ETHIOPIA

HEALTH SECTOR

DEVELOPMENT PROGRAMME

HSDP II

2002/03 – 2004/05

(EFY 1995 – 1997)

REPORT OF THE FINAL

EVALUATION OF HSDP II

31ST JANUARY – 6th MARCH 2006.

VOLUME I

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ETHIOPIA HEALTH SECTOR DEVELOPMENT PROGRAMME

FINAL EVALUATION OF HSDP II

31st JANUARY TO 6th MARCH 2006

Programme: Ethiopia Health Sector Development Programme (HSDP II)

Executing Agencies: Federal Ministry of Health and Regional Health Bureaux

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All team members were selected on the basis of their professional expertise and participated as individuals. There were 10 international and 23 national consultants in the team. The following institutions supported this evaluation with staff/consultants: FMOH (1), MOCB (1), MOFED (1), RHB (5), HAPCO (1), DACA (1), The Centre for National Health Development - Ethiopia (1), WHO (2), UNICEF (2), USAID (3) and the Italian Cooperation (3). The evaluation was funded through the Health Pooled Funds (Technical Assistance component).

LIST OF ABBREVIATIONS

ACT	Aretemisin-based Combination Therapy
ADLI	Agricultural Development-Led Industrialization
ADB	African Development Bank
AEPHCC	Accelerated Expansion of Primary Health Care Coverage
AFB	Acid Fast Basilar
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARM	Annual Review Meeting
ASRH	Adolescent Sexual and Reproductive Health
ART	Anti Retroviral Therapy
BCC	Behavioral Change Communication
BCG	Bacillus Caulmette Guérin
BEOC	Basic Emergency Obstetric Care
BF	Blood Film
BMI	Body Mass Index
BOF	Bureau of Finance
BOFED	Bureau of Finance and Economic Development (Regions)
BP	Budget Pharmacy
CAD	Central Accounts Department
CAR	Contraceptives Acceptors Rate
CB	Capacity Building
CBM	Christoffel Blinden Mission
CBO	Community-based Organization
CBRH	Community-based Reproductive Health
CDPC	Communicable Disease Prevention and Control
CDD	Control Diarrhoeal Diseases
CDTI	Community based Distribution and Treatment with Ivermectin
CEOC	Comprehensive Emergency Obstetric Care
CFAA	Country Fiscal Accountability Assessment
CHAs	Community Health Agents
CHWs	Community Health Workers
C-IMCI	Community Integrated Management of Childhood Illnesses
CJSC	Central Joint Steering Committee
CMH	Commission on Macroeconomics and Health
CRDA	Christian Relief and Development Association
CPR	Contraceptives Prevalence Rate
CSA	Central Statistical Authority
CSO	Civil Society Organisation
CSR	Country Status Report on Health and Poverty
CSRP	Civil Service Reform Programme
CSW	Civil Service Workers
DACA	Drug Administration and Control Authority
DAG	Development Assistance Group
DBS	Direct Budget Support
D&C	Dilation and Curettage

DCI	Development Cooperation Ireland
DFID	Department for International Development
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short Course
DP	Development Partners
DPPC	Disaster Prevention and Preparedness Commission
DPT	Diphtheria, Pertussis and Tetanus Vaccine
EC	Ethiopian Calendar
EHT	Environmental Health Technician
ESHE	Essential services for Health in Ethiopia
EDL	Essential Drug List
EDHS	Ethiopian Demographic and Health Survey 2000 and 2005
ENA	Essential Nutrition Actions
EFY	Ethiopian Fiscal Year
EHD	Environmental Health Department
EHSP	Essential Health Service Package
EHW	Environmental Health Worker
EOC	Emergency Obstetric Care
EOS	Enhanced Outreach Strategy
EPHA	Ethiopian Public Health Association
EPI	Expanded Program of Immunization
EPPC	Emergency Prevention & Preparedness Committee
ESHE	Essential Services for Health in Ethiopia
EC	European Commission
EU	European Union
EWS	Early Warning System
FBO	Faith Based Organization
FGM	Female Genital Mutilation
FGOE	Federal Government of Ethiopia
FH	Family Health
FHI	Family Health International
FLHW	Front Line Health Worker
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FOAG	Federal Office of the Auditor General
FP	Family Planning
GAAP	General Accepted Accounting Practices
GAVI	Global Alliance for Vaccines and Immunization
GC	Gregorian Calendar
GDP	Gross Domestic Product
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GHP	Good Hygienic Practices
GIS	Geographical Information System
GLRA	German Leprosy Relief Association
GMP	Good Manufacturing Practices
GMP	Growth Monitoring and Promotion
GNP	Gross National Product
GOE	Government of Ethiopia
GP	General Practitioner
HAART	Highly Active Anti Retroviral Treatment
HACCP	Hazard Analysis and Critical Control Points
HAP	Harmonization Action Plan

HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HBV	Hepatitis B Virus
HCF	Health Care Financing
HCFS	Health Care Financing Strategy
HCU	Health Care Unit
HDI	Human Development Index
HEA	Health Extension Agent
HEC	Health Education Center
HEEC	Health Extension and Education Centre
HEP	Health Extension Package
HESP	Health Extension Service Programme
HEW	Health Extension Workers
HF	Health Facility
HHI	Health and Health Related Indicators
HIPC	Highly Indebted Poor Countries
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HLM	Health Learning Materials
HMIS	Health and Management Information System
HO	Health Officer
HPN	Health, Population and Nutrition
HP	Health Post
HRD	Human Resource Development
HRH	Human Resources for Health
HSD&QC	Health Service Delivery and Quality of Care
HSDP	Health Sector Development Programme
HSEP	Health Service Extension Programme
HSEW	Health Service Extension Worker
HW	Health Worker
ICB	International Competitive Bidding
ICT	Information Communication Technology
IDA	International Development Association (World Bank)
IDP	Internal Displaced Persons
IDSR	Integrated Disease Surveillance and Response
IEC/BCC	Information, Education and Communication /
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
ISC	Inter-Sectoral Collaboration
ITN	Insecticide Treated Net
IRS	Indoor Residual Spraying
IYCF	Infant and Young Child Feeding
JCCC	Joint Core Coordinating Committee
JCM	Joint Consultative Meeting (FMOH and HPN group)
JICA	Japan International Cooperation Agency
JRM	Joint Review Mission
JSI	John Snow Incorporated
KAP	Knowledge, Attitude and Practice
KMC	Kangaroo Mother Care
LTTA	Long Term Technical Assistance
M&E	Monitoring and Evaluation

MAPPP	Medical Association of Physicians in Private Practice
MCST	Malaria Control Support Team
MOCB	Ministry of Capacity Building
MDG	Millennium Development Goal
MDT	Multi-Drug Therapy
MEDAC	Ministry of Economic Development and Cooperation
MEFF	Macro-Economic Fiscal Framework
MMR	Maternal Mortality Ratio
MNMM	Maternal and Neonatal Mortality and Morbidity
MOCB	Ministry of Capacity Building
MOE	Ministry of Education
MOF	Ministry of Finance
MOFED	Ministry of Finance and Economic Development
MPS	Making Pregnancy Safer
MSF	Medecins Sans Frontières (Doctors without Borders)
MTR	Mid Term Review
NAC	National Advisory Committee
NCB	National Competitive Bidding
NDL	National Drug List
NDP	National Drug Policy
NDPR	National Disaster Preparedness and Response
NGO	Non Governmental Organization
NHA	National Health Accounts
NHCS	National Health Communication Strategy
NHP	National Health Policy
NIDS	National Immunization Days
NNT	Neonatal Tetanus Treatment
NORAD	Norwegian Agency for International Development
NPEW	National Policy on Ethiopian Women
NPPB	National Prevention for the Prevention of Blindness
NTLCP	National Tuberculosis and Leprosy Control Programme
ODA	Oversees Development Aid
OECD	Organisation for European Cooperation and Development
OGA	Other Government Organisation
OGO	Other Government Organisation
OPD	Out Patient Department
OPV	Oral Polio Vaccine
OR	Operational Research
ORT	Oral Re-hydration Therapy
PADCC	Pastoral Area Development Coordinating Commission
PAP	Programme Action Plan
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PASS	Pharmaceutical Administration and Supply Service
PBS	Preventive Basic Services
PBS	Protection Basic Services
PE	Public Expenditure
PEP	Public Expenditure Programme
PER	Public Expenditure Review
PHARMID	Pharmaceuticals and Medical Supplies Import and Distribution
PHAST	Participatory Hygiene and Sanitation Transformation
PHCU	Primary Health Care Unit
PIM	Programme Implementation Manual

PLWHA	People Living With HIV/AIDS
P/L Mothers	Pregnant and Lactating Mothers
PMTCT	Prevention of Mother to Child Transmission
PMS	Performance Management System
PNC	Post Natal Care
PNS	Post Natal Service
PPD	Planning and Programming Department
PPP	Public Private Partnership
PPPH	Public Private Partnership for Health
PRSP	Poverty Reduction Strategy Paper
QA	Quality Assurance
RADWQ	Rapid Assessment of Drinking Water Quality
RBM	Roll Back Malaria
RDF	Revolving Drug Fund
RDU	Rational Drug Use
RDT	Rapid Diagnostic Test
RED	Reaching Every District
REMO	Rapid Epidemiological Mapping of Onchocerciasis
RH	Reproductive Health
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
RNE	Royal Netherlands Embassy
ROPA	Result Oriented Performance Appraisal
RTC	Regional Training Center
RWSEP	Rural Water Supply and Environmental Programme
SAFE	Surgery, Antibiotic, Face washing and Environmental Improvement
SAM	Severe Acute Malnutrition
SCN	Senior Clinical Nurse
SEPDA	Southern Ethiopian People Development Association
SDPRP	Sustainable Development and Poverty Reduction Program
SIDA	Swedish International Development Agency
SMW	Senior Midwife
SNNPR	Southern Nations Nationalities and Peoples Region
SPM	Strategic Planning & Management
SP	Special Pharmacy
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TFU	Therapeutic Feeding Unit
TLCP	Tuberculosis and Leprosy Control Programme
TOR	Terms of Reference
TOT	Training of Trainer
TT	Tetanus Toxoid
TVETC	Technical and Vocational Education Training Centre
U5MR	Under Five Mortality Rate
USD	US Dollar
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities

UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WASH	Water Sanitation and Hygiene Initiative
WB	World Bank
WC	Woreda Council
WFP	World Food Programme
WHO	World Health Organization
WJSC	Woreda Joint Steering Committee
WorHO	Woreda Health Office
WOFED	Woreda Office of Finance and Economic Development
ZHD	Zonal Health Department

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1 USD = 8.68 Birr (March EFY 1998, GC 2006)

Calendars
Ethiopian Fiscal Year / EFY (or Ethiopian Calendar / EC) refers to the Ethiopian Fiscal Year, starting on 7th July in the European calendar. The correspondence between Ethiopian and European fiscal years is given below, based on the Gregorian and Ethiopian Calendars:

Gregorian	Ethiopian
1997/98	EFY 1990
1998/99	EFY 1991
1999/00	EFY 1992
2000/01	EFY 1993
2001/02	EFY 1994
2002/03	EFY 1995
2003/04	EFY 1996
2004/05	EFY 1997
2005/06	EFY 1998
2006/07	EFY 1999
2007/08	EFY 2000

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The Ethiopian Health Sector Development Programme (HSDP) is a comprehensive national health programme that covers all aspects of policy and planning, implementation, monitoring and management of all the areas that relate to the provision of health care of its 73 million inhabitants. The evaluation of such a vast and comprehensive programme in 9 Regions, 2 city states and the Federal level itself, is a challenging and complex exercise. A large variety of actors have to be interviewed from all levels: from policy makers to implementers and service delivery staff and from other ministries, institutions and development partners.

The current evaluation of the three year HSDP II (EC 1995-1997) builds on the previous evaluation of HSDP I (March 2003), two Joint Review Missions (JRM) and three Annual Review Meetings (ARM). It incorporates new initiatives like the introduction of the Health Services Extension Programme (HSEP), the Accelerated Expansion of PHC in Ethiopia (2005-2009), the development of the Essential Health Services Package (EHSP) and the elaboration of a Child Survival Strategy. It also takes other developments into account, like the efforts to reach the Millennium Development Goals, the new Plan for Accelerated and Sustained Development to End Poverty (PASDEP Oct 2005), the efforts of the Government of Ethiopia to seek improved alignment of donors and donor efforts of harmonisation as among others reflected in numerous studies and the recently proposed Protection of Basic Services (PBS) Programme.

A multidisciplinary team of 33 national and international consultants has undertaken this final evaluation during a period of almost five weeks. They have visited all regions and interviewed many of the relevant actors and stakeholders. On the basis of their detailed Regional reports, they have compiled the final evaluation of HSDP II, based on the HSDP II components, taking its objectives, strategies, targets and indicators as points of departure.

An exercise of this magnitude requires support and inputs from a large variety of people. First and foremost, gratitude should go to the Minister of Health, His Excellency Dr. Tedros Adhanom for his openness and stimulating support to this evaluation. It has been his interest and support that made the exercise a stimulating and rewarding experience. Gratitude also goes to the State Minister of Health, His Excellency Dr. Kebede Worku for his interest in the results of the evaluation. The assignment would not have been possible without the daily and active support of the members of the JCCC, in particular Dr Nejmudin Kedir and Dr Viviane van Steirteghem. The other JCCC members, Dr Teferra Wonde, Dr Gebreselassie Okubagzhi, Ato Eshete Yilma, Dr Alemach Teklehaimanot, Mr Augusto Cosulich, Ms Rebecka Alffram, Ms Hiwot Tadesse and Dr Theo Pas, all contributed regularly with advice, useful documentation and suggestions. Ms Nigist Abraha and Ms Alemtsehay Amahatsion provided invaluable secretarial and administrative assistance to give the report its professional image.

The evaluation team would like to express special words of gratitude to all the persons interviewed in the various departments at the Federal level, in the Regional institutions, the Zones and Woredas. We hope that the time they gave us, will have been worthwhile and that their ideas and answers will be reflected in this final evaluation report (Volume I) or in the specific Regional reports, brought together in Volume II. Finally, a special word of thanks is due to Ms Mimi Church for helping us to compile the regional indicator tables (Annex 1) and the overall HSDP II performance table included below in the Executive Summary.

On behalf of the HSDP II Evaluation team, Dr Jarl Chabot (Technical Team Leader).
Addis Ababa, April 2006.

MAP OF ETHIOPIA

EXECUTIVE SUMMARY

This report presents the outcome of an evaluation of the three year HSDP II (EC 1995-1997). It builds on the previous evaluation of HSDP I (March 2003), two Joint Review Missions (JRM) and three Annual Review Meetings (ARM). It incorporates new initiatives like the introduction of the Health Services Extension Programme (HSEP), the Accelerated Expansion of PHC in Ethiopia (2005-2009), the development of the Essential Health Services Package (EHSP) and the elaboration of a Child Survival Strategy. It also takes other developments into account, like the efforts to reach the Millennium Development Goals, the new Plan for Accelerated and Sustained Development to End Poverty (PASDEP Oct 2005), the efforts of the Government of Ethiopia to seek improved alignment of donors and donor efforts of harmonisation as among others reflected in numerous studies and the recently proposed Protection of Basic Services (PBS) Programme.

A multidisciplinary team of 33 national and international consultants has undertaken this evaluation during a period of almost five weeks, from 31st of January to 6th March 2006. They have visited all regions and interviewed many of the relevant actors and stakeholders. On the basis of their detailed Regional reports, they have compiled the final evaluation of HSDP II, based on the HSDP II components, taking its objectives, strategies, targets and indicators as points of departure. Their recommendations are structured around the four main thematic areas: Service Delivery and Quality of Care, Support Systems, Finance and Governance.

This executive summary presents key messages and a prioritized list of recommendations. We advise readers to refer to specific sections for an elaborated presentation of findings, conclusions and recommendations. An overview of the Overall Performance Indicators of HSDP II (1994-1997) has been provided at the end of this executive summary.

A. SERVICE DELIVERY AND QUALITY OF CARE

Ethiopia has achieved a remarkable reduction in Infant and Under Five Mortality rates as evidenced in the recent preliminary Demographic and Health Survey (2005). Many factors including improvements in the health sector may account for this remarkable progress. Within the health sector access to health services - as measured by the potential health service coverage - has improved. Similarly, the coverage of some key health service indicators has improved. As shown in the table on HSDP II performance indicators at the end of this summary, coverage of family planning, antenatal and postnatal care, DPT3 and measles all improved. Limited to no progress is being made in the control of some communicable diseases such as Tuberculosis, Malaria and HIV/AIDS and in the births attended by skilled staff.

However, progress made in health service coverage is still below the targets proposed in HSDP II. Further, increasing access to health services has not been translated into improved outpatient visits, TB case detection rates and supervised deliveries. This is because programme implementation is not well integrated into the overall service delivery system. It is likely that their further improvement will depend on general system support through the strengthening of systems like human resources (increase in quantity and quality of health staff), pharmaceutical supplies, and improved management and supervision at Regional and

Woreda levels. Finally, the flagship Health Services Expansion Programme (HSEP) introduced during HSDP II has made tremendous progress in the majority of regions in a relatively short period. It has been well received and supported. There is general consensus among regional staff that HSEP is the best programme that Ethiopia has undertaken in recent years. However, there are concerns regarding the quality of training of HEWs, supportive supervision, lack of synchronisation between the construction of health posts and the insufficient budget allocation. Furthermore there is a need to address the curative elements of the package, especially regarding treatment of pneumonia among children under five years.

The results of the more complex and cross cutting programmes are less positive, being especially the case for the programmes with strong gender vulnerability. Despite the increase of contraceptive prevalence rate and the uptake of family planning - mostly in urban areas - the Reproductive Health Programme is unlikely to reduce maternal mortality, to deal with the high burden of maternal morbidity and to respond to adolescent health needs.

Gender as a cross-cutting issue has not progressed since the start of HSDP II, while population issues need stronger integration with health and acceptance of all levels of society. While progress has been made in IEC, much still needs to be done to reach especially the rural areas with appropriate messages in support of the programmes mentioned above. The Pastoralist Health Care programme is beginning to take shape and Emergency Preparedness and Nutrition are starting to get an institutional foothold.

Recommendations

- FMOH and RHBs to synchronize the infrastructure, human resource and support systems within the accelerated expansion of Primary Health Care (PHC), paying due attention to *all* HESP components. This requires improved planning, supervision and resource allocations at national and regional levels.
- Appoint a dedicated HSEP focal point for this purpose at Woreda level. Establish national and regional HSEP task forces to facilitate technical guidance and resource allocation so that the overall aim of the HSEP can be achieved during the intended timeframe and secure regular supply of commodities and equipment.
- The expected attrition and career development of Health Extension Workers will need to be addressed to ensure that the HSEP will not *slow down* during the HSDP III. This will require a strategic approach at national and regional level.
- Expand and mainstream HIV/AIDS and Care and Treatment by strengthening the relation between FMOH and HAPCO and by using Global Fund support for strengthening health systems (and not only HIV/AIDS).

B. SUPPORT SYSTEMS

Facility construction and rehabilitation

Under the facility construction and rehabilitation component, construction of new health facilities has progressed well, with achievements above targets for hospitals, health centres and health posts. As a result, the potential health service coverage increased from 62% to 72%, an achievement above the target of 65%. However, synchronization between construction of new facilities, supply of equipment and deployment of health staff is still an unresolved issue in some regions, with facilities being completed without timely arrangements for the provision of staff, furniture, medical equipment or water supply.

Recommendations

- Regions should prioritise making existing health facilities (hospitals, health centres and health posts) fully operational through rehabilitation and provision of appropriately trained health workers and equipment rather than new construction. New construction should be limited to Health Posts in areas (Kebeles) not yet covered. This will allow the achievement of national coverage of the Health Services Extension Programme.
- Regions should upgrade health centres in areas without hospitals or remote/inaccessible areas, through the construction of an operating theatre and posting a resident General Practitioner/Health Officer. This will ensure access to emergency surgical services especially Comprehensive Emergency Obstetric Care (CEOC) services.
- FMOH and RHBs to define and ensure the functioning of a sustainable system for preventive maintenance and repair for the infrastructure network and medical equipment.

Human Resource Development

The period under evaluation shows a slight increase of the total human resources available for both public and private sector. However, the available numbers of professionals are insufficient to serve a population as large as the Ethiopian one. The shortage is still more acute for midwifery staff (and surgeons). Moreover, the limitations in human resource deployment, management and retention have resulted in uneven distribution and inadequate utilization of the available resources. Furthermore the private sector – that is rapidly expanding - has increasingly absorbed a major share of the few staff available. Given that private providers are predominantly present in urban settings, migration of human resources to the private sector and outside Ethiopia's borders will be expected to greatly enhance disparities between regions and between urban and rural areas.

Recommendations

- FMOH to establish a HRD database being a necessary asset for planning. Central HRD must be strengthened, particularly in its strategic and stewardship capacity.
- FMOH and RHB to establish incentive schemes to retain staff, especially at outlying stations and to ensure continuing service delivery for disadvantaged populations.
- FMOH and RHBs to accelerate the development of appropriate human resource capacity for Basic and Comprehensive Emergency Obstetric Care (Health Officers and GPs with surgical skills, midwives); and develop guidelines, manuals, norms and standards.
- FMOH and RHB to develop a strong incentives package (financial and non-monetary) in addition to the standard civil-service provisions. Furthermore there is a need to balance and align the training of different categories of health workers with the essential health services package offered at different levels.
- The criteria set by the Civil Service Reform Programme are to be seriously considered in order to provide more opportunities for women in recruitment, promotion and training and thereby reduce and eventually eliminate existing gender imbalances.

Pharmaceuticals

The pharmaceutical sector has improved during the implementation of HSDP II, especially due to the establishment of Special Pharmacies (SP) which has resulted in better drug availability and increased ability to cover recurrent costs. The retention programme is not yet widely introduced within the Regions, while the two systems (Special and Budget Pharmacies) are still operating separately. This has consequences for equity, as accessibility and affordability of basic drugs for the poor are not ensured.

Urgent efforts are needed in the area of procurement and distribution, human resource availability, rational drug use, budget allocation and logistics to ensure regular supply of quality and affordable drug supply to all levels. Overall strengthening of the pharmaceutical sector is still a necessity as was the case during HSDP I.

Recommendations

- As special pharmacies and budget pharmacies currently operate as parallel systems, concrete action should to be taken by FMOH and RHBs to come up with a unified pharmaceutical system that can address the equity concerns of the poor and the availability of drugs in the different categories of pharmacies. The SP and BP support systems should be harmonised through retention mechanisms.
- FMOH to streamline the procurement of the pharmaceutical supplies and (medical) equipment especially at the central level to ensure quality, efficacy and economies of scale in drug procurement. Harmonise the Logistic Master Plan, currently being developed with the suggestions made in the proposed Protection of Basic Services (PBS).

Health and Management Information System (HMIS)

HMIS has shown some improvements over time, and the statistical reports based on data derived from various sources has been published and disseminated every year by the FMOH/PPD. Despite its limitations the reports have provided the information base for a unique trend analysis over the last 8 years, being important for planning and evaluation purposes. Because the start of the HMIS revision has been delayed at the national level, uncoordinated regional initiatives have been implemented to improve data collection and reporting. While well-intentioned, these initiatives threaten to further fragment an already fragile system. Therefore, the national HMIS revision is urgently needed to address issues around standardization of data collection and reporting procedures; and to shift the focus from merely compilation of information to use of data for decision-making purposes.

The consolidated report, based on a long list of activities and absolute levels of accomplishment (rather than based on a limited set of performance indicators) was in use for reporting to ARM. This is not suitable for performance monitoring purposes, leading to discrepancies, overlap and random errors and – most important – overloading the primary data collectors in the field.

Recommendations

- Use a limited set of HSDP indicators, common across Regions (agreed upon by all stakeholders) and consistent with priority objectives and programmes such as MDG and PASDEP. FMOH to continue to publish the annual statistical report “Health and Health Indicators”. Rely on annual reports and routine data collection for reporting to the ARM.
- FMOH to standardize data collection tools and reporting procedures and build capacity for data collection (capture), storage (repository), analysis and interpretation of data and the use of information for decision-making at all levels.
- FMOH and RHBs to validate routine data (sources) through formative (operational) research and/or sample surveys based on panel data etc. Strengthen operational research to improve relevant aspects of health management and service delivery. Where appropriate initiate gender-specific data collection to be used for decision-making.
- Build capacity in gender and urban disaggregated data collection.

C. FINANCING AND MANAGEMENT OF THE SECTOR

The total resources available for health service delivery remains extremely low in Ethiopia. The increase in per capita public health expenditure and share of total public expenditure from 4.3% in 1995 to 5.7% in 1997 is to a large extent attributable to the inflow of funds for vertical programmes and much less to the health sector service delivery system in general. This is evident by the low level of per capita expenditure at primary levels (being around 10-19 Birr per person or USD 1.2 - 2.2) which has remained unchanged during HSDP II, with significant variations between regions. External aid for public health expenditure (general or sector budget support) will most likely not increase in the near future due to various conditionalities of the development partners. The main focus therefore should be on how to allocate more of available resources to the health sector and how to improve the use of these resources.

Recommendations

- In a Federal decentralised system like Ethiopia with decision making devolved to Regional and Woreda levels, the FMOH should, through dialogue and consultations, support decision maker's at different levels to bring to their attention the need for increased allocation of resources to health within the existing overall resource envelope.
- The Health Care Financing strategy should emphasize the promotion of private sector service delivery. Furthermore the retention of revenue at facility levels requires more attention to ensure a faster rate of implementation in all Regions.
- The technical recommendations in the body of this report should be studies and used during the development of the FMOH and RHB Annual Plans of Action.

D. GOVERNANCE

The different and complementary roles of FMOH, RHBs and WorHOs are clearly specified in the HSDP II and the decentralisation policy. The decentralisation policy creates opportunities for local Governments to be responsive to local challenges; it also creates a major challenge of ensuring that national priorities are adequately funded in the Regional and Woreda plans. Weak management capacity in particular at the Woreda level stands out as a key constraint to governance in the sector. HSDP II was ambitious in trying to address most weaknesses of the Ethiopian health system in three years. In that regard, HSDP II posed a real challenge for managers to perform within the set framework. However, it also explains why most HSDP II targets have not been met, because HSDP II was overly ambitious given the available time and human resource capacity in the country.

Recommendations

- The FMOH should use direct (through technical assistance) and indirect methods (such as legislation, dialogue, advocacy, monitoring and supportive supervision) to guide the Regions and to ensure that national priorities are perceived as regional priorities. Similarly RHBs should use the same methods to guide Woredas, an issue which demands more attention, if lower levels of government are to allocate more resources for health service delivery. This will require capacity building of the representatives in the WorHOs in order to ensure a strong health representation in the Woreda Councils.

- FMOH and RHBs to strengthen planning and management capacity at all levels, especially at the Woreda level. Promote performance based resource allocation and accountability among the actors at all levels.
- FMOH and RHBs to revise the current JRM format to make it a bottom-up planning and review process, owned by the RHBs and FMOH.
- FMOH to take measures to strengthen inter-sector collaboration in particular with MOFED, Ministry of Water Resources and Ministry of Education.

HSDP II has served as a framework for aligning donors to the GOE sector policy and strategy. It has established a formal co-ordination framework including joint reviews, joint processes for monitoring and use common performance monitoring instruments. However, aid to the sector remains fragmented with a large number of donors and project-tied interventions that are guided by multiple procedures, targeting different regions and/or inputs to HSDP II, contributing to a high overall transaction cost for FMOH/GOE. Large and unpredictable inflows of external funding for vertical programmes have had limited impact on resource availability to strengthen general comprehensive service delivery, which remains the core issue to address.

Recommendations

- Donors should be encouraged to change their current practises and align their support as much as possible to the GOE budget process.
- Resource envelopes / commitments to health should first and foremost serve as a tool for improved predictability of funds and be presented by the donors in a format that can be used in the budget process as basis for estimating the overall fiscal framework.
- Performance agreements and/or Memorandum of Understanding (MOU) between FMOH and its partners or between the RHB and civil society appears to be a useful and appropriate tool to enhance collaboration, by clarifying mutual expectations, responsibilities and accountability. They should be actively pursued during HSDP III at all levels.

E. OVERALL SUMMARY

The overall goal of the HSDP was to improve the health status of the Ethiopian population. During the HSDP II period, there has been improvement in health sector performance with increased health sector outputs. This contributed to modest improvements in the health status of the Ethiopian population. The table below shows the trends in health status during HSDP II.

Trends for health status and some disease control indicators 2001-2005

Indicators	Baseline value 2001/02	HSDP II result 2002/03	HSDP II Result 2003/04	HSDP II Result 2004/05	HSDP II Target 2004/05	HSDP III Targets	MDG Target by 2015
Life expectancy				54	58		
Infant Mortality Rate	113		97	77	85	45	38
Child Mortality Rate	166		140	123		85	55
Maternal Mortality Rate	871	871	871	871	**450**	**600**	**450**
Total Fertility Rate	5.5		5.9	5.4		4	
HIV Prevalence	7.3%		4.4%	4.6%		4.4%	2.2%
TB Case Detection Rate		43.5%	45%	34%		50%	
TB Cure Rate	81%	81.9%	81.1%	81.3%		72%	
Malaria prevalence				22%		10%	
Proportion < 5 yrs underweight	47%			38%			
Proportion < 5 years stunted	52%			47%			

During HSDP II health indicators have improved even though HSDP II targets have not been fully achieved. The positive trends observed for most health indicators may be linked to investments in the past as well as vertical (earmarked) programmes "off budget", i.e. not captured in the HSDP II budget. However, our assessment of the HSDP II shows that the health service delivery system has been further strengthened despite several constraints. The implementation of the HESP will most likely further the quantity and quality of service delivery which will become visible through further improvements in key health sector indicators.

These observations stand in contrast with the prevailing low level of per capita expenditure for health and the low priority accorded to health as measured by the share of health expenditure to total public expenditure. Key issues to address are the efficiency and sustainability in the use of resources; the former is related to the continued fragmented donor contributions to the sector which undermines effective allocation of resources, while the latter is related to the low priority accorded to the health sector by Regional and Woreda levels.
A new initiative by some donors (PBS) may pave the way for improved aid efficiency, while more emphasis on supervision and support from the higher levels (Federal to Regional and Regional to Woreda) may ensure more resources allocated to peripheral health services.

F. Road map to the evaluation report

Volume I of this report presents five major sections as follows:

- Section 1 is the introduction to the report. It details the background to the assignment, followed by a brief description of HSDP II. It describes the purpose of the evaluation of HSDP II and a description of the methodology and limitations of the evaluation exercise.
- Section 2 covers Service Delivery and Quality of Care. It is the largest section, as all the (sub) components of HSDP II are being presented. In addition the areas of IEC, Environmental Health and cross cutting issues are covered as well.
- Section 3 describes Support Services which include facility construction and rehabilitation, human resource development, pharmaceutical supply & management, HMIS/M&E/OR.
- Section 4 covers Finance and management. The sub sections describe financing of the sector, status of implementation of the Health Care Financing Strategy, financial management, Governance and donor harmonization and alignment. At the end of this section, there is a summary of the implementation of previous recommendations.
- Finally, section 5 presents conclusions of the evaluation and HSDP performance. Areas covered include policy changes, performance changes and progress towards attainment of the Millennium Development Goals.

Following the main report, there are attached, a number of annexes that make reference to specific topics of interest to the reader of the evaluation report. For readers who are interested in a long-term trend overview, Annex I will be of particular interest, as this includes a unique overview of the sector performance during the last eight years.

Volume II is recommended reading for all those involved in health sector interventions in the various regions of the country. **Volume II-A** contains all the Regional reports, including regional maps, regional indicators over a full eight year period and **Volume II-B** contains the full set of Questionnaires used during this evaluation.

Overall Performance Indicators HSDP II 1995-1997

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1. Introduction

1.1. Background to the assignment

The Health Sector Development Programme drafted in EFY 1986/87 was designed for a period of 20 years with a rolling five-year programme period. It provided a long-term plan framework, the main goals being to (i) build of basic infrastructure, (ii) provide standard facilities and supplies and (iii) develop and deploy appropriate human resources for realistic and equitable health care delivery at the grass-root level. The total budget was estimated at 20 Billion Birr for the 20 years period, the first five years requiring a total of 5 Billion Birr.

Based on the overall outline of this 20 years health development plan, the first five year phase of HSDP (HSDP I 1990 – 1994), corresponding to the Gregorian Calendar (GC) 1997/08 – 2001/02, was elaborated and implemented. Its objectives and targets were detailed in the Programme Action Plan (PAP, August 1998) as follows:

- Increase access / coverage to health care from 40% to 50-55%;
- Improve service quality through training and an improved supply of inputs;
- Strengthen management of health services at federal and regional levels.
- Encourage participation of the private sector and NGOs by creating and enabling environment for participation, coordination and mobilisation of funds.

The achievements, constraints and lessons learned have been documented in the Mid Term Review (MTR, March 2001) and the Final Evaluation of HSDP I (March 2003). The Programme Implementation Manual (PIM, October 1998) set out the governance and management arrangements to be followed by all stakeholders and the performance indicators by which the programme was to be monitored.

On the basis of the recommendations made by the MTR a Three Year Health Sector Development Programme (HSDP II) covering the period (EFY 1995-1997) was prepared. Its three-year duration allowed its alignment with the planning process of the Second National Development Plan (NDP II) and the Sustainable Development and Poverty Reduction Programme (SDPRP) of the Government of Ethiopia (GOE). HSDP II was approved at the ARM 4 in 2002. It was formally reviewed twice as part of JRM 3 (March 2003) and JRM 4 (June 2004).

Based on the recommendation of the HPN-Donor/FMOH consultative Forum, the Central Joint Steering Committee (CJSC) approved the conduct of a formal evaluation of HSDP II as per the agreed procedures of the PIM. The Terms of Reference (TOR) for the evaluation of HSDP II has been drafted by the Joint Core Coordinating Committee (JCCC). It was approved by the ARM 7 in October 2005.

1.2. Brief description of HSDP II

As in HSDP I, the HSDP II comprises eight components that together define the health sector in a comprehensive way. For each component detailed objectives, targets, strategies and indicators have been proposed, while the respective budgets for each of these components have been estimated in Table 1 as follows:

Table 1. Health components of HSDP II with their budgets

HEALTH COMPONENTS HSDP II	*BUDGET (Birr)*	*PERCENT*
1. Service Delivery and Quality of Care	*3,924,851*	*57*
2. Health Facility Rehabilitation and Expansion	*1,609,119*	*23*
3. Human Resource Development	*440,983*	*6.5*
4. Pharmaceutical Supply and Management of ED	*677,417*	*10*
5. Information, Education and Communication (IEC)	*84,934*	*1*
*6. Support and Advisory Services**	*577,808*	*8.5*
TOTAL 3 YEAR BUDGET HSDP II 1995-1997	*6,868,232*	
Capital	*3,168,000*	*46*
Recurrent	*4,000,000*	*54*

* This included health management and information systems, health care financing, monitoring and evaluation and cross cutting issues.

Of the total 6.8 Billion Birr budgeted from Federal resources for HSDP II, 54% was to be allocated by Treasury for recurrent expenditure (including salaries) and 46% for capital expenditure. About 93% of the budget was meant for the regions on the basis of: (i) population size, (ii) existing infrastructure and (iii) revenue generated capacity. FMOH was to use the remaining 7%.

1.3. Purpose of the evaluation of HSDP II

The final evaluation of HSDP II will focus on documenting the achievements, constraints and challenges and the lessons learned during the implementation of HSDP II. The evaluation is expected to provide an independent assessment on the overall performance of HDSP II, its eight components and its various implementation arrangements at the level of the FMOH, the regions and the two city councils.

Its main thrust is to look how far policy changes, such as decentralization to the Woreda, the Civil Services Reform Programme and the Health Services Extension Programme have contributed to improvements in health service delivery and ultimately to the health of the people. The evaluation will also review the extent to which findings, conclusions and recommendations of the final evaluation of HSDP I, previous ARMs and the two JRMs has been given follow-up. The Evaluation Team (ET) is also expected to coordinate its work with the team that is working in the revision of the HSDP I & II Programme Implementation Manual (PIM).

The TOR has specified the following **objectives of this evaluation**:

1. Review progress in the implementation of the eight components and cross-cutting issues (Gender, Nutrition and Pastoral Health services).
2. Review the implication of major policy changes (decentralization, Civil Service Reform Programme, HSEP etc) and other initiatives related to implementation of HSDP II.
3. Review the quality of training and field level implementation of HSEP.
4. Asses the working relationships between the centre, regional RHBs and Woreda Health Offices in the implementation of HSDP II.
5. Asses the extent of resource availability and utilization at all levels as per HSDP II.

The TOR also mentioned the following **expected outcomes.**

- Identification of the strengths, weaknesses and main challenges of the implementation of HSDP II in the context of the planning, national and international health initiatives;

- Identification of best practices and lessons learned and major implementation problems;
- Draw conclusions including recommendations on useful measures that will help to improve the implementation of HSDP III;
- Identification of the impacts of major policy changes in HSDP II and recommendations to modify the management of the programme.

1.4. Methodology and limitations

The method undertaken for this evaluation is to some extent similar as the previous reviews. After extensive preparations (Annex 4/Programme) and a review of available documentation (Annex 6/Documents), detailed questionnaires (Volume II-B) were drafted for each of the components. They serve as a guide with quantitative and qualitative questions to be posed during the interviews with the different stakeholders (Annex 5/people met) at Federal level and in the Regions, Zones, Woredas and Health Facilities[1]. Six teams composed of specialists in the various fields (Annex 3/Matrix) visited all the nine regional states, the two city administrations and the Federal Ministry of Health (FMOH). Back in Addis Ababa, they shared their findings and produced reports from their regional visits. These Regional reports have been brought together in Volume II-A with regional specific data over an eight year period. Participants regrouped in 'content or thematic areas' and drafted component based reports, taking the different experiences from all the regions into account.
Once all contributions had been brought together and an executive summary had been added, the 'zero draft' report was discussed with the whole evaluation team (page by page) until consensus had been reached about its content and wording. The consensus version (first draft) was then submitted to the JCCC for approval.

An overview of performance indicators has provided the basis for the analytical work. Much effort has been made to standardise the database and make the figures as consistent over time as possible. Linking these data with the figures from the evaluation of HSDP I allows analysis over the full eight years period of HSDP I & II (EFY 1990 – 1997) for all regions and for the national level (Annex 1). Unfortunately, figures on many of the HSDP II indicators have not been regularly collected and could not be used. An one page summary of the overall performance indicators of HSDP II has been included in the executive summary. It allows an overview of the overall performance of the sector. Annex 8 provides technical notes on the reliability and consistency of these figures. By relating the findings to the available documentation of previous reviews and evaluations and relating that information to relevant indicators over an eight year period, the picture that emerges of the performance of the sector is more than a snapshot of the current situation; rather it appears a slowly moving film, providing trends towards the goals set by the HSDP programme.

This evaluation made some modifications in the methodology used. A deliberate effort was made to make the process a learning exercise for people within and outside Ethiopia. First, senior health managers from other African countries (Mozambique, Ghana, Tanzania and Uganda) participated to allow for sharing experiences and 'cross

[1] Stakeholders during the interviews were health staff at the different levels (from federal down to health facility), staff of the Ministry of Finance and Economic Development (MOFED), staff of the Ministry of Capacity Building (MOCB, Woreda Council Members, staff of HAPCO, relevant civil society groups, NGO's or representatives of the private sector and relevant donor agencies (multilateral and bilateral)

fertilisation'[2]. Secondly, participation from the various Regional Health Bureaux was actively sought and members from the RHB of Oromiya, Addis Ababa, Afar, Gambella and Harari participated in the evaluation. Finally, the component structure of HSDP I and HSDP II was modified (as suggested by JRM3) and regrouped under three 'thematic areas': (i) service delivery; (ii) support systems and (iii) finance and management[3]. It is expected that these three 'thematic areas' of the HSDP II evaluation will allow for (i) bringing on board the experiences from other countries, (ii) including the views of the regions and (iii) allowing better inter-linkages among the various components.

This evaluation acknowledges a few important limitations, the most important ones being:

- The methodology used for these reviews/evaluations is extensive and demanding. In addition it is quite 'external' in nature as little 'self-evaluation' from the Regions (and Woredas) is requested. Some therefore feel that this review process is not 'owned', particularly by those that have to implement its recommendations (being the Regional and Woreda Health teams). This is a serious limitation that should be addressed in the future, if possible by making the whole review process more 'bottom-up'.
- There was limited information available on the private sector. Furthermore, the evaluation team did not benefit from a representative of the civil society (NGOs), and the private sector, which was a weakness in the composition of the team. Also the team member of MOFED only participated part of the time. As all these institutions are essential to the performance of the sector, their contributions could not be taken on board, indicating serious limitations in the representativeness of our findings and suggestions. This evaluation therefore addresses mainly 'public service delivery' and to a lesser extent the health sector in its full scope.
- Lack of participation from Other Government Organizations (OGO) and traditional health practitioners.
- The team was not able to visit the more remote and poorer areas, due to distance and security constraints (Gambella and Somali). Such a limitation might have biased our findings towards a rosier picture than is actually the case.
- Finally, the regional teams found few RHB Heads to interview during their visits and many staff of the RHB had only recently been appointed. This was felt as a limitation as much information on the experiences with HSDP II implementation, constraints and best practises could not be provided.

[2] At the request of His Excellency the Minister of Health, team members from these four countries prepared presentations on SWAp experiences and related issues (Saturday 4th February 2006).
[3] Details about which component are included in which 'thematic area' can be found in Annex 3 (Matrix) and the Table of Contents of this report.

2. Service Delivery during HSDP II

2.1. Health service delivery and quality of care

Since 1991, Ethiopia has undertaken a range of fundamental reform measures to address the deep-rooted health problems in the country[4] and to meet the high unmet demand for health care in the rural areas. In the context of the Sector Investment Programme, the Health Sector Development Programme (HSDP) was launched in 1998 with the basic objective of improving the coverage and quality of health services[5]. In view of the MDGs, the government has introduced two *flagship* programmes: (i) the Health Service Extension Programme (HSEP) and (ii) the Accelerated Expansion of Primary Health Care Coverage (AEPHCC). It has also introduced the Essential Health Service Package (EHSP). Table 2 below provides an overview of the status of the relevant MDG indicators.

Table 2. Relevant MDG indicators within HSDP II

Indicator relevant for the MDGs	**Baseline 1994 HSDP II**	**Status 1997 End HSDP II**
% Births attended by skilled staff	10%	12%
Contraceptive acceptor rate	14%	21%
%<1 yr immunised for DPT3	51%	70%
%<1 yr immunised for measles	42%	61%
TB cure rate	66%	65%
Outpatients visits/pp/yr	0.27 (1993)	0.30
GOE per capita expenditure on health (Birr/pp in public sector)	NA	16.3

Source: HMIS data base 1996-1997 to 2004-2005 prepared during HSDP II evaluation

This chapter discusses progress in implementing the various sub-components of HSD&QC, including HSEP, EHSP and cross cutting issues relevant to service delivery. The next chapter on Support Systems reviews progress made in the AEPHC. The following box summarises progress made in implementing the two flagship programmes HSEP and EHSP.

Box 1. Objectives, progress and recommendations of two Flagship Programmes

Objectives of Flagship Programmes	**Progress**	**Recommendations**
• The HSEP aims to increase access and equity to preventive essential health interventions through community/Kebele based health services with a strong focus on sustained preventive health actions and increased general health awareness.	• HSEP implemented in nearly all Regions possibly contributing to geographical access to services; • HEW effectiveness limited by inadequate supplies and equipment inadequate supportive supervision by WorHOs • Possible contribution to improved coverage of preventive services • Communities expect curative services	• Expand and sustain the HEP though adequate funding and synchronization of training, construction and equipping of infrastructure and deploying HEWs • Reinforce supportive supervision to HEWs from Woreda level

[4] This includes (1) the development of a new Health Policy and Strategy, (2) the democratisation and decentralisation of the health system and (3) the introduction of a twenty-year Health Sector Investment Programme.

[5] HSDP II has been integrated with the Poverty Reduction and Sustainable Development Programme (PRSDP) and is guided by the Millennium Development Goals (MDGs).

Objectives of Flagship Programmes	Progress	Recommendations
	from HEWs • HEWs providing interventions at household level and mobilizing communities for preventive interventions such as immunization and construction of latrines in collaboration other Front Line Health Workers (FLHW). • Communities contribute to the construction of HPs, but play a limited and sometime unclear role in management and supervision of HEWs	• Review service package of HEWs to align with community expectations • Clarify the role of communities in management of the programme including the accountability relationship between the HEWs and Woreda administrators • Clarify place of community health agents in HSEP and their relationship with HEWs
• ESHP aims to Standardize essential services and enhance availability and delivery of equitable services for each district including pastoralists	• A comprehensive EHSP to be implemented at all levels (HP, HC, Hospitals) has been defined but not yet implemented as a systematic package of activities at all levels; However many components of the proposed package are being implemented in the context of the traditional vertical programmes • Progress has been recorded in key public health programmes as shown in indicators table • Key gaps are in the maternal health services • Package does not define how rehabilitation will be provided • Pastoralist's services are still being developed	• Use the package explicitly to define and refine investments in health sector particularly infrastructure development, equipping and pre-service and In-service training • Integrate the traditional service delivery approach with the activities defined in the EHSP package • Prioritise investments in essential obstetric care • Accelerate development of Pastoralist's services

In the next sections, the various sub-components of HSD&QC, as presented in HSDP II will be presented in some detail.

2.1.1. Health Services Extension Programme (HSEP)

The HSEP is a community based PHC service which includes a package of *basic* preventive, promotive and curative services[6]. The HSEP targets the households at Kebele level (average 5000 people) and aims in particular to reach mothers and children.

The HSEP services are provided by two female Health Extension Workers (HEWs) per Kebele. This is a new cadre of health workers who are formally employed and salaried by the respective Woredas. The HEWs undergo one-year training in selected Technical and Vocational Educational Training Centres (TVETC) and operate from a Health Post with technical support from a Health Centre and under supervision of the WorHO. Over the last four years (2002-2006) the HSEP has evolved during its development phase and pilot phase in a number of Regions (Tigray, Oromiya, Amhara, SNNPR and Dire Dawa) and is now being implemented in an accelerated mode in most of the Regions. The programme has been monitored closely and key recommendations have been formulated during the JRM 4 (March 2004) and ARM 7 (October 2005).

[6] This includes health education and communication, first aid, malaria prevention and control, HIV/AIDS and TB prevention and control, adolescent reproductive health, maternal and child health (Community IMCI), immunisation services, nutrition extension package, water and environment health.

Costs of HSEP

It is important to distinguish that the programme requires two different types of investments in order to succeed. Funds are required for the HEWs (salaries and training) and for the construction and upgrading of Health Posts (1 HP per Kebele) and Health Centres (HCs). Over the period 2003-2005, HSDP II trained 9,827 HEWs and planned to build in total 1460 new HPs, 143 new HCs and to upgrade 29 HSs. During the HSDP III (1998-2001 EC), it is planned to train 20,963 HEWs and to construct in an accelerated mode 12,249 HPs and 563 HCs and to upgrade 2,167 Health Stations.

Table 3. HEW training and infrastructure development

Phase	HEWs training	HP construction	HC construction	HS upgrading
HSDP II 1995 – 1997	9,827	1,460	143	29
HSDP III 1998 – 2002	20,962	12,249	563	2,167
Total	30,789[7]	13,709	706	2,196

Source: HSEP Coordination office (February. 2006) and AEPHCC booklet November 2004 (see Table 7, chapter 3 for updated figures on realised facility construction / expansion)

The two programmes require capital investments and a budget for the recurrent costs. The government has estimated that the total investment for the period 2005-2010 (total investment and recurrent costs) will be USD 1.69 billion. This comes down to USD 4.63 per capita per year. The estimations exclude the community contributions towards the construction of HPs. Hence, it is assumed that the total investments will be higher. Although extensive financial data were included in the AEPHCC booklet (2004), it was not so easy to estimate the annual requirements per year per HEW and HP. Four major areas of costs should be taken as cost centres to determine the running cost of health posts: (1) Salaries of the Health Extension workers, (2) Cost of drugs and medical supplies, (3) operational costs including supervision and (4) cost of preventive maintenance for the buildings. Based on the available figures the following estimations were made (Table 4):

Table 4. Estimated annual costs of HSEP

Cost centre per HP per year (excludes HCs, training HEWs and supervision)[8]	Annual costs USD	Annual HP requirements in 2001 (EC)
Annual salary of HEW	540[9]	USD 16,643,340
Annual operational costs per HP[10]	670	USD 9,135,450
Annual preventive maintenance[11]	290	USD 3,951,250
Annual amount for essential drugs and consumable kits[12] per HP	548	USD 7,366,500
Total estimate per year	2,048	USD 37,096,540

Source UNICEF proposal 2005 and AEPHCC booklet 2004 / Based on rate USD $1 = 8.68 Birr

The estimates exclude the costs for construction, upgrading and equipping Health Facilities and TVETCs, refresher courses for tutors and HEWs, apprenticeships HEWs, minimum equipment requirements, Woreda capacity development, transport and monitoring and evaluation. However, the estimation provides an overview of the minimum

[7] Different figures appeared in various documents. We follow the data of the HSEP coordination office.
[8] Based on estimated requirement of 13,625 Health Posts
[9] Based on a monthly salary of 400 Birr. It is not clear whether salaries will increase over time. Regional salary scales differ.
[10] Estimates based on UNICEF document for accelerated implementation of child survival activities through the HSEP in pastoralist communities (December 2005).
[11] See 5
[12] See 5

annual running costs per HP. These are the costs that will need to be secured at regional level. This seems an enormous challenge. From the available documents it did not become clear whether the required funding can be secured for the HSDP III and whether the regions will be able to guarantee the reservation and continuation of the minimum annual running costs of the HSEP considering the fact that other health programmes also have to be budgeted for. The budget requirements will depend on the selected health package and costing scenarios (as estimated by the WB). Based on these projected costs, it is evident that the Ethiopia really does need substantial financial support to implement the HSEP and the AEPHCC initiatives in order to guarantee its success.

Achievements

Despite the short period of implementation under HSDP II, it can be concluded that the HSEP and the AEPHCC has made a tremendous progress in the majority of the regions in a relatively short period and has been well received and supported in the regions. There is general consensus among RHB staff that the HSEP is the *best* programme that Ethiopia has undertaken in recent years. The achieved progress is truly a huge achievement and it reflects the enormous efforts that have been made to set the whole process in motion. The progress is clearly visible in the regional reports of the HSDP II evaluation mission (Volume II) and in the documents prepared by the FMOH/HSEP department. It is evident that the key strategies and core activities have been achieved to a very large extent (outreach programme, community sensitisation and promotion programme, training programme, construction and upgrading of health facilities). As a result, access and equity to community based preventive essential health care services has been increased and avenues for preventive services have been created in the rural areas. Table 5 provides an overview of the training interventions during HSDP II.

Table 5. Achievements HSEP during HSDP II 1995 - 1997

Description	1995	1996	1997	Total
• HSEP Teachers TOT trained	84	115	71	270
• HEW Trainees	2737	7090	7100[13] (UNICEF data)	16,927
• Schools opened	14	10	15	39
• Implementation/management guideline for HEWs developed in English and Amharic. Translation in other languages is ongoing				Yes
• Lecture/facilitator notes, reference text books produced				65,000
• HSEP developed on different topics related to (1) Family Health service, (2) Disease prevention and control, (3) Hygiene and environmental health, (4) Health Education and communication. Special pastoralist HSEP curriculum developed.				16 packages in 4 major programme areas developed
• HSEP distributed				85,000 copies

Source: HSEP Coordination Office (February 2006) and UNICEF proposal (December 2005)

It should be noted that the regions Harari (49 HEWs) and Dire Dawa (50 HEWs) completed the HEW training in 2005. Tigray completed the training (1200 HEW) early 2006 and will not continue further training in the 2006 academic year. Oromiya, Amhara, SNNPR and Benshangul regions have started the training of HEWs and will continue with the training under HSDP III. The emerging regions Somali, Afar and Gambella will start the training of HEWs in April-May 2006 (see also pastoralist section).

At this stage of the programme, it is still too early to determine the precise impact of the HSEP and to assess to what extent positive health performance indicators can be attributed to the HSEP and the AEPHCC. However, in the technical notes on the national

[13] Estimated number, HEWs still undergoing training

HMIS (annex 8), it has become evident that during the HSDP II a positive *swing* has become visible for key indicators. However, it should be noted that there are considerable regional differences (see for details Volume II).

Constraints and conclusions
A range of constraints associated with the rapid expansion any programme has been identified for the HSEP. These constraints can be addressed by fine-tuning implementation of the programme to improve training and deployment of HEW, as well as the overall sustainability of the programme.

The training of HEW has been affected by a number of *teething* problems and constraints which include:

- Inadequate resources including large and cramped classrooms, inappropriate teaching materials, shortages of trainers in TVETCs to face the high student intake.
- Students are not always recruited the selection and recruitment of the first group HEWs was not fully done according to the criteria (though this improved later),
- Regions provided different stipends to HEWs and different salary top-ups to trainers
- HEW training programme was affected by absence of a training plan, limited number of educational materials
- The TVETCs were not included in the planning and learning process of the HEW training and were uncertain about the future of the training. In addition, there was no systematic exchange of information and results between the TVETCs and the RHB.
- The training curriculum provides limited opportunity for practical training and apprenticeship. Certain weak areas (delivery skills, malaria, nutrition and sanitation) have been identified with graduated HEWs but have been corrected through refresher courses, including the upcoming integrated UNICEF training for vertical programmes.

The deployment of HEWs is constrained by:

- Lack of synchronisation between the construction and equipping health posts and the training results in some cases in HEWs being placed in health centres because health posts have not been constructed or HEW are posted into HPs without equipment.
- Weak supportive supervision (including work planning, referral practises and quality assurance) from RHB and WorHOs.
- Weak community support especially in areas where community stability may still be fragile; the RHBs and Woredas will need to ensure an adequate supportive environment for current and future HEWs.
- Unclear relationship between the HEWs and other earlier trained PHC workers which may lead to duplication of tasks and create confusion with Front Line Health Workers.
- The HMIS system does not capture sufficiently all the services provides by HEW.

Sustainability of the HSEP may be compromised by:

- Attrition and absence of career development of HEWs. It is assumed that continued training of HEWs will be required in the coming years. A plan for HEW replacement training has not been developed at this stage.
- Perceived concern that the female HEWs may be less successful in the context of low acceptability of messages promoted by women and security concerns in some Regions. In the pastoralist areas there seems to be need for more HEWs per Kebele given the distances in the area and the mobile character of the pastoralists.
- Difference between community expectations and the design of the health extension package with communities expecting that HEW will provide treatment for common diseases while package excludes treatment of common childhood diseases such as Acute Respiratory Infections (ARI).
- Potential overload of HEWs could result in health promotion and preventive activities being compromised in favour of curative services.

Recommendations
Overall, there is the need to increase resources to expand and sustain the HSEP and synchronize construction and equipping of health facilities, deployment of HEW and provision of supplies. Other specific recommendations relate to:

- Policy: FMOH to review the current package of services provided by HEW, striking a balance between (i) including new/other treatments (for ARI in children due to its high mortality), (ii) without overloading the HEW and (iii) ensuring that the package is responding to community expectations and technical needs.
- Policy: The expected attrition and career development of HEWs needs to be addressed to ensure that the implementation of HSEP will not *slow down* during the HSDP III. This will require a strategic approach and a replacement plan to be elaborated by national and regional levels.
- Implementation: FMOH to provide clear guidelines on roles and responsibilities between the different categories of front-line health workers (FLHW), staff in HPs and administrators / supervisors at Kebele / WorHO levels.
- Implementation: A national and regional HSEP task forces should be set up to provide technical guidance and facilitate access to resources, so that the overall aim of the HSEP can be achieved during the intended timeframe.
- Training: FMOH and RHBs to strengthen the technical capacity of the trainers and the equipment and training materials available in the TVETCs.
- Training: Monitor and evaluate the Integrated Refresher Training for HEWs ensuring supervision capacity at HC, Woreda and RHB level.

2.1.2. Communicable disease prevention and control

2.1.2.1. Malaria and vector borne diseases

Introduction
Malaria is the leading public health problem in Ethiopia. At least 68% of the total population in Ethiopia is at risk of malaria. Malaria the leading cause of morbidity and mortality accounting for about 16.6% of the total outpatient visits, 15% of the total admissions and 28.9% of the total hospital deaths (FMOH 2005).

Achievements
The Malaria Control Support Team (MCST) was established in 1998 with the founding RBM members (WHO, UNICEF, World Bank (WB), UNDP and USAID) and has now become more functional with the number of MCST members is increasing.
In 2003, the country has solicited a total of US$ 77 million from the Global fund round-two proposal for scaling-up key anti malarial interventions for five years. Marked improvement has been recorded in the pace of implementation and fund utilization of the malaria component Phase I Round 2 of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). Round-five GFATM proposal was also submitted in June 2005 and approved for funding in September 2005.

Revision and fully implementation of the new guideline for the treatment of uncomplicated P. *falciparum* using Artemether-Lumefantrine (Coartem) is one of the major achievements of the program. In July 2004, the first-line antimalarial treatment changed into Artemisisin-based Combination Therapies (ACTs), artemether-lumefantrine (Coartem®) for the treatment of uncomplicated falciparum malaria due to high treatment failure rate (35.9%) of Sulphadoxine-Pyrimethamine (SP). Cascade trainings were conducted to reach all level of health facilities on malaria diagnosis and the new treatment approach. The new

ACT, although safe and effective, is very expensive both to the individual patients and the Government. Encouraging support has been received from GFATM, UNICEF and WHO for funding the purchase of Coartem. Availability of Coartem in health facilities is improving and the teams have also observed the availability and use of Coartem in almost all visited health facilities. However, Community malaria workers in Oromiya region still used Sulphadoxine-Pyrimethamine (SP) for treating clinical malaria at community level. In areas where laboratory based diagnosis is not available, Rapid diagnostic test (RDT) has been introduced especially in health posts to make reliable diagnosis and to guide treatment decision. In this regards, shortage of RDTs was reported in most of the visited regions.

During HSDP II, an effort has been made to improve access to insecticide treated nets (ITNs). Using cost recovery schemes, ITNs distribution has been tried. With support from Global Fund and other partners free ITN distribution started in large scale in the end of 1997 EFY targeting high malaria risk areas and ensuring high coverage to achieve impact. The coverage of 2 ITNs per house hold in malaria risk areas was reported to be 14% in 1997 EFY. Currently, scaling up of ITN intervention is one of the key interventions in the malaria prevention and control program. According to FMOH report, a total of 4.5 million ITNs were purchased and distributed using resources from the Global Fund, UNICEF, etc and the coverage of house holds owing 2 ITNs increased to 23% in the mid of 1998 EFY.

The Malaria epidemics early detection and control guideline was revised, printed and distributed in 2004. In general, Malaria prevention and control program can record major achievements during HSDP II in terms of implementation and fund raising for up-scaling interventions. The program has the capacity to scale up the interventions to a level of Universal coverage in terms of access to ACT and ITN using the opportunity of the HSEP and funds for malaria from Global Fund for AIDS, Tb and Malaria (GFATM) Round 2 and 5 and other partners. With regard to Onchocerciasis control program, implementation expanded as planned from 3 to 9 projects in 2004 to cover 100% of meso- and hyper endemic districts in the country.

Constraints and conclusions

- Wide spread malaria epidemics were reported in 1995-96 EFY while 1997 EFY reported only few reports of focal epidemics. In some areas household water development schemes have contributed to the increase in malaria cases.
- Inability to pay, lack of continuous supply of ITNs, and low level of community awareness has limited ITN distributions through the cost recovery scheme.
- Indoor residual spraying (IRS) of houses has been implemented as one of the important vector control tools to reduce the incidence of malaria transmission and prevention of the occurrence of malaria epidemics. Shortage of operational funds and spray pumps were reported as constraint in the implementation of IRS.
- The malaria programme has been affected by limited numbers of permanent staff.

Recommendations

- Inter-sector collaboration between FMOH and the Ministry of Water Resources to be strengthened in planning and implementation of water related activities at all levels.
- FMOH and RHBs need to discuss and reach consensus on the role of community malaria workers in treatment of malaria as per the new treatment guidelines.
- FMOH/PASS to ensure continuous supply of ACT and Rapid Diagnostic Tests (RDTs) to all health facilities where there is no laboratory.
- Scale up universal coverage with ITNs of all households in malaria risk areas.

2.1.2.2. Tuberculosis and Leprosy

Introduction
HSDP II aimed at increasing the coverage of tuberculosis prevention and control services from 50% to 75% as a means to reduce the incidence and prevalence of TB through improved case finding and standardized treatment. The national tuberculosis and leprosy control programme (NTLCP) was committed to establishing guidelines, standards and protocol for case detection and management. Further, the programme sought to ensure availability of drugs, equipment, laboratory reagents and chemicals in sufficient quantities. Though there were no explicitly defined targets for case detection and treatment success rates during HSDP II, these parameters were included among the performance indicators.

Achievements
Four of MDG indicators are related to TB: to detect 70% of infectious TB cases, to attain 85% treatment success among detected cases, and to halve the prevalence of and deaths from TB between 1990 and 2015. Over the last three years, DOTS Woreda coverage has increased from 50% to 90% and 50% of public health facilities provide DOTS, highlighting a success in the geographic expansion of the programme. Health service coverage by DOTS, however, has yet to be accelerated further.

Constraints and conclusions
- The programme seems to progress well towards the 85% treatment success (81% in 1997). However, case detection, like the past 5 years, is way below the 70% target (34% in 1997) and needs some innovative approaches, like intensified case finding through health extension and quality assurance schemes for diagnostic laboratories. There are no reliable estimates on the real incidence of TB, and the reported notification rate may seriously underestimate the actual burden
- To achieve 85% treatment success, an important indicator of programme performance, is a big challenge given the fact that nearly a 30% of TB cases in this country are co-infected with HIV. The chronic high rates of malnutrition and the magnitude of HIV infections have created a threatening environment, in which tuberculosis has and will continue to proliferate. Overall levels of poverty as well as staffing constraints at public facilities have also posed impediments to further improvements in TB treatment and prevention. Strengthening the health system with the scaling up of ART might contribute to addressing some of these problems.

Recommendations
- Expand the community DOTS programme, particularly through HSEP.
- Intensify and expand the TB/HIV collaborative work and extend this partnership to involve also the private sector.

Leprosy
The prevalence of Leprosy was expected to decline from 0.75 per ten thousand population to 0.6/10,000. At the end of HSDP II, leprosy prevalence came down to 0.7/10,000. An encouraging move has been made in integrating DOTS/MDT into the routine health care services and this need to be strengthened further.

Recommendations
- Develop the human resource capacity in Leprosy control at peripheral and central levels in order to provide technical support to all health facilities through training, quality assessment and supportive supervision. Give adequate attention to disability prevention in the control of Leprosy.

2.1.2.3. HIV/AIDS

Introduction

The HSDP II HIV/AIDS prevention and control subcomponent is to undertake measures to reduce morbidity, disability and mortality in the country. It should be noted that there are some methodological difficulties in HIV trend analysis. During the evaluation it was difficult to assess the current prevalence, due to differences in available data. The available data suggested a decline in adult HIV/AIDS prevalence during the HSDP II, and huge differences between urban and rural areas. The cumulative number of people living with HIV/AIDS is about 1.7 million out of which more than 286,200 are AIDS cases in need of ART. More females are infected and affected by the epidemic and while HIV infection appears to be stabilizing at a high level in urban areas; infection in rural areas shows a steady increase but at a rather low pace. It can be expected that the duration of illness and the increased access to treatment will contribute to the changes in disease patterns. The economic implications are grave, as the largest number of HIV-infected people is in the 20-29 years age group. Given the rather narrow focus of HSDP II, this chapter will focus more on the HSDP II planned outputs, mainly in IEC/BCC, VCT, PMTCT and ART.

Achievements

The HIV/AIDS Prevention and Control Office (HAPCO) is responsible for coordinating the national response to the HIV/AIDS, provide financial and material support and monitor and evaluate projects nationwide. After a recent structural change HAPCO is now placed under the FMOH. Other observations on HAPCO such as unclear vertical relationships, coordination effectiveness, weak information system, have been extensively reviewed in earlier missions and evaluation reports and will not be repeated here. Over the last three years, the HIV/AIDS prevention and control work has exhibited an encouraging progress. A number of documents were produced such as the Ethiopian strategic plan for intensifying multi-sector HIV/AIDS response, Guideline for implementation of antiretroviral therapy (ART), and Accelerating Access to ART in Ethiopia (Road map for 2004-2006). Other achievements and findings of HIV/AIDS as HSDP Component are:

- The development in 2004 of the HIV/AIDS and TB Prevention and Control Extension Package that is now widely distributed and used by HEWs.
- IEC/BCC was observed to be widely available in many forms and using different communication channels. Many Anti AIDS Clubs have been formed all over the country in in-school and out-of-school settings. A community level approach, “the “community conversation programme” is operational in a number of regions with interesting results. IEC emphasis appears to be focused on individuals and less on sexual behavior, social values and norms. It targets mainly urban groups.
- STI case management is still weak and not client friendly, especially for youth. Accessibility to services (including STI drugs) remains a major challenge, as is partner notification. Guidelines for syndromic management of STDs were finalized and approximately 600 health workers trained in its use.
- Nation wide more than 650 VCT sites have been established and with the increasing number of VCT centres in the country, 450,000 clients received VCT in 1997 E. C. For example SNNPR reported 150 VCTs (124 reporting), with approximately 51.000 persons tested (with some 5% positive tests). In this Region also Pre-marital testing is gradually accepted as condition for customary weddings, which, if voluntary, is an excellent development.
- PMTCT guidelines have been developed and distributed. PMTCT is now integrated in 129 centres in the country; some 120,000 ANC clients were seen in 2005.

- Regarding ART, as mentioned, ART treatment guidelines are finalized, the Road Map 2004-6 for accelerating treatment developed, and in January 2005 the free ARV treatment initiative was launched to boost the treatment uptake. The number of health facilities providing ART reached 77, of which 13 are private hospitals. An estimated 20,000 patients are now on treatment which is substantially below the end of 2006 target of 100,000. To what extent effective referral and feedback with HCs exist, or compliance and follow-up, could not be ascertained.
- Some 19,918 people living with HIV/AIDS and 62,582 HIV orphans obtained financial as well as other types of support in the first nine months of the year 1997.

Constraints and conclusions

- The HIV/AIDS and STI Control Unit (of the FMOH) has recently been organized and integrated in HAPCO. This implies that the Federal Department of Disease Control is no longer in charge of HIV/AIDS programmes.
- VCT - a key strategy as entry point for prevention, treatment, care & support - is far from meeting demand especially in rural areas. Expansion is constrained by lack of trained counsellors, laboratory technicians, lack of reagents and testing equipment.
- A closer look at a PMTCT centres revealed a set of challenges that may be applicable to many PMTCT centres in the country: (1) high attrition of trained human resources, (2) inadequate PTMCT supplies, (3) PMTCT as an isolated project, insufficiently integrated in hospital MCH service, need to start PMTCT +, (4) weak HMIS and data recording, (5) lack of supportive supervision, (6) weak care and support for HIV+ mothers and babies (including infant feeding).
- A serious structural problem for increasing access is the limited availability of well managed antenatal care services and too few follow-up visits of the available ANC.
- Overall, despite earlier recommendations (HSDP I, 2003), care & support programmes are lagging behind in terms of quality and quantity. The Home Based Care (HBC) programme is not yet well developed, coordinated and linked to institutional services. Consequently HBC falls especially on poor female family members with limited access to information, drugs and overall support.
- With possibly some 50% hospitalised patients of HIV+ status, service providers are concerned with, and exposed to the risk for accidental exposure to HIV infection. While some activities are noted in the training of health workers on Universal Protection Protocols and supply of protective materials, Post Exposure Prophylaxis (PEP) is not available for most health workers. Overall, this area seems seriously neglected and in fact may contribute to diminishing interest for clinical health work.

Recommendations

- FMOH to strengthen and expedite the integration of the HIV/AIDS/STI control and prevention team within HAPCO.
- The HEC to develop a specific IEC/BCC strategy to improve ANC care in view of supporting the VCT and PMTCT+ components with special focus on the rural areas.
- FMOH and RHBs to strengthen the Universal Protection Programme to (i) provide all health facilities with protocols and protective materials and to (ii) make Post Exposure Prophylaxis available at all health facilities by the end of HSDP III.
- The RHBs to evaluate their ‘community conversation approach’, and inform other Regions where this approach has not yet been introduced.
- FMOH and RHBs to support and strengthen the blood safety programme with technical assistance, funds, infrastructure and equipment in partnership with the Ethiopian Red Cross (and other NGOs).
- NASCOP and FMOH to clarify the current status of the Nutrition programme in support of HIV and accelerate its implementation.

2.1.2.4. National Programme for Prevention of Blindness (NPPB)

Introduction
The major causes of blindness are cataract, trachoma, glaucoma and childhood blindness in Ethiopia. The National Programme for the Prevention of Blindness (NPPB) has been established since 1986 (EC), and received guidance and support from a national committee for the prevention of blindness. Ethiopia has also endorsed the global initiative for the elimination of avoidable blindness (Vision 2020 GC). Accordingly supported by various NGOs the NPPB has developed a Regional and national 5 year plans (2001-2005 GC), which incorporated into the HSDP II period.

Achievements
There are no ophthalmic experts responsible for the coordination of blindness control in the RHBs and the NPPB has made significant efforts to train Ophthalmic Nurses and create ophthalmic units at major Health Centres and hospitals but has faced with high turn over of such staff. During the HSDP II period, nation wide primary eye care units have increased from 23 to 53 and secondary eye units from 15 to 23.

A number of Cataract and TT surgery campaigns have been planned and implemented by NPPB in various towns of a number of regions, in collaboration with focal units in most of the regions. In Oromiya alone 6,857 cataract and 5,347 TT surgeries were conducted in EFY 1996 and in EFY 1997 also 7,011 cataract and 5,824 TT surgeries were done.

There are also community based blindness control programs supported by NGOs. It was learnt that in Amhara region, there were 13 health facilities supported to provide eye care and in 2004 and 2005 a total of 48 and 33 health workers, respectively, were given training in primary eye care/lid surgery. Similarly in Tigray region also Trachoma Surveys have been undertaken and new trachoma treatment Zeromax with follow up of the results is on going.

Constraints and conclusions
- While the national program for the prevention of blindness has made significant progress, much should be undertaken by the regions.
- At present blindness prevention program is centralized and the capacity at regional levels is very much limited. It has also been difficult to find information on Performance in Blindness Prevention as it is not captured by routine HMIS.
- The community based blindness prevention in few of the regions are very important but have limited coverage.

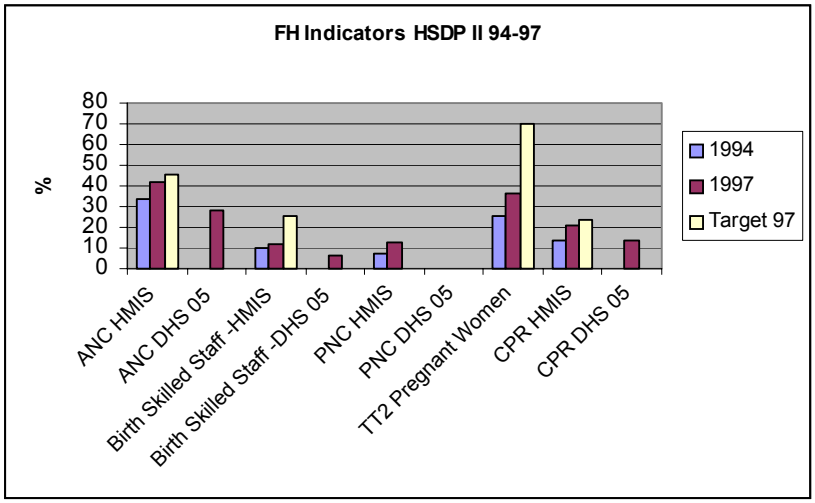
Recommendations
- FMOH and RHBs to expand training of ophthalmologists; a strategy for the retention of ophthalmologists in the regions needs to be developed.
- FMOH and RHBs to integrate NPPB into overall health service delivery.

2.1.3. Family Health Services and Child Survival

Introduction
The HSDP II objective of integrated family health services is to strengthen and gradually expand family planning, health and nutritional services for mothers, children and youth at all levels of the health system. While HSDP I reported moderate achievements in this respect, consequent ARMs point out the need for strengthening the Basic and Community Emergency Obstetric Care (BEOC and CEOC) activities in particular, as well

as an acceleration of capacity building for IMCI. Current data and field observations indicate that there has been progress in most maternal health components of the Family Health Programme, but that HSDP II targets have not been met (figure 1), especially for births with skilled staff, an important proxy-indicator for maternal health and mortality.

Figure 1. Family Health Indicators HSDP II



In addition most of the progress in Family Health has however occurred in urban areas with little change in rural, poorer regions while in addition there remain large regional disparities.

Maternal and Newborn Health

Ethiopia faces a daunting complexity of constraints to reducing Maternal and Neonatal Mortality and Morbidity (MNMM), comprehensively analysed in the documents on Making Pregnancy Safer (MPS) and in the recent Reproductive Health (RH) strategy documents. Information on Maternal Mortality Rate (MMR) is scarce but available evidence suggests that the rate is very high at around 870 per 100,000 live births. Major causes of maternal mortality include delivery and other pregnancy related complications (eclampsia, haemorrhage and unsafe abortion practises). Contributing factors are low socio-economic status; excessive workload coupled with poor nutrition and poverty, distance to facilities and lack of transport. However a RH task force has now been set up, BEOC/CEOC training of GPs and Health Officers has started and plans are being developed to equip Health Centres with CEOC capacity (staff and equipment).

Constraints and conclusions

- The health services factors to MMR are mainly related to inadequate skilled staff, equipment, supplies and inefficient health referral system compounded by poor access and utilization of maternity services. Even though more than 10 hospitals and over 40 HCs were equipped with basic essential equipment and supplies and the number of HPs increased substantially; there were major challenges in the deployment and retention of all health professionals. As regional assessments for this evaluation have also shown, peripheral and mid-level health facilities are still in critical shortage with regard to appropriately skilled health personnel for assisting deliveries.
- The HSDP II design has not sufficiently taken into account the need for a more comprehensive and robust response, certainly in the light of the MDG target for Maternal Mortality. Apparently the expectation that the RHBs would truly own and

continue the MPS and additional funding and Technical Assistance from the international community would materialize has not been met.
- Multiple constraints exist at community, systems and policy level that now vigorously need to be addressed through a National MNMM strategy and costed Plans of Action.

Recommendations
- FMOH to develop a Maternal and Neonatal Mortality and Morbidity (MNMM) strategy at all levels (community leaders, decision makers, health managers), including the procurement of equipment and materials;
- FMOH and RHBs to develop appropriate human capacity in BEOC and CEOC through the development of guidelines, manuals, norms, standards, flowcharts and the provision of specific training to Health Officers and General Practitioners
- Harmonise protocols for PMTCT, ANC, PNC, STI, FP and ITN.
- Advocate for substantial funding to implement the MNMM action plans, including the possibility of tapping into Global Funds or other funding sources.

Family Planning
Family Planning has established itself as a routine service component in most health facilities. According to HMIS data, the Contraceptive Acceptor Rate vastly increased from 14% in 1994 (EC) to 21% in 1997 (EC), with the most commonly used contraceptive modern method being injectables, followed by oral contraceptives. The DHS data suggest an increase in Contraceptive Prevalence Rate from 9% in 1994 (EC) to 14% in 1997 (EC). The steadily increasing number of HEWs will be an important asset in increasing access to contraceptives, while for example in Tigray, community based agents contribute to increased coverage. The National Contraceptive Forecast 2004/10 is a good start in FP commodity security.

Fertility has been decreasing in urban areas but the decrease has been much slower in rural areas. Total Fertility Rate (TFR) has gone down from 5.9 to 5.4. However, the current rate of change is insufficient to achieve the National Population Policy targets of 4 children per women by 2015. In addition, the high fertility rates and the prevailing high-risk fertility characteristics, expose women to repeated risks and to maternal mortality.

Constraints and conclusions
- It is estimated that 26% percent of women are unable to obtain any FP service – an unmet need consistently reported by the Regions.
- Recurrent stock-outs of contraceptive commodities, inadequate human resources at the service delivery level, poor health staff retention, and weak integration of RH services that undermine quality of care and the ability of the service delivery system to meet current demands.
- Despite nearly universal awareness of modern contraceptive methods, FP use is constrained by rumours, misinformation and by poor knowledge of method use.
- The national FP program is weakened by the lack of FMOH budgetary allocations for contraceptive procurement, contraceptive commodities.
- Weak coordination of population-related activities of the NGO and public sectors.

Recommendations
- HEC to stimulate the development of FP / IEC especially targeting rural areas, sensitive to the socio-cultural diversity and gender issues.
- RHB to promote community based distribution and social marketing mechanisms to increase contraceptive coverage in partnerships with NGOs. Improve coordination between RHB and NGOs in the framework of Regional RH programmes;
- FMOH to ensure contraceptive availability through the FP logistics system (LMIS), including efforts to integrate them in larger National Commodity Distribution systems.

- Explore broadening of the method mix, including emergency contraception.

Health of young people and adolescents
There is still limited awareness of the RH needs of young people in a high risk environment. This is reflected in the low emphasis on this group in the HDSP II. Achievements in this area appear fragmented in the health sector with scattered establishment of youth centres, although the high number of HIV/AIDS clubs in – and out-schools is a positive development. At policy and operational level much work needs to be done, which could benefit from lessons learned with large scale Youth programmes elsewhere on the Continent. The establishment of a Youth Health Unit at the FMOH is a sign of progress, which needs to be replicated in adapted forms at RHB and Woreda level. An excellent example is the integration of Youth Health in the HSEP and HEWs package of work.

Recommendations
- FMOH to develop a National Adolescent and Youth RH strategy and improve coordination under a multi sector Youth Health Policy (Education, Youth, Health).
- FMOH and RHB to establish youth-centred services in the public sector.
- FMOH and RHBs to increase Human Resource Capacity for youth programmes through appropriate training in the various training institutions.
- Strengthen advocacy for external support to Youth RH will be necessary, including access to Global Funds, justifiable on the basis of RH risks for youth.

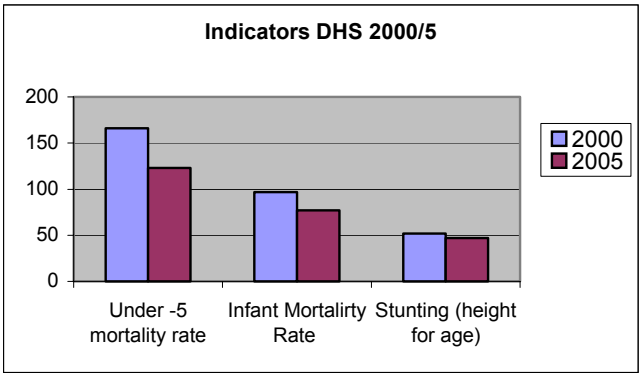
Other RH interventions
HSDP II makes scant reference to other RH interventions that affect women's health, despite high levels in the country of septic abortion and morbidity because of anaemia, fistula's, Female Genital Mutilation (FGM), cancers and STDs. Although post-abortion care services have been introduced in Addis Abeba and was observed in some Regions, it is only in the 2005 draft National RH strategy that these RH problems are further analysed and action proposed. While some prioritisation is necessary it is still recommended that the RH strategies and proposed actions in this area will receive the fullest support from FMOH and development partners.

Child Health

Achievements
Preliminary data from the 2005 Demographic and Health Survey show that the under-5 Mortality Rate has decreased from 188 to 123 per 1000, between 1993 and 1998 (EC). Infant mortality has decreased from 113 to 77 per thousand live births. It is estimated that 47% of the under-5 children were underweight in 1993 compared to 38% in 1998 (EC). This would be a remarkable result in light of the Ethiopia's low GDP and level of health expenditure.

Credit for these achievements goes to the constellation of child survival interventions (fig 2). Contributing factors were –most likely- strong external support, and expansion of the primary health care facilities. As has been observed elsewhere, IMR has associations with improvements in basic health care particularly in least developed countries. This is because most of the more direct and immediate causes, which dominantly affect infants, can be tackled by activities embodied within primary health care programs.

Figure 2. Child health indicators DHS 2000- 2005



Under-five mortality rate on the other hand is said to depend more on the socio-economic status of a nation. In addition, pneumonia, malaria and diarrhoea, high maternal fertility, especially early first pregnancy and short birth intervals, are also strongly associated with increased under-five mortality. Other factors that contribute to reductions in child mortality are socio-economic development, such as improvements in women's education and literacy, household income, safe water supply, sanitation and housing, as well as improvements in nutrition. Therefore, the reductions in under-five mortality observed during HSDP II period (188 to 123) may possibly be due to contributions of other factors than the HSDP itself.

Furthermore on EPI, nationally the 70% DPT3 coverage target for 1997 has been achieved, measles coverage is 61% (and succeeded in sharply reducing measles mortality) and 44% of children under 1 year were fully immunized. In addition the EPI programme has managed to contain the number of wild polio cases through sustained campaigns that were ongoing during the evaluation.

Constraints and conclusions

- Cold chain disruptions and lack of standardization (51 different refrigerators).
- Shortage of BCG and wastage reported in several Regions.
- Shortage of EPI managers at FMOH, RHB and Woreda levels.

Recommendations

- FMOH to execute the EPI coverage survey without delay to confirm the expected gains made by the EPI programme.
- FMOH and RHB to prioritize the execution of the planned cold chain regeneration plan, ensuring equipment standardization, maintenance and sustainability. Explore integration of this plan into a larger maintenance strategy for health.
- FMOH to ensure the sustainable availability of injection materials, negotiating and tapping GAVI and/or Global Funds.

IMCI

Achievements

As shown above**,** the nutritional status of children has improved over the HSDP period (DHS 2005 preliminary data). The proportion of underweight children of under-five years has declined from 47% in 2000 to 38% in 2005. Similarly the proportion of stunted children under-five years has declined from 52% in 2000 to 47% in 2005. However there

has been no change over the HSDP II period in the proportion of children under-fives years that were wasted.

A number of important tools and guidelines have been developed in the areas of nutrition (Infant and young Child feeding (IYCF); Guidelines for Management of sever Nutrition; Control and Prevention of Micronutrient Deficiency; Study on Malnutrition in Ethiopia) and strategy and analytical studies (RED strategy, IMCI, Enhanced Outreach Strategy; Community IMCI) in support of the Child Health Programme.
The 2005 National Child Health Strategy is a high quality comprehensive document bridging maternal and child health. In view of the rather narrow focus of HSDP II, the HSDP III should incorporate a child survival package based on this Strategy.

As one of the key Child Health interventions in HSDP II, IMCI has gradually integrated in al Regions, although scaling up of the IMCI programme (and the C-IMCI) has been slow due to budget constraints, delay by financial regulations and lack of trainers. Preliminary data indicate 39% of Hospitals and HCs have at least one health worker trained in IMCI and 28.9% of the Districts have at least one HF providing IMCI – still a considerable short-fall from the HSDP II target of 80% facilities providing IMCI. In recognition of the need to harmonize IMCI with the HSEP an adapted version of IMCI is developed and an Integrated Refresher Training of 18 days prepared for HEWs, incorporating Family Health.

Recommendations
- FMOH to monitor quality of the shortened 6 day IMCI training for health professionals and the appropriate integration of the “adapted IMCI” in the HEW tasks.
- FMOH to explore the possibility of integrating the procurement of Child Health commodities (IMCI package) in the National Commodity Plan.

2.1.4. Hygiene and environmental health

Introduction
During HSDP II, the opportunity to expand the hygiene and environmental health interventions has been greatly enlarged because of the close linkage with the Health Services Extension Programme (HSEP). The HSDP II objective was rather straight forward and formulated as: “To provide and increase the coverage of hygiene and environmental health services to the population”. A strong hygiene and environmental health programme is still critical for Ethiopia. Diarrhoea, which is a disappearing cause of death in many poor countries, is still a major cause of death for children under five years in Ethiopia (24%). Hence, the need for strong support to hygiene and environmental health can not be enough emphasised.

Achievements
It can be concluded that the HSDP II targets for access to safe water and improved sanitation have been achieved to a large extent (although they remained below the national target). This is a major achievement given the resource constrained environment in Ethiopia (Table 6).

Table 6. MDG Indicators related to water and sanitation.

Indicators (MDG indicators as well)	Baseline 1989-1993 EC (beginning HSDP I)	Status 1995-1997 (start HSDP II)	Achievement 1997	National Target 1997
Access to safe water %	27%	28.4%	36%	42%
Access to improved sanitation	10%	11.5%	29%	35%

Source HMIS

A positive trend has become visible regarding access to safe water (increased 7.6%) and access to improved sanitation (increase with 17.5%). It is evident from the data that access to improved sanitation has been more successful the access to safe water. The Hygiene and Environmental Health Department (EHD) has been progressing well with the preparation of a policy framework during HSDP II and has clearly tuned its focus to the development of innovative and effective strategies[14]. A country wide Rapid Assessment of Drinking Water Quality (RADWQ) has been carried out during 2004-2005[15]. Several major programmes implement the hygiene and sanitation strategy: (i) The HSEP. The new health extension programme is perceived to be the primary vehicle for driving sanitation improvement at the Kebele level[16], (ii) the MOH/RHB/ UNICEF supported Water Sanitation Community based Programme (disease prevention for women and children); and (iii) the World Bank supported the Rural Water Supply and Environment Programme (RWSEP) and the Water Sanitation and Hygiene initiative (WASH).

Box 2. Overview of activities by various programmes and by the regions

• Development of Hygiene Education Promotional Materials. Mass media on hygiene education. National workshops. Inter-regional experience sharing • Training of health workers, HEWs, WASH committees, school sanitation clubs, school teachers. TOT training in WASH campaign and PHAST (Participatory Hygiene and Sanitation Transformation) for RHB staff and Woredas • Food inspection	• Construction of household latrines and slabs, communal latrines, school latrines, health facility latrines, solid waste disposal pits, incinerators. • Sensitisation and mobilisation of communities WASH and PHAST campaign in all regions • Monitoring and evaluation by FMOH/EHD and ESHE to Regions. Studies on water pollution, hand/ face washing Water quality monitoring

Constraints

- The roles between the RHB, WHB and the municipalities in the management of environmental hygiene are not clearly defined in some regions.
- Budget allocations by the regions to the RHB for hygiene and environmental health are clearly insufficient and even seem to have decreased in some areas after the decentralisation (more funds for the Woredas). This has clearly affected support supervision and capacity development to the Woredas and HEWs. Budget delays and slow transfers have been reported.
- Huge staff turnover and shortages of environmental health staff affected the programme.
- The MIS at national, regional and Woreda level does not generate overall data and trend analysis that can be used for performance and impact assessments. It is difficult to assess the actual utilisation versus the coverage.
- Shortages of supplies have been reported. Especially the absence of field water quality tests is a constraint in all the regions. A systematic shortage of transport for construction materials and for support supervision has been reported.

[14] The Public Health Regulation (based on the Proclamation) has been submitted to the Council of ministers for approval. In October 2005, the National Hygiene and Sanitation Strategy for Ethiopia was completed and in December 2005, a draft National Protocol for Hygiene and "On site" Sanitation was presented. The aim of this protocol is ambitious and is to enable 100% adoption of improved hygiene and improved "on site" sanitation in Ethiopia.

[15] RADWQ Draft Country report presented in January 2006. Ethiopia was part of six pilot countries and will present the findings during an international conference (Ethiopia 2006). The study will be instrumental to identify future investment priorities

[16] (1) Excreta, solid and liquid waste disposal, (2) water quality control, (3) food hygiene, (4) proper housing, (5) vector control, (6) personal hygiene, health education and promotion

Recommendations

- FMOH and RHBs to advocate strongly for continued support to hygiene and environmental health programme at all levels. This will especially contribute to reduction of environmental health related diseases among women and children.
- Strengthen the inter-sector and inter-departmental collaboration at national level and between the RHBs and WorHOs. Address core problems such as inadequate budget allocations, limited human resources and insufficient transport and supplies.
- FMOH to assess and define the methodology of estimating the sanitation coverage in the various regions.

2.1.5. Medical services

Introduction

According to HSDP I the health policy implementation strategy has been to re-organize the health service into four tier system with a Primary Health Unit (PHU), comprising one health centre and five satellite health posts at the frontline and then a district, zonal and specialized hospital to provide referral services. Subsequently in HSDP II an innovative strategy, the Health Service Extension Package (HSEP), has been introduced as one of the sub-components of health service delivery. HSEP now also includes curative service for common conditions among the major killers of children, malaria and diarrhoea. This community based health service will have a significant contribution to the establishment of stronger referral system and it is the most important institutional framework for achieving MDGs.

Achievements

Recently a decision has been made by the FMOH and some RHBs to create a health service department separate from training. This is a very important development as medical service and training departments in the past had a combined responsibility for two important functions but had been very much occupied with problems of training schools, deployment of health workers and sensitive individual personnel issues. As a result the support to the basic health service and monitoring of quality of medical services in particular had been very much neglected.

FMOH has defined an essential health package with the objective of reducing morbidity, mortality and disability resulting from the major health and health related problems affecting most of the population. This package includes (i) Communicable Diseases Prevention and control services, (ii) family Health (iii) Hygiene and Environmental Health, (iv) Medical services and (v) Information Education and Communication; but excludes rehabilitation services.

The package to be delivered through a hierarchy of health institutions starts from health posts, health centres towards hospitals. It will range from first aid for injuries to treatment of common chronic conditions. Community participation is identified as one of the strategic approaches without explicitly defining the services to be provided by the FLHW. Measures of success will include (i) steps from the time the patient is received till he is discharged; (ii) patient management including availability of diagnostic facilities, appropriate pharmaceuticals and medical supplies, where and when required. The elements will define to a large extent ‘ patient satisfaction’ and these will therefore define the success or failure of this component of HSDP II. The following section reviews progress made in each of the components of HSDP II.

Coverage and Utilization

Potential health service coverage has increased from 61% in EC in 1995 to 72% in EC 1997. But the utilization of health service (1st OPD visits/pp/yr) target of 0.50 has not been

achieved. During HSDP II It has been 0.27, 0.36 and 0.30 in EFY 1995, 1996 and 1997 respectively. It is noted that the increased potential coverage has not been translated into increased utilization. Reasons for this discrepancy should be assessed further.
First of all it should be noted that the outpatient data is mainly acquired through routine reports by government health centres and hospitals; they are compiled by junior nurses or health assistants. Second, the trend in the utilization of medical services in all Regions has been more or less the same with the national average mentioned above. The reduction in the 1997 (EC) is attributed to the human resource shortage during the year and partly to the lower incidence of malaria cases. Finally, the temporary lack of drug supplies in some regions can be another explanation for the low utilisation figures.

It has been encouraging to also learn that some regions such as Amhara, SNNPR and Oromiya have institutionalized review meetings and supportive supervisions with integrated check list. Drug availability at budget pharmacies has much improved and special pharmacies have contributed a lot wherever they existed.

Shortage of recurrent budget and human resource are often mentioned as causes for the observed poor quality of health care but it should be stressed that even with the minimum resource available it would be possible to change some practises that are harmful to patients, such as injection safety measures that should be observed in all facilities, as the team found very little knowledge on safety procedures, absence of disposal protocols etc.

Constraints and conclusions
In most of the remote sites there are weaknesses of the anticipated preventive and promotive services. Hospitals and health centres do not provide the full range of required services, compromising the EHSP referral system. This is related to lack of the required support in the form of essential equipment, drugs and supplies and the technical back and supervision at different levels. Many health facilities at all levels, but particularly in rural areas, still do not perform at their optimum, in accordance with the expectations of both the users and the providers. There are critical essential staff shortages, high turn over of existing staff affecting continuity of services, inadequate diagnostic and pharmaceutical facilities and supplies. A number of health facilities are also without water and power supply.

As a result of these deficiencies, the new four-tier system is not yet functional in all the regions as planned. Patients do self-referrals to higher or horizontal levels, depending on their knowledge of the type and quality of service available. This has resulted in overburdening of some regions (Harari) due to influx of patients from nearby or surrounding regions (Afar), who demonstrate their confidence or rejection of the services provided in their own regions.

The dilapidated state of District hospitals in terms of Human Resources, infrastructure, lack of equipment and basic medical materials needs more attention if the credibility of the health services is to be maintained.

It has not been possible to find out the proportion of service provided by the new health posts as the routine health management information does not yet incorporate their report. The medical care provided by the private sector is also not captured in the available statistics (except Addis Ababa and Benishangul-Gumuz).

Quality of care: In spite of the emphasis made in the HSDP I, reviews on the need for improvements of quality of medical services, a clear strategy for quality assurance with defined targets have not been detailed in the HSDP II document. There has not been proper orientation, advocacy and support given to ensure adherence to prescribed

standards. It should also be noted that these documents were not available in most of the health institutions.

Recommendations

- All Regions should seriously consider the need for interim and long term strategies for an appropriate referral system based on their specific regional context. Regions like Dire Dawa and Harari could adopt the Addis Ababa city approach of three tier system.
- Regions with limited numbers of hospitals should strengthen some of their major health centres with basic diagnostics facilities and build the available professional (GPs and HOs) capacity to handle common emergency surgeries. Health centres in remote site should be provided with vehicles to facilitate referrals.
- RHBs elaborating standard documents such as the new EHSP and other guidelines related to program interventions such as malaria TB/LP, IMCI, EPI ENA, etc. should use all opportunities to promote quality and standardisation of service delivery.
- RHB and WorHO to establish quality assurance mechanisms in every health facility through community (lay-men) participation and supportive supervision.
- Woreda management should ensure availability of these documents in all facilities and their handing-over during transfer of personnel from one institution to another.
- FMOH to develop relevant indicators for quality assurance as a matter of urgency.

2.1.6. Integrated Disease Surveillance and Response (IDSR)

Integrated Disease Surveillance and Response (IDSR) is defined as an approach adapted to strengthen national diseases surveillance system by coordinating and streamlining all surveillance activities and ensuring timely provision of surveillance data to all disease prevention and control programmes. According to the National Technical Guideline of the FMOH 2003 document for IDSR, the overall objective of IDSR is to improve the ability of health workers to detect and respond priority communicable diseases at the Woreda level.

Organizationally an IDSR Team within the Department of Disease Prevention and Control Department of the Federal Ministry of Health has been established and focal persons trained at all levels in all Regions up to the level of the health Centres.

The program has developed National Technical Guideline and Training modules; established task forces for the coordination of surveillance activities and laboratory net-working, in collaboration with EHNRI).
The IDSR Team has initiated surveillance data collection from all health centres and hospitals on 22 priority diseases. In addition the 2nd five year plan on IDSR (2006-10) was prepared.

The evaluation has observed an encouraging start at some of the RHBs and Woredas in terms of use of surveillance data, while use of epidemic monitoring charts seems well established in health facilities.

Constraints and conclusions

- The major limitation of IDSR is that data is collected only from health centres and hospitals. There is parallel data collection for diseases outside the 22 target diseases e.g. HIV/AIDS.
- Delays in reporting from facilities and Woreda Health Offices.
- Lack of a culture of information sharing among the departments in the RHB and use of IDSR for decision-making.

Recommendations

- IDSR data collection should include the private sector and peripheral facilities; IDSR information should be harmonised with the overall HMIS!!
- FMOH and RHBs to provide an adequate budget for a swift response to epidemics with the recommended contingency of drugs, vaccines and supplies readily available at Woreda level;
- RHBs to improve communication in IDSR, according to specific regional conditions.

2.2. Information, Education and Communication

Introduction

The Information, Education and Communication (IEC) component has been given a prominent role in the HSDP II. The objectives of the IEC component were: to support the development and implementation of a national IEC plan and strategies with the aim (i) to improve health Knowledge, Attitudes and Practices (KAP) about personal and environmental health and common illnesses and their causes at community level and (ii) promote political and community support for preventive and promotive health services by educating and influencing planners, policy makers, managers, women groups and potential collaborators.

Achievements

- The FMOH has made a substantial effort to follow up the recommendations of the earlier HSDP evaluations and reviews. There seems to be a momentum created in the IEC/BCC strategy. One of the most visible achievements in this sense has been the publication of the National Health Communication Strategy (NHCS) 2005-2014. The strategy shows that the NHCS has clearly made a shift from IEC approaches to Behaviour Change and Communication (BCC).
- At FMOH level, the Health Education Centre (HEC) has been provided with a clear mandate coordinate all IEC related activities of federal level departments in the MOH and the related sectors and to take a leading role in policy development, training, capacity building and technical support to regions and other stakeholders, research, dissemination and evaluation. An upcoming development is that the HEC will be merged with the HSEP coordinating office in 2006 as the two programmes are considered as natural partners. It is expected that this will enhance a stronger community approach (through he HEWs).
- A major step to increased IEC competence in Ethiopia has been the development of IEC training courses for health professionals (BSc and MSc level) at Jimma University
- At regional level, the implementation of the NHCS was clearly visible at different levels (see box 3).

Box 3. IEC implementation at Regional, Zonal, Woreda and Community level (summarized from the regional reports, evaluation 2006)

• Significant support from RHBs for the IEC component in some regions. IEC focal persons assigned in some of the regions • Different RHB departments active in the IEC. Component and development of local needs based IEC materials. Focus is on improving community response to harmful practises, EPI, IMCI, Vit A, Iodine, HIV/AIDS, malaria, TB, FP, RH, personal hygiene and	• HMIS has included IEC interventions in some regions (topics, sessions, attendance). • Strong collaboration with UN partners and NGOs. • Availability of IEC materials (posters, flipcharts, leaflets, banners, billboards, audiovisual) in local languages. • Innovative approaches have taken off (HIV/AIDS related IEC/BCC, community communication enhancement committees, local film production, TV spots, radio, music

environmental health. • Increased IEC capacity building of health workers, HEWs, health agents, peer educators, local artists.	tapes, video/dvd, school drama, community IMCI dialogue, ICT in secondary schools).

Constraints and conclusions

- The majority of the regions did not develop a specific regional IEC/BCC strategy which is tuned to the diverse IEC needs, specific contexts and the coordination of multiple actors in IEC/BCC. Furthermore, measuring the achievements of the IEC/BCC component is not common as monitoring and evaluation tools are not in place for this component.
- Regions are not always informed and consulted by other agencies on the production and dissemination of IEC/BCC materials for their region.
- There is still limited knowledge regarding the NHCS and limited IEC/BCC expertise at different levels. Health workers still follow the traditional IEC approaches instead of more innovative approaches. There is also limited knowledge on the impact of the various IEC/BCC strategies and their contribution towards sustained behavioural change.
- STD prevention and control seemed to be a forgotten topic in the day to day IEC/BCC interventions, even though it is well captured in the official guidelines.
- Inadequate financial allocations, human resource shortages, limited IEC/BCC expertise, poor coordination and inter-sector integration at regional and Woreda level have affected the implementation, the quality, diversity and innovativeness of the IEC component in a number of regions.

Recommendations

- The Health Education Centre (HEC) should step up advocacy for IEC/BCC in order to ensure and sustain: (i) sufficient public and private financial allocations, (ii) coordination of multiple actors and their IEC/BCC interventions, (iii) IEC/BCC expertise a different levels and (iv) increased knowledge about the NHCS at the Woreda, health facility and HEWs level.
- There is need for advanced IEC/BCC expertise at regional levels.
- The development of regional IEC and monitoring and evaluation plans (derived from the NHCS) is essential for improved coordination of the multiple actors, for enhancing tailor-made approaches and for improved monitoring and evaluation.
- Initiate studies to assess the impact of the various IEC/BCC strategies in different regions and to adjust the strategies further to the specific needs of the target groups.

2.3. Cross cutting issues

2.3.1. Gender

In 1993, the National Policy on Ethiopian Women and other gender related sectoral policies were launched (health, population and education). They subsequently followed gender policies related to culture, social development and addressed the multi-faceted problems of women.

The objective of gender mainstreaming activities in HSDP II is to create awareness about the gender issues so that these issues are well addressed in management, health planning and decision-making processes.

Among the objectives set in the HSDP II was the establishment of women's affairs unit at the regional, zonal and Woreda levels with the placement of adequate trained staff, to

enforce gender issues in the design of projects/programs and provide follow-up on its implementation.

Most of the objectives of the Women's Affairs Department of MOH could not be realized, except limited awareness created on gender issues at various levels, the preparation of the Gender Mainstreaming Guideline and the production of two other research works. Consequently, HSDP II had to re-state and reinforce these objectives during the 1995-97 period.

It appears that implementation in HSDP II followed the same pattern as that of the HSDP I and therefore the targets set remained unattainable. Among the major defaults indicated are the (i) inability to establish the women's affairs units in the different structures; (ii) mainstreaming of gender issues into the projects and programs and (iii) creating awareness among health staff and the communities at large. Moreover, there was no research or studies conducted in the respective regions on women and health issues, while data were not fully disaggregated on gender basis. This is mainly attributed to lack of genuine commitment to gender issues, lack of mainstreaming skills and misconception of gender issues.

It was indicated in the reports that some regions and cities in which the evaluation has been conducted, believe that they have gender focal persons, most of the time experts in the family health services have mainstreamed gender issues in their respective plans and implementation strategies. However, it was realized that there was no adequate orientation or training given on gender mainstreaming skills at various levels nor an impact assessment done to determine whether the said achievements have been achieved as the result of gender equity initiatives.

Constraints and conclusions
As with HSDP I little progress has been made to integrate gender in terms of institutional strengthening and programming at national and regional levels. Awareness creation that could lead to action in planning, monitoring (HMIS) and evaluation is still lacking. It is therefore recognized that gender issues in health development are not yet adequately articulated and mainstreamed in relevant organizations in the country.

Recommendations
- Regional authorities should remain committed to establish women's affairs units and assign skilled personnel who could ensure the incorporation of gender issues in plans and programs and make follow-up on actual implementation.
- An actual and effective linkage need to be created between the WAD of the FMOH and the women's affairs units to be established at Regional levels, so that the latter could benefit from the experiences accumulated so far.
- A series of intensive gender awareness creation/raising programs need to be conducted to selected health personnel in all Regions
- Sensitize rural communities on gender issues, reducing harmful traditional practices.

2.3.2. Pastoralist health care

Introduction
Pastoralists in Ethiopia form 11% of the overall population. This means that in 2005, a total number of 8,000,000 people can be categorised as pastoralists. This also includes the semi-pastoralists. The five regions with a pastoralist population are Afar, Somali, Oromiya, SNNPR and Gambella Regions. The Country health status report (2005) highlighted that the emerging regions with pastoralists (Afar, Somali and Gambella),

generally have less favourable health indicators (see Annex 8, HMIS). This includes less developed health infrastructure, limited availability of qualified health providers and managers, very low utilisation *and* a higher percentage of pastoralist communities than the other regions. Oromiya and SNNPR regions are large, central and highly populated areas with pastoralist populations. The health statistics therefore do not reflect a pre-dominant pastoralist population but a mixed population. Furthermore, it should be noted that regions like Somali and Gambella are occasionally affected by insecurity problems.

The HSDP II document acknowledged that, at the beginning of the HSDP II phase, there was no clearly defined strategy for the pastoralist regions to ensure access to health care services. The HSDP II emphasised the need to design an appropriate health service delivery strategy for the pastoralist areas. The main objective for HSDP was formulated as: design a pastoralist health care strategy with the purpose (i) to establish a health delivery system compatible with the lifestyle and culture of the nomadic pastoralists and (ii) to ensure increased access and equity in the provision of health services.

Achievements
It can be concluded that the objectives have been partly achieved. An important achievement is that an extensive study was conducted on the Health Service Delivery in Pastoralist Areas of Ethiopia (March 2003). It is not clear to what extent the Ministry of Health has adopted the recommendations of this study. It should be realised that the actual establishment of a health service delivery system - compatible with the lifestyle and culture of the pastoralists and increased access and equity in the provision of health services - has not been achieved as yet but is clearly moving ahead. The *basic principles* for the development of pastoralist health service delivery system have been addressed in the 2003 study[17] and provide a guiding framework[18]. They concur with the vision of the Ministry of Federal Affairs.

Other positive achievements have become visible as well:

- The government has developed a programme for the accelerated development in the pastoralist areas. The Ministry of Federal Affairs coordinates the multisectoral efforts for the provision of integrated support to the emerging regions. The FMOH is key member of the board and the Health Service Department has recently established a Pastoralist Health Unit.
- The HSEP coordination office is developing a HEW training package adjusted for the pastoralist areas[19]. The HEWs will operate from the HPs but will have to take a more mobile approach in their work in order to reach the pastoralist communities. It is expected that this approach will increase access to health services in these areas.
- UNICEF has developed a proposal for the acceleration of the child survival activities through the HSEP and to improve the utilisation of health services for pastoralist communities (2005). This will include strengthening of TVET schools, minimum equipment for HPs, refresher courses for HEWs, capacity development for WorHO, IMCI expansion, technical assistance and the construction of 1,050 small HPs.

[17] This included characteristics of pastoralist populations and pastoralist social systems, health risk assessment, challenges in health care delivery in pastoralist areas and potential approaches.
[18] This includes; (1) enhance a multi sectoral approach, (2) enhance a cultural sensitive health service delivery mechanism, (3) community involvement in decision-making and the implementation process is required at all levels, (4) integration of the traditional health care system within the health care system, (5) development of an incentive scheme and capacity building for health workers[18], and (6) IEC to include simple communication strategies.
[19] The 16 modules have been simplified and translated in local languages. The trainers have received a one-month TOT training and HEW training duration has been reduced from one year six months. The HEW admission criteria have been reduced to 6-8 grade criteria. It is foreseen that the HEWs training can start by April-May 2006. The admission of HEWs will also include male candidates in order to facilitate a more cultural sensitive approach.

- Some of the emerging regions have prioritised pastoralist development initiatives and have established Pastoral Area Development Coordinating Commissions (PADCC). Pastoralist development initiatives are gaining momentum.

Constraints and conclusions

- The measurement of the achievements was quite difficult as the design of the objectives, targets and strategies were not formulated in quantified terms and did not include a *step by step* operational action plan for the design and establishment of a pastoralist health service delivery system.
- All the elements for the design and establishment of a pastoralist health service delivery system are in place but it seems that actual implementation for FMOH has to be initiated as yet. It is not clear whether the UNICEF proposal can be considered as the FMOH strategic plan. There is a need for a concrete move forward in terms of planning and budgeting. At this stage it is not known how the constraints such as the major health problems in pastoralist areas will be addressed[20] and how major problems in support system will be solved[21].
- The HEWs will definitely play an important role in the pastoralist areas but there are important issues to consider in order making the HSEP really meaningful in pastoralist areas. For example the mobility of the HEWs needs to be considered. This may not only include transport facilities and mobile accommodation facilities (tents) but may even require a higher number of HEWs per Kebele as the geographical areas are large and mobility patterns are frequent (sometimes 18 migrations in a year). Mobility and providing health services in HPs will need to be combined in such a way that different groups with different disease patterns can be served (men are often more mobile then women) at the same time.
- The HEWs will need to have a clear understanding on the entry points in the pastoralist communities. This does not only include meetings at water points or markets but requires accessibility to the complex social organisational structure of the pastoralist groups[22] and social, gender and age groups.
- There may be need to broaden the preventive and curative package for the pastoralist areas. This requires sufficient capacity building and support supervision by the WorHOs and the RHBs.

Recommendations

- Develop a strategic health service delivery plan for the pastoralist areas that addresses the major health and support system problems at all levels taking into account the government's long term strategy.
- Increase the advocacy and resource allocation for the pastoralist areas at national, regional and Woreda level so that the major health problems can be reversed.
- Adopt a flexible approach for the pastoralist areas to (1) revise recruitment criteria and increase the number of HEWs per Kebele, (2) to broaden the curative and preventive package for the static HPs and mobile visits, (3) to strengthen their capacity in

[20] Malaria, respiratory diseases, gastro-intestinal infections, parasites, skin infections and retro-viral infections. Epidemics of malaria, measles, meningitis, acute diarrhoea were frequently reported (2003 study)

[21] All the regions visited had major problems; budget shortages (especially recurrent budget), health facilities were poorly equipped, poorly maintained and faced a shortage of staff and drugs. Poor motivation, high staff turnover and inadequate training at the lower levels were identified as main problems. Management standards in the health facilities were very low (study 2003).

[22] For example, the *Gumii Gaayoo* is considered as the only legislative general assembly. Any male Borana can participate in the decision making process. This meeting occurs every eight years. Women have no control over decisions made in relation to the general assembly. They can only make suggestions, usually through the men. Health issues can be discussed during these meetings.

pastoralist health issues, community based approaches and pastoralist social systems and (4) to address the integration of vertical health programmes in the interventions at different levels.
- Establish close linkages with organisations (national and international) that have gained expertise with the provision of health services in pastoralist areas and study the most feasible approach for the different regions.

2.3.3. Nutrition

Introduction
Ethiopia has been afflicted with problems of nutrition in the past, often of a catastrophic nature. The agricultural sector is vulnerable to external shocks such as droughts, which have occurred every three years during the past decade. The human base for agricultural development is also largely illiterate and inadequately equipped with modern skills, inputs, and equipment.

Malnutrition among children in Ethiopia remained unacceptably high, with serious stunting (51.5%), underweight (47%) and wasting[23] (10.5%), although preliminary DHS 2005 data indicate some improvement. Rural and urban differences are pronounced, with the rural poor being the most disadvantaged. Severe underweight is nearly 260 percent higher among children from the poorest quintile compared to children from the richest quintile. Regional differences in child malnutrition are prominent.

Malnutrition is the underlying cause in more than half of all child deaths. Changes in child survival are strongly associated with decreases in malnutrition in countries characterized by high rates of general malnutrition such as in Ethiopia (Pelletier, 2002). About one out of three women and one out of four mothers of children less than three years old have Body Mass Indices (BMI) that are less than 18.5 indicating that the level of chronic energy deficiency among adult women is relatively high in Ethiopia compared to other SSA countries.

Issues
Despite the magnitude of the problem and impact on health, no specific objectives were set for the nutrition component in HSDP I or HSDP II. Nutrition is mainstreamed in the Family Health sub-component. In fact a number of critical recommendations HSDP I have not been incorporated in HDSP II. Nonetheless nutrition policies and strategies on the nutrition sector have been developed and are now in place (e.g. Child Survival Strategy, National Nutrition Strategy drafted and Guidelines on the Case Management of Severe Acute Malnutrition). In addition some development partners actually apply objectives of the Nutrition component of their Country Program with aims to reduce stunting by 10% and wasting by 20%, (i) focusing on Infant and Mother Malnutrition; (ii) reducing vitamin A deficiency in children less than five years of age by 40%; (iii) achieving 80% salt iodisation and (iv) reducing Iron deficiency among women and children by 30%.

There is very limited awareness in the regions of the development of a National Nutrition Strategy, no nutrition actions plans exist, neither is there a regional focal point for nutrition. The Regional Family Health Departments were given responsibility for this component to ensure collaboration with NGOs and implementing facilities in areas of Growth Monitoring and Promotion (GMP), Essential Nutrition Action (ENA), Enhanced Outreach Strategy (EOS) and Management of Severe Acute Malnutrition (SAM) (of which the last two activities were initially not included in HSDP II).

[23] DHS, 2000

While implementation of the nutrition package included in communicable diseases and family health services was found to be very limited, integration with community IMCI and implementation of GMP at community level was found to be encouraging in some of the Regions like Tigray, and the city Addis Ababa. It was noticed that most of the nutrition packages implemented in the country are strongly supported by UNICEF, such as the EOS campaigns and the Therapeutic Feeding Units (TFUs) operational in Health Facilities in most of the regions managing severely acute malnourished children.

Constraints and conclusions

- Some progress has been made in reducing the malnutrition in children (DHS 2005) and some useful policies and guidelines developed.
- Promotion of the use of iodised salt has been extremely limited and/or almost absent in all regions suggesting that this will remain a major public health issue. One constraint is the lack of clarity on the roles that the various levels of health structures must play in the promotion of iodised salt. Vitamin A distribution coverage seems to be high.
- Lack of adequate data for analysis of nutrition as a crosscutting issue is another problem.
- Lack of trained staff in the area of Nutrition is still an obstacle when implementing any nutrition initiative. Nutrition is inadequately addressed in education and, curricula of health professionals.

Recommendations

- FMOH to prepare and disseminate clear strategies with follow-up and support to implement specific health and multi-sector nutritional policies at all levels.
- Given the high levels of stunting and underweight and maternal chronic energy deficiency and anaemia, there is a clear need to accelerate and expand the Essential Nutrition Action (ENA), striving for integration with vertical programmes.
- Health workers capacity in management of SAM needs to be improved while continuing to enhance their capacity to deal with overall nutrition problems.
- Roles and responsibilities of the various stakeholders needs to be clarified in order to promote and expand the use of iodised salt.

2.3.4. Emergency Preparedness and Response

Introduction

In the last few decades, Ethiopia has been subject to a number of recurrent humanitarian crises. Disasters have been complex with multivariate causes. Severe environmental degradation, high population pressure, recurrent drought and inadequate capacities to cope with the recurrent shocks are among the major underlying causes for the recurrent humanitarian crisis in the country. Drought and disease outbreaks are among the commonest cause of disaster in Ethiopia. Around 8 to10 million people require external assistance every year for basic survival needs. HIV/AIDS, malaria meningitis, measles and other communicable diseases pose serious challenge to national development. Coordination takes place through the Disaster Preparedness and Prevention Agencies (DPPA) at different levels.

Achievements

Even though emergency preparedness and response was not treated adequately in the initial planning document of HSDP II, during the implementation period significant progress have been made in terms of responding to major humanitarian crises. The major achievements include:

- There was effective coordination at federal and regional levels.

- Joint assessment and joint appeals were conducted.
- The 2006 contingency plan was developed and disseminated in collaboration with Regional Health Bureaus.
- The establishment of the Health and Nutrition emergency task force has facilitated better transparency and dialogue with partners.
- Emergency response was conducted more efficiently.
- Identification of critical areas and institution of response. The measles campaign is the typical example for this type of response.

Constraints
- Lack of an emergency unit within FMOH and its structures down to Woreda level was the major weakness in emergency preparedness and response.
- The Early Warning System (EWS) has some important defects in detecting the non-food aspect of the crisis, especially health, water and nutrition.
- There was no institutional home for emergency nutrition.
- Disaggregated data and analysis on gender and children's issues was very weak.
- Targeting has always remained being the biggest weakness of this operation through out.
- The response from donors though very essential ultimately, at the early stage of a disaster response is inadequate and usually response is instituted late.
- HIV/AIDS was not adequately addressed.

Conclusions
- Progress has been made in areas of joint assessment, coordination and planning
- The establishment of the Health and Nutrition emergency task force has facilitated better transparency and dialogue with partners.
- Emergency response was conducted more efficiently, but late by donors and inadequate.
- Weak FMOH capacity and system, including the absence of a permanent and clear structure or body that deals with emergency health and nutrition. The linkage to the DPPA seems rather weak.

Recommendations
- Establish an emergency unit with in the FMOH to coordinate and guide the health emergency preparedness and response efforts in the relevant Regions.
- Work with DPPA, to critically examine the current National Disaster Preparedness and Response Policy and make the necessary revision in the light of recent developments such as the Productive Safety Net Program, the establishment of the Coalition on food security etc
- Elaborate an emergency preparedness and response strategy for the health sector. The role and responsibilities of the various actors in the field should be guided with an appropriate strategic document.
- Initiate Risk Mapping and vulnerability assessment, as it is not adequately treated. This valuable information if regularly updated can give the necessary direction and guidance to the various responses during and after emergencies.

2.3.5. Population issues

Introduction
As emphasized in the PASDEP (2005) rapid population growth remains a major barrier to poverty reduction and the current moment growth of about 2 million persons per year puts tremendous strains on Ethiopia's resource base, the economy, and the ability to deliver

services. The cause of high rate of population growth is the combination of high level of fertility and declining mortality. Reducing the number and spacing of pregnancies has a great impact on women and children's mortality and morbidity and is one of the most cost-effective health interventions. Indeed, the National Population Policy (1993) focuses on reducing total fertility rate to 4 by the year 2015; increasing the contraceptive prevalence rate to 44 percent by 2015. Strategies relevant for the health sector include (i) reducing maternal, infant and child mortality and morbidity; (ii) improvement in the quality and scope of reproductive health service delivery; and (iii) expansion of IEC activities and social mobilization.

Achievements

- Infant and child mortality rates are declining (DHS 2005 preliminary data).
- Use of modern contraceptive methods has increased over a period of 5 years (contraceptive prevalence rate from 11 to 14% in 2005 and the contraceptives acceptor rate increased from 14% to 21% - DHS 2005 preliminary data).
- Indications are that a higher proportion of married women in 2005 would like to delay the birth or a next child, or have no more children (DHS 2000/5);
- Fertility has declined somewhat over time, but is still very high, at an estimated 5.4 births per woman (from 5.9 in 2000), with a large urban-rural differential (DHS 2005). In fact urban fertility decline is mainly responsible for this overall decline. From this perspective the introduction of HEWs is important in supporting family planning interventions at community level in rural areas, supported by IEC for male participation.
- An active population unit has been established in SNNPR (possibly one of the few Regions to do so). A Regional Population Council has been established with Technical (Multisectoral) Population Committees at Zonal and Woreda level that should develop action plans responsive to the local context. A seminar on Reproductive Health and population will take place in 2006, organized by the Population Unit in the BOFED addressing the current population issues in the Region and develop appropriate strategies.
- The new National Reproductive Health Strategy and recent efforts on developing a contraceptive security plan, including a national logistics system support the Population Policy objectives.

Constraints and conclusions

- Generally there is low awareness of population issues and relevance of RH.
- Low capacity for implementation of the Population Policy in conjunction with the health sector.
- Given the socio- cultural diversity a relative low capacity for an effective countrywide population IEC program addressing issues pertaining to small family size and its relationship with human welfare and environmental security.

Recommendations

- Ensure consistency of targets of Population and other National Policies by updating the 1993 Population Policy also taking into consideration the HIV/AIDS epidemic.

3. Support Services under HSDP II

3.1. Facility construction and rehabilitation

Introduction
The objective of this component is to increase access to and improve the quality of health services through the rehabilitation and expansion of existing health facilities and the construction of new ones. The strategies were (i) constructing new health facilities in under-served areas, with particular emphasis on PHCUs, (ii) developing and improving national standards for all health facilities for use and adaptation by regions by giving more emphasis to rehabilitation of existing facilities to improve quality. The target is to increase the potential health service coverage from 62% to 72% and equip and furnish PHCUs according to the standards.

Achievements
The overall picture in area of construction and expansion of health facilities has been encouraging in particular in the lower levels of the health system. This is in line with Government's priority to improve access to health services at the primary level. As shown in table 7 below.
The number of health post increased by 2091 (from 1311 to 4212).

- Health centres increased by 192 compared to the HSDP target of 172.
- 785 health stations were either downgraded to health posts or upgraded to health centres.
- The numbers of hospitals increased by 36; 3 out of these were constructed by the public sector compared to the 6 new hospitals planned in HSDPII; in addition 33 new hospitals were constructed by the NGOs including the private sector.

Table 7. Expansion of Health Facilities during HSDP II

	Baseline End of HSDP I 1994			End of HSDP II 1997*			HSDP II planned (Addition (FMOH)	Performance		
Facility Types	FMOH	Others	Total	FMOH	Others	Total		Incre-ment	(%)	Remarks
Hospital	82	13	95	85	46	131	6	3	50	33 new hospitals constructed by private sector
Health Centre	388	24	412	583	17	600	172	195	113	195 HC constructed or upgraded
Health Station	2018	434	2452	1283	379	1662	-78	-735	942	36% of HS either downgraded or upgraded
Health Post	1311		1311	4212		4212	1536	2901	189	

*As per 1997 official FMOH indicators.

The general improvement in the construction sector has contributed to the improvements in implementing civil works in almost all regions. The current attempt to construct health facilities next to boreholes is an encouraging development that will improve availability of clean water in health facilities. This needs to be taken another step forward by connecting

the borehole to the elevated water tanks in the health facilities to ensure continuous supply of water.

In general, new, rehabilitated and refurbished facilities were supplied medical equipment in line with FMOH standards. Reports from regions such as Dire Dawa and Benishangul/Gumuz suggest that some health institutions have kept nearly 90% of the medical equipments functional through outsourcing of regular maintenance of medical equipments.

The health facilities are also becoming increasingly customer friendly with improved labelling system and functional flow of patients mainly from the implementation of Civil Service Reform Programme. FMOH has also started a facility mapping aimed at establishing database of health facilities and improving future investments in facility development to ensure equity in health facility distribution.

The institutional arrangement for managing civil works has recently been transferred to the Bureau of Works and Urban Development with a concurrent dismantling of capacities within RHBs. As a result all regional health bureaus are undergoing restructuring of the architectural and engineering services by maintaining single civil engineer at the bureau level to liaise with the Bureau of Works and Urban Development.

Dismantling the already established implementation capacity is wiping out institutional memories in the health sector. Inadequate technical personnel and expertise in RHB also imply limitations in handling technical, administrative and legal issues related to contract administration for civil works at regional and Woreda levels. This restructuring has been already tested in Oromia Health Bureau, and proved not to be working well. Indeed a decision has been taken to reinstate the structure.

Constraints and conclusions

Despite progress in facility expansion, there is still a huge gap to be filled. Health facilities are still limited in number, and unevenly distributed across Zones and Woredas. Furthermore, the planned strategy to rehabilitate existing facilities has been fully implemented.

Due to lack of synchronized planning some facilities were completed without arrangements being made for the provision of staff, furniture, medical equipment, and water supply. The available medical equipment are not fully utilised due to shortage of qualified health personnel. The requirement to develop medical equipment maintenance strategies is still not implemented fully.

There is inadequate budget allocation for supervision and contract administration. In most cases the budget allocated for supervision and contract administration is not proportional to what is required for the planned expansion programme.

The budget for health facility maintenance is significantly below requirements. As result, maintenance for furniture, medical and hospital equipments is a problem at all levels and the physical conditions of health facilities are generally poor. All visited health facilities experienced lack of proper house keeping in all aspects due to lack of sufficient budget for cleaning supplies and preventive maintenance. It is not only lack of maintenance there is no system in place to do preventive maintenance. Even though the buildings solidity is at a very good stage compared to the previous years they lack proper furnishing, facilities mishandled from the original standard.

Recommendations
Overall, there is the need to balance construction of new facilities with the rehabilitation and maintenance of existing ones. Specifically, FMOH should:

- Develop a programme to modify existing health facilities either to reduce or increase their size in response to the requirements of the essential services package.
- Establish a preventive maintenance strategy and advocate for adequate funding at all levels.
- Together with RHB develop an integrated investment plan that links construction, equipping, furnishing and staffing needs and use such plan to guide future investments in civil works.
- Ensure that future investments in health facility construction are planned in close collaboration with other sectors Bureaus such as Bureau of Water Resources, road sector and power supply agencies to ensure their availability in the facilities.
- Review the management arrangements governing the implementation of civil works drawing on the experience of the regions and explore options for reinstating engineering services in RHB structure.

3.2. Human Resource Development

The human resource development component of HSDP II mainly aims at training and supplying relevant and qualified health workers of different categories. The specific objectives are to (i) supply skilled human resources in adequate number to new health facilities; (ii) improve the capacity of the existing health human resources working at various levels; (iii) initiate and strengthen continuing education and in-service training; (iv) review and improve the curricula of some categories of health workers and (v) rationalize the categories of personnel.

Achievements
During the implementation of the HSDP II some important policy documents were developed: the Health Sector Human Resource Development Framework (2006-2010) finalized in September 2005 and the Essential Health Services Package published in August 2005. Another recent achievement was the restructuring of the Health Services and Training Department with the ensuing establishment of the Human Resources Development Department.

Size and Features of Health Workforce
Given the large population of more than 70 million to be served, the current size of the technical workforce composed of 45,859 is very small. The health professionals to population ratios are very low and considered among the lowest in the world. The national as well as the regional figures for the doctor to population ratio have been worsening during 1994 – 1997 EC (Table 8).

Table 8. Doctor to Population Ratio1 by Region 1994 – 1997

	1994	1997
Tigray	59,106	54,844
Afar	106,000	79,925
Amhara	91,516	142,184
Oromiya	74,075	138,802
Somali	23,914	76,696
Benishangul	29,737	43,536
SNNPR	81,552	136,695
Gambella	15,857	40,066
Harari	4,914	4,623
Addis Ababa	11,260	17,291
Dire Dawa	8,550	12,784
National	**45,175**	**67,821**

Source: Health and Health Related Indicators

The composition of the workforce shows important internal distortions, with a considerable proportion (above 40%) of low trained staff, represented by the FLHW (23%), HA (13%) and HEW (6%); better skilled cadres, medical doctors and Health Officers are only 2% and 5% respectively. Besides, for some cadres, such as midwives, the shortages are alarmingly low (Table 9). The shortage of midwives is exacerbated by the fact that about half are male and in certain regions there is even a male predominance. Moreover, in some health units there are only male midwives. This is likely to be an important setback, as women might refrain from using health facilities staffed only by male professionals especially in gynecology and obstetric related conditions. Furthermore, information gathered during the visits to the regions point to an acute shortage of emergency obstetric skills among General Practitioners. Innovative measures are needed to address these problems as indicated in the recommendations.

Table 9. Human Resources by category 1994 - 1997

	1994		1997			Change %
	No	%	No	%		1994 – 1997
Specialists	652	2%	1067	2%		64%
GP's	1,236	3%	1,386	3%		12%
Health Officers	484	1%	776	2%		60%
Pharmacists	118	0%	191	0%		62%
Midwife Nurse	862	2%	1,509	3%		75%
Other Nurses	11,976	32%	17,299	36%		44%
Pharm. Technician	793	2%	1,428	3%		80%
Lab. Technician	1,695	5%	2,837	6%		67%
Radiographer	247	1%	491	1%		99%
Sanitarian	971	3%	1,312	3%		35%
Health Assistants	8,149	22%	6,363	13%		-22%
FLHW	10,050	27%	11,200	23%		11%
HEW		0%	2,737	6%		
TOTAL	**37,233**	**100%**	**45,859**	**100%**		**23%**

Source: Compiled from Health and Health Related Indicators

Notes: [1]The population physician ratio from Health and Health Related Indicators does not include physicians employed in the private sector.

Health staff is unevenly distributed, with most health with most health care professionals clustered in major urban areas, which are the better endowed with health infrastructure. Distortions are present across regions, Woredas and health facilities. Table 10 shows the

trend in distribution of physicians by institutions. In this period, public sector (all regions, Addis Ababa) has lost a great proportion of its physicians to the private sector[24]. One of the worst hit regions is Oromiya, which has decreased from 320 physicians to 186. The proportion of medical doctors employed in public sector institutions went down from 73% in 1994 EC to 44% in 1997 EC. It is evident that the private sector tends to attract higher skilled professionals.

Table 10. Physicians distribution by institution 1994 – 1997 EC

	All regions	Addis Ababa	FMOH	Public Sector		NGO	OGA	Private	Total
				Nº	%				
1994	906	235	233	1,374	73%	32	239	246	**1,888**
1997	663	167	247	1,077	44%	578	354	444	**2,453**
Change %	**-27%**	**-29%**	**6%**	**-22%**		**1,706%**	**48%**	**80%**	**30%**

Source: Compiled from Health and Health Related Indicators (1994-1997)

The assessment of staffing patterns is difficult mainly due to lack of information. In addition, the staffing guidelines are based on the "new" restructured health care system that is not yet fully implemented. The health stations to be upgraded to health centres or downgraded to health posts are still in place.

Constraints and conclusions

- Human resources lag behind the network plan and construction. As a result, health facilities remain un-staffed for considerable periods of time after their construction. From the interviews at federal level it was gathered that regulation on both private and public health services is weak due to capacity problems.
- Managerial capacities are very scarce, particularly below the regional level. Also no effective incentive package was introduced to facilitate the (re)deployment of staff, particularly to rural areas. However, various innovative incentive schemes were observed at Regional level (e.g. topping-up of salaries, training, and non-monetary incentives).
- A common observation is the high level of staff turnover in all regions.
- Finally, poor management of available human resources further exacerbates the shortage with ensuing equity, continuity and efficiencies problems.

Capacity Building

The performance of tasks related to planning, management, monitoring and evaluation and supervision, is seriously limited by the acute shortage of trained skilled health personnel at all levels. The challenge in the area of human resources development is not only limited to the training of adequate staff, but also to attracting and retaining them, particularly in harsh rural areas and Woredas.

Training schools / universities and curriculum development

There are 40 institutions involved in health workers' training – 6 in universities including the Defence Engineering College, 16 Senior Public Health Training Schools and 17 Junior Public Health Training Schools. Training targets of HSDP II have, with some internal fluctuations, been achieved (table 11).

[24] Source: Health & Health Related Indicators 1997, private sector data available only for Addis Ababa, Benshangul-Gumuz, Dire Dawa and Harari region.

Table 11. Training targets and achievements during HSDP II

	Target	Achieved		Comments
		Number	%	
High level	1,436	1,846	129	Degree level
Middle level	4,823	8,754	181	Diploma level; highest increase for SCN
Lower level	5,684	2,225	39	Certificate level; most have been discontinued
Front line including HEW	10,869	9,827	90	Only HEW, frontline have been discontinued
Total	**22,812**	**22,652**	**99**	

A major initiative during HSDP II has been the Accelerated Expansion of Health Officers (HOs) training in selected hospitals. All universities and some 20 selected hospitals were involved in an effort to meet the HOs requirement by 2009 (i.e. training of 5000 in five years). Gondar and Jimma University have started specialist training in surgery and public health, otherwise, the status of training institutions has not changed during HSDP II. However, almost all institutions have increased significantly their intake. Thus the number of graduates has increased (table 12). This number will increase even more, when the high intakes during HSDP II start to graduate in subsequent years. An important concern is that staff development has not gone at par with the high intake and might erode the quality of education. On the other hand, there are a number of new initiatives in the education sector related to the health sector (e.g. curriculum change in medical education) in which FMOH seem to play hardly any role.

Table 12. Number of Graduates of Selected Health workers 1995-1997

	1995	1996	1997
Medical Doctors	182	289	309
Health Officers	181	249	322
Pharmacists	50	57	70
Senior Clinical Nurses	849	1,288	3,300
Senior Midwife	41	144	40
Senior Environmental Health Technician	198	225	243

Another major undertaking during the HSDP II period was the launch of the training of HEWs. Reports indicate that 2,767 were trained in 1996 and another 7,090 in 1997. Training was carried out in Technical and Vocational Training Institutes / Centres in all regions except Afar, Gambella and Somali. Overall, training conditions were inadequate (Table 13). Often no textbooks or reference material was provided to trainees. The quality of training in practical skills (practical and apprenticeship) appears low and will need reinforcing by systematic in-service training / continuing education.

Table 13. Selected Indicators of training conditions of HEW 2005

Selected Indicators of Training Conditions of HEW 2005					
TVETI	No. Student	Class-room	Student/ classroom	Number of Trainers[25]	Student/ Trainer
Axum	200	4*	50	4	50
Mekele	197	4	49	4	49
Dessie	396	8	50	11	36
D/ Marcos	323	6	54	14	25
Assela	154	3	51	5	31
Fiche	150	6	25	5	30
Goba	153	3	51	5	31
Shashemene	146	3	49	7	21
Butajira	375	6	63	5	75
Dilla	375	13	29	6	63

N° of Private Training Schools 1997 EC		
Type	N° of Schools	N° of Graduates
Clinical Nurse	11	1,680
Druggist	5	415
Medical Lab Technician	2	36
Total	11	2,131

Source: FMOH 2006

The number of private training schools has increased dramatically during the period. FMOH inventorised 11 in three disciplines by 1997 (Table 14) but anecdotal information (e.g. field report of a medical college in Oromiya enrolling 100 persons for MD training) indicate that there were many more, thus raising the issue of adequate regulation and supervision.

Table 14. Graduates of HW Training Institutions by Sex 1990-94 and 1997 EC

	1990-1994			1997		
	Both Sex	**Female**	**%**	**Both Sex**	**Female**	**%**
Medical Doctor	708	51	9%	309	21	6.8
Health Officer	683	89	15%	322	85	26.4
Pharmacist	167	18	13%	70	12	17.1
Sen. Clin. Nurse	2530	741	35%	3300	1702	51.6
Sen. Midw. Nurse	246	112	48%	40	27	67.5
Sen.Lab.Technician	982	89	10%	337	44	13.1
Sen.Env.H.Technician	729	82	13%	243	45	18.5
Others not including HEW	6216	2019	32.5	1244	399	32.1
Total not including HEW	**12261**	**3201**	**26.1**	**5865**	**2335**	**39.8**
Total including HEW				12955	9425	72.8

In-Service Training

As during HSDP I, a large number of in-service training by different sources has been given in all the regions. These are largely uncoordinated with each department/unit organizing sessions on its own. Coupled with the high number of training sessions, this has raised, at least in one region, the possibility of a negative impact on service delivery. A laudable achievement during the period is the provision of training in EOC in a number of regions.

Gender

The available data is not sufficient to make any trend assessment. However, there seems to be a slight improvement in the gender composition of graduates except for medical doctors (Table below, Graduates of HW Training institutions by sex). This is mostly because of the noticeable improvement among senior nurse graduates and the large female contingent of HEW. Otherwise, the problems identified in HSDP I evaluation in the gender composition of higher level health workers training remain the same.

Recommendations

- FMOH and RHB to accelerate the training of midwives and to revise the training of Health Officers and General Practitioners (HO/GP) in order to equip them with the basic skills for managing both medical and surgical emergencies, especially Basic and Comprehensive Emergency Obstetric Care once posted to peripheral hospitals.
- FMOH to develop workload indicators with staffing guidelines for all levels.
- FMOH to establish a HRD database being a necessary asset for planning. Central HRD must be strengthened, particularly in its strategic and stewardship capacity.
- The strengthening of managerial skills, team work and capacity for change management is a top priority to be undertaken at all levels, guided by FMOH / RHB.
- FMOH and RHB to develop a strong incentives package (financial and non-monetary) in addition to the standard civil-service provisions, recognising the economic value of health care provision.
- FMOH and RHB to strengthen the relationship with MOE and universities, particularly in the area of curriculum development in order to ensure production of trained human resources that meet the requirements of the sector, both in numbers and quality.

3.3. Pharmaceutical supply and management

According to the National Drugs Policy (NDP), November, 1993, the overall objective of the pharmaceutical sector of Ethiopia is to (i) ensure and sustain the availability of safe, effective, and quality drugs at an affordable price; and to (ii) continually promote and ensure rational use of drugs that are available in the market. Targets defined by HSDP II were to make at least 80% of the Essential Drugs (ED) available in each health facility; reduce the number of drugs per prescription from 2.0 to 1.84 and to increase generic prescription from 90% to 92%. Finally it was hoped to make the NDP, and the Essential Drug List (EDL) available in all health facilities and inspect once a year each facility that handles drugs.

This section will present achievements and constraints on the most important issues related to pharmaceuticals, being (i) policy and legislation; (ii) licensing and inspection; (iii) the budget available for drugs; (iv) procurement and logistic management; (v) storage and inventory; (vi) availability of ED and their rational use; (vii) capacity building and (viii) the inclusion of ED in the essential health services package. Conclusions and recommendations will be summarized at the end of the section. [26]

Policy and legislation

Achievements
Although the NDP was not reviewed for the last 13 years, FMOH has planned for 2006/07 some major revisions. Already, new pharmaceutical legislation has been prepared and submitted to the government for approval. The document is expected to undergo substantial revisions to accommodate recent advances in the sector; For example, a policy on supply and use of anti-retroviral drugs has already been developed and has been distributed throughout the country.
The new Pharmaceutical Master Plan is currently being drafted. It may be finalized within the coming six months.
The latest Essential Drug list (EDL) was published in 1995 with the latest developments in the sector. A list containing 'priority drugs' that should be available at all times in adequate quantities, especially in the public sector, is being developed as part of the Basic Health Care Package. It will be used as the basis for procurement. A National Pharmaceutical data bank will be established for easy reference.
RHBs/ HBs indicated their awareness of the NDP, while in some places these documents are also used as basic reference material.

Constraints
During the visit to the regions, it was found that these policy documents are only available at RHB and not at Zonal or Woreda level. Some RHBs (Amhara & Tigray) indicated that the NDP and other national policy documents had not been developed specifically for their regions. Limitations were also observed in the distribution and dissemination of important manuals and guidelines, like standard treatment guidelines (STG), drug formulary, and drug supply management manual.

[26] Note: The group working on the logistic supply and management has studied reports from HERA and the World Bank on the status of health and poverty, March 2005, as well as an assessment of the pharmaceutical sector, October, 2003.

Licensing and inspection

Achievements
There is a legislative and organizational mechanism that provides back-up for licensing, inspection and quality control to retail pharmacies to ensure the drug safety, efficacy, and quality. Most of the RHBs and facilities visited by the evaluation team confirmed that there is a standard practice of licensing, inspection (once to twice a year) in their respective regions. However, the number of licensed drug outlets has not been recently recorded.

It is assumed that the enabling conditions created by the establishment of the special pharmacies (SP) might have brought about a shift of demand on the part of the health service beneficiaries in favour of the special pharmacies versus the private sector.

Constraints
Some limitations of effective licensing, inspection and quality control as reflected by RHBs and health facilities, are (i) shortage of logistics to periodically to carry out inspection activities; (ii) increase in workload due to attrition and high turn over of staff in the sector; and (iii) oversight of the pharmacy department activities in the annual plan. There is an indication that the eastern regions of the country need strengthened inspection and control against illegal drugs that make their way across the border.

Budget for pharmaceuticals

Achievements
The budgetary allocation for pharmaceutical and logistics supplies has increased over the last years. In general the drug budget constitutes about 38 percent of total health expenditure, of which 74% is met by out-of-pocket expenses from households (ESHE / HCF 2002).

Most of the RHBs / HFs mentioned donor contributions, especially for the provision of pharmaceuticals used by some of the vertical health programs, such as Family Planning commodities (Depo Provera, condoms) and maternal health related drugs. Contributions for the various programmes are summarized in the Table below.

Table 15: Supply of Pharmaceuticals by source (x1000 Birr), 2000/01

Type of Supply	Sector	Value	%
Imports	MOH	279,936	30%
	Other Government agencies	210,481	22%
	PHARMID	151,784	16%
	NGOs	52,269	5%
	Private for profit	123,726	13%
	Sub-total	818,196	87%
Local Production	Government	63,646	6%
	Private	56,813	5%
	Subtotal	120,459	13%
Grand Total		**939,655**	**100%**

Source: FMOH / ESHE. National Baseline on drug supply and use in Ethiopia, 2002.

In view of the growing population and the increase in demand for essential health services, there remains a mismatch between the incremental budgetary allocation and the service needs (demand) created by the population growth.

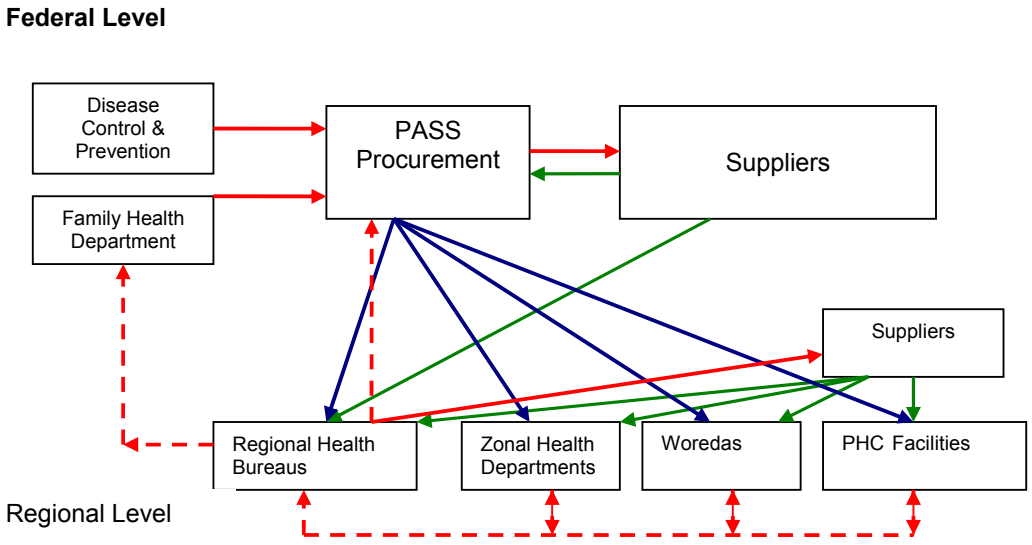
Constraints
Despite the increase mentioned above, the budget allocation for pharmaceutical supplies has been insufficient for a variety of reasons:

- There is delay in the transfer of actual drug budgets;
- Receipt of donated drugs sometimes arriving close to expiry dates (Gambella);
- Receipt of expired drugs coming in kits or as gifts;
- Lack of information as to the source and amount of drug fund from the federal level; Lack of integrated budgetary planning at regional levels.
- Vertical programme drug funds channelled to RHBs are mostly not accounted for or known by BOFED. This has created inconsistencies in resource planning by the respective regions, explained in detail in other sections of the report (4.1).

Procurement and logistic management

Achievements
Procurement is an essential component and a discipline that has primary role over the rest of pharmaceutical deliverables. The supply of safe, effective and quality drugs depends on the credibility, transparency and level of accountability entrusted upon the procurement systems and functions. There exists a variety of procurement sources: PASS, PHARMID, UNICEF kits, local and private wholesalers or contributions by vertical programmes, often in combination with each other. The flow of procurement planning from federal level to health facilities is shown in the figure below:

Figure 3. Procurement Planning Flow



The FMOH has given adequate policy and strategic directions and important legislative backup to address procurement and distribution of essential drugs. Recently, a proposal has been developed for the development of 'health Commodity Supply System Master Plan'. The eventual adoption of this plan will have far reaching consequences for the overall national procurement of health commodities.

In daily practice, drug procurement and distribution is handled at Federal (PASS) and RHB levels; as part of decentralisation, Woreda Health Offices have also been mandated to procure pharmaceuticals from anyone or several of the above indicated sources on

behalf of the health facilities under their responsibility. The total value of supply moved through the pharmaceutical market was estimated to be around Birr 939 million in 2000/01. According to these estimates, 87 percent of the country's drug needs were met through imports (purchase and donations) and 13 percent through local production. In the private sector the number of importers and wholesalers increased from 44 and 17 in EC1989 to 49 and 24, respectively in EC1994. Equally, the local production of pharmaceuticals and supplies has increased considerably.

Constraints
Transport in most situations is a limitation for the timely distribution of essential drugs and equipments. Most RHBs and or health service facilities encounter lack of the necessary logistical support to transport and avail the necessary drug supplies to their destinations. Several RHBs/ HFs suggested that procurement and logistic management deserves special Federal attention in order to achieve a comprehensive and coordinated system for procurement and distribution.

Some of the concerns expressed are (i) regular stock-outs of drugs at PHARMID; (ii) Insufficient capacity to handle procurement functions effectively by PASS (delays in procurement processes, shortage of pharmaceutical personnel at central and regional levels); (iii) too early decentralization of procurement to Woreda levels; (iv) delay in the release of funds by donors, particularly when the funds are released at the end of the fiscal year, thus risking to compromise drug quality and efficiency.
There exists an established system that RHBs provide health facilities (including HP) with drugs from the vertical programmes: antimalarial drugs, drugs for epidemics, drugs for TB and Leprosy, contraceptives for family planning and condoms. These drugs come directly from FMOH (PASS), distributed through the RHB. In these cases, selection and quantification of these drugs is done without rationalizing the specific priorities and disease burdens of some regions, leading to inadequate supply to some facilities and overstock of unneeded drugs for others.

Storage and inventory

Achievements
The shelf life of drugs and medical supplies is dependent on the status and management of the storage and inventory system. It is not enough that drugs and medical supplies are kept and secured within a locked system; the architecture of the facilities themselves should comply with the safety, efficacy and quality needs of drugs/supplies. Assessment on the pharmaceutical sector, conducted by FMOH/PASS in 2003, revealed the rating for storage conditions as 6 - 8 on a scale of 11.

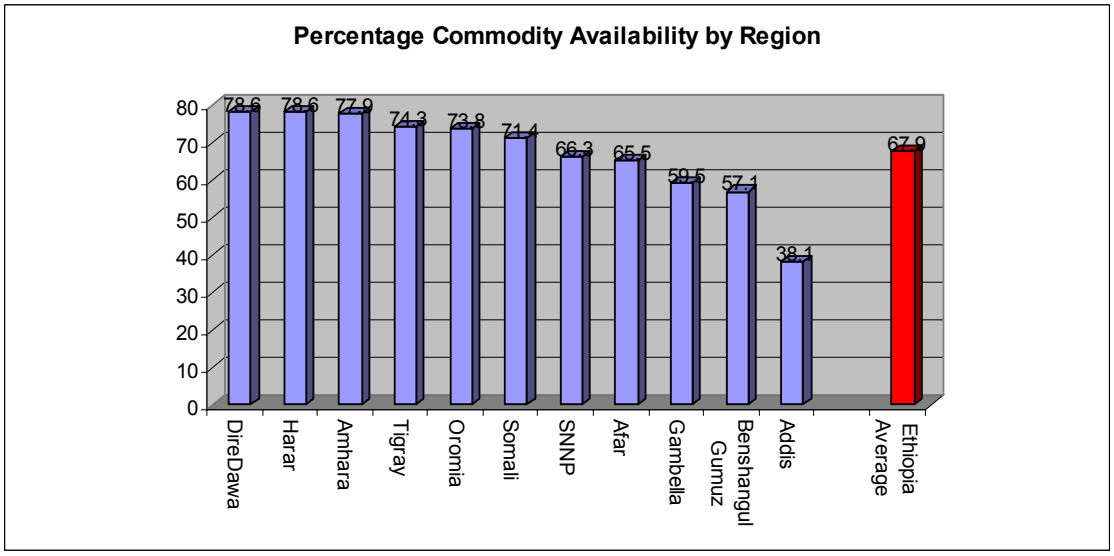
Constraints
Storage facilities were often found to be inadequate, being unfit for drug storage or poorly managed. Most of the stores lack mechanisms to monitor store temperature. Expired drugs were found in many places (received through kits or from other channels)
Stock Record Cards / Pin cards are available and used in only one third of drug facilities. It appears that regular supervision and control next to a proper Drug Management Information System is lacking. This needs further strengthening.

Availability of commodities

Achievements
Most informants told the team that there is a good availability of (essential) drugs (95-100%) in special pharmacies, whereas regular stock-out of drugs is observed in the various budget pharmacies often in the same facility. In this way, the special pharmacies appear to compensate for these stock-outs. More than half of the regions indicated that

there was no problem with the availability of drugs. Average commodity availability by region has been assessed recently as shown in the figure below.

Figure 4: Percentage Commodity Availability by Region



Constraints

Limitations with the availability of essential drugs relate to the following circumstances: Firstly, contraceptives are often not purchased through the government budget, but are received from vertical programmes or through NGOs. They are not always given for free[27]. Secondly, due to poor recording (stock cards either unavailable or not updated) and the weak reporting system (no data on drug expiry are reported), and due to the difference in drug availability between special and budget pharmacies, it is difficult to obtain a realistic estimate of drug availability in the regions. Thirdly, a few Health Facilities receive drugs beyond their needs (Dubti hospital receives a wide range of drugs that even in certain higher referral hospital are not found). Fourthly, some distant regions like Somali region, has critical shortages of essential drugs. Local populations have to rely on procurements from privately owned local pharmacies, whereby efficacy and safety of drugs is likely to be compromised.

Rational Drug Use

Achievements

Rational Drug Use (RDU) has gained focus within the NDP and related legislations. It is an area that depends on the level of professionalism of medical practitioners and pharmaceutical staff. It also depends on the quality of training availed to them. The government in general, and FMOH, PASS, and DACA in particular, are striving to their level best to promote and widen the scope of RDU in the country.

The team found[28] that on average the number of drugs prescribed per encounter was 1.9, being almost equal to the target set for HSDP II (1.84). However, there are significant variations between health facilities and regions that need careful investigation for future action. The use of antibiotics in each prescription is 58%. This is too high when compared

[27] Depo Provera is sold at 3 Birr, while contraceptive pills for 1 month are sold at 50 cents.
[28] FMOH/PASS, Assessment results on indicators for RDU, October, 2003.

with the target value of about 20%. It needs improvement. The percentage of use of injections is 23%, being an encouraging result when compared with the accepted norm of less than 15%.

Constraints
There is still a gap between current practice and the internationally established norms. This prompts the need for an extensive review and assessment towards effective rational use. However, RDU cannot be assured in the absence of a well performing public distribution channel. Standard Treatment Guidelines (STG) and the National Drug Formulary are not available in most health facilities (despite their distribution from the Federal level to RHBs) and Drug and Therapeutic Committees are not widely established or known in the majority of the facilities.

Capacity building

Achievements
Training and capacity building is given prominent focus within the national drug policy and strategy. It receives the attention it deserves from the FMOH, thereby driving and elaborating training programmes that meet the needs of pharmaceutical services at different levels and for different capacities. Most of the RHBs/HFs recognized the existence of relevant training on rational drug use (RDU), drug supply management, ART management, and the introduction of a revolving drug fund scheme. Training for up-grading pharmacy technicians to diploma level has started in various places.

Constraints
Despite the training and workshops given at central and regional levels by DACA, PASS there are few signs of clearly visible 'change' in the management of drugs at all levels. This is partly due to the high turnover of staffs that left the drug facilities after receiving the training."

Conclusions
The pharmaceutical sector has improved during the implementation of HSDP II, especially due to the special pharmacies, resulting in better drug availability and increased ability to cover recurrent costs. However, more effort is needed in the area of human resource availability, procurement and distribution channels and mechanism, rational drug use, budget allocation and logistics.

Policies, guidelines, manuals and other informational materials are not sufficiently distributed by the RHBs to health facilities. There is a high turn over of pharmacy personnel at all levels. Shortage/absence of drug budget for some facilities and lack of record keeping of data related to drug budget, absence of pharmacy and therapeutic committees, poor selection and quantification of drugs needs, inadequate supply of drugs, such as contraceptives and medical equipment, poor communication among the RHBs, Woreda Health Offices and the facilities, shortage of storage capacity and lack of necessary facilities in the stores such as thermometers, ventilators, and lack of vehicles for logistics purposes are all important factors contributing to inefficient drug supply. Finally, a reliable Drug Management Information System is virtually non-existent in most health facilities, making monitoring of the situation virtually impossible.

Recommendations
- DACA should supervise its branch offices to ensure that they are performing according to plan and regulation, and conduct continuous post marketing surveillance to detect unsafe drugs from the market to ensure the safety of the drugs in the region.
- PASS should review and install a mechanism that enables continuous supervision of health facilities and drug stores to ensure that efficient management is provided;

PASS should take every measure to foster proper selection and quantification of drugs, taking into account the basic and emerging needs of health facilities. PASS should also conduct continuous training and regular supervision on drug supply management in general and stock management in particular for those working in drug stores and in facilities.

- The recently developed 'Health Commodity Supply System Master Plan' needs to be discussed at federal and other levels, in particular with the intention to integrate procurement of commodities in the various vertical programmes;
- Bulk procurement of drugs at Federal and Regional levels should be encouraged. The role of WorHO in procurement and distribution needs further review and attention.
- Annual review meetings by RHBs should be initiated to assess the status of pharmaceutical services in their regions.

3.4. HMIS, M&E and Operational Research

Introduction

According to HSDP II, the major concerns regarding HMIS refer to gaps in coverage and delays in reporting, contributing to the inadequate use of information as the basis for decision-making in planning and management. In addition, parallel reporting systems, with programmatic and donor-supported initiatives, resulted in multiple reporting formats and an increased administrative workload. As a result, the objectives of the HMIS sub-component of HSDP II are to review and strengthen the HMIS at all levels (including community level) to produce timely information for planning, management and decision making. The objectives of the M&E components are to: (i) develop and strengthen a M&E system using standardized M&E and supervision guidelines; (ii) regularly monitor progress and achievements of HSDP components as a whole and improvements in service delivery, quality of care and financial performance; (iii) evaluate the impact, effectiveness and cost-effectiveness of HSDP components. Of note is the fact that, since M&E is mainly based on routine data sources and HMIS and M&E are strictly linked, this section of the report will include both HMIS and M&E assessment, although they are two separate components of the HSDP II (components 6 and 8, respectively).

Achievements in HMIS

HMIS has shown some improvements over time, and the statistical report from various sources (Indicators and Health-related Indicators booklet) has been published and disseminated every year by the FMOH/PPD. Despite its limitations highlighted in Annex 8, it provides the information base for trend analysis over the last 8 years, being useful for planning and evaluation purposes. There is widespread commitment to improve data collection, reporting and use at all levels and, during the field visits, simple information tools, such as EPI monitoring chart, list of top ten diseases and maps of facilities were found in almost all Woredas and peripheral facilities. Some embryonic experiences of community-based information systems have been developed using health extension workers and community volunteers, with vital statistics registration and community-based surveillance being in place in some Kebeles. The following box provides an example of some best practices in HMIS.

Box 4. Best practises in HMIS

One of the examples of use of data for decision making is the hospital management information system developed in some private non-for-profit hospitals in different regions. During the evaluation in the Oromia Region, one of these hospitals (St. Luke Catholic Hospital in Wolisso), was visited and the information system in place was 'assessed'. Cost, service and clinical data were systematically collected, entered in the computerized system and analysed according to the framework linking input, output and outcome data to assess hospital performance. Relational performance measures (such as cost per standard unit of services and number of standard services per staff) were developed for cost and productivity analysis. The usual hospital service indicators (bed occupancy rate, bed turnover rate and average length of stay) were estimated, and their comparative and explanatory power was multiplied through their joint analysis and representation according to the graphical technique used to assess the hospital performance and to identify outliers. Quality indicators were calculated, including average waiting time, percentage of patients sent out without prescription, percentage of prescriptions with antibiotics in OPD, wound infection rate after caesarean section, number of audits of perinatal deaths etc. Outcome analysis was also developed. This information was shared and discussed during regular staff meetings and new targets and standards were set in a participatory way with the aim of improving efficiency and quality in service delivery. Both outpatient and inpatient attendance increased over time, with a bed occupancy rate of about 90% in 1997, serving also as Zonal Hospital for referred patients and providing training services in its College of Nursing with 92 students currently enrolled.

Constraints in HMIS

- Since the HMIS revision has not yet started at the national level, different regional initiatives are in place to improve data collection and reporting; however, many attempts at strengthening HMIS are uncoordinated and focus on review of reporting systems and mechanisms, rather than on use of data for decision making. The HMIS unit at FMOH is also focusing on data management and compilation of basic health statistics, with little attention to data analysis and interpretation.
- Lack of use of information is the major factor affecting data quality, and the process is cyclical: poor quality data are not in demand, and the lack of demand further reduces quality in data collection and reporting. Therefore, information in the health sector is basically affected by two categories of problems: (1) insufficient use of available data for planning, implementation, service management, monitoring and evaluation; (2) inadequate quality, completeness and timeliness of data produced through the routine health recording and reporting procedures based on parallel systems. As a result, there are gaps and inconsistencies between different data sources.
- HMIS has only very partially succeeded in improving informed decision making. In general, health service staff is still required to do excessive data recording and reporting and are overwhelmed by data demands, whereas a quality assurance system is not in place and, in most cases, information is not used for planning and decision making.
- There is an overall concern that the large surveys such as welfare surveys and DHS are not well synchronised in their methodology, and are not sufficiently related to planning cycles.

Achievements M&E

M&E system has improved generally during the HSDP II implementation. However, challenges still need to be addressed. Monitoring HSDP II implementation is based on supervisory visits, review meetings and annual reports. Concerning supervision, these visits are not always being carried out on a quarterly basis as planned, suffering from human resources, financial and logistic constraints; however, progress has been made in some regions (such as Oromia), with a shift from individual departmental / sectoral supervision to integrated supportive supervision (with pool of experts from different department/services) and good practices of performing regular supervision using standardized check lists.

M&E review meetings are held periodically (generally every six months at regional level and every three months at Woreda level) and are often used not only for planning and monitoring purposes, but also for performing data quality control and providing feed-back to the peripheral units.

Various reporting mechanisms were outlined in HSDP II, notably: ”(i) the establishment of joint steering committees, at both central and regional level, to oversee implementation and (ii) regular reporting by regions and FMOH, on a quarterly basis, as an input to two Consolidated Reports (for the previous financial year and the first six months of the current financial year). These are presented for comments at the Annual Review Meeting

Constraints in M&E

- There is limited familiarity with the official list of 26 sector-wide HSDP II indicators at Regional, Woreda and health facility level. Although people use selected indicators for monitoring interventions (like EPI coverage), there is no systematic measuring of the HSDP II implementation at the peripheral level. As a result there is a gap in collecting the necessary information. Monitoring of the HSDP II indicators has not been prioritised.

- The Consolidated Report itself is still based on raw figures and absolute levels of accomplishment (rather than on performance indicators) and on a long list of data items (over 200) concerning activities implemented (ranging from key to marginal services), without any prioritization. This approach is not suitable for performance comparison and trend analysis, and may undermine the overall monitoring exercise.
- In the context of decentralization and health sector reform, new demands for monitoring the performance of the health sector have emerged, with clear statements on planned targets and measurement of actual achievements. This requires explicit standards for measuring performance, clear specifications of the relationship between inputs and outputs, and use of valid indicators to compare the actual achievements with the planned targets. In this perspective, performance monitoring should rely on a minimum set of key sector-wide indicators, as suggested in this evaluation report (see Executive Summary, Annex 1 and Annex 8) and focus on the implementation of the activities and the intermediate steps that determine how inputs are transformed into outputs, linked to the ultimate outcome of interest.

Operational Research (OR)

Some progress has been observed with the establishment of OR Units in some RHBs and the implementation of OR activities, as well as the establishment of linkages with universities, research institutions and partners in order to build capacity, to plan and coordinate research studies according to local priorities and to complement information from routine sources. Analysis from the regional reports indicates that OR is not an integrated activity in most Regions, although available data at the local level suggest critical areas that require operational research. Some studies have been undertaken at the regional level by international organisations and NGOs. However collaboration with the RHBs and exchange of information seemed rather limited. As a result, Regions have limited access to relevant information that can be used for fine-tuning health interventions. This requires sufficient attention in the revision of the HMIS and capacity building of the HMIS department.

Recommendations HMIS and M&E

- The HMIS strategy is to develop a service-oriented and action-led HMIS which will focus on a meaningful compilation of data, to be used for informed decision-making and planning at national and decentralised levels. Critical elements in this strategy should be the inclusion of (1) a set of core indicators and (2) standardization of forms for data collection and formats for data reporting.
- FMOH to establish the central data repository and constitute a permanent technical working group of experts at FMOH/PPD in charge of data quality control, validation and dissemination. FMOH to develop an electronic system for data capture, storage, analysis, interpretation and reporting.
- FMOH and RHBs to establish HMIS units at all levels (FMOH, RHB, WorHO and HF levels), and ensure that all staff are well versed with the HSDP list of core indicators.
- FMOH and RHBs to develop a capacity building programme that should include skills training in data collection, analysis and use, standardisation of data collection procedures, provision of feed-back and supervision. Such capacity strengthening is an iterative and long-term process.
- FMOH and RHBs to define a limited set of sector-wide indicators and establish the linkages between inputs, outputs, and outcome data from different sources. This requires that vertical programmes should not overburden the system with additional data collection, but should be integrated in the overall HMIS.
- FMOH and RHBs to standardize data collection and reporting procedures, including gender considerations and urban / rural differentials.

4. Finance and Governance in HSDP II

4.1. Financing the sector

During HSDP II the health sector has been under-funded compared to the initial three year HSDP II budget as well as compared to the annual budget allocations made during the regular budget process of the GOE.

Actual yearly allocations to health through the regular budget process has been only 56% of the initial three year budget presented (estimated Programme costs) in the HSDP II programme document.

HSDP II actual expenditures have been equal to 43% of estimated Programme costs. Data on budget allocation and expenditure by HSDP component is not available since the HSDP II components are not following GOE chart of accounts.

Table 16. HSDP II Programme cost, actual health budget allocated and health expenditure in EFYs 1995, 1996 and 1997 (in million Birr)

X Million Birr	1995	1996	1997	TOTAL	% HSDP
HSDP II expected programme cost	2,114	2,301	2,454	6,868	
Consolidated health budget	1,441	1,170	1,206	3,817	56%
Actual health expenditures	856	678	1,398	2,932	43%
Actual in percent of consolidated budget	59%	58%	116%	77%	

Source: HSDP II document; MOFED - Accounting figures for EFY 1995, preliminary actual for EFY 1996 and EFY 1997.

Budget allocations decreased when comparing 1995 budget allocation with 1997. Expenditures decreased from EFY 1995 to 1996 but increased substantially in EFY 1997 and exceeded the total health sector budget. This was due to a considerable amount of funds which were disbursed by vertical programme like the Global Fund (GFATM). This was not captured in the budget process, only in the accounts which explains the substantial expenditure in excess of actual approved budget.

The HSDP II target of annual government budget allocated to the health sector (8.2%) was not achieved. Government health budget has actually followed a declining trend during HSDP II: from 7.3% in EFY 1995 to 4.9% in EFY 1997. The substantial increase in expenditure between 1996 and 1997 (from 3.4 to 5.7%), is due to reasons as explained above (substantial donor inflow to vertical programmes).

Table 17. Share of GOE budget (budget and actual) allocated to the health sector

	1995		1996		1997	
	Budget	Actual	Budget	Actual	Budget	Actual
Health in % of total Public Expenditure	7.3 %	4.3 %	5.8%	3.4 %	4.9%	5.7 %

Source: MOFED, accounting figures for EFY 1995, preliminary actual for EFY 1996 and EFY 1997

As displayed in table 18, domestic resources (including general budget support) have been the main source in funding of public expenditure for health. Earmarked loans and grants declined as share of total resources from 1995 to 1996, before increasing to 32% of total funding. The trend in share of funding between different sources of funding follows the same trend as public expenditure on health as share of total expenditure. Comparing

aid commitments for health sector captured in the budget with actual outturns indicate that overall deviations between budget and actual expenditure are to a large extent attributable to unpredictable aid flows (ref. section 4.3 and 4.5 for a more detailed discussion of this issue). The table below illustrates that health sector expenditure during HSDP II has been highly dependent on the (non-)predictability of external resources.

Table 18. Total public expenditure on health by source of funding (1995-1997)

Public Expenditure on health	1995	1996	1997
External loans	15 %	22 %	18 %
External grants	19 %	5 %	14 %
Domestic	66 %	73 %	68 %
Recurrent and Capital	100 %	100 %	100 %

Source: MOFED: accounting figures for EFY 1995, preliminary actual for EFY 1996 and EFY 1997

The HSDP II budget forecast for health at central level was 6.8%, while actual budget share was 11% in EFY 1995 and 10% in EFY 1997. Although it appears that a greater share of funds was spent at federal level in EFY 1997 as compared to the first two years of HSDP II (11%, 19% and 49% in EFY 1995, 1996 and 1997 respectively), this increase is explained by the spending of substantial GFATM money for commodities and drugs on behalf of the Regions. As these funds are audited in the accounts at federal level, they appear as having been used by Federal level, but have in reality been used for items that have been sent to the Regions.

Overall regional expenditures on health have more or less remained the same during HSDP II, as is shown in the table below. Overall health expenditure at regional level (Regional and Woreda) was equal to approximately 10 Birr per capita in EFY 1995 and 1997. As explained later in this section and in section 4.3 this may partly be attributable to earmarked aid being offset in the budget process and partly because fiscal decentralisation is still in its early stages with an initial limited influence of the health sector in the planning process.

Table 19. Aggregated expenditure per capita at Woreda and Regional levels (in Birr)

	1995	1996	1997
Total Region / Woreda health expenditure	725,553,592	549,112,104	718,759,950
Total Population	69,127,021	71,066,000	73,043,510
Region / Woreda health expenditure per-capita	**10.5**	**7.7**	**9.8**

Source: MOFED

HSDP II set a target of 18% for the regional government budget allocation to the health sector. While Regional and Woreda budget data were not available to the evaluation team, preliminary expenditure data for 1997 suggest that actual expenditure has been significantly lower at Regional and Woreda levels. Preliminary actual for 1997 suggest average health sector expenditure at both Regional and Woreda levels are 10.3% of total expenditure[29]. This is further confirmed by a survey covering 20 Woredas in Amhara Region in 2004[30]. The survey showed that the budget allocated by Woreda Councils to the health sector was on average 10% of the Woreda budget.

[29] Based on flash reports from Regions and Woredas to MOFED.
[30] USAID/ESHE. 2004. Health Care Financing Survey. Amhara Region

According to this study, of the total health sector expenditure at Woreda level, an average of 41% is spent on salaries, 21% on other recurrent costs and 38% on capital costs[31]. However, it needs to be stated, that there are significant variations between Regions and Woredas. Some Woredas do not allocate any capital budget to health which represents a critical constraint in delivering and expanding adequate services, whereas other Woredas do spend the money on other items, as is documented in Box 5 below.

During HSDP II, the yearly per capita public health expenditure at regional level was between 8-10 ETB. Looking at Federal expenditure in 1997, a significant increase (from 10 to 19 Birr) is observed due to the inflow of funds from GFATM.

Table 20. Per-capita public health expenditure by Region (in Birr)

	Per capita (Birr)		
YEAR	*1995*	*1996*	*1997*
Harari Region	80	71	85
Gambella Region	74	64	50
Deri Dawa Admin Council	37	32	42
Benshangul Gumuz Region	39	30	34
A/A City Administration	26	19	24
Afar Region	30	26	21
Tigray Region	22	18	18
Amhara Region	8	7	9
Somali Region	7	6	8
SNNPR	6	5	7
Oromia Region	9	4	7
Total Regional	10	8	10
Total including Federal level	12	10	19

Source: MOFED Consolidated Accounts (except 1997 being from budget execution figures)

There is also an important variation in per capita spending between regions (see table 20), which reflects to some extent also “economy of scale” (low population/low density regions have generally higher levels of per capita expenditure). In addition, some of the urban regions like Dire Dawa and Harari regions have most likely higher levels of expenditure since these regions service to some extent neighbouring regions.

The target for HSDP II was to raise *overall per capita expenditure* (public and private) on health from 4.5 USD to 6.0 USD. The equivalent USD per capita *public expenditure* is presented in the table below using official exchange rates.

Table 21. Per capita public health expenditure (in USD)

	NHA[32] 1988	**NHA[33] 1994**	**1995**	**1996**	**1997**
Total regional			1.26	0.91	1.14
Total including Federal level	1.65	2.77	1.48	1.13	2.22

Unless there has been a substantial increase in private spending for health services (as discussed in section 4.2), the target might not have been achieved. However, without information from the National Health Accounts (NHA), currently being conducted, this

[31] Data for Woredas are only available for 1997.
[32] National Health Accounts 1995-1996.
[33] National Health Accounts 1999 - 2000

statement can not be confirmed. Comparing the 1997 figures with previous NHA survey results, it appears that actual per capita public expenditure on health has declined, even including the large inflow of GFTAM funds in 1997 (a decline of 19.9% from 1994 to 1997)

Table 22. Health expenditure in EFY 1997 disaggregated by levels: Federal, Regional and Woreda levels (in Birr)

	Expenditure	Percent	Per-capita health expenditure
Federal expenditure[34]	679,587,354	48	9
Regional expenditure	197,680,001	14	3
Woreda expenditure	521,079,949	37	7
Total health expenditure in Ethiopia	1,398,347,304	100	19

Source: MOFED Preliminary actual data

As illustrated in table 22, of the total health budget 48% is retained at federal level. Out of the remaining amount, 14% is spent at regional level (RHB, training schools and hospitals), and 37% at the Woreda health budget. The high share of spending in 1997 at Federal level was to a large extent due to the previously mentioned inflow of GFTAM funds with management and fund allocation determined by a Federal level institution and not through the regular allocation mechanism, giving discretionary powers to Regions and Woredas. These figures once more confirm the considerable under-funding of the health sector at primary levels with on average 10-19 Birr per capita available at Woreda level to finance both the Woreda Health Office and all "primary health care" activities (HCs / HPs), including the HSEP.

Box 5. Woreda allocation of budget

In some of the Woredas visited by the teams, budget allocation to health at Woreda level was calculated between 14% (Tigray) to 8% (Amhara).
In Simada Woreda (Amhara Region), the team received budget information from the Woreda Finance Office showing per-capita budget for health was equal to 3.1 Birr. In two Woredas in Tigray Region (Erob and Were Lehe Woredas) the equivalent amount was 28 Birr and 11 Birr respectively. These findings may serve to confirm the findings of severely under funded primary health care, although with significant variations between Woredas and Regions.
The constraints in service delivery stemming from low levels of funding can be illustrated by the analysis of one Woreda in Tigray. Perhaps being a little extreme compared to the average figures mentioned earlier, our findings show that almost 75% of the budget was allocated for personnel (salaries, pension, per-diem and other personnel costs), while 10% was allocated for drugs. The remaining 15% was allocated for operational costs of the WorHO and HFs. Therefore, in practical terms this WorHO can actually only plan and allocate a very small share of its resources for maintaining and expanding outreach of service delivery.

Constraints and conclusions

- The total public expenditure on health delivery remains extremely low in Ethiopia.
- The increase in 1997 is attributable to the inflow of funds for vertical programmes, not for general service delivery as evident by the low level of per capita expenditure at primary levels.
- The share of public expenditure for health has not increased, if the 1997 exceptional funds for vertical programmes are excluded.
- General external funding for public expenditure (general or sector budget support) will most likely not increase in the near future due to conditionalities of the main (bilateral) donors. Thus the main focus should be on how to allocate more of available resources to the health sector.

[34] Federal expenditure also reflects transfer of GFTAM funds to the regions

- In a Federal and decentralised system like Ethiopia with decision making devolved to Regional and Woreda level, it is not merely a question of increasing the overall resource envelope but also through dialogue and consultations focus the decision maker's attention at different levels of the need for increased allocation of resources to health within the existing resource envelope.
- The low resource envelope for health also justifies the need to further the HCF strategy to increase the overall resources available to health, among others through retention at facility levels. .
- Finally, large inflow of external funding for vertical programmes has limited impact on resource availability for general service delivery which is the core issue to address. It calls for more emphasis on alignment and effective application of aid instruments to reduce transaction cost considering the overall low level of resources available. This issue is further discussed in section 4.4.

4.2. Health Care Financing strategy

The Health Care Financing Strategy was approved by the Council of Ministers in 1991 EC establishing major initiative within the context of the overall HSDP and sought to institute a number of policy changes aimed at increasing the resources available for the health sector, improving the efficiency of resource use and promoting sustainability.

Some of the reform measures suggested by the strategy are user fee revision, revenue retention, and waiver and exemption systems. In addition, associated reform measures linked to hospital autonomy were included, where autonomy, outsourcing and private wing in public hospitals are the focus.

This chapter focuses on the HSDP II achievements in implementing these measures. Many of the initiatives stated under the HSDP II component has been started and/or implemented. However, several of the targets set have yet to be realised as reflected in the following sections.

User Fees and retention
User fees charged in government health facilities has remained essentially unchanged for the last decades. In view of the resource limitation in the health sector, increasing revenue through the revision of user fees was devised as one of the basic instruments in the strategy.
A study on user willingness and ability to pay indicated that increasing user fees with the current setting would be counter productive and suggested that the revision be deferred for sometime in the future until the following are achieved:

- A consistently available supply of pharmaceuticals.
- Availability of diagnostic and test capacity at the facility.
- Reasonable waiting times to see medical professionals.
- Respectful attitude from medical professionals and responsiveness to the needs of the clients.

The target set for HSDP II was to make 20% of GOE health expenditure to be covered by fees. This target may be considered ambitious; however, the low level of services provided has by itself generated a high user willingness to pay should they be made available. As will be discussed further below, the private sector is already a major provider of services and the clients are the major financiers of total health services already (public and private).

According to preliminary regional data on revenue and expenditure outturns actual revenue collected has fallen short of the target (12% as compared to the target of 20%, table 23).

Table 23. Revenue from user fees and health sector expenditure in million Birr 1997 (preliminary actual all regions)

	Million Birr	Percent of expenditure
Health sector revenue	88.8	12 %
Health service provision	19.6	3 %
Sales of Medicines and Medical Supplies	50.2	7 %
Medical Examination and Treatment	18.9	3 %
Total health sector expenditure	718.8	100%

Source: MOFED, regional "flash reports" – preliminary actual.

HSDP II had set as a target that 75% hospital and 50% of other service fees were to be retained by facility. Retention at facility levels has however only been piloted in the SNNPR region by introducing a retention rate of 50% of HF revenue from fees. However towards the end of HSDP II the largest regions have passed laws that allows facilities to retain 100% of their revenues.

Waiver and Exemption

The practice of waiver and exemption was introduced simultaneously with user fees. A study aiming at investigating the current levels and policies of fee wavier and exemption was conducted in EFY 1995. It documented that there has not been formal fee waiver and exemption policies and no re-imbursement mechanisms for fee waived services. However, according to the survey approximately 70% of patients visiting the health centres and hospitals were either waived or exempted[35]. If this reflects a national trend, it may serve to explain part of the lower than targeted revenue collection from user fees.

Revolving Drug Fund (RDF) & Special Pharmacies

In order to address the chronic shortages of drugs and medical supplies in public health facilities, Revolving Drug Fund (RDF) schemes have been initiated and introduced. Based on the experiences gained in these RDFs the government further initiated the opening of many Special Pharmacies (SPs) in collaboration with various Development Partners. Key special pharmacy personnel have been trained on the operation and management of the SPs. Regions have overseen the implementation of SP initiative in the health facilities.

The HSDP II target was to have special pharmacies in all GOE hospitals and 50% of health centres. Data on actual numbers of special pharmacies have not been available to the team (only the total number of pharmacies).

The number of health centres has increased from during HSDP II, while the total number of pharmacies has been reduced. The total number of pharmacies is 45% of the number of health centres, which includes pharmacies located in hospitals, the regular government (none SP) pharmacies and some private pharmacies[36].

[35] This figure most likely includes the hospital admission, but excludes the OPD patients. Regional findings indicated limited provision of waiver and exemption for OPD patients. The figure of 70% appears in the study: "Targeting Health Services in Ethiopia: a proposal for improving fee waiver and exemption systems". 06/2003

[36] Updated figures to be presented

Private sector involvement in health care

There was small number of private health facilities before 1995 because of the lack of legal framework within which the private health care providers were allowed to operate. A study on private supply and consumption of health services[37] indicate that the share between private suppliers and public suppliers of services are 50%. During the survey years private supplies grew with an average of 14.7% annually. The same survey indicates that there are substantial out-of-pocket expenses by the beneficiaries of health services of which payments for pharmaceuticals account for 62%.

Given the change in policy simultaneously with stagnation in public resources for health, the share of private supply has most likely increased further. These changes can be attributed to the government's interest and commitment to promote the private health sector within the health system during HSDP II. The health policy and strategy of the government has been instrumental in achieving some of these results although a lot more has to be done in terms of forging the public-private partnership in health.

Another area considered by the GOE was to strengthen the public – private partnership through outsourcing / contracting. A study to contract out government services in the health sector in Ethiopia found that to date the contractual arrangement is mostly focused in the provision of ancillary services (construction and maintenance of vehicles, health facilities etc). Currently there are few emerging initiatives to engage the private sector and NGOs in the provision of health services with funding or in kind inputs from the government. The study demonstrated that there is a good potential that both sectors can benefit from such an arrangement particularly in hospital catering and diagnostic services, an area that needs further investigation.

Based on the outcome of various studies, health care financing reform proto type proclamation has been developed by the FMOH. Addis Ababa, Oromia, SNNPR, Amhara and Tigray have adopted and come up with their proclamations, which have been ratified by the respective regional councils. A manual has also been prepared to facilitate the implementation of the reforms and Training Of Trainings (TOTs) has been conducted recently. Currently, Oromia and SNNPR have endorsed the regulations while Amhara and Addis Ababa have yet to endorse the regulation. So far the major problem in implementing the HCF reform has been the delay in endorsing the legal instruments and the long and protracted time needed to create consensus among stakeholders at all levels. Unfortunately, to date, the Proclamation has yet to be ratified at Federal level.

Conclusions

- Private sector provision of health services has increased and most likely at a faster rate than public sector service delivery. While recognised by the GOE, there are significant opportunities to expand PPP beyond developing strategies and conducting studies, e.g. more consistent approach to outsourcing.
- The basic legal framework was developed already before HSDP II. There has been evidence of the framework gradually being implemented in some regions although at a very slow pace.
- Of particular importance is the implementation of facility revenue retention which will serve to increase efficiency and sustainability of service delivery.

[37] "Private Expenditure Trends in Ethiopia and Implications for Health Systems Financing", FMOH, November 2000

4.3. Financial management

Issues related to the budget process
From MOFED and the perspective of the Ethiopian state budget process, HSDP is, as a sector wide programme, equivalent to public health sector expenditure at Federal, Regional and Woreda levels (budget head 340 in the recurrent and capital budgets at all levels)[38].

Regulation 17/1997 sets out the following budget procedures of specific relevance to this evaluation of HSDP II:

- The annual budget should include *all* capital and recurrent expenditures arising from taxation, external assistance and external loans.
- Once the budget has been approved it is the responsibility of the heads of each public body to provide information to enable the government to maintain necessary central control over budgetary funds.
- MOFED prepares an annual set of consolidated accounts to show actual revenue and expenditure against the approved budget, which is submitted to the office of the Federal Auditor General for audit.

Coinciding with HSDP II, new Chart of Accounts and Budget Calendar was introduced. In addition fiscal decentralisation was extended by introducing block grants directly to Woredas. The regulations establishes financial planning and budgeting cycles, time frames, and specifies the stages in each cycle. It also defines the institutional responsibilities at the different levels as presented in the box below.

Box 6. Assigned management responsibilities

Federal Level Expenditure Assignments
✓ Foreign relations ✓ Justice and internal security ✓ Macro stabilization ✓ International trade ✓ Currency and banking ✓ Immigration ✓ National interest capital projects ✓ Shared with regions: environment, airlines, and railways ✓ Tertiary education
Regional level Expenditure Assignments
✓ Secondary education ✓ **District and referral hospitals** ✓ **Nursing schools** ✓ Water supply ✓ Regional and (Zonal) roads ✓ Regional police ✓ Maintenance of irrigation systems ✓ Maintenance of smaller-scale water supply projects and energy programs ✓ Agricultural planning ✓ Shared with federal: justice, environment, police, and ✓ vocational and preparatory schools ✓

[38] In accordance with the new chart of accounts introduced by MOFED (DSA project)

Woreda level Expenditure Assignments

- ✓ Primary education
- ✓ Basic health care
- ✓ Agricultural extension programs
- ✓ Veterinary clinics
- ✓ Land use administration
- ✓ Water development, wells construction and maintenance
- ✓ Local police
- ✓ Local roads
- ✓ Shared with regions: small-scale capital projects

Source: HSDP II evaluation team

The consolidated annual budget is based on separate budget submissions of Woredas, Regions and FMOH which is consolidated by MOFED. The budget submissions are based on the regular budget classification as per government chart of accounts.

There is no specific component-wise HSDP annual budget. The initial 3 year HSDP II budget might have served as a framework for costing the respective components but does not serve as a financial monitoring instrument. Any health sector expenditure is automatically considered as HSDP II expenditure, i.e. HSDP II does not represent a specific programme intervention in financial management terms. The health sector budget (HSDP II) is contained in the consolidated annual state budget using the regular budget classification of the Government.

The consolidated Federal level budget includes a separate budget line for the Federal subsidy to Regions (based on the Federal subsidy formula). At the Regional level it shows a similar transfer to Woredas (some regions apply a similar subsidy allocation formula). This means that the consolidated budget at federal and regional levels do not display intended total sector allocations since it is left to the discretion at the lower lever (regions and Woredas) to determine the sector allocation within their fiscal framework. In the case of public health expenditure, the Regional and Woreda levels accounted for 85% of total health sector expenditure in 1995 (as per consolidated accounts for EFY 1995), and 50% in EFY 1997 (pre-actual data).

Any earmarked donor funding is offset by the Federal subsidy. This has implications for donor perceptions of *additionally* and ability to contribute to increased expenditure in a particular sector (like many of the donors in the case of HSDP I and II). Accordingly, donor contributions to HSDP II have not necessarily resulted in any increase in health sector expenditure. Some studies seem to suggest even the contrary[39].

Earmarked donor commitments to health has apparently lead to an understanding that health sector will be funded by earmarked external funding and accordingly lead to allocation of other unconditional resources (federal/regional subsidy) for other sectors. If the commitments have not been realised the impact has subsequently lead to a reduction rather than the intended increase in health sector spending (Box 7 below).

[39] "Donors Shifting to Sector and Budget Support", RESAL, May 2001

Box 7. Federal subsidy block grant

The allocation of the federal subsidy (block grant) to regions is calculated by deducting expected federal government expenditures from estimated total resource envelope of the budget each year. These resources take into account domestic revenues, counterpart funds and estimated external funding (loans and grants). The residual makes up the resources available for transfers to the regions. The federal transfer is guided by the principle of equity between regions. The federal government applies a formula that combines several indicators. The formula is prepared by MOFED and proposed to the House of Representatives, where it is discussed and approved.

The current formula includes the following three indicators: population (65%), level of development (25%), and revenue raising effort (10%). Oromiya, Amhara and SNNP receive over 79% of the total federal transfer since these regions have 81% of the population which has the highest weight the index. In addition to Somali region, these are the still the very same regions with the lowest per capita expenditure on health.

When deciding how to distribute the subsidy between regions, the federal government takes into account all other external revenues received by the regions. In particular, it takes into account external grants and loans and deducts them from the federal subsidy. This is done to ensure that the distribution approved by the House of Representatives is not distorted by donors' preferences.

Any known donor commitment to HSDP (public health) is accordingly offset by a reduction in the non-earmarked federal subsidy. In many Regions and Woredas this appears to have lead them to deduct the amount committed by donors from the subsidy and other unconditional revenue from the intended allocation to health to be funded by the subsidy. The low predictability of external aid (actual disbursements deviates substantially from amounts committed) may serve to explain the reduced rather than increased share of health sector spending observed during HSDP II.

Issues related to the integrity of the budget

Donor funding is directed through three channels:

- Channel 1 funds are managed through accounts held by MoFED and are fully incorporated into the budget process.
- Channel 2 funds are managed through deposit funds held by ministries and regional governments and are captured in the budget if the information is made avalaible to MOFED in the budget process.
- Channel 3 funds are paid directly to projects and bypass central and regional government financial control and budgeting processes.

Channel 1 funds will always be captured in the budget process ("on budget") as well as in the state accounts ("on accounts") since they are fully aligned with the GOE financial management system (fund management is entirely managed by GOE once donors have made their transfer of aid).

Channel 2 funds may be "on budget" if the information on commitments are captured in the budget process. The may also be captured in the accounts ("on acounts") if the resource use is reported through the GOE financial system. It means that funds can be "on budget", but "off accounts" thues the actual budget outtrun is underestimated. More rarely the opposite may be the case, i.e. resources not capture by the budget but stated in the accounts (bugdet utilisation is then overestimated).

Channel 3 funds will mostly be "off budget" and "off accounts"

Progress has been achieved in incorporating off-budget funds in the presentation of public funds. However, the large inflows of Food Aid and other emergency assistance are not fully incorporated into the budget (only as memo items). In case of the health sector, it has been characterised by many and increasing number of channel 2 and 3 type interventions during HSDP II, most prominently the large inflow of resources from the Global Fund in EFY 1997, being 'off-budget', but captured by the accounts. This explains the significant change in expenditure on health from EFY 1996 to EFY 1997 (section 4.1).

The unresolved issue of aid "on/off budget/accounts" continues to undermine the integrity of the budget, in particular related to donor practises of providing direct support to spending agencies (in cases which the information is not passed on to MOFED in time for integration in the budget process). This applies still to some of the so called channel 2 funds in HSDP. In the case of so called channel 3 funds, they are rarely captured by the budget and never by the consolidated state accounts since neither the FMOH nor Regional and Woreda level agencies actually executes the expenditure (applies for most traditional technical assistance and commodity aid).

Another important issue is the low *predictability* of donor commitments, in some cases due to delays in formalising agreements and executing disbursements, in others due to delays in complying with donor conditions which was to trigger the release of funding. Finally, the lack of alignment by many HSDP donors to the MOFED budget cycle further undermines the budget process.

These considerations have led MOFED to discount donor commitments made in the budget process by 70% for external loans and as much as 30% for grants reflecting a particular low predictability of grant assistance. Comparing historic data on budget versus expenditure for the health sector clearly justifies this practise when preparing the fiscal framework for the budget.
A particular case is the budget outturn in 1997. In this year capital expenditure has exceeded budget ceilings by as much as 541% at Federal level (FMOH) while it is in fact only due to the fact that large donor inflows was not captured in the budget process.

Analysis of health sector expenditure compared to budget displays a high deviation between the budget versus actual expenditure (Table 24). The deviation applies in particular to capital expenditure. If grant funded expenditure is excluded, the deviation is lower. However, this feature is displayed across many sectors and even for non-donor funded sectors like Defence. It means that the budget is not a fair approximation to actual resource use, an issue to be considered when using the budget rather than actual expenditure as targets for the HSDP II.

Table 24. Total budget versus actual expenditure for health 1995 (in Birr)

Region	Budget	Actual	Actual/budget
Tigray Region	131,801,071	88,406,659	67 %
Afar Region	68,102,495	39,196,683	58 %
Amhara Region	270,364,123	142,372,544	53 %
Oromiya Region	285,573,358	209,605,253	73 %
Somali Region	90,361,800	29,168,007	32 %
Benshangul Gumuz Region	41,074,934	22,596,241	55 %
SNNPR	170,615,226	78,443,622	46 %
Gambella Region	39,980,517	16,767,717	42 %
Harari Region	21,822,726	14,160,816	65 %
A/A City Adm.	132,331,581	71,621,597	54 %
D/D Adm. Council	25,922,343	13,214,453	51 %
Total regional	**1,277,950,174**	**725,553,592**	**57 %**
Federal	163,224,757	130,033,863	80 %
Grand total	**1,441,174,930**	**855,587,455**	**59 %**

Source: MOFED – 1995 consolidated accounts.

Improved reporting by donors, including NGO contribution to public spending is one remedy for improved coverage. However, the issue of *predictability* and alignment with the budget calendar will still remain as issues which should feature high on the HSDP II donor harmonisation agenda. Furthermore, aligning support to the government financial management system should be an equal high priority. It implies that channel 1 is the preferred option to align funding with the financial system, reduce transaction costs and improve assurance. Channel 2, and most of all channel 3, should to the extent possible be minimised.

Issues related to Accounting and Financial Reporting

MOFED is responsible for accounting and financial reporting of the Federal Government. Within MOFED, the Central Accounts Department (CAD) prepares the accounts for the Ministry itself and consolidates the monthly, quarterly and annual financial statements of the 153 Budgetary Institutions and the 11 regions from which Woreda accounts are incorporated through consolidated financial statements. In case of the latter there are substantial delays in submission of financial statements which delays the consolidation process. As observed by a recent expenditure tracking study the delays can be as much as 6-9 months in some regions with remote and low capacity Woredas.

The preparation of financial statements by Central Accounts Department (CAD) is governed by Parliamentary Proclamations, and follows Ethiopian regulations and Generally Accepted Accounting Practices (GAAP). The new double entry accounting system supported by manuals and staff trained in their use has further improved assurance and the system also has the facility to enable a record of commitments to be kept although the practice varies across regions.

The delay referred to above in submission of consolidated statements of accounts meant that for this evaluation only the ETY 1995 fiscal year consolidated statement could presented. For the year 1996 and 1997 estimates of expenditures could only be based on budget execution data contained in “flash reports“ submitted by the Woredas to Regions for consolidation and onwards to MOFED to be used for fiscal monitoring purposes.

There is a high degree of budgetary discipline and low level of un-authorized expenditure and government arrears. The risk of misappropriation and diversion of funds is accordingly low. There are two main problems effecting public accounting and reporting. As mentioned above, there is a problem of communication of aid funds from donors to Government and between government departments. Although aid is being accounted for in a manner to satisfy donor requirements, this does not necessarily mean that aid fund flows and expenditure on projects funded by aid is reported to the budget and CAD at MOFED. Until such time as these can be satisfactorily resolved, management information will continue to be incomprehensive and out of date for its purposes.

As for aid in general, there is a need to harmonise HSDP aid funding by introducing a system for communication of all aid flows to budget and CAD. While the current mapping exercise conducted by the donors may be a way forward, it does not present the information in a manner which can easily be incorporated in the budget or used for reconciliation of accounting information. It should be further refined and aligned to the budget calendar serving as an instrument to assist MOFED in making revenue forecasts for the budget.

Issues related to Internal Controls and External Audit
Most of the findings of the Country Financial Accountability Assessment (CFAA)[40] and susbequent asessments of public financial management are still valid.

The legal framework requires reporting from all levels (Federal, Regional and Woreda) on a monthly, quarterly, semi-annual and annual basis. However, as mentioned above, there are delays in collating the data. All the relevant reports consulted, and subsequently confirmed, indicate that bodies are behind schedule in preparing reports due. The delays are caused by a variety of reasons including lack of resources, lack of training, difficulties in obtaining information from remote regions, problems with data accuracy and increasing workload at Regional/Woreda levels as a result of budget delegation.

The Constitution gives power to the Auditor General to audit and inspect the accounts of Ministries and other agencies of the Federal Government and to report the findings and recommendations to the House of Peoples' Representatives. Each Region has a Regional Audit Bureau, which has an Auditor General for the Region appointed by the Regional Council of Peoples' Representatives.

The audit backlog has been reduced however, it continues to be an approximate two-year lag in auditing the Federal Government accounts and longer in many regions.

Conclusions
- There is a high degree of budgetary discipline and low level of un-authorized expenditure and government arrears. The risk of misappropriation and diversion of funds is accordingly low. The basic public financial management (PFM) criteria for extending budget support are fulfilled in Ethiopia. Why HSDP II donors, who provides general budget support as the main aid instrument to other countries with significantly weaker PFM systems and not to Ethiopia remains an issue to be explained.
- Any earmarked donor funding is offset by the Federal subsidy. This has implications for donor perceptions of *additionally* and ability to contribute to increased expenditure in a particular sector (like many of the donors in the case of HSDP I & II). Accordingly, donor contributions to HSDP II have not necessarily resulted in any increase in health sector expenditure.
- The unresolved issue of aid "on/off budget / accounts" continues to undermine the integrity of the budget, in particular related to donor practises of providing direct support to spending agencies.
- The issue of *predictability* and alignment with the budget calendar are the main issues which should feature high on the HSDP II donor harmonisation agenda, and have priority above donor harmonisation initiatives such as JFA / basket / pooling arrangements. Its means presenting annually firm and predictable commitments in a format that can be used for state budgeting purpose and at a time relevant for integration into the budget (follow the GOE budget calendar).
- Channel 1 is the preferred option to align funding with the financial system, reduce transaction costs and improve assurance. Channel 2, and most of all channel 3, should to the extent possible be minimised.

[40] Ethiopia: Country Financial Accountability Assessment, World Bank, June 17, 2003.

4.4. Governance and sector management

Health sector governance embraces the entire framework of decision making. Fundamentally, governance is concerned with achieving objectives and targets of HSDP II in a transparent, participatory and ethical manner. It requires:

- A governance structure in which inter-dependent and mutually reinforcing roles and responsibilities of the partners involved in the programme delivery are clearly described and mechanisms exist for discussions on results and resources
- An accountability framework with mechanisms for joint planning, programming and reviews
- A prioritized and credible programme whose design is based on a shared vision, and logical pathway for implementation involving a hierarchy linking activities, results and resources.
- A performance measurement strategy in which appropriate measures are defined and used to track and report on progress, evaluations are conducted to reduce the uncertainties surrounding information on performance, and institutional mechanisms exist for reviewing performance, identifying lessons and making recommendations for continuous adjustments to programme implementation.

Governance of the Ethiopian's health sector is exercised in a decentralized context. The implementation of Government's policy to devolve power and resources to the Woreda in 2002 coincided with the implementation of HSDP II. With health being one of the decentralized sectors in Ethiopia, achieving the objectives and targets of HSDP II was a joint responsibility of the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHB), and Woreda Health Offices (WorHO). The Zonal Health Offices are part of the regional health bureaus and will be phased out in some regions, as Woredas become stronger.

Effective governance is highly dependent on the quality and capacity of leadership. In that regard, HSDP II recognized that the capacity of health management at all levels was weak largely due to shortages of human resources and high turnover of staff in management positions. Management strengthening was therefore identified as an essential strategy. The following are the targets for this area of work:

- Implement the new civil service reform guidelines in the management of the health sector programme.
- Appoint and deploy health managers with appropriate management knowledge and skills at all levels of health service structure.
- Establish health management boards, Health councils/committees at federal, regional and Woreda, Kebele and health facility levels.
- Revise and implement the Programme Implementation Manual (PIM).

In addition to the above targets, joint Government and donor steering committees were to be established at the federal, regional and Woreda levels to oversee and coordinate implementation.

Box 8. An overview of progress made in implementing/achieving the above target

Target	Progress to date	Recommendations
Implement the new civil service reform guidelines in the management of the health sector programme	• Overall progress in the last three years is fair for such an ambitious programme • Scope of programme is available • Relevant studies conducted • Institutionalized in FMOH and RHBs and Focal points appointed and oriented	• Scale up CSRP based on agreed milestones • Ensure the commitment of leadership at all levels in implementation

Target	Progress to date	Recommendations
	• Business process reengineering piloted in few health facilities • Little implementation at Woreda level	
Appoint and deploy health managers with appropriate management knowledge and skills at all levels of health service structure	• Managerial capacity getting worse from fast pace decentralization and high turn over of health managers • Vacancies exist at all levels of the health system worst in the Woreda level and deprived areas • New appointees not oriented • No obvious programme for succession planning in the sector	• Develop management and leadership training programme for existing managers and orientation programme for new appointments with a focus on district level managers • Given that local governments are responsible for appointing health managers and do this with or without consulting the FMO, provide local government with minimum academic, professional and managerial qualification and experience to guide appointments of heads of health offices
Establish health management boards, Health councils/committees at federal, regional and Woreda, Kebele and health facility levels	• Not implemented but preparatory work far advanced • Draft national proclamation ready • Regions have ratified the proclamations thus laying the basis for implementation	• Speed up implementation of HCF strategy
Revise and implement the Programme Implementation Manual (PIM)	• Not implemented during the HSDP II however preparatory work is far advanced • Review team has been constituted • Situation analysis conducted • Draft ready (but could not be shared with evaluation team)	• Finalise the revision of the PIM incorporating implications of changes in the context of health sector governance
Establish joint Government and donor steering committees at the federal, regional and Woreda levels to oversee and coordinate implementation	• Functional committees at the federal level • No functional committees at the regional and Woreda level • Joint steering committee still relevant at regional level but not so relevant at Woreda level since health management board (if set up) can play this role	• PIM to provide guidance on this

Box 9. Woreda responsibilities

The Woreda level has become:
- The lowest level for plans and budgets;
- Level for system administration, health boards, community mobilization, etc.;
- Lowest level with ideally full range of facilities (hospital, etc);
- Employer of public health services;
- Concentration point for health information;
- Entry point for traction for change;
- Large enough to see intra-country disparities.

Decentralization and Health Sector Governance

Governance Arrangements

The different and complementary roles of FMOH, RHBs and WorHOs are clearly specified in the HSDP II and the Decentralisation Policy. Generally the FMOH is responsible for policy formulation, regional health bureaus adapt national policies to the regional context and provide technical support to the WorHOs, and the Woreda health offices are responsible for policy implementation. Box 9 shows importance of the Woreda level in the Ethiopian's health system.

At the Federal level, the Central Joint Steering Committee (CJSC), HPN-donor group, and Joint Core Coordinating Committee (JCCC) are established and functional. The committees provide the forum for policy dialogue, strategic thinking and donor harmonization. The participation of FMOH in some of these joint arrangements, particularly JCCC, seems to have been reduced to few staff from the PPD rather than the broad spectrum of FMOH leadership. A broader and stronger representation of the FMOH led by PPD would lead to a more effective Government-donor policy dialogue.

The FMOH is reviewing its organizational structure to align it more closely with sector priorities and promote integrated service delivery. The new organizational structure was not available for review at the time of this evaluation. However interviews with key informants suggest the following changes:

- Finance is being separated from the Administration to ensure a better focus on financial management and in anticipation of the expected changes in donor financing arrangements including the establishment of Protecting Basic Services.
- The transitional arrangement established to oversee implementation of HSEP is being institutionalized through the establishment of a department of HSEP within the Health Extension and Education Centre (HEEC).
- Service delivery and training have been separated and a service department has been established to oversee service delivery from primary health care unit (health centre & health posts) to the hospital level, including private health facilities and pastoralist health services.
- Discussions are ongoing on how to organize or re-organize the traditional vertical programme such as family health and communicable disease control to ensure that integrated support is provided to regions and Woredas.

Currently the Federal and State Ministers manage each of the heads of Departments and Services. While this promotes direct link and interaction between the politicians and Civil Servants, it does not make for effective coordination of the activities of the heads of Departments and services. FMOH may therefore consider introducing an administrative head of the FMOH (equivalent to a Principal Secretary or Chief Director in some countries) to coordinate the activities of heads of departments and services and free the Ministers to take care of political and strategic issues. This is however a cross sector issue for the Civil Service Reform and not specific to FMOH.

The proposed joint regional steering committees were established in very few regions, but none was functional at the time of this review. The Woreda Joint Steering Committees (WJSC) were not established. Similarly, the health management boards and councils were not established. As a result, the technical teams of the RHBs and WorHOs were responsible for health management. One reason for slow progress in establishing RJSC and WJSC is the lack of guidance to these levels following the central Government restructuring exercises that abolished the Social Affairs Sector and provided the education and health sectors with their own CJSC. The programme implementation manual was supposed to fill this gap but it was never revised.

The place of Zonal offices within health management needs to be revisited. In small regions it is obvious that the Zonal offices can be dismantled as soon as the capacity of Woredas is strengthened. However, in big regions such as Oromia and Amhara, and diverse regions such as SNNPR, the Zonal arrangement seems to be a necessary and permanent feature for health management. For these regions, the Zonal offices in such regions need to be strengthened.

Accountability
The FMOH faces a major challenge of ensuring that national priorities are adequately funded and implemented as part of the regional plans. Even though RHBs and WorHOs are part of the health system there is no direct accountability relationship with the FMOH. Instead the Woreda health Offices and Regional Health Bureaus are directly accountable to local governments and not to the Federal Ministry of Health. This loose accountability means that the FMOH has to use indirect methods such as legislation, dialogue, advocacy, monitoring and supportive supervision to sensitize regions and ensure that national priorities are seen as regional priorities. Similarly RHBs have to use the same methods to guide Woredas.

It appears three major routes are available to the FMOH to direct decision-making at the decentralized level. These are: (i) political administration route, (ii) community empowerment route and (iii) health sector route. The political and health sector routes are institutionalized and used commonly (but not always deliberately) while community empowerment route was the least developed and least used. A recent assessment by the Civil Service Reform Programme shows that perception and expectations of health services from the client's perspective is different from that of providers. There exists a gap between what communities expect from the HEW and what the health system is providing.

During the implementation of HSDP II the Federal Minister of Health was a member of the Council of Ministers and could directly influence decisions at this level. These decisions are then transmitted to the Regional Governments for adaptation / adoption and then to Woreda Governments for implementation. During HSDP II, the heads of WorHOs were not members of their local cabinets and could not follow up decisions related to health and directly influence cabinet decisions. This has changed recently thus creating the opportunity for WorHO heads to directly influence decisions at the Cabinets.

The ability of heads of RHBs and WorHOs to influence cabinet decisions will nevertheless depend on the extent to which they themselves are aware of national health sector policies and priorities. It is for this reason that inadequate knowledge of HSDP components and the Programme Implementation Manual, particularly at the Woreda level is a threat to implementing the programme. FMOH however seems to be very much aware of this risk addressing it. The following are elements of good practices in FMOH leadership that have recently been initiated within the health sector, which needs to be consolidated and institutionalized. Suggestions for enhancing them are also provided:

- A participatory process involving the RHBs and other stakeholders was used in the development of the HSDP III; this process is being replicated at the regional and Zonal levels in the development of regional and zonal level strategic plans for the health sector, but needs to be extended to the Woreda level.
- The political leaders at all levels have been mobilized to support the implementation of the health service extension package.
- An annual review process that brings together key stakeholders has been instituted however this should be replicated at all levels; the annual reviews must fit into each other starting from the Woreda to the federal level.
- FMOH has categorized regions into "established" and emerging (weak) regions and joint planning and focused technical support is provided to weak regions without undermining the decentralized arrangements. This practice should be institutionalized in all Regions and Woredas.
- FMOH holds bi-monthly meeting with all regional health bureaus to review progress and challenges in implementation of the national priorities in the local context.

- Coherence has been established between the priorities in HSDP II and the health priorities in SDPRP/PASDEP.

The above good practices have reinforced communication, coordination and collaboration between FMOH and RHBs on one hand and RHBs and WorHOs on the other. However, these practices have not being implemented in all regions and Woredas and therefore, they should be further promoted and strengthened.

HSDP II design and Implementation
HSDP II was ambitious in trying to address most challenges of the Ethiopian health system in three years. In that regards, the document provided the needed stretch for managers to perform. However, it also laid the basis for failure just because it was too ambitious for the available time and financial and human resources. The supplementary documents such as the Accelerated Expansion of Primary Health Care Coverage in Ethiopia and Health Service Extension Package provided a clearer articulation of the HSDP II priorities and how all the other HSDP II components interact to implement HSEP.

HSDP II specifies eight components to be implemented within health institutions at the Woreda and Regional levels. The diversities inherent in the Ethiopian context make policy implementation a major undertaking. For example, the Oromia region covers about a third of surface area of the country and has about 25 million people while the population of Gambella is 250 000. The Afar region is a predominately pastoralist area. Donor interest in the regions also varies considerably as does the human resource capacity. The diversities make it impossible to design and implement programmes in the same way and at the same pace in all regions and Woredas. Yet all regions are important for achieving national targets.

Regions and Woredas have to adapt national programmes to their local contexts. This tends to take time and provides variations in the pace and scale of implementation. Unfortunately, such variations were not explicitly recognized in the design of HSDP neither were the implications on national targets explicitly analyzed and addressed. The Regional and Woreda SPMs have tended to fill this gap in adapting the national strategies and targets to their local context. They are aligned to the national HSDP structure and format. However, it is not clear whether all the Woreda targets in a region add up to the regional targets and whether the regional targets always add up to the national target. Annual planning is well established at all levels of the health system. Annual planning is generally incremental and not related to targets in the SPM or HSDP. The annual plans are generally not costed with the result that the approved budget does not reflect what is required to achieve targets.

A key tension that still remains unresolved is whether HSDP should be structured by programmes (components) or institutional arrangements. The programme specifies what needs to be done but not does not show to what extend programmes are to be implemented in detail and how resources are allocated within the sector. An institutional structure would have specified who will do what and provided a basis for resource allocation. So far the regional and Woreda SPMs have provided the necessary bridge between institutional and programme structure. Yet there remains opportunities for FMOH to align its organizational structure more closely to the component structure or at least map the components more neatly to the existing structure. Heads of Units and Services can then be held directly accountable for performance specific components.

Performance Management
At federal level the JRM and ARM have established institutional processes for joint Government-donor review of the progress. Similar review processes are organized at the regional and Zonal levels to prepare for the annual review meetings. The practice of

reviewing regional performance as part of the joint review is commendable. However, there is no evidence that such a meeting takes place at the Woreda level. The participation in the regional and Zonal levels meetings is limited to health sector officials in the public sector and in some cases political administrators. The private sector and NGOs have recently been invited to participate in the review processes (some regions). However, there is limited opportunity for participation of community members in these processes.

HSDP defined a set of indicators and targets for monitoring performance. The JRMs usually review sector progress using these indicators. However, regions and districts do not always know the indicators and certainly do not use them for monitoring performance.

The JRM is important in providing FMOH and other stakeholders with an independent assessment of sector performance. The review process also promotes accountability (which in itself is a good management practice) and provides the sector with the opportunity to analyse and reflect on performance. The quality of the JRM is among other things dependent on the quality of the preparatory work. So far the quality of preparations for these reviews, particularly at the Woreda and regional levels, has been less than optimal. This is very worrying because of the relatively high financial and human resources cost of organizing the review. The regions do not own the review reports and also ARM decisions heavily dependent on the outcome of the reviews. The way forward is for the FMOH to consider implementing a synchronized internal review process that starts at the Woreda level, and cascades through the regional level and then ends at the national level with the JRM. Such a process will ensure that relevant reports and data are available and key personnel at all levels have updated themselves on their performance before the JRM.

Management Capacity
Decentralization to the Woreda level did not go hand in hand with a structured programme of management capacity building. The capacity building programmes implemented by health sector also emphasised upgrading the clinical skills of health workers but paid little attention given to the management and leadership training for health sector personnel especially for the Woreda Health Office teams. Worse still, many of the officers who undertook post basic training including Masters Degree courses, did not return to the public sector but sought employment elsewhere especially in the NGOs sector. For all these reasons the management capacity building efforts failed to keep up with both the high turn over of senior managers and the pace of decentralization.

Weak management capacity at all levels of the health system stands out as a key constraint to governance in the sector. Even though vacancies exist at all levels, the Woreda level is the worst affected followed by the Zones and regions in the rural and deprived areas. It is therefore urgent for FMOH to develop a capacity building programme for health managers. Secondly, the weak management capacity at the Woreda level continues to justify the existence of Zonal level, at least in the foreseeable future. The strong and open leadership aimed at mobilizing stakeholders in support of the sector priorities (refer section on accountability) is very commendable but needs to be complemented by effective leadership at the Woreda level.

Civil Service Reforms
The civil service reform programme is another ambitious programme, which aims among others to strengthen management in the health sector and contribute to overall improvement in quality and efficiency of health management and service delivery. In that regard CSRP complements other efforts improve quality of care. CSRP has five main components shown in Box 10. The FMOH has integrated this programme into its structure in establishing a civil service reform department under the Minister to be

responsible for this programme. Similarly, RHBs have also appointed focal points for CSRP that report directly to the head of RHBs, indicating a high level of commitment to the programme.

Box 10. Components of Civil Service Reforms
- Top management
- Service Delivery
- Ethics
- Expenditure Management and Control
- Human Resources

Progress in implementing each of the components has been uneven within the sector. A number of analytical studies have been conducted in the sector and pilot studies on business process re-engineering of service delivery have been implemented in a few health facilities with encouraging results. The expenditure management and control component seems fairly advanced with the implementation of the double accounting systems and national procurement law in the health sector. The implementation ethics, human resources and service delivery components have not advanced and no management training programme yet implemented. The lack of awareness of CSRP within the health system, particularly, below the regional level, and business processing re-engineering aspects stand out as obstacles to the effective implementation of the programme.

Partnerships and Participation

HSDP II recognized that the public sector alone cannot deliver the health sector objectives and targets. The document therefore envisages at least five kinds of partnerships.

These are:
- Partnerships within the health sector (Intra-sector partnership).
- Partnership with other sectors (Inter-sector collaboration).
- Partnership with the private sector (Public-Private Partnerships).
- Partnerships with communities (Community Participation).
- Partnerships with donors (Harmonization and Alignment for aid effectiveness).

Intra-sector partnerships

Intra-sector partnership is the most developed of all the partnership arrangements in the sector. It involves (i) vertical interactions between the FMOH, RHBs and WorHOs and between health institutions and health offices at regional and Woreda levels, and (ii) horizontal interaction within the divisions. This partnership arrangement is essential within the decentralized political context and has been instrumental in fostering a good relationship between the levels of the health delivery system. It has also been instrumental in ensuring continuous focus of key players at all levels on priorities of HSDP II, even in a decentralized context. The Woreda and regional health teams in the regions visited also demonstrated team work. However, health facilities in the Woreda level are not always involved in the planning and budgeting.

Intersectoral collaboration

Intersectoral collaboration is known to be essential for addressing the broader determinants of health. There are currently no structured efforts towards promoting ISC exist in the health sector. However there are good examples of ISC. The following are few examples of ISC.
- To address the human resource shortage within the health sector, the health and education sectors are collaborating to increase intake of professionals into higher learning institutions managed by the MOE.
- The training of the health extension workers also stands out as a good example of how the health and education can collaborate to implement an ambitious and important national policy. The training of the health extension worker is the priority of the Ministry of Education while the health sector focuses on deployment of the HEW.

- The construction of community water supply schemes usually follows the heath infrastructure so that the water supply will serve both the health facility and the communities.

Efforts to promote collaboration between the health and education sectors by placing the sectors under the Ministry of Capacity Building created unnecessary bureaucracy and did not work. However, the appointment of heads of WorHOs into the Woreda cabinets has created new opportunities for health to advocate for inter-sector action at all political level The collaboration and information sharing with MOFED should be strengthened.
The newly established Ministry of Women's Affairs is believed to be a potential collaboration with the FMOH, particularly in research, studies on gender, women and health related aspects.

New opportunities for inter-sector collaboration and action can also be created through establishing multi-sector health management teams at the Regional and Woreda levels. Guidelines for inter-sector collaboration and advocacy will enable heads of WorHOs and RHBs play an effective role in this area.

Public-Private Partnerships
The contribution of the private sector in health delivery has been increasing since the change in legislation allowing private practice in the country. The contribution of the private sector in health delivery will grow faster as soon as the outsourcing of health services in the hospitals is operationalized.

In anticipation of the increasing role of the private sector in health, FMOH has assigned the development of Private-Public Partnership to the Service Department. On the ground, there is very little opportunity for private sector participation in the policy dialogue even in the urban regions and Woredas where the private sector is a major provider of health services. Indeed, the private sector (both for-profit and not-for-profit) needs to become involved more actively in the health sector, as their inputs would have been important and enriching during the HSDP II evaluation.

Community Participation
Communities generally participate in the health in a number of ways. They can be owners, users, and partners in health services. Community ownership of health services was not envisaged under HSDP II. However, HSDP II identified communities as partners and users of health services. As users, communities have to be consulted on the design of health services. However in the design of services for pastoralists and the content of the Health Service Extension Package it appears consultation have not been adequate. For example, communities expect the HEW to be a "Doctor" that provides comprehensive service including clinical preventive and promotive care while the design is for preventive and promotive health.

Community participation in service delivery has not been explicitly included in the health Service Extension Package. Nevertheless, HSDP II implicitly recognizes the community to be a major resource and partner in the provision and financing but less so in the management health services. In some Woredas communities have contributed over 50% of the cost of constructing health posts. Communities also participate in the service delivery through the community health agents. Historically, community health agents such as malaria agents and reproductive health agents have been selected by communities to support delivery of specific vertical programme. It is estimated that there are currently over 20 different types of community agents operating with the health system. With the adoption of HEW programme, there is the need for the health sector to rethink the role of community agents in service delivery and how the HEW should work with such agents.

A proposal to establish community health promoters with a target of training one community volunteer for 50 households seems a logical extension to the current standards of health facility to population standards for service delivery. The community health promoter initiative also provides an opportunity for integrating activities of the different types of community based agents. However, this needs to be reviewed to ensure operational feasibility, consensus needs to be built within the sector and then community based service delivery strategies and approaches should be officially adopted as a national approach and incorporated into the Essential Health Service Package.

Box 11. Community Health Promotion Initiative

- Relies on community volunteers to undertake action based health messages in their homes
- Volunteers are selected by their communities
- One health promoter per 50 households
- Attends short and skill based training on key health messages

Communities do not play any role in health management at all levels including health posts. This is however likely to change when health management teams are set up.

Partnerships with donors

A formal structure has been established for GOE/donor dialogue and for which joint process of monitoring and reviews are undertaken. The governance structure including the various procedures for GOE/donor dialogue clearly reflects a joint effort for supporting one overall programme despite that various donor inputs have been for different levels and different components.

The perspective of the joint GOE/donors has been the overall sector development covering all its main elements. The issue of aligning processes and donor support to HSDP II is however an issue where less progress has been made, an issue discussed in some detail in section 4.5.

The Programme Implementation Manual (PIM)

The Programme Implementation Manual (PIM) was envisioned to serve as a management tool and a reference document for all those involved in the HSDP implementation. It provides practical advice and procedures on governance, financial, procurement and construction management, community participation and monitoring & evaluation.

The PIM was to be considered a 'living document', implying that it will be reviewed regularly in response to the changes in the health sector context that had implications for management. A number of changes in the Ethiopian context have necessitated a review of the PIM. These include:

- Decentralization of fiscal and administrative responsibilities to the Woreda level
- Institutional changes and restructuring of the Government bodies such as the restructuring of the common guidance framework for both the health and education sector the necessitated the establishing of specific Central Joint Steering Committee (CJSC) for each of the sectors.
- The procurement law places responsibilities for procurement in the hands of Woreda and Regional health administration depending on thresholds and could lead to uncontrolled procurement of drugs; these challenges need to be addressed by the new PIM.
- Policy reforms such as the Civil Service Reform Process has impacted on the health sector and is reshaping procedures in public finance management, procurement, planning approaches, among others.

- New development in donor coordination. For example, two new structures came into function during HSDP I: the Joint Consultative Forum (JCF) and the Joint Core Coordinating Committee (JCCC)
- Gaps in the current PIM such as absence of planning timetable and guidelines

Field observations, from the 'PIM review team' as well as the regional visits made by the HSDP II evaluation team indicate that that the PIM is not seen as a 'living document' and not known, especially at regional and Woreda levels. Rarely is made reference to its use as a *guiding* tool in the implementation of the health sector programme. It seems that government procedures are well institutionalized and that only for specific procedures and reporting formats the PIM is being consulted. This raises the fundamental question about the added value of the PIM in a decentralized context. It is advised to relate the PIM to the 'Design for a New Health Commodity and Supply System', which recently has been developed.

Following the recommendations of ARM 4, Evaluation HSDP I, JRM 3, ARM 5, a revision of the programme manual has started and is planned to be completed in March 2006. The draft revised document however was not available to the evaluation team.

Conclusions
Fiscal, political and administrative decentralization has created opportunities for local Governments to respond appropriately to the diverse health and development challenges and apply locally relevant solutions to local problems within a national framework. HSDP II (and the related PIM that was not revised) provided the unifying national framework for actions at all levels of the health system. The loose accountability relationship between FMOH, RHB and WorHOs combined with diversities inherent in the country meant that the pace of implementation of national health policies and priorities was uneven.

The health sector can use these three routs interactively to influence local level decisions and actions. Based on our analysis we suggest the following principles for improving governance of the health sector. These are:
- Strengthening partnerships, participation and dialogue with key stakeholders with a focus on results and resources.
- Strengthening managerial capacity at all levels, especially the Woreda level.
- Implementing a managerial process that promotes joint accountability and recognises inter-dependency of all levels and all stakeholders.
- Concluding the ongoing restructurering of the FMOH as soon as possible.

Recommendations
- Institutionalize a synchronised planning and review process involving the Woreda, Regional and Federal levels, being consistent with the national planning timetable. Revise the current JRM format to make it a bottom-up review process, owned by RHB
- FMOH and RHBs to strengthen planning and management capacity at all levels, especially at the Woreda level. In this respect, promote performance based resource allocation and accountability among the actors at all levels.
- FMOH and RHBs to develop planning tools and guidelines for Woredas (as part of the SPM) and launch a major capacity building initiative.
- Enhance performance management by categorising Regions based on capacity and performance in providing technical support to weak and poor performing ones.
- Scale-up the implementation of the Civil Service Reform Programme.
- Ensure that participation in ARMs and other sector management committees has sector sector-wide representation i.e. including communities, private sector and other relevant actors whose activities impinge on health.

4.5. Harmonisation and alignment

This section will discuss GOE/donor relationships under HSDP II with emphasis on processes to improve alignment to GOE policy, strategy and systems, and efforts of harmonisation between donors. It builds on the Governance and partnerships issues raised in section 4.4 above. This section will accordingly focus on two specific issues related to alignment:

- To what extent the donors have aligned their support to the HSDP II programme as defined in the HSDP II programme document.
- To what extent their financial support has been aligned to the financial management system of the GOE.

Several activities related to alignment and harmonisation were reflected in the HSDP II programme; among others:

- Develop mechanisms for better integration of the HSDP II into the budgetary process including aligning the HSDP II to the budget chart of accounts, management of and planning for donor/lender funds.
- Develop detailed financing plans showing firm commitments for external and internal sources of finance.
- Review donor procedures and constraints in the flow of funding with greater harmonisation of procedures.

HSDP II – a sector wide development programme?
A main characteristic of a Sector Development Programme is that it takes all relevant stakeholders into account in the planning process and addresses all required interventions related to an overall sector development objective. Donor engagement in Sector Development Programmes follows a Programme Based Approach, which means co-operation based on co-ordinated support for a nationally owned programme of development. While the process is known as Sector Wide Approach, the outcome is a Sector Development Programme.

Donor support for Sector Development Programmes may include a variety of aid instruments. It can be provided as general un-earmarked contributions to the state budget, specifically earmarked a sector or programme budget, specifically earmarked a programme component or a project within the programme, or provided as complementary technical assistance.

Areas of harmonisation / alignment related to Sector Development Programmes include:

- All donors subscribe to the same partner Government sector policy and strategy, and avoid adding individual policy objectives and conditionalities.
- A formal co-ordination framework in the form of a national sector programme donor group.
- The Government and donors conduct joint reviews, joint processes for monitoring and use common performance monitoring instruments.

The HSDP II programme clearly falls within the above description in as much as it has served as a framework guiding support to the sector for all major donors regardless of aid instrument. A formal structure has been established for dialogue and for which joint process of monitoring and reviews are undertaken.
The governance structure including the various procedures for GOE/donor dialogue reflects a joint effort for supporting one overall programme despite that various donor inputs have been for different levels and different components. The perspective of the joint GOE / donors has been the overall sector development.

As mentioned in other parts of this report, from a national budget process perspective HSDP II covers all public health expenditure in Ethiopia. Despite that the HSDP II budget classification deviates from the budget classification of the GOE, the component structure of the HSDP II has served to guide input under one "sector expenditure programme" for the sector. In a donor mapping study recently initiated (after the close of HSDP II), it seems however that the donor definition of HSDP expenditure, is wider than the GOE definition[41]. Accordingly, it may be required to revisit the issue of having a common understanding of what the HSDP programme embraces and what may be linked but not necessarily falls within the programme.

HSDP II and alignment

HSDP II has served as a framework for aligning donors to the same partner Government sector policy and strategy to avoid adding individual policy objectives and conditionalities. It has established a formal co-ordination framework which has among others also guided joint reviews, joint processes for monitoring and use common performance monitoring instruments. However, donor support to the sector is still characterised by a large number of individual projects requiring individual donor and GOE efforts for monitoring as per individual project agreements.

Project tied interventions guided by multiple procedures targeting different regions and/or inputs to HSDP II contribute to a high overall transaction costs for GOE (FMOH / RHB).

Table 25. Number of donors and projects to the health sector[42]

	1994	1995	1996	1997
Number of projects	76	106	73	61
Number of donors	13	16	15	13

Source: MOFED budget and DCI donor mapping study

As illustrated in table 25 above, despite the decline in number of projects ("on" and "off" budget) from EFY 1995 to EFY 1997, the number of projects as well as donors has remained high throughout the HSDP II which has created substantial demands on GOE capacity for coordinating donor inputs. Equally so has the level of fragmentation remained high with numerous interventions tied to specific components and sub-components of HSDP II as well as to specific regions.

Although data on total transaction cost is not readily available, judging from the FMOH accounts as much as 5% of their overall expenditure (equivalent to the average health sector expenditure of 5 Woredas) appears to be charged to costs related to GOE/donor dialogue, coordination, reviews and reporting (excluding the cost associated to staff time but including costs of program reviews with input of external consultants).

Most of the donor contribution to the HSDP II has been provided as channel 2 or 3 support, in the former partially on-budget, in the latter case off-budget, i.e. the financial contribution has only to a limited extent been aligned with the budget, budget execution and accounting system of GOE.

[41] It also includes emergency food aid inputs which, from a health perspective may be a required intervention, but is not defined as health expenditure in the context of GOE budget classification.
[42] The table most likely underestimates the number of projects and donors each year. There are additional donors identified but since their portfolios are unknown they have not been included in the table. They may however be captured when the mapping study has been completed. The table includes official development assistance routed through international NGOs (INGO) but excludes INGO's own projects as well as ODA through Ethiopian NGOs.

Even more important is the limited alignment of commitments and disbursements to the budget cycle as well as the poor predictability of commitments made when captured by the budget. As mentioned in section 4.3 (Box 7), the volatility of aid in general and for HSDP II in particular may have lead, through offsetting other resources, to an overall decline in health sector expenditure rather than the opposite (measured as share of total public expenditure and on per capita basis).

The HSDP II states an intention of developing "financing plans" which is assumed to mean a schedule of firm commitments and disbursement plans by donors in a format that can be used in the budget process as basis for estimating the overall fiscal framework. This is a core issue in aligning support to the GOE financial management system that has not been respected by a substantial part of the donor community.

Furthermore, disbursement through Federal treasury (direct budget support) should be an overall priority for aligning support to the budget, budget execution and accounting process. It should have featured high on the agenda which would not even require a process of developing a pooling arrangement (which is a harmonisation issue, not necessarily leading to improved alignment). These issues should be addressed if aid is to be more predictable to reduce the adverse impact of the decline in expenditure.

The development of financing plans showing firm commitments for external and internal sources of finance was to serve this purpose. The above mentioned mapping study of past and projected donor support was to serve the same purpose based on the recommendations of many of the harmonisation studies undertaken. None of the above activities was undertaken during HSDP II. The recent mapping study (not yet completed at the time of this evaluation) needs to be revised to enable it to serve as information for fiscal management and input to the budget process since in its current format it does not present information according to GOE fiscal year nor by transfer mechanism ("channels")

Harmonisation through pooling

In terms of harmonisation, the HSDP II document specifically mention the development of pooling mechanism as one activity to be undertaken for improved harmonisation of financial flows. There have been numerous studies of relevance for aligning and harmonisation instruments in Ethiopia, also specifically for the health sector, during the implementation of HSDP II[43] (one study was an outcome of HSDP I). While very little progress has been made in actual alignment of aid instruments and harmonisation of them among donors by applying standard tools like Joint Financing Arrangements / Sector Budget Support (SBS) / basket funding and pooling arrangements (which has been implemented for many years in other countries by the very same donors), some donors initiated changes towards direct budget support. Due to recent political developments, further direct budget support has been suspended.

Simultaneously, the GOE, World Bank and DfID has jointly started a process of developing a new mechanism under the label of Protecting Basic Services for Health (PBS) with four components of which one is an attempt to resource the Woreda health offices through a block grant funding (additional resources to the general block grants) as well as a pooling arrangement for centrally procured pharmaceuticals. This is to address two key constraints also found by this evaluation:

[43] Ref. among others; "Donors shifting to Sector and Budget Support", May 2001. "Strategic Assessment Study for Pooling Support to the Ethiopian HSDP 2 in Human Resource Development and Pharmaceutical Supply", April 2002. *Aid Modalities in Ethiopia – a report to Development Cooperation Ireland*, August 2004. "Bilateral Donor Coordination Experience of the Federal Government of Ethiopia", January 2005. "Harmonisation in the Health Sector in Ethiopia", September 2005, "Effective Aid and Decentralization in Ethiopia", December 2005.

- The supply of essential drugs
- The overall low resource availability at the primary health care level

Although at a preliminary stage of design, the PBS may serve as a way forward ensuring resource flows to the sector in a manner less subject to political conditionalities like direct budget support (DBS), it requires specific financial management arrangements by the GOE if funds are not to be entirely offset by the federal subsidy. A detailed assessment of the PBS proposal with suggestions for improvement is presented in annex 9.

While alignment should be considered the core issue and direct budget support the only means of ensuring full alignment, this mission acknowledges that full alignment is not feasible in the short term due to political circumstances as explained above. Thus Sector Budget Support / pooling may at least serve to unify transfers from donors to the GOE, if the donors do not accept transfer of resources to a central revenue account.
A technical assistance pool (among other for funding of this evaluation) has recently been established. Several of the same donors to the HSDP II in Ethiopia have established Joint Financial Arrangements (JFA) based on the model template developed jointly between several OECD headquarters and applied in countries such as Nepal and Vietnam. Such a JFA appears not to have been considered among the donors in Ethiopia. Even with the numerous studies and proposed processes presented in the course of HSDP II, concrete steps only seem to have surfaced recently in the form of the PBS.

Conclusions related to alignment

- Donor support to the sector is still characterised by a large number of donors and project-tied interventions guided by multiple procedures targeting different regions and/or inputs to HSDP, contributing to high overall transaction costs for FMOH / RHB
- Although data on total transaction cost is not readily available, judging from the FMOH accounts costs related to GOE/donor dialogue, coordination, reviews and reporting remain high.
- Most of the donor contribution to the HSDP II has been provided as channel 2 or 3 support, in the former partially on-budget, in the latter case off-budget. The financial contribution has to a limited extent been aligned with the budget, budget execution and accounting system of the GOE.
- In cases that commitments have been captured by the budgetary process, they have been offset by domestic resources i.e. earmarking of funds have been neutralised and not served as additional resources for the health sector.
- While a recent initiative by some donors to mobilise additional resources for the health sector, Protection of Basis Services (PBS), may serve to address many of the constraints related to aid management and as process for harmonisation, the main issues which needs to be addressed regardless of harmonisation efforts are (i) alignment of donor support to the budget process and (ii) predictability of aid commitments to reduce the current donor practises that reduce the effectiveness of public sector management, its planning and budgeting.

4.6. Previous recommendations

Over the past years the sector development programme was evaluated and discussed regularly. This has resulted in numerous recommendations (evaluation of HSDP I, ARM 2002, 2003, 2004, 2005 and the Joint Review Meetings in 2003 and 2004). At the Annual Review Meeting in 2003 a backlog of more than 300 recommendations was identified. At the same meeting, the need to prioritise the recommendations on the base of urgency and importance to facilitate HSDP II implementation was emphasised. In order to allow

follow-up, recommendations were structured based on their appropriateness and relevance in place and time. They were judged on their limitations – in light of developments and processes that go beyond the health sector - and checked for their validity. This willingness to implement recommendations was illustrated by the translation of the recommendations into concrete activities to be undertaken during the Plan of Action 1995.

The seven reviews and evaluations added up to approximately 300 recommendations, being distributed among the components as follows: HSD/QA (67); support systems (35); cross cutting issue (26); health management, partnerships, PIM (20); governance (15); HMIS (28); financing the sector (7); HCF (7); decentralisation and policy environment (11); others (29). An overview of the most important recommendations made over the HSDP II period has been summarised in annex 7. Due to the variety of subjects, it has not been possible to provide detailed information or comments on the level of achievement on all these recommendations.

A large set of recommendations was formulated around the need to strengthen capacity at all levels and on Human Resources Development. Successes in these areas clearly depend on progress towards the implementation of reforms like the Civil Service Reform Programme and the implementation of an overall HRD and HRM strategy. The same can be said for recommendations regarding harmonisation, pooling of funds and financing the sector in general. A recommendation to secure sufficient resources for health at the Woreda level is difficult to implement, taking into consideration the current decentralisation of resources to the Regions and the Woredas.

The lack of association between the HSDP and the budget process was underscored as a major constraint. A number of recommendations were formulated to ensure that the HSDP follows budget procedures and structures agreed upon with MOFED and BOPED. This issue has been dealt with, partly within the context of the ongoing budget reform process. However, there remain components in the HSDP that are difficult to incorporate in the budget chart of accounts.
Recommendations that deal with the rational and efficient utilisation of recourses at the Woreda level, and the fair allocation of block grant at the Woreda level are difficult to follow up from the perspective of the health sector alone. This is not an area that can be dealt with in isolation but needs to be addressed as part of the ongoing dialogue between donors and the Woreda Council.

Recent exercises on donor mapping reveal the difficulty in tracing donor resources and depict irregularities and unpredictability in resource allocations. The assurance of sufficient resources for health at the Woreda level is a matter of dialogue between FMOH, RHB and Woreda Health Offices within the context of a devoluted system. Solving capacity constraints regarding planning and financial management forms part of the current Civil Service Reform Process.

The recommendations illustrated a somewhat uneven distribution among the components (and subcomponents): disease control for malaria and tuberculosis received relatively less recommendations, same for hygiene and environmental health and pastoralists. Despite this, there has been due attention to the main challenges including the formulation of guidelines, advocacy for IEC, resource availability for specific programmes etc. The only area that lagged behind, with regards to the implementation of recommendations is the area of pastoralist health. In general it can be concluded that the number of recommendations in the areas of management, governance, finance and support systems (recommendations for system strengthening) outnumbered the disease-specific recommendations.

With regard to the feasibility of these recommendations, the following observations can be made:

- Firstly, the set of recommendations is a mix of process-oriented recommendations and result/performance based recommendations. Recommendations differ greatly and vary from 'put gender guidelines to practice' to 'establish audio units in all larger regions'. There are a number of general recommendations on the strengthening of processes, such as 'strengthen management capacity' and 'stimulate dialogue between Federal, Regional and Woreda levels'. Progress towards these processes may be difficult to measure, but foremost, these are processes that need to mature and develop over time.
- Secondly, implementation of recommendations may require a larger time span; therefore some recommendations have a high 'reappearance' rate. During HSDP II the second phase of the decentralisation was implemented. Immediate results are not only to be seen in the years to come. More specific recommendations, such as the development of manuals and guidelines, which are easier to measure and monitor, did show implementation down to the Regional and Woreda levels. The distribution and implementation of these national policies and their adaptation to local contexts and circumstances may also take more time.
- Thirdly, implementation of recommendations does depend on an understanding of recommendations and allowing for internalisation processes and making them context-specific. This highly depends on good communication (between the levels and within the sector) and feed-back processes at all levels and between the levels.

The structure of review meetings and periodic evaluations provides a solid framework for an extensive monitoring process. The path that was chosen does allow for evaluation of progress. However as noted in the introduction, the large number of recommendations may hinder this exercise to some extent. It can be concluded that despite efforts to make recommendations more practical, the decision-making process did not allow recommendations to take off properly. Many of the recommendations were not materialized into concrete actions. Furthermore the recommendations have not sufficiently been shared with Departments and Regions. It will therefore be crucial to develop feed-back mechanisms to the Regions and Woredas, and to establish a two-way dialogue on progress, constraints and challenges encountered during the course of the implementation of HSDP II. Evaluations like HSDP I and II, though important to assess progress are limited in their ability to capture all the dimensions that affect progress in implementation. This process will become more meaningful when the regions become more closely involved in the review process and can provide feedback in an early stage on the status of implementation of their recommendations. Suggestions have been made to complement (or replace parts of the current evaluation) structure, by proposing a more bottom-up approach, which allows for increased participation from the regions. A first step in this regard is the recent proposal of regions to organise Regional ARMs with support and presence from the Federal level. The sharing and documentation of innovative practices between all levels is an area that may be developed more strongly. This approach will reduce the costs of the large scale evaluations and will increase the involvement of stakeholders. It will allow for a more participatory and probably more meaningful review process, as it provides a wider scope and a better focus on overall achievements of health sector development.

5. Overall HSDP II performance

5.1. Policy changes

5.1.1. National Health Policy

The National Health Policy (NHP) was approved by the Council of Ministers in September 1993. The policy has been guiding the design and implementation of HSDP I and II. The policy is based on ten principles:

1. Democratization and decentralization of the health system;
2. Development of the preventive and promotive components of health care;
3. Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources.
4. Promoting and strengthening of inter-sectoral activities.
5. Promotion of attitudes and practices conducive to the strengthening of national self-reliance in health development by mobilizing and maximally utilizing internal and external resources.
6. Assurance of accessibility of health care for all segments of the population.
7. Working closely with neighboring countries, regional and international organizations to share information and strengthen collaboration in all activities contributing to health development, including the control of factors detrimental to health.
8. Development of appropriate capacity, based on assessed needs.
9. Provision of health care for the population on a scheme of payment according to ability, with special assistance mechanisms for those who cannot afford to pay.
10. Promotion of the participation of the private sector and non-governmental organizations in health care.

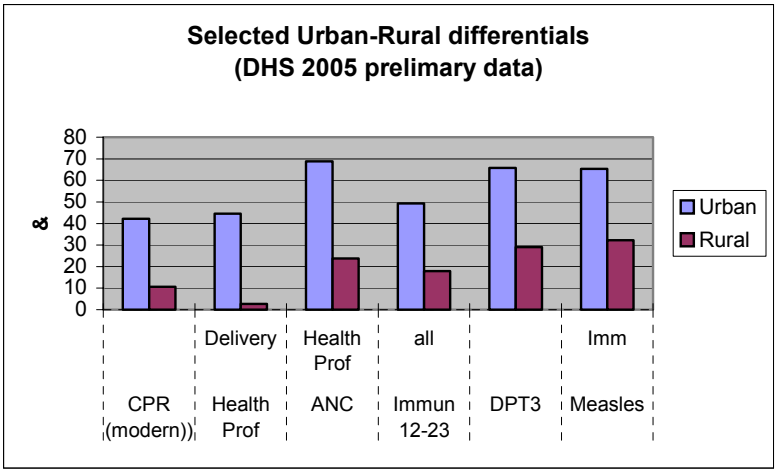
To achieve the objectives outlined in this policy, the health care delivery is still under transformation from a six-tier into a four-tier system. The overall management and supervisory functions of the new system remain with the Federal Ministry of Health (FMOH) and Regional Health Bureaus (RHBs) which roles and responsibilities are defined by the national and regional constitutions. In the current organizational framework of the health sector, the FMOH's responsibilities comprise policy formulation; standard-setting; issuance of licenses and qualification of professionals; establishment of standards for research and training; and coordination of external loans and grants. It appears that many of the policy provisions in the documents should be revisited, given recent developments (such as the 4-tier system modification by the Regions; the new role of the private sector etc.).

5.1.2. Sustainable Development and Poverty Reduction Program

The implementation of the HSDP II was also guided by the Sustainable Development and Poverty Reduction Programme (SDPRP), Ethiopia's first poverty reduction strategy, (2000/01-2003/04 (ETY 1993 – 1996). HSDP (I and II) have been the main instruments for the implementation of SDPRP targets. HSDP II targets reflect the overall health sector targets displayed in the SDPRP and the PASDEP 2005/6 -2009/10 (new name for SDPRP). Implementation of HSDP II should therefore have led to improve health status of the population, increased productivity and hence poverty reduction.

The real question is whether HSDP II (and III) are adequately articulated and implemented to contribute to poverty reduction. Given the urban/rural divide in many health indicators, an explicit shift in emphasis on health strategies for rural areas is required accompanied by appropriate resource allocation (Figure 4). Indicators show enormous discrepancies between urban and rural areas. New developments like the HSEP and AEPHCC hopefully will contribute to reducing urban/rural dichotomy. A positive development is that HSDP III has a clear focus on the MDGs. It will especially be important to critically assess the target set for the reduction of Maternal Mortality Ratio in HSDP III, as the indicator is actually higher than for HSDP II.
It is not articulated how health contributes to poverty reduction. Therefore it is proposed to use a set of indicators which can be used as proxy poverty reduction indicators that capture urban and rural characteristics and equity considerations. The indicators in figure 5 could be used as such proxy indicators.

Fig 5. Selected Urban-Rural differentials



Source: DHS 2005 preliminary results

5.1.3. National Policy on Ethiopian Women

The main objectives of the 1993 National Policy on Ethiopian Women (NPEW) related to health include:

- Facilitating the necessary conditions whereby rural women can have access to basic social services.
- Tackling problems like Harmful Traditional Practices, insufficient access to training and employment; inadequate RH services.
- Research on women's workload and increase of income.

Inadequate nutrition, high fertility rate, limited knowledge of FP, low CPR, low health services coverage are mentioned as major concerns for furthering the development of women. These issues are still extremely relevant and more awareness creation of the NPEW at RHB and Woreda level is necessary, with discussion on the integration with RH services. The recently developed draft RH strategy should also provide more impetus to the implementation of this policy.

5.1.4. National Population Policy

The National Population Policy (1993) focuses on reducing total fertility rate to 4 by the year 2015; increasing the contraceptive prevalence rate to 44 percent by 2015. Strategies relevant for the health sector include reducing maternal, infant and child mortality and morbidity; improvement in the quality and scope of reproductive health service delivery; and expansion of IEC activities and social mobilization.

Integration of the policy with Reproductive Health is starting to develop, but more needs to be done in areas of awareness creation and linkage with the health sector at policy, strategy and operational level. This is discussed in greater detail in Chapter 2.3.5. In this respect HSEP is a good example of integration. .

5.1.5. Health Services Extension Programme

The HSEP is a core HSDP II strategy, fully consistent with the National Health Policy, SDPRP 2000/01-2003/04 and PASDEP 2005/6 -2009/10 and ADLI strategy. Given the critical nature of the HSEP in this context it deserves special attention as the Government's main thrust to make essential care universally accessible to individuals and families in the community with full community participation. With a package of 16 health service components, trained Female Health Extension Workers (2 per Kebele) will target households at the village level, in particular women and children.

To date close to 10,000 HEWs have been trained in all but three Regions. In some ways reminiscent of post- Alma Ata PHC programmes in the early eighties, the difference appears to be a very strong commitment to the HSEP that could be observed at all levels of the health system, accompanied with resource shifts towards this level of preventive and promotive care. In conjunction with the planned Accelerated Expansion of Primary Health Care Coverage this should lead to universal PHC coverage with associated health benefits and poverty reduction. Given the critical nature of this strategy it would be important to systematically monitor and evaluate the HSEP process.

5.1.6. Decentralization

While the management structure of Ethiopian health services previously was centralized the new Health Policy and Strategy represented a significant shift towards decentralizing the health system combined with efforts to strengthen the Regional, Zonal and Woreda health departments.

At the inception of HSDP II, authority and functions were further devolved to Woreda levels with fiscal autonomy and responsibility for primary health care services.
The objectives of this policy is to increase local participation aimed at strengthening ownership in the planning and management of government services; to improve efficiency in resource allocation; and to improve accountability of government and public service to the population.

Under the new system, the Woredas receive block grants and are responsible for setting priorities, delivering services, and determining budget allocations at the local level within the framework of broad national policies. The Woreda council is responsible for the planning and implementation of all Woreda development programs including health services. For example, the Woreda is responsible for construction of health centres (HCs) and health posts (HPs) and for the procurement of drugs and equipment. However, in actual practice, this process is still evolving because Woredas still depend on regional and central levels for a number of health system related services such as the

recruitment and allocation of health personnel and the procurement and distribution of supplies.

While the process of decentralization started at the inception of HSDP II, a number of implementation issues still need to be resolved to fully achieve the assumed benefits of the policy. The issues relates first and foremost to capacity in undertaking the functions assigned as well as being provided adequate financial and human resources.

Another issue, also observed by this evaluation, was (1) the lack of priority accorded to health in some Woredas because of an initial absence of the head of the Woreda Health Offices in budget discussions in the Woreda Councils; and (2) health being disadvantaged in the allocation of Woreda block grants because of (perceived and actual) donor resources for health.

5.1.7. Private sector development

In line with the GOE policy the private sector is to be promoted for a more prominent role in health service delivery and financing (reference section 4.2). The findings from this evaluation seem to suggest that this policy is still in its preparatory stage of implementation.

Certificates for the operation of private hospitals are issued only by the FMOH of the, while certificates for clinics at all levels are issued by the concerned RHBs on the basis of the rules and regulations of the MOH. According to the guidelines of the MOH, the RHBs have the responsibility for supervising, monitoring and evaluating the activities of all clinics. The supervision of the operation of private hospitals is the responsibility of the MOH.

5.1.8. Civil Service Reform Programme

Another major initiative that has an impact on the implementation of health activities is the Civil Service Reform Program (CSRP), which was introduced in ETY 1993. The CSRP is implementing 15 national capacity building programs related to different sectors and sub-sectors as well as broader capacity building initiatives.

There are major linkages between components of this programme to capacity building and human resources development efforts of the HSDP II. Among the key elements of CSRP of relevance to HSDP are:

- Improving performance and service delivery of federal and regional civil service institutions.
- Strengthen management systems of federal and regional civil service institutions.

To develop targeted interventions in various sector institutions, several baseline studies have been conducted for others Federal ministries and a sample of regional bureaus, among others the Federal Ministry of Health.

The survey revealed a relative strong satisfaction with the management and working environment. Both internal staff and “external beneficiaries”, consider FMOH staff as hard working dedicated staff. On the other hand, beyond the low salary leading to high staff turnover, the total workload and shortage of staff were identified as major constraints for performance.

These findings suggest a need to put more attention to capacity of the FMOH for effectively perform their mandate including management of HSDP, support and supervision of lower levels of government (Regions). The same findings also apply to Regional Health Bureaus.
New developments like the HSEP and AEPHCC hopefully will contribute to reducing urban/rural dichotomy. A positive development is that HSDP III has a clear focus on the MDGs.

5.1.9. Health Care Financing Strategy

In order to increase resources available for the health sector and improve financial sustainability the HCF strategy was introduced in GC 1998. During HSDP II this strategy has been partially implemented through establishment of Special Pharmacies. To date, only a very limited number of regions have approved the HCF Proclamation, its guidelines and implementation manuals (sector 4.2). Full implementation of the HCF strategy will need to take place during HSDP III.

5.2. Health Service Performance

5.2.1. Access and equity

Access in the Ethiopian health care system is measured by the potential health service coverage i.e. the number of facilities available in a given area as per the national standard, which rather is availability coverage in its true sense. The potential health service coverage (HC+HS+HP), calculated this way, including public facilities and NGOs increased from 62% in 1994 to 72% in 1997 showing a 10% increase over a three year period. When availability of human resources is measured such as doctors, and nurses a mixed picture is observed. Availability of doctors has been declining over the years from a ratio of 1: 45,175 in 1994 to 1: 67821 at the end of HSDP II period. This indicates that the production of doctors is not commensurate with available demand in the labour market. As the national target for HSDP III indicates a ratio of 1:14,000, some 1984 doctors have to be trained by the end of HSDP III. This is a daunting task given the level of brain drain that has become the hallmark of the health sector especially of doctors in Ethiopia.

On the other hand, there has been an improvement with respect to availability of nurses and midwifes. Given the present trend there might be a possibility to meet the target of HSDP III of 1: 6759 for midwifery. Looking at the level of utilization (per capita measures of hospital admissions or out patient visits for various areas) as a reflection of effective availability of services, outpatient visit pp/yr had been fluctuating over the period of HSDP II. It was about 0.30 in 1994 EFY, dropped to 0.27 in 1995 EFY, rose again to 0.36 in 1996 and dropped once more to 0.30 in 1997 EFY, which is much lower than the target of 0.50 for end of HSDP II. There are also huge regional variations in terms of utilizations as could be seen as by the figures for Tigray and Gambella which stood at 0.79 and 0.55 respectively, and the utilization for Somali as low as 0.08, which is by far below the national target.

Table 26. Outpatient Visits per capita by Region

Region	1995(2002/03)	1996(2003/04)	1997(2004/05)	Trend 1995-1997
Addis	0.44	0.47	0.46	Increased
Harari	0.84	0.00	0.06	Notification problems
Dire Dawa	0.33	0.34	0.39	Increased
Gambella	0.10	0.00	0.55	Increased
Benshangul/Gumuz	0.53	0.69	0.46	Decreased
Tigray	0.74	0.77	0.79	Increased
Oromia	0.26	0.38	0.19	Notification problems
SNNPR	0.16	0.15	0.21	Increased
Amhara	0.24	0.37	0.41	Increased
Afar	0.49	0.75	0.00	No information
Somali	0.09	0.09	0.08	Same level
Total	0.27	0.36	0.30	
Average 1	0.38	0.36	0.33	
Average 2	0.33	0.36	0.42	

Average 1 = obtained from all regions; Average 2 = excluding regions with notification problems (Afar, Harari and Oromiya).

Although the rate of service utilization did not correspond to the steady increase of facilities in HSDP II period, admissions/100p/yr increased from the 1995 level of 0.4 to 1.6 in EFY1997, suggesting a relatively better utilization of inpatient services.

5.2.2. Quality of care

Unfortunately due to time constraints, absence of clear indicators and the low profile of quality of care in HSDP II, the quality of patient care has not been thoroughly reviewed in this evaluation. There were no clear indicators developed to measure the changes in the quality of service as compared to the baseline values. The availability of drugs and medical supplies that strongly affects the quality of care, has been a major issue during HSDP I. There seems to be a fairly good supply of pharmaceuticals during HSDP II, and this was further enhanced due to expansion of revolving drug fund scheme (special pharmacies) in many parts of the country. As a means to improve the standard of care, upgrading of low- and mid-level health workers (health assistants, nurses) through post-basic training was extensively done. However, less vigour has been observed in the area of on-job refresher training, and when available, it is not systematically organized to address all elements of basic care in an integrated manner.

Although there are standard guidelines for the diagnosis and treatment of some important illnesses such as malaria, TB and childhood illnesses, most health facilities lack the guidelines or other references. Supportive supervision and establishment of quality assurance committees within health facilities are among key components of ensuring quality of services. There are efforts in the area of supportive supervision, which need to be strengthened; however, efforts to establish quality assurance committees have not yet yielded tangible results. Besides, there is an urgent need to develop a minimum set of indicators for measuring quality of the services provided.

Ensuring quality of care also requires looking at client/customer perspectives. Operational research in this area is limited; a study done by the World Bank showed varying levels of patient satisfaction between urban and rural areas and between regions, ranging from 45% to 65% overall satisfaction. In view of rapid expansion of health services in the

country, the FMOH and RHBs will need to strengthen operational research as a key element to identify existing gaps and plan towards improving the quality of care.

5.2.3. Efficiency

Conceptually, efficiency has two dimensions; namely technical efficiency and allocative efficiency, referring to the relation between inputs and desired results. While technical efficiency is producing outputs in the right way at minimum cost, allocative efficiency implies producing the right outputs to maximize the achievement of health goals. Given the target of 8.2% government budget allocation to health for 1997 FY, much has been achieved in terms of efficiency gains with a level of 5,7% of the government budget allocated for health. Progress has been achieved in terms of, for instance, PHS coverage, EPI coverage, and attended deliveries. According to a World Bank report, "given the limited available resources, it will be necessary to determine more efficient ways of delivering health services, and [in this regard] the health extension/community outreach program is a welcome complement to the facility based services that have been traditionally offered by the public health system".

5.2.4. Sustainability

Financial sustainability
The improvements in health sector performance, as noted above, are mainly found in vertical programmes which are mainly funded by development partners. There was however minimal or no improvements in the performance of the other programmes that are funded from the government budget, which was extremely low or even declined over the HSDP II period. Such programmes include reproductive health (deliveries in health facilities increased from 10% to 12%), IMCI and OPD utilisation (increased from 0.03 in 1994 to 0.3 in 1997) and many others. It worth noting that performance of such programmes depend on a well functioning health system with well equipped and appropriately staffed hospitals and health centres, which at the moment is not the case but are instead in dire need of support and strengthening. So whereas the performance of vertical programmes which are supported by donors improved, performance of other services and programmes that are supported by government, and hence under-funded, was minimal. This therefore raises the fundamental question of sustainability of the performance of the health sector. In addition donor aid commitments to the health sector (as a proportion of public expenditure on health) fluctuated a lot during HSDP II period. Thus in view of the low predictability of external aid and the fact that such funds are usually not used for health systems strengthening, Government and development partners should start thinking seriously about developing sustainable funding mechanisms for the health sector. Alignment of all the available health sector funds to the government systems (budget process) should be promoted and government should explore other funding mechanisms to internally generate additional resources in order to increase ownership and sustainability of funding for the health sector and hence its performance.

Technical sustainability
Weak technical, including managerial capacity at federal level, but especially in the regions, will greatly undermine the sustainability of the health sector performance. The health sector needs to take bold steps in building capacity especially in planning and management.

5.3. Attainment of Millennium Development Goals

The HSDP II was one of the central tasks implemented during the Sustainable Development Poverty Reduction Programme, which has now been renamed Plan for Accelerated and Sustained Development to End Poverty. HSDP II has provided inputs in the elaboration of the needs assessment for the Millennium Development Goals (MDGs). The design of HSDP III and its implementation are focused on the prevention and control of poverty related diseases with increased intensity aiming at achieving PASDEP and MDG targets. At the current level of performance, witnessed during HSDP II period, the prospects for attainment of MDGs in Ethiopia do not look promising. A lot of effort and resources will be required to accelerate the current slow progress to attain the MDGs.

Although infant and child mortality rates have been declining over the last five years, the rates remain very high. At the current slow rate of decline, attaining the child survival Millennium Development Goals (MDGs) will be quite challenging. Full implementation of the Health Extension Program during HSDP III will be crucial in addressing the major causes of childhood morbidity and mortality.

The prospects of achieving the maternal mortality rate-related MDGs (reduce the MMR by three-quarters by 2015) will however be a particularly daunting challenge, as these are dependent on access and utilization of well staffed and functioning health system. In addition, the fact that the FMOH still does not have an estimate of maternal mortality ratio in the country makes forecasting the prospects even more uncertain.

With regard to prevention and control of poverty related diseases (HIV/AIDS, TB and Malaria), there are well designed interventions, set within the health care system. However, the eventual capacity of the health system to institutionalize the already started initiatives might be put to question, unless the staffing gaps observed during HSDP II are properly addressed. The health extension and accelerated expansion of primary health care facilities will be the backbone for realizing the MDGs. In addition, it is expected that synergies between the MDGs of other sectors, like education, water, sanitation and population, will contribute to the achievements of the health sector MDGs and hence the importance of effective and sustainable intersectoral collaboration. Including prevalence (ao. of MMR) as an indicator in the next census will provide essential information to assess the actual status of the MDG achievements.

The estimated costs of the health sector MDGs are extremely higher than the current per capita health expenditure in the country. In addition, the requirements in terms of external assistance are very high. This raises two issues that need to be addressed in the context of a several fold increase in health sector financing:

- The issue of affordability of the programme given the available resources; and
- The absorption of the absorption capacity of the health system.

ANNEXES

Annex 1. Indicators by Region & Summary 1990-1997

Annex 2. Terms of Reference Evaluation HSDP II

Introduction

Ethiopia has embarked on the sector-wide program called (Health Sector Development Program (HSDP) since 1997. HSDP is based on Health Sector Strategic Framework designed for a period of 20 years with a rolling five-year program period. The 20 years program provided a long-term planning framework with the main goals of (i) building basic infrastructure, (ii) provision of standard health care facilities and supplies and (iii) development and deployment of appropriate skill and mix of professional health workers of various categories mainly for the delivery of effective, efficient and equitable primary health care services at the grass-root levels where it matters most.

Based on the 20 years long-term strategic direction of the health sector development framework, the first five-years plan called HSDP I was launched for implementation in 1997/98 covering five-years from 1997/98-2001/02 (E.F.Y 1990-1994). HSDP I comprised detailed Program Action Plan (PAP) with summaries of the main focus of the all regional and FMOH plans including a Program Implementation Manual (PIM, October 1998). These two documents define the objectives, the strategies, the responsibilities and the various financial and administrative procedures to be adopted by all actors at various levels of the health care system. It also includes a number of performance and output measurement indicators for active monitoring and periodic evaluation of the program.

After the successful completion of HSDP I, a second phase, HSDP II (for three years) covering EFY 1995-1997 was launched in July EFY 1994. The purpose of preparing a three-year HSDP in the second phase was to align the Health Sector Development Plan with the second National socio-economic Development Plan of the Government. The preparation of HSDP II has benefited from the implementation of HSDP I and has been further refined by the inclusion of main recommendations from the findings of HSDP I Mid-Term Review (MTR) including new policies in response to international and national health development initiatives.

In accordance with the provisions of the Program Implementation Manual (PIM), the performance of the Sector Program has been continually reviewed through successive Government-Donors Joint Review Missions (JRMS) and Annual Review Meetings (ARMs). During the last eight years, four Joint Review Missions have reviewed HSDP and the results were presented to Annual Review Meetings.

In addition to the JRMs, extensive Mid Term Review in 2001 and the Final Evaluation of the HSDPI in 2003 were conducted with a multidisciplinary team composed of both international and national consultants, the results of which were presented to the ARM of 2001 and 2004, respectively.

Whilst HSDP II was built on the experience of HSDP I, the last three years of HSDP II were characterized by the introduction of new and important global and national health development initiatives. These include, among others:

- Sustainable Development and Poverty Reduction Program (SDPRP)
- Woreda Decentralization
- The Health Services Extension Program (HSEP)
- Civil Service Reform Programme
- Global Fund to combat AIDS,TB and Malaria (GFTAM)
- President's Emergency Plan for AIDS Relief (PEFAR)
- Accelerated Expansion of primary health care
- The Millennium Development Goals (MDGs)
- Essential Health Care Services Package
- Child Survival Strategy

An innovative government policy initiative aimed at the institutionalisation of the village health care delivery through the Health Services Extension Program (HSEP) was introduced as one of the key focuses of HSDP II. As the flag ship of the fundamental reorientation of the health care delivery system, the core thrust of the HSEP is to bring closer basic and essential health services to the communities and households at Kebele level towards the achievement of health MDGs by the year 2015.

In view of these far reaching circumstances, the final evaluation of HSDP II is expected to shed light on how far the health sector has dented the most pressing health problems of the Ethiopian people, especially in the rural areas.

Based on the recommendation of the HPN-Donor/FMOH Consultative Forum, the Central Joint Steering Committee (CJSC) has approved the conduct of a formal evaluation of HSDP II towards the end of 2005 as per the agreed procedures of the PIM. This Terms of Reference (TOR) for the evaluation of HSDP II have been drafted by the Joint Core Coordinating Committee (JCCC) and approval by the ARM 2005.

The HSDP II evaluation, which will be the joint efforts of the Government and health development partners, will basically focus on the review of E.F.Y 1995 -1997 (2002/03-2004/05) plan implementation, achievements, and identification of constraints and challenges. The review is expected to cover the FMOH and all nine regions and the two city administrative councils. All eight components including the major crosscutting issues will be reviewed in the context of the HSDP II development program.

General scope of the final evaluation of HSDP II

The Final Evaluation of HSDP II is expected to review the progress made, the problems encountered and the experiences gained in the process of implementing the program. The evaluation is expected to provide pertinent information on the overall performance of HSDP II covering all the eight program components as well as cross-cutting issues.

The evaluation will review the findings, conclusions and recommendations of the previous JRMs, ARMs including Mid-Term Review, Final Evaluations of HSDP I and lessons learned from these reviews. The evaluation needs to use WHO synthesis document on health sector relevant reviews and recent studies in the health sector of Ethiopia as reference documents.

The main thrust of this final evaluation is to look into the implication of policy changes such as decentralization to the Woredas, the Civil Services Reform Program, the Health Services

Extension Program to HSDP and to recommend the most appropriate sector-wide approach to the changed landscape. In this context the Evaluation Team is advised to coordinate its work with the team that is working in the revision of the HSDP Program Implementation Manual (PIM). The PIM deals with the management of the HSDP.

The scope of the Final Evaluation is also expected to identify over-arching issues such as strengths, weaknesses, opportunities and main challenges of the HSDP.

Objectives of the HSDP II final evaluation

The general objectives of the final evaluation are to: -

1. Review progress in the implementation of the eight components and cross- cutting issues (Gender, Nutrition and Pastoral Health services);
2. Review the implication of major policy changes (decentralization, CSRP, HSEP etc) and other major initiatives to the implementation of HSDP II;
3. Review the quality of training and field level implementation of HSEP;
4. Asses the working relationships between the centre, regional RHBs and Woreda Health Offices in the implementation of HSDP II;
5. Assess the extent of resource availability and utilization al all levels as per the plan of HSDP II.

Expected outcomes of the HSDP II evaluation

1. Identification of the strengths, weaknesses and main challenges of the implementation of HSDP II in the context of the planning, national and international health initiatives.
2. Identification of best practices and lessons learnt, major implementation problems, and draw a conclusion including recommendations on useful measures that will help to improve the implementation of HSDP III.
3. Identification of the impacts of major policy changes in the HSDP and recommendations to modify the management of the program.

Specific issues to be addressed

4.1. Health Service Delivery and Quality of Care:

The evaluation will review the adequacy of the health delivery system in terms of its structure (organization of health facilities by level) and its process (Staffing, equipment, essential drugs) for the effective, efficient and equitable delivery of preventive care, first contact curative care, and first referral care at various levels of the health care system including HESP. The evaluation under this component also deals with the program implementations of Reproductive Health, Child and Maternal Health, HIV/AIDS, Malaria and Tuberculosis focusing on MDG Goals 4, 5, and 6.

4.2. Health Facility Rehabilitation and Expansion[44]:

The objectives of Health Facility Expansion and Rehabilitation are to increase the physical access to health services through the rehabilitation of the existing facilities and construction of new ones. The evaluation for this component will assess progress and problems in the fulfilment of targets in facility expansion and rehabilitation and its impact on access.

4.3. Human Resource Development

The Human Resource Development strategy is meant to address not only the issue of recruitment, training, deployment and management of an adequate number and mix of motivated staff, but also to address the long-term and comprehensive strategic planning for human resource for health in relation to the likely availability of public health training institutions including the private sector.

The evaluation is expected to assess the implementation of plans in such areas as human resource development, strengthening and expanding training institutions and planning human resource capacity.

4.4. Pharmaceutical supply and Management

The objective of this component is to ensure the regular and adequate supply of effective, safe and affordable essential drugs of high quality in the public, private NGOs and Civil Society based health care providers. The evaluation therefore will assess progress and constraints in the procurement, storage and distribution system and the application of the essential drug list at the different levels.

4.5. Information, Education and Communication

The evaluation will assess performance in the development of I.E.C strategy, institutional capacity at different levels, activities in promoting community support and raising health awareness, etc.

4.6. Strengthening health sector management and management of Information System

The evaluation will assess the existing initiatives in the field of MIS and will make recommendations to harmonize and standardize the development of HMIS across the country and review best practices

4.7. Health Care Financing

The evaluation will assess to what extent HSDP II planned resource requirements have been translated into annual budgets during the last three years. This includes analysis of resource allocation and expenditure, recurrent budgets, non-salary recurrent cost and resources made available for drug supply and the redistribution of these resources among different components of the program. It will also assess the status of the implementation of Health Care Financing Strategy.

4.8. Monitoring and Evaluation

The objectives of this component are (i) to monitor improvement in service delivery, financial management, and (ii) to evaluate the impact, the effectiveness and the cost-effectiveness of the various HSDP components. The evaluation will assess to what extent the M&E system is used at various levels of the health delivery system.

4.9. Cross-cutting Issues

The evaluation will also assess progress/problems in relation to such crosscutting issues as gender, nutrition, pastoralist health service, governance and partnership.

V. Approach and methodology of the HSDP II Evaluation

A. Review of relevant documents:

- HSDP documents (HSDP I and HSDP II)
- Periodic reports to the respective regional councils, FMOH and others
- Annual consolidated reports
- Reports of the previous JRMs and ARMs
- The HSDP I MTR and Final reports
- Demographic Health Surveys (DHS), 2000, 2005
- Relevant policy documents like SDPRP I & II, MDG and MDGs Need Assessment Report, Public Expenditure Review (PER), Civil Service Reform Program (CSRP), Decentralization Policy, Policy on Ethiopian Women, National HIV/AIDS Policy and Strategy, Population Policy and others, HSEP, etc.
- WHO synthesis document of relevant reviews and recent studies on the health sector of Ethiopia.

B. Semi-structured interviews/discussions with:

- Members of the CJSC and RJSC
- FMOH staff of the relevant departments and teams
- HAPCO staff of the relevant departments and teams
- MOFED, FMOE and other relevant federal authorities
- RHB staff, Regional MOFED and other relevant authorities
- Staff of health facilities at regional, Woreda and health posts/health centres levels
- Staff of Woreda Health Offices
- Community members/beneficiary assessment.
- NGOs (CRDA), community and religious leaders at national and regional levels
- Representatives of donor agencies and development partners proactive in the health sector
- Professional Associations (Ethiopian Public Health Association, Ethiopian Economists Associations, Physicians Associations in Private Practice, etc.)
- Institutions of Higher Learning

C. Questionnaires (providing qualitative information), used by the MTR-teams that focus on the eight program components have to be reviewed.

VI. Reporting and Dissemination of Results

The Team Leader will present the final evaluation report to both the HSDP Secretariat and the Joint Core Coordinating Committee (JCCC). Both have the responsibility of overseeing that the evaluation is conducted in accordance with the TOR and it is their joint responsibility in submitting the final report to the CJSC for guidance. Upon the guidance of CJSC, the evaluation report and any other comments as may be deemed necessary by the CJSC will be distributed to all partners (Government agencies, donors, etc.) and will be presented at the ARM 2006 for discussion and final approval.

VII. Team Leader

The Team Leader who shall be a senior specialist in any of the public health fields related to the TOR of this review. He/She will be selected by the JCCC and will:

- Be accountable to both the HSDP Secretariat and JCCC;
- Have overall responsibility for the day-to-day direction of the evaluation
- Finalize, in collaboration with the JCCC, the instruments/questionnaires and introduce these to all team members;
- Assign, in consultation with the JCCC, team members to sub-teams and identify sub-team leaders;
- Identify and discuss any issues/problems with the JCCC;
- Make visit(s) to any of the sub team(s) in the field, if needed;
- Maintain regular contact with team members in the field
- Be responsible for the consolidation and analysis of inputs from team members to produce a coherent report.
- Be responsible for the quality of the report as stipulated by the TOR of the HSDP II evaluation.

VIII. The Team Members

To permit adequate coverage of all the regions, the evaluation team will consist of six sub-teams, each composed of four specialists in the components to be reviewed i.e. a total of 20 to 30 experts. This number excludes the team leader and the members of the JCCC. As much as possible, preference will be given to specialists already familiar with the HSDP in order to maintain continuity. As much as possible, no part-time team membership will be recruited. The composition of each sub-team will have appropriate mix of national, international, GOE and donor personnel and will also reflect adequate gender balance. Based on the specific tasks assigned by the team leader, a team member is expected to successfully complete the following tasks depending on his/her areas of assignment:

- Each team member shares the duties and responsibilities specified for the evaluation;
- Each member of the team is accountable to the team leader;
- Assess the progress in HSDP II implementation by reviewing and analyzing documents, interviewing appropriate institutions and making site visits;
- To collect information required for the evaluation.

- The review teams will report on their findings on each of the components, as specified in this TOR. The report of the final evaluation of HSDP II will thus be composed of chapters for the components, the crosscutting issues and the overall governance and management structure.
- Perform other relevant duties assigned by the team leader.

IX TIME TABLE FOR FINAL EVALUATION OF HSDP II

No	ACTIVITY	TIME SCHEDULE
1	Finalize the TOR	August 30, 2005
2	Have the TOR approved by the CJSC	September 13, 2005
3	Start recruiting expatriate and national consultants	November 15, 2005
4	Prepare budget requirements and discussion by JCCC	November 25,2005
5	Prepare questionnaires	January 9-11,2006
6	Recruit administrative assistant	January 2, 2006
7	Communicate evaluation/review program, TOR and questionnaires to RHBs	January 14, 2006
8	Make evaluation /review documents ready	January 31 – February 3, 2006
9	Finalize logistics preparation	January 31 – February 3, 2006
10	Preparatory meeting with evaluation/review teams	January 31 – February 3, 2006
11	Evaluation/review visits to the regions	February 5 -17, 2006
12	Return of teams to Addis Ababa	February 18-19, 2006
13	Internal Sharing of Information and report writing	February 20-28, 2006
14	Submission of zero draft	March 3, 2006
15	Finalization of the evaluation report	March 6, 2006
16	Presentation of the evaluation report	March 8, 2006
17	Printing and dissemination of the evaluation report	March 18, 2006

Annex 3. Matrix of team members and regional visits

THEMATIC AREAS		I. SERVICE DELIVERY	II. SUPPORT SYSTEMS	III. FINANCE AND MANAGEMENT
TEAM ASSIGNMENTS BY REGION AND COMPONENTS / SPECIAL AREAS OF ATTENTION	**TRAVEL ARRANGE-MENTS AND DATES**	+ SERVICE DELIVERY: HSEP & PROGRAMMES; ESS. PACKAGE & QOC + PHARMACEUTICALS + IEC AND ENV. HEALTH + CROSS CUTTING ISSUES (Emergency Relief, Pastoralists, Gender and Nutrition)	HUMAN RESOURCES DEVELOPMENT, TRAINING AND CAPACITY BUILDING FACILITY CONSTRUCTION & PHC ACCELERATION M&E / HMIS & OPER. RES.	+ HEALTH CARE FINANCING + FINANCING SECTOR: HOW MUCH, WHERE, HOW, SDPRP/PER GBS/DBS + FINANCIAL MANAGEMENT: FLOW, UTILISATION BY WHO, REPORTING. + SECTOR MANAGEMENT; GOVERNANCE & CSRP. + PARTNERSHIP ARRANGEMENT HARMONISATION & MOU / MDG
COMPONENTS		**1 + 4 + 5 + 9**	**2 + 3 + 8**	**6 + 7**
TEAM 1 AFAR ADDIS ABABA	 Car: 04/2-11/2 Car: 13/2-17/2	Ms Hadera Tesfaye* Dr Juan Carlos Bandera/Samson Dessi (Unicef)	Ms Amélia Cumbi (Int) Ato Yeyehirad Kitaw (Centre for Hlth Devt)	Ato Getachew Gebremichael (MOCB) Ato Bogale Gidey (RHB / Harari)
TEAM 2 BENSHENGUL-GUMUZ FMOH	 Plane: 4/2-11/2 Car: 13/2-17/2	Dr Estifanos Biru* Ato Ajeme (RHB / Oromiya) Ms Yetimwork Tekle (HAPCO)	Dr Habtamu Aragawi (WHO) Ato Salehune Kefyalew (FMOH)	Ms Esther Jurgens (Int) **Mr Jens Clausen (Int)** Ato Seid Ahmed (RHB / Gambela)
TEAM 3 GAMBELLA SNNPRS	 Plane: 4/2-11/2 Car: 12/2-18/2	Ato Getahun Gurmesa (DACA) **Dr Jan Willem Harnmeijer (Int)**	**Dr Grace Murindwa (Int)** Dr Solomon Emiyu* (USAID)	Ato Tamiru Terefe (MOFED)
TEAM 4 OROMIA	 Car: 06/2-17/2	Dr Tesfaye Bulto* (USAID) Dr Dereje Muluneh (Unicef)	Dr Sandro Accorsi (Italian Coop)	**Dr Eddie Addai (Int)**
TEAM 5 TIGRAY AMHARA	 Plane: 05/2-11/2 Plane: 12/2-18/2	Ms Patricia Schwerzel (Int)	Ato Reta* (RHB Addis)	Mr. Stefano Rossi (Italian Coop)
TEAM 6 SOMALI HARERI DIRE DAWA	 Plane: 05/2 Car: Plane: 17/2	**Ms Mebrat Woldetensae** Dr Ahmed Hingora (Int) Dr Damen Hailemariam (WHO)	**Ato Leulseged Ageze* (USAID)**	Ato Jemal Idiris (RHB / Afar) Ato Million Admassi* (Italian Coop)

* = Suggested Sub-Team leader, coordinating the visit to the field and the two Regional Reports;
Bold = coordinators / facilitators responsible for coordination of write-up of the three thematic areas.

Annex 4. Work programme of Evaluation Team

DAY	MORNING	AFTERNOON
Monday 30-01-2006	Arrival Team members	14.00 Meeting Preparatory Team Collection of Documentation
Tuesday 31-01-2006	08.30-09.30 Start of the evaluation 09.30-10.30 Introduction team members 10.30-11.00 Tea / Coffee 11.00-12.30 Overview assignment	14.00-15.30 Briefing session for all team members by FMOH 15.30-16.00 Tea / Coffee 16.00-17.30 Continuation
Wednesday 01-02-2006	09.00-10.30 Tasks to be undertaken during assignment 10.30-11.00 Tea / Coffee 11.00-12.30 Briefing session for all team members by all JCCC members.	14.00-15.30 Thematic Groups: Improve/comment questionnaires / Prepare presentations Minister. 15.30-16.00 Tea / Coffee 16.00-18.00 Regional Teams: Prepare programme in the field and tickets / travel.
Thursday 02-02-2006	09.00-10.30 Thematic Groups: Improve /comment questionnaires; Security 10.30-11.00 Tea / Coffee 11.00-12.30 Continuation	14.00-15.30 Thematic Groups: Finalisation of improved questionnaires 15.30-16.00 Tea / Coffee 16.00-18.00 Submission new set of questionnaires.
Friday 03-02	Regional Teams: Prepare work in the regions; collect materials / Tickets-DSA 13.00 Distribution new set of questionnaires (hard copy)	14.00-16.00 Meeting Expatriate Regional Consultants with participants 'Flagship course'. « Experiences with MDG » 20.00 Social evening
Saturday 04-02	*09.00-12.00 Presentation SWAp experiences in Ghana, Uganda, Tanzania, Mozambique and Ethiopia. Senior management FMOH, RHB Heads.*	*Departures of teams. Where possible interviews with RHB Heads present for the 'Flagship Course' will be conducted.*
Sunday, 05-02	*Departure to Regions*	
Monday, 06-02	Start of assignment at RHB level	Visit to BOPED and ROCB Visit Secondary Hospital
Tuesday 07-02	Visit one Woreda Health Office Visit DH or HC	Visit two Kebeles (HP/HEW)
Wednesday 08-02	Visit another WHO (with NGO?) Visit HC / MOFED Office	Visit two Kebeles (HP/HEW)
Thursday 09-02	Visit Training School and/or Vocational Training Centres (HEW)	Prepare debriefing RHB Start writing Regional Report
Friday 10-02	Debriefing to RHB	Continue writing Regional Report
Saturday, 11-02	*Travel to next Region*	
Sunday, 12-02	*Travel to Next Region*	
Monday 13-02	Start of assignment at RHB level	Visit to BOPED and ROCB Visit Secondary Hospital
Tuesday 14-02	Visit one Woreda Health Office Visit DH or HC	Visit two Kebeles (HP/HEW)
Wednesday 15-02	Visit another WHO (with NGO?) Visit HC / MOCB Office	Visit two Kebeles (HP/HEW)
Thursday 16-02	Visit Training School and/or Vocational Training Centres (HEW)	Prepare debriefing RHB Start writing Regional Report
Friday, 17-02	Debriefing to RHB	Continue writing Regional Report

DAY	MORNING	AFTERNOON
Saturday, 18-02	*Travel back to Addis Ababa*	*Travel back to Addis Ababa*
Sunday, 19-02	*Prepare presentation of regional findings*	
Monday 20-02	Prepare presentations of regional findings; some additional interviews	14.00-15.00 Gambella 15.00-15.30 Tea / Coffee 15.30-17.00 Somali / Harari 17.00-18.00 Dire Dawa
Tuesday 21-02	08.30-09.30 Tigray 09.30-10.30 Oromiya 10.30-11.00 Tea / Coffee 11.00-12.00 SNNPR 12.00-13.00 Afar	14.00-15.00 Afar 15.00-16.00 Benishangul Gumuz 16.00-16.30 Tea / Coffee 16.30-17.30 Amhara
Wednesday 22-02	08.30-09.30 Addis Ababa 09.30–11.00 FMOH 11.00-12.30 Summary Findings 12.30-13.00 Tasks ahead	17.00 Each Team to finalise their Regional Reports and submit soft copy of two Regional Reports at PPD
Thursday 23-02	Meeting of the three Thematic Groups: Share findings from the regional visits and discuss overall conclusions / recommendations Divide writing tasks	14.00 Initiate writing out the findings for each of the thematic and component areas (individually).
Friday 24-02	08.00 Initiate writing out the findings for each of the sections	Discuss results and improve on the text (individually)
Saturday *25-02*	*Share first draft of the various sections* *Finalise the various contributions*	*18.00 Submit soft copies of the various sections at GHION*
Sunday, 26-02	*Relax / Editing*	*Relax / Editing*
Monday, 27-02	Editing Zero draft	17.00 TL to finalise Zero draft
Tuesday 28-02	Print zero draft for all team members	15.00 Come to receive Zero draft EACH TO READ FULL ZERO DRAFT
Wednesday 01-03	09.00 Discuss Zero Draft with the whole team page by page	14.00 Continuation of discussion on Zero draft (page by page)
Thursday 02-03	Incorporate all comments into First Draft	Print First Draft for JCCC members
Friday 03-03	Submit First draft to JCCC and all team members	
Saturday, 04-03	*Most team members return home*	
Sunday, 05-03	*Relax*	*Relax*
Monday 06-03	09.00 Discuss First Draft with JCCC (page by page)	14.00 Continuation to discuss First Draft
Tuesday 07-03	Finalise the evaluation document	Finalise the evaluation document
Wednesday 08-03	Chabot to return to Kenya, if possible. Otherwise he will return on Thursday	

Annex 5. List of persons met

Name	Position	Organization
Federal Ministry of Health		
Dr Tedros Adhanom G/yesus	Minister of Health	FMOH
Dr Nejmudin Kedir	Head Department PPD	FMOH
Ato Yohannes Taddese	Head of Department	Human Resources and Training (Formerly Health Services and Training) Department
Dr Betru	Head of Department	Health Services Department
Wro. Hiwot Mengiste	Acting Head of Department	Family Health Department
Dr. Alemayehu Seifu	Head Department	Disease prevention and control department
Ato Girma Hailemichael	Head of Section	Disease Control section, DPPC
Ato Worku G/Selasse	Head of Department	Environmental Health and Hygiene Department MOH
TsehayNegus Bayu	Head, Planning and programming Service	Health Education Centre (HEC)
Wondwossen Demis	General manager	HEEC
Tsigeroman Aberra	Head	Women's affairs department, FMOH
Other Ministries		
Ato Dereje Mekonen	Federal CAD	MOFED
Ato Nigussie Tefera	Macro Policy & Management	MOFED
Ato Gulfe Metaferia	Macro Policy & Management	MOFED
Ato Degu Lakew	Head Accounts	MOFED
Mr. Wilyam Kleiman	Chief Technical Advisor	MOCB / CSRP
Zahara Ali	Department head	Ministry of Women's Affairs
Ato Abraham	Head, planning department	DACA
Shimeles Mazengia	Advisor	HAPCO
Development Partners		
Dr. Gebreselassie Okubagzhi	Senior Health Specialist	World Bank
Dr.Alusegun Babaniyi	WR	WHO
Dr. Teferra Wolde	Principal Advisor	WHO
Dr. Abonesh Haklemariam	Advisor MPS	WHO
Mr. Michel Hjelmaker	Social Sector Expert	European Commission
Ato Eshete Yilma	Health Sector Development	USAID Ethiopia
Ms. Marion Kelly	HIV/AIDS Advisor	DFID Ethiopia
Dr. Theo Pas	First Secretary Health – HIV/AIDS	Embassy of the Kingdom of the Netherlands
Mr. Augusto Cosulich	Project Coordinator	Italian Cooperation
Ms. Rebecka O. Alffram	First Secretary	Embassy of Sweden
Ms. Adeye Befecadu	Programme Officer	Embassy of Sweden
Ms Hiwot Tadesse	Programme Officer	Development Cooperation of Ireland
Ms. Semira Alhadi	Executive Director / Programs	Christian Relief Development Association
Ms. Mimi Church	Consultant MIS	

Annex 6. Documents consulted

Federal Ministry of Health (FMOH) and Government of Ethiopia (GOE)

Date	Title and Reference
FMOH, 1997	Health Sector Development Programme 1997/98 – 2001/02 (HSDP I)
FMOH, Oct. 1998	Program Action Plan for the HSDP I (PAP)
FMOH, Dec 1998	Program Implementation Manual HSDP (PIM)
FMOH, March 2001	Report of the Mid Term Review Mission, 7th Feb – 8th March 2001 (including Regional reports)
FMOH, March 2003	Report on the final evaluation of HSDP I, 30th Jan – 3rd March 2003
FMOH, Febr. 2003	Questionnaire for end evaluation HSDP I, final version
FMOH, March 2003	Report on the Third Joint Review Mission (JRM III)
FMOH, June 2004	Report on the Fourth Joint Review Mission (JRM IV)
FMOH, June 2002	Health Sector Development Programme 2002/03 – 2004/05 (HSDP II)
FMOH, Sept. 2005	Health Sector Development Programme 2005/06 – 2009/10 (HSDP III)
FMOH, Jan 2006	Expectations of the Ethiopian health reform team from the visit to countries with best practice
FMOH, Nov 2004	Accelerated expansion of PHC Coverage in Ethiopia 2005-2009.
FMOH, April 2005	Essential Health Service Package (HP, HC and DH levels)
FMOH, Dec. 2005	Millennium Development Goals (MDGs) needs assessment (synthesis report)
FMOH, Annual	Health and health related indicators; editions of 1994, 1995, 1996 and the preliminary version of 1997.
FMOH, Oct 2005	Code of Conduct to promote harmonisation in the health sector Ethiopia
FDRE, --/2005	Proclamation on Health Service Delivery, Administration and Management
MOFED, May 2003	Ethiopia: Poverty reduction support policy matrix of SDPRP
MOFED, Oct 2005	Ethiopia: Building on progress: a plan for accelerated and sustained development to end poverty (PASDEP)
MOFED, undated	SDPRP II Policy Matrix (Governance, Institutional and Public Fin Mgmt) linked to the MDG targets
FMOH/HPN, April 2005	HPN Donor Group comments on the health sector Matrix of SDPRP and its indicators
DAG, May 2005	DAG note on Policy content SDPRP (final draft) and Guidance Note on DAG/TWG involvement in the review of PASDEP.
FMOH, Jan 2006	Technical Working Group comments on PASDEP; including differences in the finance figures between PASDEP and HSDP III.

Programmes, components and projects

Author & Date	Title and Reference
2. Service Delivery during HSDP II	
2.1. Health Service Delivery and Quality of Care	
2.1.1. Health Services Extension Programme (HSEP)	
FMOH, undated	Basic concepts of the Health Services Extension Programme (HSEP)
FMOH, Sept 2004	Training manuals extension package (14 volumes)
CNHD Eth / Earth Inst. Colombia Uni, August 2005	Training of Health Extension Workers: First Intake Assessment
FMOH, July 2005	Health Service Extension – Implementation guideline
HSEP, Oct 2005	Health Sector Extension Package Support Group. Presentation ARM V.
HSEP, Nov 2005	Advocacy for WASH at the Woreda level
Nov 2004 (1997 EC)	Community health promoters Initiative. A reference Guideline for HW in Amharra Regional State
2.1.2. Communicable Diseases: HIV / AIDS and Tuberculosis and others	
FMOH / DPCD, undated	Accelerated access to HIV/AIDS treatment in Ethiopia. Road map for 2004-2006
FMOH, Oct 2002	AIDS in Ethiopia (disease prevention and control department)
HAPCO / ILO, undated	Questions on managing HIV/AIDS in the workplace
FMOH / DPCD, October 2002	AIDS in Ethiopia
Crystal, Sept 2002	Joint Review of the ENARP Project in Ethiopia 1994-2002
Garbus Lisa, April 2003	HIV/AIDS in Ethiopia published by AIDS Policy research Centre, University of California, San Francisco
HAPCO, March 2003	Joint Mid Term Review (MTR) of the Ethiopian HIV/AIDS National response 2001-2005.
HAPCO, Dec 2003	National Monitoring and Evaluation Framework for the Multi-Sectoral Response to HIV/AIDS in Ethiopia
FMOH / HAPCO, Dec. 2004	Ethiopian strategic plan for intensifying multi-sectoral HIV/AIDS response, 2004-2008
CCM, Feb 2004	Structure and functions of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Country Coordinating Mechanism of Ethiopia.
HAPCO, June 2005	Ethiopian HIV/AIDS National response 2001-2005. Consolidated national report of the terminal evaluation of the IDA support for EMSAP
Aantjes, Sept 2005	HIV/AIDS threatening civil society; a study on the response of nine NGOs in Ethiopia
Crystal, Sept 2001	Evaluation of the five year National TB and Leprosy Control Programme (NTLCP) of FMOH (final report with annexes)
2.1.3. Family Health Services: Reproductive Health, FP, IMCI and EPI and others	
Macro, USA, Nov. 2002	Evaluation of programme options to meet unmet need for family Planning in Ethiopia
WHO, Undated	An assessment of Reproductive Health needs in Ethiopia
FMOH, May 2005	National Reproductive Health Strategy

Author & Date	Title and Reference
FHD / Tesfanesh, Nov 2005	National Reproductive Health Strategy, Presentation ARM
FMOH / FHD, July 2005	National Strategy for Child Survival in Ethiopia
FMOH, May 2005	National Reproductive Health Strategy 2005 – 2015
FMOH / FHD,	Evaluation of Safe Motherhood
2.1.4. Hygiene and Environmental Health	
Nov 2005	Advocacy. Facts for WASH (Woreda level)
2.1.5. Medical Services	
FMOH, April 2005	Essential Health Services Package (EHSP)
2.2. Information, Education and Communication (IEC)	
FMOH / HEC, Oct 2004	National Health Communication Strategy Ethiopia 2005 – 2014
2.3. Cross cutting issues (gender, pastoralists, nutrition, emergency relief, population)	
TGOE, Office of the Prime Minister, April 1993	National Population Policy of Ethiopia
TGOE, Office of the Prime Minister, September 1993	National Policy on Ethiopian Women
FMOH / Women's Affairs Department, December 2002	Gender Mainstreaming Guideline in the Health Sector
FMOH / Women's Affairs Department, November 2002	The role and contribution of Ethiopian women in the provision of traditional health services
FMOH / Women's Affairs Department, September 2003	The impact of poverty on women's health in selected localities of Ethiopia
FMOH, March 1999	Proceedings of pastoralist areas health service design workshop
FMOH, May 2002	Preparation for Study on Pastoral Health Care in Ethiopia including a Visit to Pastoralists in Borana (trip report # 5)
FMOH, March 2003	Health Service Delivery in Pastoral Areas of Ethiopia
3. Support Systems under HSDP II	
3.1. Facility construction and rehabilitation	
FMOH, Nov 2004	Accelerated expansion of PHC Coverage in Ethiopia 2005-2009
3.2. Human Resource Development	
FMOH, April 2002	Strategic Assessment Study for Pooling Support to the Ethiopian HSDP II in Human Resource Development and Pharmaceutical Supply
FMOH/PPD, Sept 2005	Health Human Resource Development framework 2006-2010, including HRD Annex final.
Lindelow M., Semeels P., Lemma T., April 2005	The Performance of Health Workers in Ethiopia Results from Qualitative Research. The World Bank Policy Research Working Paper 3558

Author & Date	Title and Reference
Serneels, Lindelow, Jose Garcia-Montalvo and Abigail Barr (2005)	An Honourable Calling? Findings from the first Wave of a Cohort Study With Final Year Nursing and Medical Students in Ethiopia
3.3. Pharmaceutical (and commodity) supply and management	
FMOH, Nov 1993	National Drug Policy (NDP) of the Transition Government of Ethiopia.
FMOH / PASS, Dec 2004	Report of the 1st Mission of Technical Assistance to PASS for the Pharmaceutical Logistics Systems Study in Ethiopia (R. Verhage)
FMOH, April 2002	Strategic Assessment Study for Pooling Support to the Ethiopian HSDP II in Human Resource Development and Pharmaceutical Supply
Bannenberg, Nov 2005	Design of a health commodity supply system for Ethiopia. Presentation for HPN Group
Bannenberg, Dec 2005	Summary design for a new health commodities supply system
FMOH, Nov 2005	Leadership Meeting: Findings on Health Care Supply System Design. Presentation by Edmealem Ejigu
DACA, January 2004	Standard Treatment Guidelines for Zonal Hospital (first edition)
DACA, January 2004	Drugs Formulary For District Hospital
DACA, May 2004	Essential Drug List for Ethiopia
DACA, Undated	Workshops on Drug policy and Irrational Drug Use
FMOH, Oct 2003	Assessment of the pharmaceutical sector in Ethiopia.
FMOH / UNICEF	Terms of reference to design a new pharmaceutical master plan, Ethiopia
UNICEF, July 2005	Development of master plan for commodity distribution workshop.
FMOH, Dec 2005	Pooling funds of key health commodities; notes of a meeting.
3.4. Health Management Information Systems (HMIS, M&E and Oper. Research))	
RHB SNNPR, June 2002	Health Management Information Systems (HMIS), a referenced guideline for health workers in the SNNPR.
Crystal, March 2003	Assessment of Health Management Information in Ethiopia; Report of an assignment for the Delegation of the EC, as part of the Final Evaluation of HSDP I and the Joint Review Mission of HSDP II (JRM3)
4. Finance and management under HSDP II	
4.1. Health Care Financing Reforms	
FMOH, 1998	Health Care and Financing Strategy.
HCF, Oct 2005	Health Financing Reform, progress and status Presentation ARM V
FMOH, Nov 2005	Implementation Manual for Health Financing Reforms. Final document (revised)
4.2. Financing the sector and 4.3 Financial Management	
MOCB	Summary of the DSA Project. Brief of the Civil Service Reform
February 8,2002.	SNNPR Budget Reform.
FDRE	Federal Negarit Gazetta, 19th December 1996. Proclamation No. 57/1996 Federal Government of Ethiopia Financial Administration Proclamation. Federal Negarit Gazetta, 1st July 1997. Council of Ministers Regulations No. 17/1997 Council of Ministers Financial Regulations. Vol. 1 Budget Summary. Volume 2-3 Budget Details – EFY 1994 - 1997
MOFED	Developing a Formula for Block Grant Allocations to Woredas. Draft for Discussion

Author & Date	Title and Reference
Econ, 2002	ECON Rapport 70/01. Ethiopia; Public Expenditure Review (PER)
EC, May 2001	Diagnosis of Existing Control Capacities in Ethiopia
EC, 2002	Integrated Financial Management System for Govt of Ethiopia – Draft Financing Proposal
EC, 2003	Guidelines for European Commission Support to Sector Programmes
FDRE, Aug 2002	Civil Service Reform Program – Assessment of the Implementations of the Budget Reform in the Southern Nations, Nationalities and Peoples Regional Government, Awassa
FDRE, Sept 2002	The National Capacity Building program. (Paper for Aid Harmonisation Workshop)
GOE / MEDaC	Federal Budget Grant Formula Revisited", MEDaC Journal, Vol. 5, No 3, Addis
GOE / MEDaC, March 2000	The Federal Budget Grant Formula in Ethiopia, Addis Ababa
GOE	Ethiopia: Interim Poverty Reduction Strategy Paper, Addis Ababa, 2000/01 - 2002/03
IMF, March 2002	Ethiopia. Second Review under the three-year arrangement under the Poverty Reduction and Growth Facility, Requests for Augmentation of Access and for Waiver of Performance Criterion, and Second Annual Program, African Department
IMF, July 2002	Aide Memoire Ethiopia – Improving Fiscal reporting under Decentralisation, by CSchiller, MDavies & DLast, Fiscal Affairs Department
IMF, 2005	The Federal Democratic Republic of Ethiopia: Selected Issues and Statistical Appendix, 2005
IMF, 2006	The Federal Democratic Republic of Ethiopia: Poverty Reduction Strategy Paper—2003/04 Annual Progress Report, 2006
Jowett M, May 1998	Economic Analysis of HSDP Ethiopia 1997-2002. Irish Aid.
Lister, Stephen	Implementing Sector Development Programmes in Ethiopia, Oxford,
MOFED / DSA project, April 2002	Brief on the Budget, Accounting and Expenditure Planning Reform by the DSA under the Civil Reform Program
MOFED, Sept 1998	Excellence Management & Accounting Consultants. Financial Reporting System on the Use of Donor Funds. Final Report. (Vol.1)
MOFED, Dec 2001	Decentralisation Support Activity Project. The Regional Grant: An Interim Option for FY 1995. Perran Penrose
MOFED, Feb 2000	Decentralisation Support Activity Project. Budget Reform Design Manual Chart of Accounts, Budget Preparation and Presentation. Version 2.1.
MOFED, Feb 2002	Decentralisation Support Activity Project. Civil Service Reform Program. SNNPR Budget Reform Developing a Formula for Block Grant Allocations to Woredas. Perran Penrose
MOFED, Oct 2001	Decentralisation Support Activity Project. Public Expenditure Program (PEP) Policy Brief. Perran Penrose
MOFED, Jan 2000	Manual 3 FGE Accounting System Vol.1+2+3. Version 1
MOFED, Dec 2003	Ethiopia: Sustainable Development and Poverty Reduction Program (SDPRP), Annual Progress Report (2002/2003)
ODI. Mick Foster.	Integrating aid into budget Management

Author & Date	Title and Reference
OECD / DAC, 2005	Harmonising Donor Practices for Effective Aid Delivery, vol. 2. DAC guidelines and Reference Series. Preliminary Edition
OECD / DAC, 2005	Good Practice Note on Providing Support to Sector Programmes
ODI, 2000	Sector-Wide Approaches to Health Development, Ethiopia Case Study
SPA Secretariat, 2005	Toward Sector Support Alignment SPA- 2004 Sector Program Tracking Report
SPA-6 Budget Support Working Group, 2005	Survey of the Alignment of Budget Support and Balance of Payments Support with National PRS Processes
UNDP, 2003	Development Partners in Ethiopia: A Summary of Development
Vennemann M, 2001	Health, Development and the Sustainability of Health Financing: The case of Ethiopia
WB, Dec 2001	Ethiopia. Focusing Public Expenditures on Poverty Reduction, Vol I
WB, June 2002	Project Appraisal Document for the capacity Building for decentralized Service delivery Project
WB, Nov 2001	Ethiopia Woreda Studies Volume 1 The Main Phase
WB, April 2000	Ethiopia Public Expenditure Review 2000 (main report)
WB, Dec 2001	Ethiopia Focusing Public Expenditures on Poverty Reduction. Vol. 1+2+3
WB, Nov 1999	Ethiopia Public Expenditure Review 1999
WB, August 2000	Ethiopia Public Expenditure Review 2000
WB, Feb 1999	Ethiopia Regionalization Study
WB, June 2001	Ethiopia PER, Block 2, Tracking of Public Expenditures for Poverty Reduction. Draft Working Paper
WB, Sept 1999	Ethiopia Public Expenditure Review (PER)
WB / IMF, 2001	Ethiopia. Tracking Poverty Reduction Spending in HIPC's, Assessment of Budgeting Systems
WB, 2004	Ethiopia: Tracking Poverty-Reducing Spending: Second Assessment And Action Plan (AAP)
WB, 2003	Country Financial Accountability Assessment (CFAA) Vol. 1 – Main Report
WB, 2003	Country Financial Accountability Assessment (CFAA) Vol. 2 – Detailed Report
WB, 2005	Ethiopia - A Country Status Report on Health and Poverty, Volume I: Summary
WB, 2005	Ethiopia - A Country Status Report on Health and Poverty, Volume II: Main Report
WB, 2002	Medium Term Expenditure Frameworks: From Concept to Practice. Preliminary Lessons from Africa
WB, 2004	Module 4: Innovative Practices in Support of PRSPs: A Case Study on Donor Alignment and Harmonization, The Ethiopian Case
WB, 1998	Project Appraisal Document, Health Sector Development Program
4.4. Sector Management / 4.5. Governance of the health sector	
MOCB, April 2002	Civil Service Reform Program. Summary of the DSA Project. Brief of the Civil Service Reform
FMOH, Dec 2005	Recommendations of ARM V, to be included in HSDP III
FMOH, Oct 2005	PIM Revision work plan

Development Partners and external studies

Author & Date	Title and Reference
Pop Housing / Census Com. 2005	Ethiopian Demographic Health Survey; preliminary results (and EDHS impact indicators)
ODI, Jan. 2000	Current issues in Sector-wide approaches to health development; Ethiopia case study, by Brown and Foster
DAC, Undated	Harmonising Donor Practises for effective AID Delivery (DAC Guidelines and Reference series). Volume 2
World Bank, March 2005	Ethiopia, a country status report on health and poverty, Volume I and II. Draft Report No. 28963-ET
World Bank, Undated	Ethiopia, Protection of Basic Health Services (PBS); Annex 4. detailed project description
DfID Ethiopia, December 2004	Ethiopia: support to public sector capacity building programme
NORAD, Jan 2006	Donor practises in providing sector budget support (draft report)
NORAD, Feb 2004	Joint Financing Arrangements (guidelines and issues to address)
Dublin, Oct 2005	Sector Budget Support: draft note from Dublin Workshop of Strategic Partnership for Africa (SPA) working groups (zero draft)
Mokoro Ltd, June 2005	Accountability for and effectiveness of AID in Ethiopia
Dom, March 2005	Effective Aid and Decentralization in Ethiopia (discussion paper)
USAID, Jan 2005	Fragile States Strategy
WHO, August 2005	Synthesis of Table of Contents of recent reviews and studies in health
WHO, August 2005	Synthesis of Recent Reviews and Studies Conducted in the health sector

OTHERS (Regions and Woredas)

Author & Date	Title and Reference
	See Regional reports Volume II

Annex 7. Follow-up on previous recommendations

Overview all recommendations May 2002 till October 2005 (summary)								
MONTH / YEAR	**MAY 2002**	**MARCH 2003**	**MARCH 2003**	**APRIL 2003**	**JUNE 2004**	**SEPT 2004**	**OCT 2005**	**MARCH 2006**
ACTIVITY / comp.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care / HEP								
HEP	- Finalize the HEP by incorporating recommend-dations from ARM 2002. - Prepare curriculum for training of HEW.	- Include Community IMCI within HEP. - Include nutrition and EPI in the HEP.	-Create dialogue between FMOH and stakeholders on HEP. - Evaluate current HEP before expanding nationwide. - Allow flexibility for RHB to adapt HEP to their local situations.	- Develop the full HEP packages (preventive and curative).		- Accelerate HEP implementation. - Harmonise HEP with all programmes and with MDG.	- Provide logistic & financial support for HEP implementation. - Conduct seminars and workshops on HEP. - Mobilise support from Diaspora. - Develop HEP brochures / leaflets. - Establish career structure for HEW. - Implement Accelerated Expansion PHC. - Share experiences with DP and RHB. - Introduce HEP database. - Build capacity in WorHO to supervise HEP.	Most recommendations were translated into concrete activities. Positive developments: resources were mobilised and due attention to the various elements of HEP. Harmonisation of HEP with other components of the programme and MDGs not yet materialised.

Overview all recommendations May 2002 till Oct 2005								
MONTH / YEAR	**MAY 2002**	**MARCH 2003**	**MARCH 2003**	**APRIL 2003**	**JUNE 2004**	**SEPT 2004**	**OCT 2005**	**MARCH 2006**
ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
Disease Control / Malaria	- Develop guidelines on Malaria treatment.	- Expand RBM programme (incl. drugs, spraying and ITN). - Elaborate guidelines to handle funds from ITN sales.						Recommendation were few and broad; yet progress reported (guidelines, expansion of RBM programme).
Disease Control / TB	- Develop guidelines on DOTs/MDT.	- Develop national IEC Plan. - Strengthen supervision and on-the-job training & M&E. - Initiate joint TB/HIV activities.						National guidelines developed. Joint TB/ HIV activities need strengthening.
Disease Control / HIV/AIDS	- Introduce PMTCT guidelines.	- Elaborate Care and Support programmes (incl. Home Based Care). - Avail ART and PMTCT drugs and test kits. - Train staff in STI management. - Monitor VCT Centres on quality of counselling.	- Provide test kits. - Avail PMTCT and ART drugs in selected sites. - Revise decision to charge money for STI. - Strengthen blood safety practises.	- Provide stocks of HIV/AIDS test kits. - Strengthen blood safety practises in all HF and hospitals.			- Establish task force to review HIV/AIDS policy. - Harmonise HSDP III with HIV/AIDS, ART and SPM. - Develop Care and Support strategy. - Expand HIV/AIDS information kits to Woreda. - Develop AIDS	Not all recommendations followed: care and support programmes are lagging behind in terms of quality and quantity. HBC system not yet well developed, coordinated and linked to institutional services.

Overview all recommendations May 2002 till Oct 2005								
MONTH / YEAR	**MAY 2002**	**MARCH 2003**	**MARCH 2003**	**APRIL 2003**	**JUNE 2004**	**SEPT 2004**	**OCT 2005**	**MARCH 2006**
ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
							communication strategy. - Train HW in VCT. - Mainstream AIDS in service delivery and training. - Improve AIDS coordination.	
Family Health / Maternal Health	- Develop guidelines on Community Based RH and FP.	- Advocate for support and commitment from highest levels to enhance RH programs. - Make FP services available in all HF/communities. - Improve Emergency Obstetric Care (EOC) services & referral systems.	- Strengthen supportive supervision and reporting between communities and health facilities.				- Finalise RH Strategy and divulgate it. - Ensure incorporation HR Strategy in POA 99. - Define 'attended deliveries' for Ethiopian context.	Difficult to trace some of the recommendations for example support and commitment to enhance RH programmes: MMR continues to be very high. The call for a comprehensive and robust response remains legitimate.
Family Health / Youth & Child Health		- RHB to initiate youth and adolescent services. - Expand IMCI services (and						A number of important tools and guidelines developed in area of nutrition and analytical studies

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
		TOT for IMCI). - Continue NID and include Vitamin A.						in support of the Child Health programme. Few recommendations were formulated in the area of youth health: much work to be done at policy and operational level.
Hygiene & Environmental Health / WATSAN and waste disposal		- Strengthen support to Environmental Department. - FMOH to support regulation and licensing. - Strengthen Regional PH laboratories.						Though few in number, most recommendations were followed up. Support for this area increased; positive trends in regulation and licensing and the conduct of studies.
Medical Services / Coverage and EHSP	- FMOH to revise four-tier system. - Include Disease Control, Family Health in HEP. - Finalise EHSP.	- Solve urgent problem of 6 – 4 tier system. - Provide support to RHB/ WorHO to calculate catchment areas. - Define EHSP	- Define EHSP in terms of outputs.			- Accelerate expansion of PHC coverage. - Implement EHSP urgently.		HF do not provide the full range of required EH services, thereby compromising the EHSP referral system. The four-tier system not

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
		before standardising staff and other requirements.						matured completely.
Medical Services / Quality		- Improve utilization by addressing QC and the referral system, rather than increasing the number of facilities.						Despite emphasis on need to improve quality of medical services a clear strategy on quality assurance is lacking.
IEC		- Develop National BCC Strategy. - Target production of materials to specific audiences. - Propose coordination for all IEC stakeholders (Technical WG).	- Reorient IEC strategies towards behaviour change of specific target groups.	- Develop cultural specific IEC materials. - Develop IEC guidelines. - Develop BCC Strategy. - Establish Audio Visual units in all larger regions.				Majority of recommendations were followed up. Cultural appropriate materials being developed. Also analysis of trends and problem areas was included in HSDP III.
Cross Cutting/ Gender		- Establish Gender units in RHB and provide staff. - Put gender	- Assess implementation capacity to mainstream gender strategy.	- Mainstream gender planning and implement gender strategy. - Assign gender				Most targets were unattained, including the establishment of gender units in

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
		guidelines into practice. - Build capacity in gender mainstreaming for all staff. - Contract external support where required.	- Appoint full time gender focal points in all RHB.	staff and build capacity. - Include gender disaggregated data in HMIS.				different structures; gender mainstreaming; and raised awareness on gender issues. Little research been done (especially in the regions) and data not fully disaggregated on gender basis.
Cross Cutting/ Pastora-lists		- Involve Pastoralists in the setting up of their health services. - Ensure multi-sector approach to pastoralist health care. - Adapt services to lifestyle of pastoralist societies.	- Involve Pastoralists in the setting up of their health services. - Coordinate with other (NGO) interventions.	- Design and deliver health services together with pastoralist communities. - Encourage and support NGOs.				None of the recommendations followed up. Only recently more attention to the area of Pastoralist Development, including health (HEW and outreach services). A 2003 study provides framework, yet needs to be translated in POA.

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
Cross Cutting/ Nutrition		- Elaborate National Nutrition Policy. - Allocate nutrition focal persons at all levels. - RHB and RC to initiate nutrition activities in HF. - Strengthen nutrition capacity for all HF staff. - Launch IEC breastfeeding campaign. - Coordinate nutrition interventions among all stakeholders.	- Include nutrition BCC intervention in child health services. - Continue Vitamin A distribution.	- Elaborate National Nutrition Policy related to food security. - Distribute Vitamin A, iron and folic acid (iodised salt). - Include therapeutic feeding in all HF in emergency relief areas.				Some progress was made, useful policies and guidelines were developed. Vitamin A distribution high. Lack of adequate data for analysis of nutrition as a crosscutting issue.
Cross Cutting/ Emer-gency			- Develop Emergency preparedness in RHB, WorHO / HF. - Train staff in nutrition rehabilitation.		- Establish Emergency Response Unit within FMOH and provide staff.			Emergency response grew in importance: joint assessments and appeals were conducted. Health and nutrition emergency TF established; though emergency units

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Health Service Delivery and Quality of Care								
								throughout FMOH structure still lacking.
Cross Cutting/ Population								No specific recommendations in previous reviews. In general low awareness of population issues and relevance of benefits of RH. Low capacity for implementation of the Population Policy in conjunction with the health sector.

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Support Services								
Construc-tion/	- Increase budget for preventive maintenance. - Revise Regional construction plans.	- RHB to make comprehensive construction plans (incl. HRD and preventive maintenance)	- RHB to reconsider ambitious construction plans (recurrent cost implications).	- Prioritise rehabilitation over expansion. - Develop maintenance programmes.				Despite progress in facility expansion, there is still a huge gap to be filled. HF are limited in

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Support Services								
	- Expand radio communica-tions.	with other Ministries. - Standardise construction plans. - Strengthen pre-construction capacity.	- Provide electricity, water and waste disposal in HF to be rehabilitated.	- Revise construction guidelines. - Strengthen RHB construction capacity.				number and unevenly distributed across Zones and Woredas. The planned strategy to rehabilitate existing facilities was implemented. Overall there is a need to balance construction and rehabilitation of health facilities.
Human Resource Developm ent	- Refine TOR for long-term HRD study. - Fill vacancies in HR Department. - Train GP and HO in EOC. - Oblige physicians to serve in public hospitals.	- Empower HRD with legal mandate to regulate and decide staff deployment. - Delineate responsibilities of partners: MOE, MOCB, Councils etc. - Involve Associations, NGO and private sector in training and capacity B.	- Set and maintain Federal standards. - Review responsibilities of HW and their training, career and licensing (including HEW). - Conduct HRD strategic study urgently. - Integrate the training of various vertical programmes.	- Review appropriateness of monovalent workers. - Develop comprehensive HRD Plan. - Define cooperation between public – private and NGO sectors in HRD for health. - Support training schools to increase their		- Develop comprehensive HRD Strategy.	- Seek membership in 'training quality assurance agency'. - Finalise HR for health study. - Develop HRD Strategy. - Develop guidelines for staff retention.	A number of recommendations were taken up, however main set back is the huge number of vacancies at all levels of the health system, but most severe at the Woreda level and deprived areas. Human Resource Development Strategy has not

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Support Services								
		- Initiate study for HRD Strategy. - Regulate/license private training institutions. - Redefine confusing responsibilities of HW. - Promote training of polyvalent workers. - Emphasise quality rather than quality and strengthen Continuing Education. - Reinforce incentive schemes for staff in remote areas. - Increase the number of midwives urgently. - Revitalise RTC with resources, define their tasks. - Re-establish national Certificate exams.	- FMOH, RHB and RC to review staff requirements at WorHO level. - Elaborate training plans to upgrade performance of admin and support staff. - Elaborate remedial education for women from disadvantaged areas. - Review the role of the RTC and give them the mandate they require for in-service training.	annual output for midwives and PH Nurses. - Review guidelines on deployment, transfer and training of HW. - Re-establish National Certification Exams for HW from certificate levels upward.				yet been developed. This is a priority, and needs to be based on a sound analysis of the problem.

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Support Services								
Logistics /Pharmaceuticals		- Review NDP and 1987 Essential Drug List (EDL) - Develop Master Plan for Pharmaceutical Sector. - Harmonise procurement and supply logistics, incl. storage and inventory control. - Harmonise donor flow of funds for drug procurement. - Initiate coordinating meetings with stakeholders in Pharmaceutical Sector. - Decide on Indicators for Pharmaceutical Sector.	- Create TWG for Pharmaceutical Sector under HPN Donor group (incl. TOR and POA). - Pool funds for procurement at Regional level. - Initiate mapping of all support to pharmaceutical Sector. - Conduct drugs supply and logistics study. - Initiate study for a viable logistics management system at Regional and Federal levels.	- Create TWG for Pharmaceutical Sector under HPN Donor group (incl. TOR and POA). - Review NDP and EDL. - Develop 3 yr plan for pharmaceutical supply. - Improve logistic supply systems - Strengthen training of pharmaceutical staff, develop upgrading possibilities. - Decide on Indicators for Pharmaceutical Sector.			- Finalise the Pharmaceutical Master Plan and popularise the strategy. - Ensure its incorporation in POA 1999.	EDL was published; new legislation submitted for government approval. NDP not yet revised (is planned). Policies, guidelines and other information materials not sufficiently distributed by RHBs to HFs. High turnover of pharmacy personnel at all levels. Monitoring difficult due to lack of Drug Management Information System. Health Commodity Supply System Master Plan recently conducted.
HMIS /	- Strengthen	- Bring HMIS and	- Adopt HMIS	- Develop HMIS		- Develop	-Revise HMIS.	Despite many

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Support Services								
	national M&E systems and build capacity. - Initiate Operational Research (OR).	M&E under the same component. - Reduce number of indicators and align HMIS with HSDP reporting. - Adopt HMIS from SNNPR and Tigray in other regions. - Develop national HMIS Strategy. - Use TASF to strengthen HMIS. - Link HMIS to SDPRP indicators.	from SNNPR and Tigray in other regions. - Revise HMIS reporting format and define the indicators. - Harmonise indicators HSDP II with Indicators from HSDP I evaluation and from those in the HHRI Booklet. - Link HMIS to SDPRP indicators.	Strategy and revise reporting formats. - Harmonise indicators HSDP II with Indicators from HSDP I. - Strengthen HMIS Units at Federal and Regional levels. - Build capacity for OR. - Align indicators with SDPRP.		National HMIS Strategy. - Revise HMIS formats and indicators.	- Develop HMIS Strategy. - Define indicators and manuals. - Monitor implementation of ARM 2005 recommendations .	recommendations to develop a strategy and some improvements over time (publication of the indicator booklet; commitment and information tools in all Woredas and peripheral facilities), major concerns regarding HMIS refer to gaps in coverage and delays in reporting and use of data for decision making and. HMIS and M&E are linked but remain 2 separate components in HSDP; limited monitoring HSDP indicators.

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Finance and Governance								
HCF Reforms		- Take decision to move from analysis to implementation.	- Prepare vigorously for implementation.	- Define legal framework for HCF implementation. - Expand Special Pharmacies.			- Develop Concept paper on Community Health Insurance. - Develop guidelines on Social Health Insurance. - Conduct third National Health Account Study.	A basic legal framework was developed, and recommendations suggested to embark on the implementation. This process started, however only towards the end of HSDP II (and at a very slow pace).
Financing the Health Sector		- Align budget reforms with HSDP component structure. - Increase recurrent funds at WorHO levels. - Elaborate procedures to receive GFATM funds. - All expenditures should be costed accurately. - Undertake regular donor mapping exercise.	- Establish pooled funds for financing Pharmaceutical Sector, HRD and support to PPD. - Invite KPMG (=LFA) to start assessment PR (=FMOH). - Establish CCM (= CJSC).	- Align HSDP structure with MOFED Chart of Accounts. - BOPED to provide budget ceilings timely. - Undertake Public Expenditure Review (PER) for health sector. - Build capacity in planning and fin management.			- Dialogue with DP to secure adequate resources. - Avoid off-setting of donor resources. - Ensure fair share from block grants.	Some of the recommendations were taken forward (efforts to align HSDP structure with Chart of Account; donor mapping; capacity building through the CSRP). PER has not taken place as yet. The decision to increase funds at WorHo level is a decision to be taken at that

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Finance and Governance								
		- Strengthen PPD technical capacity (TASF).						level. Dialogue between FMOH, RHB, WorHO and DP must remain at the heart of the reform process.
Gover-nance.	- Explore possibilities to harmonise external assistance. - Establish TWG to follow-up implementation of HSDP (under FMOH-HPN Group).	- Review relevance of HSDP I framework, redesign the component structure. - FMOH, RHB and RC should take decisions regarding the Health Sector jointly. - Stimulate inter-regional sharing of experiences. - Improve inter-department communication. - ARM to become forum to discuss performance and to provide information on	- Strengthen bottom-up (district) planning. - Establish Technical Assistance Fund (TASF) for ST and LT (financial) assistance in various areas.	- Review relevance of HSDP I framework, redesign the component structure. - Establish Technical Assistance Fund (TASF) to support HMIS, HRD and Pharmaceuticals. - Strengthen PPD with staff/external assistance. - Enhance coordination with RHB, MOFED and MOCB.	- FMOH to review its own mandate in the light of decentralisation. - Strengthen links with RHB / other Ministries.	- Prepare HSDP III (see steps suggested in JRM4). - Strengthen FMOH-RHB working relations (bi-monthly meetings).	- Encourage signing Code of Conduct. - Evaluate adherence to Code of Conduct. -Link HSDP III with PASDEP and MDG.	Positive development in area of TA (for specific tasks and PPD); working relations with RHB improved (yet, progress to be made in linking up with other ministries – more specifically with MOFED- as well as with NGOs and the private sector). HSDP III was prepared and linked with MDG and PASDEP. Bottom-up planning still needs to be improved, with

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Finance and Governance								
		financial contributions by all stakeholders.						due attention to inclusion of all stakeholders.
Decentralisation and CSRP		- Ownership of Regional HSDP is with RHB and RC. - Advocate membership of staff WorHO in the Woreda Councils.	- Provide guidelines for decentralisation process. - Review staff/manpower requirements. - Build planning and management capacity in WorHO. - RHB role to WorHO is guidance and supervision.	- Provide guidelines for decentralisation process. - Review manpower requirements and fill vacancies. - Accelerate CSRP in health. - Promote transparent allocation of block grants.	- Harmonise Federal and Regional SPM and use it for HSDP III.		- Study resource flows at Woreda level. - Learn lessons from RHB planning and develop formats and guidelines. - Reach consensus on RHB-FMOH planning. - Translate HSDP III in major languages. - Popularise HSDP.	Progress in CSRP, however with different results within the sector. Guidelines for decentralisation process as such, were not developed. Harmonisation of SPM and HSDP remains challenging; as well as developing (planning and management) capacity and increasing the ownership of the HSDP process at the local level. Transparency in allocation of block grants increased (between the levels), now focus

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Finance and Governance								
								on transparency within the levels.
Institutional issues		- Chair of FMOH-HPN Group to be part of the CJSC. - Replace RJSC with technical committee under RC with broad membership from public and private sectors.	- Include staff WorHO in Woreda Council. - Start to prepare HSDP III, linking responsibilities with funding (performance based planning), define time frame and technical unit in PPD, resp. to CJSC (funds from TASF). - Define responsibilities for AIDS response between FMOH, HAPCO, RHB/RC.	- Expand CJSC with NGO and private sector. - Start preparing HSDP III (steps). - Revitalise RJSC and link it with CJSC. - Institute Bi-annual meetings with RHB. - Harmonise HSDP with SDPRP and MDG. - Define responsibilities for AIDS response between FMOH, HAPCO, RHB/RC.		- Harmonise new HSDP III with Regional SPM, new SDPRP (PASDEP), MDG and other global contributions. - Collaborate closely with RHB and private sectors.	- Start TA part of Health Pooled Fund and explore possibilities of expansion. - Conduct bi-monthly meetings with RHB. - Organise donor pledging conference. - Establish governance bodies in regions and districts. - Ensure representation in Councils all levels.	There was increased intra-sectoral interaction and partnerships (vertical and horizontal), however few HF at Woreda level are involved in planning and management. Towards the end of HSDP II attention to proper representation of health in Woreda Council and to harmonisation issues, which creates new opportunities to advocate for health.
NGO and private sector	- Consider the contribution of NGOs in HSDP and HESP			- Include NGO and private sector in planning. - Stimulate Private Provider				NGO and private sector limited included in planning. Contribution of

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ACTIVITY compon.	**ARM 4**	**EVAL HSDP I**	**JRM 3**	**ARM 5**	**JRM 4**	**ARM 6**	**ARM 7**	**COMMENTS**
Finance and Governance								
				Associations. - Improve coordination in FMOH / Regions.				this sector to HSDP is not prominently promoted, and not made visible.
PIM	- Revise and update the PIM.	- FMOH to review PIM together with RHB (priority).	- Raise awareness on HSDP in lower levels: sensitise RHB, BOFED and RC, WorHO and Woreda Council.	- Revise and update the PIM.			- Update the PIM.	PIM has only recently, this month, been updated.

Annex 8. Technical notes on the national HMIS

The process of preparing tables to support the investigations of the HSDP-II evaluation team revealed several limitations in the availability and reliability of required data. Notes on these limitations suggest priority areas for the FMOH HMIS and M&E strengthening process that has just begun. The question of whether these are the most appropriate indicators to monitor and evaluate HSDP-II is not discussed in these notes. The HSDP-II evaluation team elected to supplement, and occasionally substitute, the HSDP-II indicators with others; this suggests that the original indicator list contained gaps and inadequacies. The tables contain blanks for some key HSDP-II indicators to make the point that required data are not available.

The first step in preparing the tables was to find the data required for the indicators specified in Annex 1 of the HSDP-II strategy document. (A complete list of these indicators is included at the end of these notes, along with their data sources). Various sources – HMIS, MOFED, and surveys (primarily WMS and DHS) – provide data for 13 of the 26 indicators. Data for some of the remaining indicators may be available somewhere, but half of the HSDP-II indicators are not readily available from the annual FMOH publication, *Health and Health Related Indicators* (HHRI). HHRI includes a set of tables, with some charts; it includes no systematic interpretation of the data. FMOH/PPD acknowledges this gap and attributes it to severe staff shortage. The main body of this HSDP-II evaluation describes the scarcity of indicator presentation and discussion during FMOH's Annual Review Meeting (ARM). In short, use of indicators to monitor and evaluate HSDP-II appears to be a rare event.

The errors and discrepancies identified during preparation of the HSDP-II tables and review of the indicators with regional teams fall into four main categories: population, service delivery counts, financial data, and harmonization of routine HMIS data and survey results. Significant discrepancies between federal and regional data were noted during discussions with regional teams; most can be attributed to differences in service delivery and administrative / support system records.

A primary source of the discrepancies between regional and federal data can be attributed to the way in which the federal HMIS collects and stores its data. Data are collected from regions on an as needed basis, using manual forms designed for specific purposes, primarily for the ARM and for preparing the annual HHRI, which is published by FMOH/PPD. These data are entered (another potential source of discrepancies) and stored in Excel spreadsheets designed to produce the tables required for the annual meetings and reports. These data do not include estimates of reporting completeness, so it is not possible to know whether observed changes reflect the actual situation or are simply artefacts attributable to reporting completeness.

This process introduces two main limitations in the federal data and its use for monitoring and evaluation. First, when the region updates its data (typically every quarter), FMOH/PPD and regional data become inconsistent. Regional updates are forwarded to vertical programs at the federal level, but these updated data are not forwarded to PPD. Second, manipulation of the data in spreadsheets is more complex and error prone than it would be if the data were stored in a relational database, like Microsoft Access. With a database, algorithms for different presentations, including time trends and comparisons between areas, as well as tables, can be implemented, tested, and applied confidently again and again as data are updated.

A second major source of error lies in the absence of standards, definitions, and documented guidelines for collecting data and estimating populations. Examples of these errors are included below.

PPD has recently begun an HMIS/M&E strengthening process. This process includes steps to address these problems.
1. Establish procedures and the necessary technology for regular, electronic transmission of data from regional databases to an FMOH/PPD database.
2. Establish and document standards for data collection and aggregation and for consistent population estimates.
3. Establish guidelines, manuals, and training for using the information to plan and monitor performance.
4. Establish feedback and supportive supervision to reinforce performance improvement using evidence-based decision making.

Triangulation, or comparing results from several different sources of data, such as routinely collected HMIS data and surveys, is an important technique for arriving at an estimate of the actual situation. Surveys are often considered a more reliable method for estimating coverage than a routine HMIS because they do not suffer from uncertainties regarding target populations; they include services provided in the private sector; and the surveyors presumably have no incentive to influence the results. In a setting like Ethiopia with a weak vital events registration system, surveys are considered the only reliable way to estimate mortality and birth rates.

Survey data have been included in the HSDP-II tables. However, applying a triangulation process and interpreting survey results related to mortality require expert advice. Issues in interpreting DPT3 coverage and Infant, Child, and Under 5 Mortality Rates are illustrated below. A permanent working group of technical experts has not been established to guide these investigations; such a group is needed.

Methodology and observations. Previous HSDP evaluations have collected data during regional interviews, then compiled these data into national tables. This process required that interview teams spend time on data collection rather than investigating the evidence itself. Additionally, the HSDP indicators generated by this process sometimes differed from other national data sources.

This HSDP II evaluation used a different process to prepare the indicator tables. Regional and national data published in HHRI were used to prepare the tables prior to the teams' departure to the field[45]. While this process does not guarantee more accurate data, the data are likely to be more internally consistent, and trends more reliable, assuming reporting completeness remains the same, because inaccuracies originate in systematic errors rather than random errors and artefacts of reporting periodicity. Some specific examples are provided in the observations below:

[45] EDHS 2000 and 2005 data, HIV/AIDS data from DPCD/FMOH, and NHA data supplement the HHRI data as noted in the tables.

1. **Population.**

- Census data. The census data used for population projections are some 10 years old. This fact doubtless introduces discrepancies between actual and projected population, particularly in areas with high levels of migration, such as urban areas. The next census is schedule for 2007 (GC).
- Discrepancies between levels. The population errors reported here do not reflect discrepancies between assumed population at federal, regional, Woreda, and facility levels. These discrepancies are known to exist and should be a topic for systematic investigation.
- Rounding and arithmetic errors. The HHRI booklet reports target populations as both proportion of total population and an absolute value. Because of rounding errors in the published proportions, absolute figures were used to calculate proportions in the tables included in this HSDP report.[46] There are also some discrepancies between absolute figures and proportions that appear to be arithmetic or data entry errors: for example, the proportion of surviving infants in Amhara in 1997 (EC) is listed as 3.2% (Table 3.1), while the proportion calculated from the absolute value (Table 5.1) is 3.5%.
- Inconsistencies between target populations. There are inconsistencies between the target populations for delivery, under ones, and surviving infants. Under ones are the number of children under one year at mid-year; in Ethiopia, this is the target population for the first infant antigen, BCG. Surviving infants is the number of infants that survive the first year of life; this is the target population for later infant antigens like DPT3 and measles. One expects the number of surviving infants to be smaller than the number of under ones, since some of the under ones will die before reaching their first birthdays. However, in 1997 the under one proportion was reported as 3.2% and surviving infants as 3.5%. One explanation for this inconsistency is that surviving infants were first used in 1994, when the under-ones were 3.7% and the surviving infants were 3.5%. In subsequent years the proportion of surviving infants remained constant while the proportion of under-ones decreased. These two contradictory methodologies for population projections appear to have led to the current contradictions in target populations. FMOH/PPD has discussed this problem with CSA and the conclusion was reached that a solution must await the next census. Similar self-contradictory assumptions in Harari in 1992-3 led to the number of under-ones exceeding the number of births.

2. **Service delivery counts.**

- Data completeness. The current HMIS does not record the proportion of expected reports that have been received. Therefore, the accuracy of an indicator at a single point in time cannot be estimated unless there are other sources for the same information. It is usually assumed that trend data are consistent, even though they may not reflect the actual situation, so that rising coverage represents an improvement. Trend data may not be reliable when an indicator is introduced. For example, Bed Occupancy Rate (BOR) was introduced in 1995 (EC); however, the large regions did not report the number of patient days which is required to calculate the indicator. More reported in 1996, and by

[46] Before 1991 (EC) absolute target populations were not included in HHRI. They were included in 1991, however with some inconsistency since the total population remained the same as in 1990. For the years 1989-1991, target populations in this report were calculated from proportions. From 1992 onwards the proportions were calculated from absolute values. Women of reproductive age (WRA) and children under five years have been calculated from proportions since absolute values for these populations have not been consistently included in HHRI.

1997 all regions except Afar reported this statistic. As a result, the calculated BOR increases from 16% to 22% to 50% over those 3 years. This increase is simply an artefact of reporting and does not reflect dramatically improved utilization. Similar considerations affect the number of OP visits per capita before 1994 and 1995 onwards.

- Inconsistent data definitions. Different regions occasionally use different definitions for reporting data. For example, in Oromia, the regional office calculates per capita annual OPD visits based on first visits only, while the national standard includes both first and follow-up visits.
- Arithmetic errors. HHRI contains occasional errors that can be attributed to mistakes in arithmetic. For example, in 1995 Table 10.1 reported the OP per capita visits as 0.54; the data used to calculate this indicator are reported on the same line as the indicator and produce a result of 0.44.

3. Financial data.

HHRI includes financial data on budget and expenditures from MOFED. These data are preliminary and have not been audited. In the months after the close of the Ethiopian fiscal year they apparently change quite frequently. In 1997, for example, only a few months after the 1997 HHRI was compiled, the data available from MOFED are already quite different from those published in the 1997 HHRI. There also appear to be regional inconsistencies in the reporting guidelines used. For example, the Oromia figures include donor and GOE funds, while other regions include GOE funds only.
The following comments and recommendations were made by the financial experts on the evaluation team. They have been incorporated into the HSDP II data tables.

HHRI appears to present budget execution figures ("preliminary actual") as actual expenditure, not actual expenditure as per CAD/MOFED accounts. In presentation of the information a clear distinction should be made between whether consolidated actual, budget execution figures, initial and adjusted budget figures are being used, especially since deviation between them are substantial, in particular in the health sector (compared to e.g. education).

Since aid to Ethiopia is highly volatile/unpredictable (a fact that also explains the variations from one year to another in total and regional health sector expenditure), from a management perspective it would inform the decision makers if time series of budget and expenditure were presented by three sources of funding i.e. domestic including budget support (channel 1), direct disbursements to spending agencies (channel 2) as well as channel 3 (if captured by the budget). While channel 1 would show less fluctuations from one year to another, channel 2 and 3 would show significant variations as well as deviations between budget and actual.

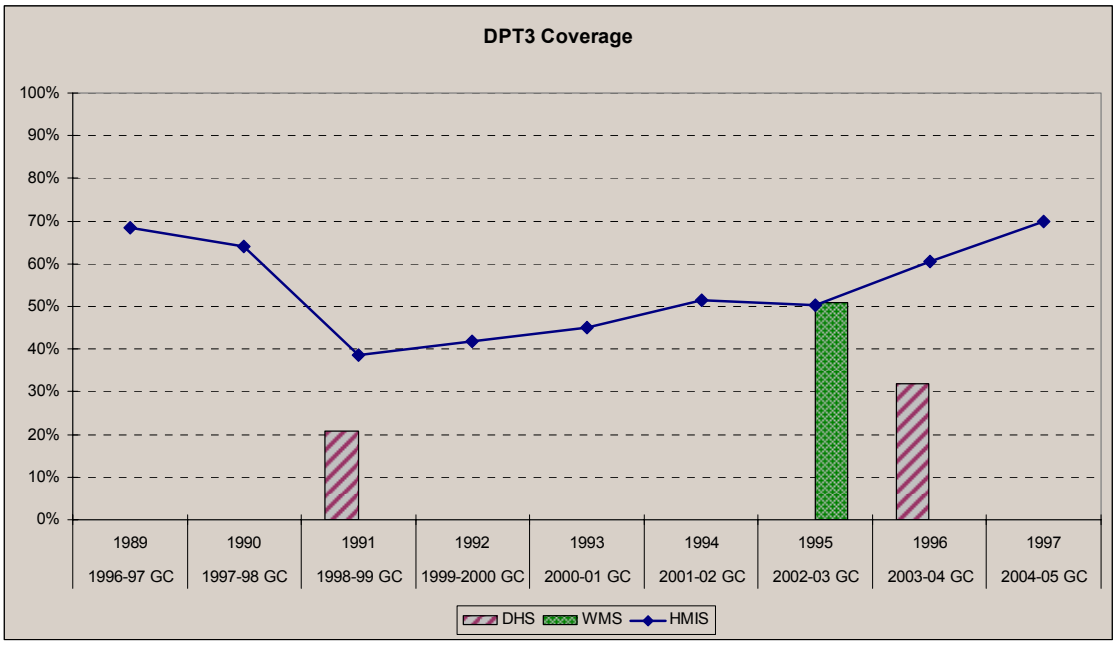
It will serve to distinguish between changes in actual resource flow and changes due to the fact that external resources captured by the budget are not always captured in the state accounts (thus leading to an underestimation of actual total expenditure on health). Consolidated actual figures are only available two years after the close of the fiscal year. Thus budget execution figures (from the Macro Policy and Management Department in MOFED) can be used for the recent years to get full time-series of data including recent years.

Previous years expenditure figures should be updated to include the final consolidated accounts rather than continue to use "preliminary actual" (execution figures).

Another aspect which is becoming increasingly important is the share of expenditures at different levels. MOFED has, in recent years, captured information on expenditure at Woreda level through quarterly flash reports which are consolidated annually. This information is of equal importance to assess the actual resource flowing to the primary health care level.

4. Routine data and survey results.

- Comparison of indicators collected through survey and routine HMIS. Care must taken in making these comparisons.[47] A recent study of data from 45 countries suggests that DPT3 coverage estimated through survey is some 15-20 percentage points lower than that reported through the routine system.[48] This has been the situation in Ethiopia until two recent surveys were conducted. The following graph compares the DPT3 coverage reported by the HMIS, WMS2004 and EDHS 2005. An expert group is needed to interpret these results.

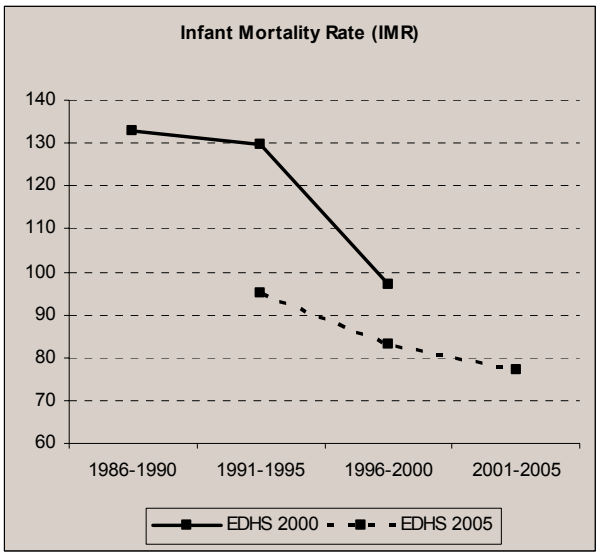


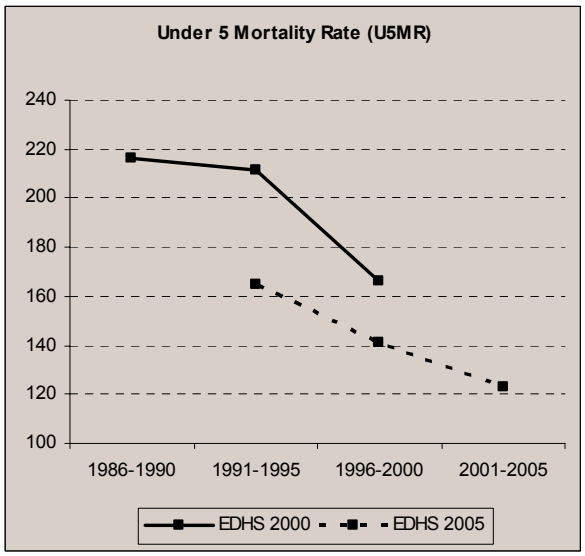
[47] For example, the EDHS reports vaccination coverage against the 12-23 month population for the survey year; therefore it reflects the accomplishment of the previous year. For example, 2005 survey results should be compared with 2004. Regional totals reflect the proportion of 12-23 month olds who have received a vaccine, regardless of whether it was received before their first birthday (as reported by the routine HMIS), or after that birthday. While the proportion receiving the vaccine before their first birthdays is reported at the national level, for the sake of consistency with regional figures, the national figure used in this report is the proportion of 12-23 month olds who have received a vaccine, regardless of age at vaccination. ANC and delivery coverage also reflect the situation in a period before the year of survey. These coverage statistics are based on all pregnancies in the five years before the survey. Therefore a survey conducted in mid-2005 reflects the situation in late 2002-early 2003.

[48] Murray, C. *et al*. Validity of reported vaccination coverage in 45 countries. *Lancet* 2003; 362: 1022–27.

The results are difficult to interpret, with one survey corresponding quite closely with routine data and the other being considerably lower.

- Interpretation of survey results. Similar problems of consistency can be found even within a single survey methodology. The DHS methodology estimates IMR, U5MR and CMR for 5 year intervals in the 15 years preceding the survey. Results from the EDHS 2005 are lower than expected based on the results of EDHS 2000. Again an expert group is needed to interpret these results.





A similar problem appeared in the DHS 2004 results for Madagascar. The results have been defended by expert consultations. A similar consultation is needed to determine whether a similar explanation applies to EDHS 2005.

5. HSDP II indicators.

The following list is taken from the HSDP-II strategy document, Annex 1. The rightmost column contains the indicator's data source identified during the HSDP-II evaluation. The remaining columns are in the original source, being Annex 1 of HSDP II document.

Table XXX. List of Indicators for Monitoring HSDP II at the National Level

Ser. No.	Category	Indicator	Purpose (What it Measures)	Responsible Agency	Data Source
1	Process	Percentage of population living within walking distance (10km) from a health facility [public or private not for profit] getting the national minimum health care package (NMHCP) by Woreda.	Equity and access	RHB, WHO	?
2	Output	Utilization rate of OPD visits per person per year	Utilization	HF, WHO, RHB	HMIS
3	Output	Percentage of deliveries assisted by trained health workers	Utilization	HF, WHO, RHB	HMIS
4	Output	Caesarean section rate i.e. the percentage of deliveries assisted by trained health workers performed through a caesarean section.	Quality of the referral system	HF, WHO, RHB	?
5	Output	Postnatal care coverage	Preventive care for mothers and neonates	HF, WHO, RHB	HMIS

Ser. No.	Category	Indicator	Purpose (What it Measures)	Responsible Agency	Data Source
6	Output	Contraceptive prevalence rate of new and continuing acceptors (CPR)	Utilization	HF, WHO, RHB	survey
7	Output	Percentage of children < I yr. receiving 3 doses of DPT according to schedule by Woreda	Utilization	HF, WHO, RHB	HMIS
8	Output	Percentage of under weight children under five years	Nutritional status	FMOH,RHB	survey
9	Output	TB case notification rate per 100,000 population	Measure of effectiveness of the national Intervention Strategy (Community Based - DOTs)	FMOH, RHB	HMIS
10	Output	Sero - prevalence rate	HIV infection rate	HFs and Testing Centers	ANC surv'l
11	Output	Percentage of Health Facilities with functioning HIV/AIDS Counselling Unit	Measure of effectiveness of counselling units	FMOH,RHB	?
12	Output	Availability of five indicator drugs eg. two antibiotics, Anti-malarial, ORS.	Drug management protocols	FMOH, DACA RHB,WHO	?
13	Output	Proportion of health centres with at least the minimum staffing norms by level	Level of staffing implementation of the health policy	HFs, WHO, RHB	?
14	Process	Malaria case fatality rate	Control measures to reduce malaria mortality	HFs, WHO, RHB	HMIS
15	Output	Number of trainees completing their studies vs. targeted numbers	Effectiveness of training schools	FMOH,RHB	?
16	Process	Percentage of WorHOs that submit to regional level, quarterly HMIS reports on time	Management capacity through completeness and timeliness of reporting system.	WorHOs	?
17	Process	Number of RJSC meetings per year	How closely the S.C. monitors the progress of implementation	RHB	?
18	Output	Per capita expenditure- on health services (should include recurrent and capital expenditure from all sources)	Financial management	RHBs, FMOH	NHA
19	Process	Actual expenditure vs. budget allocation	Absorption capacity at the national level	FMOH ..	MOFED
20	Input	percentage of GOE budget allocated to health sector	Commitment of GOE to health	FMOH	MOFED
21	Input	Total public (GOE and donors) allocation to health per capita	Equity of health resource allocation	FMOH	NHA
22	Process	percentage of un earmarked donor funds to the health sector through FMOH	Trend of the nature of health funding	FMOH	?
23	Process	Percentage of co-operating partners using a single set of procurement procedures	Extent to which partners are prepared to use common procedures	FMOH	?
24	Output	Proportion of surveyed population expressing satisfaction with the health services	Quality of service delivery.	FMOH,RHB	?
25	Output	Number of health workers and support staff that participated in gender related workshops	Level of awareness	FMOH,RHB	?
26	Output	Number of girls enrolled and graduated from heath training schools	gender mix	FMOH,RHB	?

Annex 9. Donor support to HSDP II

Harmonisation and/alignment

Since the inception of HSDP, the issue of joint donor mechanisms (labelled pooling) to harmonise financial transfers to the health sector has featured high on the agenda. Several proposals and studies have been conducted during the 8 years of programme implementation, but only recently has a process started to concretise a joint arrangement. Before offering some comments and providing input to the process based on the findings from this evaluation, this annex presents some key issues that need to be addressed regardless of whatever joint arrangement is agreed to on the donor side. This is based on the overriding principles found in the OECD/DAC harmonisation process and the Paris Declaration;

- The key issue for donors should be *alignment* with partner Government systems. It reduces transaction costs and improves aid efficiency and effectiveness. The more that is achieved by a higher degree of *alignment* with government systems, the less specific *harmonisation* between donor systems is needed.

The above should be the key issue keeping in mind that the terms *alignment* and *harmonisation* are related but not synonymous[49].

- Alignment refers to the extent to which donor policies, procedures and practices are based on and follow partner Government policies, strategies and procedures and use partner Government systems and procedures for management of the support provided.
- Harmonisation refers to the unification of donor procedures and practices between donors in constituting a common approach.

Harmonisation without alignment can in many cases leads to higher transaction costs for partner governments evident from many reviews of donor harmonisation efforts, including setting up sophisticated join donor arrangements.

Key characteristics of aid management problems under HSDP II

The key characteristic of donor support to HSDP is fragmentation of aid instruments, in particular caused by the high number of donors and projects demanding compliance with multiple procedures for financial management and monitoring. It is further complicated because donor support to HSDP does not observe and align with the GOE public financial management system and budget process for inclusion in the budget, actual transfers ensuring inclusion in the state accounts and/or imposing extraordinary accounting and auditing requirements.
The general consequences of this fragmentation are all visible in Ethiopia, particularly in the Health Sector:

- Difficulty in forecasting aid inflows which severely undermines the budget process and the policy level discussion on the allocation of resources.

[49] DAC Guidelines and reference series, *Harmonising Donor Practises for Effective Aid Delivery*, 2003

- Donor support to HSDP is less predictable than other types of government resources.
- Donor support to HSDP is substantially more volatile / unpredictable than domestic resources, and that the relative volatility grows when aid constitutes a high share of total HSDP resources.
- The predictive power of donor's commitments tends to be lower in sector with overall low level of resources, which is the case for the health sector in Ethiopia
- Low predictability of aid has an adverse impact on actual resource allocation to a sector. Stagnation (and for some years even decline) in actual health sector expenditure can be explained by low predictability of donor support.

Efforts to reduce adverse impact of low predictability of aid

In an attempt to neutralise these effects of low predictability of aid in general, MOFED has been "discounting" donor aid projections when preparing its budget with 70% for loans and 30% for "assistance" (grants), based on the average level by which disbursements of loans and grants have fallen short of donor commitments. This is possible when aid flows are small enough to neutralise the effect, however, with external assistance ("on budget and accounts") accounting for more than 70% of total capital expenditure, as in the case of the health sector, sudden inflows not captured by the budget may alter sector spending significantly and contrary to planned expenditure and distort intra-sector resource allocations (like high capital costs without recurrent resources for operations).

Causes of low predictability

The causes for lack of predictability in aid can in general can be divided into two main categories:

- *Technical and administrative matters*.
  This includes poor alignment with national processes and the recipient's budget cycle and disbursement delays due to administrative problems, bureaucratic procedures or time-consuming coordination between donors. Disbursement delays caused by technical and administrative matters are to a large degree unintended, and should, according to best practices, be avoided whenever possible. There is a substantial scope for improvement in this area. The most important way to improve predictability is to make multi-year commitments and information about future disbursements in time for inclusion in budget preparation.

- *Conditionalities*.
  Lack of fulfillment of economic or political governance conditions, or performance related conditions may lead the donor to hold back planned disbursements. Unclear conditions or unclear consequences when conditions are not met aggravate the predictability problem caused by conditionality. The lack of predictability caused by conditionality is, on the other hand, partly deliberate. In the eyes of the donor, conditionality is intended as an incentive to promote policy change and/or programme results and secure that the aid is used as intended.

Impact of fiscal decentralisation for aid management.

Ethiopia's fiscal devolution to Regions and Woredas pose an additional challenge, in particular for sector support though all aid instruments. The main modality for inter-

government fiscal transfers is the channelling of un-earmarked funds, granting discretion for each level to allocate resources according to each level's identified priorities.

The implementation of national policies depends on to what extent national policy targets are translated into expenditure allocations at all levels, also the levels that make allocations at there own discretion i.e. the Regions and Woredas. In Ethiopia, these are the levels that actually deliver the major share of public health services.

Funding of the Regional and Woreda level expenditure in general is made through allocation of Federal subsidy to Regions and Regional subsidy transferred to Woredas as general unconditional grants based on a formula for allocation[50]. These constitute the major resources complementing locally generated revenue and are the major source of funding for health sector expenditure at these levels. How much is allocated to health is partly depending on the overall resource envelope, the priority accorded to health in the respective Regional and Woreda budget process, as well as the extent by which the health sector is receiving direct donor contributions in which case it is usually offset by regular budget allocation (i.e. aid is fully fungible, if it is not delivered at volume higher that the level can offset in the budget). Because aid commitments captured by the budget are not translated into disbursements (due to the off-setting principle), the net effect has been declining rather than increasing the level of resources for health sector.

The Protection Basic Services (PBS)

Although at a preliminary stage of design, a new initiative jointly by FMOH, World Bank and DfID has evolved to develop two arrangements for providing coordinated donor support to increase resources for the health sector. The PBS offers an opportunity for more coordinated and "quick disbursing" operations from a donor perspective. In particular, it may serve to be instrumental in ensuring that resources still flow to the sector since General and Sector Budget support is currently constrained. A review of the initial outline, poses some concerns regarding the additional transaction costs, low predictability and the offset by regular resources for health, i.e. substituting rather than being additional to the budget. However, if the arrangement in its final design, takes the issues raised above into account, it may serve to provide additional resources for health.

The proposal consists of two main components which both address key issues raised in this evaluation;

1. The issue of unpredictable and uncoordinated supply of drugs due to severe bottlenecks in public procurement, supply and distribution. By introducing a *pooling arrangement for pharmaceutical supplies* combined with technical assistance, it is to ensure a more regular supply of essential pharmaceuticals for all levels of the health delivery system. The rationale for a centralised mechanism is related to economy of scale in procuring essential items in bulk which is not considered feasible at Regional and Woreda institutions.

[50] Some Regions are apparently however, applying a mix of transfers both block grant and earmarked subsidies to programmes of which the former is dominating.

2. Prevailing low level and share of total expenditure for health at primary levels. By proposing an additional *block grant mechanism*, parallel to the Regional level block grants, the intention is to ensure additional resources for primary level health services.

"Pharmaceutical supply"

The recent development of a Logistic Master Plan, commissioned by UNICEF proposes a comprehensive reform in the entire GOE system related to supply of pharmaceuticals from procurement to distribution. While the PBS proposal appears not have taken this proposal into account, it may consider incorporating the proposal in the design of the pharmaceutical component in its intention to reform the whole procurement and distribution system.

"Block grant to Regions and Woredas"

A complementary block grant to Regions and Woredas will add transaction costs and most likely will not lead to additional resources for primary levels due to the fact that all external resources are being offset in the Federal and Regional subsidy calculations i.e. the net impact will only be higher transaction costs if specific arrangements are not made to ensure "additionally". The PBS proposal reviewed by the team has not elaborated what specific arrangements will be made in this respect.

Building on the findings from this review, the following suggestions can be made:

- In the PBS document, the World Bank is proposed as a fund manager for a fund to transfer unconditional donor grants. These are to be transferred through the regular financial system of GOE, but with specific budget lines created to monitor flow and use of funds at different levels of the sector.

Whether or not these specific funds will be earmarking health sector expenditure is not known, but that is in our view not the key issue. While the size of the fund is not known (pending which donors would subscribe to the arrangement) it is intended to create an opportunity to increase resources for health at primary levels. To increase the average Woreda expenditure on health will require an estimated 61.3 million USD per year which should be achievable, if some of the fragmented project interventions will be routed through this arrangement.

Based on the evaluation findings, various approaches may be considered to ensure that it will promote higher priority to health sector. An outline is presented below. Regardless of the approach chosen, the arrangement will require some form of agreement or understanding with Regions and Woredas, if the resources made available to the health sector from the "pool" are not be offset in the budget process.

The "consultative approach"

One finding from this review is that there is an opportunity for Federal and Regional levels to put more emphasis on the role of *supporting* and *supervising* lower levels to ensure that health is given adequate priority through the budget process. If successful, additional funding through a donor "block grant pooling arrangement" will not require that resources are earmarked for any specific purpose since the overall volume and share of health sector expenditure will increase as a result of such a consultative and "supervisory" process.

The "performance based approach"

The financial resources could also be linked to the change in overall resource allocation for health at Regional and Woreda levels. It will need to be preceded by a qualified assessment of the minimum required health sector expenditure and take into account requirements of other sectors as well (i.e. that the incentives in this arrangement do not have adverse impact on other key sectors like water supply, agriculture and education).
There are 11 Regions and 585 Woredas. The above described process will require substantial efforts to actually assess performance for each of them. With substantial capacity constraints in planning and budgeting as well as financial monitoring constraints in many Woredas (as evident by substantial delays in preparation of financial statements), the actual information required to assess financial performance will take a very long time.
However, MOFED receives execution reports from Woredas and Regions on a quarterly basis, and although not consolidated accounting figures, they can serve the purpose for monitoring financial performance.

The first year allocation can be provided in accordance with the regular block grant formula applied by the Federal and Regional levels. Subsequent share of funding could be linked to actual incremental increase in health sector expenditure compared to the initial budget.
Monitoring of performance could be based on two sets of indicators:

- One set as trigger for release of additional funding i.e. actual increase in health sector expenditure to be matched by releases from the "additional block grant", if the performance based approach is chosen.
- Another set of indicators to assess actual performance in outputs; i.e. to ensure that the resources are actually generating intended outputs.

The box below offers a proposal for some simple, achievable and verifiable indicators for the latter set of indicators.

Woreda Grants and Performance Monitoring

Under the assumption that Woreda Health Offices will receive annual block grants to improve service delivery, a set of performance indicators is required. The indicators should be preferably be easily available e.g. integrated in current M&E/HMIS systems and reflect to the extent possible the effects of additional funding.

On the basis of the HSDP II evaluation and the existing HMIS, the following indicators would seem appropriate, although some may need modification according to specific Woreda conditions.

A final list needs to be discussed with selection of Woreda Health Offices / RHBs.

1. Planning, Management and Evaluation
    a) Planning: Timely Annual Woreda Health Work Plans according to RHB standards;
    b) Management/monitoring:
        - Average number of integrated supervisory visits per HC, HP and HEW. Sources would be WorHO annual report, verifiable through the supervision reports.
        - % of Health Facilities with equipment inventory lists updated annually (supervision reports), integrated in Annual Report
    c) Evaluation: Timely Annual Woreda Health Reports according to RHB standards reflecting the routine performance indicators, including the selection described below.

2. In terms of the Woreda health programme, performance indicators should include those consistent with the Essential Health Service Package (EHSP) and available through HMIS and Annual Reports:
    a) Per Capita Health Care utilization (OPD based on EHSP formula)
    b) % women that attended Ante Natal Care (ANC) services
    c) % under < 1 yr immunized for measles
    d) % women that had their delivery done by skilled staff
    e) % Health Facilities following IMCI protocol
    f) % Population coverage with latrines

    Where appropriate:
    g) Number PMTCT and VCT clients

Note that this selection includes indicators from most EHSP components.

		HSDP II					
	baseline 1994* 2001-02 GC	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	67,220,000	69,127,021	71,066,000	73,043,510			
	2,682,445	2,758,609	2,836,054	2,915,033			
	2,682,445	2,758,609	2,836,054	2,915,033			
	11,632,130	12,118,482	11,933,136	12,077,375			
	2,545,926	2,477,274	2,408,625	2,431,822			
	2,381,309	2,451,430	2,517,670	2,587,784			
	15,992,002	16,944,030	16,972,977	17,526,883			
Health Status	**113**			**77**		**45**	
	188			**123**		**85**	**67**
	871				**450**	**600**	**450**
	5.9			5.4		4	
	47%			38%			
Service Delivery Outputs: Family Health	11%	10%	17%	26%			
	25%	28%	32%	43%			
	17%						
	34%	27%	41%	42%	45%	80%	
	27%			28%			
	10%	**9%**	**9%**	**12%**	**25%**	**32%**	
	6%			**6%**			
	7%	7%	16%	13%			
	2%						
	14%	**17%**	**19%**	**21%**	**24%**	**45%**	**44%**
	9%			**14%**			
	51%	**50%**	**61%**	**70%**	**70%**	**80%**	
	21%			**32%**			
	42%	**43%**	**52%**	**61%**			
	27%			**35%**			
	30%	32%	37%	44%		54%	
	14%			20%			
Service Delivery Outputs: Disease Prevention and Control		**44%**	**45%**	**34%**		**50%**	
	66%	**66%**	**63%**	**65%**		**85%**	
	81%	82%	82%	81%			
		72%	63%	85%	75%	72%	
			8.3%		**<7%**	**<4.4%**	
	4.1%	4.2%	4.4%	4.6%			
	1.74%	1.79%	1.82%	1.83%			
	-	4%	-	6%	15%	2%	
Hygiene and Env. Health				**36%**	**42%**		
				29%	**35%**	**80%**	
Access to Public Medical Services	62%	61%	64%	72%		100%	
	1:163,155	1:153,275	1:136,929	1:121,739	!:135,000		
	0.27	**0.27**	**0.36**	**0.30**	**0.50**	**0.66**	
	-	0.4	0.1	1.6			
	1:45,175	**1:53,012**	**1:59,971**	**1:67,821**		**1:14,000**	
	1:6,956	1:7,145	1:6,716	1:6,082			
	1:17,233	1:13,512	1:14,928	1:13,682		1:6,759	
				1:26,687		1:2,500	
Quality and Management							
					80%	100%	
						80%	
Efficiency and Finance	#N/A	1,441,174,930	1,170,340,000	1,643,110,000			
					8.20%	'Double'	
	#N/A	20.8	16.5	22.5			
	#N/A	**12.4**	**9.5**	**19.1**	**18.0**	**9.6**	
	$5.60				$6.00	$9.60	
	#N/A	59%	58%	85%			
		16%	22%	50%			
					20%	100%	
Demographic	2.87%	2.84%	2.80%	2.78%			

Unless otherwis*alth and Health Related Indicators* . MDG and SDPRP indicators in bold type

Financial data:

The budget a om CAD/MOFED

The Federal onsolidated accounts from CAD/MOFED

The Regional

Regional expres (preliminary actuals) from the flash reports from Woredas/regions, collected and consolidated by MOFED

*1994 baseline: water and sanitation from World Development Report 1996

Total annual H, HCF Secretariat. 2004. *Ethiopia's Second National Health Account* , Addis Ababa.

**1997 DHS (*Eth* Hygiene and Env. Health Indicators from *Welfare Monitoring Survey* (WMS) 2004

***HIV data fron

HIV Seropresitmated from EPP model; incidence estimated from SPECTRUM model.

****growth rate *alth Related Indicators*

Trend analysis 1989 - 1997

Number of woredas: 585

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	1990 1997-98 GC	1991 1998-99 GC	1992 1999-2000 GC	1993 2000-01 GC	1994 2001-02 GC	Target 1994 (Nat'l)	1995 2002-03 GC	1996 2003-04 GC	1997** 2004-05 GC	Target 1997 (Nat'l)	Target HSDP III (Nat'l)	MDG Target (Nat'l)
Demographic statistics	Total Population	57,272,564	61,672,000	61,672,000	63,494,707	65,344,000	67,220,000		69,127,021	71,066,000	73,043,510			
	Expected pregnancies	2,319,539	2,497,716	2,725,490	2,806,308	2,607,471	2,682,445		2,758,609	2,836,054	2,915,033			
	Expected deliveries	2,319,539	2,497,716	2,725,490	2,806,308	2,607,471	2,682,445		2,758,609	2,836,054	2,915,033			
	Children under-five years	8,432,500	9,090,091	10,834,551	11,330,231	11,516,595	11,632,130		12,118,482	11,933,136	12,077,375			
	Children under-one year	1,495,219	1,612,535	2,509,257	2,683,225	2,612,297	2,545,926		2,477,274	2,408,625	2,431,822			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						2,381,309		2,451,430	2,517,670	2,587,784			
	Women of Reproductive Age (15-49 years)	13,152,237	14,186,678	14,869,167	14,996,831	15,496,494	15,992,002		16,944,030	16,972,977	17,526,883			
Health Status	**Infant Mortality Rate (DHS)**	**105**			**113**						**77**		**45**	
	Under five Mortality Rate (DHS)	**172**			**188**						**123**		**85**	**67**
	Maternal Mortality Ratio (DHS)	**560 - 850**			**871**							**450**	**600**	**450**
	Total Fertility Rate (DHS)	6.1			5.9						5.4		4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				47%						38%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			9%	14%	15%	11%		10%	17%	26%			
	% pregnant women TT2+ coverage (HMIS)	34%	27%	29%	24%	29%	25%		28%	32%	43%			
	… (DHS)				17%									
	% ANC Coverage (HMIS)	28%	24%	26%	29%	35%	34%		27%	41%	42%	45%	80%	
	… (DHS)				27%						28%			
	% Births attended by skilled staff (HMIS)	**9%**	**9%**	**8%**	**6%**	**10%**	**10%**		**9%**	**9%**	**12%**	**25%**	**32%**	
	… (DHS)				**6%**						**6%**			
	% PNC Coverage (HMIS)	4%	3%	4%	5%	7%	7%		7%	16%	13%			
	… (DHS)				2%									
	Contraceptive acceptor rate (HMIS)	**9%**	**6%**	**6%**	**11%**	**16%**	**14%**		**17%**	**19%**	**21%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**9%**						**14%**			
	% < 1 yr immunised for DPT3 (HMIS)	**68%**	**64%**	**38%**	**42%**	**45%**	**51%**		**50%**	**61%**	**70%**	**70%**	**80%**	
	… (DHS)				**21%**						**32%**			
	% < 1 yr immunised for measles (HMIS)			**31%**	**34%**	**39%**	**42%**		**43%**	**52%**	**61%**			
	… (DHS)				**27%**						**35%**			
	% Fully immunised under one year (HMIS)			25%	22%	23%	30%		32%	37%	44%		54%	
	… (DHS)				14%						20%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**44%**	**45%**	**34%**		**50%**	
	TB Cure Rate %				**62%**	**63%**	**66%**		**66%**	**63%**	**65%**		**85%**	
	TB Treatment Success Rate %				78%	79%	81%		82%	82%	81%			
	% Hospitals & HCs providing DOTS / MDT								72%	63%	85%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									8.3%			**<7%**	**<4.4%**
	HIV/AIDS Adult prevalence (%)***	3.3%	3.5%	3.6%	3.8%	3.9%	4.1%		4.2%	4.4%	4.6%			
	HIV Incidence (%)***	1.47%	1.36%	1.63%	1.65%	1.69%	1.74%		1.79%	1.82%	1.83%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate						-	-	4%	-	6%	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**27%**									**36%**	**42%**		
	Access to improved sanitation %	**10%**									**29%**	**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	64%	71%	57%	57%	59%	62%		61%	64%	72%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:222,850	1:221,047	1:202,868	1:176,865	1:171,058	1:163,155		1:153,275	1:136,929	1:121,739	1:135,000		
	Outpatient visits / pp / yr			**0.06**	**0.05**	**0.04**	**0.03**		**0.27**	**0.36**	**0.30**	**0.50**	**0.66**	
	Admissions / p100p / yr				0.2	0.3	-		0.4	0.1	1.6			
	Doctor/Population Ratio	**1:38,619**	**1:43,957**	**1:48,069**	**1:50,273**	**1:47,836**	**1:45,175**		**1:53,012**	**1:59,971**	**1:67,821**		**1:14,000**	
	Nurse/Population Ratio	1:13,921	1:12,774	1:11,219	1:9,458	1:7,987	1:6,956		1:7,145	1:6,716	1:6,082			
	Midwife/WRA Ratio	1:52,609	1:52,157	1:33,043	1:18,334	1:17,751	1:17,233		1:13,512	1:14,928	1:13,682		1:6,759	
	HEW/Population Ratio										1:26,687		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	669,718,136			776,502,000	1,425,800,000	#N/A		1,441,174,930	1,170,340,000	1,643,110,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	11.7	#N/A	#N/A	12.2	21.8	#N/A		20.8	16.5	22.5			
	GOE per capita expenditure on health (Birr / pp)	**9.5**			**9.1**	**12.4**	**#N/A**		**12.4**	**9.5**	**19.1**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$)***	$4.09			$5.60							$6.00	$9.60	
	Absorptive capacity (expenditure / budget)	82%			74%	57%	#N/A		59%	58%	85%			
	Bed Occupancy Rate								16%	22%	50%			
	% fees retained											20%	100%	
Demographic statistics	growth rate*****		7.68%	0.00%	2.96%	2.91%	2.87%		2.84%	2.80%	2.78%			
	pregnant pc	4.05%	4.05%	4.42%	4.42%	3.99%	3.99%		3.99%	3.99%	3.99%			
	delivery pc	4.05%	4.05%	4.42%	4.42%	3.99%	3.99%		3.99%	3.99%	3.99%			
	under five pc	14.72%	14.74%	17.57%	17.84%	17.62%	17.30%		17.53%	16.79%	16.53%			
	under one pc	2.61%	2.61%	4.07%	4.23%	4.00%	3.79%		3.58%	3.39%	3.33%			
	sutrviving infants pc						3.54%		3.55%	3.54%	3.54%			
	wra (15-49) pc	22.96%	23.00%	24.11%	23.62%	23.72%	23.79%		24.51%	23.88%	24.00%			

Unless otherwise noted, all data are from the Annual FMOH publication, *Health and Health Related Indicators*. MDG and SDPRP indicators in bold type

Financial data - 1989-1994: budget and expenditure data from HHRI

1995: Budget and expenditure figures are consolidated accounts from CAD/MOFED

1996-1997: Federal budget and expenditure figures are also consolidated accounts from CAD/MOFED

Regional budget figures from HHRI; regional expenditure figures are budget execution figures (preliminary actuals) from the flash reports from Woredas/regions, collected and consolidated by MOFED.

*1989 survey sources: IMR, U5MR, MMR, and TFR from Planning and Human Resource Development Project (PHRD) 1996 ; access to safe water and sanitation from *World Development Report* 1996

**1997 DHS (*EDHS 2005*) preliminary results, subject to confirmation. 1997 Hygiene and Env. Health Indicators from *Welfare Monitoring Survey* (WMS) 2004

***HIV data from *AIDS in Ethiopia* , September 2004. HIV Seroprevalence (ANC) from sentinel surveillance; adult prevalence esitmated from EPP model; incidence estimated from SPECTRUM model.

****Total annual per capita expenditure on health (US$ / pp)

1988 (recorded as 1989): Federal Ministry of Health, NHA Team. 2001. *Ethiopia:1995/96 National Health Accounts*, Addis Ababa.

1992: Federal Ministry of Health, HCF Secretariat. 2004. *Ethiopia's Second National Health Account*, Addis Ababa.

*****growth rate calculated from absolute population figures in annual *Health and Health Related Indicators*

in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups

from 1991 onwards, population proportions for pregnancies, deliveries, under ones, and surviving infants calculated from target group sizes in annual *Health and Health Related Indicators*; under fives and wra proportions used to calculate target group sizes

Trend analysis 1989 - 1997

Number of woredas: 28

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	2,313,488	2,424,000	2,424,000	2,495,837	2,570,000	2,646,000		2,725,002	2,805,000	2,887,615			
	Expected pregnancies	93,696	98,172	49,450	50,915	58,339	60,064		61,858	63,674	65,549			
	Expected deliveries	93,696	98,172	49,450	50,915	58,339	60,064		61,858	63,674	65,549			
	Children under-five years	186,930	195,859	210,161	224,875	241,580	256,662		277,950	286,110	300,312			
	Children under-one year	36,553	38,299	55,025	62,927	67,241	62,745		62,654	62,563	62,472			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						55,199		56,847	58,516	60,239			
	Women of Reproductive Age (15-49 years)	718,569	754,834	803,798	844,841	873,800	904,932		961,926	964,920	993,340			
Health Status	**Infant Mortality Rate (DHS)**	**78**			**81**								**45**	
	Under five Mortality Rate (DHS)	**108**			**114**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	1.8			1.9								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				14%						11%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			4%	0%	0%	4%		4%	5%	5%			
	% pregnant women TT2+ coverage (HMIS)	22%	28%	58%	63%	57%	59%		58%	73%	54%			
	… (DHS)				22%									
	% ANC Coverage (HMIS)	47%	51%	73%	87%	92%	83%		80%	82%	83%	45%	80%	
	… (DHS)				83%						88%			
	% Births attended by skilled staff (HMIS)	**17%**	**23%**	**27%**	**41%**	**37%**	**33%**		**33%**	**40%**	**37%**	**25%**	**32%**	
	… (DHS)				**69%**						**79%**			
	% PNC Coverage (HMIS)	5%	5%	12%	0%	14%	16%		17%	19%	30%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**32%**	**12%**	**7%**	**7%**	**43%**	**13%**		**34%**	**22%**	**18%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**32%**						**45%**			
	% < 1 yr immunised for DPT3 (HMIS)	**97%**	**106%**	**69%**	**65%**	**176%**	**71%**		**73%**	**78%**	**72%**	**70%**	**80%**	
	… (DHS)				**81%**						**84%**			
	% < 1 yr immunised for measles (HMIS)			**59%**	**54%**	**160%**	**61%**		**65%**	**71%**	**69%**			
	… (DHS)				**88%**						**79%**			
	% Fully immunised under one year (HMIS)			51%	1%	130%	62%		64%	10%	65%		54%	
	… (DHS)				74%						70%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**116%**	**142%**	**91%**		**50%**	
	TB Cure Rate %				**66%**	**75%**	**71%**		**72%**	**58%**	**67%**		**85%**	
	TB Treatment Success Rate %				77%	83%	81%		79%	79%	79%			
	% Hospitals & HCs providing DOTS / MDT								53%	54%	97%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**10.5%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	15.7%	15.6%	15.4%	15.2%	15.0%	14.8%		14.7%	14.6%	14.5%			
	HIV Incidence (%)***								1.94%	1.99%	2.03%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**97%**										**42%**		
	Access to improved sanitation %	**65%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	72%	163%	35%	40%	95%	88%		88%	86%	78%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:128,527	1:134,667	1:121,200	1:124,792	1:107,083	1:110,250		1:97,322	1:103,889	1:99,573	!:135,000		
	Outpatient visits / pp / yr			**0.25**	**0.51**	**0.55**	**0.73**		**0.44**	**0.47**	**0.46**	**0.50**	**0.66**	
	Admissions / p100p / yr				-	0.6	-		0.7	0.2	0.8			
	Doctor/Population Ratio	**1:11,176**	**1:13,174**	**1:13,851**	**1:13,491**	**1:11,953**	**1:11,260**		**1:13,625**	**1:12,808**	**1:17,291**		**1:14,000**	
	Nurse/Population Ratio	1:4,124	1:4,591	1:4,360	1:5,818	1:4,393	1:3,388		1:3,303	1:3,459	1:4,734			
	Midwife/WRA Ratio	1:10,414	1:11,266	1:10,305	1:17,601	1:10,160	1:4,788		1:11,589	1:7,658	1:10,136		1:6,759	
	HEW/Population Ratio										#DIV/0!		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	49,052,205			97,162,000	115,660,000	#N/A		132,331,581	156,790,000	59,339,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	21.2	#N/A	#N/A	38.9	45.0	#N/A		48.6	55.9	20.5			
	GOE per capita expenditure on health (Birr / pp)	**16.6**			**18.5**	**22.0**	**#N/A**		**26.3**	**18.6**	**23.8**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	78%			48%	49%	#N/A		54%	33%	116%			
	Bed Occupancy Rate								-	27%	16%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		4.78%	0.00%	2.96%	2.97%	2.96%		2.99%	2.94%	2.95%			
	pregnant pc	4.05%	4.05%	2.04%	2.04%	2.27%	2.27%		2.27%	2.27%	2.27%			
	delivery pc	4.05%	4.05%	2.04%	2.04%	2.27%	2.27%		2.27%	2.27%	2.27%			
	under five pc	8.08%	8.08%	8.67%	9.01%	9.40%	9.70%		10.20%	10.20%	10.40%			
	under one pc	1.58%	1.58%	2.27%	2.52%	2.62%	2.37%		2.30%	2.23%	2.16%			
	sutrviving infants pc						2.09%		2.09%	2.09%	2.09%			
	wra (15-49) pc	31.06%	31.14%	33.16%	33.85%	34.00%	34.20%		35.30%	34.40%	34.40%			

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in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups

from 1991 onwards, population proportions for pregnancies, deliveries, under ones, and surviving infants calculated from target group sizes in annual *Health and Health Related Indicators*;

under fives and wra proportions used to calculate target group sizes

Region: SNNPR
Trend analysis 1989 - 1997
Number of woredas: 29

			HSDP I						HSDP II					
		baseline 1989* 1996-97 GC	1990 1997-98 GC	1991 1998-99 GC	1992 1999-2000 GC	1993 2000-01 GC	1994 2001-02 GC	Target 1994 (Nat'l)	1995 2002-03 GC	1996 2003-04 GC	1997** 2004-05 GC	Target 1997 (Nat'l)	Target HSDP III (Nat'l)	MDG Target (Nat'l)
Demographic statistics	Total Population	1,135,149	1,188,000	1,188,000	1,215,809	1,243,000	1,272,000		1,301,001	1,330,000	1,358,718			
	Expected pregnancies	45,974	48,114	44,075	45,107	42,013	42,994		43,974	44,954	45,925			
	Expected deliveries	45,974	48,114	44,075	45,107	42,013	42,994		43,974	44,954	45,925			
	Children under-five years	129,407	135,432	179,744	184,560	220,011	186,984		193,849	190,190	191,579			
	Children under-one year	15,211	15,919	40,273	42,173	41,528	40,430		39,558	38,686	37,814			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						37,439		38,292	39,146	39,991			
	Women of Reproductive Age (15-49 years)	244,625	256,370	595,307	271,490	278,432	284,928		297,929	297,920	304,353			
Health Status	**Infant Mortality Rate (DHS)**	**118**			**129**								**45**	
	Under five Mortality Rate (DHS)	**174**			**229**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	3.3			4.9								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				51%						34%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			0%	1%	0%	0%		1%	19%	-			
	% pregnant women TT2+ coverage (HMIS)	2%	7%	9%	3%	2%	6%		8%	23%	-			
	… (DHS)				10%									
	% ANC Coverage (HMIS)	8%	8%	22%	5%	13%	16%		17%	25%	-	45%	80%	
	… (DHS)				26%						15%			
	% Births attended by skilled staff (HMIS)	**1%**	**3%**	**3%**	**0%**	**4%**	**3%**		**1%**	**2%**	**-**	**25%**	**32%**	
	… (DHS)				**6%**						**5%**			
	% PNC Coverage (HMIS)	0%	0%	0%	0%	1%	0%		1%	0%	-			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**3%**	**11%**	**4%**	**13%**	**10%**	**8%**		**10%**	**6%**	**-**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**8%**						**6%**			
	% < 1 yr immunised for DPT3 (HMIS)	**11%**	**42%**	**8%**	**5%**	**3%**	**4%**		**20%**	**41%**	**-**	**70%**	**80%**	
	… (DHS)				**1%**						**3%**			
	% < 1 yr immunised for measles (HMIS)			**7%**	**8%**	**4%**	**5%**		**23%**	**25%**	**-**			
	… (DHS)				**11%**						**8%**			
	% Fully immunised under one year (HMIS)			1%	1%	2%	2%		0%	0%	-		54%	
	… (DHS)				0%						1%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**17%**	**58%**	**60%**		**50%**	
	TB Cure Rate %				**-**	**-**	**-**		**-**	**34%**	**24%**		**85%**	
	TB Treatment Success Rate %				-	-	-		-	86%	81%			
	% Hospitals & HCs providing DOTS / MDT								60%	55%	145%	75%	72%	
	HIV Prevalence (among 15-24 pregnant women)* **									**11.8%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	2.1%	2.2%	2.3%	2.4%	2.4%	2.5%		2.5%	2.5%	2.5%			
	HIV Incidence (%)***								0.30%	0.31%	0.31%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**0%**										**42%**		
	Access to improved sanitation %	**0%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	67%	59%	66%	67%	67%	74%		71%	73%	71%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:283,787	1:237,600	1:237,600	1:243,162	1:248,600	1:159,000		1:162,625	1:147,778	1:150,969	!:135,000		
	Outpatient visits / pp / yr			**0.28**	**0.28**	**0.23**	**0.44**		**0.49**	**0.75**	**0.00**	**0.50**	**0.66**	
	Admissions / p100p / yr				0.1	0.1	-		0.1	0.2	-			
	Doctor/Population Ratio	**1:75,677**	**1:84,857**	**1:79,200**	**1:71,518**	**1:82,867**	**1:106,000**		**1:76,529**	**1:95,000**	**1:79,925**		**1:14,000**	
	Nurse/Population Ratio	1:25,799	1:12,913	1:11,000	1:7,844	1:5,574	1:6,523		1:6,051	1:5,588	1:5,907			
	Midwife/WRA Ratio	1:61,156	1:85,457	1:59,531	1:24,681	1:9,601	1:10,176		1:10,273	1:9,610	1:9,818		1:6,759	
	HEW/Population Ratio										-		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	22,664,000			44,094,000	41,830,000	#N/A		68,102,495	30,950,000	59,339,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	20.0	#N/A	#N/A	36.3	33.7	#N/A		52.3	23.3	43.7			
	GOE per capita expenditure on health (Birr / pp)	**7.8**			**14.6**	**18.3**	**#N/A**		**30.1**	**26.3**	**20.6**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$)											6.00	9.60	
	Absorptive capacity (expenditure / budget)	39%			40%	54%	#N/A		58%	113%	47%			
	Bed Occupancy Rate								-	6%	-			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		4.66%	0.00%	2.34%	2.24%	2.33%		2.28%	2.23%	2.16%			
	pregnant pc	4.05%	4.05%	3.71%	3.71%	3.38%	3.38%		3.38%	3.38%	3.38%			
	delivery pc	4.05%	4.05%	3.71%	3.71%	3.38%	3.38%		3.38%	3.38%	3.38%			
	under five pc	11.40%	11.40%	15.13%	15.18%	17.70%	14.70%		14.90%	14.30%	14.10%			
	under one pc	1.34%	1.34%	3.39%	3.47%	3.34%	3.18%		3.04%	2.91%	2.78%			
	sutrviving infants pc						2.94%		2.94%	2.94%	2.94%			
	wra (15-49) pc	21.55%	21.58%	50.11%	22.33%	22.40%	22.40%		22.90%	22.40%	22.40%			

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*1989 survey sources: IMR, U5MR, and TFR from *1994 Population & Housing Census of Ethiopia*
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in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups
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Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 113

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	14,792,670	15,850,000	15,850,000	16,295,514	16,748,000	17,205,000		17,669,006	18,143,000	18,626,047			
	Expected pregnancies	599,103	641,925	694,230	713,744	661,546	679,598		697,926	716,649	735,729			
	Expected deliveries	599,103	641,925	694,230	713,744	661,546	679,598		697,926	716,649	735,729			
	Children under-five years	2,242,569	2,404,445	2,778,505	2,898,972	2,930,900	2,959,260		3,074,407	3,029,881	3,054,672			
	Children under-one year	411,236	440,630	634,000	677,146	657,664	643,694		626,968	610,242	593,516			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						603,211		619,479	636,097	653,033			
	Women of Reproductive Age (15-49 years)	3,360,895	3,610,630	3,658,180	3,764,264	3,885,536	4,008,765		4,240,561	4,245,462	4,358,495			
Health Status	**Infant Mortality Rate (DHS)**	**116**			**112**								**45**	
	Under five Mortality Rate (DHS)	**170**			**183**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	4.3			5.9								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				52%						49%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			17%	26%	28%	18%		13%	24%	40%			
	% pregnant women TT2+ coverage (HMIS)	21%	23%	24%	33%	36%	25%		21%	33%	44%			
	… (DHS)				16%									
	% ANC Coverage (HMIS)	18%	4%	21%	25%	30%	29%		30%	34%	42%	45%	80%	
	… (DHS)				19%						27%			
	% Births attended by skilled staff (HMIS)	**6%**	**7%**	**6%**	**6%**	**8%**	**8%**		**7%**	**8%**	**12%**	**25%**	**32%**	
	… (DHS)				**3%**						**4%**			
	% PNC Coverage (HMIS)	3%	2%	4%	4%	6%	6%		7%	8%	14%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**7%**	**7%**	**11%**	**14%**	**18%**	**16%**		**18%**	**21%**	**30%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**8%**						**16%**			
	% < 1 yr immunised for DPT3 (HMIS)	**61%**	**71%**	**51%**	**62%**	**55%**	**65%**		**62%**	**68%**	**75%**	**70%**	**80%**	
	… (DHS)				**20%**						**32%**			
	% < 1 yr immunised for measles (HMIS)			**41%**	**47%**	**51%**	**50%**		**50%**	**62%**	**64%**			
	… (DHS)				**27%**						**35%**			
	% Fully immunised under one year (HMIS)			34%	24%	27%	27%		35%	45%	37%		54%	
	… (DHS)				14%						17%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**31%**	**37%**	**24%**		**50%**	
	TB Cure Rate %				**31%**	**62%**	**67%**		**68%**	**69%**	**65%**		**85%**	
	TB Treatment Success Rate %				75%	80%	80%		80%	81%	77%			
	% Hospitals & HCs providing DOTS / MDT								95%	70%	93%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**9.5%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	3.7%	4.0%	4.3%	4.7%	5.0%	5.4%		5.8%	6.1%	6.5%			
	HIV Incidence (%)***								0.99%	1.02%	1.03%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**12%**										**42%**		
	Access to improved sanitation %	**7%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	52%	62%	55%	52%	54%	54%		52%	47%	57%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:273,938	1:283,036	1:283,036	1:243,217	1:217,506	1:209,817		1:218,136	1:157,765	1:147,826	!:135,000		
	Outpatient visits / pp / yr			**0.18**	**0.15**	**0.15**	**0.15**		**0.24**	**0.37**	**0.41**	**0.50**	**0.66**	
	Admissions / p100p / yr				-	0.3	-		-	-	0.4			
	Doctor/Population Ratio	**1:59,889**	**1:71,719**	**1:78,079**	**1:95,856**	**1:76,127**	**1:91,516**		**1:109,068**	**1:124,267**	**1:142,184**		**1:14,000**	
	Nurse/Population Ratio	1:22,145	1:18,052	1:14,897	1:11,040	1:8,843	1:11,079		1:11,092	1:11,483	1:9,294			
	Midwife/WRA Ratio	1:86,177	1:68,125	1:35,865	1:9,181	1:24,907	1:35,476		1:24,654	1:35,978	1:13,970		1:6,759	
	HEW/Population Ratio										1:25,942		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	122,193,412			133,931,000	193,300,000	#N/A		270,364,123	205,600,000	213,574,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	8.3	#N/A	#N/A	8.2	11.5	#N/A		15.3	11.3	11.5			
	GOE per capita expenditure on health (Birr / pp)	**6.1**			**4.7**	**4.9**	**#N/A**		**8.1**	**6.6**	**9.0**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	74%			58%	42%	#N/A		53%	58%	78%			
	Bed Occupancy Rate								-	-	72%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		7.15%	0.00%	2.81%	2.78%	2.73%		2.70%	2.68%	2.66%			
	pregnant pc	4.05%	4.05%	4.38%	4.38%	3.95%	3.95%		3.95%	3.95%	3.95%			
	delivery pc	4.05%	4.05%	4.38%	4.38%	3.95%	3.95%		3.95%	3.95%	3.95%			
	under five pc	15.16%	15.17%	17.53%	17.79%	17.50%	17.20%		17.40%	16.70%	16.40%			
	under one pc	2.78%	2.78%	4.00%	4.16%	3.93%	3.74%		3.55%	3.36%	3.19%			
	sutrviving infants pc						3.51%		3.51%	3.51%	3.51%			
	wra (15-49) pc	22.72%	22.78%	23.08%	23.10%	23.20%	23.30%		24.00%	23.40%	23.40%			

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in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups
from 1991 onwards, population proportions for pregnancies, deliveries, under ones, and surviving infants calculated from target group sizes in annual *Health and Health Related Indicators*;
under fives and wra proportions used to calculate target group sizes

Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 20

		HSDP 1							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	493,083	523,000	523,000	536,619	551,000	565,000		580,000	594,000	609,509			
	Expected pregnancies	19,970	21,182	22,486	23,075	22,040	22,600		23,200	23,760	24,380			
	Expected deliveries	19,970	21,182	22,486	23,075	22,040	22,600		23,200	23,760	24,380			
	Children under-five years	74,801	79,339	90,479	93,211	94,221	95,485		99,180	97,416	98,740			
	Children under-one year	12,081	12,814	20,240	21,133	21,119	20,644		20,399	20,154	19,909			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						20,394		20,936	21,441	22,001			
	Women of Reproductive Age (15-49 years)	117,157	124,265	124,892	128,574	132,240	132,210		143,840	143,748	148,111			
Health Status	**Infant Mortality Rate (DHS)**	**206**			**98**								**45**	
	Under five Mortality Rate (DHS)	**139**			**198**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	3.4			5.4								4	
	% Under five years underweight / stunted (HMIS)													
	... (-2SD, WfA) (DHS)				42%						45%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			7%	11%	2%	6%		8%	4%	20%			
	% pregnant women TT2+ coverage (HMIS)	24%	14%	10%	18%	7%	12%		19%	15%	26%			
	... (DHS)				14%									
	% ANC Coverage (HMIS)	10%	24%	27%	25%	32%	27%		33%	42%	40%	45%	80%	
	... (DHS)				26%						25%			
	% Births attended by skilled staff (HMIS)	**5%**	**12%**	**9%**	**11%**	**14%**	**9%**		**10%**	**11%**	**11%**	**25%**	**32%**	
	... (DHS)				**9%**						**5%**			
	% PNC Coverage (HMIS)	0%	0%	1%	1%	2%	1%		2%	2%	3%			
	... (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**7%**	**12%**	**7%**	**18%**	**18%**	**25%**		**20%**	**7%**	**7%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**8%**						**10%**			
	% < 1 yr immunised for DPT3 (HMIS)	**56%**	**35%**	**16%**	**27%**	**19%**	**21%**		**28%**	**42%**	**45%**	**70%**	**80%**	
	... (DHS)				**16%**						**31%**			
	% < 1 yr immunised for measles (HMIS)			**20%**	**26%**	**19%**	**20%**		**28%**	**36%**	**43%**			
	... (DHS)				**19%**						**33%**			
	% Fully immunised under one year (HMIS)			14%	16%	10%	11%		19%	23%	25%		54%	
	... (DHS)				12%						19%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**27%**	**18%**	**37%**		**50%**	
	TB Cure Rate %									**69%**	**81%**		**85%**	
	TB Treatment Success Rate %									79%	89%			
	% Hospitals & HCs providing DOTS / MDT								111%	83%	108%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**13.0%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	2.0%	2.2%	2.3%	2.5%	2.7%	2.8%		2.9%	3.0%	3.1%			
	HIV Incidence (%)***								0.43%	0.43%	0.42%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**0%**										**42%**		
	Access to improved sanitation %	**0%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	157%	159%	176%	204%	182%	201%		197%	199%	190%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:164,361	1:130,750	1:130,750	1:76,660	1:78,714	1:80,714		1:82,857	1:59,400	1:55,410	1:135,000		
	Outpatient visits / pp / yr			**1.07**	**0.86**	**0.76**	**0.65**		**0.53**	**0.69**	**0.46**	**0.50**	**0.66**	
	Admissions / p100p / yr				0.7	0.4	-		0.7	0.9	9.9			
	Doctor/Population Ratio	**1:17,003**	**1:20,115**	**1:18,679**	**1:18,504**	**1:25,045**	**1:29,737**		**1:27,619**	**1:34,941**	**1:43,536**		**1:14,000**	
	Nurse/Population Ratio	1:6,242	1:4,054	1:2,938	1:2,543	1:2,701	1:2,665		1:2,886	1:1,747	1:2,200			
	Midwife/WRA Ratio	1:39,052	1:20,711	1:8,921	1:11,689	1:5,510	1:5,288		1:5,532	1:2,712	#DIV/0!		1:6,759	
	HEW/Population Ratio										1:20,317		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	16,584,669			18,246,000	33,490,000	#N/A		41,074,934	27,050,000	23,879,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	33.6	#N/A	#N/A	34.0	60.8	#N/A		70.8	45.5	39.2			
	GOE per capita expenditure on health (Birr / pp)	**17.5**			**19.8**	**22.0**	**#N/A**		**39.0**	**30.0**	**34.2**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	52%			58%	36%	#N/A		55%	66%	87%			
	Bed Occupancy Rate								15%	16%	63%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		6.07%	0.00%	2.60%	2.68%	2.54%		2.65%	2.41%	2.61%			
	pregnant pc	4.05%	4.05%	4.30%	4.30%	4.00%	4.00%		4.00%	4.00%	4.00%			
	delivery pc	4.05%	4.05%	4.30%	4.30%	4.00%	4.00%		4.00%	4.00%	4.00%			
	under five pc	15.17%	15.17%	17.30%	17.37%	17.10%	16.90%		17.10%	16.40%	16.20%			
	under one pc	2.45%	2.45%	3.87%	3.94%	3.83%	3.65%		3.52%	3.39%	3.27%			
	sutrviving infants pc						3.61%		3.61%	3.61%	3.61%			
	wra (15-49) pc	23.76%	23.76%	23.88%	23.96%	24.00%	23.40%		24.80%	24.20%	24.30%			

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*1989 survey sources: IMR, U5MR, and TFR from 1994 Population & Housing Census of Ethiopia; MMR from World Development Report 1997; access to safe water and sanitation from HSDP
**1997 DHS (*EDHS 2005*) preliminary results, subject to confirmation. 1997 Hygiene and Env. Health Indicators from *Welfare Monitoring Survey* (WMS) 2004
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in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups
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Ethiopia HSDP-3: Evaluation report - Annex xxxxx

Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 0

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	1990 1997-98 GC	1991 1998-99 GC	1992 1999-2000 GC	1993 2000-01 GC	1994 2001-02 GC	Target 1994 (Nat'l)	1995 2002-03 GC	1996 2003-04 GC	1997** 2004-05 GC	Target 1997 (Nat'l)	Target HSDP III (Nat'l)	MDG Target (Nat'l)
Demographic statistics	Total Population	274,562	306,000	306,000	317,484	330,000	342,000		357,000	370,000	383,529			
	Expected pregnancies	11,120	12,393	11,903	12,350	12,210	12,654		13,209	13,690	14,191			
	Expected deliveries	11,120	12,393	11,903	12,350	12,210	12,654		13,209	13,690	14,191			
	Children under-five years	30,751	33,844	46,971	50,988	52,800	54,720		58,905	58,090	59,831			
	Children under-one year	5,079	5,661	12,026	13,606	13,412	12,687		12,228	11,769	11,309			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						11,318		11,814	12,244	12,692			
	Women of Reproductive Age (15-49 years)	75,010	82,957	83,875	87,499	91,080	94,392		102,102	101,380	104,703			
Health Status	**Infant Mortality Rate (DHS)**	**115**			**106**								**45**	
	Under five Mortality Rate (DHS)	**168**			**176**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	2.51			3.6								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				31%						30%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			9%	4%	12%	7%		6%	5%	5%			
	% pregnant women TT2+ coverage (HMIS)	33%	25%	48%	16%	53%	29%		33%	32%	36%			
	… (DHS)				43%									
	% ANC Coverage (HMIS)	42%	34%	20%	24%	45%	30%		30%	48%	52%	45%	80%	
	… (DHS)				58%						53%			
	% Births attended by skilled staff (HMIS)	**39%**	**16%**	**16%**	**19%**	**23%**	**23%**		**21%**	**33%**	**26%**	**25%**	**32%**	
	… (DHS)				**34%**						**27%**			
	% PNC Coverage (HMIS)	0%	0%	15%	2%	0%	0%		0%	2%	2%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**24%**	**5%**	**26%**	**28%**	**55%**	**17%**		**60%**	**11%**	**6%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**31%**						**32%**			
	% < 1 yr immunised for DPT3 (HMIS)	**66%**	**94%**	**48%**	**41%**	**40%**	**52%**		**66%**	**48%**	**53%**	**70%**	**80%**	
	… (DHS)				**52%**						**62%**			
	% < 1 yr immunised for measles (HMIS)			**36%**	**34%**	**32%**	**47%**		**59%**	**39%**	**46%**			
	… (DHS)				**53%**						**56%**			
	% Fully immunised under one year (HMIS)			21%	13%	0%	18%		30%	6%	31%		54%	
	… (DHS)				35%						43%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**162%**	**160%**	**79%**		**50%**	
	TB Cure Rate %					**63%**	**65%**		**45%**	**76%**	**67%**		**85%**	
	TB Treatment Success Rate %					81%	83%		85%	79%	71%			
	% Hospitals & HCs providing DOTS / MDT								80%	50%	75%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**10.7%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	9.0%	9.0%	8.9%	8.8%	8.8%	8.7%		8.7%	8.7%	8.7%			
	HIV Incidence (%)***								1.25%	1.25%	1.26%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**21%**										**42%**		
	Access to improved sanitation %	**6%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	56%	119%	118%	88%	52%	111%		83%	100%	95%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:137,281	1:153,000	1:153,000	1:158,742	1:165,000	1:114,000		1:119,000	1:74,000	1:76,706	1:135,000		
	Outpatient visits / pp / yr			**0.42**	**0.39**	**0.28**	**0.33**		**0.33**	**0.34**	**0.39**	**0.50**	**0.66**	
	Admissions / p100p / yr				2.2	2.3	-		2.1	1.7	3.0			
	Doctor/Population Ratio	**1:8,320**	**1:8,270**	**1:9,000**	**1:9,071**	**1:9,167**	**1:8,550**		**1:8,707**	**1:11,935**	**1:12,784**		**1:14,000**	
	Nurse/Population Ratio	1:3,813	1:3,974	1:4,026	1:2,913	1:3,028	1:2,631		1:2,606	1:2,552	1:2,019			
	Midwife/WRA Ratio	1:15,002	1:41,478	1:27,958	1:9,722	1:10,120	1:18,878		1:17,017	1:8,448	1:4,552		1:6,759	
	HEW/Population Ratio										1:7,671		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	6,920,039			16,090,000	219,560,000	#N/A		25,922,343	18,890,000	15,784,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	25.2	#N/A	#N/A	50.7	665.3	#N/A		72.6	51.1	41.2			
	GOE per capita expenditure on health (Birr / pp)	**20.5**			**19.2**	**211.6**	**#N/A**		**37.0**	**31.5**	**42.4**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$)											6.00	9.60	
	Absorptive capacity (expenditure / budget)	81%			38%	32%	#N/A		51%	62%	103%			
	Bed Occupancy Rate								-	10%	52%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		11.45%	0.00%	3.75%	3.94%	3.64%		4.39%	3.64%	3.66%			
	pregnant pc	4.05%	4.05%	3.89%	3.89%	3.70%	3.70%		3.70%	3.70%	3.70%			
	delivery pc	4.05%	4.05%	3.89%	3.89%	3.70%	3.70%		3.70%	3.70%	3.70%			
	under five pc	11.20%	11.06%	15.35%	16.06%	16.00%	16.00%		16.50%	15.70%	15.60%			
	under one pc	1.85%	1.85%	3.93%	4.29%	4.06%	3.71%		3.43%	3.18%	2.95%			
	sutrviving infants pc						3.31%		3.31%	3.31%	3.31%			
	wra (15-49) pc	27.32%	27.11%	27.41%	27.56%	27.60%	27.60%		28.60%	27.40%	27.30%			

Unless otherwise noted, all data are from the Annual FMOH publication, *Health and Health Related Indicators*. MDG and SDPRP indicators in bold type
Financial data - 1989-1994: budget and expenditure data from HHRI
1995: Budget and expenditure figures are consolidated accounts from CAD/MOFED
1996-1997: Federal budget and expenditure figures are also consolidated accounts from CAD/MOFED
Regional budget figures from HHRI; regional expenditure figures are budget execution figures (preliminary actuals) from the flash reports from Woredas/regions, collected and consolidated by MOFED.

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Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 9

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	194,837	206,000	206,000	211,312	216,000	222,000		228,002	234,000	240,394			
	Expected pregnancies	7,891	8,343	7,519	7,713	7,517	7,726		7,934	8,143	8,366			
	Expected deliveries	7,891	8,343	7,519	7,713	7,517	7,726		7,934	8,143	8,366			
	Children under-five years	23,790	25,153	31,003	32,288	33,048	33,744		35,340	35,100	35,819			
	Children under-one year	4,540	4,800	7,148	7,656	7,605	7,430		7,317	7,204	7,091			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						6,778		6,962	7,145	7,340			
	Women of Reproductive Age (15-49 years)	52,664	54,302	55,311	56,970	58,536	59,940		63,157	62,946	64,426			
Health Status	**Infant Mortality Rate (DHS)**	**99**			**123**								**45**	
	Under five Mortality Rate (DHS)	**142**			**233**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	3.1			4.5								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				39%						27%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			5%	1%	9%	5%		11%	0%	3%			
	% pregnant women TT2+ coverage (HMIS)	18%	11%	25%	8%	25%	37%		34%	0%	33%			
	… (DHS)				25%									
	% ANC Coverage (HMIS)	35%	0%	33%	27%	38%	42%		0%	0%	20%	45%	80%	
	… (DHS)				50%						37%			
	% Births attended by skilled staff (HMIS)	**14%**	**10%**	**11%**	**8%**	**13%**	**15%**		**11%**	**0%**	**12%**	**25%**	**32%**	
	… (DHS)				**24%**						**15%**			
	% PNC Coverage (HMIS)	6%	6%	4%	3%	5%	13%		10%	0%	5%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**9%**	**2%**	**4%**	**4%**	**29%**	**27%**		**24%**	**0%**	**4%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**16%**						**16%**			
	% < 1 yr immunised for DPT3 (HMIS)	**17%**	**26%**	**21%**	**17%**	**40%**	**36%**		**37%**	**0%**	**22%**	**70%**	**80%**	
	… (DHS)				**13%**						**20%**			
	% < 1 yr immunised for measles (HMIS)			**16%**	**19%**	**32%**	**24%**		**37%**	**0%**	**16%**			
	… (DHS)				**20%**						**31%**			
	% Fully immunised under one year (HMIS)			5%	3%	0%	18%		27%	0%	13%		54%	
	… (DHS)				11%						16%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**83%**	**109%**	**119%**		**50%**	
	TB Cure Rate %									**21%**	**31%**		**85%**	
	TB Treatment Success Rate %									58%	65%			
	% Hospitals & HCs providing DOTS / MDT								67%	67%	100%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**19.9%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	3.5%	3.6%	3.6%	3.7%	3.7%	3.8%		3.9%	3.9%	3.9%			
	HIV Incidence (%)***								0.51%	0.51%	0.51%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**0%**										**42%**		
	Access to improved sanitation %	**0%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	257%	167%	240%	265%	234%	279%		259%	226%	275%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:64,946	1:68,667	1:41,200	1:26,414	1:43,200	1:27,750		1:28,500	1:29,250	1:30,049	!:135,000		
	Outpatient visits / pp / yr			**0.47**	**0.82**	**0.80**	**0.63**		**0.10**	**0.00**	**0.55**	**0.50**	**0.66**	
	Admissions / p100p / yr				1.3	-	-		0.6	-	4.6			
	Doctor/Population Ratio	**1:12,177**	**1:17,167**	**1:17,167**	**1:16,255**	**1:21,600**	**1:15,857**		**1:19,000**	**1:19,500**	**1:40,066**		**1:14,000**	
	Nurse/Population Ratio	1:3,542	1:6,059	1:1,791	1:1,589	1:1,367	1:1,423		1:1,443	1:1,481	1:969			
	Midwife/WRA Ratio	1:26,332	#DIV/0!	1:13,828	1:14,242	1:3,252	1:19,980		1:3,715	1:3,703	1:2,684		1:6,759	
	HEW/Population Ratio										#DIV/0!		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	9,604,447			11,621,000	27,070,000	#N/A		39,980,517	17,600,000	16,801,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	49.3	#N/A	#N/A	55.0	125.3	#N/A		175.4	75.2	69.9			
	GOE per capita expenditure on health (Birr / pp)	**39.7**			**52.0**	**45.3**	**#N/A**		**73.5**	**64.2**	**49.9**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	80%			95%	36%	#N/A		42%	85%	71%			
	Bed Occupancy Rate								-	-	40%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		5.73%	0.00%	2.58%	2.22%	2.78%		2.70%	2.63%	2.73%			
	pregnant pc	4.05%	4.05%	3.65%	3.65%	3.48%	3.48%		3.48%	3.48%	3.48%			
	delivery pc	4.05%	4.05%	3.65%	3.65%	3.48%	3.48%		3.48%	3.48%	3.48%			
	under five pc	12.21%	12.21%	15.05%	15.28%	15.30%	15.20%		15.50%	15.00%	14.90%			
	under one pc	2.33%	2.33%	3.47%	3.62%	3.52%	3.35%		3.21%	3.08%	2.95%			
	sutrviving infants pc						3.05%		3.05%	3.05%	3.05%			
	wra (15-49) pc	27.03%	26.36%	26.85%	26.96%	27.10%	27.00%		27.70%	26.90%	26.80%			

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1995: Budget and expenditure figures are consolidated accounts from CAD/MOFED
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Regional budget figures from HHRI; regional expenditure figures are budget execution figures (preliminary actuals) from the flash reports from Woredas/regions, collected and consolidated by MOFED.

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Trend analysis 1989 - 1997 116

Number of woredas: 0

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	142,474	154,000	154,000	160,233	166,000	172,000		178,000	185,000	189,550			
	Expected pregnancies	5,770	6,237	5,729	5,961	5,910	6,123		6,337	6,586	6,748			
	Expected deliveries	5,770	6,237	5,729	5,961	5,910	6,123		6,337	6,586	6,748			
	Children under-five years	15,060	16,062	22,576	24,420	25,232	25,972		27,590	27,380	28,243			
	Children under-one year	2,208	2,387	5,729	6,429	6,354	5,987		5,765	5,544	6,445			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						5,399		5,587	5,807	5,950			
	Women of Reproductive Age (15-49 years)	38,582	41,041	41,765	43,391	44,820	46,096		49,128	49,025	50,231			
Health Status	**Infant Mortality Rate (DHS)**	**113**			**118**								**45**	
	Under five Mortality Rate (DHS)	**166**			**191**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	2			4.4								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				27%						27%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			13%	13%	9%	7%		13%	14%	19%			
	% pregnant women TT2+ coverage (HMIS)	35%	41%	48%	43%	44%	65%		44%	49%	56%			
	… (DHS)				35%									
	% ANC Coverage (HMIS)	42%	29%	37%	51%	49%	52%		41%	51%	57%	45%	80%	
	… (DHS)				50%						41%			
	% Births attended by skilled staff (HMIS)	**30%**	**16%**	**26%**	**26%**	**22%**	**20%**		**18%**	**25%**	**24%**	**25%**	**32%**	
	… (DHS)				**26%**						**31%**			
	% PNC Coverage (HMIS)	4%	4%	0%	11%	11%	1%		6%	14%	19%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**18%**	**16%**	**10%**	**53%**	**161%**	**184%**		**162%**	**34%**	**29%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**25%**						**29%**			
	% < 1 yr immunised for DPT3 (HMIS)	**68%**	**160%**	**64%**	**59%**	**52%**	**66%**		**75%**	**69%**	**88%**	**70%**	**80%**	
	… (DHS)				**51%**						**46%**			
	% < 1 yr immunised for measles (HMIS)			**53%**	**55%**	**40%**	**53%**		**63%**	**59%**	**68%**			
	… (DHS)				**59%**						**40%**			
	% Fully immunised under one year (HMIS)			43%	48%	39%	45%		51%	48%	67%		54%	
	… (DHS)				36%						35%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**94%**	**76%**	**103%**		**50%**	
	TB Cure Rate %				**71%**	**78%**	**83%**		**77%**	**80%**	**71%**		**85%**	
	TB Treatment Success Rate %				73%	78%	83%		77%	85%	75%			
	% Hospitals & HCs providing DOTS / MDT								71%	71%	71%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**8.8%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	8.6%	8.4%	8.3%	8.2%	8.1%	8.0%		8.0%	8.0%	8.1%			
	HIV Incidence (%)***								1.15%	1.16%	1.17%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate					-	-		-	-	-	15%	2%	
Hygiene and Env. Health	**Access to safe water %**	**0%**										**42%**		
	Access to improved sanitation %	**0%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	126%	192%	107%	159%	166%	166%		154%	149%	145%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	#DIV/0!	1:154,000	1:77,000	1:80,117	1:83,000	1:28,667		1:89,000	1:92,500	1:94,775	!:135,000		
	Outpatient visits / pp / yr			**0.92**	**0.28**	**0.79**	**0.81**		**0.84**	**0.00**	**0.06**	**0.50**	**0.66**	
	Admissions / p100p / yr				4.6	4.1	-		5.7	-	31.3			
	Doctor/Population Ratio	**1:3,392**	**1:2,655**	**1:2,962**	**1:3,338**	**1:3,388**	**1:4,914**		**1:3,358**	**1:3,700**	**1:4,623**		**1:14,000**	
	Nurse/Population Ratio	1:2,065	1:5,923	1:1,621	1:1,282	1:1,114	1:1,333		1:886	1:864	1:886			
	Midwife/WRA Ratio	1:4,287	1:3,420	1:4,176	1:3,099	1:3,201	1:2,881		1:2,233	1:2,132	1:2,283		1:6,759	
	HEW/Population Ratio										1:3,868		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	9,209,400			9,591,000	17,230,000	#N/A		21,822,726	15,530,000	17,186,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	64.6	#N/A	#N/A	59.9	103.8	#N/A		122.6	83.9	90.7			
	GOE per capita expenditure on health (Birr / pp)	**56.4**			**54.6**	**44.8**	**#N/A**		**79.6**	**71.2**	**85.4**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	87%			91%	43%	#N/A		65%	85%	94%			
	Bed Occupancy Rate								40%	90%	43%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		8.09%	0.00%	4.05%	3.60%	3.61%		3.49%	3.93%	2.46%			
	pregnant pc	4.05%	4.05%	3.72%	3.72%	3.56%	3.56%		3.56%	3.56%	3.56%			
	delivery pc	4.05%	4.05%	3.72%	3.72%	3.56%	3.56%		3.56%	3.56%	3.56%			
	under five pc	10.57%	10.43%	14.66%	15.24%	15.20%	15.10%		15.50%	14.80%	14.90%			
	under one pc	1.55%	1.55%	3.72%	4.01%	3.83%	3.48%		3.24%	3.00%	3.40%			
	sutrviving infants pc						3.14%		3.14%	3.14%	3.14%			
	wra (15-49) pc	27.08%	26.65%	27.12%	27.08%	27.00%	26.80%		27.60%	26.50%	26.50%			

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Regional budget figures from HHRI; regional expenditure figures are budget execution figures (preliminary actuals) from the flash reports from Woredas/regions, collected and consolidated by MOFED.

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***HIV data from *AIDS in Ethiopia* , September 2004. HIV Seroprevalence (ANC) from sentinel surveillance; adult prevalence esitmated from EPP model; incidence estimated from SPECTRUM model.

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in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups

from 1991 onwards, population proportions for pregnancies, deliveries, under ones, and surviving infants calculated from target group sizes in annual *Health and Health Related Indicators*; under fives and wra proportions used to calculate target group sizes

Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 197

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	20,039,201	21,694,000	21,694,000	22,353,506	23,023,000	23,704,000		24,395,000	25,098,000	25,817,132			
	Expected pregnancies	811,588	878,607	1,006,602	1,037,203	957,757	986,086		1,014,832	1,044,077	1,073,993			
	Expected deliveries	811,588	878,607	1,006,602	1,037,203	957,757	986,086		1,014,832	1,044,077	1,073,993			
	Children under-five years	3,100,064	3,356,062	3,985,188	4,175,635	4,236,232	4,290,424		4,464,285	4,392,150	4,440,547			
	Children under-one year	561,098	607,432	926,334	991,049	960,574	936,146		908,694	881,243	853,791			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						871,503		896,909	922,755	949,195			
	Women of Reproductive Age (15-49 years)	4,452,710	4,829,084	4,980,942	5,139,071	5,318,313	5,499,328		5,830,405	5,847,834	6,015,392			
Health Status	**Infant Mortality Rate (DHS)**	**118**			**116**								**45**	
	Under five Mortality Rate (DHS)	**173**			**194**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	4.9			6.4								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				42%						34%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			5%	17%	11%	13%		12%	13%	23%			
	% pregnant women TT2+ coverage (HMIS)	41%	31%	38%	26%	29%	33%		22%	30%	35%			
	… (DHS)				16%									
	% ANC Coverage (HMIS)	26%	33%	26%	28%	33%	36%		16%	43%	36%	45%	80%	
	… (DHS)				27%						25%			
	% Births attended by skilled staff (HMIS)	**7%**	**8%**	**6%**	**0%**	**6%**	**7%**		**7%**	**6%**	**6%**	**25%**	**32%**	
	… (DHS)				**5%**						**5%**			
	% PNC Coverage (HMIS)	5%	5%	4%	5%	5%	7%		6%	6%	8%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**7%**	**4%**	**0%**	**7%**	**9%**	**9%**		**11%**	**15%**	**18%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**9%**						**13%**			
	% < 1 yr immunised for DPT3 (HMIS)	**69%**	**55%**	**33%**	**34%**	**39%**	**53%**		**40%**	**53%**	**63%**	**70%**	**80%**	
	… (DHS)				**16%**						**29%**			
	% < 1 yr immunised for measles (HMIS)			**26%**	**27%**	**32%**	**42%**		**34%**	**43%**	**53%**			
	… (DHS)				**29%**						**29%**			
	% Fully immunised under one year (HMIS)			24%	22%	26%	35%		27%	32%	43%		54%	
	… (DHS)				10%						20%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**43%**	**44%**	**33%**		**50%**	
	TB Cure Rate %				**69%**	**66%**	**66%**		**68%**	**64%**	**66%**		**85%**	
	TB Treatment Success Rate %				77%	76%	82%		84%	84%	83%			
	% Hospitals & HCs providing DOTS / MDT								66%	57%	91%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**3.4%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	2.2%	2.2%	2.3%	2.4%	2.5%	2.6%		2.8%	2.9%	3.0%			
	HIV Incidence (%)***								0.45%	0.46%	0.46%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate											15%		
Hygiene and Env. Health	**Access to safe water %**	**0%**										**42%**		
	Access to improved sanitation %	**4%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	64%	71%	52%	55%	50%	57%		58%	61%	67%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:270,800	1:285,447	1:252,256	1:240,360	1:201,956	1:206,122		1:173,014	1:150,287	1:139,552	1:135,000		
	Outpatient visits / pp / yr			**0.23**	**0.28**	**0.28**	**0.10**		**0.26**	**0.38**	**0.19**	**0.50**	**0.66**	
	Admissions / p100p / yr				-	0.3	-		-	-	3.1			
	Doctor/Population Ratio	**1:55,053**	**1:71,834**	**1:75,326**	**1:83,409**	**1:86,228**	**1:74,075**		**1:105,151**	**1:120,663**	**1:138,802**		**1:14,000**	
	Nurse/Population Ratio	1:19,860	1:18,184	1:15,107	1:12,371	1:12,156	1:10,187		1:9,638	1:9,309	1:7,618			
	Midwife/WRA Ratio	1:85,629	1:87,802	1:46,551	1:31,336	1:26,592	1:49,543		1:25,572	1:23,772	1:18,284		1:6,759	
	HEW/Population Ratio										1:34,888		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	157,220,303			162,737,000	298,190,000	#N/A		285,573,358	278,440,000	341,627,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	7.8	#N/A	#N/A	7.3	13.0	#N/A		11.7	11.1	13.2			
	GOE per capita expenditure on health (Birr / pp)	**7.2**			**5.1**	**5.8**	**#N/A**		**8.6**	**4.4**	**6.9**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$)											6.00	9.60	
	Absorptive capacity (expenditure / budget)	92%			70%	45%	#N/A		73%	40%	52%			
	Bed Occupancy Rate								-	-	94%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		8.26%	0.00%	3.04%	3.00%	2.96%		2.92%	2.88%	2.87%			
	pregnant pc	4.05%	4.05%	4.64%	4.64%	4.16%	4.16%		4.16%	4.16%	4.16%			
	delivery pc	4.05%	4.05%	4.64%	4.64%	4.16%	4.16%		4.16%	4.16%	4.16%			
	under five pc	15.47%	15.47%	18.37%	18.68%	18.40%	18.10%		18.30%	17.50%	17.20%			
	under one pc	2.80%	2.80%	4.27%	4.43%	4.17%	3.95%		3.72%	3.51%	3.31%			
	sutrviving infants pc						3.68%		3.68%	3.68%	3.68%			
	wra (15-49) pc	22.22%	22.26%	22.96%	22.99%	23.10%	23.20%		23.90%	23.30%	23.30%			

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***HIV data from *AIDS in Ethiopia*, September 2004. HIV Seroprevalence (ANC) from sentinel surveillance; adult prevalence esitmated from EPP model; incidence estimated from SPECTRUM model.
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in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups
from 1991 onwards, population proportions for pregnancies, deliveries, under ones, and surviving infants calculated from target group sizes in annual *Health and Health Related Indicators*;
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Trend analysis 1989 - 1997

Number of woredas: 104

			HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	1990 1997-98 GC	1991 1998-99 GC	1992 1999-2000 GC	1993 2000-01 GC	1994 2001-02 GC	Target 1994 (Nat'l)	1995 2002-03 GC	1996 2003-04 GC	1997** 2004-05 GC	Target 1997 (Nat'l)	Target HSDP III (Nat'l)	MDG Target (Nat'l)
Demographic statistics	Total Population	11,087,357	12,132,000	12,132,000	12,515,599	12,903,000	13,293,000		13,686,002	14,085,000	14,489,705			
	Expected pregnancies	449,038	491,346	589,615	608,258	549,668	566,282		583,024	600,021	617,261			
	Expected deliveries	449,038	491,346	589,615	608,258	549,668	566,282		583,024	600,021	617,261			
	Children under-five years	1,625,407	1,780,978	2,288,095	2,409,253	2,425,764	2,445,912		2,545,596	2,493,045	2,521,209			
	Children under-one year	292,706	320,285	542,300	583,602	559,863	538,897		516,544	494,191	547,264			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						502,065		516,909	531,979	547,264			
	Women of Reproductive Age (15-49 years)	2,627,704	2,881,350	2,888,629	2,973,706	3,070,914	3,163,734		3,353,070	3,352,230	3,520,998			
Health Status	**Infant Mortality Rate (DHS)**	**128**			**113**								**45**	
	Under five Mortality Rate (DHS)	**189**			**192**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	4.4			5.9								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				54%						35%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			5%	4%	7%	4%		11%	20%	35%			
	% pregnant women TT2+ coverage (HMIS)	58%	35%	24%	17%	26%	16%		23%	39%	61%			
	… (DHS)				18%									
	% ANC Coverage (HMIS)	52%	33%	25%	27%	34%	30%		32%	41%	61%	45%	80%	
	… (DHS)				28%						30%			
	% Births attended by skilled staff (HMIS)	**13%**	**10%**	**8%**	**6%**	**9%**	**7%**		**7%**	**7%**	**18%**	**25%**	**32%**	
	… (DHS)				**5%**						**4%**			
	% PNC Coverage (HMIS)	2%	2%	2%	2%	3%	4%		0%	41%	19%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**8%**	**7%**	**8%**	**10%**	**11%**	**13%**		**20%**	**24%**	**19%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**8%**						**11%**			
	% < 1 yr immunised for DPT3 (HMIS)	**80%**	**64%**	**30%**	**32%**	**31%**	**38%**		**55%**	**74%**	**91%**	**70%**	**80%**	
	… (DHS)				**17%**						**33%**			
	% < 1 yr immunised for measles (HMIS)			**24%**	**25%**	**26%**	**31%**		**47%**	**64%**	**83%**			
	… (DHS)				**24%**						**38%**			
	% Fully immunised under one year (HMIS)			17%	18%	0%	22%		32%	44%	58%		54%	
	… (DHS)				11%						20%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**54%**	**38%**	**37%**		**50%**	
	TB Cure Rate %				**48%**	**48%**	**58%**		**60%**	**59%**	**66%**		**85%**	
	TB Treatment Success Rate %				78%	79%	82%		82%	83%	84%			
	% Hospitals & HCs providing DOTS / MDT								86%	79%	80%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**5.4%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	1.7%	1.8%	1.9%	2.1%	2.3%	2.4%		2.6%	2.8%	2.9%			
	HIV Incidence (%)***								0.43%	0.44%	0.45%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate											15%		
Hygiene and Env. Health	**Access to safe water %**	**22%**										**42%**		
	Access to improved sanitation %	**10%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	65%	64%	64%	58%	66%	60%		60%	76%	91%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:167,990	1:146,169	1:146,169	1:116,968	1:120,589	1:116,605		1:115,983	1:110,906	1:89,998	!:135,000		
	Outpatient visits / pp / yr			**0.31**	**0.23**	**0.20**	**0.16**		**0.16**	**0.15**	**0.21**	**0.50**	**0.66**	
	Admissions / p100p / yr				0.2	0.3	-		0.4	-	0.4			
	Doctor/Population Ratio	**1:43,480**	**1:45,781**	**1:55,908**	**1:69,531**	**1:77,729**	**1:81,552**		**1:73,187**	**1:114,512**	**1:136,695**		**1:14,000**	
	Nurse/Population Ratio	1:21,487	1:19,349	1:15,299	1:13,078	1:10,981	1:10,233		1:8,240	1:6,932	1:6,203			
	Midwife/WRA Ratio	1:82,116	1:90,042	1:43,114	1:34,578	1:20,891	1:21,970		1:14,706	1:13,198	1:14,430		1:6,759	
	HEW/Population Ratio										1:19,320		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	109,528,471			126,967,000	219,560,000	#N/A		170,615,226	165,060,000	162,089,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	9.9	#N/A	#N/A	10.1	17.0	#N/A		12.5	11.7	11.2			
	GOE per capita expenditure on health (Birr / pp)	**8.2**			**5.8**	**5.4**	**#N/A**		**5.7**	**5.4**	**6.8**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	83%			57%	32%	#N/A		46%	46%	61%			
	Bed Occupancy Rate								22%	-	35%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		9.42%	0.00%	3.16%	3.10%	3.02%		2.96%	2.92%	2.87%			
	pregnant pc	4.05%	4.05%	4.86%	4.86%	4.26%	4.26%		4.26%	4.26%	4.26%			
	delivery pc	4.05%	4.05%	4.86%	4.86%	4.26%	4.26%		4.26%	4.26%	4.26%			
	under five pc	14.66%	14.68%	18.86%	19.25%	18.80%	18.40%		18.60%	17.70%	17.40%			
	under one pc	2.64%	2.64%	4.47%	4.66%	4.34%	4.05%		3.77%	3.51%	3.78%			
	sutrviving infants pc						3.78%		3.78%	3.78%	3.78%			
	wra (15-49) pc	23.70%	23.75%	23.81%	23.76%	23.80%	23.80%		24.50%	23.80%	24.30%			

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****growth rate calculated from absolute population figures in annual *Health and Health Related Indicators*

in 1989 and 1990, population proportions in annual *Health and Health Related Indicators* used to calculate target groups

from 1991 onwards, population proportions for pregnancies, deliveries, under ones, and surviving infants calculated from target group sizes in annual *Health and Health Related Indicators*;

under fives and wra proportions used to calculate target group sizes

Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 51

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	**1990** 1997-98 GC	**1991** 1998-99 GC	**1992** 1999-2000 GC	**1993** 2000-01 GC	**1994** 2001-02 GC	**Target 1994** (Nat'l)	**1995** 2002-03 GC	**1996** 2003-04 GC	**1997**** 2004-05 GC	**Target 1997** (Nat'l)	**Target HSDP III** (Nat'l)	**MDG Target** (Nat'l)
Demographic statistics	Total Population	3,439,860	3,602,000	3,602,000	3,698,144	3,797,000	3,898,000		4,002,000	4,109,000	4,218,297			
	Expected pregnancies	139,314	145,881	133,274	136,831	137,072	140,718		144,472	148,335	152,281			
	Expected deliveries	139,314	145,881	133,274	136,831	137,072	140,718		144,472	148,335	152,281			
	Children under-five years	453,374	474,744	562,993	570,624	584,738	600,292		632,316	628,677	641,181			
	Children under-one year	41,278	43,224	119,947	122,634	126,241	129,291		132,619	135,948	139,276			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						126,730		132,619	133,590	137,144			
	Women of Reproductive Age (15-49 years)	697,260	730,486	805,047	833,562	861,919	888,744		940,470	945,070	974,427			
Health Status	**Infant Mortality Rate (DHS)**	**0**			**99**								**45**	
	Under five Mortality Rate (DHS)	**0**			**184**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	0			5.7								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				44%						51%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			1%	1%	1%	1%		1%	1%	1%			
	% pregnant women TT2+ coverage (HMIS)	6%	0%	4%	8%	3%	5%		4%	4%	8%			
	… (DHS)				8%									
	% ANC Coverage (HMIS)	6%	0%	5%	6%	3%	15%		5%	15%	4%	45%	80%	
	… (DHS)				15%						7%			
	% Births attended by skilled staff (HMIS)	**3%**	**0%**	**1%**	**2%**	**2%**	**6%**		**3%**	**4%**	**3%**	**25%**	**32%**	
	… (DHS)				**7%**						**5%**			
	% PNC Coverage (HMIS)	1%	1%	0%	9%	0%	1%		1%	1%	1%			
	… (DHS)				4%									
	Contraceptive acceptor rate (HMIS)	**1%**	**0%**	**2%**	**2%**	**2%**	**4%**		**2%**	**2%**	**0%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**0%**						**3%**			
	% < 1 yr immunised for DPT3 (HMIS)	**11%**	**0%**	**5%**	**9%**	**6%**	**4%**		**5%**	**5%**	**11%**	**70%**	**80%**	
	… (DHS)				**24%**						**6%**			
	% < 1 yr immunised for measles (HMIS)			**6%**	**9%**	**6%**	**4%**		**6%**	**7%**	**13%**			
	… (DHS)				**39%**						**6%**			
	% Fully immunised under one year (HMIS)			3%	9%	0%	1%		3%	4%	6%		54%	
	… (DHS)				22%						3%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**28%**	**18%**	**17%**		**50%**	
	TB Cure Rate %				**64%**	**74%**	**77%**		**79%**	**75%**	**77%**		**85%**	
	TB Treatment Success Rate %				69%	78%	79%		81%	77%	78%			
	% Hospitals & HCs providing DOTS / MDT								12%	13%	18%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**3.7%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	2.2%	2.3%	2.3%	2.4%	2.4%	2.5%		2.5%	2.5%	2.5%			
	HIV Incidence (%)***								0.32%	0.33%	0.34%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate											15%		
Hygiene and Env. Health	**Access to safe water %**	**0%**										**42%**		
	Access to improved sanitation %	**0%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	30%	32%	31%	37%	31%	46%		48%	44%	42%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:312,715	1:327,455	1:360,200	1:205,452	1:379,700	1:229,294		1:200,100	1:241,706	1:263,644	!:135,000		
	Outpatient visits / pp / yr			**0.04**	**0.07**	**0.04**	**0.00**		**0.09**	**0.09**	**0.08**	**0.50**	**0.66**	
	Admissions / p100p / yr				0.1	0.1	-		0.2	0.1	0.1			
	Doctor/Population Ratio	**1:79,997**	**1:83,767**	**1:94,789**	**1:78,684**	**1:99,921**	**1:23,914**		**1:87,000**	**1:97,833**	**1:76,696**		**1:14,000**	
	Nurse/Population Ratic	1:24,396	1:25,546	1:17,401	1:12,665	1:11,201	1:3,001		1:12,314	1:10,673	1:10,957			
	Midwife/WRA Ratio	1:232,420	1:243,495	1:80,505	1:46,309	1:34,477	1:6,172		1:4,125	1:19,689	1:23,201		1:6,759	
	HEW/Population Ratio										#DIV/0!		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	25,152,490			38,853,000	69,180,000	#N/A		90,361,800	53,710,000	31,830,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	7.3	#N/A	#N/A	10.5	18.2	#N/A		22.6	13.1	7.5			
	GOE per capita expenditure on health (Birr / pp)	**5.9**			**7.7**	**4.7**	**#N/A**		**7.3**	**5.8**	**8.3**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	81%			73%	26%	#N/A		32%	44%	111%			
	Bed Occupancy Rate								6%	8%	7%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		4.71%	0.00%	2.67%	2.67%	2.66%		2.67%	2.67%	2.66%			
	pregnant pc	4.05%	4.05%	3.70%	3.70%	3.61%	3.61%		3.61%	3.61%	3.61%			
	delivery pc	4.05%	4.05%	3.70%	3.70%	3.61%	3.61%		3.61%	3.61%	3.61%			
	under five pc	13.18%	13.18%	15.63%	15.43%	15.40%	15.40%		15.80%	15.30%	15.20%			
	under one pc	1.20%	1.20%	3.33%	3.32%	3.32%	3.32%		3.31%	3.31%	3.30%			
	sutrviving infants pc						3.25%		3.31%	3.25%	3.25%			
	wra (15-49) pc	20.27%	20.28%	22.35%	22.54%	22.70%	22.80%		23.50%	23.00%	23.10%			

Unless otherwise noted, all data are from the Annual FMOH publication, *Health and Health Related Indicators.* MDG and SDPRP indicators in bold type
Financial data - 1989-1994: budget and expenditure data from HHRI
1995: Budget and expenditure figures are consolidated accounts from CAD/MOFED
1996-1997: Federal budget and expenditure figures are also consolidated accounts from CAD/MOFED
Regional budget figures from HHRI; regional expenditure figures are budget execution figures (preliminary actuals) from the flash reports from Woredas/regions, collected and consolidated by MOFED.

*1989 survey sources: IMR, U5MR, and TFR from 1994 Population & Housing Census of Ethiopia; MMR from World Development Report 1997; access to safe water and sanitation from HSDP
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Region: SNNPR **14,792,670**
Trend analysis 1989 - 1997 116
Number of woredas: 34

		HSDP I							HSDP II					
		baseline 1989* 1996-97 GC	1990 1997-98 GC	1991 1998-99 GC	1992 1999-2000 GC	1993 2000-01 GC	1994 2001-02 GC	Target 1994 (Nat'l)	1995 2002-03 GC	1996 2003-04 GC	1997 2004-05 GC	Target 1997 (Nat'l)	Target HSDP III (Nat'l)	MDG Target (Nat'l)
Demographic statistics	Total Population	3,359,883	3,593,000	3,593,000	3,694,650	3,797,000	3,901,000		4,006,008	4,113,000	4,223,014			
	Expected pregnancies	136,075	145,517	160,607	165,151	153,399	157,600		161,843	166,165	170,610			
	Expected deliveries	136,075	145,517	160,607	165,151	153,399	157,600		161,843	166,165	170,610			
	Children under-five years	550,349	588,174	638,835	665,406	672,069	682,675		709,063	695,097	705,243			
	Children under-one year	113,228	121,084	146,235	154,870	150,696	147,975		144,528	141,081	152,935			
	Surviving infants (DPT3, Measles, FIC Target 1994 on)						141,273		145,076	148,950	152,935			
	Women of Reproductive Age (15-49 years)	767,061	821,360	831,420	853,464	880,904	908,933		961,442	962,442	992,408			
Health Status	**Infant Mortality Rate (DHS)**	**123**			**104**								**45**	
	Under five Mortality Rate (DHS)	**181**			**169**								**85**	**67**
	Maternal Mortality Ratio (DHS)											**450**	**600**	**450**
	Total Fertility Rate (DHS)	5.4			5.8								4	
	% Under five years underweight / stunted (HMIS)													
	… (-2SD, WfA) (DHS)				48%						42%			
Service Delivery Outputs: Family Health	% non-pregnant women TT2+ coverage (HMIS)			37%	17%	46%	9%		4%	32%	3%			
	% pregnant women TT2+ coverage (HMIS)	16%	27%	30%	12%	34%	10%		130%	31%	67%			
	… (DHS)				14%									
	% ANC Coverage (HMIS)	27%	43%	44%	72%	79%	67%		71%	68%	39%	45%	80%	
	… (DHS)				36%						35%			
	% Births attended by skilled staff (HMIS)	**27%**	**29%**	**28%**	**31%**	**41%**	**37%**		**35%**	**35%**	**34%**	**25%**	**32%**	
	… (DHS)				**5%**						**6%**			
	% PNC Coverage (HMIS)	4%	5%	13%	25%	38%	34%		32%	39%	37%			
	Contraceptive acceptor rate (HMIS)	**13%**	**8%**	**17%**	**37%**	**38%**	**44%**		**34%**	**40%**	**35%**	**24%**	**45%**	**44%**
	Contraceptive prevalence rate (modern) (DHS)				**10%**						**16%**			
	% < 1 yr immunised for DPT3 (HMIS)	**83%**	**95%**	**76%**	**76%**	**79%**	**89%**		**89%**	**82%**	**89%**	**70%**	**80%**	
	… (DHS)				**56%**						**52%**			
	% < 1 yr immunised for measles (HMIS)			**70%**	**67%**	**71%**	**79%**		**84%**	**74%**	**83%**			
	… (DHS)				**67%**						**63%**			
	% Fully immunised under one year (HMIS)			37%	50%	58%	68%		74%	65%	74%		54%	
	… (DHS)				44%						33%			
Service Delivery Outputs: Disease Prevention and Control	**TB Case Detection Rate**								**31%**	**51%**	**29%**		**50%**	
	TB Cure Rate %				**65%**	**72%**	**68%**		**64%**	**68%**	**82%**		**85%**	
	TB Treatment Success Rate %				83%	81%	80%		81%	80%	87%			
	% Hospitals & HCs providing DOTS / MDT								55%	57%	73%	75%	72%	
	HIV Prevalence (15-24 pregnant women)* **									**7.2%**		**<7%**	**<4.4%**	
	HIV/AIDS Adult prevalence (%)***	3.3%	3.5%	3.7%	3.8%	4.0%	4.1%		4.3%	4.4%	4.6%			
	HIV Incidence (%)***								0.62%	0.65%	0.66%			
	% Hospitals / HCs with VCT													
	Malaria case fatality rate											15%		
Hygiene and Env. Health	**Access to safe water %**	**21%**										**42%**		
	Access to improved sanitation %	**7%**										**35%**	**80%**	
Access to Public Medical Services	Potential Coverage HF (HC+HS+HP) (MoH+NGO)	109%	78%	79%	80%	80%	79%		83%	83%	96%		100%	
	% population within 10km of HC or HP													
	HC / Pop Ratio	1:159,994	1:189,105	1:119,767	1:127,402	1:130,931	1:139,321		1:114,457	1:128,531	1:87,979	1:135,000		
	Outpatient visits / pp / yr			**0.85**	**0.72**	**0.80**	**0.54**		**0.74**	**0.77**	**0.79**	**0.50**	**0.66**	
	Admissions / p100p / yr				0.7	0.8	-		0.7	0.9	1.0			
	Doctor/Population Ratio	**1:39,068**	**1:34,219**	**1:46,662**	**1:52,037**	**1:53,479**	**1:59,106**		**1:47,130**	**1:44,707**	**1:54,844**		**1:14,000**	
	Nurse/Population Ratio	1:6,899	1:5,411	1:7,229	1:5,855	1:4,325	1:3,870		1:3,278	1:3,060	1:2,987			
	Midwife/WRA Ratio	1:95,883	1:54,757	1:46,190	1:47,415	1:6,204	1:7,390		1:5,114	1:5,259	1:7,140		1:6,759	
	HEW/Population Ratio										1:10,558		1:2,500	
Quality and Management	JSC / RJSC meetings													
	%Tracer drugs available											80%	100%	
	HMIS completeness and timeliness rate												80%	
Efficiency and Finance	Government budget allocation to health (Birr)	54,878,262			38,774,000	93,320,000	#N/A		131,801,071	95,560,000	112,462,000			
	% GOE budget allocated to health											8.20%	'Double'	
	GOE per capita budget for health (Birr / pp)	16.3	#N/A	#N/A	10.5	24.6	#N/A		32.9	23.2	26.6			
	GOE per capita expenditure on health (Birr / pp)	**13.7**			**10.0**	**13.8**	**#N/A**		**22.1**	**17.8**	**18.2**	**18.0**	**9.6**	
	Total annual per capita expenditure on health (US$											6.00	9.60	
	Absorptive capacity (expenditure / budget)	84%			95%	56%	#N/A		67%	76%	68%			
	Bed Occupancy Rate								32%	38%	54%			
	% fees retained											20%	100%	
Demographic statistics	growth rate****		6.94%	0.00%	2.83%	2.77%	2.74%		2.69%	2.67%	2.67%			
	pregnant pc	4.05%	4.05%	4.47%	4.47%	4.04%	4.04%		4.04%	4.04%	4.04%			
	delivery pc	4.05%	4.05%	4.47%	4.47%	4.04%	4.04%		4.04%	4.04%	4.04%			
	under five pc	16.38%	16.37%	17.78%	18.01%	17.70%	17.50%		17.70%	16.90%	16.70%			
	under one pc	3.37%	3.37%	4.07%	4.19%	3.97%	3.79%		3.61%	3.43%	3.62%			
	sutrviving infants pc						3.62%		3.62%	3.62%	3.62%			
	wra (15-49) pc	22.83%	22.86%	23.14%	23.10%	23.20%	23.30%		24.00%	23.40%	23.50%			

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