

Implementing Effective Leadership and Coordination Systems for Better Health Outcomes in Ethiopia (2004–2016)



KDI SCHOOL
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PROJECT DATA

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Executive Summary

Over the past 15 years, the Ethiopian government has designed and implemented policy programs and strategies to enhance its coordination and leadership capacities and to promote effective health sector outcomes. The country has repeatedly encountered calamities, both manmade and natural. In particular, its 17-year civil war (1974–1991) took a heavy toll in lives, destroyed social and physical infrastructure, and further aggravated the country’s socioeconomic problems. After the war, from the 1990s to the mid-2000s, the Ethiopian health landscape was discouraging, characterized by high maternal and child mortality, the expansion of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), and pervasive tuberculosis.

The aforementioned factors put pressure on the Ethiopian government to address the country’s health problems through different programs and policies. One fundamental approach was the use of comprehensive policy planning to bring concerned parties toward the same vision and results. In line with this approach, the government designed an innovative policy intervention, the Health Extension Program (HEP), in 2004 as an integral part of the second Health Sector Development Program (HSDP). This intervention was believed to build efficiency and effectiveness in terms of finance mobilization and utilization and to fill skill gaps and enhance accessibility, which were the main constraining factors in the execution of the first HSDP. However, the outcomes of the program in the first years of implementation were not as hoped; the program faced delivery challenges including inadequate stakeholder coordination and engagement and diffused leadership and commitment among the government and stakeholders. To address these problems, the government implemented various coordination

and leadership strategies to leverage the impact of overall involvement in the health sector.

While the aforementioned scenarios were taking place in Ethiopia's health sector, the situation was changing in the global health structure. The international society began to sense the ineffectiveness of stakeholders' health sector engagement in developing countries, which was characterized by fragmentation, volatility, proliferation of aid from development partners, and lack of ownership of the policy environment by the countries' governments. This situation resulted in a divergence of focus and interests among the stakeholders in the sector emanating from the weakness of both the governments and their development partners. Therefore, coordinating the engagement of interested parties to enhance aid effectiveness and ownership has become the sector's issue of the day.

In line with this focus, the One Plan, One Budget, and One Report approach brings all participants in the health sector to the same level of mutual accountability. This approach also aims to consolidate all commitment, efforts, and approaches of stakeholders on to one platform, where the plans, budgets, reports, and evaluation processes appear as one integrated package. In 2007, this approach was incorporated into the International Health Partnership (IHP) which was proclaimed in Paris. Its basic principles are (a) enhancing the ownership of aid in recipient countries, (b) aligning and harmonizing aid efforts concerning the health sector, and (c) realizing efficiency and mutual accountability to achieve strong and sustainable health systems in developing countries.

On the basis of the principles of the IHP, Ethiopia prepared its own country compact in 2008. Consequently, the Millennium Development Goals Performance Fund (MDG PF) was crafted as an instrument to bring the compact's commitment into practice, starting with two donors who together contributed US\$10 million to the fund. In 2009, to guide the administration of this fund, the first Joint Financial Agreement (JFA) was signed, containing the main responsibilities and duties of the government and donors. Both the number of participants in the fund and the amount contributed to it were far below what had been hoped for because of the leadership and coordination constraints of mobilization. Realizing this, the Ethiopian government launched overall efforts to enhance its coordination and reform efforts in political diplomacy, leadership, structural adjustment, and capacity building.

The coordination mechanisms practiced since 2009 have been tailored to the context of the country and are based on IHP principles and MDG PF structures. The overarching coordination mechanism has been led by the Joint Consultative Forum (JCF), which consists of ministers and heads of bilateral and multilateral development partners. It focuses on and discusses strategic issues every quarter. The JCF is technically supported by the Joint Core Coordinating Committee (JCCC), which includes experts from the Federal Ministry of Health (FMOH) and development partners (DPs) and focuses on planning, evaluation, and auditing and reporting systems. Without the JCF's consent, no plan is approved and implemented in Ethiopia's health sector. This coordination has helped to align the interests of different stakeholders and to enhance the effectiveness and efficiency (the value for money) of aid through improved allocation of money toward commonly identified gap areas, common administration, and mutual accountability. Furthermore, the Ethiopian government, being nourished with these flows of coordinated information and lessons, has transformed its internal process of business administration.

The DPs have also used their own coordination facility, the Health, Population, and Nutrition (HPN) Forum, since 2009. They set their own agenda, identify challenges, and discuss them in detail through this platform. "When we come to JCCC meetings, we sound as one voice reflecting the issues that are agreed on in the HPN consultations," said a health expert from Irish Aid.¹ The HPN Forum also invites and incorporates the interests and perspectives of civil society organizations (CSOs) that work with donors on specific health programs. This triangular coordination mechanism helps to consolidate and integrate the overall efforts in the health sector and align different interests.

Besides strengthening the coordination efforts, the Ethiopian government has focused on its planning process as a means of leveraging leadership and commitment. The planning system, which uses both top-down and bottom-up approaches, encompasses, includes, and accommodates the voices of all who are engaged with the health sector, enabling the government to play its leadership role. Having prepared these clear strategies, the government could use them to convince donors to join the network of the health sector fund.

1 Author interview with Abenezer Tamerat, Irish Aid, August 2017.

The country's prime minister and leaders in the sector have geared all their efforts toward attaining the MDG goals, with strict leadership in the implementation of plans in mutually accountable bases, particularly since the third HSDP was enacted in 2008. "The Ethiopian government's plans and strategies are so attractive that they are worthy of being financed by donors," asserted one expert from the United Nations Population Fund (UNFPA).² Because of these efforts, the JFA was revised in 2011, and the number of participants and their contribution amounts increased significantly, from 2 to 8 and from 10 million to 230 million, respectively.

In summary, the outcomes registered in the Ethiopian health sector over the past 15 years are impressive. The coordination, negotiation, transformation, implementation of strategic drafting processes, and, particularly, the bringing of stakeholders to a uniform level of concern and consensus have helped to fill the gaps in the sector efficiently and effectively by increasing the value for money spent on development. This process has greatly improved the sector's overall results, particularly in HIV prevalence and maternal and child health, and the strength of the health system's infrastructure.

Introduction

"The efficiency and the value for money in the health sector of this country [Ethiopia] is very high." Thus did Marco Gerritsen, a senior health and development expert working in the Embassy of the Netherlands, sum up the sense of overall progress registered over the past 15 years in the Ethiopian health sector.³ The country—which had faced a multitude of health problems, including high maternal and child mortality, widespread malaria, and high HIV prevalence—now serves as a model for health sector attainment. These successes are guided by innovative coordination and leadership mechanisms to mobilize resources from stakeholders. However, these achievements were not gained in any simple or easy way. This case study will trace the establishment of strong channels for health funding in Ethiopia through the creation of the MDG PF.

Ethiopia is a melting pot of diverse cultures, languages, and religions, with a total population of around 100

million (CSA 2013). More than 80 ethnic groups inhabit the country, many with their own language; Amharic is the country's working language. Ethiopia is Africa's oldest independent country and has great geographical diversity, ranging from peaks up to 4,550 meters above sea level to a depression of 110 meters below sea level. The country has nine regional states (Afar; Amhara; Benishangul-Gumuz; Gambela; Harari; Oromia; Somali; the Southern Nations, Nationalities, and Peoples' Region [SNNPR]; and Tigray) and two cities run by their own administrative councils, Dire Dawa and Addis Ababa. The regional states and city administrations are subdivided into 817 administrative *woredas* (districts). A *woreda* is the country's basic decentralized administrative unit and has an administrative council composed of elected members.

Two decades ago, Ethiopian citizens faced many health problems, which were further aggravated by the lack of human, infrastructural, and social capital in the country. The country's civil war from 1974 to 1991 took hundreds of thousands of lives, displaced many more citizens, and destroyed physical and social infrastructure. After the collapse of the Derg military regime, a transitional government was established in 1992 and led the country for three years, learning how to administer the government. The new permanent government, established in 1995 after the first election, lacked a clear strategy for the first five to eight years to address the deep-rooted problems in various sectors of the economy.

Recognizing this problem, the government introduced the Health Extension Program (HEP) in 2004. This program employed health workers to staff posts and provide basic health services. The essence of the program was a diffusion model, in which model households received training in good practices and then transmitted these practices by demonstration to other households in the neighborhood. However, this program was not effective in its early years of implementation because of coordination, leadership, and capacity challenges. The government needed to adapt its mechanisms for delivering the program.

Since 2008, context-tailored coordination mechanisms adapted from the implementation of the MDG PF have enabled the government to coordinate stakeholders to implement the HEP in a more efficient way. The basic structures of the MDG PF, such as the JCF and the JCCC, have facilitated mutual understanding between the government, DPs, and CSOs. Additionally, the HPN

2 Author interview with Dr. Awoke Tasew, UNFPA, August 2017.

3 Author interview with Marco Gerritsen, Embassy of the Netherlands, August 2017.

Forum, composed of DPs and CSOs, has enhanced coordination among stakeholders since its establishment in 2013. Efficient functioning of these structures resulted in a well-aligned, predictable, and harmonized aid structure in the country that has supported the implementation of the HEP in a sustainable way.

In addition to effective coordination mechanisms to implement the HEP, the government has transformed its overall planning, resource mobilization, and monitoring and evaluation systems since the second half of the 2000s. These processes have helped to enhance the quality of its plans and have facilitated the government's leadership of those plans through resource mapping. The overall process of leadership and coordination has improved the health status of citizens so that mothers are not afraid of giving birth, children are mentally and physically healthy and free from easily controllable diseases and malnutrition, health infrastructure is available in every part of the country, and donors have greater trust in the health system.

Development Challenge: Improving Health Services

In the 1990s and early 2000s, Ethiopia lagged behind other African countries on development indicators. The country suffered from a high burden of disease and high maternal and child mortality. For example, according to a survey conducted by the Ethiopian Central Statistical Agency (CSA) and an annual report by the FMOH, infectious communicable diseases and maternal and neonatal conditions constituted 60–80 percent of the country's disease burden in 2005, leading to unacceptably high morbidity and mortality rates (a maternal mortality rate of 873/100,000 births and an under-five mortality rate of 166/1,000 live births) (World Bank 2005). In addition, in 2005, only 1.3 percent of children under five slept under insecticide-treated mosquito nets; only 32 percent of children exclusively breastfed; only 37 percent of children with diarrhea were given oral rehydration therapy; only 17 percent of children with a fever or cough were brought to a health facility; immunization coverage remained low; and only 6 percent of mothers were assisted by a skilled health worker during delivery (CSA and ICF International 2012). These problems were aggravated by interrelated factors such as scarce education and information facilities; a shortage of health facilities within a reachable distance; an overall

shortage and skewed distribution of human resources; and inadequate, fragmented, and inefficient financial mobilization capacity (5.6 USD per capita per year in 2000) (World Bank 2000).

Recognizing the pervasive nature of these problems, the Ethiopian government developed the Health Extension Program (HEP) in 2004/05 as a major policy intervention to tackle the health challenges highly prevalent in the country's rural areas. Aligned with the Millennium Development Goals (MDGs), particularly MDG 4 (reducing child mortality), MDG 5 (improving maternal health), and MDG 6 (combating HIV/AIDS, malaria, and other diseases), the HEP has been implemented since 2004/05 in all regions of Ethiopia, along with four subprograms (disease prevention and control; family health, particularly maternal and child health; environmental hygiene and sanitation; and health education and communication) and 16 packages (listed in table 1).

The implementation of the program relied on a diffusion model and selected families that were perceived as economically and socially successful. A training course on the packages of the HEP, covering 96 hours, was given to these families; they then started demonstrating and practicing the contents of the training. The idea was that the practical behavioral changes observed in the model households would have a ripple effect, attracting other households to follow their examples. This effect would then diffuse into the villages, reaching yet more households.

Previous experiences and lessons from earlier community health workers' initiatives were also identified and incorporated into the design of the HEP, such as those involving traditional birth attendants and other voluntary workers. In addition, the project benefitted from South-South cooperation and experience-sharing between Ethiopia and the Indian state of Kerala.

Delivery Challenges: Leadership; Coordination and Engagement

By 2004/05, the Ethiopian government had begun to implement the HEP. The idea of leading all stakeholders with common strategic priorities to achieve the same goals was central to the program. The government also aspired to mobilize resources from different sources in a coordinated manner to fill the financial, structural, and capacity gaps facing the program. However, due to lack of

Table 1. Packages of the Health Extension Program

Disease prevention and control
HIV/AIDS and STIs
Tuberculosis
Malaria prevention and control
First aid emergency measures
Family health
Maternal and child health
Family planning
Immunization
Nutrition
Adolescent reproductive health
Hygiene and environmental sanitation
Excrement disposal
Solid and liquid waste disposal
Clean water supply
Food hygiene
Healthy home environment
Personal hygiene
Rodent control
Health education
Health education and communication (cross-cutting)

Note: AIDS = acquired human immune deficiency syndrome; HIV = human immunodeficiency virus; STI = sexually transmitted infection.

Source: Mangham-Jefferies, Mathewos, Russell, and Bekele 2014.

efficient and effective coordination and engagement and of leadership and commitment mechanisms employed in practice, the initial results were not as desired.

Coordination and Engagement

At the beginning of the process traced by this case study, the intra- and intersectoral coordination mechanisms among stakeholders in the Ethiopian health sector were very weak. DPs and CSOs had no opportunities to make their voices heard and integrated into the government’s policy planning processes. The country lacked a well-functioning coordination structure to communicate government and other stakes in the sector in a formal and regular manner. Building mutual understanding and consensus had been very challenging. In addition, for a long time bilateral and multilateral DPs engaged in the country’s health sector had no means to coordinate among themselves. Setting common agendas, discussing these agendas so that the organizations would speak with one

voice, and enacting change on the part of the government had long been almost impossible. Furthermore, the CSOs also lacked a common platform with which to share their experiences, integrate their activities, and align with government plans and priorities.

These factors created a lack of quality, efficiency (in the government planning and evaluation process), and mutual trust, all of which hindered the coordinated and full engagement of the stakeholders in implementing the program. It also resulted in a fragile and highly proliferated aid structure in the health sector: donors found themselves working with many CSOs and projects in different parts of the country, losing opportunities to create efficiency, economies of scale, and value for money. One diplomat described the situation thus: “Each of us [donors] were acting like frogs on a bucket, jumping here and there without well understanding what the next step might be.”⁴

Leadership and Commitment

The process of preparing the first HEP was neither inclusive nor participative. The generation of ideas, the prioritization of those ideas, and target generation and indicator setting were carried out by government experts behind closed doors. The interests of stakeholders practicing in the health sector were not given full consideration. Following this trend, reports of government and stakeholder performance were not presented or publicly monitored and evaluated frequently. Only rarely did the priorities, targets, and budgets of stakeholders in the health sector align.

The DPs each had their own programs and projects, working with various CSOs to attain the targets of their programs in different locations. These DPs and CSOs were not attuned to the main programs, strategies, and priorities of the government because of the lack of strict government leadership and commitment. This resulted in high proliferation and fragmentation of the aid architecture. As one stakeholder summed up the issue, “There are more than 80 partners that want such dialogue. If the government wants to accelerate a program in one region, it is also necessary to engage two or three implementing partners in each region to ensure their alignment to the national priorities, as there are

⁴ Author interview with Marco Gerritsen, Embassy of the Netherlands, August 2017.

many DPs working in different areas” (FMOH and Italian Corporation 2014).

The machinery of the government at all levels of administration failed to engage actively in the planning process from inception to implementation to leverage its leadership and commitment at the desired level. Priorities were identified and set from the top, and low-level bureaus and offices were consulted on these priorities only irregularly. Intervention identification was not practiced efficiently, increasing the cost of interventions and hindering the development of financial strategy. This disorganization, in turn, obstructed the gap identification, prioritization, and reprioritization process and the development of innovative and strategic ways to fund mobilization activities.

Tracing the Implementation Process: Innovative Solutions for the Delivery Challenges

To tackle the delivery challenges facing the HEP and much of Ethiopia’s health sector, the Ethiopian government created new mechanisms to enable it to effectively exercise leadership and coordinate the many stakeholders working in the sector.

Solution 1: Context-tailored coordination mechanism

At the same time as the challenges described above were ongoing, the international community was working to create innovative ways to solve challenges in the health sectors of developing countries in a coordinated manner. One approach, based on the principle of one plan, one budget, and one report, emerged; initiated and advocated by former British Prime Minister Gordon Brown since 2005. This principle proposes the alignment of the government’s, donors’ and CSOs’ planning, budgeting, and reporting systems in one format in order to enhance aid ownership, alignment, and harmonization in the recipient country.

To bring these principles into reality, the IHP was signed in Paris in 2007. Ethiopia was among the first countries to sign this partnership and considered it a prospective solution for the country’s lack-of-coordination and engagement-alignment problems. It was hoped that this would result in coordination of planning, budgeting, and financing in the Ethiopian health sector; leveraging of that coordination to fill the

gaps caused by financial and aid constraints; creation of an organized structure to facilitate the implementation of the HEP; and tackling of the country’s human capital and infrastructural gaps.

On the basis of these principles, in 2008 Ethiopia prepared its own country compact program and operationalized the MDG PF. The program was administered based on the government financial system directly allocated to the channel-two fund-mobilizing modality of the FMOH, which commonly draws on pools of funds from the government finance and purchasing system but does not solely rely on either government treasury systems (referred to as channel one) or donor systems (channel three). The country adapted the IHP system to its domestic context. The structures of the MDG PF (in particular, the JCF and the JCCC), along with a flexible multi-donor trust fund managed through government procedures, have helped link donors and recipients in order to finance high-impact interventions. These structures were regarded as the most helpful aid-coordinating modality because they could lower transaction costs, enable allocation of funds to where they were most needed, strengthen government systems, improve predictability of funding, and coordinate all concerned stakeholders.

To guide the use of this fund, the first JFA was signed by the FMOH, the Ministry of Finance and Economic Development (MOFED), and DPs in 2009. This fund would be managed by the government’s finance system, and purchasing for it would require a dependable, strong, accountable, and transparent financial mechanism. “The DPs, before signing and participating in this system, evaluated the financial, auditing, purchasing, and structural capacities of the government, and they got them sound and worth trusting,” explained Dr. Awoke Tasew, a cluster lead with UNFPA.⁵

This system made it possible to integrate the interests of the different stakeholders and focus them toward common goals. Abenezer Tamerat, a health expert working with Irish Aid, explained that “Irish Aid has been acting in the health sector by designing its own country-specific program since 1994. The implementation of the MDG PF has created a conducive structure and environment to align its program with government priorities and has identified gap areas to

5 Author interview with Dr. Awoke Tasew, UNFPA, August 2017.

address in coordination with all stakeholders.”⁶ The funds are allocated to financial channel two, and are used and administered by the ministry based on government financial procedures.

The overarching structure of the MDG PF aid architecture is the JCF; its members are the two health ministers and heads of bilateral and multilateral agencies. They meet quarterly to discuss strategic and policy issues in the health sector. This forum has its own technical wing called the JCCC. Its members are experts from the Policy Planning Directorate (PPD) of FMOH and health experts from bilateral and multilateral donors, and it is led by the director of the PPD. Tseganeh Amsalu, a health finance mobilization advisor for the FMOH, noted that “the existence of this architecture in the Ethiopian health system has brought about efficient mechanisms of coordination, alignment, and engagement in the health sector.”⁷

The JCCC, as the technical wing of the JCF, meets every two weeks to discuss transformation, strategic and comprehensive planning, auditing, reporting and monitoring, and evaluation issues concerning the health sector. Without the consensus of this coordination committee, no intervention or target is approved to be financed by the MDG PF. Dr. Awoke Tasew, the UNFPA cluster lead, explained the functioning of this mechanism, stating that “we discuss every part of the health sector plan (interventions, targets, programs, initiatives, and such) in detail and approve it with consensus in our JCCC meeting. If the government wants to add some other interventions, targets, or priorities to the plan, it must notify us; and [the changes are] approved only with our agreement.” The proper functioning of this mechanism helped to coordinate and align priorities, targets, and directions.⁸

The JCCC also monitors and evaluates whether funding has gone to the main priority areas that it is designated for. “If any targets are set by the government without prior recognition of the donors, then the JCCC evaluates and asks for justification,” explained Gerritsen of the Netherlands embassy.⁹ The government should present its justification to the members of the JCCC to persuade it to include new targets. “A discussion is held,

and if consensus is reached, then the target is included in the plan.”

Dr. Awoke recalled one occasion, for example, when the FMOH included a target without prior consent of the JCCC to purchase 500 ambulances in one budget year. After the HPN forum requested more information about this purchase, “the government brought sound justification, and finally, we approved [the target].”¹⁰

Marco Gerritsen of the Netherlands Embassy added that “this process builds confidence and trust in working with the government.”¹¹ In addition, if humanitarian issues are raised due to drought or other emergencies, then the fund is allocated only on the basis of the consent of the donors witnessing the flexibility of the mechanism. “This helps efficient and effective utilization of the fund in a most coordinated way,” said one expert from the World Health Organization (WHO).¹²

This effective implementation of the JCF and the JCCC has brought about a strong system of coordination among the bilateral and multilateral DPs participating in the health sector, enabling them to work in an integrated manner. The HPN Forum, which is cochaired by one representative from each bilateral and multilateral DP, has been used to create coordination among them. As one expert from the WHO explained, “We set our own agenda for discussion during our HPN meeting and reach a common stance about it, having strong debate. Then, as one voice, we take our agreed-upon points to the government during the JCF meeting with the government officials.”¹³

The bilateral and multilateral DPs also include CSOs in the HPN Forum and help their voices to be heard. Interviewees indicated that CSO participation in these meetings was common.¹⁴

The coordination mechanism for the CSOs has also improved following the effective implementation of the JCF and the JCCC. To align and coordinate their activities with the government’s, CSOs participate in the planning, monitoring, and evaluation process. They align with the priorities of their specific donors, following the framework of the government’s plan. “We (the DPs) work with our program-specific CSOs by providing them with finance, and we plan together. Based on this plan, they

6 Author interview with Abenezer Tamrat, Irish Aid, August 2017.

7 Author interview with Tseganeh Amsalu, FMOH, August 2017.

8 Author interview with Dr. Awoke Tasew, UNFPA, August 2017.

9 Author interview with Marco Gerritsen, Embassy of the Netherlands, August 2017.

10 Author interview with Dr. Awoke Tasew, UNFPA, August 2017.

11 Author interview with Marco Gerritsen, Embassy of the Netherlands, August 2017.

12 Author interview with an expert from the WHO, August 2017.

13 Author interview with an expert from the WHO, August 2017.

14 Author interview with Dr. Awoke Tasew, UNFPA, August 2017.

align their activities and priorities with the government's plan. The policy coordination and alignment with the government's prior directions is always at the forefront," said one donor country representative.¹⁵ CSOs also have a common consultation forum with the government at the federal and regional levels. The chair of the CSO health forum, Mekonnen Biru, pointed out that in 2013, the minister of health began to organize and augment the activities of health sector CSOs by encouraging the formation of the health forum.¹⁶

Using these consultation, coordination, and consolidation mechanisms, CSOs identify the government's main capacity gaps and try to fill "financial, human-resource, and logistical gaps of the government in a coordinated manner."¹⁷ The CSO forum also carries out advocacy and promotion work in the least-developed regions of the country. For example, in the Arsi and West Arsi zones of the Oromia region, the public committee organized by the CSOs has played a significant role in monitoring and evaluating government activities regarding good governance and other basic services in all sectors, including health, education, and agriculture, that are involved with the MDG PF. The committee works to enhance public and social awareness of the performance of government offices. It urges government leaders to post financial, budgeting, and auditing reports on the doors of the offices to be clearly seen by society. Through these arrangements, citizens become aware of what is taking place, and their feedback helps the government efficiently allocate and use resources in the health sector and in other sectors.

This public committee run by the CSOs also actively follows and monitors, alongside local administrative units, the activities of the health extension workers. For example, Mekonnen, the CSO forum head, explained, "If a woman delivers her baby in the house, then the extension workers in that particular area become responsible and accountable for that." Thus, emphasizing the impact of these government-CSO-DP coordination mechanisms involving the JCF and the JCCC, Mekonnen asserted that "this process of coordination, from planning to evaluation, has helped us to fulfill our role in coordinated and aligned ways to make a tangible impact on the health sector."¹⁸

The ministry also has its own internal coordination mechanism that helps it to measure its successes and failures before it meets with the DPs and CSOs at the JCF. The Joint Steering Committee (JSC) is very strong and well organized. In it, the directors of each department, the ministers, the regional bureau heads, and the heads of FMOH agencies meet quarterly to discuss their internal business process in order to identify problems and give immediate solutions. The discussion focuses mainly on financial issues of budgeting, use, and reporting of MDG PF funds. Each department presents timely reports about its allocated budget, the use of those funds, liquidation, and auditing, and monitoring mechanisms are taken seriously.¹⁹

To share the burden of this coordination process within the ministry, the finance department sends text messages to each of the concerned bodies about their financial utilization status every week. The departments and regional bureaus to whom the budget is directly allocated are notified of their utilization rate and liquidation status. If there is any delay or discrepancy in their financial reporting, they are asked to justify it through this short text messaging system. The directories and ministries are notified to follow up with the bureaus and teams that are under their immediate supervision regarding the finances allocated to them. Sufiyan Abdul, who was the Director of the Medical Input Logistics and Supply Directorate of the FMOH explained that this helped to control resource misutilization at the lowest level and reduce it compared with other social sectors in the country.²⁰

The proper use of the aforementioned coordination process by stakeholders, underpinned by the JCF and the JCCC, has helped to solve a lot of challenges. DPs use their platform to identify problems and push the government to make reforms and improvements. For example, almost 80 percent of the MDG PF is allocated for the purchasing of health equipment and medicine; however, the purchasing, utilization, liquidation, and auditing rates were very low. "Almost 50 percent of the budget was carried over for the next year, and the audit reports for many years were not complete," Abenezer, the expert from Irish Aid, noted.²¹ This situation led donors to discuss it in the HPN Forum, where they took one common position about it: they would urge the

15 Author interview with Marco Gerritsen, Embassy of the Netherlands, August 2017.

16 Author interview with Mekonnen Biru, CCRDA, August 2017.

17 Author interview with Mekonnen Biru, CCRDA, August 2017.

18 Author interview with Mekonnen Biru, CCRDA, August 2017.

19 Author interview with Sufiyan Abdul, FMOH, August 2017.

20 Author interview with Sufiyan Abdul, FMOH, August 2017.

21 Author interview with Abenezer Tamrat, Irish Aid, August 2017.

government to make adjustments quickly. For emphasis, the case was presented to the ministers of health. Since then, the Pharmaceuticals Fund and Supply Agency (the agency that manages the purchasing process) has started to reengineer its internal business process using business process reengineering (BPR). For this, Dr. Awoke explained, “the donors have provided technical and financial support. The leadership of the agency has also changed. This coordinated effort of the donors has resulted in changes in the agency; the purchasing and utilization rate is now progressing well.”²²

The government also uses its JSC to generate ideas and design strategy to solve challenges. In particular, the country’s medical equipment purchasing system has long been very weak, with complicated processes and many hurdles.²³ To solve this problem, a medical equipment policy is being designed, focusing on a well-known suppliers list, specific brands, and the bidding process. This policy is expected to enhance the value for money despite the tradeoff of increasing costs because of the limited number of identified suppliers and brands.

The other problem in the medical equipment purchasing process is that the ministry lacks a team of experts to follow up and perform installation and maintenance of the purchased medical equipment. According to Sufiyan Abdul of the FMOH, this task was previously performed by experts from engineering departments of other sectors, who were not particularly specialized in the area. To address this problem, one bioengineering sub team containing 10 experts has been organized since 2015. As Sufiyan Abdul explained, “This team is always ready to make quick installations and maintenance of medical equipment that is purchased and ready under our authorization.”²⁴ This development helped to speed up the installation and maintenance process so that health services could be provided at the desired time. Similar structures are also organized at the regional level, because regional offices found a similar trend that delayed the installation and maintenance process. The effective integration and coordination of stakeholders was reflected in the improvement of the finance utilization rate.

Solution 2: Leveraging leadership and commitment through the planning and resource mobilization process

Despite all these improvements in the coordination of stakeholders, the participation of donors in the MDG PF and the amounts they contributed were not as large as promised. Donors required clearly designed and well-articulated plans and strategies before they would finance anything. In response, the Ethiopian government directed its whole machinery toward enhancing and leveraging its dialogue and negotiating capacities. To this end, it has invited new leaders in the health sector landscape since 2007 to support its leadership, negotiation, and commitment role through efficient planning.

The leadership and commitment role of the government in the mobilization and coordination of stakeholders was critical to resolving this challenge. Recognizing this, the Ethiopian government came up with an overall planning mechanism as a leadership and commitment strategy to include all stakeholders horizontally and vertically. The main directions, interventions, targets, and financial strategies are crafted using the expertise of professionals, leaders’ experiences, and wisdom from various stakeholders actively engaging in the sector. “When a plan is approved, it becomes a common language throughout the country, including among the DPs and the CSOs,” Sufiyan Abdul of the FMOH, explained. This strategy allows the government to play its leadership role clearly and to position itself in the front seat, and it has become an instrument to leverage the commitments of the government, donors, civil society, and the public at large.

The planning mechanism operates as follows. First, a technical team is established, and the team drafts an action plan that will serve as a guideline and benchmark for the whole planning phase. This action plan is presented to the leadership council of the FMOH, donor groups, CSOs, and other key stakeholders. Then comments on the action plan are organized, and the final action plan is approved. The preparation of this action plan enables the consideration and inclusion of all the interests and focus areas of the various stakeholders in the planning process. On the basis of this action plan, the team prepares the core plan that contains the main targets, priorities, and thematic areas that will become the pillars for the preparation of the comprehensive plan.

Mebrhatom Belay, a Policy Planning Senior Expert at the FMOH, explained the importance of this mechanism

22 Author interview with Dr. Awoke Tasew, UNFPA, August 2017.

23 Author interview with Sufiyan Abdul, FMOH, August 2017.

24 Author interview with Sufiyan Abdul, FMOH, August 2017.

for coordination, saying that “the approved document becomes a point of reference for all other plans in the sector prepared by all concerned bodies. This process of planning entails and assures decentralization, sharing of priorities and visions, and inclusiveness.”²⁵

This core plan, as an indicative plan, includes the main priority areas, targets, and thematic areas for the next years in the health sector, which originate from health sector policies, previous performance, and ongoing global agendas. “Then, after the team prepares this plan that contains the main targets, indicators, directions, and thematic issues, it sends the plan to regional bureaus,” Mebrhatom explained.²⁶ The regional bureaus (the next level below the federal government) adapt the plan to their situations based on socioeconomic, infrastructural, organizational, and other factors. Then the plan is transferred to the zonal health office administrations (the next level below the regions); there, the zones also adjust and amend the plan, considering enabling and constraining factors. Finally, the plan reaches the lowest administrative units, the *woredas*. This planning process, from top to bottom, encourages each administrative unit to fit the plan to its existing realities, ensuring the contextualization, inclusiveness, and decentralization of the plan. Through this process, the government is in the driver’s seat, showing its directions and priorities clearly to the stakeholders. One expert from WHO interviewed described the government’s role as “assertive. . . it always plays the driving role in designing sound strategies that attract others toward it.”²⁷

After the completion of the top-down phase of the planning process, the bottom-up phase starts with the *woredas*. Based on the sectoral indicative core plan framework, the *woredas* identify interventions that can be performed, given their capacity constraints. After including all their amendments, the *woredas* transfer their health plans to the zones. The zone health offices include all relevant improvements within their authority, then transfer the plan to the regional level, from which it is finally sent to the federal ministry.

According to the planning experts interviewed, this process is characteristic of the Ethiopian health sector’s overall planning system. “The Ethiopian health sector’s planning system is a blend of both top-down and

bottom-up approaches, enabling synergies and engaging stakeholders from all parts of the country,” explained Mebrhatom, the planning expert.²⁸ This blend helps drive the inclusion of relevant thematic areas, priorities, and interventions, and the final core plan becomes a foundation for the comprehensive planning process. Development partners also receive this core plan and provide comments and feedback. After discussion, the core plan is approved, and it feeds into the comprehensive plan, which contains detailed targets and indicators and refined prioritized interventions.

In the planning process, as Mekonnen, the CSO forum head, explained, “Selecting the most appropriate planning and budgeting tool that fits with the economic, political, and social situation of the country is essential. We, as health sector planning experts, are always exploring modern and new planning tools; however, when we get a tool, we do not use it as it is. The tool is hybridized with the existing ones and internalized to the existing situation of the country.” In line with this, the strengths and weaknesses of existing and new planning tools are thoroughly analyzed. Next, the tools’ best features are identified and used in combination with the existing tools. “In this way, the improved tool is presented to the council and approved to be used,” said Mebrhatom of the FMOH.²⁹

Until the fourth Health Sector Development Plan (of 2010), the planning tool used was Marginal Benefit Analysis for Bottlenecks (MBB), which is based on identifying the main challenges in health sector interventions. This planning tool has weaknesses: it does not magnify strategic themes and perspectives, link plans from different levels, or measure the contribution of each unit to the overall impact. Once the importance of these weaknesses came to light, improving the change tool and planning instrument became relevant. A newer tool, which comprises all the important features that MBB lacks, was identified: the Balanced Scorecard (BSC). The BSC consists of stakeholder analysis, pain and enabler identification, perspectives, targets, baselines, indicators, and initiatives, and it is easily cascaded to the smallest unit of administration. However, that tool alone did not bring the planning and impact analysis mechanism to full realization. Therefore, a new tool that included characteristics of both the BSC and MBB was created. This new hybrid tool allowed users to perform stakeholder analysis, bottleneck analysis,

25 Author interview with Mebrhatom Belay, FMOH, August 2017.

26 Author interview with Mebrhatom Belay, FMOH, August 2017.

27 Author interview with an expert from the WHO, August 2017.

28 Author interview with an expert from the WHO, August 2017.

29 Author interview with Mebrhatom Belay, FMOH, August 2017.

perspective and thematic area selection, pain and enabler identification, targeting, baselines and impact and cost projections, initiatives, and cascading procedures. Last, the new tool was presented to the council and approved. “After training the experts in the tool, finally it was applied to prepare the fourth health sector development plan in 2010,” Mebrhatom said.³⁰

The next phase in the planning stage is identifying basic interventions, targets and priority directions, and strategies. The identified strategies are sent to the lower stages of administration, which refine them and send them back to the PPD. The strategies are also sent to the DPs, the CSOs, and the council of management, who provide comments and feedback. Based on all these perspectives, angles, criticism, and constructive inputs, some interventions are omitted, others are combined, and others are continued, with the final targets set for them. Then, based on these final targets, resources are mapped and the scenario for plan preparation is decided.

In previous plan preparation processes, stakeholder engagement was questionable. The new approach to leadership has helped make the planning process more participative and inclusive. In the preparation process of the HSDP and the Health Sector Transformation Plan (HSTP), the DPs and CSOs participated from the inception stage onward. Mekonnen described this process of plan preparation as follows: “Donors and CSOs were first divided into groups based on the specific programs that they specialized in. Then we discussed the issues in detail and made our exercise of brainstorming, problem identification, stakeholder analysis, and target setting. Then we wrote our draft plans based on the thematic areas.” This process is practiced in the 20-year vision–creation exercise and in the HSTP and HSDP planning preparations. “This [process] made us feel a sense of ownership and helped us to participate in the monitoring and evaluation processes in a well-informed manner,” Mekonnen added.³¹

Resource Mobilization as a Means of Leadership and Commitment, Alignment, and Ownership

The Ethiopian health sector financing landscape was characterized by program-specific and volatile aid. The

aid structure was not owned or led by the government. It was dominated by Donor-CSO interactions and alienated from the government’s strategies and priorities, leading to high proliferation and fragmentation in the sector. However, the introduction of new and innovative finance-mobilization systems and resource-mapping exercises has helped to strengthen government ownership, leadership, coordination, and alignment of interests.

Marco, from the Netherlands’ embassy, stated that “we give financial aid to the government based on our result-based evaluation of government performance. In addition, we [the donors] work with the CSOs whose activities relate to our prior country strategies. . . . Their activities are aligned with the government’s policy and priorities.” This system is carefully designed and implemented by the government to put the government at the forefront of leadership in setting priorities, main activities, sources of finance, promises of commitments, and alignment of activities.

The resource mobilization process is based on two factors. First, it relies on the fact that the health care financial strategy’s main objective is raising sustainable finance through domestic resources, innovative financing, and prepayment systems (such as health insurance). Second, it depends on the costs of the targets of the HSTPs. The main priorities and activities are first approved on the basis of agreement and active involvement of stakeholders. The amount of resources required to finance the plan is then estimated by the planning process and sent to the resource mobilization experts for further prioritization and resource-gap analysis.

Resource Mapping Process

The resource mobilization process occurs as follows. First, the main interventions and their activities are listed in a clear form. Then the resources needed to finance these interventions are mapped in consultation with the donors and the government. The interventions are given to donors, and the donors map the amounts they can allocate to each intervention according to their program’s budget. The resource mapping exercise also includes identifying what resources are needed, in which region, through which financing channel, and at what specific place. This identification of resources includes the MDG PE, which is used to fill identified gaps.

The resource mapping process that is performed at all levels of government administration enhances the predictability and the government ownership of aid. The

30 Author interview with Mebrhatom Belay, FMOH, August 2017.

31 Author interview with Mekonnen Biru, CCRDA, August 2017.

process helps the government set priorities and puts the government in a leadership role, with “others [following] the government’s policies and directions with common understanding and consent.”³² The exercise is also done with the CSOs, allowing the activities of all stakeholders to be aligned and coordinated to the government’s priorities.³³ After learning what resources can be mobilized from development partners, the resources needed from the government treasury are identified.

This process finally shows financed programs, interventions, and specific activities. It also helps to identify resource gaps, which are filled in various ways. “After identifying the gaps through the resource mapping process, we first try to fill the gaps using channel-two pool funds, including the MDG pool fund. If still there is a gap, then reprioritizations of interventions and targets are made. After all this, if the gap still exists, we prepare proposals and approach the donors to fill the gap,” Tseganeh, the health finance mobilization advisor for the FMOH, elaborated.³⁴

This resource mapping process has helped to enhance the predictability of aid finance for long-term planning. Antonio Oritiz, a senior program officer for health with the Spanish development agency AECID, described a “four-year country-specific strategy clearly showing our engagement in the health sector. This strategy is aligned to the government’s strategies, plans, and priorities using the resource mapping process. We allocate and strategize our financing mechanism based on this process.”³⁵ The alignment of funding for at least three or four years is crucial for stable and predictable mobilization. Adding to this statement, Tseganeh confirmed that “almost all donors have a practice of describing their finance allocation plans for at least three years, [creating] stable and predictable resources to finance health sector strategic plans.”³⁶

The resource mobilization expert characterized the resource mapping process as “a menu in the restaurant that shows varieties of foods, in one format, that come processed from one kitchen using different recipes.”³⁷

The resource mapping process also enhances commitment, mutual trust, and accountability among

stakeholders in the sector. “We trust the government and its system of financial mobilization and utilization. . . . if not . . . we will not allocate our money to finance its activities,” Marco said, describing the efficiency of resource mapping and trust-building activities.³⁸ In general, this predictability-, transparency-, commitment-, and leadership-enhancing role of the resource mapping process demonstrates and reflects the attractiveness of the government’s fast-gear implementation strategy. According to Tseganeh, “Donors are willing to finance government strategies. . . . Believing. . . for the sake of good reasons and results.” He added that the strength of the country’s financial system, which is characterized by a low corruption rate, is one of the main factors enhancing the predictability and improving the efficiency of health resource mobilization. “The strength of the financial system is very high. Penetration is almost impossible. It is very difficult to waste even a single dollar in this strong financial system,” said Tseganeh, the health financing mobilization advisor.³⁹

Lessons Learned

The impressive results achieved in the past 15 years by Ethiopia’s health sector were made possible by meaningful contributions from all stakeholders involved in implementing the interventions. The context-tailored coordination mechanisms through the MDG PF facilities and the leadership and commitment to creativeness witnessed in the planning and resource mobilization processes have paved the way for accelerated changes in the sector.

“No mother should die while delivering a baby” is now a common motto in Ethiopia, and its realization is observable on the ground. In 2000, 871 of every 100,000 mothers lost their lives while delivering. By 2015, this number had fallen to 412 of every 100,000, attributed to the expansion of health facilities and health professionals at the *woreda* level (NPC 2015).

Protecting and caring for pregnant women before and after delivery is considered a duty, not a simple routine task, in all administrative units. Providing ante- and postnatal delivery services at the highest possible level is becoming one of the most essential performance

32 Author interview with Tseganeh Amsalu, FMOH, August 2017.

33 Author interview with Tseganeh Amsalu, FMOH, August 2017.

34 Author interview with Tseganeh Amsalu, FMOH, August 2017.

35 Author interview with Antonio Oritiz, AECID, August 2017.

36 Author interview with Tseganeh Amsalu, FMOH, August 2017.

37 Author interview with Tseganeh Amsalu, FMOH, August 2017.

38 Author interview with Marco Gerritsen, Embassy of the Netherlands, August 2017.

39 Author interview with Tseganeh Amsalu, FMOH, August 2017.

indicators; every administration is measured at that indicator, and none is willing to remain behind at it. The number of births attended by a skilled provider rose to 28 percent from 6 percent, and the number of births taking place in a health facility has increased to 26 percent from 5 percent over the same span of years mentioned above.

Living conditions and healthy years of living for children have improved. Children are now regularly getting all necessary vaccinations during their early years. Deaths of children before reaching the age of 5 were as high as 166 per 1,000 live births in 2000; that number decreased to 88 by 2015. Now, thanks to improvements in immunization coverage, the physical and mental development and health of Ethiopian children is increasing (NPC 2015).

Ethiopia now owns, directs, and delivers results using its plan and aid in well-coordinated ways. No amount of money is allocated in the health sector without the government's knowledge. The government attracts donors by designing well-articulated plans and strategies. The resource mobilization process encompasses every part of each finance source, aligning it with interventions and targets. The government directs where the finance should be allocated by advising on the prioritization and reprioritization of targets. "The quality of aid is more important than the quantity. We know what needs to be done and how to do it. But we cannot do it without flexible, predictable financial support. Give us the money, and we will account for it and deliver results," said Dr. Tedros A. Ghebreyesus, the former minister of health (FMOH 2013a). Because of improvements in leadership and negotiation capacity, the amount of money collected in the MDG PF has reached 230 million in 2014, compared with the starting point of 10 million in 2008. The negotiation, diplomatic, and political power of the government has been very strong, and this strength was seen as helpful for setting agendas and creating an effective strategy.⁴⁰

The dramatic expansion of health infrastructure, and improvement in financial management and utilization, has laid a sound foundation for the sustainability of Ethiopia's health sector. The number of health posts built per year nationwide has increased from 6,192 in 2006 to 16,048 in 2013 and the number of health centers constructed reached 3,245 in 2013, up from 668 in 2005 (Alebachew and Waddington 2015). Medical equipment facilities are being installed in most of the centers. The

financial administration and utilization rate has shown progress, witnessing the building of a continuing system. The utilization rate of the MDG PF has increased from 25 percent in 2008 to 75 percent in 2015 (FMOH 2015).

This improved utilization of the MDG PF and enhancement in leadership and commitment using effective planning and resource mapping has helped to reduce administrative costs and create good value for money by procuring commodities at favorable prices, from both the government's and the donors' perspectives. According to a report on the returns on development funding, the cost of managing a separate project with its own staff and management arrangements is estimated to be 15–20 percent of a project's overall cost; however, the administrative cost of the MDG PF is estimated to be less than 2 percent, because funders are buying into existing systems (FMOH 2013b)

The implementation of the MDG PF has brought sustainable system strengthening, unlike project-type funding, because the implementation is achieved by working through institutionalized systems of government finance, purchasing procedures, and professional health workers who are funded from the government's budget. This process encourages learning by doing, improving errors, and adaptation, which strengthen and improve the overall health system in sustainable ways. The performance fund is seen by donors as an effective channel for support (AusAID 2012).

Led by well-coordinated and highly committed government officials and by harmonized stakeholder engagement, the operation of the MDG PF has created a built-in opportunity for mutual accountability and trust. The governance procedures and external audits are additional safeguards in a sector that fared well in a major World Bank study in 2012: "Corruption in Ethiopia's health sector is not as pervasive as in other countries or sectors. . . . The diagnostics strongly suggest that, in Ethiopia, corruption in the delivery of basic services (primary health, basic education, rural water supply, and justice) is comparatively limited and much lower than in other low-income countries" (Plummer 2012).

A number of factors were key in allowing the creation of the following components of the Ethiopian health sector:

Planning process. All stakeholders are involved in an inclusive and participative planning process. The planning process combines a top-down approach, which

40 Author interview with an expert from the WHO, August 2017.

establishes government priorities, and a bottom-up approach, which ensures that the interests of low-level administration and the public at large are accommodated. Donors and CSOs are actively involved in the planning process, which the government leads, owns, and directs.

Efficient financial procedures. Mutual accountability and trust are built through internal and external auditing, and innovative mechanisms control proper utilization and liquidation through short messaging. These efforts result in a low corruption rate in the health sector.

Evidence-based management. A continuous flow of information from the community level, using family-based data processing connected to health management information at the federal level, supports the health

sector’s evidence-based decision mechanisms. On the basis of this data, targets are prioritized and reprioritized. The equitable development process, which is based on the redistribution of finance to low-performing areas, is made according to the areas’ rankings on the achievement of basic indicators. The allocation of resources to encourage balanced growth in agreement with the DPs is supported by an efficient shared information system.

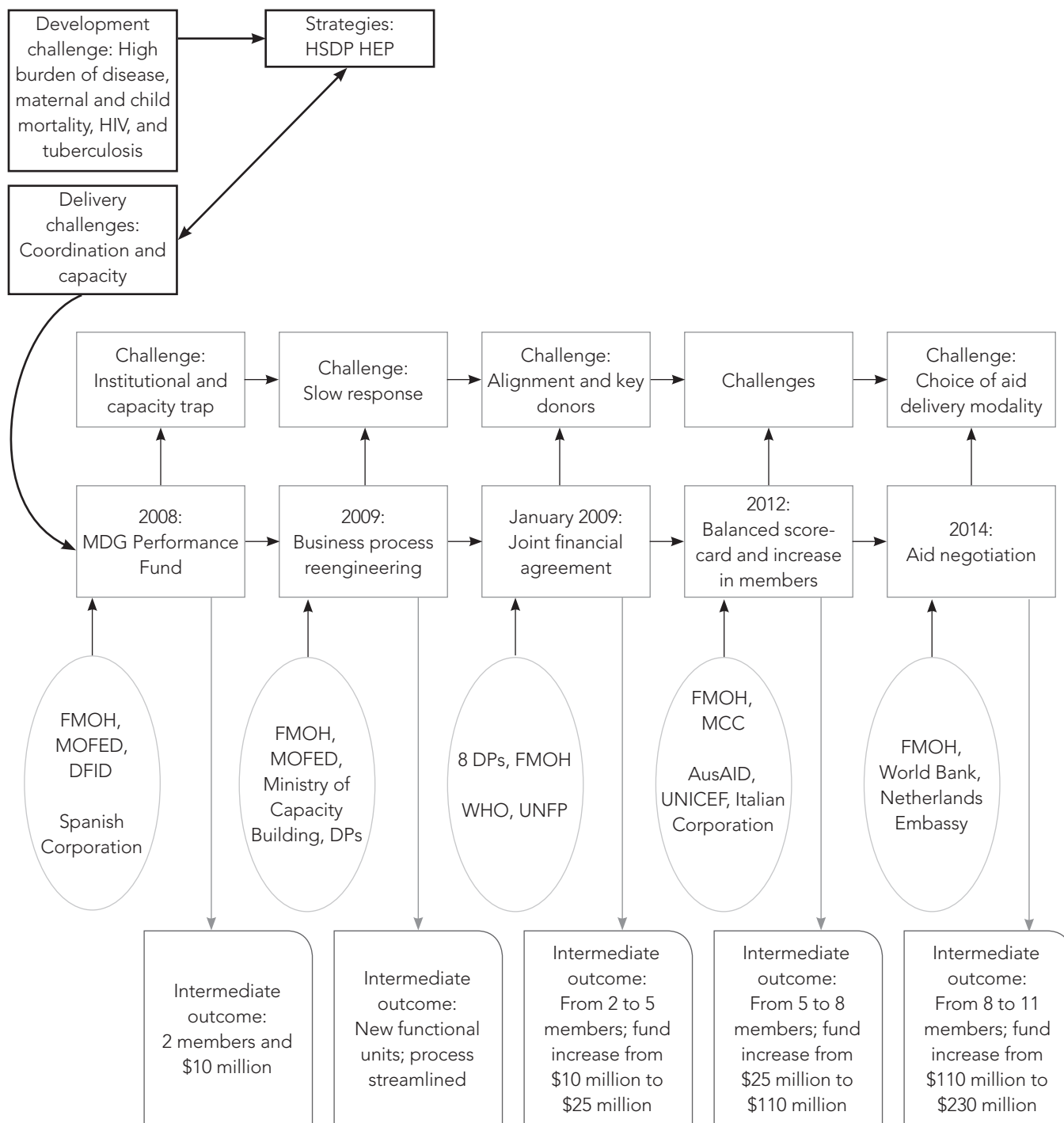
Context-tailored planning and resource-mapping tools. Planning tools tailored to the existing institutional context, financial situation, and government priorities are implemented. This enables government priorities to be effectively translated into plans that can then be put into action.

Abbreviations

AECID	Spanish Agency for International Development Cooperation	JCCC	Joint Core Consultative Committee
AIDS	Acquired Immunodeficiency Syndrome	JCF	Joint Consultative Forum
AusAID	Australian Aid	JFA	Joint Financial Agreement
BPR	Business Process Reengineering	JSC	Joint Steering Committee
BSC	Balanced Score Card	MBB	Marginal Benefit Analysis for Bottlenecks
CCRDA	Consortium of Christian Relief and Development Associations	MCC	Millennium Challenge Corporation
CSA	Central Statistical Agency	MDG	Millennium Development Goal
CSO	Civil Society Organization	MDG PF	Millennium Development Goals Performance Fund
DFID	Department for International Development (UK)	MOFED	Ministry of Finance and Economic Development
DP	Development Partner	PPD	Policy Planning Directorate
FMOH	Federal Ministry of Health	STI	Sexually Transmitted Infection
HEP	Health Extension Program	UNFPA	United Nations Population Fund
HIV	Human Immunodeficiency Virus	UNICEF	United Nations Children’s Fund
HPN	Health, Population, and Nutrition	WHO	World Health Organization
HSDP	Health Sector Development Program		
HSTP	Health Sector Transformation Plan		
IHP	International Health Partnership		

Annex 1. Process Map

Figure A.1. Process and stakeholder map of the MDG Performance Fund modality implementation



Note: AusAID = Australian Aid; BSC = balanced scorecard; DFID = Department for International Development (U.K.); DP = development partner; FMOH = Federal Ministry of Health; HEP = Health Extension Program; HIV = human immunodeficiency virus; HSDP = Health Sector Development Program; JFA = Joint Financial Agreement; MCC = Millennium Challenge Corporation; MDG = Millennium Development Goals; MOFED = Ministry of Finance and Economic Development; UNFPA = United Nations Population Fund; UNICEF = United Nations Children's Fund; WHO = World Health Organization. All dollar amounts are U.S. dollars unless otherwise indicated.

Bibliography

- Alebachew, Abebe, and Catriona Waddington. 2015. "Improving Health System Efficiency in Ethiopia: Human Resource for Health Reforms." World Health Organization.
- AusAID. 2012. "Design Summary and Implementation Document in Support of the Ethiopia Health Sector Development Program." AusAID.
- CSA (Central Statistical Agency). 2013. "Population Projection of Ethiopia for All Regions at Woreda Level from 2014–2017." CSA, Addis Ababa.
- CSA (Central Statistical Agency) and ICF International. 2012. "Ethiopia Demographic and Health Survey 2011." CSA and ICF International, Addis Ababa and Calverton, MD.
- Federal Ministry of Health (FMOH). 2013a. "Ethiopia's Health Sector: Excellent Returns on Your Development Funding." FMOH, Addis Ababa.
- . 2013b. *Health Sector Development Program IV: Annual Performance Report, EFY 2005 (2012/13)*. Addis Ababa: FMOH.
- . 2015. *Health Sector Transformation Plan-1: Annual Performance Report, EFY 2007 (2015/16)*. Addis Ababa: FMOH.
- FMOH and Italian Corporation. 2014. "Policy and Practice, Information for Action." *Quarterly Health Bulletin* 6 (1).
- Mangham-Jefferies, Lindsay, Bereket Mathewos, Jeanne Russell, and Abeba Bekele. (2014). "How do health extension workers in Ethiopia allocate their time?" *Human Resources for Health* 12: 61.
- National Planning Commission (NPC). 2015. *GTP II Annual Progressive Report*. Addis Ababa: NPC.
- Plummer, Janelle. 2012. *Diagnosing Corruption in Ethiopia: Perceptions, Realities, and the Way Forward for Key Sectors*. Washington, DC: World Bank.
- World Bank. 2000. *World Development Indicators 2000*. Washington, DC: World Bank.
- World Bank. 2005. *World Development Indicators 2005*. Washington, DC: World Bank.



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