# AusAID Design Summary and Implementation Document in Support of the Ethiopia Health Sector Development Program (HSDP IV)

Quality at Entry Report

Fiona Duby

April 2011

AusAID HRF
HLSP in association with IDSS
GPO BOX 320
15 Barry Drive
Canberra City ACT 2601
Tel: +61 (2) 6198 4100
Fax: +61 (2) 6112 0106
www.ausaidhrf.com.au

# Contents

# Acronyms

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| AusAID | Australian Agency for International Development |
| AAMCHI | Australia-Africa Maternal and Child Health Initiative |
| DFID | Department for International Development |
| DSID | Design Summary and Implementation Document |
| EOC | Emergency Obstetric Care |
| FMOH | Federal Ministry of Health |
| FRA | Fiduciary Risk Assessment (March 2011) |
| GOE | Government of Ethiopia |
| HEW | Health Extension Workers |
| HMIS | Health Management Information System |
| HPF | Health Pooled Fund |
| HPN | Health Population and Nutrition (Donor Group) |
| HSDP | Health Sector Development Programme |
| JANS | Joint Assessment of the National Strategy |
| IHP | International Health Partnership |
| M&E | Monitoring and Evaluation |
| MDGs | Millennium Development Goals |
| MDG/PF | Millennium Development Goal Performance Fund |
| PBS | Protection of Basic Services fund (trust fund managed by World Bank) |
| UNICEF | United Nations Children's Fund |

# Executive Summary

## Summary Assessment

This is a clear and comprehensive proposal. It provides detailed analysis and demonstrates an in-depth understanding of the health sector in Ethiopia, the mechanisms intrinsic to sector support and the issues that need to be addressed. The experience from three national health plans and a health system that is evolving and devolving have provided a strong and well-informed basis for HSDP IV.

Australia's strategic approach to aid in Africa has maternal and child health as a priority, funding these through government led systems. This is entirely consistent with the Paris Declaration. For support to Ethiopia, AusAID provides justification for an interim arrangement through a UNICEF-managed health pooled fund while capacity is built in the GOE to address some shortcomings identified by a Financial Risk Assessment. The decision to fund through this (FMOH led) mechanism instead of the multi-donor Protection of Basic Services trust Fund managed by the World Bank is sound as it will have greater ownership and involvement by FMOH, is less bureaucratic and with fewer opportunity costs for FMOH than using (World Bank) parallel systems. It also has potential for a smoother transfer to the MDG/PF once it is decided that current fiduciary risks have been overcome.

AusAID will be collaborating with like-minded and well-established development partners (DPs) in support of a tried and tested GOE led health sector development strategy (HSDP IV). Implementation is guided by numerous and rigorous joint monitoring and evaluation structures and systems. Ethiopia has also signed a compact with the International Health Partnership (IHP), making its progress on harmonisation and governance of the health sector accountable to an external review process.

AusAID recognises the challenges in asserting itself as an influential partner. However, it also recognises the value it can add as a more flexible partner, without historical encumbrances. The proposal rightly points out that attribution is contrary to the spirit of a pooled funding modality, but it is also important for AusAID to monitor the effectiveness of its support such as can be measured by quality of partnerships, influence, innovation and quality of technical assistance. While this will be done to some extent by the QAI assessment, this is a generic tool. Measuring AusAID performance will therefore be easier where performance indicators and targets are clearly set out within an M&E framework. Fiduciary risks and mitigation included in the proposal could be included. This latter point is important in achieving Australia's objectives of working through FMOH's MDG fund.

The proposal will support the technical approaches agreed by the different partners for HSDP implementation. Priorities and approaches are undoubtedly founded on robust evidence. However, experience from other countries suggests that some of these need further assessment. Otherwise, suggested additions and amendments to this comprehensive proposal are minor.

## Rating Summary

The following summarises the ratings given for each of the criteria:

| Criteria | Rating |
|---|---|
| **Relevance** | **5** |
| **Analysis and learning** | **4** |
| **Effectiveness** | **5** |
| **Efficiency** | **5** |
| **Monitoring and Evaluation** | **4** |
| **Sustainability** | **5** |
| **Gender** | **4** |

| *Satisfactory rating (4, 5 and 6)* | | *Less than satisfactory rating (1, 2 and 3)* | |
|---|---|---|---|
| 6 | Very high quality; needs ongoing management & monitoring only | 3 | Less than adequate quality; needs to be improved in core areas |
| 5 | Good quality; needs minor work to improve in some areas | 2 | Poor quality; needs major work to improve |
| 4 | Adequate quality; needs some work to improve | 1 | Very poor quality; needs major overhaul |

# 1. AusAID Design Summary and Implementation Document in support of the Ethiopia Health Sector Development Program

## 1.1. Background

AusAID is developing a five-year (2010-15) $140 million Australia-Africa Maternal and Child Health Initiative (AAMCHI) in Eastern Africa. AAMCHI will support Government efforts to improve maternal and child health (MCH) indicators through strengthening national systems. It will complement this approach with specific activities in midwifery training, improving basic obstetric and newborn care, and expanding access to family planning. Early countries of bilateral focus are Ethiopia, Tanzania, and Southern Sudan complemented with regional and multi-country activities. Assistance is expected to be delivered principally through partnerships with governments (including contributions to pooled sector funds), collaboration with likeminded partners (UK, US and Gates Foundation) under a recently-formed *Alliance for Reproductive, Maternal and Newborn Health*, and grant funding to effective NGOs, regional organizations and multilateral agencies.

## 1.2. The health sector in Ethiopia

With a population of 84 million, 83 per cent living in rural and often remote areas, the challenges of effective health service delivery in Ethiopia are substantial. Almost half of the population is under the age of 15 (45 per cent) and about 25 per cent of the population is women of reproductive age. While the maternal mortality rate is going down (from 673/100,000 in 2004 to 590/100,000 in 2009)[1], due to the significant efforts of the GOE and development partners, at current levels of progress, the goal of MDG5 (267/100,000 in 2015) will not be achieved.

The GOE has implemented a series of consecutive Health Sector Development Programs (HSDP), starting 13 years ago (in 1997/98) and based on the 1993 Health Policy of the GOE. The current Health Sector Development Plan (IV, 2010/11 – 2014/15) started in July 2010 with the ultimate goal 'to improve the health status of the Ethiopian people, through the provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population.' Over the period of the last two sector development programs, Ethiopia has made significant progress in addressing major health challenges and improving health service delivery. It has also demonstrated leadership and a strong commitment to ensuring improved health outcomes. The proposal highlights many of the various achievements and health outcomes.

[1] Various MMR figures are given in different reports. While HSDP IV mentions 590/100,000, the UN Stats database < http://unstats.un.org/unsd/mdg/Data.aspx > mentions 470/100,000 (2008). Up-to-date reliable figures can be expected in the upcoming Demographic and Health Survey (DHS), expected to be finalised in the beginning of 2012.

## 1.3. Description

| | |
|---|---|
| **Description of the Initiative** | AusAID conducted two scoping missions in the East African Region, resulting in an Implementation Plan in December 2010. The plan identified, among its bilateral activities, a contribution to the Millennium Development Goal Performance Fund (MDG/PF) of the Federal Ministry of Health (FMOH) in Ethiopia. *There are three principal channels available for direct support.*<br><br>**1) The MDG/PF** is a pooled multi-donor funding mechanism completely integrated in the HSDP IV, managed by the FMOH (specifically, the Directorate General of Policy, Planning and Finance) with a priority on MCH. It is included as a budget line in the GOE Chart of Accounts. The aim of the Fund is to bring about a simplified single route for donor resources to reach the FMOH.<br><br>**2) The Health Pooled Fund** (HPF III, July 2011 – June 2015), was established by Development Cooperation of Ireland, the Royal Netherlands Embassy and DFID in July 2005 as a starting point to implement the health sector harmonization plan to ensure aid effectiveness. The Development Partners that currently participate in this pooling arrangement are: The Republic of Ireland, represented by Irish Aid (IA),The Kingdom of the Netherlands, represented by the Royal Netherlands Embassy (RNE), The United Kingdom, represented by the Department For International Development (DFID), Sweden, represented by the Swedish International Development Agency (SIDA), Italy, represented by the Italian Co-operation (IC), The Republic of Austria, represented by the Austrian Development Cooperation (ADC) and UNICEF. It is managed by UNICEF on behalf of the FMOH and is generally meant to cover expenses related to technical assistance in supporting the implementation of the HSDP.<br><br>**3) The Protection of Basic Services fund (PBS)** is a multi-donor Trust Fund managed by the World Bank, established in 2005. Its aim is to protect and promote basic services for the poor. Financial management and funds disbursement follow World Bank regulations.<br><br>Key variables for consideration in selection of the delivery mechanism are: i) risks and their management; ii) relative effectiveness and sustainability; iii) activities and services supported and (iv) relative scope for achieving AusAID's strategic objectives. Consideration of these variables led to the development of a staged approach, in which funding will be initially channelled through HPF III and later through both MDG/PF and HPF III. Funding through MDG/PF will commence upon satisfactory implementation by FMOH / PFSA of risk mitigation measures – an option under consideration by other |

| | |
|---|---|
| | development partners (GAVI, World Bank, USAID and GFATM) with combined funding of up to $1 billion. AusAID's expects its decision to channel funds initially through HPF III to act as a driver of reform and thereby clear the way for MDG/PF funding from multiple sources while at the same time helping FMOH to access technical assistance to support reform efforts. |
| **Objectives summary** | AusAID will support a program-based approach (PBA) focused on the FMOH's sector programme, outlined in the fourth Health Sector Development Plan (HSDP IV). The PBA is based on the 'One Program, One Budget, One Report' principles of coordinated support for a locally owned program of development. Subject to fiduciary risk criteria, AusAID will transition to the FMOH-managed MDG/PF.<br><br>This transition period will provide AusAID with opportunities for policy dialogue and influence and a sound basis to work collaboratively with Government and other development partners to achieve improved health outcomes. AusAID support has two key objectives:<br><br>**Objective 1:** to leverage its influence to improve MCH outcomes in Ethiopia by creating incentives for strengthening systems critical to health service delivery<br><br>**Objective 2:** to act as a practical driver for increased development effectiveness in MCH through improved harmonisation and alignment<br><br>Minister Rudd has clearly articulated Australia's commitment to channelling support through the Government of Ethiopia's MDG/PF, which has significant potential developmental and ownership benefits. It is believed that AusAID's decision not to channel funds through the MDG/PF at this time will send a strong message and be an incentive for FMOH to remedy shortcomings in fiduciary management, with technical assistance offered to assist with this. (It is assumed, but not clearly stated, that another FRA will be conducted to assess progress against agreed financial and governance criteria).<br><br>AusAID is joining a well-established group of bilateral and multilateral DPs and as a relative newcomer to the DP environment, has no political 'baggage' in Ethiopia, can exercise greater flexibility than others and has the potential to stimulate new ideas and challenge the status quo and aid effectiveness. At least this is how the document reads and is refreshing in its honest and pragmatic approach.<br><br>AusAID's purpose is to support and strengthen delivery of Ethiopia's HSDP IV for better results on MDGs 4 and 5. The two objectives (above) of this proposal specifically define AusAID's role (attribution) in making this happen. |

# 2. Australian Aid – Rated Quality Criteria

## 2.1. Relevance (Rating: 5)

| Assessment | Required actions |
|---|---|
| The question of alignment is already answered as Australia is supporting the GOE's national health plan and development priorities.<br><br>The support is entirely consistent with AAMCHI, focused in Eastern Africa (with Ethiopia, Tanzania and Sudan identified as focus countries). Assistance is expected to be delivered through<br><br>• partnerships with governments (including contributions to pooled sector funds)<br><br>• collaboration with likeminded partners (UK, US and Gates Foundation) under a recently formed Alliance for Reproductive, Maternal and Newborn Health and<br><br>• grant funding to effective NGOs and multilateral agencies.<br><br>The AAMCHI Concept Note was peer reviewed in December 2009 and it was agreed that the proposed focus of the program was relevant and appropriate and that Ethiopia should be one of the first priority countries for engagement. In addition, it was agreed that working through the sector-wide approaches would be the most appropriate mechanism.<br><br>The choice of the UNICEF-managed HPF as an interim arrangement appears sound (compared with the World Bank PBS with its parallel procedures) and is likely to provide a smoother transfer to full funding through MDG/PF. The 2007 evaluation of HPF highlighted a number of bureaucratic bottlenecks especially in the area of TA procurement (in part due to a requirement to use the UN systems) which might signal some alarm bells. While the most recent independent evaluation cited by the proposal (not seen by the assessor) notes that HPF II was an 'effective, timely, responsive and demand-driven fund', it is not explicitly stated that the problems identified have been overcome, especially since one of UNICEF's requirements will be to manage TA. If FMOH is to manage TA in future years, the UNICEF-led process needs to be highly transparent and collaborative enabling FMOH to build the systems, skills and contacts.<br><br>The proposal discusses the challenges and the opportunities for AusAID to bring added value as a relatively new, smaller donor, in an environment where one of the purposes of harmonised sector programmes led by recipient governments limits the branding opportunities for individual donors. While embracing the aims of the Paris Declaration, most DPs are under political pressure to demonstrate | |

| | |
|---|---|
| results for Overseas Development Assistance (ODA) in an increasingly competitive and restricted economic environment. This is where tensions are likely to arise for AusAID between attribution and support for pooled funding modalities.<br>o It might be useful therefore for an M&E framework to show how AusAID will contribute in terms of:<br>a) contribution to planning, reviews, technical working groups and<br>b) quality and effectiveness of TA, and how TA will be managed to ensure synergy with other donors and GOE stewardship | |

## 2.2. Analysis and learning (Rating: 4)

| Assessment | Required actions |
|---|---|
| The proposal is comprehensive, well written, clear and logical and draws from available joint reviews and assessments to justify approaches adopted. The proposal shows a good understanding of the institutional environment and provides adequate detail of the systems and frameworks governing HSDP implementation. The proposal might add information on political and environmental risks that could undermine progress on delivery of the HSDP.<br>MDGs 4 and 5 technical approach. The proposal highlights key priorities for the health sector agreed between FMOH and development partners. Achievement of MDGs 4 and 5 in particular rank highest. While the HSDP is developed by technical experts, it is assumed that AusAID will also contribute technical expertise in the areas of MNCH. Thus a few observations are made on the HSDP approach reflected in the proposal:<br>**Maternal Health**<br>• Contraceptive prevalence in Ethiopia at 9.7 per cent for modern methods is low and use of long acting methods is especially low. The objective to substantially increase the conceptive prevalence rate as one of the most cost effective approaches to reducing maternal, child and neonatal mortality is consistent with Australian and global policy. Emphasis in HSDP on long acting methods such as Implanon (a single-rod long acting reversible hormonal contraceptive implant under the skin of a woman's upper arm) and the IUCD is appropriate. However, the proposal for Health Extension Workers (HEW) in rural settings to insert the Implanon raises some concerns. Firstly, if this method is given emphasis, there is the risk that the 'cafeteria' approach of offering all methods will be diminished. While Implanon is simpler to insert and remove | |

than Norplant, there appears to be very little literature on its use, especially in nonclinical settings. If problems arise (such as side effects, difficulties in removal) these are a strong deterrent to users. There is plenty of evidence to support this. If Australian guidelines (based on global best practice) are to be followed, there are safety/quality assurance issues to be addressed.

- Addressing the 3 delays is critical to improving the very low levels of skilled attendance for delivery. Cultural factors are a major factor in some areas, especially among the pastoralist populations. Providing mother and culture-friendly delivery environments will stimulate demand and provision of maternity waiting homes will be help reduce the second delay. Provision of transport (i.e. E-Ranger type motorcycle ambulances, already tried in some parts of Ethiopia), but many are needed for significant numbers of women to access these. Use of mobile phones to reduce delays and aid referrals can work well and can transmit information on maternal deaths so that these are reported quickly. Other country experience may be useful.
- The importance of evidence (service statistics and research) in maternal health could be given more emphasis. Maternal death audits at facility level are important, but will only record a small proportion of the deliveries in Ethiopia. Consideration needs to be given to HEW-managed vital registration/maternal death audits. Where a 'blame culture' exists, there is a tendency for inaccurate reporting. Can AusAID TA add value here?
- Training of anaesthesia and surgery professionals has worked very well in Mozambique, increasing access to caesarean section. This is a good option where there are HR gaps.

**Newborn and child health**

- 30 per cent of under-five deaths in Ethiopia are during the neonatal period. Birth asphyxia accounts for 24 per cent of this, with infections at 35 per cent. It would make sense therefore to include management of infections as a priority together with birth asphyxia. There is evidence that the percentage of low birth weight babies is increasing. Kangaroo care should therefore be integral to the package for newborn care.
- Introduction of new vaccines is not specific. Is this valid? Is the current selection well managed and are antigens widely and routinely available?
- The proposal does not discuss partnerships in detail, or how AusAID will work with specific partners though it mentions its support to Hamlin and their work in fistula.

## 2.3. Effectiveness (Rating: 5)

| Assessment | Required actions |
|---|---|
| The 2010 Alebachew and Walford report states that<br><br>'for HSDP IV, the government has clear vision on "where to go" and is actively "driving" the process of improving the effort towards realizing the health MDGs. The IHP process in general and the JANS process in particular have built on the existing sector coordination and dialogue mechanisms established for the HSDP.'[2]<br><br>Australian aid will contribute to implementation of the HSDP IV with its agreed objectives. Suggestions might be considered in the contexts of:<br><br>• future technical discussions on HSDP<br><br>• AusAID-specific TA in support of the above<br><br>The development of HSDP IV has been a participatory process, building on previous years of implementation and based on current needs. It is assumed that there is an annual national implementation plan for the HSDP that sets out clearly what will be done for the year, by whom and at what cost. It should also indicate what will be paid by DPs external to the pooled funding arrangement and highlight gaps in committed funds.<br><br>**An AusAID-specific performance framework** to capture the oversight and TA inputs integral to AusAID support or, if available, external to the agreed bilateral budget has been discussed. This will guide future internal (QAI) assessments. The proposal might provide more detail on management and TA arrangements for AusAID to provide an appropriate level of technical advice and oversight and political/donor collaboration and influencing.<br><br>• What technical/advisory support will be based in Addis AusAID?<br><br>• What is envisaged in terms of TA in all areas where AusAID might provide added value. For example, strengthening evidence, fiscal management, human resource planning, health financing, and engagement of private sector?<br><br>• Concerns about donor inconsistencies expressed in the IHP partnership assessment are very forthright – have these been addressed and what can AusAID learn from these?[3] | |

[2] Lessons from the Joint Assessment of National Strategy (JANS) Process in Ethiopia. Abebe Alebachew and Veronica Walford. August 2010
[3] ETHIOPIA Report of the Assessment of IHP Compact Implementation Summary of Findings and Recommendations

## 2.4. Efficiency (Rating: 5)

| Assessment | Required actions |
|---|---|
| Insofar as the HSDP IV itself is concerned, the proposal provides a clear overview of the many mechanisms used to implement, monitor, evaluate and finance the HSDP. This includes the International Health Partnership +.<br><br>The proposal indicates expected financial contributions for HSDP over the coming five years from GOE (US$1.4 billion) and from DPs (US$3 billion), highlighting a financing gap of US$6 billion up to US$9.3 billion respectively. Positive news is that disbursement of GOE and donor funds was high – an indication that systems are working and DPs are committed to getting funds to flow. It is not yet clear how financing gaps will be met, though priorities can be adjusted to fit available financing.<br><br>The proposal points out that improvements in the area of maternal health are difficult to achieve, as they depend largely on an improvements in various support systems (staff, planning and finance, M&E). The proposed civil service reforms are therefore critical to this and the proposal rightly notes that this is challenging and will require long-term support for system strengthening, which is currently underfunded. The proposal states that the AusAID will contribute to improve MCH outcomes within this broader 'system' orientation but does not provide further detail.<br><br>• It is not clear how technical assistance from AusAID will be managed. Will this be part of the TA Pooled Fund managed by UNICEF? How will AusAID protect the GOE's leadership in managing TA without compromising on quality of TA?<br><br>The successful leadership role of The Minister, Dr Tedros Adhanom Ghebreyesus, is referred to in the proposal. Leadership matters and can determine success or failure and provide a significant incentive for increasing donor investment as in the case of Ethiopia. However, history has also shown that sustained success lies in strong institutions. The proposal could do more to emphasise the importance of strengthening and measuring progress in governance and wider civil service reform (unless it is considered that the IHP+ is expected to fulfil this function?).<br><br>• The proposal suggests that AusAID has the opportunity to influence both GOE and DPs – and as a relatively new donor in a "donor dense" environment, there are real opportunities. Potential for success will depend largely on AusAID readiness to a) be flexible; b) take risks and c) ability to provide high calibre and adequate quantity of effective technical (and diplomatic) support in country. | |

| | |
|---|---|
| • The proposal talks about AusAID 'bringing renewed energy to existing sector harmonisation forums. A key means to achieving this is through participation in the Health, Population and Nutrition Sector Working Group'. Participation in technical working groups will also enable AusAID to exert influence in technical areas where it has expertise or can contract this in. | |

## 2.5. Monitoring and Evaluation (Rating: 4)

| Assessment | Required actions |
|---|---|
| An overall Result Framework (RFW) has been agreed between FMOH and Donors for delivery of HSDP IV. Annual and five-year performance indicators and targets for MCH/family planning have been set and the data sources have been identified. The different mechanisms for M&E of the HSDP IV have evolved over time and there appear to be more than enough. There is always a danger of having too many performance mechanisms that become a major opportunity cost for GOE. Some of the weaknesses and challenges have been highlighted in the proposal to which this assessment will respond.<br><br>AusAID's purpose is to support and strengthen delivery of Ethiopia's HSDP IV for better results on MDGs 4 and 5. The two objectives (above) of this proposal define AusAID's role (attribution) in making this happen. A simple Monitoring and Evaluation (M&E) framework to measure progress against these two objectives above as already discussed would therefore be appropriate and inform the QAI.<br><br>The proposal discusses Ethiopia's demonstrated leadership and commitment to ensuring improved health outcomes and describes the many systems for harmonised, decentralised and accountable planning and M&E. For example, the IHP Compact, Joint Financing Agreement, 'One Plan, One Budget and One Report.' AusAID will participate in the various Joint Reviews (Joint Review Mission, Annual Review Meeting).<br><br>The Health Management Information System (HMIS) is vital for resource planning and commonly undermined by the parallel systems of partners unwilling to harmonise. Evidently, in Ethiopia, there remain challenges in getting all stakeholders to harmonise data management. The proposal also highlights discrepancies in some of the service statistics generated by HMIS and since this is commonly a challenging area, it provides an opportunity for AusAID to contribute to efforts to improve data quality. (DFID already has a proposed regional programme that includes Ethiopia and there may be others).<br><br>To assist with the 'needs based' approach discussed in the document, | Include M&E frame-work for AusAID support<br><br>More emphasis on potential role for AusAID in knowledge management. |

| | |
|---|---|
| there could be more emphasis given to the relationship between generation of HMIS, quality assuring data and translating the results and trends into very easily understood summaries that can be used at national and, importantly, sub-national levels. Typically, data are not fed back/downwards and there is loss of incentive to health workers generating data. Interpretation of results and use of data for planning is not easy unless the information is disseminated in a user-friendly form. This includes policy makers.<br><br>As already discussed, with so few births in facilities and with no Civil Registration and Vital Statistics System (?), data on maternal and newborn health are bound to be highly unreliable. | |

## 2.6. Sustainability (Rating: 5)

| Assessment | Required actions |
|---|---|
| The HSDP is owned and led by GOE, with 32 per cent of it funded by GOE (against the 15 per cent Abuja target), with the balance paid by development partners and out of pocket expenditure from the population. According to the recent NHA, National Health Expenditure (NHE) increased by 128 per cent between 2004/05 and 2007/08 from USD 522M to USD 1.2B. GOE contributions grew less by 71 per cent in the same period.<br><br>As part of its GTP priorities, the GOE plans to increase its allocation for health from the current USD 249M in 2009/10 to USD 298M in 2014/15. Many of the activities funded by the MDG/PF are developmental in nature and respond to national priorities. They are expected to be maintained by the national budget after the initial investments have been made. A good example is the salaries for the HEW, paid by the GOE. Once the recruitment and training costs for these 32,000 HEW have been met, their monthly operational costs will become less (although still substantial).<br><br>Planning is both bottom up and top down, so all levels of the system are engaged. There is increased involvement of civil society in planning and review processes. Ethiopia, while facing some very substantial challenges, has demonstrated steady progress in many areas and very strong commitment to its leadership of the health sector.<br><br>Ethiopia is into its fourth national health sector plan and has demonstrated progress in health outcomes and systems. There remain some weaknesses, which the proposal has discussed. The GOE is in the driving seat and likely to remain so. Subject to remedying the shortcomings raised in the last FRA, there is every likelihood that all | |

| | |
|---|---|
| development partners will put funds through the GOE in the longer term. If there are no major environmental or political catastrophes, if development partners maintain current levels of financing for the next ten years and if population growth does not increase beyond the capacity of services, sustainability of the sector is likely. The potential impact of serious political and/or environmental events does not appear to be captured in the proposal. Does AusAID have provision for humanitarian relief? Would the health budget be affected or is it ring-fenced? | |

## 2.7. Gender Equality (Rating: 4)

| Assessment | Required actions |
|---|---|
| The proposal (rightly) links Gender with Social Inclusion.<br><br>The Ethiopian Constitution recognises the principle of equality of access to economic opportunities, employment and property ownership for women. Following this, the government formulated a national gender policy, known as the National Policy on Women. The proposal refers to (i) the training manual on physical violence, framework on gender and health, analysis of data on female workers and the new version of the HMIS with gender disaggregated data to be rolled out to all health facilities, indicating that this (the HMIS) will be one of the main opportunities to address existing gender inequalities. In addition, specific efforts under HSDP IV will target nomads and pastoralist populations for who provision of health services are particularly challenging. Data will now be disaggregated for gender.<br><br>The recognition that gender mainstreaming requires engagement by all sectors is very appropriate. This is reflected in the proposal through creation of a Board with representation by 6 ministries to focus on four emerging regions with poor indicators.<br><br>AusAID policy states that '*Donor and partner government agencies, civil society, and regional organisations all need to increase their capacity for integrated gender and poverty analysis'*. <u>To take gender mainstreaming beyond a box ticking exercise is the difficult part:</u><br><br>o Who will be responsible for capacity building of sectoral ministries in gender and ensuring that gender is properly integrated and implemented;<br><br>o How will gender equity be addressed within the civil service?<br><br>o How will men's health needs be addressed since their health (especially reproductive and sexual health) impacts on women | See bullets |

- How to ensure that women are offered the complete range of family planning methods, that there is no coercion, (in order to meet GOE targets) and that quality assurance is measured and acted on.
- How will laws on child marriage be upheld and how relevant are they in areas where customary laws prevail (especially Pastoralist areas?)
- The role of civil society (including academia) in gender mainstreaming is vitally important, especially in reaching remote, vulnerable populations. Civil society is not specifically mentioned
- What is the potential role of AusAID TA on gender?

In a country where a high number of women are physically and socially disabled by childbirth and obstetric fistula in particular, focus on disability is very important. The proposal makes this link citing the role of Hamlin but CSOs generally have an important role to play in advocacy, rehabilitation and community mobilisation among others.

## Safeguards and commitments

| Criteria | Assessment | Yes/No |
|---|---|---|
| **Environment** | The proposal reports that there is no expected negative impact on the environment through this programme with potential environmental risks including an increase in clinical and other waste products from increased utilisation of health services.<br><br>Attention to building of new facilities with environmental risk assessment is appropriate.<br><br>Use of renewable technologies in health institutions is lacking. This is especially important for ensuring that rural facilities can provide EmOC 24/7 and reduce utility costs<br><br>Also missing is the positive impact on the environment that increasing family planning is likely to have. | **Yes** |
| **Child Protection** | The proposal states that the programme will support Australia's child protection policy and will work with all engaged partners to ensure compliance. | **Yes** |
| **Imprest Accounts** | | **N/A** |

# 3. Other comments

## 3.1. Risk Management

Risk and mitigation strategies are provided with financial management, procurement and supply chain the areas of greatest concern. It is suggested that components where AusAID sees itself as having a specific role could be incorporated into an AusAID M&E framework. The proposal also discusses the risk that Australia's assistance will be subsumed and diluted within the other larger donor inputs and discusses mitigation strategies that include: maximising partnerships and highlighting positive experiences and results in joint projects and initiatives; participating in both the Joint Core Coordinating Committee and the Joint Consultative Forum and contributing its experience to policy related problems and issues; participation in harmonised sector programmes. Wider risks such as political instability and natural disaster (neither of which is improbable!) are important to incorporate as they have budgetary implications in terms of humanitarian and environmental support.

There is great confidence in current leadership with good reason. However, there is a very real risk that if this leadership is lost, progress in the health sector could lose momentum. If, however, the systems and senior personnel are adequately robust to overcome any problems resulting from loss of leadership then this could be stated.

Having an adequate number of appropriately qualified and experienced personnel in country is important for the impact of AusAID support and influencing. This would be an assumption in an M&E framework.

# Annex: Key documents referred to

AusAID. Australia's strategic approach to aid in Pakistan. December 2010

AusAID Guideline: Completing a Quality of Entry Report

AusAID Guideline: Independent Appraisal and Peer Review

AusAID. Environmental Management Guide for Australia's Aid Program 2003

AusAID. Family Planning and the Aid Program: Guiding Principles. August 2009

AusAID. Gender equality in Australia's aid program – why and how. Mach 2007

HRF Child Protection Policy and Child Protection Code of Conduct

Australian Aid: Promoting Growth and Stability. White Paper. April 2006.

AusAID. Family Planning and the Aid Pogram: Guiding Principles. Aug 2009

The MCH – Implementation Plan for Africa, Maternal and Child Health (Dec 2010).

Joint Financing arrangement between the Federal Democratic Republic of Ethiopia and development partners on support to the MDG fund.

Ethiopia. Demographic Health Survey. 2005

Health Sector Development Program (HSDP III 2005/06 – 1009/10)

Health Sector Development Program (HSDP IV, 2010/11 – 2014/15);

FDR Ethiopia. MOH. National Reproductive Health Strategy 2006 - 2015

Ethiopia International Health Partnership (IHP+) Compact (August 2008)

Health Pooled Fund Evaluation Report. Health Pool Fund Evaluation Team. April 2007.

Joint Financing Arrangement between the Federal Democratic Republic of Ethiopia and the Development Partners on support to MDG Fund (March 2009) and the HSDP Harmonisation Manual (2007);

MOH. Scaling Up For Better Health in Ethiopia. IHP+ Roadmap for harmonization and alignment of government and partner programmes and financing towards attaining the health related MDGs. February, 2007

Appraising the MDG/PF (DFID, September 2008)

Key findings of the fiduciary risk assessment (FRA, March 2011).

Ethiopia International Health Partnership (IHP+) Compact (August 2008), including its roadmap drafted in February 2007.

MDG Health Fund Appraisal. Social Inclusion. Karen Johnson. 24th September 2008

Lessons from the Joint Assessment of National Strategy (JANS) Process in Ethiopia. Abebe Alebachew and Veronica Walford. Draft - 11 August 2010

Harmonisation in the Health Sector in Ethiopia. Catriona Waddington and Girma Teshome. June 2005/updates added September 2005

# HLSP Disclaimer

The Health Resource Facility (HRF) provides technical assistance and information to the Australian Government's Australian Agency for International Development (AusAID). The Health Resource Facility is an Australian Government, AusAID funded initiative managed by Mott MacDonald Limited trading as HLSP in association with International Development Support Services Pty Ltd (IDSS), an Aurecon Company.

This report was produced by the Health Resource Facility, and does not necessarily represent the views or the policy of AusAID or the Commonwealth of Australia.

This document has been prepared for the titled project or named part thereof and should not be relied upon or used for any other project without an independent check being carried out as to its suitability and prior written authority of HLSP being obtained. HLSP accepts no responsibility or liability for the consequences of this document being used for a purpose other than the purposes for which it was commissioned. Any person other than the Commonwealth of Australia, its employees, agents and contractors using or relying on the document for such other purpose agrees, and will by such use or reliance be taken to confirm his agreement, to indemnify HLSP for all loss or damage resulting therefrom. HLSP accepts no responsibility or liability for this document to any party other than to the agency and agency representatives or person by whom it was commissioned.