems; health financing; infrastructure and transportation; health workforce numbers, motivation and training; and others. With this opportunity, however, comes the challenge of monitoring GAVI's investment and learning from past and ongoing proposal and implementation processes, so as to continue to improve them.

b). Objectives of the HSS tracking study overall and in this country

The GAVI Secretariat, along with its inter-agency Health Systems Strengthening Task Team, sought an interim assessment of HSS application and early implementation experience with a focus on how countries are planning, budgeting and implementing their programs, as well as on how HSS funds will be spent and managed once disbursed.

In August 2008, GAVI awarded JSI Research and Training, Inc. (JSI) a contract to work with its partner organization in Sweden, InDevelop-IPM, to jointly implement the Tracking Study to conduct implementation-level HSS tracking and produce case studies in six HSS-recipient countries over a period of 13 months. The Tracking Study has been designed to provide real-time evidence from the country-level regarding the technical, managerial, and political processes for the successful implementation of GAVI HSS grants. The end products of this work will be a set of six country Case Studies, a multi-country workshop and multi-country synthesis paper. The Tracking Study complements comprehensive evaluations of GAVI HSS planned for 2009 and 2012.

Tracking Study objectives are as follows:

- improve the quality of project design/applications and strengthen implementation;

- develop responsibility and ownership over the monitoring of GAVI HSS and promote its integration into ongoing processes at the country level; and
- establish a network of countries implementing HSS—beginning with the countries in the case studies—and facilitate cross-country learning and capacity building.

Ethiopia is among the six GAVI HSS recipient countries selected for inclusion in the Tracking Study. The GAVI HSS support in Ethiopia is given in the context of the Health Sector Development Plan III (HSDP-III), which involves training of health extension workers (HEWs) providing basic health services at the grassroots level; upgrading existing health facilities and constructing additional ones to enhance access and utilization of services; providing equipment and health commodities; and strengthening regular supportive supervision and HMIS.

In Ethiopia, the Tracking Study objectives are two-fold, as follows:

- Assess the progress/underlying factors in management, coordination and financial mechanisms which support HSS implementation at the federal, regional and woreda levels.
- Assess the status of the HSS support implementation using the performance indicators included in the FMoH funding application.

This Tracking Study primarily focused on three main thematic areas: health workforce training, increased access to health services, and organization and management of health services. The specific areas for the Study within the thematic areas include assessment of the HEWs Integrated Refresher Training Package, training of health center staff on integrated Management of Neonatal and Childhood Illness (IMNCI), construction of health posts, provision of equipment for health centers, and development and implementation of the health commodities supply system.

HSS Tracking Study methods

The GAVI-HSS tracking study was conducted in two phases. The first phase was designed to understand country operations and to develop methodology for detailed studies in the regions in phase two. The methods used in each phase are described below.

Phase I: During Phase 1, three members of the HSS Tracking Study core team made an initial assessment visit to Ethiopia from 10-21 November 2008. The team conducted interviews with key informants and reviewed relevant documents. Using a semi-structured interview guideline, the Study Team members conducted 25 interviews with individuals who were either involved in the HSS application process or knowledgeable of its implementation or of HSS efforts in Ethiopia generally.

A wealth of material on Ethiopia health system strengthening efforts were identified and reviewed, including: the HSDP-III Strategy document, the HSDP Harmonization Manual, Annual Performance Report and Mid-Term Review, the GAVI HSS proposal, Annual Progress Reports to GAVI, and reports of the Independent Review Committee (IRC), which reviews those reports. Materials developed under the framework for the International Health Partnership were also reviewed, including the Taking Stock Report, the Compact between the FMoH and Development Partners, the appraisal document for the Joint Financing Arrangement (JFA) and the Joint Financing Agreement itself. Materials from the WHO and Health Metric Network were also reviewed, including an Assessment of the Ethiopian National Health Information System and a report on Strengthening M&E practices in the context of scaling up the International Health Partnership (IHP) compact. Numerous additional documents were also reviewed over the course of the Tracking Study. Following the initial study protocol, all information reviewed was coded and "mapped" against the Case Study outline. A complete list of documents appears in Annex I.

Phase II: The HSS Tracking Study in Ethiopia utilized qualitative study methods. The study focused on capturing actual experiences in implementing the GAVI-HSS program in selected regions of the nation. The study areas were selected purposively; the selection criteria included population size, GAVI HSS funding amount, and absorption and liquidation capacity of the region. Accordingly, the Amhara and Oromia regions were selected because of their population size and large amount of funding from HSS GAVI. The Afar region was selected to represent the emerging regions of the nation and because of its engagement in construction of health posts using GAVI-HSS funding.

In each region, zones and woredas were selected based on the following criteria: received GAVI HSS fund (yes or no); having trained and deployed HEWs (fulfilled the standards[4] of the MOH or did not fulfill the standards); and level of routine immunization coverage (routine immunization coverage greater than or below 50 percent according to the information obtained from the RHB); and having at least one functioning health center. Based on the above criteria, the Team selected zones and woredas in each region together with relevant experts from the specific regions; the purposive sampling allowed inclusion of both well- and poor-performing woredas. Selected zone and woredas in each region are shown below:

Table 1: Regions, Zones and Woredas Selected for GAVI-HSS Tracking Study in Ethiopia, June 2009

Region	Zone	Woreda
Amhara	North Wello	Kobo
	North Shewa	Shewarobit
Oromia	Bale	Sinana
	Southwest Shewa	Wonchi
Afar	-	Buremodayitu
	-	Amibara

In each woreda, the main health center with its satellite health posts was included in the study. In all study areas, there was only one functioning health center at the time of the field visit. Study respondents for Phase 2 of the Study at each level are displayed by type and number in Table 2.

[4] The HSDP standards specify having two health extension workers per health post and five health posts for each health center.

Table 2 Respondents for GAVI-HSS Tracking Study in Ethiopia, June 2009

Level	Position
Federal	Policy, Planning and Finance General Directorate delegate and experts
Region (n=5)	RHB head or delegate Planning and Programming Department head or delegate Health Extension Department head or delegate Family Health Department or delegate
Zone (n=5)	ZHD head or delegate Planning and Programming Department head or delegate Health Extension Department head or delegate Family Health Department or delegate
Woreda (n=9)	WorHO head or delegate Planning and Programming Department head or delegate Health Extension Department head or delegate
Health facility HC (n=3), HS (n=5) HP (n=16)	Facility head or delegate Health Extension supervisors Health Extension workers

The data collection methods included review of documents and records, interview of key informants, and observation of health facilities. Based on the objectives of the study, comprehensive data collection tools for reviews, and interviews were developed by the Study Team and commented upon by an expert panel that includes experts from the FMoH. The tools were prepared in English and then translated into the national language for field use.

Before the actual data collection, the Study Team visited each of the study regions to explain the purpose of the study and to select the study sites. Then, a two-day training was provided for the Study Team in Addis Ababa. Data were collected by a team of three experts in each selected study unit by physically visiting the sites and performing face-to-face interviews. Relevant observations of facilities and services were made using a uniform observation checklist at the selected health centers and health posts. The teams were led by experts with master's level training in public health and social sciences. The team spent one week in each selected woreda. The study coordinator and core team experts supervised the data collection process in all three regions. The field work was conducted from mid-April to mid-May 2009. The data was analyzed based on the objectives of the Tracking Study. Qualitative data collected from in-depth interviews was analyzed using thematic techniques. This country Case Study Report was prepared using an outline provided by the HSS Tracking Study core team to ensure consistency of presentation of findings across the six countries participating in the Tracking Study.

Description of the review process

During the development of the study protocol, input was sought from the unit responsible for HSS coordination and oversight in the Policy, Planning and Finance General Directorate (PPF-GD) of the Federal Ministry of Health (FMoH). The PPF-GD approved the study protocol and the study tools prior to the field work.

A draft country case study report was prepared and shared with the HSS Tracking Study core team and PPF-GD staff for comments before the country workshop. The revised draft report was discussed in a country workshop conducted on 31 July 2009. The agenda for the workshop and a list of participants appear in Annex II. During the workshop, the findings were thoroughly discussed and additional input useful for enriching the country report were gathered. The final country report is produced by incorporating the comments and input gathered from the country workshop.

II. Country Context

Ethiopia is located in the Horn of Africa, has a total area of approximately 1.1 million square kilometers, and shares borders with five countries—Eritrea in the north, Djibouti in the east, Sudan in the west, Kenya in the south, and Somalia in the southwest. Ethiopia has a diverse topography, and geographic and climatic zones, which significantly influence health conditions in the country.

Ethiopia is the second most populous country in Africa, with a population of 73.9 million[5] and an annual growth rate of 2.6 percent, representing a yearly increase of 2 million persons. Ethiopia has witnessed an average annual reduction in total fertility of 1.4 percent between 1990 and 2007. Nonetheless, the total fertility rate remains high, with 5.9 children per woman during the years of 1995 to 2000[6]. The Ethiopian population is heavily skewed towards the younger ages, with children (0-14 years) and youth (15-24 years) together accounting for almost 64 percent of the total.

Ethiopia is one of the least urbanized countries in the world since 84 percent of the total population lives in rural areas. Gross national income per capita stands at US $220 far, below the sub-Saharan average of US $952. Nearly 4 out of ten (39 percent) of Ethiopians live below the international poverty line of US $1.25 per day. Literary levels in Ethiopia are low. The total adult literacy rate during the years of 2000-2005 was 36 percent[7]. Primary school net/enrollment/attendance between the years of 2000 and 2006 was 45 percent.

A federal government structure was created by the new Ethiopian constitution, introduced in 1994. The federal structure is composed of nine Regional States—Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambella and Harrari—and two city Administrations (Addis Ababa and Dire Dawa). These Regional States and City Administrations are further divided into 810 woredas, which is the basic decentralized administrative unit with an elected administrative council. Woredas are further divided into units of dwellings commonly known as kebeles.

a). Health situation, priorities and programs

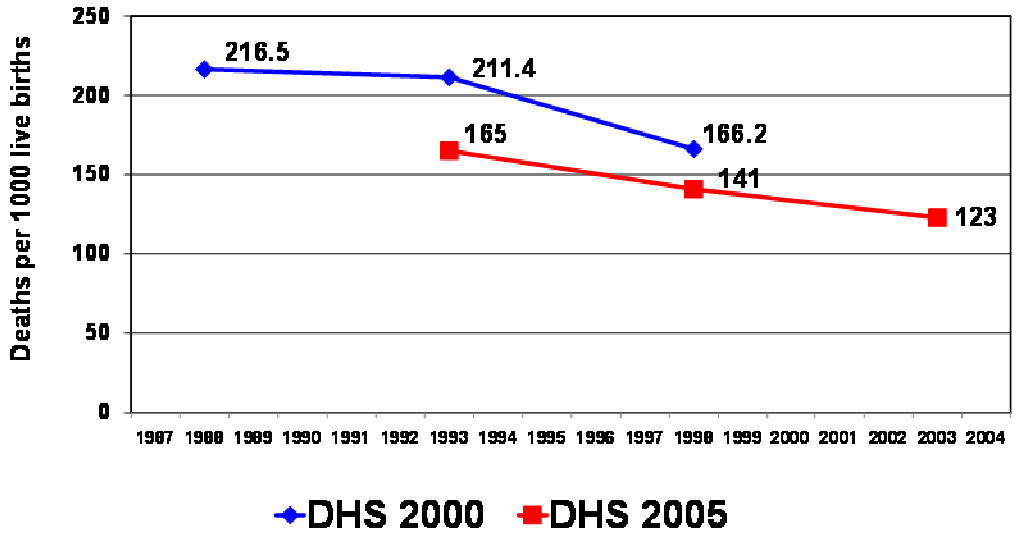
Ethiopia's health status is poor relative to other low-income countries, including Sub-Saharan Africa. The disease burden in the country is largely due to preventable infectious ailments and nutritional deficiencies, with infectious and communicable diseases accounting for about 60-80 percent of the health problems in the country. The risk factors associated with high levels of morbidity and mortality are prevalent in Ethiopia, including poverty, low education levels, inadequate access to clean water and sanitation facilities, poor access to health services and low expenditure on health. However, numerous positive improvements have been made in the health status of the country following implementation of sector-wide health and development programs.

Under-five mortality rates are consistently declining. The most recent survey (Ethiopia Demographic and Health Survey or EDHS 2005) estimates under-five mortality at 123 deaths per 1,000 live births (Figure 1). Abut 90 percent of mortality in under-fives is caused by pneumonia, neonatal causes (prematurity, asphyxia and neonatal sepsis), malaria, diarrhea and measles. Malnutrition is the underlying cause in over half of these deaths. Poor nutritional status, infections and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality

[5] Population Census Commission, FDRE, Summary and Statistical Report of the 2007 Housing and Population Census. December 2008.
[6] HDSP III
[7] http://www.unicef.org/infobycountry/ethiopia_statistics.html#46

ratios in the world, which is currently estimated at 673/100,000 live births. Only six percent of women deliver with the support of a skilled birth attendant.

Figure 1: Trends in under-five mortality rates, Ethiopia, 1998 to 2003

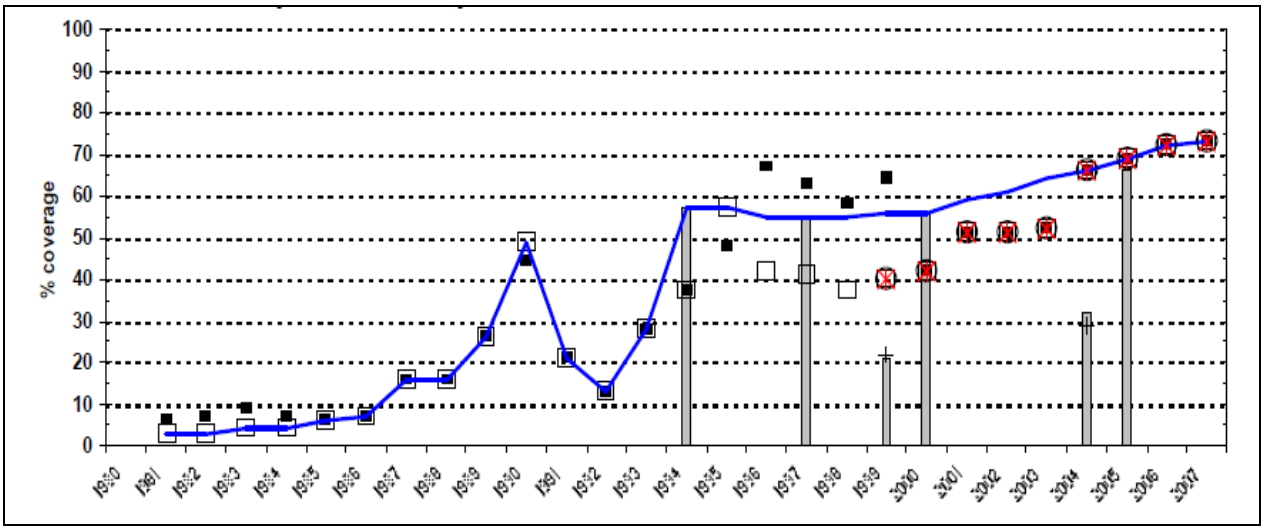


Source: Ethiopia Demographic and Health Surveys 2000 and 2005.
Note: Under-five mortality rates appear at the mid-point of the five year period for the estimate.

Levels of DPT3 coverage have shown a steady increase, with current coverage levels reaching 73 percent of infants[8]. Since 2004, these data are based on national reports confirmed by survey. The Somali and Gambella regional states reported the lowest DPT3 coverage, 15 percent and 35 percent, respectively.

[8] DPT3 coverage rates based on multiple data sources, including independently conducted regression analyses of survey data, appear in Annex III.

Figure 2: DPT3 coverage rates, Ethiopia, 1980 to 2007

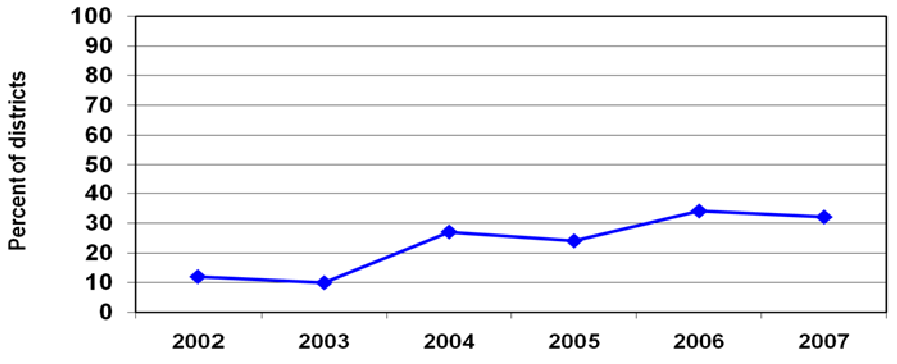


Source: www.who.int/immunization_monitoring/data/eth.pdf

The Expanded Program on Immunization (EPI) was introduced in Ethiopia in 1980 with the goal of increasing immunization coverage by 10 percent annually and reaching 100 percent coverage in 1990, a goal that has not been achieved. The current long-term goal of the Federal Ministry of Health (FMoH) EPI Strategy is to achieve 90 percent DPT3 coverage in all regions. By 2007, 32 percent of woredas (or districts) report DPT3 coverage greater than 80 percent (Figure 3) by implementing the approaches called Reaching Every District (RED) and Sustainable Out-reach Services (SOS).

Percent of districts with ≥ 80% coverage with DPT3, Ethiopia, 2002-2007

Figure 3: Percent of districts with ≥ 80 % coverage with DPT3, Ethiopia, 2002 – 2007



Source: WHO vaccine-preventable diseases monitoring System 2008 global summary – country profile: Ethiopia. http://www.who.int/vaccines/globalsummary/immunization/countryprofileresult.cfm.

The GAVI Alliance has been supporting Ethiopia since 2001. The first grant was for Immunization Services Support. The largest single and longest running grant is for pentavalent vaccine support from 2005 to 2015. Total GAVI support to Ethiopia amounts to US $401,100,819. Figure 4 depicts the GAVI funding in Ethiopia from 2001 to 2015.

Figure 4: The GAVI Funding In Ethiopia (2001-2015)

Type	Total Value (U.S.$)	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Hepatitis B Vaccine	-																
Pentavalent vaccine	290,664,000																
Vaccine Introduction grant	100,000																
Civil Society support Type A	1,200,000																
Civil Society support Type B	3,300,000																
Injection safety	3,287,800																
Immunization support services	30,554,820																
Health system Strengthening	76,499,935																
Total	405,606,555																

Source: GAVI Alliance Country Fact sheet, June 2008
http://www.gavialliance.org/resources/Ethiopia_GAVI_Alliance_country_fact_sheet_June_2008_ENG.pdf

Immunization programming is challenged by the same set of constraints that impede the implementation of general health services in Ethiopia, including understaffing and high turnover of staff at all levels, inadequate follow-up and supportive supervision, shortage of transportation, lack of motivation of service providers, poor functioning of outreach sites, and a weak referral system.

b). Health care reforms and health systems strengthening efforts

Ethiopia has put tremendous efforts towards strengthening and reforming its health systems. The FMoH has been implementing the Business Processes Re-Engineering (BPR), initiated a new

THROUGH THE HSDP-III, THE GOVERNMENT OF ETHIOPIA SEEKS TO:

- COVER ALL RURAL KEBELES WITH HEP TO ACHIEVE UNIVERSAL PRIMARY HEALTH CARE COVERAGE BY YEAR 2008;
- REDUCE MATERNAL MORTALITY RATIO TO 600 PER 100,000 LIVE BIRTHS FROM 871;
- REDUCE UNDER-FIVE MORTALITY RATE FROM 140 TO 85 PER 1000 LIVE BIRTHS AND IMR FROM 97 TO 45 PER 1000 LIVE BIRTHS;
- REDUCE THE TOTAL FERTILITY RATE FROM 5.9 TO 4;
- REDUCE THE ADULT INCIDENCE OF HIV FROM 0.68 TO 0.65 AND MAINTAIN HIV PREVALENCE AT 4.4;
- REDUCE MORBIDITY ATTRIBUTED TO MALARIA FROM 22% TO 10%;
- REDUCE THE CASE FATALITY RATE OF MALARIA (AGES 5 YEARS AND ABOVE) FROM 4.5% TO 2% AND CASE FATALITY RATE IN UNDER-5 CHILDREN FROM 5% TO 2%; AND
- REDUCE MORTALITY ATTRIBUTED TO TB FROM 7% TO 4% OF ALL TREATED CASES.

PROGRESS TOWARDS THESE OBJECTIVES AS REPORTED BY THE MID-TERM REVIEW APPEAR IN ANNEX IV.

pooled funding mechanism called the Millennium Development Performance Fund (MDG-PF), entered into an International Health Partnership Compact with development partners, adapted the Protecting Basic Services model in partnership with the World Bank, and initiated a Joint Financing Agreement (JFA) in order to fully and effectively utilize resources for health development that are available nationally and internationally.

The Ethiopian Government (GOE or the Government) has made health sector reform a priority. The GOE is committed to meeting targets set by global initiatives, notably, the Millennium Development Goals (MDGs). Ethiopia's efforts to achieve the MDGs are guided by its Five-Year Medium-Term Development Plan -- A Plan for Accelerated and Sustained Development to End Poverty (PASDEP). According to the MDG Monitor[9], Ethiopia is on track to achieve most if its development goals, but major challenges remain in some areas, including the low level of per capita aid, unpredictability of aid, low agricultural productivity, vulnerability to both external and domestic shocks, inflationary pressure largely driven by food inflation, and weak implementation capacity at the woreda level.

The corresponding health component of the PASDEP is the Health Sector Development Program, which the Government has been implementing since 1997. Based on experience gained through the Health Sector Development Programmes–HSDP-I (1997/98 to 2001/02) and HSDP-II (2002/03 to 2004/05), the Government is currently implementing HSDP-III from 2003/04 through 2009/10 (EFY 1998 through 2003).

The ultimate goal of HSDP-III is to improve the health status of the Ethiopian people by providing adequate, optimum and quality promotive, preventive, basic curative and rehabilitative health services to all segments of the population.

A significant policy influencing HSDP design and implementation over time is that of decentralization, which provides the administrative context in which health sector activities take place. Decision-making processes in the development and implementation of the health system are shared between the Federal Ministry of Health (FMoH), the Regional Health Bureaus (RHBs) and the Woreda Health Offices. As a result of recent policy measures taken by the Government, the FMoH and the RHBs are directed to focus more on policy matters and technical support, while the Woreda Health Offices have been directed to play the pivotal role of managing and coordinating the operation of the primary health care services at the woreda levels.

[9] http://www.mdgmonitor.org/country_progress.cfm?c=ETH&cd=231

Table 3: Ethiopia: General health systems indicators

Per capita total expenditure on health (average exchange rates)	US $7	(2006)
Government Expenditure on health as % of total government expenditure	10.6	(2006)
External resources for health as a % of total expenditure on health	43	(2006)
Nursing and midwifery personnel density per 10,000 population	2	(2003)
Physician density (per 10,000 population)	< 1	(2003)
Hospital beds (per 10,000 population)	2	(2006)

Source: World Health Organization

The HSDP-III underwent a Mid-Term Review in the period 2007/2008[10]. The Review Team concluded that the first major objective of HSDP III—expansion of primary health care to all kebeles through the Health Extension Program—will be reached (described below). The other major objectives of HSDP III are unlikely to be achieved during its lifespan although substantial improvement can be expected in infant and under-five mortality. Reductions in these key indicators can be attained through expanded coverage and improved performance of proven child health interventions undertaken by HEWs and with appropriate support and supervision. The Review Team concluded that long-term improvements in maternal health will be more difficult to realize as they depend on fundamental health system strengthening in areas including human resource development, planning and infrastructure, logistics and adequate referrals systems.

The HSDP–III Mid-Term Review observed a tendency to "verticalize" the expansion of health services (HIV/AIDS, malaria, and TB), with anecdotal evidence pointing to a diversion of human resources away from other services, particularly HIV/AIDS. While the Review Team observed successful implementation of these components, they nonetheless concluded that intended outcomes of HSDP-III cannot be achieved through expansion of these efforts alone. Health support systems require concerted efforts to be strengthened, with particular attention to the maintenance system, logistics management system, referral system, planning and monitoring, supervision and leadership and management capacity, particularly at lower levels.

Governance of the HSDP-III is guided by the HSDP Harmonization Manual (HHM), which includes a Code of Conduct, developed in 2005 and signed by 14 development partners. The Mid-Term Review acknowledged substantial progress toward improved partner communication and structures but also noted that most coordination structures are still weak, especially at the lower levels.

Governance structures for HSDP-III are similar to those used in previous phases and include, at the highest levels, a Joint Government-Donor Steering Committee (CJSC), which serves as the top policy-making body in health and oversees and coordinates HSDP-III implementation. The CJSC is chaired by the Minister of Health and membership includes MOH (chair), a rotating chair person of the HPN-Donor Group (co-chair), MOFED, WHO, World Bank, USAID, an elected member of the European Health Partners, and the Christian Relief Development Association (CRDA). The Policy Planning and Finance Directorate General of the FMoH serve as the secretariat to the CJSC. Regions and woredas are also served by joint steering committees. A Joint Core

[10] Ethiopia Health Sector Development Programme (HSDP III) 2005/06 – 2010/11 (GC) (1998 – 2003 EFY). Mid-term Review. Volume I. Component Report. Independent Review Team. Final report. 12th July 2008.

Coordinating Committee (JCCC) serves as a functional, technical arm of the Joint Consultative Forum of the FMoH/HPN and HSDP Secretariat.

The Mid-Term Review noted that these governance and coordination bodies could benefit from more regular sharing of information on developments and decisions being taken in areas including expected levels of funding and disbursement, expected external missions, arrivals of new technical assistance, bottom-up woreda planning, HRH, HMIS and progress with the master-plan for pharmaceuticals and logistics. The Mid-Term Review proposed a re-structured model of coordination.

A central element of the HSDP-III is the Health Extension Program (HEP), an effort designed to deliver health promotion, immunization and other disease-prevention measures, and a limited number of high-impact curative interventions, in order to address the main causes of maternal, neonatal and childhood morbidity and mortality. The program includes disease prevention and control, hygiene and sanitation, family health services, and health education. These services are to be delivered through the health extension program, volunteer community promoters, and strengthening the quality of and demand for clinical care (particularly treatment of ARI and malaria in children, assisted delivery, HIV testing and counseling, as well as prevention of mother to child transmission [PMTCT]) in existing health stations and HCs.

The Mid-Term Review of the HSDP-III found that the Health Extension Program was making substantial progress towards its intended results as summarized in Table 4. Notably, in the past four years, 25,000 Health Extension Workers (HEWs) have been deployed. The Mid-Term Review also noted that all HEWs are paid through woreda budgets. Other studies have also demonstrated that community-level engagement of the HEWs in many of the regions is effective and highly appreciated. Although observations so far strongly suggest that the HEP program is making substantial contributions to improve-health seeking behavior, the data required to substantiate this finding needs to be generated.

Table 4: Progress towards targets of the Health Extension Program, Mid-Term Review of the HSDP-III 2008

Health Extension Program Targets	Achievements at Mid-Term Review
The construction of 13,625 health posts. The HSDP III target is 15,000 health posts in place by the end of 2001 (GC 2007/08).	There were 11,000 health posts in place at the end of EFY 2000. This is 73% coverage. Construction work is continuing. The 100% target is likely to be achieved by the end of HSDP III.
A total of 30,000 HEWs: This will ensure two HEWs per health post.	By May 2000 (GC 2007/08), there were 24,500 HEWs trained and deployed (82% of the target). The HSDP III target of 30,000 HEWs will be reached in 2008/09.
A ratio of 1 HEW per 2,500 people.	In May 2000 the ratio was 1:3265 persons. The target is very likely to be achieved.
Supervisors were not envisaged in the plan; however, adjustments have been made to train supervisors later.	A total of 3,000 supervisors have been trained (100% target)
A strong collaboration with a network of VCHWs at the kebele level.	Progress is being made: a guideline has been prepared to harmonize the collaboration with the VCHWs. A total of 900,000 Model Households have "graduated."

During the implementation of HSDP-III, the FMoH has also engaged in an important reform initiative, termed Business Process Re-engineering (BPR), which is aimed at the redesign and full decentralization of health care. Among the principles guiding BPR are:

- Organizing around outcomes instead of around functions and departments
- Providing a single point of contact for customers and suppliers
- Capturing information once at the source and sharing it widely
- Using triage, not a one-size-fits-all strategy

The FMoH has made extensive analysis of the current work activities, health care practices and overall organizational structure in order to identify its strengths, weaknesses, opportunities, and threats. As a result, various departmental functions have been merged and/or categorized. The FMoH is currently working through seven core processes and support processes[11] (Table 5).

Table 5: FMoH Business Process Re-engineering Core and Support Processes

Core processes	Support processes
Health Care Delivery	Audit
Public Health Emergency Management	General Services
Research & Technology Transfer	Legal Office
Pharmaceutical Supply	Civil Services
Resource Mobilization and Health Insurance	Finance and Procurement
Health and Health-related Services and Product Regulatory Core process	Planning, Monitoring and Evaluation
Health Facility Construction/Infrastructure Core Process	Human Resource Development

As part of the Planning, Monitoring and Evaluation core process, the health management information system (HMIS) has been re-designed with new procedures and structures being introduced from the level of the health facility to the FMoH.

Health services in Ethiopia are financed through four main sources. These are government (both federal and regional); bilateral and multilateral donors (both grants and loans); non-governmental organizations; and private contributions. The National Health Accounts[12] for financial year 2000/01 show that the major contribution is made by the households (36%), government (33%), and bilateral and multilateral donors (16%). The recent increase in government spending on health has been complemented by fiscal decentralization and broad reforms in the management of public finance.

HSDP-III cost estimates and scenarios were prepared using the Marginal Budgeting for Bottlenecks method and tools with external technical assistance. Over its life, the HSDP-III is estimated to cost between US $1,792 and 4,800 million. On a per capita basis, the HSDP-III is expected to cost between US $4.6 to 12.2 per year per

[11] Annual Performance Report of HSDP-III. Federal Ministry of Health. EFY 2000 (2007/2008). October 2008.
[12] Federal Ministry of Health. Planning and Programming Department, 2005. Health Sector Strategic Plan (HSDP-III) 2005/6-2009/10.

person. Parameters of the HSDP-III costs scenarios[13] and the anticipated funding sources are summarized in Table 6. The FMoH is currently working with an estimated financial gap of US $2.8 billion under scenario III. Global health initiatives (GHIs), notably the Global Fund and GAVI, have become major financiers of HSDP III and have enabled the FMoH to negotiate greater regional and woreda allocations to health.

Table 6: Estimated Costs and Financing Plan for the HSDP-III, Ethiopia (in US$ million)

	2005/06	2006/07	2007/08	2008/09	2009/10	Total
Estimated costs						
HSDP III: Scenario 1	329.1	378.1	443.9	515.0	593.5	2,259.8
HSDP III: Scenario 2	475.6	541.9	634.7	734.9	843.2	3,320.3
HSDP III: Scenario 3	593.2	712.8	862.8	1,021.1	1,189.4	4,379.3
Financing by source						
Government	74.3	88.9	100.2	113.6	132.2	509.2
Global Fund	92.2	146.9	150.0	145.7	145.4	680.3
Bilateral and multilateral (including PBS)	125.8	86.2	62.0	51.7	48.2	373.9
GAVI new vaccine	26.8	26.8	26.8	26.8	26.8	134.0
Total available	319.05	348.93	339.04	337.8	352.56	1,697.39
Projected Gap						
(Scenario 1)	10.08	29.2	104.9	177.23	240.95	562.39

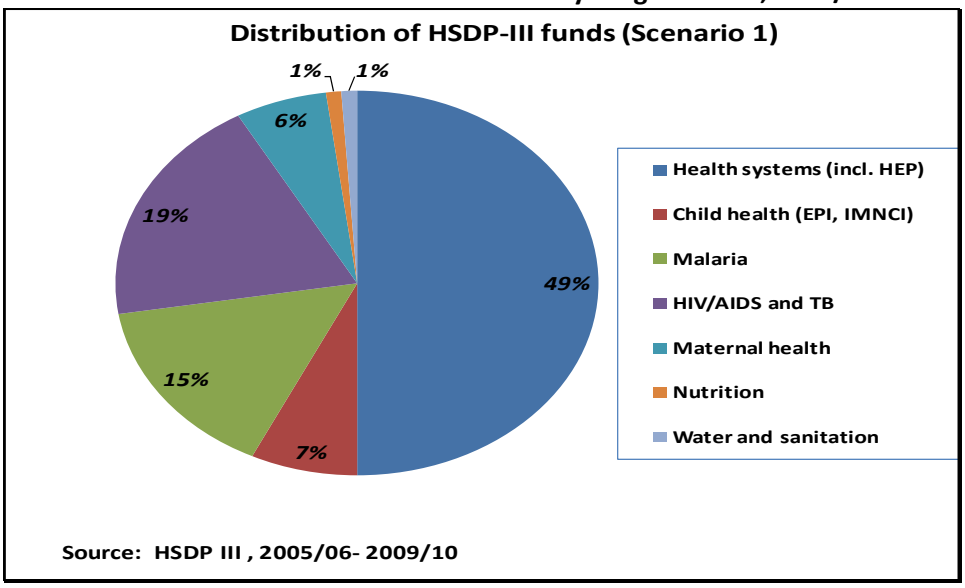
Source: FMoH HSS Application to GAVI.

Notes: The government budgets shown for 2005/05 represent actual budget allocation for the health sector. Amounts for the remaining years are drawn from the PASDEP document after deflating by 25% to account for external loan and assistance reflected on-budget. In 2005/06, on-budget external loan and assistance accounted for 25% of the health budget. Global Fund amounts shown are for all grants awarded in Rounds 1-5. Biltaeral and multilateral donors in Ethiopia include ADB, AECD, Dfid, EC, Irish Aid, Italian Cooperation, Packard Foundation, RNE, SIDA, UNICEF, USAID, WB and WHO.

The HSDP–III resources are largely oriented towards the expansion of basic health services via the HEP. As seen in Figure 5, roughly all HSDP-III funds are estimated to go towards health systems strengthening. HIV/AIDS, tuberculosis and malaria account for another 34 percent of the total.

[13] Scenario 1: Roll-out of HEP, with two HEWs per health post for each kebele over the next five years, as well as upgrading health centers and limited upgrading of hospitals and curative services.
Scenario 2: Full implementation of the Accelerated Expansion of Primary Health Care Coverage (AEPHCC), increase access to health centers to 94% of the population in five years, and significant ly expanded hospital coverage.
Scenario 3: Based on the MDG Needs Assessment with full achievement of all targets without resource constraint.

Figure 5: Estimated Distribution of HSDP-III Funds by Program Area, 2007/08 to 2009/10



Several channels exist for the funding of the Ethiopian health sector through government and donor sources (Table 7). The Government of Ethiopia encourages donors to use Channel 1a as the preferred channel of funding[14] since that encourages systems thinking and effective utilization of resources.

Table 7: Main channels of donor funding for the Ethiopian health sector

Funding Channel	Key feature	Managed by	Used by
Channel 1a	Un-earmarked pool of both Government and donor funds for direct budget support. Included PBS Component A (block grants).	MOFED, BOFED, WOFED	Donors
Channel 1b	Unpooled, earmarked funds for specific activities consistent with Government priorities.	MOFED, BOFED, WOFED	Larger multilateral and bilateral donors
Channel 2	Support channeled to sector units at federal, regional and/or woreda levels to expend and account for funds. Included under Channel 2 is the MDG-PF, a pooled fund supporting a range HSDP-III priority activities and the PBS Component B.	MOFED FMoH	Multilateral and bilateral donors For the MDG-PF, GAVI HSS (since 2007). In April 2009, new partners joined via the JFA.

[14] Federal Ministry of Health. The HSDP Harmonization Manual (HHM).September 2005 (EFY 1997). First Edition 2007.

Funding Channel	Key feature	Managed by	Used by
Channel 3	Off-budget, not disbursed according to Government procedures; donors may procure and contract, and government ensures that expenditures are included in HSDP accounting and audit; often used for provision of technical assistance, commodities.	Donors	Most UN agencies and some bilateral donors
	Included under Channel 3 is the Health Pooled Fund which supports technical assistance and study tours by FMoH.	UNICEF fiduciary procedures	Multilateral and bilateral donors

Source: Harmonization Manual, Mid-Term Review of HSDP-III and interviews.

A significant development under HSDP-III has been the creation of the Millennium Development Performance Fund (MDG PF). Established in 2005 and used by GAVI HSS for the first time in 2007, the MDG Fund is managed by the FMoH following established Government procedures, which ensure transparency and accountability. The MDG-PF supports the Health Extension Programme, maternal health programs and technical assistance.

Until early 2009, the MDG Fund operated with one participating donor—the GAVI health systems strengthening grant awarded in 2007. In April 2009, the government of Ethiopia and seven development partners[15] signed a new Joint Financing Arrangement, which is attracting other donors to use the same mechanism[16]. New and existing initiatives to support to the health system, essential health commodities and capacity building will be requested to channel their support through the MDG Fund. An independent appraisal of the MDG-PF implementation in August 2008 revealed that it is generally a well-functioning partnership. The assessment also pointed out financial management capacities, procurement procedures, and issues of social equity and inclusion as needing to be addressed to be more effective.

The MDG Fund has three areas of emphasis, with associated ledgers. The first components supports the Health Extension Program through the provision of basic infrastructure (health posts); equipment (cold chain, etc.), essential health commodities (vaccines, contraceptives, ITNs), HEW training and integrated systems for logistics, supervision and reporting. The second component supports obstetric care through efforts aimed at expansion and proper functioning of the referral system required to improve maternal health. Funds channeled through this component cover the costs of provision of basic emergency obstetric care (BEOC) and comprehensive emergency obstetric care (CEOC) equipment and commodities; training in BEOC and CEOC; and measures to improve transportation of obstetric emergency cases to the appropriate facilities. The third component is for process support and technical assistance.

The Mid-Term Review Team revealed that the Government has successfully strategized for the expansion of health services at the kebele level and planned well for support systems to enable its implementation. The MTR points to the "unprecedented facility expansion of health posts and centers, and the staggering numbers of HEWs that are being trained and deployed in the sector" with a corresponding budgetary focus on salaries

[15] The Department for International Development (DFID, UK), The Spanish Development Cooperation, Irish Aid, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank and the World Health Organization.

[16] Joint Statement of the Government of Ethiopia and Signatory Development Partners. Official Launch & Signing Ceremony of the Joint Financial Arrangement *between the* Federal Democratic Republic of Ethiopia & Development Partners. 15 April 2009. Addis Ababa.

at lower levels and infrastructure expansion at higher levels. This expansion brings with it corollary obligations for operational costs, which the MTR felt were not addressed.

Partners in health systems strengthening efforts

Numerous donors have been working in Ethiopia on various disease areas while also contributing to overall health systems strengthening efforts. In 2007/08, donor commitments to the health sector totaled US $4,069 billion with disbursements at US $3.317 billion (Annex V).

UNICEF Ethiopia works closely with the Government and other partners on priorities and programs described in the Country Program Action Plan, 2007-2011. The largest single component of the UNICEF Country Program, equaling US $130 million over the period, is devoted to Young Child, Adolescent and Women's Health, which includes contributions to health policy and systems development.

Ethiopia has received support from the GFTAM to support three program areas: HIV/AIDS, TB and Malaria. The latest grant it was awarded was the Round 8 Malaria Grant in 2008. Between Rounds 1-8, the Global Fund has approved US $1.30 billion and disbursed US $571 million.

Ethiopia is one of PEPFAR's 15 focus countries and has been provided with over US $48 million in Fiscal Year (FY) 2004, US $83.7 million in FY 2005, about US $123 million in FY 2006, and US $241.8 million in FY 2007 to support its HIV/AIDS prevention, treatment and care programs. PEPFAR provided more than US $354.5 million in FY 2008.

In a newly launched Protecting Basic Services grant (PBSII), the World Bank will support the objectives of the MDG-PF through a second account, with combined funds equaling US $87.7 million[17] between 2008/09 and 2011/2012. This element of the PBS grant seeks to support the GOE in its efforts to accelerate the attainment of health-related MDGs consistent with the goals and objectives of HSDP-III, and within the principles and arrangements underpinning the International Health Partnership (IHP) Compact, as well as the framework around the MDG Performance Fund (MDG-PF). The World Bank will create and sustain a pooled funding, called the Multi-Donor Trust Fund (MDTF) as a second account contributing to the MDG Fund's objectives but subject to the World Bank's rules and regulations on financial management, procurement, and environmental safeguards. The MDTF is envisioned as an interim phase, while MDG-PF establishes its procedures and performance to allow development partners not yet able to fully harmonize or to channel funds directly to the MDG Fund. These resources will finance Ethiopia's health sector strategy by providing flexible funding for priority activities: procurement and distribution of critical health commodities; and health system strengthening to support the accelerated attainment of health-related MDGs. The FMoH will have overall responsibility for the oversight, coordination, monitoring and evaluation of this element of the PBSII grant. The Pharmaceutical Fund and Agency Supply Agency (PFSA) will manage the procurement and distribution of health commodities on behalf of the MoH.

[17] Comprised of contributions from the IDA of US $10.0 million equivalent; CIDA US $56.6 million equivalent; Italy US $10.2 million equivalent; and RNE US $10.9 million equivalent.

III. GAVI HSS Proposal Development and Application Process

a). History of the country's GAVI HSS application

Ethiopia submitted an initial GAVI HSS proposal on 30 October 2006. The Independent Review Committee (IRC) submitted a set of questions and clarifications which were addressed in a response (15 January 2007). Based on the recommendations of the IRC, the GAVI Alliance approved the country proposal on 1 March 2007. The first tranche of HSS funding, totaling US $23.7 million, was received six week later (4 April 2007).

b). Coordination and decision-making

Several key informants reported that the GAVI Alliance encouraged Ethiopian health authorities to apply for HSS funding as the country meets most of the eligibility criteria. The Ethiopia country proposal was developed through a well-coordinated process by the FMoH and its development partners. The GAVI HSS proposal was developed immediately after a thorough consultative process used for developing the HSDP-III. The HSDP III development process involved all departments of the FMoH, all levels of the health system, development partners, and an umbrella organization of CSOs and NGOs (CRDA); and it identified health sector priorities and key gaps in three scenarios. The GVAI HSS proposal development benefited from that process immensely and extended the same procedures in finalizing the proposal. The GAVI HSS proposal was approved by the existing coordinating bodies that have broad membership from Government, development partners and CSOs and was endorsed by the CJSC.

Nature and level of any technical assistance (TA) received during the process

In addition to the substantial participation of in-country development partners to proposal development, several external consultants supported the proposal development. A WHO HSS expert, assigned to the FMoH, played an important coordinating role in proposal development. In addition, a health economist based in UNICEF headquarters assisted in the preparation of the budget. This same consultant developed the costing models for the HSDP-III using the Marginal Budgeting for Bottlenecks approach. An external consultant, working with DFID, reviewed and provided input to the draft proposal. This same consultant was involved in the development of the HSDP Harmonization Manual. Overall, the process was regarded as one of the most effective and efficient by the FMoH and its development partners. Some experts said, "the process used for GAVI HSS proposal was good…it might be difficult to repeat."

Decision-making process

The working groups carefully considered the application materials for GAVI and initially discussed the relative distribution of resources among the three components. The process was described as a series of consultations with very active engagement of development partners, notably UNICEF and WHO. Members of the ad hoc working group each developed components of the proposal, which were harmonized by the WHO HSS expert. The document was then reviewed by all members of the ad hoc committee as well as other key individuals. With comments incorporated from this review, the proposal was submitted to the head of the then Planning and Programming Department of the MOH (now PPF-GD) and then reviewed sequentially by several coordinating bodies with comments incorporated at each stage. These presentation/reviews included the Health Population and Nutrition Donors Group and the Joint Core Coordinating Committee (JCCC). The proposal was endorsed by the CJSC, which indicates the level of interest and commitment by the Government to GAVI HSS support. The HSDP-III consultative process that identified the priority areas and key gaps in the health sector provided a lead-time for a faster development of the GAVI HSS proposal.

The process was largely undertaken by the public sector along with the donors. The CJSC is the highest decision-making body that approved and signed the GAVI HSS proposal. As a member of the CJSC, the Christian Relief and Development Association, an umbrella organization representing over 100 NGOs, was a signatory to the proposal. All levels of authorities in the health system, key development partners, and the CSO/NGO sector are actively engaged in the decision-making process. Further dissemination of the issues and decisions made by the CJSC is dependent on the availability of effective communication media and culture among the participating organizations.

c). Stakeholder perceptions of the proposal development/application process

Satisfaction/dissatisfaction with the planning process and the resulting HSS application

Stakeholders involved in the process consistently reported a high degree of satisfaction with the GAVI HSS proposal planning process and the resulting HSS application. Stakeholders felt that the process was appropriately government-led and participatory. One respondent called the HSS proposal "the first and best document of this type." Almost every respondent mentioned the flexibility of the GAVI Alliance in terms of its support to health systems. The IRC review was reportedly not "overly time-consuming," and, indeed, satisfactory responses were prepared in a timely manner. Respondents also felt that the GAVI Alliance feedback was quick and funds were disbursed promptly.

Suggestions for improving the proposal development/application process

Respondents proposed several means to improve the application process[18]. Among those are changes to the application form and guidelines themselves. Some respondents found the expectations and intentions of the application guidelines unclear. Others reported that the format was difficult to follow. A few respondents mentioned the focus on child health during the proposal development stage needs to be diffused since the overall aim of the fund is to provide system-wide support. Several respondents questioned why the CJSC had to sign the proposal, since seeking their signatures was time-consuming.

d). Analysis of the GAVI HSS proposal development/application processes

A particular strength mentioned was the use of technical assistance from agencies already thoroughly familiar with the HSDP-III and the harmonization process. Most of the individuals and agencies that participated in the GAVI HSS proposal were very familiar with the country's health system and were active participants of the HSDP-III consultative process.

The proposal developed through the consultative process raised the level of confidence of all parties. The GAVI Alliance Board approved the proposal promptly and the first tranche of funding was released within eight weeks of the Board approval. This rapid transfer of funds can be compared to the Global Fund experience in Ethiopia, where the period between Board approval and the first tranche of funding averaged 13 months[19]. For Ethiopia, the entire period between GAVI HSS proposal submission to the receipt of the first tranche of funds was only seven months.

[18] Ethiopia applied for HSS funding in the first round. The application guidelines and forms have been modified substantially since that time.

[19] Calculation is based on seven grants between Rounds 1 and 7. Please note that after Board approval, the Global Fund engages in a series of in-country assessments of institutional capacity as part of their grant negotiation process. In Ethiopia, once a GF grant is signed (at the conclusion of the negotiation process), the first tranche is received, on average, in 65 days.

IV. Content and Characteristics of the GAVI HSS Application

a). Description of country's GAVI HSS approach

Drawing from reviews and studies prior to the proposal development, the proposal recognized the need to greatly increase access and utilization of health services in order to improve primary health care coverage, including immunization, and to spur further reductions in morbidity and mortality among children and mothers. In order to increase access and utilization, the proposal sought to rehabilitate and expand existing facilities and ensure that they are staffed by appropriately trained and motivated personnel who have regular supplies of vaccines and drugs and effective technical and administrative support. In accordance with this objective, the proposal outlined an allocation of resources by GAVI HSS themes as follows:

Table 8: Allocation of the GAVI HSS Funds by Themes, Ethiopia

	GAVI HSS themes	Percentage of the total budget
1	Health workforce mobilization, distribution and motivation	18%
2	Supply, distribution and maintenance for PHC drugs, equipment and infrastructure	62%
3	Organization and management of health services at district level and below	20%

The single largest activities under these categories are (a) upgrading health stations to health centers, and (b) equipping health posts. These two components together account for 50 percent of all HSS grant funds.

Key activities, their scope, geographic targeting, and expected results

The HSS proposal incorporated a set of priority activities under each of three thematic areas. These activities and expected results by the end of the grant appear in Table 8. The GAVI HSS funds in Ethiopia are spent at the central level, approximately 77 percent of all HSS funds, primarily to coordinate and manage the procurement of equipment, supplies, and facility construction on behalf of the GAVI woredas/regions. The remaining funds (23 percent) are distributed to regions according to an established equity formula used to allocate health sector funds.

The GAVI HSS did not consider targeting specific geographic areas as the support is designed to assist the overall performance of the Ethiopian Health System and activities were aligned with HSDP priorities. The GAVI HSS funding was seen as instrumental to filling critical gaps identified through the consultative process, and it also considered the special needs of emerging regions. For example, health post construction was allowed from the fund only in the emerging regions.

Allocation of resources was made based on the equity formula and approved by the CJSC. Woredas with the greatest need were identified by the regional and zonal health bureaus. Accordingly, 109 woredas were selected for greater support through GAVI HSS funds, which include provision of vehicles and IT equipment. The health systems in all regions were expected to benefit from the fund through improvement of supplies and training that are implemented sector wide. The expected end results of the GAVI HSS support include improvement in health systems performance, coverage of services, and motivation of the health force.

Table 9: Key GAVI HSS Activities, Their Scope, and Expected Results

GAVI HSS activities and their scope and expected result		
THEME 1: HEALTH WORKFORCE MOBILIZATION, DISTRIBUTION AND MOTIVATION		
1a)	Integrated Refresher Training courses for HEWs	**25,050 HEWs receive IRT**
1b)	Support for HEWs apprenticeship	**12,600 HEWs complete apprenticeship**
1c)	Training of Health Center staff in IMNCI	**5,400 staff train in IMNCI**
1d)	Integrated Refresher Training of Woreda and Health Center Management Teams	**7,440 woreda staff trained in health mgt.**
THEME 2: SUPPLY, DISTRIBUTION AND MAINTENANCE SYSTEMS FOR PHC DRUGS, EQUIPMENT AND INFRASTRUCTURE		
2a)	Upgrading of 212 Health Stations to Health Centers and equipment of 300 HC	**212 health stations upgraded to HC/ and 300 HC equipped**
2b)	Materials for construction of 100 Health Posts	**100 health posts built**
2c)	Equipment for 7,340 Health Posts	**7,340 health posts equipped**
THEME 3: ORGANIZATION AND MANAGEMENT OF HEALTH SERVICES AT DISTRICT LEVEL AND BELOW		
3a)	Strengthening Monitoring and Evaluation	**109 woredas equipped with computers, printers, UBS; annual regional HEP review mtgs conducted; HMIS roll-out materials prepared and distributed**
3b)	Vehicles for 109 WorHOs	**109 woredas in need equipped with vehicles**
3c)	Support to initiate implementation of the Health Commodities Supply System	**HCSS national policy and standard setting established; reg. Essential Health Commodities Units created in addition to a new procurement and distribution agency (PHARMID); roll-out of the LMIS; capacity development workshops on Procurement, Selection and Quantification at all levels.**

The unit costs established for GAVI HSSS funding are consistent with the costing assumptions used for the HSDP-III, which used the Marginal Budget for Bottleneck method and were linked to costing scenarios generated for the HSDP-III[20]. However, there was unprecedented level of inflation that impeded full realization of the targets. For example, the fund allocated for construction considered normal cost inflation, but actually a threefold increase in cost occurred during the implementation period and significantly reduced the level of implementation in construction. This is covered in more detail in Section VI.

The proposal allocated the majority of HSS resources for capital investment (including basic equipment and construction) in anticipation that recurrent costs (maintenance, salaries and operating costs) will be covered though Government of Ethiopia budgetary sources, along with pooled funds available through the PBS grant. In addition, as a goal of the HSDP-III, the GOE was expected to increase its overall allocation to the health sector by 60 percent.

[20] The HSDP-III strategy lays out three costing scenarios, each with differing levels of population coverage and scenarios for the achievement of MDGs.

Relationship of themes/activities chosen to past assessment findings and recommendations

The proposal's overall approach greatly benefited from assessments and studies conducted between 2004 and 2006. Notable among these existing assessments was the final evaluation of the HSDP-II. Each document was reviewed and the findings regarding health system strengths and weakness, major problems and study recommendations were summarized. The proposal also summarized progress made towards the recommendations. One pertinent finding arose from the EPI Financial Sustainability Plan, which concluded that there were too few facilities. particularly ones closest to the community, and recommended that the HEP be strengthened and HEWs supported to enhance coverage, reduce vaccine wastage and increase community involvement. Overall, the findings from these assessments were carefully considered in the development of the HSDP-III and, subsequently, the design of the GAVI HSS proposal. The GAVI HSS design was matched with priorities and gaps identified through a consultative process that led up to the HSDP-III development (launched in 2005). Bottlenecks identified in the assessments related to the expansion of health services—through appropriately skilled HEWs, adequately equipped and supplied HPs, and requisite support from the health center and woreda–were prioritized in the GAVI HSS proposal.

Financial and management arrangements proposed

The GAVI HSS proposal specified that funds would flow through the MDG-PF (described in Section II). The MDG-PF is managed by the Policy, Planning and Finance General Directorate (formerly called the Planning and Program Department). As described in the proposal, the utilization of the MDG-PF would by-pass the Ministry of Finance and its regional bureaus to enhance efficiency and timeliness. However, the implementation plans would be consistent with the Ethiopian fiscal year (July 8 to July 7). Once received in the FMoH, the funds would be disbursed through the following means:

- FMoH contracts for goods and services to be delivered at the regional, zonal and woreda level. Contracts were to be developed with GTZ, UNICEF, IPASO and the Ethiopia Pediatric Society.
- Funds transferred to the Regional Health Bureau for transfer to the zones and woredas.

Financial and activity reporting is initiated at the woreda and flows upward to the zone and to the region. RHBs were to consolidate reports and submit them to the PPF General Directorate on a quarterly basis. The PPF General Directorate consolidates regional reports and supplements with information from federal-level activities. A quarterly progress report is submitted to the CJSC regularly.

The CJSC has overall responsibility for approving annual plans, budgets and quarterly progress reports for GAVI HSS funding. The PPF General Directorate provides management and oversight of the fund and the corresponding activities. According to the proposal, two additional staff members are hired at PPF-GD to perform these functions: a program manager and an accountant.

b). Monitoring and evaluation plan

The proposal includes a set of indicators to be monitored at the following levels:

- HSS inputs
- HSS outputs and activities
- Outcomes – capacity of the system
- Outcomes - impact on immunization, and MNC interventions
- Impact on child mortality

For the first two levels (inputs and outputs), indicators are presented for each of the three theme areas. Annual targets are also presented for each indicator, and values are attached regularly. However, the data source for each indicator is not fully specified. The proposal provides neither definition of indicators, information on the frequency of collection or reporting nor where baseline data are available. These indicators are summarized in Annex VI. The IRC review of the Ethiopia proposal noted that the monitoring framework was "slightly weak" with some baselines and data sources missing. This is due to the fact that during the proposal development, it was difficult to use the HSDP III indicators as HMIS was not scaled up yet. Therefore, the FMoH and its partners decided to select indicators other than those in the HSDP III. Findings of a comparison between indicator sets are described in Section IV.

c). Attention in the HSS application to core GAVI HSS principles

Country-aligned and country driven

In both its objectives and activities, the HSS proposal is highly aligned with the national health sector development plan (HSDP-III). Activities were designed in partnership with the development partners and therefore complementary to all other country efforts. GAVI HSS monies are to be channeled through the FMoH's preferred mechanism, the MDG-PF. As much of the GAVI HSS is in capital investment (construction, supplies and equipment), the GOE has taken greater responsibility for the associated recurrent costs.

Harmonization

The approaches employed for the GAVI HSS application were in line with the Code of Conduct developed and signed by the FMoH and some of its development partners in the Harmonization Manual. As the Ethiopia proposal was prepared during the first round of GAVI HSS funding, the application did not include the instruction to describe other donors' efforts or funding in the area of HSS. However, as described earlier, the proposal development followed a well-coordinated process whereby all major stakeholders in the health sector took part. The process allowed focusing on priority areas and filling well-defined gaps in the health sector. It also avoided redundancy and duplication of efforts by aligning the resources according to needs of the country and, specifically, of the regions. Much of the activities were aligned and harmonized with the already accepted sector-wide plan (HSDP-III).

Results-oriented

The HSS proposal is clearly aimed at making substantial improvements to the provision of primary health care through the Health Extension Program. Direct linkages to immunization depend on the new resources invested in the health posts and HEWs to bring services closer to the community, thereby increasing access and use. By so doing, the proposal aims to improve coverage and use of a range of maternal and child health services, including immunization.

Predictable and additional

The proposal describes an anticipated resource mapping exercise that would help to confirm that the GAVI HSS resources are indeed additional to available funds and contribute to filling the financing gap for HSDP-III Scenario 1.

Inclusive and collaborative

The stakeholders involved in proposal development saw the processes as participatory and all inclusive. It appears that stakeholders appreciated the value added through the collaborative undertaking, and more partners are interested in joining in the implementation of the harmonized country plan. Although the nature of the system-wide project implementation dictated that most activities be implemented by the public sector, encouraging steps were taken by the FMoH to involve stakeholders in the implementation process. For example, funding for IMNCI training of health center staff was implemented through the Ethiopian Pediatric Society, and some goods and services were delivered by development partners.

Catalytic

The GOE clearly saw the GAVI funds as catalytic (see box text quote this page). One example of this catalytic role was the use of the MDF-PF. For the first several years of its existence (2006 through 2009), GAVI was the only funder to channel its monies through the MDG-PF. By early 2009, the FMoH and additional donors had negotiated a Joint Financing Arrangement, and those partners were prepared to channel their resources through the MDG fund as well.

> "… we see GAVI HSS support as an important breakthrough in improving aid effectiveness, thereby enabling us to achieve greater improvements in health outcomes per dollar of aid that we receive from all sources."
>
> --Ethiopia HSS proposal

Sustainability-conscious

The FMoH is cognizant of the recurrent cost requirements associated with the GAVI HSS investments. There was no financial sustainability plan included in the proposal, which acknowledged that the GOE would be dependent on donor support for some time to come. However, the proposal does give consideration to the commitment of the GOE to continuously improve the annual health budget, and the woreda councils improve their commitment through enhanced advocacy by woreda-level health staff.

d). Analysis of the GAVI HSS proposal development/application process

The primary strength of the GAVI HSS proposal lies in its close alignment with the on-going Health Sector Strategic Plan (HSDP-III). By working within a well-defined and agreed-upon set of objectives and priority activities, the GAVI HSS funds, as proposed, had the potential for rapid start-up and implementation. In addition, the concurrence of timelines between GAVI HSS and the HSDP-III meant that the GAVI proposal benefited from the analytical base of evaluations and assessments that contributed to the overall design of the HSDP-III. The alignment of budget and financial mechanisms is also notable, with the GAVI HSS proposal utilizing the same budgeting assumptions and scenarios as the HSDP-III and channeling monies through the nascent MDG-PF. Taken together, these strengths can help to characterize the GAVI HSS fund, as employed in Ethiopia, as an innovation.

The most notable weakness in the proposal was the monitoring and evaluation plan. In fact, there was no actual M&E plan *per se*, rather a listing of indicators with some indication of likely data sources and targets. The proposal includes a sound framework for the indicators presented with inputs, outputs, outcomes (for systems as well as populations) and impact. The indicators proposed align quite well with the GAVI HSS framework (Annex VII). Many of the indicators have good face validity (i.e.. these are the type of variables that reflect key elements of the strategy and that should be used to monitor the implementation of the Health Extension Program (HEP) and its component HSS funding). In addition, the FMoH Health Information System (HIS) has been under revision for some time now (over two years); therefore, the proposal was limited in its ability to draw on existing HIS and routinely generated data.

However, by reviewing the M&E section of the proposal along with the three Annual Progress Reports submitted to GAVI, it is evident that the initial M&E plan would have benefited from more careful consideration. Notable is the lack of any form of indicator definition, including numerators and denominators[21]. Over time, the indicators have undergone substantive changes in wording, revision of baselines and very limited progress reporting. By June 2009 (when the 2008 APR was submitted), only 21 of the original 37 indicators (57 percent) had baseline data (see Annex V). Of the originally proposed 37 indicators, only 6 have had any form of quantifiable progress reporting.

The proposal includes several measures which would seem of significant value in tracking progress in the HEP, notably:

- percent of health posts with 10-day kerosene supply
- percent of health posts providing EPI twice monthly (at a minimum)
- percent of health posts with no essential drug shortages in the last 3 months
- percent of health posts supervised at least once in the last 2 months by the woreda health team.

Unfortunately, these measures have not been collected or reported.

[21] Numerators and denominators do appear for a few indicators in the 2008 APR.

V. Implementation Experience/Absorptive Capacity

a). Management and coordination of the GAVI HSS in practice

GAVI-funded HSS activities have been implemented in Ethiopia since April 2007, with the first disbursement of funds. Given the distribution of funds (with a majority expended at the FMoH level for activities in the woredas), the management and coordination functions adapted at the central level were fundamental for effective implementation. As per the proposal, the HSS fund is managed and overseen by the Policy, Planning and Finance General Directorate (PPF-GD) of the FMoH. PPF-GD provides overall management of the funds, monitoring and facilitating implementation. It also ensures timely release of funds and guidance on the implementation process. The PPF-GD is also taking responsibility for managing the new Global Fund Round 8 grant as well as the newly awarded GAVI CSO grant. The implementation to date has closely followed established procedures for procurement, budgeting and reporting at the FMoH. Management and coordination during implementation have been examined in further detail as described below.

Central-level organization

The equivalent of a Health Sector Coordinating Committee (SCC) in Ethiopia is the Central Joint Steering Committee (CJSC). One of its purposes is to give general guidance for the preparation of health sector strategic plans, annual review meetings, joint review missions and evaluations of the Health Sectors plans[22]. Along with these activities, CJSC oversees the development and implementation of GAVI HSS to ensure that the activities are consistent with the national health sector development framework (annual plans).

The Joint Central Coordinating Committee (JCCC), the technical arm of the CJSC and coordinating body of the health sector, also plays an important coordinating role for the GAVI HSS funding. The regular meetings of the JCCC consider a range of issues related to implementation of the HSDP-III. In regards to the GAVI HSS funding, the JCCC has the authority to review and approve requests for re-programming (both from federal and regional levels) as well to review the Annual Progress Report to GAVI. Over the past several months, the JCCC has dealt with re-programming or modification requests including shifting of US $5.9 million in unspent funds from the Health Commodity Supply System (HCSS) to construction costs for warehouses for the Pharmaceutical Fund and Supply Agency (PFSA) and a re-programming of monies in the SNNPR region from Integrated Refresher Training, where the monies could not be absorbed into areas of greatest demand, including supportive supervision and furnishing of health posts. The process of re-programming is highly regulated by the JCCC and passes through thorough scrutiny for relevance and legitimacy.

The FMoH immunization program and the immunization ICC are not directly engaged in HSS management and coordination. However, membership of the JCCC and ICC is overlapping.

Coordination between national and sub-national levels

At the regional level, an estimated 23 percent of all GAVI HSS monies are planned and disbursed, including funds for training of HEWs, capacity development for woreda health officers, and annual HEP reviews. In accordance with standard procedures, the FMoH, with CJSC approval, allocates the GAVI HSS fund to the regions based on the national equity formula, which includes population size, absorption/liquidation capacity, implementation capacity, and infrastructure and disease burden.

[22] HSDP Harmonization Manual (HHM, 2007)

As described in the Harmonization Manual, regions and districts also have coordinating bodies to perform similar functions at their respective levels (Regional Joint Steering Committee and Woreda Joint Steering Committee). During the Tracking Study interviews with regional and woreda health staffs, these coordinating bodies were not shown to exist.

Recognizing the gap in the supervision of the lower-level health system, which was also observed during the Tracking Study, efforts are underway to strengthen supervision through the Integrated Supportive Supervision (ISS) training. When the training is completed and the trainees deployed to woredas, the supervision at the health centers and health posts should be immensely improved. One full-time HEW supervisor will be allocated for five HEWs. The fundamental principle for introducing ISS includes creating opportunities for health workers and their supervisors to work as a team identifying problems and findings solutions together. Supervisors act as facilitators, trainers, mentors and coaches for HEWs. (See Annex VIII for the timing and condition of supportive supervision from the federal to the health facility level.)

The construction of HPs is undertaken in a coordinated manner between the federal and regional systems. While the RHBs are responsible for construction of health posts by mobilizing resources within the region, the FMoH is responsible for providing the necessary equipment. However, the construction of health posts in emerging regions was given special consideration, and budget allocated from the GAVI HSS funds for construction. Accordingly, the Tracking Study Team was informed during the field visit that 10 HPs have been constructed using this fund in Afar region.

GAVI HSS funding mechanisms are recognized as the most efficient at all levels. Once initial disbursement is made to the regions (RHBs), quarterly activity reports along with the statement of expenditure are expected by the FMoH. According to the information obtained from the FMoH, the first two installments were disbursed without any condition, but the third and fourth installments were transferred depending on the region's absorption capacity and level of liquidation. Some delays were observed in providing activity reports and statements of expenditure from the zonal and regional levels to the FMoH, which in some instances were attributed to a short liquidation period.

There is also an annual review meeting where representatives from federal and regional government agencies, selected woreda health offices, HPN development partners' working groups, NGOs, professional associations, universities, the private sector, and relevant local and international consultants take part. During this meeting, progress made during the year is reviewed, key gaps are identified, experiences are shared, and the plan for the coming year is initiated.

Decision-making process

Key decision-makers include JCCC, composed of staff from PPF-GD and five staff (with HSDP experience) from the Health Population and Nutrition Development Partners group. The GAVI HSS focal point at the PPF-GD of the FMoH is responsible for the planning and programming of all the activities of the FMoH, including those funded by GAVI HSS. At all levels, the decision-making processes for spending as well as procurement are bound by the Government financial, audit, and procurement regulations.

As the GAVI HSS fund is earmarked, after the budget is disbursed to the region by the FMoH, the region controls the utilization of resources within the specified areas of activities. The RHB departments with direct responsibility for implementing GAVI HSS activities are the planning, family health and health extension departments. The woreda Health offices (in Amhara and Oromiya regions) play a role in planning, recruiting and sending HEWs for training and follow-up in the upgrading of health facilities. The process appears to be well understood by the concerned bodies at all levels.

GAVI HSS oversight is carried out through the existing hierarchical structures and processes used by the health system. When activities and budget re-programming is needed, requests are presented up through the system to obtain approval from the JCCC.

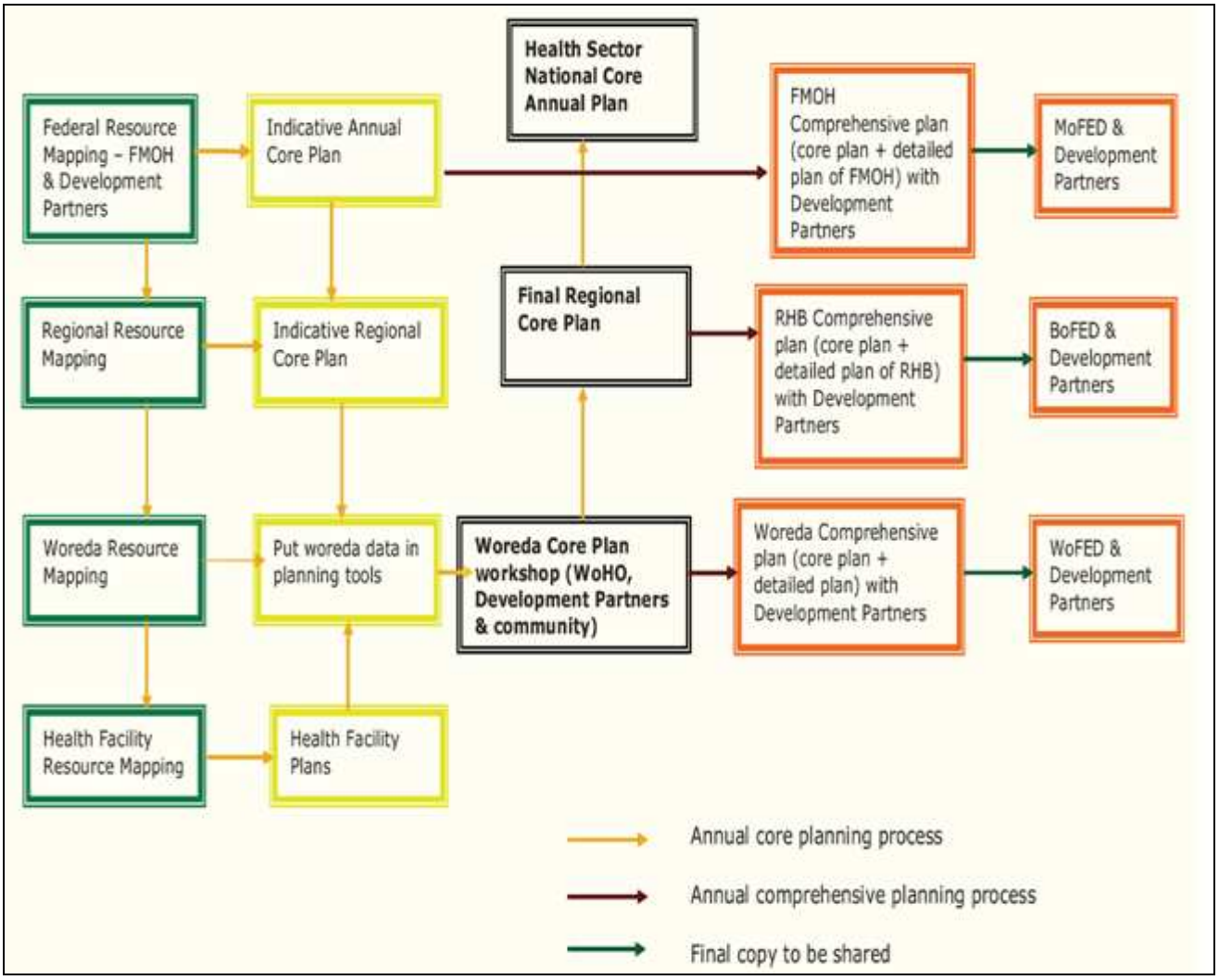
Planning and budgeting process

Two plans guide the health system in Ethiopia: a longer-term Strategic Plan and an Annual Plan, both approved through appropriate bodies at different levels. The Strategic Plan is a reflection of HSDP in a particular region or woreda. The annual plans are the main implementing mechanisms for the strategic plans. Planning at the regional, zonal and woreda level is done based on the indicative plan prepared at the federal level. This indicative plan provides regions with a general direction based on the goals of the HSDP and international commitments. Based on this indicative plan, woredas are expected to plan their own activities. However, the intensity of the planning process at the regional and lower levels is dependent on the availability of experienced personnel.

Regions are required to prepare and submit their own five-year strategic plans, which should include a budget and a financing plan. The financing plan is expected to include all sources of finance in the region. Zones and woredas are expected to develop strategic plans in the same manner. Zones and woredas assist health facilities to prepare strategic plans. The review meetings regularly conducted at various levels are instrumental in coordinating and monitoring the planning process. Once strategic plans are finalized, the next step is to develop the annual plan to translate the broader objectives into practical activities. Developing annual plans also involves consultation with major stakeholders, including relevant Government institutions, donors, NGOs and the community at each level.

The figure below depicts the annual planning cycle that is used in the current health system in Ethiopia.

Figure 6: The Annual Planning Cycle



Source: Harmonization Manual, 2007

For GAVI HSS activities, relevant departments and divisions prepare their respective plans. Finally the plan developed at all levels is consolidated by the PPF-GD and is submitted to the CJSC for conforming integration to the National Health Sector Program (HSDP).

Based on its field visits, the Study Team found that the GAVI HSS fund is released to the respective zones or regions based on a detailed implementation plan made at the zonal level (in the Amhara and Oromiya regions), and at the regional level in the Afar region. In the case of the Afar RHB, GAVI HSS funds have not been channelled to the woredas because woredas lack the capacity to implement the activities of GAVI HSS. The GAVI HSS money is pooled at the regional level, and all planned activities are performed through the RHB.

Nature and source of any technical assistance (TA) received during implementation

The FMoH effectively utilizes technical assistance through development partners and CSOs. Notably, for GAVI HSS, the FMoH utilized the Ethiopian Pediatric Societies for providing the IMNCI course for health workers, nurses and health officers. The WHO country office provided TA during the development of the proposal and later during its implementation. Working under contract with the FMoH, UNICEF has been instrumental in

procuring and equipping health posts. Working similarly under FMoH contract, GTZ is upgrading health stations to health centers. The FMoH, in collaboration with its development partners, provides technical support to the regions during the planning and implementation of GAVI HSS activities. However, regional- and woreda-level study respondents suggested that additional TA is needed at their level.

b). Attention during implementation to the core GAVI HSS principles

Country-aligned and country-driven

Implementation of the GAVI HSS grant is strongly aligned to HSDP-III priorities. Use of the MDG-PF for the flow of funds is one of the FMoH's preferred channels for sector funding. Decisions about resource allocation and disbursement follow the country's procedures and practices. The key decision makers at all levels are involved in the implementation of the agreed-upon plans.

Harmonization

Harmonization is defined as a coordination of activities among all stakeholders to reduce the transaction cost of delivering aid and services. The GAVI HSS application has not added any separate entity, such as a project management unit, that requires additional cost. The GOE's commitment to harmonization and alignment has been elaborated in the Ethiopian Plan for Sustainable Development to End Poverty (PASDEP), which formed the basis for subsequent health development strategies.[23]

The support is also aligned to the priorities of the Government of Ethiopia, and mainly focuses on improving health care coverage through supporting the health extension program and construction and upgrading of health facilities. The plan is aligned to the MDGs and many other bilateral and multilateral initiatives that aim to support the health sector in Ethiopia.[24]

Results-oriented

Drawing from the analyses and strategies developed for the HSDP-III, the GAVI HSS activities are directly aimed at improving the performance of the health system at the grass roots level.

It is important to note that alleviating the system-wide bottlenecks that include human resource shortages, low per diem rates, delayed payment, transportation problems, and shortage of supplies and drugs need more concerted and sustained efforts.

Resources - predictable and additional

GAVI HSS support is directly linked to the national plan, HSDP-III and represents additional and gap-filling resources. GAVI has affirmed that the fund will be available until 2010, and a multi-year plan was prepared. The GOE approach to developing a pooled fund mechanism is another example of efforts to increase the system-wide availability and predictability of funds targeted to gaps in HSDP-III implementation.

Based on the study field work, it was found that the arrival of funds at the regional and zonal levels is not always predictable. Funds are usually disbursed from the FMoH to the RHB through the finance account of the health bureau. Then the RHB disburses it to the ZHB since they are the ones responsible for coordinating IRT

[23] MoFED. Ethiopia: Building on Progress: A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) (2005/06-2009/10).

[24] Federal Ministry of Health, Ethiopia. The HSDP Harmonization Manual (HHM). 2007.

activities. When the GAVI budget arrives, they are informed by letter. This sequence of activities can result in funds arriving out of sync with the annual planning and budgeting cycle.

Inclusive and collaborative

The major stakeholders drawn from Government agencies and bilateral and multilateral agencies were involved in the design of the program, its implementation and the monitoring of HSS activities. CSOs, in the form of the Ethiopian Pediatric Association, are engaged in GAVI HSS implementation. An important step was the participation of GAVI Secretariat staff in the Joint Review Mission conducted by the Government with its partners to monitor the implementation process. An annual review meeting regularly conducted by FMoH, RHBs and development partners is another key mechanism for monitoring the implementation process, whereby bottlenecks are identified and solutions are sought collectively.

Sustainability conscious

The design and implementation of GAVI HSS is in line with the broader health sector development plan of the country. The GOE and the FMoH are working to substantially increase the public spending for health through regular budget and by creating mechanisms for a more coordinated utilization of donor funding in collaboration with development partners. The GOE has already committed a substantial amount of resources to support the salary and activities of the HEWs in every small administrative unit of the country (two HEWs are assigned per kebele). A strong supervision system will be put in place shortly to ensure quality of services at the grassroots level.

The woreda-based planning process initiated in the last two years offers the best opportunity to enhance budget allocation for the health sector through an informed negotiation process. The development of sector-specific public expenditure reviews (PER) as part of the resource mapping exercise during the planning process also strengthened the collaboration with MOFED/BOFED and development partners by providing opportunities to negotiate on sector budgetary ceilings at all levels and identifying areas that require additional or new funding.

The implementation of the "matching health center," described above, is another approach that encourages increased resource allocation for the health sector by the lower administrative bodies. The emerging initiative is to introduce performance-based contracting by the FMoH to the RHBs and WorHOs to ensure effective and timely use of resources. The mechanisms created and/or being created to negotiate greater funding from local and regional governments are believed to be cornerstones for enhancing sustainability of the health sector development strategies beyond GAVI HSS funding.

Catalytic

The FMoH has made effective use of GAVI HSS funds through the MDG-PF. While some development partners remained cautiously supportive[25], they have been increasingly positive due to favorable experiences gained through the GAVI HSS funding. In April 2009, seven additional development partners signed a Joint Financing Arrangement with the Government of Ethiopia committing their agencies to use the MDG-PF for health systems strengthening funds. The GAVI HSS grant can be seen as a catalyst to this step.

In addition, funds from global health initiatives, including GAVI, have been used by FMoH to leverage and negotiate for additional health resource commitments from the regional levels. For example, the FMoH and RHBs have agreed on a "matching health center" scheme whereby every FMoH-constructed health facility will be matched by a RHB-financed health facility—an innovative means to increase resource allocation from domestic sources.

[25] ETHIOPIA HEALTH SECTOR DEVELOPMENT PROGRAMME HSDP III 2005/06 – 2010/11 (GC) Mid-Term Review.

c). Financial management and flow of funds

Financial procedures, roles and responsibilities

The FMoH has responsibility and accountability for the performance of the health sector as a whole. For the GAVI HSS grant, the FMoH manages and coordinates contracts for facility upgrades, equipping of health posts and health centers, procurement of vehicles and IT equipment, and IMNCI training.

Immediately below the FMoH, Regional Health Bureaus (RHBs) play a crucial role in disbursing the funds in accordance with rules and regulations. The GAVI HSS funds were transferred to the MDG Performance Package fund of the Government, except for the first installment, which was established to promote a broader harmonization and alignment of donor funding to the sector.

The FMoH disbursed the funds to the regions directly via their bank accounts within the specified time frame. The regions disbursed the allocated budget to the zones and woredas health offices through the respective finance and economic development offices. That is due to the fund pooling system introduced by the regional governments.

The Finance and Economic Development Bureaus in the Oromia and Amhara regions have two main sub divisions: Planning and Programming, and Accounting and Procurement. The main responsibilities of the donor fund divisions of the accounting and procurement department include notifying the concerned department of the zonal/ woreda health office of the arrival of funds; monitoring liquidation of money at the woreda and zonal level to the regional health bureaus; and monitoring whether funds are utilized in accordance with the time frame and established procedures.

Overall, the Study Team observed that the health sector uses a very secure Government finance handling system for GAVI HSS funds. The Government financial regulation stipulates clear procedures for utilizing and accounting financial resources and has internal audit procedures.

Flow of funds and bottlenecks

The flow of funds and reporting procedures through the health system is depicted in Figure 7. A detailed description of the procedure has been discussed earlier in section I. The figure shows the planning, budgeting, expenditure, procurement and liquidation process. The system is well recognized by relevant bodies at all levels. The GAVI HSS fund is disbursed by the FMoH to regions, accompanied by a letter that states the amount of funds disbursed by specific GAVI HSS activities and the time when the funds should be liquidated.

The RHBs control the utilization of the GAVI Funds disbursed to the region and ensure that funds are utilized for specified activities stipulated in the proposal. Any reprogramming of the budget is forbidden without the knowledge and permission of the appropriate body through the PPF-GD. In Amhara and Oromia, some portion of the funds is disbursed to zones and woredas for implementation of specific GAVI HSS activities. The RHBs send letters to the respective regional Bureaus of Finance and Economic Development (BOFED) about the specific GAVI HSS activities and the allocated budget for each zone/woreda. However, the implementation and coordination efficiency of the procedures is dependent upon the availability of adequately trained manpower at various levels. In the Afar region, the funds remain at the regional level since there is no zonal structure and the woredas have limited implementation capacity.

Generally, it appears that relevant authorities at all levels know the purpose and the mechanisms for using GAVI HSS funds. However, respondents in the regions reported a delay in the arrival of the fund release notification letter with the budget breakdown, which in turn delays the implementation of activities. It was also mentioned that the fact that the regions wait until every recipient zone/woreda submits activities and

liquidation reports is the main reason for the regions' delays in reporting to the FMoH. The limited capacity at the finance offices, which is compounded by high staff turnover, is another bottleneck identified by respondents. Those bottlenecks are system-wide problems that require urgent improvement. The Study Team has been informed by the PPF-GD that the FMoH has recognized the problem and is working to put in place a web-based accounting system that promotes transparency, accountability, timely utilization of funds, and timely reporting.

The study respondents also indicated that the work force often complain about the use of regular Government per diem rates for GAVI HSS activities. Explaining to the work force how the various funding mechanisms operate in the system may help clarify misunderstandings about the use of funds at the lower levels.

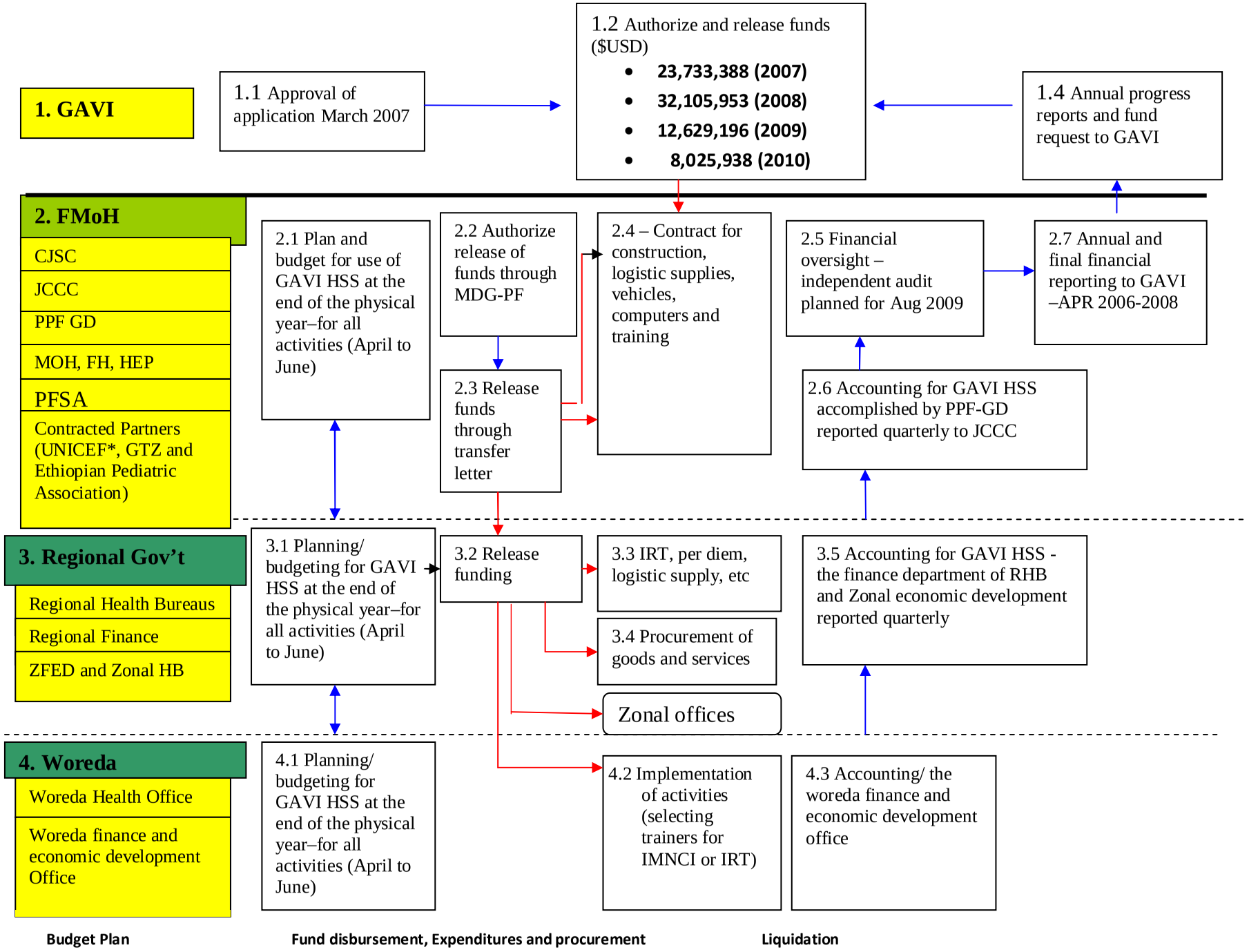


Figure 7: Planning, Fund Disbursement, Expenditure and Liquidation

*In most cases, refrigerators and health post kits were supplied by UNICEF directly to the woredas (health centers and health posts).

GAVI HSS allocation/spending compared to plan

According the information obtained from the Annual Progress Reports submitted to the GAVI Alliance by the FMoH, the funds allocated by GAVI for each disbursement period was fully released. The FMoH also reported full utilization of funds received from GAVI. Table 10 shows the four separate releases and the status of utilization.

Table 10: Amount of Funds Disbursed from GAVI Alliance from 2007-2010

Items	Year			
	2007	2008	2009	2010
Amount funds approved	23,733,388	32,105,953	12,629,196	8,025,938
Date of funds arrived	Apr-07	Sep-07	Oct-07	Mar-09
Amount spent	23,733,388	32,105,953	12,629,196	-
Balance	0	0	0	-
Amount requested				8,025,938

Source: GAVI APR 2008

Table 11 below depicts the regional transfer of funds from GAVI HSS through the FMoH, including the balances settled by statement of expenditure (SOE) and unsettled balance from regions to the FMoH. To date, 74 percent of all transfers to the RHBs have been settled through a statement of expenditures.

Table 11: Regional Transfer from GAVI HSS with Settled and Unsettled Balances, 2009

Regional transfer from GAVI HSS			
Regions	**Total Transfer**	**Settled by SOE**	**Unsettled Balance**
SNNPR	16814711.73	11679912.43	5134799.30
Gambella	3007297.81	2268551.63	738746.18
Harar	529211.80	528500.32	711.48
Amhara	21563990.07	14130982.58	7433007.49
Dire Dawa	737135.76	580867.40	156268.36
Afar	3408674.75	2692550.42	716124.33
Benisahngul	3050735.62	1268911.35	1781824.27
Tigray	5637474.78	4653560.86	983913.92
Somale	6795698.98	4069530.40	2726168.58
Oromiya	27155219.53	23857870.54	3297348.99
Addis Ababa	119604.62	-	119604.62
Total	88819755.45	65731237.93	23088517.52

Source: FMoH, PPF-DG

While the Study Team conducted the fieldwork in the regions, it was not possible, except in the Afar region, to obtain a reconciled report of activities and expenditures that confirmed full utilization of funds received from GAVI HSS. However, the Team was informed that the GAVI fund is utilized for IRT training for HEWs, to distribute supplies and drugs to health facilities, and to pay per diem for immunization outreach programs. It was not also possible for the Study Team to verify expenditure by specific activities at the lower levels because the record keeping had not been organized in a way to make that possible. It appears necessary to train the lower-level staff to improve their financial recording by expenditure to facilitate monitoring of funds utilization at all levels.

As part of the routine self-assessment of procedures for taking immediate corrective actions, the Amhara and Oromia RHBs conducted reviews of the financial procedures in the respective regions. The self-assessments revealed that there were some improper recording and misreporting of expenditures, and suggested improvements in recording, organizing and reporting expenditures. The frequent turnover of staff in the finance departments was mentioned as one of the bottlenecks in improving recording and reporting. Based on that report and as a routine practice, the FMoH and RHBs have undertaken a series of supportive supervisions and on-site trainings to improve the situation. As mentioned earlier, the FMoH is trying to implement a web-based accounting system that is expected to solve inconsistencies in recording and reporting.

Attention to financial sustainability

The continuing efforts by the FMoH and all other levels of the health system to secure more Government funding for the health sectors has produced encouraging results. Both the central and local governments have increased budget allocation to the health sector. Innovate approaches such “matching health center” further encourage the involvement of local governments in expanding access to the communities under their jurisdiction. Further details are given below to indicate the level of commitments to maintaining the achievements through GAVI and other related funds in the long term.

The construction of health facilities (health post, upgrading of health stations to health centers and constructing new ones) are included in the sector development plans of woredas. The resources required for construction are drawn from locally available financial sources and through community contributions, which encourages mobilizing the community in utilizing its own resources towards sustaining the grass roots health system. In some areas where construction of health posts is not yet accomplished, community members provide houses for the HEWs for delivering the service to the community while mobilizing resources for the construction.

Although not directly associated with the GAVI HSS grant, the introduction of the new health care financing strategy allows for the collecting of user fees for services. The *woreda* health office also allocates some amount of budget for purchasing medicines. This money is used as a revolving fund by the health center. In the long run, it is predicated that the health centers will run themselves without Government support. These mechanisms create hope for establishing and maintaining self-sufficient health care financing.

d). Monitoring and evaluation practices

Indicators, information systems, procedures at each administrative level

The FMoH is responsible for collecting, analyzing and reporting routine health indicators nationally. All levels of the health system take part in the HMIS. There are established procedures for the HMIS, which specifies the data collection and reporting tools as well as the reporting frequency.

The routine HMIS/M&E is the main source of data for the indicators selected for monitoring the HSDP strategic plans and donor-supported activities. It has been under reform since 2005 in order to make it sufficient and efficient to provide the needed information for monitoring health interventions. The process of selecting indicators for the new HMIS has been ongoing since July 2006 with a national workshop attended by federal, regional, and woreda officials, and by development partners.[26,27,28,29] The ultimate goal of this exercise is to ensure that the HMIS satisfies the needs of all stakeholders and avoids duplication of effort. The HMIS reform is also designed to better define indicators, redefining standard global indicators based on the Ethiopian context (medical technology at each level of the health service organization), improving the capacity of institutions and individuals to improve information use and sharing among stakeholders. At the time of the development of the GAVI HSS proposal, this process was not mature enough to be incorporated. Thus, the selection of indicators was mutually agreed upon by the FMoH and GAVI Alliance.

Use of monitoring data for program management, planning or policy making

The Health Sector Development Program (HSDP) III Strategic Plan states that the objectives of Monitoring and Evaluation include improving informed decision making and promoting optimum use of resources. The national Health Management Information System (HMIS) is aggregated quarterly based on nationally agreed indicators. This source has been used as the major source of information for monitoring the performance of immunization programs. The FMoH publishes a booklet entitled "health and health related indicators." Although the publication is very informative at the country level, it has limited utility at the lower levels because data are not disaggregated by region, zone and woreda level. Thus, a system of producing a report containing disaggregated data needs to be encouraged at the regional level to promote informed planning, budgeting and other decision-making processes.

Currently the GAVI HSS activities are monitored using data that is captured through routine HMIS and supplemented by other sources. In the future, the FMoH anticipates fully integrating the indicators for monitoring all basic activities through the HMIS. The roll-out of HMIS reform is also supported by GAVI HSS by way of providing resources for training and preparation of materials for HMIS.

e). Analysis of implementation experience

The GAVI HSS has been implemented in Ethiopia for three years, 2006/07 to 2008/09. The Tracking Study revealed that the GAVI HSS funds have been effectively implemented through the health system. Most of respondents of the study agreed that it has positively influenced the health system as compared to vertical programs, which mostly end up fragmenting the health system.

The GAVI HSS support was aligned to the national priorities identified through a comprehensive consultative process involving all major stakeholders, which identified poor access to health services, low-quality services, poor logistics and supply management, and shortage of the workforce for health as the main bottlenecks for improving the health status in Ethiopia. The GAVI HSS-supported program focuses on applying system-wide interventions to alleviate the bottlenecks using the Government structure and procedures. The main strategies

[26] Federal Ministry of Health Management Information System (HMIS) /Monitoring and Evaluation (M&E) HMIS Procedures Manual: Data Recording and Reporting Procedures *HMIS / M&E Technical Standards: Area 3 January 2008.*

[27] Federal Ministry of Health, Health Management Information System (HMIS) /Monitoring and Evaluation (M&E) Indicator Definitions *HMIS / M&E Technical Standards: Area 1.january 2008.*

[28] Federal Ministry of Health. HMIS/M&E Information Use Guidelines and Display Tool *MIS/M&E Redesign: Technical Standards Area 4 version 1. May 2007.*

[29] Federal Ministry of Health, Health Management Information System (HMIS) /Monitoring and Evaluation (M&E) Disease Classification for National Reporting and Case Definitions *HMIS/M&E Technical Standards: Area 2 January 2008.*

include construction and upgrading of health facilities, training of frontline and mid-level health workers, supporting the logistics and supply management system, and assisting the HMIS reform.

The GAVI HSS implementation fully adhered to the principles of harmonization and alignment of donor support to government efforts. This approach is exemplary, further promoting a unified action to improve the poor health status of the nation by avoiding fragmentation of efforts. The health work force is accustomed to fragmented and uncoordinated donor support and will need proper orientation to the procedures and benefits associated with more harmonized donor support for system strengthening. In some areas, shortage of supplies and maintenance of equipment hindered the full functionality of health facilities. The deployment of HEW supervisors and efforts to strengthen the supportive supervision at all levels would greatly improve performance at the grassroots level. Furthermore, regions need to identify bottlenecks in their local contexts and introduce appropriate tailored interventions. It is very important to continuously strengthen the implementation capacity of the lower-level health system, particularly the woreda level, to ensure efficient implementation of activities and timely reporting.

VI. Country Performance against Plans and Targets

a). GAVI HSS-funded activities carried out as compared to plan

Health workforce mobilization, distribution, and motivation for provision of quality health services

Under this theme, training of HEWs, IMNCI for nurses and health officers, and woreda management team capacity building are implemented.

The IRT training for HEWs

The FMoH is responsible for developing and distributing the standard refresher-training guide and manual to the regions. The training is made to address knowledge and skills gaps of HEWs, using a flexible modular approach to respond to the needs identified in evaluations, including the need for better skills in cold chain management. According to the curriculum, the training lasts 18 days training (GAVI HSS country proposal).

The proposal specifies the woreda health office personnel (who attended the TOT) to be responsible for providing the training at the woreda level under the close supervision of the regional health bureau-based quality assurance team (GAVI HSS country proposal). In practice, that responsibility was bestowed on the region in Afar and in zones in the Amhara and Oromiya regions. Although the selection criteria used for the refresher training varies by region, successful completion of the basic 10-month training and prior job experience as an HEW are compulsory in all regions. The Study Team observed that not all IRT trainees are provided with the standard manual for their future reference. As it is difficult to remember everything learned, the need for providing a manual to ensure proper utilization of the knowledge and skills included in the IRT is clear.

Accordingly, between the year 2006 and 2008, a total of 18,362 HEWs from all the regions were trained on IRT. For that purpose, US $8,531,250 was disbursed to the regions. The achievement of this activity compared against the target set for the three years is about 84 percent (Annual Progress Report).

Table 12: Annual targets and achievements for health extension workers refresher training

Year	2006	2007	2008	2009	TOTAL
Annual Targeted Number of HEWs for IRT	4,950	13,250	3,425	3,425	25,050
Actual trained HEWs on IRT	4,950 (100%)	8,941 (67%)	4,471(130%)	-	
Allocated budget in US$	1,546,875	4,140,625	1,070,313	1,070,313	7,828,126

Source: GAVI Country proposal and Annual Progress reports 2006-2008.

Some deviations from the national guidelines about HEWs are observed in the Afar region. For instance, most of the HEWs are males due to the difficulty of finding females with even basic education. HEWs work at the health centers and health stations or without a health post at their kebeles. Inadequate follow-up of the trainees after the training is a common problem in the region. This clearly signifies the need for more technical as well as financial support to emerging regions.

The IMNCI training

The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) was a strategy adopted to improve the quality of the management of childhood illnesses. It has three components: improving the skills of the health workers, the health system, and the family and community practices. The training is given to nurses and health officers for six days. The main activities under IMNCI are prevention and control of ARI, diarrhea, malaria, malnutrition, measles and HIV/AIDS (Annual Performance Report of HSDPIII, 2007/08).

At the time of the GAVI HSS development, only 30 percent of the Health Centers had IMNCI-trained staffs. The proposal indicated a further training of 5,400 health workers in IMNCI to bring the proportion of health centers with staff trained up to 70 percent, enabling the health centers to play the role of first-level referral function more effectively by 2010. GAVI HSS fund supports the training of 1,350 health officers and nurses per year for four years (GAVI HSS Country proposal). The IMNCI training is outsourced to the Ethiopian Pediatric society. Accordingly, US $360,000 was transferred to the society. In the year 2007, a total of 656 health workers were trained on IMNCI case management, 36 on IMNCI facilitation skills, and 27 on IMNCI supervision. In addition, post-training follow-up of the trainees by the trainers was conducted at 220 sites (Annual Progress Reports). During 2008, a total of 703 health professionals were trained on IMNCI case management, 20 in IMNCI facilitation skills, and 31 on IMNCI supervision. The selection of health workers for the training is the responsibility of RHBs. The overall two-year achievement of the IMNCI training against the plan is approximately 54 percent (calculated from the three Annual Progress Reports).

Table 13: Annual target for IMNCI training and the achievement

Year	2006[30]	2007	2008	2009	Total
Annual No. of Targeted IMNCI trainees	1,350	1,350	1,350	1,350	5,400
Achievement		719 (53%)	754 (55%)		
Cost in US$	360,000	360,000	313,135	360,000	1,440,000

Source: GAVI Country proposal and annual Progress reports 2006-2008

Upgrading and Equipping of Health Stations to Health Centers

In line with recommendations of the final evaluation of HDSP II, upgrading of existing health facilities is a priority over the construction of new ones. Accordingly, in the year 2007 the FMoH outsourced to GTZ the upgrading construction of 200 health stations to health centers at a cost of about US $16,250,000. Of all the health stations, 182 were upgraded to Type "B" health centers and 30 to Type "A." In the year 2008, 70 health stations were outsourced to GTZ at a cost of US $9,655,244 (Annual Progress Reports).

[30] The start of this activity was delayed, which is why performance during the specific year is not available.

Table 14: Annual physical and financial targets for the upgrading of Health Stations to Health Centers

Year	2006	2007	2008	2009	TOTAL
Annual target to upgrade HSs to HCs	35	71	71	35	212
Achieved	-	46	70		
Allocated Budget in USD	3,250,000	16,250,000	9,655,244	3,250,000	19,500,000

Source: GAVI Country proposal and annual Progress reports, 2006-2008

The construction of health posts

The construction of 100 health posts in four emerging regions—Afar, Benishangul-Gumuz, Somali, and Gambela—was another support program of the health system. Compared to other regions, these regions are poor in terms of the social and the economic infrastructure. According to the target set, each of the four regions will have 25 new health posts, to be constructed using GAVI funds. For this purpose, US $187,500 was transferred to each region. The FMoH provided a standard construction design for the regions.

The achievement in construction was generally poor because of the escalating costs of construction in the country. A total US $93,750 was allocated for construction of new health posts. Due to the increased costs of construction, the targets for this activity have been revised from 100 health post to 30. To date, 26 posts have been or are being constructed with GAVI HSS funds (10 each in Gambela and Benishangul-Gumuz and 6 in Somali). In some cases, costs were supplemented through the regions.

The organization of primary care units differs from the general standard provided by the FMoH in the pastoral areas. In the Afar region (a predominantly pastoral region), the construction of health posts and centers is based on population settlement. Accordingly, the number of health posts per kebele is locally determined; some may have more than one and others may have none. The adaptation in the pastoral areas helps avoid resource wastage and encourages focusing on population served rather than just achieving geographic coverage.

Organization and Management

To strengthen the organizational and managerial functions of the health system, the GAVI HSS funds have supported the new HMIS roll-out, supportive supervision, and the purchase of IT equipment and vehicles. A total of 109 woredas were selected to receive a set of computer, printer, and UPS. A total of 109 vehicles were purchased and distributed to the regions using GAVI HSS funds. This activity was intended to support the supervision of HEWs and the distribution of vaccines and other essential commodities.

The HMIS team in the Policy, Planning and Finance General Directorate manages the funds allocated for strengthening the monitoring and evaluation system. Disbursements have been used to (a) strengthen monitoring and evaluation in the regions and (b) (approximately US $860,028) to print the HMIS format and guidelines, supervise and conduct an annual review meeting with HEW (US $890,018). The money allocated for these purposes has been completely utilized (Annual Progress Report).

The annual regional meeting is also part of this support; US $201,750 was disbursed to the regions in two rounds, with a reported 100 percent utilization. During woreda-level review meetings, the HEWs present activity reports, share lessons learned and seek solutions for reported challenges (Annual Progress Report).

Table 15: Annual HMIS support and the allocated funds and expenditure

Year	2006[31]	2007	2008	2009	Total
Planned HMIS support cost (US$)	890,018	861,768	860,018	851,751	3,463,555
Disbursed amount in USD		**890,018**	**860,018**		
Planned HEP review meetings, cost in (US$)	86,750	115,000	116,750	125,017	443,551
Disbursed amount in USD		**201750**			

Source: GAVI Country proposal and Annual Progress Reports, 2006-2008

Equipping 7,340 health posts with health post kits was another activity planned to be funded by GAVI HSS. US $20,154,600 was allocated for this purpose. In 2007-2009, UNICEF distributed 7,050 health post kits at a total cost of US $10,002,136 (UNICEF interview and APR 2006-2008).

Table 16: Health Post Kit Distribution Status by Region

Detail: UNICEF Health Post kit distribution status by region (1 Sep 2007- 11 Jun 2009)								
		Full kit type A			Full kit type B			Total full kits (A + B)
		GAVI	*Others*	*Total full kits type A*	*GAVI*	*Others*	*Total full kits type B*	
1	Tigray	94	25	**119**	193	117	**310**	**429**
2	Afar	32	-	**32**	53	11	**64**	**96**
3	Amhara	505	105	**610**	1,225	499	**1,724**	**2,334**
4	Oromia	514	91	**605**	953	480	**1,433**	**2,038**
5	SNNPR	257	254	**511**	802	349	**1,151**	**1,662**
6	Somali	48	25	**73**	136	90	**226**	**299**
7	B.Gumuz	15	5	**20**	55	17	**72**	**92**
8	Gambella	30	2	**32**	28	2	**30**	**62**
9	Hareri		4	**4**	2	9	**11**	**15**
10	Dire-Dawa		6	**6**	6	11	**17**	**23**
Total		**1,495**	**517**	**2,012**	**3,453**	**1,585**	**5,038**	**7,050**

Source: UNICEF

The refrigerators recently provided by UNICEF, at the request of the FMoH, were reported to be different from the brand distributed earlier. The new brand is reportedly difficult to maintain in the study regions[32]. During

[31] The activity started late, so no data is available for the specified year.

[32] I The Tracking Study team conducted observations and interviews in a range of health posts, including some that were not slated to receive the GAVI-financed supply kits.

site visits, the Tracking Study team found that most health posts had cold boxes and provided periodic vaccination with vaccines brought from the health center (characteristic of type B health posts). In health posts with refrigerators, kerosene was oftentimes absent.

When vaccines are deposited at the woreda health offices, some HEWs, where transportation is not available, reported an additional burden.

The shortage of supplies and commodities is one of the challenges to be addressed through GAVI HSS funding. Accordingly, a substantial amount of the budget is allocated for improving the Health Commodities Supply System (HCSS). Implementation under this area was delayed due to the preparatory steps needed for the HCSS master plan, including organization of the new Pharmaceutical & Medical Supplies Import & Wholesaler Share (PHARMID). Out of the total US $7,740,590 allocated for improving HCSS, US $4,714,198 was transferred to the PHARMID/PFSA to facilitate the purchase of essential commodities and supplies. In 2008, the remaining monies were reprogrammed to construct regional distribution hubs for the PFSA.

b). HSS inputs and outputs compared to targets

Table 17: GAVI HSS Activities, Inputs, and Targets as of 2006 -2007

GAVI HSS activities	GAVI HSS inputs (US $)		GAVI HSS target set in for the FY 2006 – 2008	Expenditure 2008	Progress against the target
	FY 2006-08	2008			
Activity 1: Upgrading skills of 25,050 HEWs	8,531,250	2,843,750	21625	2,843,750	22,833 trained
Activity 2: Apprenticeship for 12600 health extension students.	1,633,150	511,750	9175	511,750	10,600 benefited
Activity 3: Capacity strengthening for Woreda health management team	1,319,670	659,835	3720	659,835	7,841 benefited
Activity 4: Training of health workers for IMNCI	720,000	360,000	2700	313,135	1,473 trained till 2007 and in 2008, 703 health professionals an IMNCI case management, 20 on IMNCI facilitation skills and 31 on IMNCI supervision. Training was conducted at 23 sites.
Activity 5: Upgrading of 212 health stations to health centers	25,905,244	9,655,244	106	9,655,244	The construction of 212 GAVI-sponsored health centers is outsourced to GTZ, along with another 300 health centers funded by another sources. Of the total 512 HCs outsourced to GTZ, the construction of 180 has been completed in the year 2008. Of those completed, 70 are sponsored by GAVI HSS.
Activity 6: Equipment of 300 health centers	6,886,407	3,251,462	155	3,251,462	Procurement completed
Activity 7: Construction of 100 health posts	750,000	93,750	30	93,750	Funds secured initially for 100 health posts could only cover the construction of 30 health posts due to price escalation
Activity 7: Equipping of 7,340 health posts	20,154,600	10,002,136	7,050	10,002,136	The procurement and distribution of health post kits is handled by UNICEF.

Activity 8: Purchase and distribution of 109 Vehicles for 10 woredas	2,507,000	835,000		*835,000*	Completed
Activity 9: Purchasing and distribution of IT equipment for 109 woreda health offices		300,000		0	Procurement completed and reported last year.
Activity 10: Monitoring and evaluation	1,751,786	860,018		860,018	HMIS format was printed.
Activity 11: Support implementation of HCSS	7,740,590			7,740,590	The procurement and distribution is being done. The construction of central warehouse is on progress
Activity 12:Management of HSS	300,000	150,000		150,000	GAVI HSS workshop is conducted. Extensive regional monitoring visits were done by FMoH staffs

Source: GAVI Country proposal and annual Progress reports **2006-2008.**

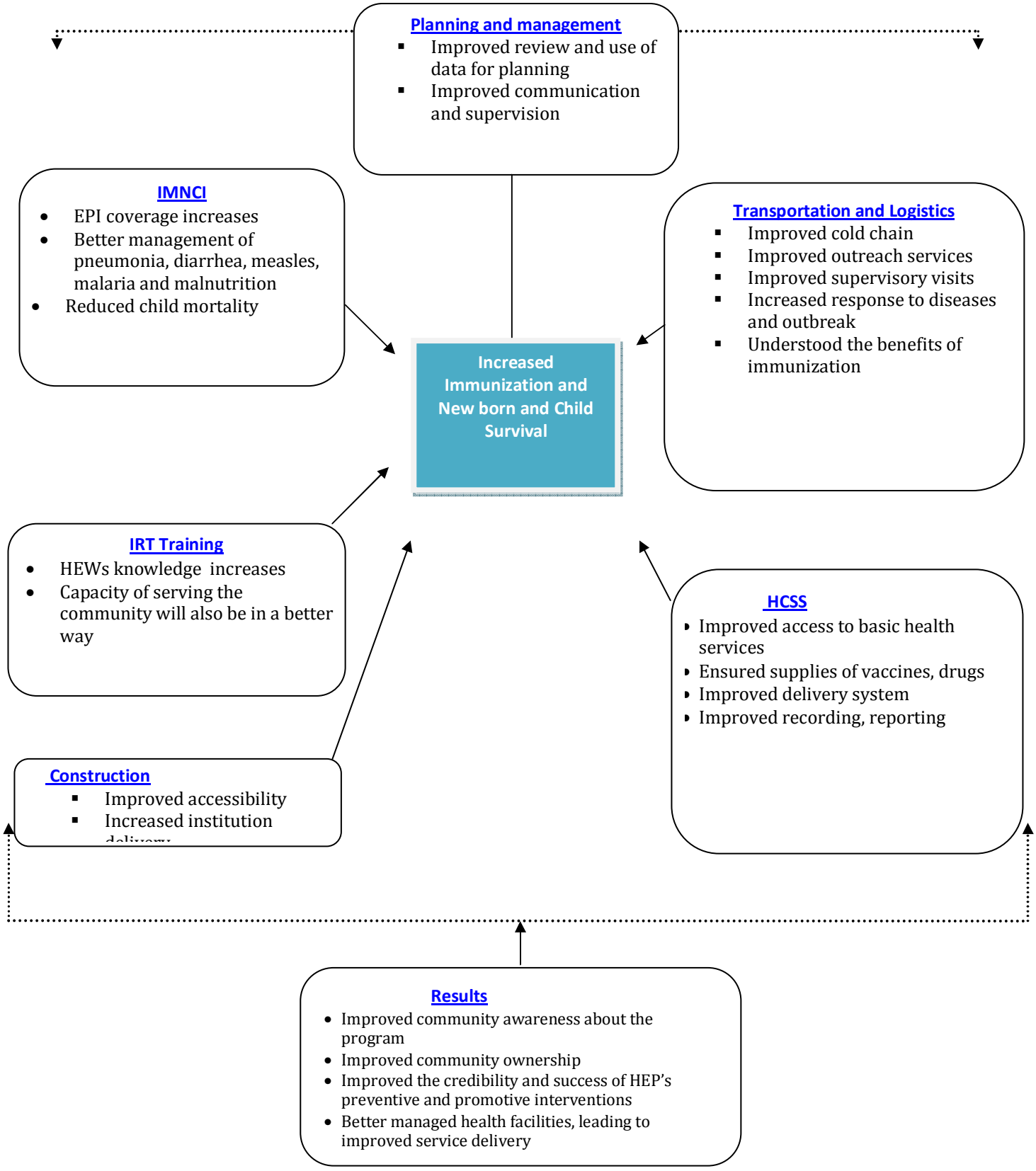
c). Progress toward outcomes

The GAVI HSS implementation is believed to have made significant contributions towards improving the performance of the national immunization programs and reducing child mortality.

The trained HEWs are providing extensive prevention and primary care services to the households in their respective kebeles. These activities, coupled with other sectoral interventions, have brought about appreciable knowledge and attitudinal changes regarding childhood immunization. The routine immunization coverage is steadily increasing in most regions. The preliminary findings of the JSI/L10K studies conducted in 2009 in Amhara, Oromiya, SNNPR and Tigray in the same study clusters as that of the DHS 2005 revealed significant improvements in immunization coverage since 2005. The overall DPT3 coverage in the four studied regions increased from 32.3 percent in 2005 to 63.7 percent in 2009; the measles immunization coverage (an MDG indicator) increased from 35.6 percent in 2005 to 68.3 percent on 2009; and the proportion of fully immunized children increased from 20.4 percent in 2005 to 46.3 percent in 2009. The study also revealed that 69.4 percent of the clusters have two HEWs per kebele and that HEWs are active in the provision of child immunization. The same study showed reasonable utilization of health services provided at the health posts by HEWs; 55.2 percent of women with children 0-11 months reported visiting the health posts in the last six months. The reasons given for visiting include 64.6 percent for child immunization, 37.2 percent for antenatal care (ANC), and 23.4 percent family planning. These observations in the field indicate the positive progress being made to reach more people with basic health services.

Furthermore, the construction and upgrading of the health facilities substantially increased access and quality of services. The logistics and organization of outreach services is greatly improved. Improved community participation and ownership of health posts laid the foundation for sustainable health care delivery at the grassroots level. The activities and the expected results are summarized in Figure 8.

Figure 8: Linkage of GAVI HSS Activities to Improved Immunization and Other Child Health Outcomes



VII. Conclusions

a). GAVI HSS proposal development and application process

The Ethiopia country proposal was developed through a well-coordinated and all inclusive process by the FMoH and its development partners. The GAVI HSS proposal was preceded by a thorough consultative process used for developing the HSDP-III, which was used as a spring board for the proposal. Overall, the process was regarded as one of the most effective and efficient by the FMoH and its development partners. In the words of one expert, "The process used for GAVI HSS proposal was too good…it might be difficult to repeat." Moreover, stakeholders involved in the process were remarkably consistent in their praise for the GAVI HSS proposal development, calling it Government-led, participatory and focused on key priority gaps in the health system.

b). Strengths/weaknesses of the HSS content application

The primary strength of the GAVI HSS proposal lies in its close alignment with the on-going Health Sector Strategic Plan (HSDP-III) and its rapid start-up and implementation. The focus on expanding access to the primary health care services and the special considerations made to emerging regions are also key strengths of the proposal. Country ownership and emphasis on sustainability are clearly visible.

The most notable weakness in the proposal was the monitoring and evaluation section: the failure to provide a clear evaluation framework and data source.

c). HSS implementation experience/absorptive capacity

Capacity to implement HSS activities at national and sub-national level as planned

Overall, no significant limitation in the absorption capacity is noted at either the national or sub-national level. Most of the planned activities are accomplished at all levels. However, the short liquidation period for GAVI HSS funding has resulted in delays in reporting and liquidation in some regions. The unprecedented escalation of construction costs also led to under-performance of the health post construction in the emerging regions.

Capacity to allocate, manage, account for and spend GAVI HSS funding as planned

As the GAVI HSS fund is clearly earmarked by activity, the implementation was conducted without any major challenges. The presence of well-established financial procedures and their firm application at all levels facilitated smooth disbursement and accounting. The recording and reporting of expenditure at the lower level, however, require improvement. Strengthening of training and supportive supervision needs to be considered for the work force on the financial units. It is hoped that the web-based accounting system under development by the FMoH will provide a lasting solution to financial management challenges.

Capacity to monitor HSS performance targets and use monitoring data to revise its HSS approach

The FMoH has fairly good capacity and systems in place to monitor GAVI HSS performance targets. The data are widely used during the review meetings and preparation of annual plans. The FMoH has also recognized the limitations of the HMIS in providing comprehensive and timely information. The limitations also include a shortage of human resources, inadequate supervision and lack of disaggregated data by zone/woreda. Efforts to improve the HMIS to be more useful and comprehensive in addressing the needs of the health sector and its development partners are underway.

d). Application of Paris Declaration and other core GAVI principles during implementation

The principles of the Paris Declaration have been mostly applied during planning and implementation of GAVI HSS activities. The following core principles have been examined:

Inclusiveness/participation of a variety of public, private, multilateral, bilateral stakeholders

During GAVI HSS proposal development, implementation and monitoring of the HSS activities, a broader range of stakeholders from NGOs, GOs and the private sector, including CSOs, was involved. Ethiopia has well-established and functional structures, such as CJSC and JCCC, to encourage and ensure the wider participation of major stakeholders.

Alignment/integration with national processes

The GAVI/HSS proposal directly emanated from the process that was used to develop the country's health sector development plan (HSDP-III). Such strategies and activities are highly integrated and aligned with the routine health system. The overall goal of the GAVI /HSS fund is supporting the Government to meet all the targets set in its strategic plan.

Complementarity/coordination of donor inputs

The FMoH is working with the donor community to maximize the benefits to the people of Ethiopia. Greater participation of the donor community was ensured through involvement of all stakeholders in the process of planning, implementing and evaluating the health system of performance. There are different committees which have different roles and responsibilities and actions of all parties in bringing about the desired level of impact. Different guidelines, working documents and procedures were produced to avoid duplication, antogonization, and fragmentation of efforts by different partners. GAVI/HSS has demonstrated its compliance with the core principles by aligning its objectives to Government priorities, pooling funds and using the Government system to monitor the progress of HSS implementation.

Harmonization of donor requirements

The FMoH has succeeded in harmonizing donor requirements without disrupting the routines in the health system by engaging donors in sustained and effective dialogues. Most donors appear to have been convinced to channel their funds through the Government system, which minimizes the system's transaction cost and fragmentation. Efforts are continuing to encourage using the Government system by the majority of the funding agencies, mainly by demonstrating the impact created by the already engaged donors.

Progress toward expected outputs and outcomes

According to the FMoH reports, the national under-five mortality is reduced from 166 per 1,000 live births in 2000 to 123 per 1,000 live births in 2005. Other studies also show a significant improvement in immunization since 2005; for example, the L10K baseline survey revealed an increment in DPT1 from 60.1 percent to 84.3% percent, suggesting improved population access to immunization. The same survey also revealed that DPT3 coverage increased from 32.3 percent in 2005 to 63.7 percent in 2009. Further, the FMoH reports that the national routine full immunization coverage has increased from 75.6 percent in 2005/6 to 81 percent in 2008/9. These achievements suggest that sustained efforts to increase primary health care services can bring significant results in the short term. Although not directly attributable to GAVI HSS, the HSS funds are clearly an important contributor to the achievements of the HEP.

VIII. Recommendations to Strengthen GAVI HSS Application Process and to Bolster Implementation

a). To country policy and program decision-makers

- Sustain the participatory process and ensure the involvement of stakeholders not included previously at the national and regional levels to provide a coordinated approach to oversight and information sharing on the HEP roll-out.
- Make further efforts to strengthen the coordination and management capacity of the health system at the regional and lower levels.
- Continue efforts to strengthen supportive supervision that is guided by standard operation procedures at all levels. Integrated Supportive Supervision (ISS) requires simple problem-solving tools for the supervisor and HEWs to use together. There is ample opportunity to pilot-test different types of approaches and materials to determine their relative effect.
- Sustain the competence and motivation of trained health workers by providing continuous refresher training and reference materials. Strengthen the capacity of the regions to manage in-service training programs.
- Give priority attention to the monitoring and evaluation of the HEP.

b). To stakeholders in-country

- Multilateral and bilateral development partners should come forward to negotiate common ground with the FMoH to contribute their share to the country's health sector development plan without causing system fragmentation.
- NGOs, civil society organizations, and the private sector should be proactive in the health sector development process through the agencies representing them in the coordinating committees (CJSC and JCM).

c). To the GAVI Alliance

- Sustain its support and closely work with the FMoH to ensure that progress is made according to the performance indicators.
- Support the FMoH in promoting integrated approaches to donor funding based on the actual achievements, if at all possible, by signing the Joint Financial Arrangement to extend its catalytic roles.

d). To other global actors in health systems strengthening

- Support the system approach to health development to create a unified and comprehensive health care system in order to realize meaningful changes in the health status of the Ethiopian people.

- Ensure that resources are used to fill identified gaps rather than duplicating or disrupting existing efforts. Full harmonization of their efforts with Government initiatives and respecting the IHP Compact is highly desirable.

e). To other countries planning to apply for or beginning to implement GAVI HSS

- Ensure that a comprehensive health sector plan is developed based on a solid situation assessment and actual needs before applying to GAVI.
- Ensure that mechanisms are created for greater involvement of relevant stakeholders in all matters related to assessing, planning, and monitoring health programs.
- Have in place managerial and financial systems that use transparent procedures with reasonable accountability at both the national and sub-national levels.
- Ensure that the proposal is developed according to GAVI's core principles and following the proposal development instructions.

IX. Annexes

Annex I: List of documents reviewed and their sources

S. N	Documents reviewed	Source
1	HSDP III 2005/6-2009/10	FMoH
2	Annual Performance Report of HSDP III,2008	FMoH
3	GAVI HSS country Proposal	FMoH
4	HSDP Harmonization Manual (HHM),2007	FMoH
5	Joint Financing Arrangement between the Federal Democratic Republic of Ethiopia and Development Partners on support to the MDG fund	FMoH
6	GAVI Alliance Annual Progress Report	FMoH
7	HSDP- III Woreda Based Annual Core Plan	FMoH
8	Maternal Mortality Ratio and Trends in U5 Mortality rates in Ethiopia	Ethiopian Demographic Health Survey
9	DPT 3 Coverage Rates Ethiopia,1980-2007	www.who.int.immunization_monitoring/data/eth.pdf
10	Percent of districts with >=80% coverage with DPT3	WHO vaccine-preventable disease monitoring system 2008global summary-country profile: Ethiopia
11	GAVI Alliance Country Facts sheet	www.gavialliance.org
12	Mid Term Review Report of HSDP III,2005/06-2010/11	FMoH
13	Ethiopia Health and Health Related Indicators,2000	FMoH
14	Building Progress ;A plan for Accelerated and Sustained Development to End Poverty,2005/06-2009/10	FMoH
15	FMoH Health Management Information Systems Monitoring and Evaluation procedures manual,2008	FMoH
16	FMoH HMIS Indicator Definintion,2008	FMoH
17	FMoH, HMIS M&E Disease Classification for National Reporting and case definitions	FMoH
18	HSDP III of Amhara region	RHB
19	Access to and use of RMNCH Services in Ethiopia: The role of HEWs Preliminary Results from L10K Baseline survey,2009	JSI Inc., Addis Ababa, Ethiopia
20	Maternal Health Seeking Behaviors Ethiopia: Findings from L10K Baseline survey,2009	JSI Inc., Addis Ababa, Ethiopia
21	HSDP III of Oromiya region	RHB
22	Financial documents prepared by Afar, Amhara and Oromiya regions	RHB
23	Zonal strategic plans	ZHB
24	Woreda annual Plans	WorHO
25	Zonal and Woreda Activity Reports	ZHB, WorHO
26	Health Facilities annual plans and Activity Reports	HFs

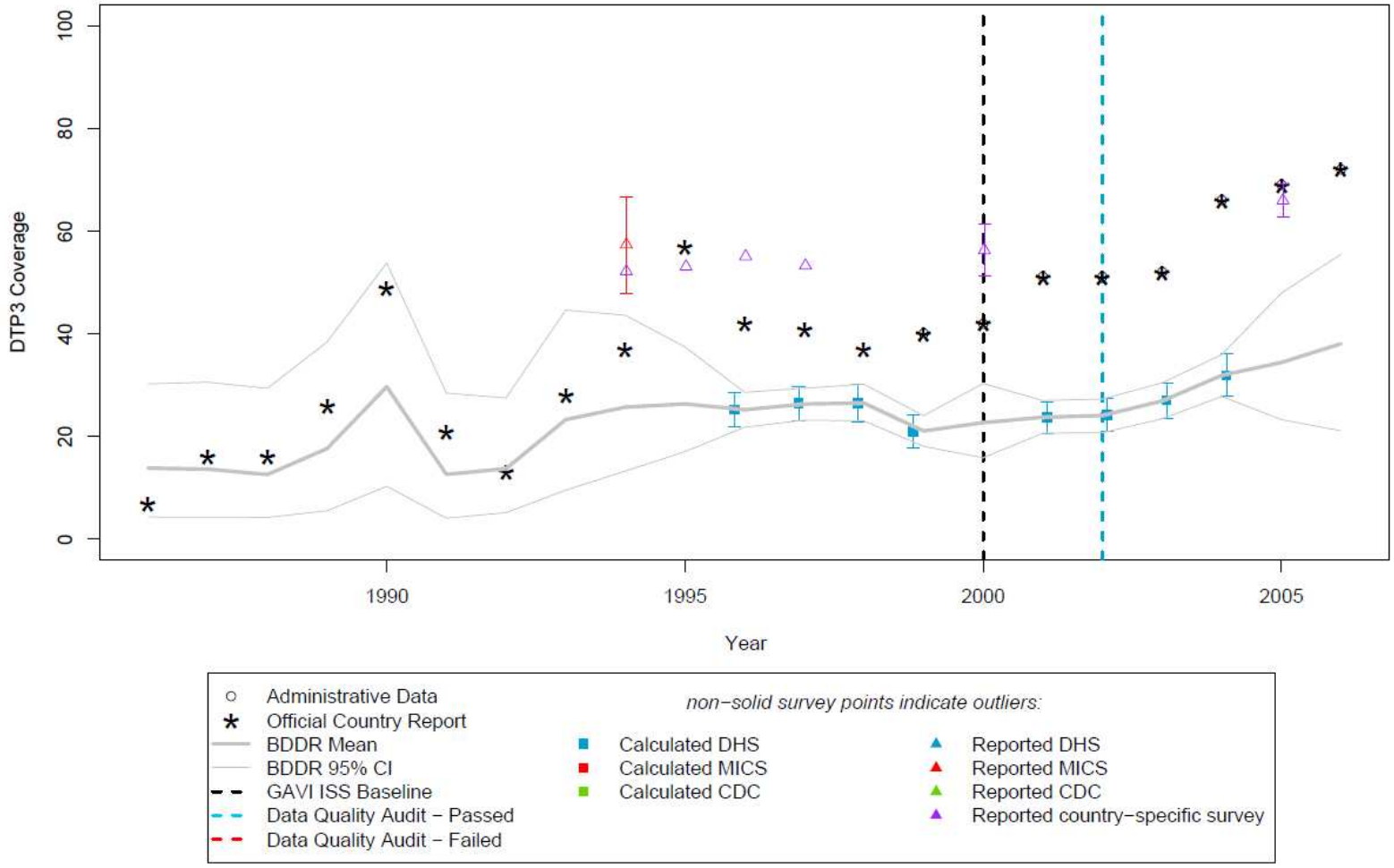
Annex II: GAVI HSS Ethiopia Country Workshop participants and agenda

S. N	Participants name	Organization
1	Dr. Nejmudhin Kedir	FMoH
2	Dr. Mekdim Encossa	FMoH
3	WZ Roman Tesfaye	FMoH
4	Ato Numerry Mohammed	Afar RHB
5	Dr. Gadessa Anbesse	Oromiya/Bale ZHB
6	Ato Wakgari Edessa	Oromia/South west shewa ZHB
7	Ato Zenebe Letta	Oromiya, WorHO
8	Ato Naod Degefu	Oromiya,WorHO
9	Yemane Berhane,	Addis Continental Institute of Public Health
10	Asmeret Moges Mehari	
11	Dr. Belaineh Girma	
12	Temesgen Workayehu,	
13	Nigusu Aboset,	
14	Tewodros W. Giorgis,	
15	Beth Plowman	JSI Research & Training Institute, Inc.

Time	Activity	Responsible
8:30-9:00	Arrival of Workshop Participants	
9:00-9:10	Welcome	Planning and Program Department, FMoH
9:10-9:30	Introduction • Review of Agenda • Introduction of Participants	ACIPH
9:30-10:30	Presentation of Country Tracking Case Study • Study objectives • Methods overview • Main findings • Conclusions and recommendations	Prof. Yemane Berhane
10:30-11:00	Coffee/Tea Break	
11:00-12:00	General Questions and Discussions	Study Team
12:00-1:30	Lunch Break	
1:30-2:30	Group work (three groups) • Theme 1: Health workforce motivation and mobilization	Participants

	• Theme 2: Construction of health posts • Theme 3: Health commodities supply system- management and coordination	
2:30-3:00	Coffee/Tea Break	
3:00-4:00	Group work presentation and discussion	Participants and Study Team
4:00-5:00	Case Study Completion and Next Steps	Participants and Study Team

Annex III: DPT3 coverage data, Ethiopia 1986 – 2006, multiple sources including Independently-Conducted regression analyses based on available survey data



Source: Figure 3. Underlying Data and Survey-Based Estimates of DTP3 Coverage (Percentage) by Country *Tracking progress towards universal childhood immunizations and the impact of global initiatives* ***Institute of Health Metrics and Evaluation.***
http://www.healthmetricsandevaluation.org/resources/news/2008/Dec_12_2008.html

Annex IV: Progress towards these objectives as reported by the Mid-Term Review

MTR Findings in Major HSDP III Objectives

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY HSDP III
1. To cover all rural kebeles with the HEP to achieve universal PHC coverage by 2008	Availability of HEW will be reached by the end of 2008, but their functionality is still limited due to delayed construction of health posts (72%) and distribution of health post kits (30%) and lack of supervision.
2. To reduce maternal mortality ratio from 871 to 600 / 100,000 live births	Since DHS 2005, no recent figures are available, but the attainment of this target is unlikely due to serious gaps in the implementation of the Reproductive Health Strategy, B/CEmONC in particular.
3. To reduce the under-five mortality rate from 123 to 85 per 1000 live births and infant mortality rate from 77 to 45 per 100 live births.	Since DHS 2005, no recent figures available, but further reduction is likely to happen, if the implementation of the vertical programmes and nutrition interventions will advance as planned. Furthermore, sustaining the trend of UFMR reduction is unlikely unless community-based pneumonia

MAJOR OBJECTIVES HSDP III	PROGRESS HALF-WAY HSDP III
	management is introduced and newborn care is integrated in existing MNCH programmes
4. To reduce the total fertility rate from 5.4% to 4%	No recent figures available, but unlikely to have been reduced substantially, due to limited access to contraceptives. However, funding is increasing.
5. To reduce the adult incidence of HIV from 0.68% to 0.65% and maintain the prevalence of HIV at 3.5%	Adult incidence rate is 0.28%. The adult (15 till 49 years) prevalence rate is 2.1% (GOE, 2007).
6. To reduce morbidity and mortality attributed to Malaria from 22% to 10%.	The recent overview of HSDP III 9 months implementation (in 2000 EC) show morbidity at 90.000 cases and mortality at 35.000 cases, being a 48% and 55% reduction in morbidity and mortality respectively.
7. To reduce the case fatality rate of Malaria in age groups 5 years and above from 4.5% to 2% and case fatality rate in under 5 children from 5% to 2%.	In-patient case fatality for > 5 years old is 3.3% and for the < 5 years, the figure is 4.5% (FMOH 1999). The case fatality of the > 5 years old seems to have improved.
8. To reduce mortality attributed to Tuberculosis from 7% to 4% of all treated cases.	TB case fatality is reported at 5%, but this figure is against a very low CDR of only 32%

Annex V: Donor commitments to the Health Sector

	Forums	Membership	Responsibilities	Timeframe
1	**Federal Level**			
1.1	Central Joint Steering Committee	• Minister of Health (Chairperson) • State Minister of Health • PPF-GD of FMoH (secretariat) • Oromia Health Bureau Head • MoFED • Representatives of Multi-lateral and Bilateral Donors • HPN Donor Working Group Chairperson • NGOs • Private sector • Health professionals associations	The CJSC is the highest governance body which decides, guides, oversees and facilitates the implementation of HSDP.	Quarterly (July, October, January, April)
1.2	FMoH-Donors Joint Consultative Meeting	• State Minister of Health (Chairperson) • Heads of departments and services of FMoH • Head of Health Education Centre, • Drug Administration and Control Authority • Ethiopian Health and Nutrition Research Institute • HPN Donors Working Group (Chairperson is co-chair) • NGO representatives • Head of Oromia Health Bureau • Head of the Addis Ababa City Administration Health Bureau.	The general objectives are to promote dialogue and regular exchange of information; enhance the spirit of partnership between the Government, donors and other stakeholders; and facilitate the implementation, monitoring and evaluation of HSDP.	Every two months
1.3	Joint Core Coordinating Committee	• PPF-GD staff, with Head as Chairperson • 5 senior staff (with HSDP experience) from HPN Donors Group	The Joint Core Co-ordinating Committee is a committee that serves as the technical arm of the CJSC and the FMoH-HPN Donors Joint Consultative Forum. The JCCC assists and works closely with the Secretariat	Weekly (or as needed)

	Forums	Membership	Responsibilities	Timeframe
			of HSDP in following up the implementation of the decisions of the CJSC and the Joint Consultative Forum, as well as the recommendations of the various review missions of HSDP	
1.4	FMoH-RHBs Joint Steering Committee	• Minister of Health (Chairperson) • State Minister of Health • Regional Health Bureau Heads • Heads of departments/services • Team leaders of the Ministry and RHBs (as needed)	The basic objective of this forum is to facilitate the effective and smooth implementation of HSDP priority issues.	Every two months (July, September, November, January, March, May)
1.5	Annual Review Meeting	• Federal and regional government agencies • selected Woreda Health Offices • HPN Donors Working Groups • NGOs • Professional Associations • Universities • Private sector representatives • Local and international consultants	Brings together representatives (usually over 200) from federal and regional government agencies, selected Woreda Health Offices, HPN Donors Working Groups, NGOs, Professional Associations, universities, the private sector and local and international consultants.	Annual (end September/early October)
2.	**Regional Level**			
2.1	Regional Joint Steering Committee	• Head of the Regional Health Bureau (chair) • Regional Bureau of Finance and Economic Development • Regional Bureau of Capacity Building • two Woreda Health Bureaus • representatives of donors and NGOs	The structures and functions of the RJSCs will, to a large extent, be similar to those of the CJSC at the central level.	Quarterly (August, November, February, May)
2.2	Regional Review Meetings	RHB staff, WorHOs, hospitals, NGOs, donors and major private providers.	To review their plans and progress. They also introduce and explore new policy or implementation issues.	Bi-annual (September, February)

	Forums	Membership	Responsibilities	Timeframe
3.	**Sub-Regional Level**			
3.1	Woreda Joint Steering Committees	• Woreda administrator/deputy (chairperson) • Head of the Woreda Health Office (secretariat) • Heads of the health centers in the woreda • Medical director of the district hospital. • WoFED • Regional Health Bureau • NGOs As far as is practical: Women's Affairs Office, Education, Water, Agriculture and Youth Association.	This committee should be consulted about the strategic and annual woreda health plans and should review progress against the annual plan on a quarterly basis. Links between this committee and the woreda council are important – the committee should ensure that health is a regular item on the agenda at woreda council meetings.	Quarterly
3.2	Kebele HIV and Health Committee	• Kebele administrator (chair) • Health Extension Workers (secretariat) • Community health workers • Representative from the Woreda Health Office • Community representative (Community Based Organizations, women, youth, PLWHA network, etc.) • Development Agents (agriculture) • school development committee • NGOs • Kebele level health, education and agricultural government focal persons, where they exist.	This committee plays a crucial role because it brings together different sectors at a practical level, and because it is a vital link between the health system and the community. The committee also provides a good opportunity to enhance community participation in the health sector, especially in relation to the Health Extension Program.	Monthly

Annex VI: Ethiopia GAVI HSS proposal indicators, categorized by level

Level	Health workforce	Supply, distribution, and maintenance system	Organization and Management
HSS inputs	% of woredas receiving timely funding for undertaking HEWs refresher course % of TVET schools provided with resources for apprenticeship	% of contracts signed for renovation/ expansion of Health Stations # of procurement actions initiated	# of vehicles procured # of regions supported for introduction of HCSS
HSS activities and outputs	# of HEWs who have received one/ two sessions of refresher Courses Ratio of trainees/tutor during apprenticeship % of HEWs' trainees having completed all key immunization /cold chain maintenance tasks on apprenticeship check list # of Woreda health team members trained on IRT # of Health Workers (HC level) trained in IMNCI	# of Health stations upgraded # of Health Posts equipped # of Health Centres equipped	# of regions with annual workplan for implementation of the new Master Plan for Logistics of Essential Health commodities % of HPs set up in a cluster system for vaccine storage # of regional hubs handling cold chain equipment, cold chain consumables, vaccines and injection equipment % of woredas with essential drugs/ vaccines/ consumables store with up to date/accurate records % of HPs with refrigerator having sufficient kerosene for 10 days # of woredas (out of 109 targeted) equipped for support supervision
Outcomes-systems capacity	% of Health Posts providing immunization services at least twice a month % of HEWs recording refrigerator temperature twice daily (in Health posts with refrigerator) % of women attending at least one ANC consultation % of Health Posts providing TT immunization during ANC % of rural kebeles with access to a full package of Health Extension services: proxy : a. IEC for sanitation, b. HP with latrine, c. ANC, d. FP, e. Immunization, f. malaria treatment in < 5's , g. clean deliveries % of Health , posts with no essential drugs/vaccines/consumables stock out in the past 3 months: proxy : a. measles vaccine, b. Vitamin A, c. AD syringe, d. Co-Artem, e. ORS		

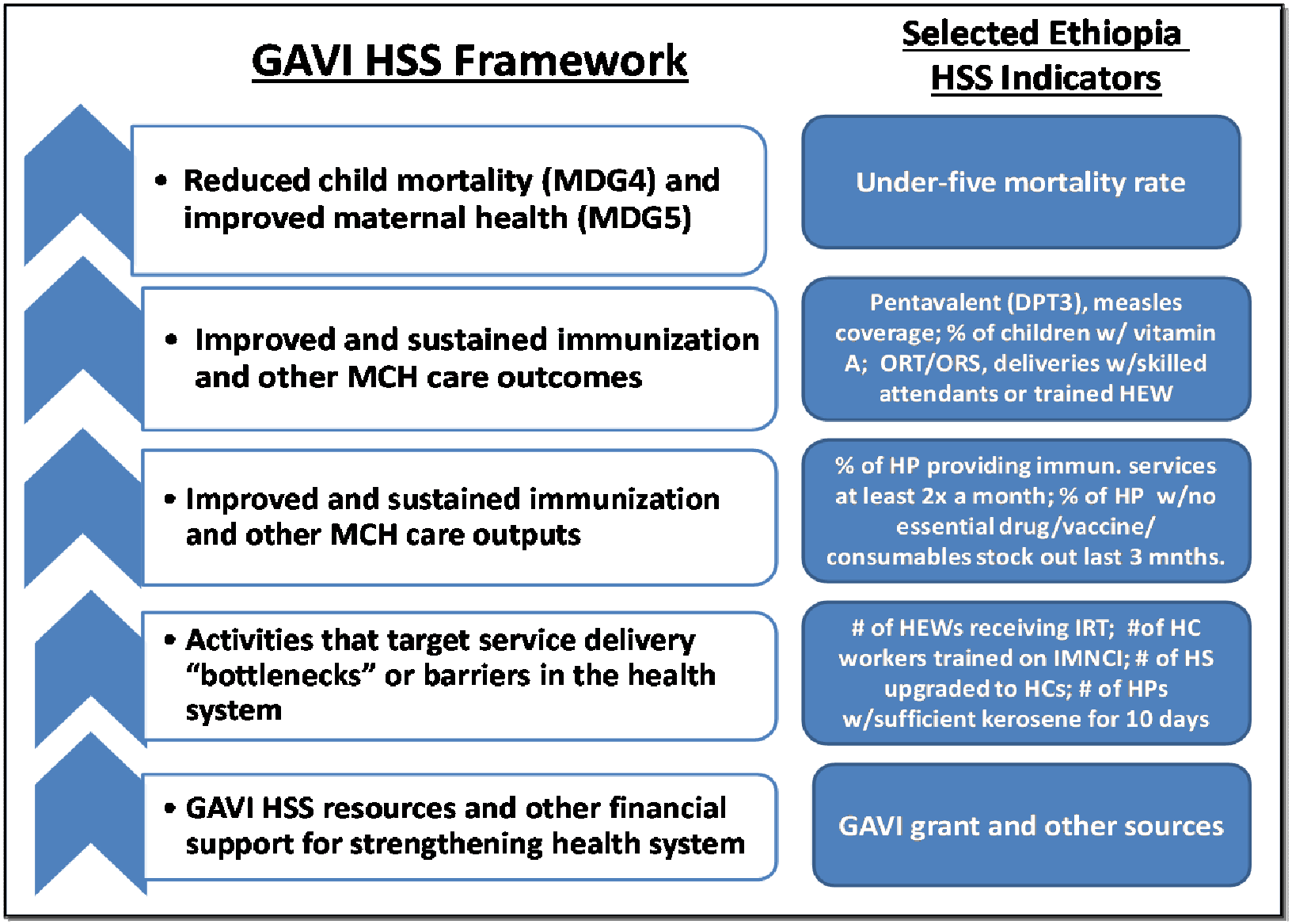
	% of pregnant women with access to a facility providing Basic Obstetrical Care % of Health Posts supervised at least once in the past 2 months by the Woreda health team % of HEP review recommendations implemented
Outcomes-coverage and use of interventions	Pentavalent (DPT3) coverage Measles immunization coverage % of children 6-59 months receiving Vitamin A supplementation every six months % of children 12-59 months receiving Albendazole twice a year % of children with diarrhea receiving ORT/ORS at HP level % of children treated following the IMNCI protocol at the HC level % of deliveries with skilled birth attendant or trained HEWs (clean delivery)
Impact	Mortality in Children under five years of age

Annex VII: Follow-up on HSS proposal indicators

Level		Baseline (year)	Target	Data reported in APR		
				2006	2007	2008
HSS inputs	% of woredas receiving timely funding for undertaking HEWs refresher course	2006/07	Yes	BL	RBL	
	% of TVET schools provided with resources for apprenticeship	2006/07	Yes	BL	RBL	
	% of contracts signed for renovation/ expansion of Health Stations	2006/07	Yes	BL		
	# of procurement actions initiated		Yes			
	# of vehicles procured		No			
	# of regions supported for introduction of HCSS		No			
HSS activities and outputs	# of HEWs who have received one/ two sessions of refresher Courses*	Jan. 2007	Yes	BL	Progress	Progress
	Ratio of trainees/tutor during apprenticeship*	2006/2007	yes	BL	--	Progress
	% of HEWs' trainees having completed all key immunization/cold chain maintenance tasks on apprenticeship check list*	2006/07	Yes	BL	--	Progress
	# of Woreda health team members trained on IRT	June 2007	No	--	BL	
	# of Health Workers (HC level) trained in IMNCI	June 2006	No	--	BL	
	# of Health stations upgraded	2006	Yes	BL		Progress
	# of Health Posts equipped	Feb. 2007	Yes	-	BL	Progress
	# of Health Centres equipped	2006/07	Yes	--	--	BL
	# of regions with annual workplan for implementation of the new Master Plan for Logistics of Essential Health commodities	2006	yes	BL		
	% of HPs set up in a cluster system for vaccine storage	June 2006	No	--	BL	
	# of regional hubs handling cold chain equipment, cold chain consumables, vaccines and injection equipment		no			
	% of woredas with essential drugs/ vaccines/ consumables store with up to date/accurate records		Yes			
	% of HPs with refrigerator having sufficient kerosene for 10 days		Yes			
	# of woredas (out of 109 targeted) equipped for support supervision		Yes			

Level		Baseline (year)	Target	Data reported in APR		
				2006	2007	2008
Outcomes-systems capacity	% of Health Posts providing immunization services at least twice a month		Yes			
	% of HEWs recording refrigerator temperature twice daily (in Health posts with refrigerator)		Yes			
	% of women attending at least one ANC consultation	June 2006	Yes	BL	RBL	
	% of Health Posts providing TT immunization during ANC		Yes			
	% of rural kebeles with access to a full package of Health Extension services: proxy : a. IEC for sanitation, b. HP with latrine, c. ANC, d. FP, e. Immunization, f. malaria treatment in < 5's , g. clean deliveries		Yes			
	% of Health posts with no essential drugs/vaccines/consumables stock out in the past 3 months: proxy : a. measles vaccine, b. Vitamin A, c. AD syringe, d. Co-Artem, e. ORS		Yes			
	% of pregnant women with access to a facility providing Basic Obstetrical Care		Yes			
	% of Health Posts supervised at least once in the past 2 months by the Woreda health team		Yes			
	% of HEP review recommendations implemented	2006/07	Yes			BL/Progress
Outcomes-coverage and use of interventions	Pentavalent (DPT3) coverage	2005, 2006	Yes	BL	RBL	
	Measles immunization coverage	2005,2006	Yes	BL	RBL	
	% of children 6-59 months receiving Vitamin A supplementation every six months	June 2005	Yes	--	BL	
	% of children 12-59 months receiving Albendazole twice a year	June 2005	Yes	--	BL	
	% of children with diarrhea receiving ORT/ORS at HP level		Yes			
	% of children treated following the IMNCI protocol at the HC level		Yes			
	% of deliveries with skilled birth attendant or trained HEWs (clean delivery)	June 2006	Yes	BL		
Impact	Mortality in Children under five years of age	2005	Yes	BL		

Annex VIII: GAVI HSS framework and correspondence with selected Ethiopia HSS indicators



Annex IX: Timing and condition of supportive supervision from federal down to the health facility level

Supervisory Responsibility and Frequency		
Supervision to	**Responsible**	**Frequency of supervision**
Health post	WorHO	Monthly
Health Center	WorHO	Every 2 months
Zonal/Regional Hosp	RHB	Quarterly
WorHO	ZHD/RHB	Quarterly
RHB	FMoH	Biannual