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Report No: 112244

PROGRAM PAPER

ON A

PROPOSED RESTRUCTURING

AND A

PROPOSED ADDITIONAL FINANCING IN THE AMOUNT OF SDR 110.6 MILLION
(US$150 MILLION EQUIVALENT)

TO THE

FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

WITH A PROPOSED GRANT
FROM THE GLOBAL FINANCING FACILITY
FOR EVERY WOMAN AND EVERY CHILD
IN THE AMOUNT OF US$60 MILLION

AND

A PROPOSED GRANT
FROM THE POWER OF NUTRITION TRUST FUND
IN THE AMOUNT OF US$20 MILLION

IN SUPPORT OF
THE HEALTH SUSTAINABLE DEVELOPMENT GOALS PROGRAM FOR RESULTS

April 20, 2017

Health, Nutrition & Population
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective as of March 31, 2017)

Currency Unit	=	Ethiopian Birr (ETB)
ETB 22.84	=	US$1
US$1	=	SDR 0.7370

FISCAL YEAR
July 08 – July 07

ABBREVIATIONS AND ACRONYMS

ACG	Anti-Corruption Guidelines
ANC	Antenatal Care
APTS	Auditable Pharmaceuticals Transactions and Services
BPR	Business Process Reengineering
BSC	Balanced Score Card
CASH	Clean and Safe Health Facility Initiative
CBHI	Community Based Health Insurance
CHD	Community Health Days
CHMIS	Community Health Management Information System
CIFF	Children's Investment Fund Foundation
CPR	Contraceptive Prevalence Rate
CPS	Country Partnership Strategy
CRVS	Civil Registration and Vital Statistics
CSA	Central Statistics Agency
CSC	Community Score Card
DHS	Demographic and Health Survey
DLI	Disbursement Link Indicator
DQA	Data Quality Assurance
EHIA	Ethiopian Health Insurance Agency
EHNRI	Ethiopian Health and Nutrition Research Institute
EOS	Enhanced Outreach Services
EPHI	Ethiopian Public Health Institute
ESAP	Ethiopia Social Accountability Program
ESPES	Enhancing Shared Prosperity through Equitable Services
ESSA	Environmental and Social Safeguards Assessment
EWEC	Every Woman and Every Child
FEACC	Federal Ethics and Anti-Corruption Commission
FM	Financial Management
FMOH	Federal Ministry of Health
FPPA	Federal Public Procurement and Property Administration Agency
FTA	Financial Transparency and Accountability
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFF TF	Global Financing Facility Trust Fund
GFF	Global Financing Facility

GMP	Growth Monitoring and Promotion
GMU	Grant Management Unit
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
GTP	Growth and Transformation Plan
HAPCO	HIV/AIDS Prevention and Control Office
HCF	Health Care Financing
HCMIS	Health Commodities Management Information System
HEW	Health Extension Worker
HFS	Health Financing Strategy
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno-Deficiency Virus
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HPN	Health Population and Nutrition
HRH	Human Resources for Health
HRITF	Health Results Innovation Trust Fund
HSDP	Health Sector Development Plan
HSS	Health System Strengthening
HSTP	Health Sector Transformation Plan
ICT	Information and Communication Technology
IDA	International Development Association
IEC	Information, Education and Communication
IFA	Integrated Fiduciary Assessment
IFA	Iron and Folic Acid Tablets
IFAC	International Federation of Accountants
IFMIS	Integrated Financial Management Information System
IFRs	Interim Financial Reports
IGFT	Intergovernmental Fiscal Transfer
IHP+	International Health Partnership Plus
IMR	Infant Mortality Rate
IP	Implementation Progress
IPF	Investment Project Financing
IPPSC	Infection Prevention and Patient Safety Committees
ISR	Implementation Status Report
IT	Information Technology
JANS	Joint Assessment of National Health Strategies
JCCC	Joint Core Coordination Committee
JCF	Joint Consultative Forum
JFA	Joint Financing Agreement
JRIS	Joint Review and Implementation Support
KPIs	Key Performance Indicators
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDGs PF	Millennium Development Goals Performance Fund
MEFCC	Ministry of Environment, Forest and Climate Change
MNCH	Maternal, Neonatal and Child Health
MOFEC	Ministry of Finance and Economic Cooperation
MTR	Mid Term Review
MWM	Medical Waste Management
NBE	National Bank of Ethiopia

NERs	Net Enrollment Rates
NGOs	Non-Governmental Organizations
NNCB	National Nutrition Coordination Body
NNP	National Nutrition Program
OFAG	Office of the Federal Auditor General
PAP	Program Action Plan
PBS	Promoting Basic Services
PDO	Program Development Objective
PEFA	Public Expenditure and Financial Accountability
PFM	Public Finance Management
PFM	Public Finance Management
PforR	Program for Results
PFSA	Pharmaceuticals Fund and Supply Agency
PHC	Primary Health Care
PIM	Project Implementation Manual
PMU	Project Management Unit
PN	Power of Nutrition
PP	Program Paper
PPD	Policy and Plan Directorate
PPSD	Project Procurement Strategy for Development
PSNP	Productive Safety Nets Project
QCBS	Quality and Cost Based Selection
REACC	Regional Ethics and Anti-Corruption Commission
RFB	Request for Bid
RHBs	Regional Health Bureau
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
SA	Skilled Birth Attendance
SARA	Service Availability and Readiness Assessment
SBD	Standard Bidding Document
SDG	Sustainable Development Goal
SDGPF	Sustainable Development Goal Pool Fund
SDR	Special Drawing Rights
SHI	Social Health Insurance
SNNP	Southern Nations, Nationalities and Peoples
SPA+	Service Provision Assessment Plus
SPL	Social Protection and Labor
STEP	Systematic Tracking of Exchanges in Procurement
STIs	Sexually Transmitted Infections
TA	Technical Assistance
TFR	Total Fertility Rate
TWGs	Technical Working Groups
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
UNIS	Unified Nutrition Information System
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
VAS	Vitamin A Supplement
VERA	Vital Events Registration Agency
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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ETHIOPIA

Health Sustainable Development Goals Support Program for Results
Additional Financing

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AFRICA REGION

HEALTH, NUTRITION AND POPULATION GLOBAL PRACTICE

A. DATA SHEET

Program ID: P160108 Regional Vice President: Makhtar Diop Country Director: Carolyn Turk Practice Manager: Trina S. Haque Team Leader: Anne Bakilana	Lending Instrument: Program for Results Current Approval Date: February 28, 2013 Current Closing Date: June 30, 2018 Report No: 112244
Borrower:	Federal Democratic Republic of Ethiopia
Responsible Agency:	Federal Ministry of Health Federal Vital Events Registration Agency

Financing Information

Key Dates

Program	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Current Closing Date	Revised Closing Date
P123531	CR#5209	Active	February 28, 2013	March 29, 2013	June 17, 2013	June 30, 2018	July 31, 2021
P123531	TF#14107	Active	March 29, 2013	March 29, 2013	March 29, 2013	June 30, 2018	July 31, 2021
P123531	TF#14815	Active	December 23, 2013	December 23, 2013	December 23, 2013	February 28, 2017	-

Disbursements (in Millions)

Program	Ln/Cr/TF	Status	Currency	Current	Revised/ Cancelled	Disbursed	Un-disbursed	% Disb.
P123531	CR#5209	Active	USD	100.00	-	61.5	38.5.0	61.5
P123531	TF#14107	Active	USD	20.00	-	13.80	7.20	70.00
P123531	TF#14815	Active	USD	0.400	-	0.210	0.190	52.5%

Policy Waivers

Does the Program require any waivers of Bank policies applicable to Program-for-Results operations?	Yes [ ]	No [X]
Has the waiver(s) been endorsed or approved by Bank Management?	Yes [ ]	No [ ]

B. Summary of Proposed Changes

Change in Program's Development Objectives	Yes [ ]	No [X]
Change in Program Scope	Yes [X]	No [ ]
Change in Results Framework	Yes [X]	No [ ]

Change in Legal Covenants	Yes [X]	No [ ]
Change in Loan Closing Date(s)	Yes [X]	No [ ]
Cancellations Proposed	Yes [ ]	No [X]
Change to Financing Plan	Yes [X]	No [ ]
Reallocation between and/or Change in DLI	Yes [X]	No [ ]
Change in DLI Verification Protocol	Yes [X]	No [ ]
Change in Key Parameters (Disbursement Arrangements, Institutional Arrangements, Technical, Fiduciary, and Environmental and Social aspects)	Yes [X]	No [ ]
Change in Program Action Plan	Yes [X]	No [ ]
Other Change(s)	Yes [X]	No [ ]

C. Program Status

Overall Health Sector Progress: Ethiopia has made steady progress towards achievement of its main health improvement goals. There is good progress in reducing mortality and morbidity among children and women, and there is evidence that for select indicators, the poor have directly benefitted from the progress experienced across the health sector in improved outcomes and strengthened delivery systems. Over the last two decades, under five mortality rate declined from 166 deaths per 1000 live births in 2000 to 67 in 2016 and infant mortality rate (IMR) declined from 97 deaths per 1000 live births in 2000 to 48 deaths per 1000 live births in 2016. Between 2000 and 2016, Contraceptive Prevalence Rate increased from 8 percent to 36 percent; Total Fertility Rate declined from 5.5 to 4.6 children per woman; and births attended by skilled attendants increased from 6 percent to 28 percent. However, Ethiopia remains one of the poorest countries in the world with lagging indicators in maternal and child health, especially neonatal mortality. Equitable access to basic services is a concern, while quality of services and readiness of facilities to provide quality services is a major hindrance to Universal Health Coverage. Financial protection from catastrophic illness remains inadequate and is one of the most challenging agenda for the next decades. Ethiopia faces key challenges in the Early Years agenda, including stunting and maternal nutrition status which must be addressed.

Program progress: Progress towards achievement of the PDO is Satisfactory. Steady progress has been made in seven of the eight DLIs, apart from DLI#6 on the Balanced Score Card (BSC). To date, US$75 million (US$61.5 million IDA; US$13.8 million Health Results Innovation Trust Fund; and US$200, 000 from the Health Results Innovation Trust Fund) has been disbursed. Overall, the Government's commitment in addressing key challenges in the sector has resulted in improvement in health outcomes. The commitment of partners supporting the Government's program has remained strong throughout the period of implementation. Similarly, there is steady progress in most areas of the Program Action Plan, but Implementation Progress was rated Moderately Satisfactory because of delays in some of the actions under the Program Action plan as well as delays in meeting legal covenants.

Legal Covenants: Overall, progress in improvement of the financial management system of the sector as a whole, though steady, has been slow due to very limited capacity and a system of accounting and supply chain management that remains largely manual and unable to cope with a growing sector. There has been delay in meeting the Dated Covenant (Financing Agreement Schedule 2 Section V.A) on clearance of a backlog of Audits for the Pharmaceuticals Fund and Supply Agency. There has also been delay in submission of Procurement Audits - The Pharmaceuticals Fund Procurement Audit for EFY 2006 (FY2013/2014) which was due by January 2015, was submitted in May 2016 in Amharic; and the Procurement Audit for EFY 2007 (FY2014/2015) was submitted late. The new Integrated Fiduciary Assessment (IFA) that was undertaken as part of the preparation of the AF aimed to understand root causes to unresolved backlog of audits and lack of capacity of the Government to address Fiduciary issues. The IFA found key gaps including a shortage of capacity in financial management, audit and procurement.

Fiduciary Management: The financial management system of the program provides reasonable assurance that Bank loan proceeds are being used for the intended purpose. However, some areas including the delay in meeting the dated covenant on clearing the backlog of the Pharmaceuticals Fund audits for the EFYs 2001-2004 which were delayed have now been cleared. There is gradual but slow progress in continuous disclosure of agreed procurement information and issuance of calls for prequalification bidders. Progress under various procurement improvement actions in the Program Action Plan is still required.

Governance: The original program identified Program Action 13 - Federal Ethics and Anti- corruption Agency (FEACC) sharing information with the Bank on allegations of fraud and corruption and actions being taken to address these- as one of the main areas to track progress in governance. As per the program agreement and the Memorandum of Understanding between FEACC and the Bank, FEACC has submitted a letter to the Bank confirming that there has not been fraud and corrupt practice reported in implementing the Health SDGs Program for Results.

Environmental and Social Safeguards: Overall, the MOH has made progress on some of the actions agreed upon under the original program, including establishing and operating infection prevention and patient services committees at health facilities and availing appropriate temporary storage facilities for hazardous waste until final disposal is completed. The program has seen progress in select Program Actions on Environmental and Social Safeguards, with delay caused by weaknesses in institutional mechanism for coordination and reporting on environmental and social safeguards.

Development Objectives/Results

Program Development Objectives

Original PDO: To improve the delivery and use of a comprehensive package of maternal and child health (MCH) services. The PDO will remain the same.

Change in Program's Development Objectives: N/A

Change in Program Scope

The PforR boundary will remain the same. The proposed AF will continue to support results under the Sustainable Development Goals Performance Fund (SDG PF) which formed the boundary under the original program. The SDG PF, formerly called the MDGs PF, has a focus on primary health care and will support key Maternal and Child Health interventions. The AF will channel that support through SDG Performance Fund through non-earmarked funds in support of key initiatives identified in the HSTP. The program scope will remain the same though program expenditure has been increased due to the longer time period for implementation, the inclusion of new DLIs and results areas such as nutrition and health care financing, as well as the dropping of the DLI on the Balanced Score Card.

The following changes are made to the original PforR:

(a) Addition of new DLIs that will trigger disbursements upon attainment of results on: (i) Contraceptive Prevalence Rate among rural women: DLI#4; (ii) Fiduciary Management improvement: DLI#9 on timely financial audit reports; automation of the financial management system of the Pharmaceuticals agency have been added; (iii) Nutrition: DLI#10 on Vitamin A Supplementation; DLI# 11 on Iron and Folic Acid tables; (iv) DLI#12 on Growth Monitoring and Promotion have been added; (v) Improving quality of health care as well as Adolescent and School Health: DLI#13 on adolescent health sector strategies development and roll out; vi) Financial protection through Community Based Health Insurance: DLI#14 has been added; (vii) Enhanced Community Participation in Health Service Delivery: DLI#15 on increased us of the Grievance Redress Mechanism and use of Community Score Cards have been added.
(b) Dropping DLI #6 on the Balanced Score Card whose implementation modality changed when the Government rolled-out the BSC country wide in a manner that would not make it possible to measure the impact of the approach on service delivery.

(c) Restructuring of DLI#2 on pentavalent 3 vaccine which has been allocated more time to meet the targets due to delays in undertaking of the relevant surveys.
(d) Scaling up DLIs under the original program whose targets have been met but which require stretch targets for further results, the scaled DLIs are: i) Skilled Birth Attendance: whose targets are increased from a baseline of 10% at the start of the operation to 36%; ii) Antenatal Care Coverage: Changed focus from women only having one antenatal care visit to having four antenatal care visits with targets to be increased from 32% to 38%; iii) Contraceptive Prevalence Rate: original target was met and DLI is changed to CPR (rural) to be increased from 32.4% to 37%; iv) Undertaking of Facility Surveys: Targets are added to ensure that the surveys continue to be undertaken during the life of the program and become institutionalized.
(e) Changes in the Program Action Plan: A number of actions have been met under the original operation and will not be tracked under the AF. The following changes are made to the Action Plan: i) Refinement of actions from the original program; and ii) Addition of actions in support of DLIs in new areas that have been added under the proposed AF.

Change in Results Framework

The Results Framework has been updated to reflect the changes above (see Annex II for details). In summary, targets for new, scaled and restructured DLIs have been added. In addition, results for the IPF component have been added.

Change in Legal Covenants

The Dated Covenant (Financing Agreement Schedule 2 Section V.A) related to clearance of Audits of the Pharmaceutical Fund Supply Agency (PFSA) for Financial Statements for EFY 2001-2004 has been met. Therefore, instead of using a Dated Covenant in the proposed AF, specific DLIs on PFSA fiduciary management capacity have now been added and will be accompanied by specific actions in the Program Action Plan which will allow for continued dialogue in these areas.

The following covenants have been added under the proposed AF with respect to the IPF components:

Under the Financing Agreement Section I, C (2): The Recipient through VERA shall carry out the following: (a) Within three (3) months from the Effective Date, establish, and thereafter maintain during the period of Project implementation, with composition and terms of reference satisfactory to the Association and with adequate resources to carry out its responsibilities under the Project, a Technical Committee to provide support on technical issues in Project implementation, monitor and evaluate Project implementation and facilitate exchange of information among stakeholders on best practices; (b) Within three (3) months from the Effective Date: (i) (A) finalize and adopt a Project Implementation Manual ("PIM") detailing Project implementation arrangements, including organizational, administrative, monitoring and evaluation, environmental and social monitoring and mitigation, financial management and procurement and which PIM shall have been: prepared in accordance with terms of reference acceptable to the Bank; and approved by the Association; and (B) thereafter, implement the Project in accordance with the PIM and not amend, abrogate, or waive any provision of the PIM without the prior written agreement of the Association; and (ii) Establish a Project Coordination Team, with terms of reference, staffing and other resources satisfactory to the Association, which team shall be responsible for coordinating Project activities at all levels of implementation, liaising with MoFEC and MOH and other government agencies and proposing any updates to the PIM, and include a financial management specialist, a procurement specialist, a coordinator, and an information technology specialist, all with qualifications and experience satisfactory to the Association.

Under the Financing Agreement Section I, C (4): The Recipient, through MOH and VERA, shall: (a) not later than September 30th of each year, prepare and furnish to the Association, an annual work plan setting out the program of activities and training proposed for implementation under the Project during the following year, together with a proposed procurement plan and budget for the purpose; and (b) exchange views with the Association on each of the proposed annual work plan, and shall thereafter adopt, and carry out the program of activities and training for the following year as shall have been agreed with the Association, as such annual work plan may be subsequently revised during the following year with the prior written agreement of the Association.

Under the Financing Agreement Article 4.01: The Additional Condition of Effectiveness consists of the following, namely, Co-financing Agreements have been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it have been fulfilled.

Financing

Change in Loan Closing Date(s)

The closing date is extended to June 30, 2021 to allow for adequate time to implement and track results.

Loan No.	Status	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
CR#52090	Active	June 30, 2018	June 30, 2021	June 30, 2018
TF#14107	Active	June 30, 2018	June 30, 2021	June 30, 2018

Cancellations Proposed: No cancellations in loan amounts are proposed.

Change in Financing Plan (USD)

Source (s)	Currency	At Approval	Current (from AUS)	Proposed
IDA	USD	100.00	100.00	150.00
HRITF	USD	20.00	20.00	0.00
Global Financing Facility	USD	-	-	60.00
Power of Nutrition	USD	-	-	20.00
Total	**USD**	**120.00**	**120.00**	**230.00**

Reallocation between and/or Change in DLI (see Annex X for details)

DLI#6 Balanced Score Card will be dropped and (undisbursed amounts reallocated to scaled DLI 1). Progress in the roll out of a Balanced Score Card Approach with links to institutional incentives was delayed due to the decision to scale-up the Balanced Score Card initiative nation-wide across all sectors making it impossible to obtain results in the way that was originally designed.

Changes in DLI Verification Protocol (see Annex X for details): The DLI verification protocol has changed to bring on board means of verification pertaining to new DLIs. Verification protocol for scaled or restructured DLIs will remain the same. The Verification Protocol has been changed to reflect the inclusion of new DLIs and for stretched targets for existing DLIs.

Change in Key Parameters (Disbursement Arrangements, Institutional Arrangements, Technical, Fiduciary, Environmental and Social)

The addition of an IPF component will change the pure PforR into a hybrid PforR. The IPF component (US$21 million) will have a separate implementation modality, and will include both Ministry of Health and the Federal Vital Events and Vital Statistics Agency (VERA) as implementation agencies. In addition, an IPF component has been added to render support to three specific areas: Sub-Component 1: Will support the design and establishment of a centralized electronic Civil Registration and Vital Statistics system. In addition, the component will support technical assistance and capacity building at the Vital Events Registration Agency, as

well as procurement of equipment to facilitate the registration process. Sub-Component 2: Capacity Building and Technical Assistance for implementation of the National Nutrition Program II; and Sub-Component 3: Unallocated amount for technical assistance and capacity for activities to be undertaken by MOH that will be identified during implementation. (see Annex I for details).

Change in Program Action Plan

The Program Action Plan has been changed to reflect added focus on Fiduciary Management; Environmental and Social Safeguards; Gender; as well as Technical areas that had not been covered before including nutrition, postnatal care, health care quality and adolescents' health.

The following Actions have been dropped from the Program Action Plan:

- *Action #1:* Developing and implementing Balanced Score Card approach to assess facility performance and related institutional incentives.
- Action #6: Separating procurement and distribution process for purposes of improving advance settlement and accountability; aging analysis to be prepared every quarter to monitor delays; once the procurement cycle is completed and goods are delivered at PFSA the advances will be liquidated in the books of account. A monitoring mechanism of delivery to ultimate beneficiaries will be developed separately.
- Action #7: Exchange rate will be applied on the basis of actual rate of transfer while reporting expenditures to minimize reported exchange losses. A reconciliation will be completed to adjust actual foreign exchanges losses/gains and accounting losses/gains - will also be dropped. This is because the Bank has confirmed that there is no actual gain /loss that arises in the transactions of PFSA with FMOH since all payments and transfers are made in foreign currency.
- Action #10: FMOH through appropriate consultation to consider establishing a Fiduciary subcommittee of Joint Core Coordination Committee to monitor budget performance of Sustainable Development Goals Performance Fund is dropped following contributors; agreement that there is no need to establish such a committee.

The following actions have been added to the Program Action Plan:

- Development and implementation of Postnatal Care Directives in support of the HSTP goal of improving postnatal care, neonatal mortality and maternal morbidity and mortality.
- FMOH undertaking training and building capacity in cause of death registration as part of strengthening the CRVS system.
- FMOH to develop and Implement a Gender Based Violence Strategy for the Sector and undertake analytical work on gender disaggregated indicators from HMIS data.
- Pharmaceuticals Commodity Distribution Process - Roll out of Auditable Pharmaceuticals Transaction and Service and provide progress update to ensure adequate monitoring mechanism of delivery of pharmaceutical commodities to ultimate beneficiaries at the branch level.
- Financial Management System: Identify solutions to long term accounting software choice so as to address record reconciliation challenges.
- Governance: Ensure the deployment of Ethics and Anticorruption Liaison Officer and experts at PFSA and regional Hubs and build capacity for the control of Fraud and Corruption. Ensure the deployment of Ethics and Anticorruption Liaison Officer and experts in Regional Health Offices and build capacity of the staff at regional and Woreda level.
- Procurement: Introduce Framework Contracting Method for common and repetitively procured items.
- Procurement: Undertake Assessment/ study and develop Coding and Categorization system of procurable items.
- Procurement: Review and improve the Standard Bidding Documents and agree with Federal Public Procurement Agency; and review current Bid Evaluation reporting methods and develop a template that keeps and records all relevant Evaluation Information.

• Environment and Social: Strengthen the coordination and reporting on environmental and social safeguards processes in FMOH, including updating of relevant documents to incorporate environmental impact and risk criteria in the site selection screening for all health facilities; build capacity of staff of the regulatory body on areas of health care facilities regulatory and inspection work.
Other Change(s): N/A

B. Program Paper

I. Introduction

1. **This Program Paper seeks the approval of the Executive Directors to provide an Additional Financing (AF) for the Ethiopia Health Sustainable Development Goals (SDGs)[1] Program for Results (PforR) (P123531) in the amount of US$150 million equivalent in IDA credit.** The Credit will be complemented by a grant of US$60 million from the Global Financing Facility for Every Woman and Every Child Trust Fund (GFF TF); and a grant of US$20 million from the Power of Nutrition Trust Fund. The proposed AF aims to scale up development impact of the program through: (i) Increased focus on the Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health agenda which aims to reduce maternal and child deaths; (ii) Build the Government's capacity in key areas including fiduciary management; coordination of the Early Years and Nutrition multisectoral agenda; iii) Support the expansion of Community Based Health Insurance; and iv) Strengthen the Government's Civil Registration and Vital Statistics system. The Program Paper does not propose changes to the original Program Development Objectives – to improve the delivery and use of a comprehensive package of maternal and child health services.

2. **The proposed AF responds to the Government's request to continue support to the PforR with non-earmarked harmonized resources to the sector using country systems**. The Government's program is defined by the Health Sector Transformation Plan 2015-2020 (HSTP) - a costed plan with targets to be achieved by 2020. The HSTP is a continuation of 20 years of Health Sector Development Programs that have provided strong guidance in key areas leading to consistent progress in health outcomes over the last decades. It is aligned with Ethiopia's Second Growth and Transformation Plan (GTPII 2015/16-2019/20), which sets ambitious targets for Ethiopia to become a lower middle income country by 2025. The HSTP has translated GTP II goals into concrete directions for the improvement of coverage, quality and access to equitable essential health services, while enhancing implementation capacity of the health sector at all levels of the system. Its focus on quality and equity requires a shift in the status quo to drive improvements at the national scale over the next five years. Areas of focus have been further elaborated through sub-sector strategies that together define the HSTP and hence the overall Government program for the period.[2]

3. **The proposed AF will contribute to the reduction of the financing gap under the Government's program.** The costing of the HSTP considered various scenarios, including different targets, development partners financing and domestic resources that would be available to finance implementation of the program. The HSTP faces a financing gap of approximately US$4 billion which is around 21 percent of the total cost of the plan.[3] A significant part of this financing gap is for activities that would improve Reproductive, Maternal and Child health whose implementation requires US$2.35 billion. These activities are more detailed and elaborated under the Reproductive Health Strategic Plan (2016-2020) which is nested under the broader HSTP. The proposed AF will help to reduce the financing gap under the HSTP and will specifically target the financing gap for maternal and child health services.

4. **The proposed AF for the PforR will maintain the original program boundary and continue to support maternal and child health outcomes through the Sustainable Development Goals Performance Fund (SDG PF).[4]** The goal of the SDG PF is to accelerate achievement of better maternal

[1] Original Program name was Health Millennium Development Goals Program for Results (PforR)
[2] Key sub-sector strategies include the Reproductive and Maternal Health Strategy; Health Care Financing Strategy; etc.
[3] Total Cost of HSTP is an estimated US$15.7 billion, the Government's contribution is US$8 billion, and Development Assistance is US$4.3 billion and an estimated gap of US$4 billion.
[4] The Sustainable Development Goals Performance Fund (The Pool Fund) is new name for the Millennium Development Goals Performance Fund.

and child health outcomes through harmonized support by providing approximately $739 million over the life of the program. The focus of the SDG PF is improvement of delivery of maternal and child health services through primary health care units and strengthening sector capacity, including human resources, financial management and supply chain management, health management information systems and health technologies.

5. **The Program Paper proposes the following changes to the original program design**: i) Addition of Disbursement Linked Indicators (DLIs) that will trigger disbursement upon attainment of results on: (a) nutrition; (b) increased proportion of rural households with protection from high out of pocket expenses for health care; (c) improved access to skilled birth attendance in lagging regions; (d) strengthening adolescent and postnatal health services; and (e) select fiduciary and system targets including specific targets in community participation and engagement; ii) Dropping DLI #6 on the Balanced Score Card approach whose implementation roll-out would not allow for the measurement of its impact on service delivery as was envisaged under the original program design; iii) Scaling up DLIs whose targets have been met but which require stretch targets for further results; iv) Changes in the Program Action Plan to spur action in areas such as postnatal care, community engagement, gender based violence; fiduciary management; and v) Addition of an Investment Project Financing (OP/BP 10.00) component to support identified gaps in capacity and information systems (Annex I).

6. **The largest proportion of the proposed AF will be allocated to the PforR with disbursements made directly to the SDG PF.** Approximately US$209 million (or 91 percent) of the proposed AF will be disbursed upon achievement of DLIs. Of this amount, US$106 million will be allocated to DLIs that have been scaled up from the original program and approximately US$103 million is allocated to results to be achieved under new DLIs. Nine percent of the proposed AF is allocated to the IPF component (US$21 million).

7. **The addition of an IPF component aims to address two critical areas**: i) support the Federal Vital Events Registration Agency (VERA) in building a Civil Registration and Vital Statistics System (CRVS), which is central to sound maternal and child health information and child marriage; and ii) filling needs in capacity building and technical assistance responding to challenges and lessons from implementation of the original PforR. The experience of implementation support since the PforR became effective has highlighted key capacity gaps in fiduciary management; Health Care Financing; Health Management Information Systems, etc. The IPF component will support select result areas of the system that are critical, including a knowledge agenda around Health Care Financing; Nutrition; Reproductive Health; Gender Based Violence as well as areas that require multisector interventions.

8. **The IPF component will have three sub-component:** (i) Sub-Component 1: Supporting the Civil Registration and Vital Statistics System (CRVS) (US$15 million): The Federal Vital Events Registration Agency will be responsible for implementation of activities that will support the Government's efforts to build a Civil Registration and Vital Statistics system through technical assistance, capacity building and procurement of equipment; (ii) Sub-Component 2: Technical Assistance and Capacity Building for Nutrition (US$5 million): The sub-component will support the Government's National Nutrition II Agenda in various capacity building areas including multisectoral coordination, evaluations and documenting lessons; and (iii) Sub-Component 3: An unallocated amount (US$1 million) will be reserved to support technical assistance and capacity building activities in various areas including financial management and procurement capacity at the Pharmaceuticals Agency and FMOH; implementation of Health Care Financing Strategy; data and management information systems including MOH vital events registration responsibilities, and undertaking of facility based/ other surveys.

9. **The proposed AF is aligned with the Country Partnership Strategy (CPS) for the period FY13-16.** It addresses challenges identified in the Systematic Country Diagnostic (2016) while continuing a strong focus on leveraging the efforts of partners and use of country systems. The proposed AF has a strong focus on building systems that will cushion the poor against health expenditure shocks which is consistent with the Africa Region Strategy principles. The AF will support the Government in its effort to combine and leverage domestic, private, and international resources as part of its health financing strategy that aims to roll out health insurance to cover 80 percent of the population in the next five years.

10. **Financing from the Global Financing Facility will contribute to reduction of the gap in financing of Reproductive, Maternal and Child Nutrition, and Child and Youth health.** Partnerships fostered under the Facility will bring together attention and resources to areas such as Health Care Financing, Fiduciary Management; and Health Management Information Systems, including strengthening of CRVS. The Power of Nutrition TF will support nutrition sensitive interventions that are known to make a difference to stunting in children, health of women and systems needed to collect sound data on nutrition. The proposed AF will also support Government efforts on provision of information on what citizens should expect from their Government by adding selected DLIs/ actions to measure how citizens are engaged in decisions made about their health, an area that has been identified as a priority under the HSTP.

11. **The proposed AF is complementary to the overall Bank support to the health sector in Ethiopia.** The PforR will continue providing support through the Federal Ministry of Health, in coordination with the Bank's **supported programs such as** Enhancing Shared Prosperity through Equitable Services (ESPES) target service delivery at sub-regional levels. ESPES also supports cross-cutting areas key to strong service delivery including fiduciary management, information systems and social and environmental safeguards. The Bank also supports Citizen's engagement and Social Accountability systems, strengthening capacities at regional and Woreda levels through ESAP II (Ethiopia Social Accountability Project) that builds social accountability systems through direct support through Civil Service Organizations, of which a number are in the health sector. The proposed AF will strengthen established linkages with ESPES and ESAP for support at local level, and will look into additional needs within the health sector for strengthening environmental and social safeguards through ESPES. The proposed AF aims to address many of the system challenges that are best handled at the Federal level including national level efforts in Health Care Financing, CRVS etc. The proposed AF fills in a gap in Nutrition, Gender and Citizen's engagement dialogue and coordination that need to be led by the Federal Ministry of Health.

12. **The request is consistent with the Bank's guidelines for AF, namely that the program is well performing**: (i) Overall Implementation Progress (IP) has been consistently rated satisfactory or moderately satisfactory over the most recent 12 months; (ii) Progress towards the Program's Development Objective has been rated satisfactory throughout the period of implementation, with consistent progress in DLIs and key health outcomes; and (iii) progress is being made in meeting key loan covenants, including audit and financial management reporting requirements. The program is making a contribution to Ethiopia's steady progress towards achievement of its main health improvement goals. There is consistent progress in reducing mortality and morbidity among children and women, and there is evidence that the poor are benefitting from the progress experienced across the health sector in improved outcomes and strengthened delivery systems.

II. Background: Sector Context and Challenges

13. **Ethiopia is a large and geographically diverse country, with a total population of about 90 million.** The United Nations projects that the population of Ethiopia will reach 130 million by 2025 and 190 million by 2050, becoming one of the world's ten largest countries by population size by 2050. Increasing contraceptive prevalence rates (from 8 percent to 35 percent between 2000 and 2016), and declining fertility rates (from 5.5 to 4.6 children per woman between 2000 and 2016), have contributed to the slower rates of population growth.[5] Due to population momentum, the population of young people is projected to comprise over 50 percent of the total population. Sustaining the decline in population growth rates is important. Ethiopia faces a future with a growing labor supply, fast urbanization and an opportunity for faster economic growth with potential for a demographic dividend - a result of a changing age structure following decades of declining birth rates and improving survival rates. Development prospects for the youth in terms of their education, skills development and ability to find a job, are strongly linked to the ability of the system to meet their health needs.

14. **Ethiopia has achieved high rates of economic growth and made substantial progress in social and human development over the past decade**. Ethiopia's overall record of achievement in basic service delivery over the last decade has been strong. The Government's financing for service delivery has grown reflecting strong commitment and ownership. The Government's Intergovernmental Fiscal Transfer (IGFT) or block grant system, has been accompanied by donor-financed programs and the SDG Support Fund.[6] All of these significantly contributed to the GTP service delivery targets including the meeting of child mortality reduction, net enrollment rates (NERs) and rural access to clean water targets.

15. **Ethiopia's two decades of consistent progress towards the achievement of better health outcomes is a result of strong implementation of successive Health Sector Strategies.** These strategies have been instrumental in providing clear guidance and direction for the sector since 1996. Notable results are seen in access to Primary Health Care services, particularly by the rural poor through the Ethiopian Health Extension Program. Over the last two decades, under five mortality rate declined from 166 deaths per 1000 live births in 2000 to 67 in 2016 and infant mortality rate (IMR) declined from 97 deaths per 1000 live births in 2000 to 48 deaths per 1000 live births in 2016. Between 2000 and 2016, Contraceptive Prevalence Rate increased from 8 percent to 36 percent; Total Fertility Rate declined from 5.5 to 4.6 children per woman; and births attended by skilled attendants increased from 6 percent to 28 percent. Ethiopia's attainment of MDGs for child health years ahead of the target date is a reflection that human development and achievement of the SDGs are top priorities in the country's development targets.

16. **A major achievement of the sector is improvement in health service utilization.** This is reflected in the growing equity in utilization of essential maternal and child health services which is one of the major achievements for the sector. It also corresponds well to overall economic development trends of the last two decades. Data show that the poor have directly benefitted from the progress experienced across the health sector in improved outcomes and strengthened delivery systems. For example, the DHS 2005 shows that the coverage of modern contraceptives among highest wealth quintile was more than eight times higher than that of the lowest quintile (33.7 vs. 4.0 percent), while the DHS 2016 shows that it is now about two times higher (45.7 vs. 21.9 percent).

17. **A key factor in the success of the sector has been the rapid expansion of health professionals to population ratio.** The ratio has increased from 3 per 10,000 populations in 2009 to 7.6

[5] World Population Prospects. 2015. 3.5 percent in the 1990-1995 period to 2.3 percent in the 2015-2020 period.
[6] A Government Fund which finances capital expenditures.

per 10,000 in 2014.[7] While this is still lower than the WHO estimates for the basic requirement to reach adequate coverage rates for key primary care interventions, it has made a difference in rural areas.[8] The shortage of human resources for health is well recognized in Sub-Saharan Africa and Ethiopia is no exception. Ethiopia has prioritized the reduction of human resource shortages in the health sector. There has been a notable increase in the number of higher education institutions in the public sector, from 8 to 57 universities in the last two decades, of which 34 are universities and hospital-based colleges offering degree programs, and 23 are regional health science colleges offering technical and vocational qualifications (levels 1 to 5). Private health science colleges have also flourished, with 24 institutions offering accredited programs as of 2012/2013. Specifically, the number of medical schools has increased to 33 and public midwifery schools to 49.

18. **The rapid increase in availability of health services is supported by the expansion of the Health Extension Workers program at the community level**. The Health Extension Program, which now has 40,000 health workers, has facilitated access to the package of key services at the community level. This is associated with the rapid uptake of reproductive and child health services at the community level. Specifically, the Health Extension Workers program is associated with increases in the proportion of women who receive antenatal care and whose deliveries are attended by skilled professionals – one of the tasks of HEW include following up on expecting women and encouraging delivery at a health care facility.

19. **The Government's Growth and Transformation Plan II (GTPII 2015/16 - 2019/20) sets a long-term goal for Ethiopia to become a lower middle income country by 2025. Under GTP I, e**conomic growth helped to reduce poverty in both urban and rural areas; since 2005, 2.5 million people have been lifted out of poverty, and the share of population below the national poverty line has fallen from 38.7 percent in 2004/05 to 29.6 percent in 2010/11 (using a poverty line of close to US$1.25/day). The country's per capita income of US$550 (Atlas GNI, 2014) is substantially lower than the regional average of US$1,257 and is the eleventh lowest worldwide. Poverty reduction and shared prosperity are the country's top agenda – it ranked 173 out of 187 on the Human Development Index (2014).

20. **GTP II has reaffirmed the Government of Ethiopia's commitment to human development, with very** specific **goals for the health sector**. Over the last 10 years, Ethiopia's overall record of achievement in basic service delivery has been strong. The Government's financing for basic service delivery has grown, showing increasing national commitment and ownership and recognition of the role that access to service delivery plays in poverty reduction. The HSTP 2015-2020 has set ambitious goals in improving health outcomes, with a strong focus on improving access to quality health services for the poor, and improving the overall quality of health care services. The Plan was based on thorough analysis of ongoing challenges and identified specific interventions in maternal and child health services that need to be strengthened.

Accelerating Progress in Key Health Outcomes - Impetus for the HSTP

21. **The Government's** HSTP **notes that despite notable sector achievements, challenges limiting the population's equitable access to quality health services require significantly more resources**. Maternal mortality remains unacceptably high even though it has declined from 871 maternal deaths per 100 000 live births in 2000 to 412 in 2016. Unlike sharp declines in other childhood mortality rates between 2000 and 2016, neonatal mortality rate reduced modestly, remaining high at 29 deaths per 1000 live births in 2016. Sixty – seven percent of all deaths of children aged under 5 years in Ethiopia

[7] Human Resources for Health strategy 2009-2025. Revised in 2015.
[8] Counting only physicians, nurses and midwives. Ratio needs to reach 23 health care professionals per 10,000 population,

take place before their first birthday. The 2016 DHS shows that about 13 percent of women aged 15-19 have had a birth or were pregnant at the time of the survey. The use of modern contraceptives in both married and unmarried adolescents is lagging. Successive surveys have shown that CPR among rural women has grown fast from a very low base, still, data show that 49.8 percent of women aged 15–19 living in urban areas use a modern contraceptive method, while only 32.4 percent of those living in rural areas use those modern methods (DHS 2016). The proportions are lower (0.7 percent) for unmarried adolescents who might be less informed and less aware of sexual and reproductive health issues.

The Early Years Agenda

22. **Ethiopia faces various challenges in ensuring that investments that impact learning, skills, labor productivity and overall quality of life are made in early years of children's development**. The first thousand days from conception are crucial to a child's future in terms of physical and mental abilities – the nutrition status of mother and child are key to ensuring this initial development. In spite of the significant progress and accomplishments in key human development indicators over the past two decades in Ethiopia, there has been little coordinated investment in areas such as early stimulation, Early Childhood Development, etc. Childhood stunting, micronutrient deficiencies, lack of dietary diversity and inadequate child feeding practices, particularly low rates of exclusive breastfeeding and complementary foods need to be addressed. High disease burdens such as acute respiratory infections, malaria, and diarrhea, exacerbated by lack of access to clean water and sanitation, further compound the problem. Mothers are often underweight and poorly nourished, due to both lack of access to nutritious food and lack of knowledge and demand. Consequences of malnutrition manifest themselves later in the life, with high costs associated with stunting due to cognitive and physical impairment, higher morbidity and mortality, and lower productivity.

Nutrition outcomes are improving at a slow pace

23. **Nutrition remains a serious and under-addressed issue with a need for much stronger and focused efforts in coordination with sectors outside health that influence nutrition status**. More than 1 in 3 children (38 percent) aged under-5 are stunted and 10 percent of children are wasted.[9] Three regions have stunting rates over 40 percent.[10] Nearly one third of Ethiopian women are malnourished[11] and 23 percent are anemic, which affects not only women's own health, but also contributes to the intergenerational cycle of undernutrition.[12] Moreover, under nutrition can impair cognitive and physical development, which affects educational attainment, workforce capacity and productivity, and economic progress. A recent study found that 28 percent of all child mortality in Ethiopia and 16 percent of repetitions in primary school are associated with undernutrition.[13] Micronutrient deficiencies are also pervasive in Ethiopia: 38 percent of children 6 - 59 months are Vitamin A deficient, 44 percent of children aged 6-59 months and 22 percent of pregnant women are anemic and only 15 percent of households use iodized salt. [14] [15]

24. **Latest data and assessments undertaken for the preparation of the proposed AF showed a clear need for the program to focus more on nutrition outcomes**. This is in line with health sector interventions in line with the National Nutrition Program II goals. Given the multisectoral nature of the agenda, capacity building in support of implementation of National Nutrition Program II, including

[9] Central Statistical Agency (CSA) and ORC Macro (2016). Ethiopia Demographic and Health Survey (DHS), 2016. CSA.
[10] Amhara (46%), Benishangul-Gumuz (43%), and Afar (41%)
[11] 27% of women are thin (have body mass index (BMI) below 18.5). CSA and ORC Macro (2011). DHS, 2011. CSA.
[12] CSA and ORC Macro (2016).
[13] AUC, NEPAD, UNECA, WFP (2012). The Cost of Hunger in Africa: Social and Economic impact of Child Undernutrition in Egypt, Ethiopia, Swaziland and Uganda. UNECA
[14] Demissie, T., et al. (2010). Magnitude and distribution of vitamin A deficiency in Ethiopia. Food Nutrition Bulletin: 31(2): p. 234-41.
[15] Central Statistical Agency and ORC Macro (2011). Ethiopia Demographic and Health Survey, 2011. Central Statistical Agency.

strengthening coordination of multisectoral nutrition activities at all levels; strengthening monitoring of National Nutrition Program II implementation through support to improved data flow and quality, and Operational research on community-based nutrition activities especially social mobilization and growth monitoring and promotion (GMP) and an independent evaluation of the scale-up of community based nutrition activities.

Adolescent Girls Agenda

25. **Youth (ages of 15-29 years) constitute approximately over 40 percent of the estimated total population of 90 million.** Data show that this age group has remained underserved with regard to receiving appropriate health care. Approximately 30 percent of women marry by age 15, and the 2016 DHS shows that about 13 percent of women aged 15-19 have had a birth or were pregnant at the time of the survey. Young women and men face barriers to health services – data show that 40 percent of women aged 15–19 living in urban areas use a modern contraceptive method, as compared to only 17 percent of those living in rural areas. Given that age at sexual debut is still quite young, and that married adolescents have the highest unmet need for contraception for spacing purposes and is the group with the greatest demand for family planning, it is critical to strengthen services to reach and address the needs of this age group. In addition, Female Genital Mutilation, Gender Based Violence, especially in child marriage, increases their risk of adverse health outcomes such as unintended pregnancy, HIV and other sexually transmitted infections (STIs).

Access to Quality Services

26. **The HSTP notes the achievement in improving overall accessibility to services and has put equitable access to quality health services among its top priorities for 2015-2020.** Total Fertility Rate has reached a below replacement level at 1.7 births per woman in Addis Ababa, the capital city, while remaining highest at 6.4 children per woman in the Somali region. The DHS 2016 shows that the coverage of modern contraceptives among highest wealth quintile is twice as high (45.7 vs. 21.9) than that of lowest quintile.[16] In respect to regional differences, the current use of contraception in Addis Ababa is 50.1 percent while in the Somali Region it is 1.5 percent.[17] Data show high inter-Woreda inequalities in contraceptive acceptance rate across all regions with the exception of Somali, with the variations being considerably higher in the big regions of Southern Nations, Nationalities and Peoples (SNNP), Amhara and Oromia.[18] For skilled birth delivery, a gap of 50 percentage points remains between the poorest and the wealthiest. Data from the latest DHS 2016 shows that the national level of skilled birth attendance is at 27.7 percent nationwide but ranges from 16.4 in Afar to 97 percent in Addis - a difference of about 80 percentage points.

Quality of Services

27. **Data from the 2014 Service Provision Assessment Plus indicates that availability of quality basic services, including readiness of facilities to provide reproductive health services needs improvement**. Data show that there has been great progress in ensuring availability of antenatal care services with 80 percent of facilities providing this service and the overall coverage is even across the regions. However, there are challenges in the availability of a *comprehensive package* of services. According to the 2014 Service Provision Assessment only 41 percent were deemed able to provide a comprehensive package of services. For example, assessment of the availability of the eight tracer items in facilities, such as trained staff and guidelines, equipment, medicines and commodities, shows that

[16] Family Planning in Ethiopia: An Analysis of Successes, Challenges and Future Directions. World Bank (forthcoming)
[17] Mekkonen, Y; Family Planning in Ethiopia: An Analysis of Successes, Challenges and Future Direction; World Bank, Ethiopia, May 2016 (Draft)
[18] Ibid.

only 7 percent of facilities have all eight.[19] Only 23 percent of the facilities have the laboratory capacity to conduct Hemoglobin tests, a basic test during Antenatal Care visits, with significant geographical differences (2 percent in Gambela vs. 54 percent in Addis Ababa). Approximately 55 percent of all health facilities excluding health posts, provided delivery service with the services being available at over 87 percent of hospitals and 97 percent of health centers. However, the mean availability of Basic Emergency Obstetrics Neonatal Care signal functions was 46 percent- with the availability of key items such as parenteral anticonvulsants being available in less than one third of the health facilities and assisted vaginal delivery being provided in only two out of the five health facilities surveyed. The mean availability of Emergency Obstetrics Neonatal Care signal functions was 30 percent in health facilities excluding health posts.[20]

Human Resources for Health

28. **Overall shortage, uneven distribution, rapid turnover and shortage of providers with skills for priority maternal and new born care services remain major challenges**. Such shortages are more acute for physicians, midwives, nurses and specialists, especially obstetricians and anesthetists. The physicians to population ratio is 1: 58, 290 which is quite low compared to World Health Organization standard of 1: 10,000 (Health Indicators 2013/2014). The Health Extension Program and the Health Development Army have brought together groups of women to mobilize the community and promote healthy behavior, leading to significantly improved access to Primary Health Care services, particularly for the rural poor. Currently, 40, 000 Health Extension Workers provide services, mostly in rural areas, complemented by 440, 000 Health Development Army groups. Under the HSTP, the Government plans to expand the network of Health Extension Workers and the Health Development Army to reach a larger rural population, and to upgrade the skills of HEW from level 3 to 4. Emerging regions and in pastoralist and migratory population areas require a tailored approach and modality.

Low Levels of Health Financing

29. **The Government's ambitions to achieve Universal Health Coverage is hindered by low levels of health financing.** Although per capita health expenditure has increased from US$5.6 in 1999/00 to US$28.4 in 2013/14, it is below the US$32.2 target set out in the Strategy and the US$86 required to provide a basic package of health services in low-and-middle income countries.[21] Between 1999/00 and 2013/14 Government spending accounted for only 26 percent of total health expenditure on average, whereas external source and households' out-of-pocket expenditure accounted for 35 and 34 percent, respectively. Out-of-pocket payments remain higher than most countries in the region (34 percent of total health expenditure in 2013/14 and US$9.6 per capita) and are above the average for Sub-Saharan Africa, presenting a major barrier to access for the poor and millions of people are at risk of health related financial impoverishment. According to LSMS 2016, 56 percent of those that did not seek care cited cost of care as the reason for not consulting a care giver.[22] [23] The poorest households are most

[19] The SPA+ data shows only 23% of the facilities have capacity to conduct Hemoglobin test (basic test for ANC visits) - only 2% facilities in Gambela Region had this capacity while those in Addis Ababa have relatively better capacity (54%) – the highest. Only 11% and 36% of the surveyed facilities have capacity to test Dry Blood Spot (DBS) collection and TB microscopy respectively which are basic tests for TB control program, with huge disparities among regions: no facilities in Benshangul Gumuz have a capacity in testing DBS collection (0%) while approximately 15% of facilities in Oromia Region have capacity for the test. The microscopic test for TB, which is also a basic test, was being done by 60% facilities in Harar and only 8% facilities in Gambela (the lowest in comparison with other regions).

[20] Among hospitals and health facilities that provide delivery service, though on average 68 percent of the health facilities were ready to provide Basic Emergency and Essential Obstetric and Newborn Care Service, none of them had all the 25 tracer items for Basic Emergency and Essential Obstetric and Newborn Care Service.

[21] McIntyre D and Meheus F. 2014. Fiscal Space for Domestic Funding of Health and Other Social Services. Working Group on Financing Paper 5. Chatham House.

[22] Reference period is four weeks before the survey

[23] Central Statistical Agency. Living Standards Measurement Survey. 2016. LSMS Integrated Surveys if Agriculture Ethiopia Socioeconomic Survey (ESS).

affected – among those that had an illness a higher proportion of lowest quintile households (48.1 percent) compared to only 11.8 percent in the wealthiest quintile did not seek care.

30. **External funding as a share of total health expenditure has dropped significantly between 2010/11 (50 percent) and 2013/14 (34 percent).** Government funding has doubled (15.6 percent in 2010/11 to 30 percent in 2013/14), reflecting the Government's commitment to health. Health expenditure remains dependent on external sources. While progress has been made in harmonizing donor support through the SDG Performance Fund, a proportion of earmarked funds (channel two) is for specific diseases (malaria, HIV/AIDs/ Tuberculosis); and part of channel three external financing (see Table 1) remains off-budget and unpredictable.[24]

Low Government Budget Allocation

31. **Government budget allocation for health has been increasing in nominal terms, though it remains low as a share of total Government expenditure**. The allocation for health has been low, accounting for an average of 7.4 percent of regional expenditures, 0.8 percent of federal allocation, and 3.7 percent of the overall national Government expenditure. Recurrent health expenditure has almost doubled over the last four years. Whereas expenditures on capital investment have increased at a much slower rate than recurrent, it started to decline from 2013/14. This could be an indication that there is a shift from expansion of infrastructure to service provision and operation. This will require a further disaggregation and analysis to assess trends in the non-salary portion of the recurrent expenditure. In line with the decentralized service provision arrangements, a substantial portion of the health expenditure is incurred by the subnational Governments, i.e. Regions and Woreda councils. For the years 2011/12 to 2013/14, on average, 95 percent of the recurrent and 75 percent of the capital health expenditure is regional (this includes Woreda). Budget execution rate is fairly high with over 93 percent for recurrent and over 75 percent for capital budget. Execution rate at the federal level is slightly higher compared to the regional levels.

Table 1: Financing managed by FMOH (Channel 2) and Partners (Channel 3), US$ million

	2011/12			2012/13			2013/14			2014/15		
	Commit.	Expend.	%	Commit.	Expend.	%	Commit.	Expend.	%	Commit.	Expend.	%
All Channel 2	468.3	370.0	79	488.0	588.4	121	575.0	588.4	102	575.0	419.9	73
Except SDG PFs	309.6	304.4	98	252.8	456.8	181	362.2	487.8	135	458.2	210.4	46
SDG PF	158.8	65.6	41	235.2	131.5	56	212.8	100.6	47	116.7	209.5	179
Channel 3	253.2	278.3	110	220.0	289.4	132	221.1	132.1	60	111.1	371.6	334
Total Channel 2, 3	721.5	648.3	90	708.0	877.8	124	796.1	720.5	91	686.1	791.5	115

Note: Commit = Commitment, and Expend. = Expenditure

32. **External funding through channel 2 (managed by FMOH) and channel 3 (managed by other implementing partners) is a substantial part of the health financing (Table 1).** Expenditure through Channel 2 has been close to US$500 million annually since 2011/12, and of this, over US$120 million is the SDG Performance Fund, which is targeted to financing of Primary Health Care Services such as reproductive, maternal and child health programs. Expenditure through Channel 3, implemented by various implementing partners, continues to be substantial at annual average of over US$250 million.

[24] Ethiopia's Fifth National Health Accounts. 2013/2014. Forthcoming.

A Changing Health Financing Architecture

33. **The HSTP describes the country's ambitions to achieve Universal Health Coverage using a combination of health systems strengthening and financial protection measures to cover the majority of households by 2020.** The Government has developed a second health financing strategy in 2015 (awaiting approval by Cabinet of Ministers), which proposes a major shift in the health financing architecture away from out-of-pocket payments to health insurance for all Ethiopians. Two parallel approaches are proposed: Formal sector workers (public and private) will be covered through a Social Health Insurance, while Community Based Health Insurance Schemes will cover informal sector worker. The Government's Universal Health Coverage agenda aims to ensure that sector financing transitions in a responsible manner from one based on donor financing to a domestic financed and sustainable sector. This requires a shift in various aspects, including: developing a comprehensive implementation roadmap for the Health Care Financing Strategy, rolling out of Community Based Health Insurance and Social Health Insurance; building institutions and capacity in health insurance functions such as purchasing, targeting, resource mobilization, economic analysis, health care management and financing at all levels; and engaging the private sector and civil society organizations in support of the efforts of mobilizing domestic financing and improving access to quality health services. The Government is already implementing select areas of the draft Health Care Financing Strategy while refining remaining areas to be rolled out later.

Health Information System

34. **The Government continues to reform and redesign the national Health Management Information System starting in 2008.** Reforms led to standardized information system across all tiers of the health system and States. Those reforms, included efforts to promote the use of technology in the delivery of health services comprising telemedicine, tele-education, and mobile health, electronic Health Management Information System, Electronic Medical Records, Geographic Information Systems, and Human Resource Information Systems. The Health Information System is managed by different authorities: the routine Health Management Information System is managed primarily by the Government while the population based information is generated predominantly by the Central Statistical Agency, Ethiopian Public Health Institute, universities and individuals conducting research. The new Vital Events Registration Agency will also be a key source of the health information.

35. **The Government continues to prioritize improvement in quality of its health information system.** There is a strong recognition that lack of quality data is a hindrance to the generation and dissemination of data for effective decision-making and performance monitoring. The key gaps which have been identified are: i) overall implementation of the new health information system is lagging behind in generation and use of information; and, ii) absence of integrated information system within the respective agencies that engage in the collection and analysis of routine, population based and other health related data. To address these gaps, FMOH has identified two key agenda: i) An information revolution: i.e. making best use of the availability, accessibility and quality information through appropriate information technology, and ii) Enhancing the use of information evidence based decision making at all levels that will improve the quality and equity of care. Though the Technical Assessment concluded that the Government's monitoring systems are capable of monitoring the performance of the program to be supported, there is a need for comprehensive and coordinated support of the information revolution agenda.

Civil Registration and Vital Statistics System

36. **The 2005 DHS results show that only 6.6 percent of births of children under five years were registered by local or municipal authorities – but the majority of these registered children did not have birth certificates since there was no official civil registry.** The lack of a Civil Registration and Vital Statistics system is a constraint to sound maternal and child health information; hinders the registration of deaths and marriages including monitoring of underage marriages, as well as the development of a modern system of identification that provides legal identity for all (Sustainable Development Goals: sub-goal 16.9). Improvement of the CRVS system will require significant support, not only for the MOH but also for VERA, Ministry of Justice and Central Statistics Agency (CSA), as well as religious bodies that officiate marriages and burials. Ethiopia rolled out its Civil Registration system under the Federal Vital Events Registration Agency (VERA) in August 2016 to register births, deaths, marriages and divorces. This is a challenging task for any country but more so for a country with a population of about 90 million people who are mostly rural.

Financial Management

37. **The Public Expenditure and Financial Accountability (PEFA) ratings of 2014 had placed Ethiopia in the top tier of countries in the Africa Region in public financial management (PFM).** Some of the areas where further improvements were needed are in the areas of multi-year planning, tax collections, budget execution, procurement, and internal audit.

38. **The sector has seen slower progress in strengthening of financial management, procurement systems and governance systems**. The Integrated Fiduciary Systems Assessment (IFA) undertaken as part of preparation of this proposed AF found that, with identified risk mitigation, the system in place gives assurance that financing from the Bank into the Pool Fund is well managed. Partner-supported areas of financial management have adequate capacity to produce financial reports and audit reports for the system (most were submitted with acceptable quality although some delay in submission).

39. **Some system weaknesses, especially at the country's Pharmaceuticals Procurement Agency, include continued lack of qualified staff for auditing and procurement**. The rapid turnover of staff is often cited as a major factor in the weakness of the system. The lack of an automated financial management system is a major hindrance to production of timely reports. Disjointed financial management software, in places where they are being used, also adds to the weaknesses of the system and contributes to the delay in the submission of financial reports. The Integrated Fiduciary Assessment has noted that the Agency needs to work on short, medium and long term solutions to fully automate processes at its headquarters along with the branches.

Procurement

40. **The Pharmaceutical Fund and Supply Agency is one of the largest procurement agencies in the country - annually undertaking around $400 million of procurement**. Projections suggest a steady growth in the next few years – yet it faces significant challenges. Weaknesses in supply chain management, procurement and financial management remain a serious concern which has prompted a Business Reengineering Process aiming to address critical areas. Through support from various partners, the Pharmaceuticals Agency has over the years steadily aligned its procurement system with the country directive. Currently, the Government has called for increased support to the Pharmaceuticals Agency to ensure that sufficient technical support is provided in all aspects of its operations. The Bank has been one of the key partners supporting fiduciary aspects at the Agency and progress is apparent.

41. **Audit findings indicate that the share of Open Tender method has significantly increased over the past years**. The Pharmaceuticals Agency has started posting procurement information in its website thereby increasing transparency in its system as per the agreed DLI action, though challenges remain in regularly updating the website information and posting complete information. The Pharmaceuticals Agency has established Health Commodities Management Information System to track distribution and stock movement and capture Purchase Order information. Procurement oversight has improved over the past couple of years as a result of regular annual procurement audits by the Federal Public Procurement and Property Administration Agency (FPPA) and responsiveness of the Pharmaceuticals Agency to the audit observations.

42. **Continuing challenges in procurement and some systemic weaknesses in the Agency are being addressed in order to meet Program goals of equitable access to quality services**. The main challenges observed in the procurement system are: (a) The need to strengthen data management and performance monitoring; (b) Transparency of procurement information still needs improvement including the information that is publicly made available through the Pharmaceuticals Agency website; (c) The Standard Bidding Document used needs review and improvement; (d) There is no comprehensive and standard bid evaluation report template that provides all the required information consistently for all procurement; (f) Staff in the Procurement Directorate at the Pharmaceuticals Agency need to have their procurement skills upgraded - this should be fulfilled through a dedicated procurement skills-upgradation program; (g) There is a need to improve the procurement planning system; and (h) There is too much repetitive approach to the market for similar products thereby reducing efficiency and increasing the transaction load on the procurement unit.

Fraud and Corruption

43. **Ethiopia has a robust legal framework to address Fraud and Corruption risks**. The principal institutions for the fight against corruption are the Federal Ethics and Anti-Corruption Commission (FEACC) established in 2001 and the Federal Attorney General formed in 2016.[25] FEACC including Regional Ethics and Anti-Corruption Commissions and the Federal Attorney General have adopted both preventive and curative approaches in combating corruption in the country. FEACC is responsible for coordinating efforts of anti-corruption across regions, sectors and preparing a country report. Since 2007, all the nine Regional Governments have established their own Regional Ethics and Anti-Corruption Commissions as per the regional laws. Federal and Regional Governments have a well-defined complaint handling mechanism as well as multiple channels of checks and balances for controlling Fraud and Corruption and maladministration.[26]

44. **There are challenges related to structures as well as capacity for effective complaint handling within the sector:** (a) There is a need to strengthen the Government's structure which monitors and combats fraud and corruption at the Pharmaceuticals Agency Regional Hubs by assigning ethics and anticorruption officers and building their capacities; (b) Providing more ethics and anticorruption officers in the Regional Health Bureau in order to strengthen the structure which monitors and combats fraud and corruption at regional level; (c) Limited capacity in systematic tracking, recording and reporting of fraud and corruption at federal, regional and Woreda levels; (d) Weak capacity of complaint-handling staff; (e) Limited practice of oversight/management of Fraud and Corruption risk, incidents, priorities, complaint responses in joint discussion fora among FMOH and Regional Health Bureaus and decentralized health institutions; (f) the capacity in tracking information and reporting of fraud and corruption actions in procurement, distribution/dispensing of pharmaceuticals

[25] Federal Attorney General Establishment Proclamation No.943/2016, Federal Ethics and Anti-Corruption Commission Proclamation No. 880/2015

[26] Procurement and Property Disposal and Complaint Handling Department, FPPA. 2016.

needs further strengthening. The Business Reengineering Process at the Procurement Agency offers entry points for addressing these key areas.

Community Engagement and Participation

45. **The health sector has put in place systems that cover both upstream (policy level) and downstream (service delivery level) engagement; and patients, communities, providers and health authorities engage on a continuous basis**. There are however weaknesses, and a need to improve various areas as identified during the program's January 2016 Mid Term Review as well as through the implementation support work of other Citizen's Engagement and Social Accountability programs supported by the Bank such as ESAP2 and ESPES that support the Government's efforts at Regional, Woreda and Kebele levels. For example, beneficiary feedback flows between the different stakeholders do exist, however, given the oral nature of these engagements, it is impossible to assess the strength of the feedback flows and extent to which grievances are handled in some regions with pastoralists' populations that were the focus of the original program (Gambella, Somali, Afar, and Benishangul-Gumuz), and systematic engagement with the communities remains very limited and might require support. The HSTP recognizes citizen's engagement and social accountability tools as a foundation of service delivery as it gives citizen's voice in how services are delivered

46. **Under the proposed AF, stronger ties to Bank supported social accountability tools (FTA, ESAP, PBS and ESPES) will be built.**[27] The approaches under the different tools address both the supply and demand side of citizen engagement. On the supply side, the Government has pushed for greater budget transparency, in particular through FTA which has enabled citizens to access budget and expenditure information at the woreda and kebele level. On the demand side, with support from CSOs vetted by MOFEC, ESAP and ESPES have aimed to strengthen the capacity of citizens – and more generally communities- to use this information in order to engage the authorities in budget discussion (pre- and post- budget allocations) and develop, finance and monitor the implementation of 'joint action plans' to resolve potential service delivery issues at the woreda and kebele levels. ESAP and ESPES aim to target 300 woredas, with limited coverage in pastoralists regions. Therefore, the Government will use the AF and other Bank supported programs to improve health service delivery by:

a. *Establishing bridges and synergies with FTA, ESAP, PBS and ESPES, to strengthen social accountability mechanisms at the woreda and kebele levels*. In particular, in coordination with MOFEC, the program should aim to scale-up the -already existing- transparency and social accountability mechanisms, and systematically implement them in the health sector, including in the emerging regions.
b. *Strengthening and building upon existing engagement mechanisms in the health sector*: In particular, ensure that the Grievance Redress Mechanism and community consultations are documented (refer to the governance section and the Social assessment for specific interventions).
c. *Supporting the Government in designing and implementing Community Scorecards (in development since the beginning of FY2016*): In addition, link the CSC to existing accountability tools under the SDG PforR; FTA, ESAP, PBS and ESPES, especially to feed the development of joint action plans.

Environmental and Social Safeguards

47. **Environmental and Social System Assessment (ESSA) that was conducted for the original Health MDG PforR in 2012 identified a number of areas for institutionalizing and strengthening issues around environmental and social safeguards**. An update to the ESSA conducted in order to inform the proposed AF found that, overall, the MOH has made progress on some of the actions agreed

[27] FTA, ESAP, PBS and ESPES

upon, including establishing and operating infection prevention and patient services committees at health facilities and availing appropriate temporary storage facilities for hazardous waste until final disposal is completed. Progress has been slower in documentation of land acquisition for health facilities construction, and outreach and specific actions focused on providing services to vulnerable persons. The most critical is the lack of an effective institutional mechanism for coordination and reporting on environmental and social safeguards. Therefore, ensuring clarity on the institutional arrangements for implementation and monitoring of environmental and social safeguard commitments is critical. The update of the original ESSA, shows that there is an urgent need to strengthen the capacity in updating relevant documents to incorporate environmental impact and risk criteria in site selection screening for all health facilities; build the capacity of staff of the regulatory body on areas of health care facilities regulation and inspection work; and enforce compliance with the Medicines Waste Management and Disposal Directive on health facilities constructed before the issuance of the directive.

Gender aspects that affect women's health

48. **Ethiopia has some of the lowest gender equality performance indicators in Sub-Saharan Africa.** The Global Gender Gap report 2016 ranks Ethiopia at 109 out of 144 countries in terms of the magnitude and scope of gender disparities.[28] Ethiopian women still face cultural practices and behaviors that are harmful to their health and that of their children. For example, Female Genital Mutilation is widely practiced throughout the country, and persists across socio-economic groups. An estimated 23.8 million Ethiopian girls and women are subjected to the practice. Obstetric Fistula, another common condition is a result of prolonged and/or obstructed labor, early marriage, teenage pregnancy, and low socio-economic status, scarcity of healthcare units in rural areas and a low rate of skilled care during pregnancy and delivery. The WHO estimates that at least 8,000 Ethiopian women develop new fistulas every year. Early marriage and child bearing, limited use of contraceptives, and limited access to reproductive health information and education contribute to the high rate of unwanted adolescent pregnancies, one of the major reproductive health challenges faced by adolescents in Ethiopia.[29] Summary findings of DHS 2016 show that more than 35 percent of ever married women have experienced physical, emotional or sexual violence from their husband or partners. This is higher among older women; formerly married women; those living in rural areas and higher in Oromia, Amhara and Harari regions.[30]

49. **The Government of Ethiopia is explicitly committed to the achievement of gender equality.** Its Constitution clearly stipulates the rights of women and the Women's Policy of Ethiopia reiterates the Government's commitment to gender equality. Ethiopia is a signatory of key international instruments on gender issues including the Convention on the Elimination of All Forms of Discrimination against Women, the Beijing Platform and African Charter on Human and People's rights. The revised Federal Criminal Code and Regional Family Law support measures against different forms of gender-based violence, including child marriage and female genital mutilation. Both GTP I and II articulate well the gender gaps in education, health, employment, etc. and have put in place plans to address the challenges, many of which have deep cultural roots. In response to these challenges, Ethiopia has had great success in mobilizing women as catalyst for change – examples are found in the all-woman Development Army that works across sector issues to ensure health, education, water and sanitation are core issues within the households. The Health Extension Workers Program is another example that has led to improved access to basic services for rural women.

[28] Analytical summary - Gender and Women's Health: WHO/AHO: AFRO.

[29] Ethiopia DHS. 2016. Indicates that 30 percent of women aged 25-49 were married by age 15, which usually translates into early childbearing and adverse health consequences for both the mother and her newborn. Ethiopia DHS 2016. Key Indicators Report.

[30] Ethiopia DHS 2016. Key Indicators Report.

50. **Continued challenges require changing attitudes and practices that affect women's health**. This is a responsibility of multiple stakeholders- but the health sector has a unique role to play as many of the negative practices have lasting and negative health outcomes for women and the health sector has a unique role to play in addressing the multifaceted challenges. While there is political will and commitment to address gender inequality, there is limited capacity to finance and implement community-based interventions targeting actions to address these differences. Tracking disaggregated data by gender is a critical step to understating the challenges. Developing a road map on how to address the Gender Based Violence on health sector is crucial to inform the policy makers as well as implementers at all level.

III. The Rationale for Proposed Additional Financing and Restructuring

51. This section presents the rationale for the proposed restructuring and AF to the PforR. The rationale for adding an IPF component is discussed in Annex I (Description and Appraisal Summary for IPF Component). The restructuring and AF to the PforR was deemed more appropriate than a new operation for the following reasons:

Responding to Government Request

52. **The proposed AF responds to the Government's request to continue support of the Sustainable Development Goals Performance Fund (SDG PF).** This is a non-earmarked and harmonized fund that prioritizes achievement of better maternal and child health outcomes. The proposed AF will ensure the Government is able to meet its commitment to reduce preventable maternal and child deaths by building on the progress made. It will also enable the Government to comprehensively address reproductive health issues with a focus on adolescents, quality of health services and other areas of the health system. The proposed AF will: (i) allow current priority areas in Reproductive, Maternal, Child, Youth health to continue receiving support (e.g. increasing access to safe family planning methods and immunization); (ii) scale up activities that have proven to be effective (e.g. expansion of access to skilled birth attendance) and Antenatal Care; iii) focus on areas that have been identified as requiring focus in the HSTP (e.g. post-partum care and adolescent reproductive health); and iv) Support the building of Ethiopia's CRVS system as a way of strengthening availability of key statistics as well as address other needs for registered vital events.

Continued Relevance of Government's Program

53. **The program identified under the original operation remains highly relevant and the PforR instrument has been effective in meeting program goals**. The continued relevance of the program made the proposed AF more appropriate compared to a new operation. The AF will continue to channel resources the SDG PF that has been effective in building partnership around a common agenda in support of the Government's identified priority areas, and continued focus on priorities for economic development and poverty reduction. The proposed AF is an effective and efficient way to provide continued and scaled up support to the program, building on well-performing implementation arrangements. The proposed AF will help to reduce the financing gap identified as part of the Government's strategy and it will use existing implementation and institutional arrangements to maximize outcomes, while at the same time bringing additional resources and build stronger partnerships.

Addressing a Financing Gap

54. **The proposed AF will support the Government's efforts to expand options for financing its development efforts.** It will allow the Government to strategically combine and leverage sources of financing including domestic, private, and international resources in line with the agreements/ conclusions of the Financing for Development Conference held in Addis Ababa in 2015. The proposed AF will support the roll out of Community Based Health Insurance which is an important part of the Health Care Financing strategy that aims to address the large gaps in domestic health financing resources.[31] Partnerships under the GFF will also enable the Bank (through Bank Executed Trust Funds) to support the client in building capacity in health care financing and involvement of the private sector in health.

Strengthening Partnerships

55. **The GFF and Power of Nutrition partnerships contribute to an existing harmonized approach towards addressing maternal and child health financing needs.** They will also contribute to coordinated support for health care financing and CRVS agenda. So in addition to the financing provided through these partnerships, they also assist the Government in building capacity in several key areas that are a priority in the HSTP. Some of the capacity building efforts are channeled through partners as well as through Bank executed activities that aim to build capacity in areas where the Bank has comparative advantage - such as Health Care Financing.

Government Commitment

56. **The Government has shown continued commitment to improve the health of its population as a core pillar of the overall country development process**. In line with GTP II, the HSTP identifies key challenges facing the sector and crafted strategies to address systemic bottlenecks and sets out ambitious targets on key health outcomes. The HSTP has a well-defined results chain linking the inputs to the outcomes envisaged and how these outcomes contribute to the SDGs and GTP II results.

A Description of the Government's Program to be supported by the proposed AF

57. **The Government's Program is defined by the Health Sector Transformation Plan (2015-2020).** The HSTP aims to address a broad range of challenges in the sector, including: i) Quality of Care; ii) Equitable Access to Health Care Services; iii) Non Communicable Diseases; iv) Health Management Information System; etc. The HSTP defines a set of ambitious targets on key health outcomes as well as directions on how to attain health goals under the GTPII. This has been done through a well-defined results chain linking inputs to outcomes envisaged and how these outcomes contribute to the Sustainable Development Goals and GTP II results.

58. **A cornerstone of the HSTP is the focus on quality and equity, planned as an iterative process requiring careful supportive supervision and tracking of performance.** It establishes goals in terms of improving equity, coverage and utilization of essential health services, quality of health care, and enhancing implementation capacity of the health sector at all levels of the system. The HSTP renews the strong priority given to Reproductive, Maternal, and Child Health and Nutrition. It sets ambitious targets for nutrition, maternal and child health outcomes to be achieved by 2020, which would ensure it is on track to achieve its commitments under the SDG agenda. Strategic initiatives have been identified to help achieve outcomes through high impact interventions of in Reproductive Maternal and Child Health, nutrition, prevention as well as control of communicable and non-communicable diseases.

[31] A strategy nested within the HSTP, elaborating details of how the Government will address financing of the sector

59. **The HSTP aims to achieve Universal Health Coverage through health systems strengthening and financial protection measures to cover the majority of households by 2020**. The Government's Universal Health Coverage agenda aims to ensure that sector financing transitions in a responsible manner from donor financing to a sustainably financed domestic system. The Government has recently developed a second Health Financing Strategy to guide the country's progress towards Universal Health Coverage. The draft Health Financing Strategy proposes Social Health Insurance for the formal sector and Community Based Health Insurance for the informal sector. These are among the main mechanisms to increase financial risk protection and contribute towards increasing domestic resources for health. The Government plans to launch the Social Health Insurance implementation among the formal sector in the near term and has developed a strategy to scale up Community Based Health Insurance for rural residents. Community Based Health Insurance schemes were first piloted in 13 woredas and based on the experience and lessons the Government aims to scale up coverage to 80 percent of the woredas by 2020.

60. **The HSTP is the Government's costed program with well-defined set targets to be achieved between 2015-2020.** The financing needed to reach targets was calculated under two scenarios: i) The base case scenario costing assumes achievement of comparatively more modest but realistic targets set in Government Program for the coming five years; and ii) The best-case scenario which has more ambitious targets and requires much higher human resources capacity and infrastructure requiring higher investment.[32] Under the base case scenario, the total cost of implementing the Government Program between 2015 and 2020 is an estimated US$15.6 billion; while under the high case scenario the cost is US$22 billion**.** The difference between the two estimates is due to the higher costs of infrastructure; human resources and medicines supply under the high case scenario. Projected Government allocation to its program is US$6.3-8 billion and Development Assistance is US$4.3 billion, there is an estimated gap of US$3.3 billion under the base cost scenario. The funding gap on Reproductive Health (2016-2020) requires US$2.35 billion, this shows the need for intensified efforts to mobilize resources for Reproductive Maternal and Child Health to address preventable maternal and child deaths and reduce inequalities.

61. **The Government has identified various channels to address the financing gap under its Program.** This includes the roll out of health insurance schemes that could raise a total of US$409 million through Social Health Insurance. In addition, Community Based Health Insurance could generate US$376 million. Other channels that could be used to address the financing gap are listed in Table 1 and include resources flowing through channel 3 that are managed through implementing partners. Channel 3 resources remain a substantial part of health financing. As part of its Health Financing Strategy, the Government is also exploring innovating financing mechanisms; enhancing efficiency especially on procurement, supply management and human resources productivity and evidence based planning.

62. **Appraisal of the Program found that the HSTP is technically sound.** Some key aspects of the preparation of the HSTP include: i) The *costed strategic plan is well aligned with Ethiopia's Growth and Transformation Plan II and Sustainable Development Goals*; and validated by Joint Assessment of National Strategy tool that was developed by International Health Partnership Plus-WHO; well established processes and tools for evidence-based planning and efficient use of resources on a sustained basis; ii) *Clearly defined and costed set of evidence-based interventions supported by a results framework with multi-year financing plan*; the One Health budgeting tool was employed to come up

[32] Base Case scenario assumes a target MMR=199/100,000 by 2020 compared to 177/100, 000 by 2020 in the High Case scenario. CPR targets under Base Case scenario is 55% by 2020 compared to 65% under HC scenario. Reduce IMR from 46.4/ 100, 000 to 19.33/100, 000 for BC compared to reduction to 16.7/ 100, 000 live births by 2020 under HC scenario.

with two scenario resource requirements for implementation of the HSTP; and iii) *Highest level political commitment to achieve health Sustainable Development Goals*; Clearly defined governance structures involving key stakeholders; and Strong donor coordination and aid harmonization governed by the International Health Partnership Plus compact, previous Sector Strategies harmonization manual, and Joint Financing Arrangement.

63. **The proposed AF to the PforR operation will contribute to better health outcomes for women and children together with other key partners supporting the SDG PF.** The fund addresses specific gaps in priority program areas (mostly maternal and child health) and health systems. The PforR uses targets for disbursement based on the past trends observed within the country and other developing countries and focuses on indicators that are under the direct control of the Government following the PforR principles.

The Program Boundary - Sustainable Development Goals Performance Fund

64. **The program boundary under the original program will continue to be the SDG PF which has a strong focus on reproductive, maternal and child health interventions through strengthening of primary health care services**. There are no proposed changes to the program boundary under the proposed AF, though program expenditure has been increased due to the longer time period for implementation, the inclusion of new DLIs and results areas such as nutrition and health care financing, as well as the dropping of DLI on the Balanced Score Card.

65. **The PforR will continue to support SDG PF which addresses a subsection of priorities under the Government program**. The select areas are key to the achievement of Sustainable Development Goals related to women and children's health. The SDG Performance Fund has the following main objectives: i) Supporting HSTP priorities in Maternal and Child Health services; ii) Improving the Primary Health Care units; and iii) Strengthening sector capacity, including human resources, financial management and supply chain management, health management information systems and health technologies. Therefore, the SDG Performance Fund supports a subset of the overall Government Program, with a focus on Maternal and Child Health- an area where key indicators are lagging. Limiting the focus of the SDG Performance Fund ensures that the most critical interventions which are linked to the achievement of the PDO will receive support. In addition, it also limits the program to a reasonable scope within the larger HSTP.

66. **The SDG PF is still supported by 11 development partners under the management of the Federal Ministry of Health**.[33] The total expenditure of the SDG PF is approximately US$739 million over the 2015-2020 period. The SDG PF uses country systems for procurement and financial management, both of which have been successfully managed. SDG PF partners have a contributors' dialogue platform, not only on the management of the pooled resources but also on health sector issues more broadly.

67. **The SDG Performance Fund provides complementary resources, consistent with the one plan and one budget concept, to under-funded areas needed to meet HSTP goals.** SDG PF is part of the strong donor coordination and aid harmonization governance structures defined under the International Health Partnership Plus compact and previous Sector Strategies harmonization manual.[34]

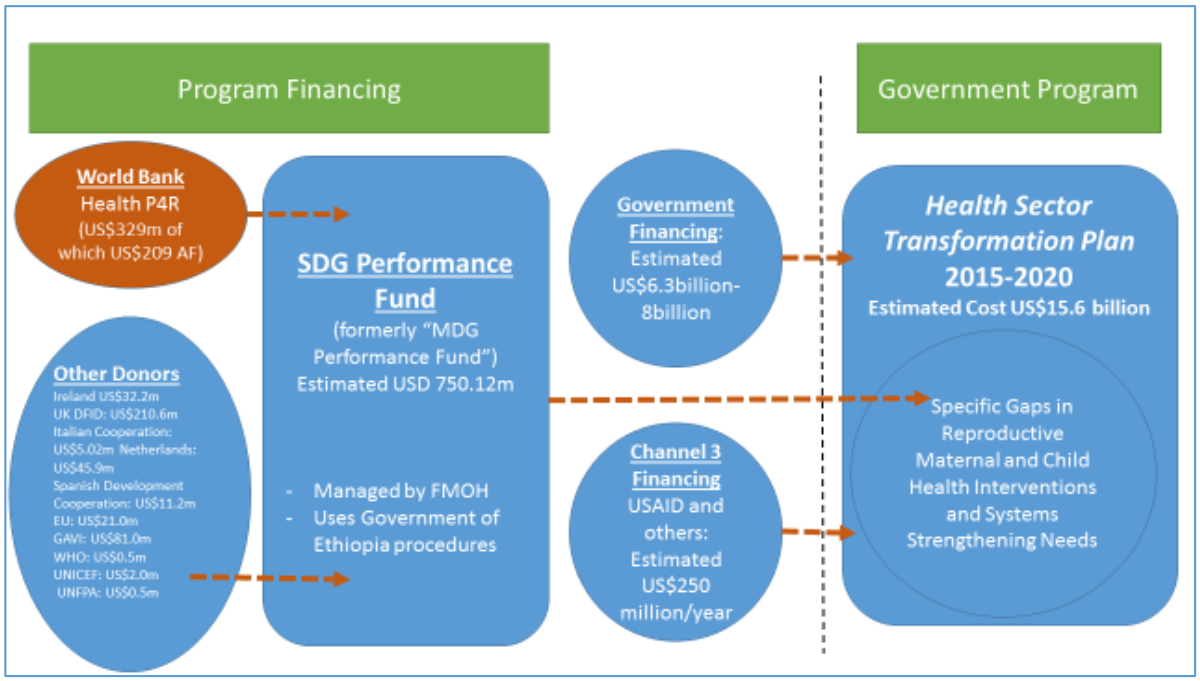
[33] UK DFID, UNICEF, EU, GAVI, Netherlands Government, Spanish Development Cooperation, UNFPA, Irish Aid, WHO, Italian Cooperation and the World Bank. Millennium Development Goals Pool Fund was renamed Sustainable Development Goals Pool Fund.

[34] IHP+ refers to refers to the global compact signed in London on 5th September 2007 as the international commitment toward improved aid effectiveness in the health sector. For ET, it refers specifically, to the Ethiopia country compact signed in Addis Ababa on 26th August 2008, setting out the framework for increased and more effective aid, and accelerated actions toward the achievement of the health sector development

Joint Financing Arrangement signed between the Government and SDG PF contributors sets out jointly agreed terms and procedures for SDG Performance Fund management.[35] This includes planning, financial management, governance framework and decision-making, reporting, review and evaluation, audit and supply chain management. It also sets out the principle of aligning with the "one *plan, one budget, one report"* framework by using collectively agreed country-led arrangements for planning, execution and reporting. Signatories also use a common mechanism for any annual process of validation of the sector plan.

68. **Ethiopia's SDG PF partners have committed to using the existing donor harmonization system and structures.** There are no additional donor-specific requirements other than the Bank's in terms of verification, the results framework and audit reports. SDG PF contributors supporting the fund through the result based financing mechanism align their support to the best level in the selection of disbursement triggers and validation process. The SDG PF uses country systems for procurement and financial management. Implementation experience under the original operation has shown that the management structures in place are capable of managing both successfully.

Figure 1: SDG Program Boundary and Financing (US$ Million)



Note: Program financing for the period 2015-2020. Government Financing of its HSTP Program is estimated at US$6.3billion- US$8billion. The figure only shows SDG partners contributions and does not include those who contribute to Government Program through other channels. The figure does not show the $21 million IPF component in support of CRVS; Nutrition and Capacity Building and Technical Assistant.

69. **As stated in the country IHP+ Compact, the SDG PF is one of the Government's preferred modalities for providing support to the sector, the others being sector budget support and the block grant system.** SDG PF contributors commit resources on a three-year time-frame and support Maternal and Child Health priority gaps under the HSTP framework, upholding the principles of equity and quality. The Joint Consultative Forum (JCF) agrees on key priorities within wider sector planning discussions between FMOH and partners. This multi-stakeholder platform also allows key stakeholders

goals. The Sector Harmonization Manual which sets out a basic set of planning and implementation procedures, activities and governing bodies, to guide behavior of all Development Partners in the health sector. It defines the concept of „one plan, one budget and one report.

[35] The signatories are Ministry of Health; Ministry of Finance and the 11 development partners.

(Government, bilateral and multi-lateral financial agencies, foundations, civil society, private sector, etc.) to be involved in the discussions. The JCF is the highest governing body and serves as a joint forum for dialogue on sector policy and reform issues between the Government and key stakeholders and to oversee the implementation of the SDG PF, and other donor-supported projects. The Forum is chaired by the Minister of Health and co-chaired by the Chair of Health Nutrition and Population (HNP) Partners.

IV. The Original Program and Progress to date

70. **The Health MDGs PforR was the first Bank operation using the PforR instrument in the Health, Nutrition and Population Global Practice**. It was also the first program using the PforR instrument in Ethiopia's country program. The Program is financed through an IDA Credit (Cr. #5209) in the amount of SDR65.1 million (US$100 million equivalent) and Grant (TF#14107) in the amount of US$20 million from the Health Results Innovation Trust Fund. The Program was approved on February 28, 2013 and became effective on June 17, 2013 with an original closing date of June 30, 2018. Technical Assistance support is provided through an additional Grant from the Health Results Innovation Trust Fund (TF#14815) in the amount of US$400, 000 that was approved and became effective on December 23, 2013, with an original closing date of June 30, 2015 which was extended to February 28, 2018. To date, US$75m (US$61.5 million IDA; US$13.8 million Health Results Innovation Trust Fund; and US$200, 000 from the Health Results Innovation Trust Fund) has been disbursed.

71. **The PDO is to improve the delivery and use of a comprehensive package of maternal and child health services.** The PDO is aligned with sector priorities – it is a subset of the strategic objectives of the Government's Health HSTP. The PforR focuses on results from Maternal and Child Health services and strengthening select areas of the health system, including procurement, financial management, safeguards, monitoring and evaluation. Upon attainment of results, funds flow into the Pool Fund which has a focus on maternal and child health.

72. **The PforR and the proposed AF are well aligned with other Bank support to the** HSTP **goals.** Those programs target health service delivery at sub-regional levels and support cross-cutting areas key to strong service delivery including fiduciary management, information systems, safeguards and citizens' engagement. The Enhancing Shared Prosperity through Equitable Services (ESPES) PforR provides for salaries of health extension workers through block grants that flow through the Ministry of Finance and Economic Cooperation. The multisectoral ESPES tracks health results in key areas including coverage of pentavalent 3 and training of health extension workers. The program also supports Citizen's engagement and Social Accountability systems, strengthening capacities at regional and Woreda levels. In addition, ESAP II project builds social accountability systems through direct support through Civil Service Organizations, of which a number are in the health sector. The ESPES program also support the capacity building for environmental and social safeguards at regional and Woreda levels, benefitting health sector staff at lower levels. The proposed AF will strengthen established linkages with ESPES and ESAP for support at local level, and will look into additional needs within the health sector for strengthening environmental and social safeguards through ESPES.

Progress under the Ongoing Program

73. **Ethiopia has made important steps in reducing the burden of maternal and child ill health and is one of a few countries that successfully met its childhood mortality reduction targets ahead of the 2015 MDGs targets.** Analysis shows that the poor have directly benefitted from the progress experienced across the health sector in improved outcomes and strengthened delivery systems. A clear and sustained vision for strengthening the health sector through successive planning has underpinned

Ethiopia's progress in health outcomes. By making full use of the decentralized governance structure, the health sector has strengthened the delivery of key health services from the national to the community level. The devolved federal structure of governance provides for shared responsibility for health policy, regulation, and service delivery between the FMOH, Regional Health Bureaus, and Woreda Health Offices. Ethiopia's health financing system is characterized by strong donor harmonization, a focus on cost-effective interventions, and a commitment to ensuring financial protection for the poor.

74. **Progress towards achievement of the Program Development Objective is Satisfactory.** Implementation Progress was rated Moderately Satisfactory in last ISR, mostly reflecting slow progress in meeting the Dated Covenant on clearance of the EFYs 2001-2004 backlog of Pharmaceuticals Fund and Supply Agency audits, which has now been met. Overall, there is steady progress being made in reaching the PDOs - all eight DLIs have recorded progress; and for seven of the eight DLIs progress has been consistent, apart from DLI#6 on the Balanced Score Card where further progress is stalled. There has been consistent and verified progress on all DLIs (summarized in Annex III). For example: Deliveries attended by a skilled birth provider (DLI#1) has seen consistent progress from a baseline of 10 percent in 2011 to 16 percent in 2014 mini DHS and currently at 28 percent in the 2016 DHS. Results for the proportion of pregnant women receiving at least one antenatal care visit has also seen consistent improvement, increasing from 43 percent in 2011 to 58.5 percent in 2014 and 62 percent in 2016 DHS. Contraceptive Prevalence has also consistently increased from 27 percent in 2011 to 35 in 2016 DHS.

75. ***Financial Management:*** **The financial management system of the program provides reasonable assurance that Bank loan proceeds are being used for the intended purpose**. However, some of the financial management system areas have been of concern: (i) the backlog of Pharmaceuticals Agency audits for the EFYs 2001-2004 was only cleared after various extensions of due dates. The new IFA (summarized in Annex VI) has identified aspects of the system in need of support: (i) Improved transparency of the Agency's monitoring system for dissemination of pharmaceuticals and medical supplies as recommended by the Office of the Federal Auditor General's (OFAG) performance audit; (ii) Performance Fund financial management concerns, including delayed reports; large undisbursed balances, require additional support to resolve; (iii) The automation of the Agency's accounts also requires support.

76. ***Procurement:*** **The original program identified various program action points and DLI #8 on Improved Transparency of the Pharmaceuticals Fund and Supply Agency to address weaknesses in the main public procurement agency.** There is noted progress under DLI#8 though there is still slow progress in continuous disclosure of agreed procurement information and issuance of calls for prequalification of bidders. Given the increasing demand for pharmaceuticals and medical equipment, the Pharmaceuticals Agency needs to improve its system and be in a position to efficiently fulfil growing demand. Among these: (i) There is a need to improve the procurement planning system; (ii) The Pharmaceuticals Agency needs to introduce procurement performance measurement and monitoring system; (iii) Packaging items based on product category for efficient procurement processing and for better competition is a challenge; (iv) There is too much repetitive approach to the market for similar products thereby reducing efficiency and increasing the transaction load on the Pharmaceuticals Agency procurement unit which can be improved through introduction of framework contracting. Progress under various procurement improvement actions in the Program Action Plan is still required.

77. ***Governance*****: The original program identified Program Action 13 (*Federal Ethics and Anti-Corruption Commission (FEACC) sharing allegations of fraud and corruption and actions being taken with the Bank)* as one of the main areas to track progress in governance**. To date, the Bank is not aware of allegations of corruption that have been raised in relation to the Sustainable Development Goals Performance Fund. As per the program agreement and the Memorandum of Understanding (MOU) between FEACC and the Bank, FEACC has submitted a letter to the Bank confirming that there

has not been fraud and corrupt practice reported in implementing the Health SDGs PforR. The letter also indicates that FEACC's inspection team made an assessment of the procurement system of Pharmaceuticals Fund and Supply Agency and concluded that there is no visible evidence that indicated fraud or corrupt practices. The website developed by the Agency captures debarred suppliers with links to Federal Public Procurement Agency (FPPA) site and World Bank list of debarred suppliers.

78. ***Environmental and Social Safeguards*: The program has seen mixed progress on the four Program Actions on Environmental and Social Safeguards in support of program implementation**. There is relatively good progress in the following agreed actions: (i) All health facilities establishing and operating infection prevention and patient services committees, and (ii) Availing appropriate temporary storage facilities for collection of hazardous wastes until final disposal is completed. Bank implementation support noted that implementation of the actions is not consistent across all health facilities, and achievements vary across regions. Some of these delays stem from MOH restructuring of the Directorate for Pastoral Health Promotion and Disease Control that was responsible for coordinating health initiatives in the four emerging regions (Afar, Benishangul-Gumuz, Gambella, and Somali), as well as specific teams focusing on environmental health, hygiene and sanitation activities at the national level (including joint initiatives with the Ministry of Environment, Forest and Climate Change). The functions of this Directorate have now been distributed across various units including Health System Strengthening, Water, Sanitation and Hygiene (WASH) and Clean and Safe Health Facility Initiatives teams under Health System Strengthening Directorate, Medical Service Directorate and other Directorates. The lack of an effective institutional mechanism for coordination and reporting on environmental and social safeguards across different directorates presents a challenge that will be supported through the AF.

Progress in HRITF Capacity Building and Technical Assistance (TF014815) (US$400, 000)

79. **The objective of the Health Results Innovation Trust Fund is to facilitate the implementation of the Ethiopia Health SDGs PforR, including the procurement of consultants who provide the technical assistance to the FMOH responding in a timely manner to specific needs of the Ministry of Health**. Some of the Techical Assistance provided included: (i) technical support to Ethiopia Public Health Institute for the facility survey; (ii) management support to the grant management unit in the MOH; (iii) technical support to the Government for the development of the Balanced Score Card Approach approach; and (iv) independent verfication of agreed information on website and updates of the Pharmaceuticals Agency. The following activities have been supported: Ethiopia Service Provision Assessment Plus; Grant and Finance Management Technical Assistance; Procurement Information Verification for the DLI on Pharmaceuticals Agency transparency. The total disbursed amount is US$208, 205 (52.1 percent).

Lessons from the Original Program

80. The Ethiopia Health SDGs operation has been active for about 3.5 years now, and during that period both the Bank and the Government have learnt key lessons from experiences in implementation and supervision. Some of these lessons learnt during program implementation have been taken on board in the restructuring and design of the Additional Financing. The following are some of the key lessons*:*

81. ***Instrument fit for Country Context:*** Implementation experience has shown that the stated expectations for the PforR instrument, including increased focus on results, institutional capacity strengthening, and fiduciary management of the SDG Performance Fund and of the system has been successfully met. The instrument met the country's demand for financing and expertise to improve the performance and effectiveness of their development programs. The instrument was a good fit given the country's tradition of articulating clear goals and targets and plans as seen through GTP I and under

GTP II, as well as other sector strategic documents. In the Health sector that tradition has been translated through HSDPs I-IV and under the ongoing HSTP. As a country that prides itself as a member of International Health Partnership, harmonized donor relations and the strong stewardship function within the MOH, the PforR has proven to be well suited to the country context. It has also enhanced partnerships through dialogue, support for one strategy and reduced duplication of development effort through the one budget, one tool, and one report system.

82. ***Country Systems have shown increasing capabilities:*** The use of the Government's own systems for procurement and financial management have provided assurance that Bank financing is used appropriately, and ensures that the environmental and social impacts of the programs are progressively being addressed. While the system still has recognizable weaknesses in these areas, the PforR instrument has allowed for gradual progress in some aspects of the system and provided an avenue for dialogue on improvement on identified areas. Improvement in transparency of procurement information is a notable example of how the system is gradually improving.

83. ***Increased focus on results has improved availability of data on service delivery:*** The PforR has been an effective instrument in increasing the emphasis on results and institutional capacity building for survey design, data collection and analysis. This has been achieved through the various DHS, facility surveys and Data Quality Assurance surveys that have been undertaken either as part of verification protocols or as input to evaluations and design of strategies.

84. ***Disbursement Linked Indicators as triggers for disbursements:*** Implementation experience shows that health targets were realistic though system strengthening targets have been a stretch, e.g. DLIs on procurement transparency. The process of linking DLIs to disbursement resulted in a strong commitment from the Government and secured attention of partners, more so than did the dated covenant. Risk of not meeting the targets and hence the possibility of losing funds was part of the driving force.

85. ***Use of the Program Action Plan for Dialogue*:** Implementation experience and implementation support shows that following up on individual items under the Program Action Plan generated substantive dialogue on bottlenecks, capacity needs and institutional design challenges. Though central to achievement of some DLIs, they did not receive as much attention and focus as did DLIs. The turnover of staff meant that there was a gap in knowledge of the instrument and the weight that Program Action Plan items carried.

V. Proposed Restructuring and Additional Financing to the Program

86. **Restructuring of the original PforR and design for the proposed AF is informed by new and incremental assessments.** The Technical Assessment as well as the ESSA Updates prepared for the original program in 2012 were updated by synthesizing latest released data, new information and knowledge produced since then. A new Integrated Fiduciary Assessments was prepared in order to understand recent changes and challenges in fiduciary management. Areas not covered in the original assessment that were addressed in the update to the Technical Assessments include citizen's engagement and social accountability, nutrition and gender.

87. **Assessments, together with partner consultations were used to inform the proposed changes to the original program**. The preparation of the proposed AF was led by the FMOH, and included the guidance of a Technical Working Group constituted by the FMOH with participation of technical teams from FMOH and MOFEC. The consultative process included the Joint Consultative Forum (JCF) and Joint Core Coordinating Committee (JCCC) which are the established platforms for

dialogue between the Government and partners. Consultations also involved the H6 partners[36]; Health Population and Nutrition Partners group and the SDG PF contributors. The preparation process met the GFF's requirement of having a multi-stakeholder platform that includes key stakeholders (Government, bilateral and multi-lateral financial agencies, foundations, civil society, etc.) that already exists in Ethiopia's current governance.

88. **The Technical Assessment confirmed that the PDO remains relevant.** In order to enhance development impact, the proposed Additional Financing will continue using DLIs to reflect the Government's focus on quality, equity, information revolution, and Woreda transformation. The closing date is proposed to be extended until June 30, 2021. Implementation arrangements will change to reflect the addition of an IPF component (Annex I).

Changes to Program Financing

89. Table 2 below shows the proposed changes to the Program. Approximately 9 percent (US$21 million) of the proposed AF of $230 million will be allocated to the IPF Component, and the remainder US$209 million will be in support of the Sustainable Development Goals Performance Fund. The Global Financing Facility Trust Fund will be provided through lagged financing – the first $20 million will be available upon effectiveness of the grant agreement while the remaining US$40 million will be available on August 15, 2018 through an amendment of the grant agreement.

Table 2: Proposed Changes to Program Financing

	Original US$ m		**Undisbursed original PforR US$ m**		**Proposed AF US$ m**				**Program with Additional Financing US $ m**			
	IDA	**HRITF**	**IDA**	**HRITF**	**IDA**	**GFF**	**PN**		**IDA**	**HRITF**	**GFF**	**PN**
PforR	100.00	20.00	39.00	7.20	140.00	51.50	17.50		240.00	20.00	51.50	17.50
IPF:												
1: CRVS					10.00	5.00	0.00		10.00	0.00	5.00	0.00
2: Nutrition					0.00	2.50	2.50		0.00	0.00	2.50	2.50
3: Unallocated					0.00	1.00	0.00		0.00	0.00	1.00	0.00
IPF subtotal					10.00	8.50	2.50		10.00	0.00	8.50	2.50
Sub-total	**100.00**	**20.00**	**39.00**	**7.20**	**150.00**	**60.00**	**20.00**		**250.00**	**20.00**	**60.00**	**20.00**
Total	**120.00 (Original)**		**46.20**		**230.00 (Total AF)**				**350.00 (Original + AF)**			

Changes to the Dated Covenant

90. **The Dated Covenant related to Auditing of Pharmaceutical Fund Supply Agency Financial Statements for EFY 2001-2004 (Financing Agreement Schedule 2 Section V.A) was met and will not be extended under the proposed AF.** Instead, a DLI on timely submission of the Pharmaceuticals Agency's Audit reports has been introduced, together with proposed capacity building and technical assistance to be supported under the IPF component. The Agency's Procurement Audit for EFY 2006 (FY2013/2014), which was due by January 2015, was submitted in May 2016 in Amharic; and the Procurement Audit for EFY 2007 (FY2014/2015) was also submitted late. Implementation experience demonstrated that Technical Assistance and Capacity Building is needed to ensure that the FMOH is able to produce timely and quality audit reports for the Pharmaceuticals Agency.

[36] H6 partners are: UNICEF, WHO, UNAIDS, UN Women; UNFPA and the World Bank.

New DLIs will be added

91. **Table 3 lists the DLIs that have been added under the proposed AF, chosen because of their contribution and relevance to the PDO**. Concerns about quality of services; improving access to services by youth, especially adolescent girls, and ensuring that pharmaceuticals and medical supplies are available at facilities are central to the PDO, and are addressed through DLIs.

92. **DLIs that aim to support results of the Government's Universal Health Coverage agenda have also been added**.[37] The UHC agenda forms part of the Health Care Financing strategy (nested within HSTP) proposes a major shift in the health financing architecture, away from out-of-pocket payments to health insurance for all Ethiopians. Two approaches are proposed: formal sector workers (public and private) will be covered through a Social health insurance (SHI), while community based health insurance schemes (CBHIs) will cover mostly rural populations. Results in the roll out of CBHI are part of an important strategy to ensure that the two pronged approach to health insurance coverage does not widen inequities between the rich and the poor. It is therefore important that equity features predominantly in the design of CBHIs and that the roll out is carefully evaluated and lessons drawn.

93. **DLIs on nutrition target results in micronutrient availability including Vitamin A and Iron Folate have also been added**. The DLIs aim to accelerate attainment of better nutrition outcomes through availability of micronutrients as well as strengthening the Growth Monitoring and Promotion programs that promote improved nutrition practices and identify malnourished children and link them to community nutrition programs as well as the health facilities. The proposed new DLI on Community Participation and Engagement for Service delivery aims to strengthen participation in the decision making process by the community which is central to service delivery.

Table 3: New Disbursement Linked Indicators

DLI #	Result Area	Disbursement Linked Indicators	Value US$ Million AF			
			IDA	GFF	PN	Total
9	**Strengthening Systems**: Improving Pharmaceuticals Fund and Supply Agency Capacity	**9 (1):** Introduction of Procurement KPIs developed by FPPA at PFSA	2.00	0.00	0.00	2.00
		9 (2): Automate the PFSA core business fiduciary system using Selected Software in PFSA headquarters and in Addis Ababa City	7.00	0.00	0.00	7.00
		9 (3): PFSA submission of backlog audit reports and timely quality audit reports thereafter	6.00	0.00	0.00	6.00
10, 11, 12	Maternal and Child Nutrition	**10a:** Percent of children age 6-59 months receiving Vitamin A supplements (VAS)	2.50	0.00	2.50	5.00
		10b: Percent of Woredas in Non-Emerging regions delivering vitamin A supplements to children through routine systems (i.e., health facilities)	2.50	0.00	2.50	5.00

[37] Provision to all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; and ensure that the use of these services does not expose the user to financial hardship.

DLI #	Result Area	Disbursement Linked Indicators	Value US$ Million AF			
			IDA	GFF	PN	Total
		11: Percent of pregnant women receiving iron folic acid tablets	5.00	0.00	5.00	10.00
		12a: Percent of children age 0-23 months participating in Growth Monitoring Promotion (GMP)	7.50	0.00	7.50	15.00
		12b: Percent of Woredas in Emerging Regions transitioning from Enhanced Outreach Services (EoS) to Community Health Days (CHDs)	2.5	0.00	2.50	5.00
13	Quality of Health Care Services	**13 (1):** Percent of PHC facilities having all drugs from the MoH list of essential drugs available	7.00	0.00	0.00	7.00
		13 (2): Develop and implement postnatal care service directive to improve the quality of postnatal services	0.00	5.00	0.00	5.00
		13 (3): Improve quality of adolescent health services	0.00	6.00	0.00	0.00
14	Health Care Financing	**DLI 14 (1):** Percent of Woredas with functional community-based health insurance schemes	6.50	13.50	0.00	20.0
		DLI 14 (2): Undertake community-based health insurance schemes review every two years	5.00	0.00	0.00	5.00
15	Community Participation and Engagement for Service Delivery	**DLI 15 (1)**: Devise and implement a mechanism for documenting consultations when communal/ private land is used for construction of health facilities	5.00	0.00	0.00	5.00
		DLI 15 (2): Development and implementation of Health Sector Community Score Card	5.00	0.00	0.00	5.00

Scaled Up and Restructured DLIs

94. *DLI#1: Skilled Birth Attendance* targets under the original operation are fully achieved. The results of the 2016 DHS show that there is room to encourage further results in this area. This DLI has therefore been scaled up, with further targets to be achieved over the life of the program. DLI#1a on SBA for the bottom three performing regions according to DHS 2016 has also been added.

95. *DLI#2: Children 12-23 months Immunized with Pentavalent 3 vaccine* has been restructured and more time allocated to meet targets due to delays in undertaking of the relevant surveys needed to measure achievement.

96. *DLI#3: Antenatal Care 1* targets under the original operation are fully achieved and therefore will be replaced by Antenatal Care 4 (DLI#3a) - bringing more focus on quality of services. The DLI was selected for scale up given the results from DHS 2016 which shows that ANC1 has reached a high level (62%) while ANC4 levels are still very low (DLI#3a).

97. *DLI#4: Contraceptive Prevalence Rate* targets under the original operation are fully achieved and verified under the 2016 DHS. The results of the 2016 DHS show that there is room to spur further results in rural areas and therefore a DLI has been added to target CPR in rural areas (DLI#4a).

98. *DLI#5: Health Management Information System:* Given the importance of further improving the HMIS, as well as the results of the recent DQA, the DLI is scaled up to encourage further attention in this area, with the aim of reaching 86 percent target (of facilities reporting HMIS data on time) (DLI# 5a).

99. *DLI#7: Collection of Facility Data (SARA/SPA)*: The DLI is extended to the outer years of the program to ensure that HFS continue to be collected to inform strategy and policies on the quality of services being provided (DLI# 7).

100. *DLI#8: Procurement Transparency*: Given the gradual process in improving procurement transparency at the Agency, the DLI has been scaled up with more emphasis being placed on overall improvement in performance monitoring and data management system, a program that is being rolled out across the Government system (DLI#8).

Dropped DLI

101. *DLI#*6 on *Development and implementation of Balanced Score Card (BSC) approach to assess performance and related institutional incentives* will be dropped and the amounts reprogrammed to other DLIs. Under the program, DLI 6a was expected to measure the development of the BSC protocol and the plan for its roll out; and DLI 6b was expected to measure the initial implementation, review and decision on national scale-up based on impact evaluation and scaling up to 200 Woredas. Progress was delayed due to the decision taken by the Government to scale-up the BSC initiative nation-wide across all sectors and not in the manner that was envisaged originally. For this reason, achievement of the series of results specified under this DLI (i.e., pilot of BSC and institutional incentives, impact evaluation of the pilot, and decision to scale up) will be difficult to achieve.

Actions dropped from the Program Action Plan

102. Action #10: *FMOH through appropriate consultation to consider establishing Fiduciary subcommittee of JCCC to monitor budget performance of SDG PF, advances, reporting, procurement and audit issues*- will be dropped following consensus among SDG PF partners that there is no need to establish standing subcommittees under the Joint Core Coordinating Committee as the Committee deals with operational and technical issues.

103. Action #7: *Exchange rate will be applied on the basis of actual rate of transfer while reporting expenditures to minimize reported exchange losses. A reconciliation will be completed to adjust actual foreign exchange losses/gains and accounting losses/gains* - will also be dropped. This is because the Bank has confirmed that there is no actual gain /loss that arises in the transactions of Pharmaceuticals Fund and Supply Agency with MOH since all payments and transfers are made in foreign currency. The gains/losses that are shown in books are not actual gains and losses, rather currency translation differences which arise due to differences in currency of reporting. Accordingly, there will be no more

action required from the both MOH and the Agency in this regard. The anticipated revisions of technical, safeguards and fiduciary assessments will guide the selection of DLIs and action points to be introduced.

104. Action *#1: Developing and implementing balanced scorecard approach to assess facility performance and related institutional incentives* - The implementation of the BSC tool has been fully rolled out to all levels, but without a piloting approach that would allow identification of lessons on the impact of incentives on performance at the various levels. These actions under the Program were linked to achievement of DLI#6. Discussion on efforts to link payment to performance show little interest in the Government to expand on this policy direction hence the need to restructure the DLI.

Changes in DLI Verification Methods

105. The verification protocol has been accordingly adjusted to reflect the inclusion of new DLIs and the increased focus on quality and equity. The revised verification protocol including identification of surveys is found in Annex XI. The Government will appoint and maintain, independent verification agents that will verify the data and other evidence supporting the achievement of one or more DLIs.

VI. Implementation Arrangements for the Program for Results

106. **The proposed AF to the PforR operation will use existing institutional and implementation arrangements under the original program**. The FMOH will be responsible for planning, budgeting and reporting funds released from the Pool Fund, through which IDA funding will be disbursed under the AF to the PforR operation. The Joint Consultative Forum chaired by the MOH and co-chaired by one of the partners in the sector will continue to be the highest body for dialogue on sector policy and reform issues between Government of Ethiopia, its partners and wider stakeholders. Disbursement arrangements will also remain the same, disbursing directly to the Pool Fund that supports the priority needs of the health sector

Implementation Support for the Program for Results

107. **The original implementation support arrangements continue to be relevant under the AF**. In addition to the technical skills needed under the ongoing operation, specific expertise in Health Care Financing, Nutrition and Gender will be added to the Technical team from the Bank. Implementation support will also involve closer linkages with support being provided by the Bank through other programs, especially with the Social Protection and Labor Global Practice that has larger programs that support Citizen's Engagement and Social Accountability through ESAP and ESPES. Implementation support and policy dialogue on Nutrition and the Early Years' agenda will be undertaken in close collaboration with other Global Practices including SD (Agriculture); SPL (PSNP, ESPES), Education and WASH. A Nutrition specialist will be added to the country team to support closer collaboration through the Bank supported programs, and ensure participation in dialogue with other partners and with the Government. The work on CRVS will be supervised in close collaboration with the Poverty group's proposed work undertaken by the Central Statistics Agency - both ongoing and proposed under the AF to the ESPES.

108. **The supervision of the Additional Financing will involve closer partnerships with the SDG PF contributors and other Health Population and Nutrition working groups.** There will be closer collaboration with partners that support the Health Care Financing agenda and those that support improvement in data systems, e.g. Gates Foundation; Global Fund; USAID and others. Specifically, the Bank team will work closely with partners on the dialogue and follow up on the Risk Assurance plan.

Bank Executed Trust Funds from partners that support the GFF platform will further support the Government through TA and capacity building for specific areas, including Health Care Financing.

Results Monitoring for the Program for Results

109. **An assessment of Monitoring and Evaluation arrangements found that Ethiopia has multiple data sources that can be used to effectively monitor and evaluate results under the AF to the PforR**. The proposed AF will draw on most of the original data sources used to monitor results under the original program, plus addition sources of data that will become available during the course of implementation. The Government has identified the need to further improve the quality of its health information system in order to generate and disseminate quality data. The agenda, which has the support of partners in the sector, includes advancing data collection, aggregation reporting and analysis and promoting a culture of information use; harnessing information technology and improving access and feedback systems, in particular community scorecards when the MOH implement them. The following routine administrative sources (Health Management Information System); population-based surveys (Demographic and Health Survey) and population censuses; health facility surveys (Service Availability and Readiness Assessment); disease and behavioral surveillance systems; a newly launched civil registration and vital statistics system; financial and management information systems; and research studies, will be available for monitoring results under the Government Program.

VII. Risks for the Program

110. **The overall risk rating for Ethiopia is rated high due to the political situation in the country that could impact the country program more broadly**. Since PforR disburses directly into a pool fund managed at the Federal level, the current situation might not have an immediate effect on the implementation of the program. However, if current crisis continues or there is an escalation and spread, the current outcomes and results of the health sector will not be sustained, and the implementation of the program as well as the related disbursements will be affected.

Table 4: Systematic Operations Risk-Rating Tool (SORT)

#	Risk Category	Original Rating (H, S, M, L)	Revised Rating (H, S, M, L)	Rationale for Change
1	Political and Governance	-	H	Recent and underlying political tensions could increase access constraints and hinder improvement for the achievement of the program's objectives.
2	Institutional Capacity for Implementation and Sustainability	-	S	Low capacity of VERA can affect the implementation of CRVS activities and hence the operation. VERA is a new agency that has to meet a very ambitious set of goals over the next few years. The other agency that is key to the achievement of the program goals is PFSA, whose capacity still needs strengthening in order to ensure that the systems for the supply of medicines and medical equipment is strong.

#	Risk Category	Original Rating (H, S, M, L)	Revised Rating (H, S, M, L)	Rationale for Change
				Low management and monitoring capacity at sub-national levels remains a risk for achieving health outcomes at local level, in particular in emerging regions.
3	Fiduciary	S	S	PFSA procurement processes remain inefficient (risk of low availability of medicines) and delays in published audits may delay disbursements from donors which could affect program's targets. Capacity to manage the SDG PF is growing with improvement in performance that is observed over time.
4	Environment and Social	M	H	Social tensions can significantly affect the capacity of the program to deliver health services, in particular in the regions with the highest social tensions. The environmental risk is moderate. Mismanagement of medical waste could affect population's health and program's objectives. Specific actions to address these risks are included in the Program Action Plan, and safeguards local capacity building efforts by ESPES will also contribute to mitigate the risks.
5	Stakeholders	-	S	The risk is substantial as it is related to the high political and governance risk. Stakeholders perception of social disruption might have an impact on program financing or implementation and support to the overall Government plan. Robust coordination mechanisms between all partners and the MOH are in place and helps to mitigate against the elevated risk due to current country context.
	Other	-	-	
	OVERALL	**S**	**H**	**Due to the current political and social situation, the risk for the achievement of program's objectives is high.**

Key: L=Low; M= Medium; S=Substantial; H= High

Risk Mitigation

111. **Strong stewardship of the sector, coupled with vibrant partner and Partners-Government platforms for dialogue provide the right platforms for discussion of how various risks can be mitigated**. (See Annex V in Technical Assessment including the H6 Partners (UNICEF, WHO, UNAIDS, UNFPA, UN Women and World Bank), Health Population and Nutrition Partners Group, Sustainable Development Goals Performance Fund Contributors, Joint Core Coordination Committee,

and Joint Consultative Forum). A good example is the Risk Assurance Plan that was jointly prepared between partners and the Government to identify areas that require additional attention in order to ensure stronger implementation of the strategy. The HPN partners, including those that are Pool Fund Contributors have identified the Risk Assurance Plan as one area for close dialogue with Government, and a number of working groups on specific areas of the Risk Assurance Plan have been formed to allow for close follow up. Reporting on the Risk Assurance Plan will be regular (every quarter) and will be elevated for discussion at the Joint Core Coordination Committee or Forum.

112. **Risks that result from lack of capacity have identified mitigation activities under the IPF component**. For example, fiduciary risks are mitigated by training activities and Technical Assistance for PFSA that have been proposed under sub-component 3. Similarly, new areas that are to be supported, such as nutrition and CRVS will also have TA supported by UNICEF. Risk mitigation will also address Health Care Financing initiatives through enhanced implementation support and TA to be covered under Bank executed activities and TFs.

VIII. Corporate Requirements

Gender

113. **The proposed AF continues its focus on health concerns that affect women and children, and will continue to track results in key health indicators for women and children.** Under the proposed AF, new areas, including nutrition of women and children, adolescent health will receive more attention. The IPF component will bring attention to gender issues through Technical Assistance and Capacity Building.

Climate Screening

114. **The proposed AF to the Program will include a PforR and an Investment Project Financing (IPF) component and for that reason the operation is required to generate an output report from applying the World Bank Group's Climate and Disaster Risk Screening Project Level Tool**. The project level Climate and Disaster Risks Screening Tool provides early stage due diligence on climate and disaster risks at the concept stage of project development. The tool uses an exposure - sensitivity - adaptive capacity framework to consider and characterize risks from climate and geophysical hazards, based on key components of a project and its broader development context. The tool does not provide detailed risk assessments, rather it flags risks to inform consultations, enhance dialogue with local and other experts, and define further analytical work at the project location. As a result of previous screening process for the original program, four regions were identified as requiring special attention: Afar, Benishangul-Gumuz, Gambella, and Somali. The current and future hazards identified for these four regions include extreme temperature and drought as these regions have been exposed to strong temperatures and droughts in the past and may continue to be exposed to the harshness from these climate hazards. This early stage due diligence will be used to strengthen the consideration of climate and disaster considerations in key components of the project design, including the physical (e.g., health facilities/infrastructure, etc.) and non-physical aspects (e.g., capacity building of health practitioners, institutional strengthening at the community level, early warning systems, etc.). The broader sectoral (e.g., appropriate policies on healthcare, a robust health insurance system, etc.) and development context conditions (e.g., access to technology for health care administration, climate-related early warning systems, density of health care network in rural areas, etc.) could help modulate the risks to the delivery of the outcome/service level.

Grievance Redress and Citizen Engagement

115. **Ethiopia has a complaint handling system which allows citizens and companies to channel grievances.** In the health sector, these include the PFSA Complaint Handling System related to procurement processes, as well as several grievance redress mechanisms related to fraud and corruption, and citizen engagement and social accountability tools accessible by citizens and communities to resolve service delivery issues. These are described in detail in the Annexes of the Technical Assessment. The proposed AF will strengthen existing systems and support new citizen engagement mechanisms, in particular the implementation of Community Score Cards strategy through DLI#15, and the Program Action Plan. The Implementation of the score card and CE overall in the proposed program will draw on good practices from the ongoing CE operations and assure promotion of coordination and harmonization as provided for by the Government vision for CE in the long term.

116. **Communities and individuals who believe that they are adversely affected as a result of a Bank supported operation, as defined by the applicable policy and procedures, may submit complaints to the existing Program grievance redress mechanism or the World Bank's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org

Annex I: Appraisal Summary for Investment Project Financing (IPF) Component

Rationale for adding an IPF Component

1. The proposed AF will add an IPF component (OP/BP 10.0) in order to support key gaps in capacity and technical assistance needs. The experience of implementation support since the PforR became effective has highlighted key capacity gaps in Fiduciary Management; Health Care Financing; Health Management Information Systems, etc. The IPF component will support select areas that are critical to the success of the PforR and will support the CRVS agenda, supporting activities under both Vital Event Registration Agency (VERA) and MOH. Capacity building, and a knowledge agenda around Health Care Financing; Early Childhood Development; Reproductive Health and Gender Based Violence that require multisector interventions will provide much needed support to the Government. The component will also address fiduciary capacity building needs of the PFSA.

Project Sub-components and Implementation Arrangements

2. The IPF component for a proposed amount of US$21.00 million will support three areas: i) Support for Civil Registration and Vital Statistics system; ii) Technical Assistance and Capacity Building to Support NNP II; and iii) Other Technical Assistance and Capacity Building activities to be undertaken by MOH that will be identified during the course of implementation.

Sub-component 1: Support to Civil Registration and Vital Statistics System (US$15 million)

3. The Federal Vital Events Registration Agency became operational in 2013 and the official registration of births, deaths, marriages and divorces in the country was launched in August 2016. Registration of these vital events is paper-based and the key priority of the Government is to convert to an electronic system, which is essential for more timely, accurate, and efficient registration. Furthermore, VERA, being a newly established agency, requires equipment at federal, regional, woreda and kebele levels to facilitate different activities of the registration process.

4. In order to strengthen availability of quality data on births and deaths as well as registration of marriages and divorces, this sub-component will support the CRVS agenda under the Federal Vital Event Registration Agency (VERA). Activities support result area 3 on system strengthening, specifically on availability of reliable data on maternal and child health. The component will provide technical support and capacity building for VERA to convert from a paper-based registration system to an electronic system. As a newly established agency, VERA will also be supported to procure motor cycles and field vehicle to facilitate supervision and monitoring of registration activities as well as transfer of registration document between kebeles, woredas, and zones, regional and federal offices. In addition, the AF will support the procurement of equipment required for storage and archiving of documents at the points of registration to ensure that the documents are kept in a secure environment.

5. Technical assistance is required to advise on automating the CRVS system as currently the registrations of births, deaths, marriages and other vital events are undertaken manually. This is essential for fast-tracking the processes of registration and certification and for building a database for production of statistics. In addition, support will be required for development of processes for registration; and where to undertake registration. Technical assistance is also required to advise on the safeguarding and archiving of registration documents (completed and unused) which are official and confidential documents.

6. Thus, technical assistance will be provided to VERA to prepare for an electronic civil registration system and maintain a database of vital events. This will cover undertaking a comprehensive assessment of the IT environment and establishing the needs for the country; preparing a costed IT strategy; system design; and procurement of required ICT equipment. This will also include piloting innovations for CRVS.

7. Other areas of support for VERA will include procurement of equipment for safeguarding and archiving of registration documents; and providing motorcycles and field vehicle to facilitate movement of registration documents, and for supervision and monitoring of registration activities. In addition, support will be provided for advocacy and public awareness of registration of vital events, including preparation of a CRVS communications strategy and preparation, procurement and distribution of information, education and communication (IEC) materials. To oversee the implementation of these activities, a CRVS coordinator will be recruited at VERA.

Implementation Arrangements: The Federal Vital Events Registration Agency

8. Activities under Sub- Component 1 (Support to Civil Registration and Vital Statistics (US$15 million)) will be the implemented by the Federal VERA, with technical assistance provided by UNICEF on behalf of the Government through contract agreement between VERA and UNICEF using Bank approved contract template. UNICEF will contract consultants to provide technical assistance for this project, including for preparation of TOR required to hire the firm for the preparation of the CRVS Information Technology strategic plan and detailed costing; system design; and establishment of the centralized electronic system. Working with UNICEF, the project will support hiring of competent technical assistants and a procurement officer to support the project. These consultants will provide backup services as well as knowledge transfer to VERA staff. In addition, UNICEF will support activities for advocacy and awareness creation on the importance of CRVS. VERA will be responsible for the procurement of equipment required for the implementation of the project, as well as for the financial management of the project. All goods, works, non-consulting services and consulting services required for the project and to be financed out of the proceeds of the financing shall be procured in accordance with the requirements set forth or referred to in the Procurement Regulations and provisions of the Procurement Plan.

9. The Board of Management for VERA will provide overall strategic guidance for the implementation of the project, with its duties stipulated in Regulation No. 278/2012. A Technical Committee will be established to provide support on technical issues in the implementation of the project. Among other responsibilities, the Committee will monitor and evaluate the implementation of the project; facilitate exchange of information on best practices; provide technical advice on activities of the project; and make recommendations for consideration by the Steering Committee. The World Bank will be responsible for providing implementation support as required; and organize regular support missions, including mid-term review and project completion report. A Project Implementation Manual (PIM) detailing project implementation arrangements will be produced within three months of project effectiveness date.

Results under Sub-Component 1: Civil Registration and Vital Statistics System

10. In order to monitor progress towards achieving the objectives of this project, a set of specific indicators was agreed upon with the Government as outlined in the Results framework matrix (Annex II). The results framework describes targets for the project, related performance indicators and arrangements for monitoring results. Key results indicators are the following:

- Percentage of births in a given year registered

- Percentage of all deaths in a given year registered
- Functional centralized electronic CRVS system
- Proportion of kebeles visited by woreda supervisors per month
- Proportion of cabinets procured, delivered and used for storage of CRVS forms

11. The data required to monitor these results will be derived from administrative sources that will be maintained by VERA and from existing administrative information systems at FMOH or mid-year population estimates produced by Central Statistics Agency. These include summary reports of births and deaths from VERA; data on births and deaths from the health management information system (HMIS) and the community health management information system (CHMIS); or annual number of births and deaths estimated by CSA. An independent contractor will be hired to test the electronic centralized CRVS system and the World Bank will provide implementation support to monitor the availability and use of cabinets for CRVS purposes.

Sub-Component 2: Technical Assistance and Capacity Building to Support National Nutrition Program II (US$5 million)

12. This sub-component will support selected capacity building activities contributing to the implementation of NNP II, including: (i) Strengthening coordination of multisectoral nutrition activities at federal, regional, zonal and woreda levels; (ii) Strengthening monitoring of National Nutrition Program II implementation activities through support to improve data flow, quality, and utilization of nutrition specific and sensitive indicators included in the National Nutrition Program II results framework; (iii) Operational research and evaluation, including baseline and end-line nutrition surveys; (iv) Coordination for Early Childhood Development; and (v) Nutrition and other related health system strengthening activities. The operational research will focus on community-based nutrition activities including social mobilization and growth monitoring and promotion (GMP). An independent evaluation of the scale-up of community based nutrition activities in a sub-set of woredas will be financed through the IPF component using baseline and end-line surveys. In addition, this sub-component will support Technical Assistance which will be provided by UNICEF through a contract agreement between FMOH and UNICEF using a contract template acceptable to the Bank.

Results under Sub - Component 2: Support to the National Nutrition Program II

13. In order to monitor progress towards achieving the objectives of this project, a set of specific indicators was agreed upon with the Government as outlined in the Results framework matrix (Annex II). The results framework describes targets for the project, related performance indicators and arrangements for monitoring results. Key results indicators are the following:

- Proportion of woredas with nutrition coordination platform established
- Proportion of woredas reporting multisectoral nutrition information to national level
- Number of nutrition operational research studies conducted
- Completion of National Nutrition Program evaluation
- Number of joint reviews of National Nutrition Program II carried out

14. The data required to monitor these results will be derived from administrative sources that will be maintained by FMOH. These include National Nutrition Coordination Body and National Nutrition Technical Committee annual reports, reports from HMIS, and (when it is operational) the Unified Nutrition Information System for Ethiopia.

Sub-Component 3: Technical Assistance and Capacity Building (US$1 million)

15. A list of activities to be supported under the sub-component will be finalized at a later date, following consultations between the Government and partners on anticipated support for capacity building. A potential list of activities to be supported includes: i) Reproductive Health and Gender Based Violence; ii) Health Care Financing and Health Economics; and iii) Fiduciary management capacity building: support various capacity and Technical Assistance needs of the Pharmaceuticals Fund and Supply Agency and FMOH. Activities to be undertaken will be prioritized by FMOH at a later date.

Implementation Arrangements for Sub-Components 2 and 3: Federal Ministry of Health

16. The implementing agency for the activities under Sub-Component 2 (Technical Assistance and Capacity Building to Support National Nutrition Program II) and Sub-Component 3 (Unallocated/ Technical Assistance and Capacity Building Component) will be the FMOH. Technical assistance needed for Sub-Component 3 will be provided by UNICEF on behalf of the Government through contract agreement between MOH and UNICEF using Bank approved contract template.

17. Overall responsibility for coordinating and monitoring nutrition interventions falls under a National Nutrition Technical Committee, which has representatives from all implementing sectors[38] and nutrition partners. Nutrition-related policy and planning is governed by the National Nutrition Coordinating Body, chaired by the State Minister of Health in charge of Programs. At lower levels, the nutrition case team in the FMOH also works with nutrition focal points within the Regional Health Bureaus and woreda Health Offices. To enhance accountability, it was agreed in National Nutrition Program II that the National Nutrition Coordinating Body will regularly report progress on implementation to the office of the Deputy Prime Minister.

Environmental and Social for IPF Component

18. The Technical Assistance and capacity building components will mostly support coordination and technical assistance activities related to multisectoral nutrition coordination, implementation, monitoring and evaluation. The physical setting is not relevant for safeguard analysis as the capacity building component does not involve any capital investment or civil works and will strengthen local technical skills in health and nutrition sectors. There will be no land acquisition or restriction of access in this IPF.[39]

Fiduciary Management for IPF Component

19. A Financial Management Assessment was conducted in accordance with the Financial Management Practices Manual for World Bank-financed investment operations issued by the Financial Management Sector Board on March 1, 2010, and reissued on February 4, 2015, and the supporting guidelines. In conducting the assessment, the Bank team has reviewed the financial management system of FMOH and VERA.

20. The project will build on the strengths of the country's public finance management (PFM) system such as the budget process, classification system, and compliance with financial regulations. The program also benefits from the country's internal control system, which provides sufficiently for the

[38] Implementing Sectors: Health; Education; Agriculture and Natural Resources; Livestock and Fishery Resource Development; Industry; Water, Irrigation, and Electricity; Labor and Social Affairs; Trade; Finance and Economic Cooperation; Women and Children Affairs; Government Communication Affairs; Youth and Sport; and National Disaster Risk Management Coordination Commission

[39] For more detail refer to the Project's ISDS.

separation of responsibilities, powers, and duties, and it benefits from the effort being made to improve the internal audit function. The experience of MOH in bank financed operations is an asset to the project while the lack of experience of VERA for such operations could be a challenge.

21. The FM arrangements for the program (see Annex I for details) follow the Government's channel 2 fund flow mechanism, where funds from donors flow directly to MOH and VERA. Both these agencies will open separate designated accounts to be used for their respective activities. Additional finance staff is recommended for VERA whereas the existing staff at MOH has the capacity to effectively manage the IPF parts of the operation. The program will use report-based disbursement, with submission of Interim Financial Reports (IFRs) with two quarters' expenditure forecast to the Bank and replenishment of project accounts accordingly. Both MOH and VERA will submit Interim Financial Reports (IFRs) quarterly within 45 days of the quarter end. The project will have two independent auditor's report every year, to be submitted to the Bank by FMOH and VERA within six months of the year end (EFY).

22. The conclusion of the FM assessment is that the FM arrangements meet the IDA requirements according to OP/BP 10.00. An action plan has been developed to mitigate the risks identified in the project.

Financial Management, Budget Preparation and Approval

23. The project will follow the Government's budget system, recorded in the Government's budget manual.[40] Both FMOH and VERA follow the Government budgeting process and cycle to prepare and approve budget. Accordingly, for the project, both FMOH and VERA will prepare in detail the annual work plan and budget of the project for their respective sub- components and obtain the necessary approval from the World Bank and MoFEC following the Government's budget calendar. The budgets should be prepared in detail to provide for adequate information on the sub- components and activities. The approved budget for each of the implementers will be approved by MoFEC and form part of the entities annual budget to be proclaimed by the parliament.

Budget Control

24. Budgets should be regularly monitored at all levels. The budget monitoring system both at FMOH and VERA was found to be adequate. The budget of the project should be at least quarterly monitored against actual expenditure by both FMOH and VERA. The budget variances will be adequately explained and justified through the quarterly IFRs.

Accounting

- ***Accounting policies and procedures:*** The Government of Ethiopia follows a double entry bookkeeping system and modified cash basis of accounting, as documented in the Government's Accounting Manual. Both MOH and VERA use the Government's accounting policies and procedures. These policies and procedures will be used for the project with some modification to the fund flow, reporting and auditing aspects of the project which are outlined in the sections of this report.

[40] The Ethiopian budget system is complex, reflecting the fiscal decentralization structure. Budget is processed at federal, regional, zonal (in some regions), woreda and municipality levels. The budget preparation procedure and steps are recorded in the government's budget manual. The budgets are reviewed at first by MoFED then by the Council of Ministers. The final recommended draft budget is sent to parliament around early June and expected to be cleared at the latest by the end of the fiscal year.

- ***Accounting software:*** The FMOH uses IFMIS whereas VERA uses IBEX accounting system for its treasury transaction as well as for donor financed operations. FMOH will continue to use IFMIS for this project. However, at VERA, although there is intention to use IBEX for the project, the system may not produce reports by the sub-component and category of expenditures. It is therefore important to configure and enable the system to produce reports on these aspects as required. Should this not work as intended, then other software for the project could be adopted.

- ***Staffing***: The Grant Management Unit (GMU) of the MOH is fully staffed with qualified and experienced finance professionals. Accordingly, this project will be overseen by the existing staff. At VERA, according to the new study that has just been concluded and submitted to Ministry of Civil Service for approval allows for 27 professionals under the four units of the finance, procurement and property administration directorate. Currently, the number of positions that is filled is only 10. In addition to the regular finance staff, UNICEF has recruited an accountant to assist the Agency. However, the position is currently vacant and still in the process to be filled. The accountants currently working are fully occupied handling the treasury budget transactions and they cannot handle additional assignments. Even if all the vacant positions are filled, there is a risk that there will be staff turnover or risk of attracting qualified staff with the existing salary scale. Therefore, employing dedicated accountant for part of the project implemented by VERA is recommended.

Internal Control and Internal Audit

25. ***Internal Control:*** Internal control comprises the whole system of control, financial or otherwise, established by management in order to (i) carry out the project activities in an orderly and efficient manner; (ii) ensure adherence to policies and procedures; (iii) ensure maintenance of complete and accurate accounting records; and (iv) safeguard the assets of the project. The overarching principle is that regular Government systems and procedures would be followed, including those relating to authorization, recording and custody controls.

26. ***Both FMOH and VERA have adequate internal control systems in place which will be used for this project***. There is segregation of duties where by authorization to execute transaction, recording of the transaction and custody of assets involved in the transaction are performed by different persons. Ordering, receiving, accounting for and paying for goods and services are appropriately segregated. One exception is the procurement & property administration section is not yet separated from the finance section (the two are under the same directorate- Finance and Procurement Directorate). Separation of the two sections will further enhance the control. In addition, overlap of responsibility that weakens control has been observed at VERA where one of the bank signatory is also involved in financial reporting and preparing bank reconciliation statement. Furthermore, the control over property administration needs improvement at VERA in that stock controlling and custody are not separated and asset register (user control card) is not complete. Count of fixed assets is conducted annually but it does not indicate record balance to evidence comparison with records. Such and other control weakness were also observed in the internal and external auditors' recommendations. To strengthen internal controls and reduce risks, VERA will continue implementing auditors' recommendations.

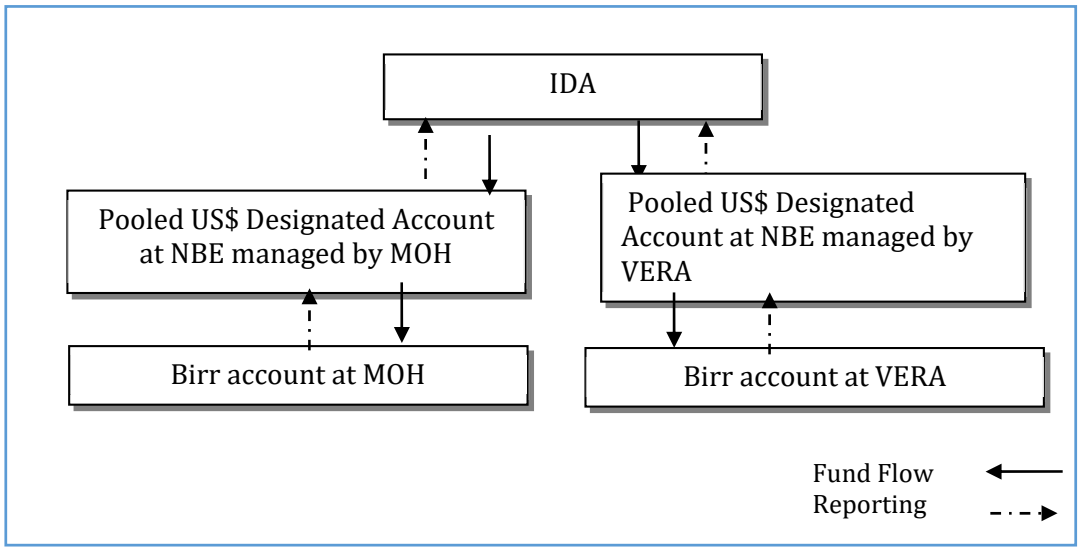
27. ***Internal Audit:*** Both VERA and MOH have internal audit units which follow the MOFEC's internal audit manual. However, these units are understaffed compared to the structural positions provided. The MOH internal audit unit has 4 unfilled vacant posts out of 16 positions. The directorates at MOH and VERA have prepared a comprehensive annual risk-based audit plan for EFY 2009. In addition, follow up of the rectification of internal and external auditors' findings and providing capacity building training to the internal auditors are incorporated in the plan. The report preparation and follow up was deemed adequate. However, particularly at VERA, the plan may not materialize due to the sever understaffing of the unit. All effort should be exerted to ensure the filling of the positions. Both

directorates will be responsible to include the project in their annual work plan and make necessary reviews as planned.

Fund Flow and Disbursement Arrangements

28. ***Fund Flow Arrangements:*** the project will follow channel two fund flow mechanism of the Government whereby fund will flow directly to FMOH and VERA. At this stage, regional bureaus or other entities are not expected to implement the project and as such flow fund to other entities from both FMOH and VERA is not anticipated. Therefore, IDA funds will be deposited into two separate designated accounts to be opened by the FMOH and VERA at the National Bank of Ethiopia (NBE). Funds from the separate designated US$ accounts will be further transferred into Birr accounts to be held by FMOH and VERA to be used for payment for goods and services. Fund flow arrangements for the project are as per Figure 1 below.

Figure 1: Funds Flow Arrangement



29. ***Disbursement Method***: FMOH and VERA will apply the report based disbursement method. Disbursement will be made quarterly to cover cash requirements for the next six months based on the forecasts contained in the IFRs. The project will have the option of using advance, direct payment and replenishment methods of disbursement. The detail of the documents required and the procedures will be indicated in the disbursement letter for the project. If the sub-components to be implemented by FMOH will be outsourced to a UN Agency, detail agreements will be reviewed by the financial management team of the Bank before the agreement is finalized to ensure adequate FM arrangements are put in place.

30. ***Designated Account:*** FMOH and VERA will each open the Designated Accounts denominated in US dollars in the National Bank of Ethiopia on terms and conditions acceptable to IDA. The limit of the Designated Accounts would be 6 months forecasted expenditures.

Financial Reporting Arrangements

31. ***Financial Reporting:*** both FMOH and VERA report to MoFEC and donors on the treasury and donor financed operations timely. For this project both of FMOH and VERA will prepare quarterly interim unaudited financial reports (IFR). These will be submitted to the World Bank within 45 days of the end of the quarter. The format and the content, consistent with the World Bank's standards, have been agreed with both FMOH and VERA. At a minimum, the report will include: a statement of sources and uses of funds and opening and closing balances for the quarter and cumulative; a statement of uses of fund that shows actual expenditures appropriately classified by main project activities (categories, sub-components) including comparison with budget for the quarter and cumulative; a statement on movements (inflows and outflows) of the project Designated Account including opening and closing balances; a statement of expenditure forecast for the next two quarters together with the cash requirement; notes and explanations; and other supporting schedules and documents.

32. In compliance with the Government's financial rules and regulations as well as IDA requirements, FMOH and VERA will produce annual project financial statements similar to the contents of the quarterly IFRs. The annual financial statement will be similar to the IFRs, with some modifications as to be indicated in the audit TOR. These financial statements will be submitted for audit within three months after the end of each year (EFY).

External Audit

33. Annual audited financial statements and audit reports (including Management Letter) will be submitted to IDA within six months from the end of the fiscal year (EFY) by both MOH and VERA. The annual financial statements will be prepared in accordance with the standards indicated in the audit TOR that have been agreed to by both MOH and VERA. The audit will be carried out by the Office of the Federal Auditor General (OFAG), or an auditor nominated by OFAG and acceptable to IDA.

34. The audit will be carried out in accordance with the International Standards of Auditing (ISA) issued by the International Federation of Accountants (IFAC). The auditor will prepare a work plan to cover all the major risk areas. The following mechanisms are proposed to systematically monitor the timing of audit reports and the timely action on audit findings: (i) Both FMOH and VERA have the responsibility to prepare audit action plans within one month of the receipt of the annual audit report. (ii) Within two months of the receipt of the audit report, action must be taken on all audit findings and notified to the Bank.

35. In accordance with the Bank's policies, the Bank requires that the borrower disclose the audited financial statements in a manner acceptable to the Bank; following the Bank's formal receipt of these statements from the borrower, the Bank makes them available to the public in accordance with The World Bank Policy on Access to Information.

Financial Management Covenants

36. Financial Management Covenants related covenants for part of the project implemented by MOH and VERA will include the following:

- Maintaining satisfactory FM system for the program;
- Submission of IFRs for the program for each fiscal quarter within 45 days of the end of the quarter covering the quarter, year to date and project life information, in form and substance satisfactory to the World Bank; and

- Submission of annual audited financial statements and audit report within six months of the end of each fiscal year.

Implementation Support Plan

37. Financial Management implementation support mission will be an integrated part of the project's implementation reviews to ensure the continuing adequacy of the financial management arrangements and to ensure that expenditures incurred under project parts remain eligible for the Bank's funding. Implementation support of the project part implemented by VERA will follow the main project. However, as the FM risk of the project part implemented by VERA is rated as substantial, it is recommended that the project will be supervised twice per year. Risks will be recalibrated after implementation support. Implementation support activities will include:

- Onsite visit to FMOH and VERA. The visit would include a review of the controls and the overall operation of the FM system; review of internal audit, selected transaction reviews, and sample verification of existence and ownership of assets;
- Reviews of IFRs and follow-up on actions needed;
- Review of Audit Reports and Management Letters, and follow up on action needed.

38. Based on the assessment conducted, the financial management arrangements for the IPF part of the project implemented by FMOH and VERA satisfy the World Bank's minimum requirements. The arrangements provide reasonable assurance that accurate and timely information on status of the proposed project will be available.

Financial Management Action Plan

Table 8: The table below shows the financial management action plan for the project

	Action	**Date due by**	**Responsible Body**
1.	*Budget:*		
	Finalize budget preparation early before beginning of budget year.	Early preparation of budget will be annually.	FMOH/VERA
	Track budget availability as each transaction occurs. Provide variance analysis with explanation regularly along with reporting.	Budget control is during project implementation.	FMOH/VERA
2.	*Accounting:*		
	Maintain separate accounting records and documentation for the project implementation transaction that are subject for review of auditors and supervision missions.	During implementation.	FMOH/VERA
	IBEX, which is selected by VERA for the project, should be configured to report on project sub- component, sub-component, & category of project expenditures.	Start early and finalize within one month after effectiveness.	VERA
	Recruit an accountant for the project at VERA.	Within three months after project effectiveness.	VERA
3.	*Internal Audit:*		

	Strengthen internal audit directorate and encourage increase of its engagement in providing the required service.	During implementation.	VERA
4.	*Reporting*:		
	Submit quality IFRs to the Bank within 45 days from end of the relevant quarter in agreed format.	Ongoing, during implementation.	FMOH/VERA
5.	*External Audit*: Project Audit		
	Finalize Audit TOR and recruit auditor at early stage of the project.	Audit TORs were finalized during Negotiation. Recruit within 6 months after effectiveness.	FMOH/VERA
	Project financial statements will be prepared in time.	3 months after end of the year (EFY).	FMOH/VERA
	Ensure that the external auditor has complied with the Audit TOR.	Ongoing annually.	FMOH/VERA
	Submit annual audited financial statements, audit report and management letter.	Within 6 months after end of year (EFY).	FMOH/VERA
	Submit Government's response to the findings in the annual audit report to Bank and an action plan for any follow-up actions including the status thereon.	Within one month of submission of audit report to the Bank.	FMOH/VERA
	Prepare status report of action taken on audit findings.	Two months after submission of audit report to the Bank.	FMOH/VERA
	Disclose audit reports to the public in accordance with The World Bank Policy on Access to Information.	Annually.	

Procurement

39. Procurement for Sub-Component 1 will be carried out in accordance with the World Bank Procurement Regulations for IPF borrowers (Borrowers Regulations), July 2016, as well as the provisions stipulated in the Financing Agreement. The sub-component will finance the cost for consultancy service to design the vital information registration system, TA service for VERA, furniture to establish civil registration offices, motor cycles for woredas, and ITC infrastructure and computers for the system, printing certificates and registers etc.

40. A procurement risk assessment of the VERA was carried out. The VERA has no past experience working with the World Bank and applying related policies and procedures. To address the identified risks the following mitigation measures are proposed to be undertaken within three months of effectiveness: (a) delineate procurement function such that the same staff will not be responsible for procurement process, payment and product acceptance, (b) hire senior procurement officer as member of Project Management Team to be responsible for project related procurement activities, (c) ensure procurement documents under the project are adequately kept in safe and easily retrievable manner, (d) prepare procurement plan for all items with efficient packaging strategy with support from the Bank, (e) ensure accepted procurement documents are used for project procurement activities, (f) ensure adequate bid and proposal preparation period is given for bidders under the project; (g) ensure procurement training is provided to staff dealing with procurement; (h) ensure adequate period is given for bidders

to lodge complaints in accordance with applicable provisions, and (i) assign dedicated staff for contract management.

41. Procurement Plan: The Procurement Plan under the Sub-Component 1 will include the main activities indicated under Annex I. The Borrower shall submit the Procurement Plan through Systematic Tracking of Exchanges in Procurement (STEP), and it will be disclosed by the Bank to the public when the detail plan is approved through STEP. The Procurement Plan, as agreed between the Bank and the Borrower, will specify procurement methods and their applicable thresholds, as well as activities that will be subjected to the Bank's prior review, for all packages. The Procurement Plan (Dated February 28, 2017) will be updated on an annual basis or as needed throughout the project duration to reflect the actual project implementation needs and improvements in institutional capacity.

42. Procurement for Component 2 will involve only a Technical Assistance contract agreement between the FMOH and UNICEF. A procurement plan that will indicate this contract will be submitted by FMOH's Finance and Procurement Directorate through STEP.

Procurement Arrangement

43. **Institutional arrangement for procurement:** The VERA will be the implementing agency of Sub-Component 1. A Project Management Team will be established in the VERA and will be responsible for ensuring that the fiduciary aspects of the project are managed including procurement. One senior Procurement Officer will be hired for the team to manage procurement implementation under the sub-component. The VERA management will ensure the Team is adequately provided with facilities and necessary logistics.

44. **Applicable procurement regulation:** Procurement for the IPF sub-component will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers (Borrowers Regulations), July 2016, and the provisions stipulated in the Financing Agreement.

45. **Key Procurement under Sub-Component 1**: The sub-component main objective is to strengthen availability of quality data on births and deaths as well as registration of marriages at national level. Achievement of this objective requires supply and installation of an IT system, mainly IT and Networking equipment and the associated software. The registration system is expected to be installed throughout the whole country at a minimum of 1000 woredas. Given the wide coverage, a complete definition of the scope of procurement requires prior study. A consulting firm will be selected to undertake detail study and the output of the consultancy service will provide the required detail for subsequent procurement.

- *Selection of Consultants:* The main consultancy service will involve service to design a system for establishment of web-based connectivity at all levels, defining interoperability function, developing software, specifying specifications or functional requirements, defining quantities and providing training. VERA will select the consulting firm. VERA will also hire UNICEF to avail Technical Assistance services through deployment of professionals. The sub-component will additionally involve hiring of individual consultants for project implementation.

- *Procurement of goods and Non-consulting services:* Goods and Non-Consultancy procurement under the sub-component will include ICT infrastructure and computers for the registration system needed to establish civil registration offices in 1000 woredas, file cabinets to establish civil registration offices at 18,506 kebeles, motorcycles for 1000 zones and woredas, and one vehicle. The detail of each procurement activity is indicated in the Procurement Plan.

- *Procurement of works:* Works are not anticipated at this stage.

Procurement Risk Assessment

46. A procurement risk assessment of the VERA to implement procurement activities for the sub-component was carried out and the overall procurement risk rating is high. VERA did not have much procurement experience in the past. It did not have prior engagement in working with procurement system of the World Bank or other major donor. Its procurement experience is mostly using shopping method to procure small value goods. As is the institutional arrangement in other federal agencies, the Finance, Procurement and Property Administration Directorate is responsible for procurement activates.

47. The main procurement related risks are: (a) procurement function mixed with finance function and weak segregation of duties among staff, (b) inadequate number of experienced procurement staff, (c) poor practice of procurement record management, (d) weak procurement planning and usage, including inefficient packaging of items leading to use of too much shopping, (e) inconsistent use of procurement documents, (f) issuance of inadequate bid preparation period, (g) lack of experience in processing consultancy selection process including lack of exposure to consultancy evaluation, (h) improper application merit point system evaluation for small value goods, (i) limitations in preparing bid evaluation reports, (j) weak complaint handling, and (k) poor contract management system.

48. To address the identified risks the following mitigation measures are proposed: (a) delineate procurement function such that the same staff will not be responsible for procurement process, payment and product acceptance; (b) ensure procurement documents under the project are adequately kept in safe and easily retrievable manner; (c) hire senior procurement officer as member of Project Management Team to be responsible for project related procurement activities; (d) prepare procurement plan with an efficient packaging strategy; (e) ensure accepted procurement documents are used for project procurement activities; (f) ensure adequate bid and proposal preparation period is given for bidders under the project; (g) ensure procurement training is provided to staff dealing with procurement; (h) ensure adequate period is given for bidders to lodge complaints in accordance with applicable provisions; and (i) assign dedicated staff for contract management.

49. **Selection methods:** The following table describes the various procurement methods and thresholds to applicable for the Sub-component 2 procurement activities.

50. **Prior Review:** The project Procurement Plan agreed between the Borrower and the Bank has indicated activities that will be subjected to Bank's prior review based on risk and complexity of activity. This will be updated annually or as necessary during implementation, based on the procurement capacity assessment during implementation support missions and will be reflected in the updated procurement plan as appropriate.

51. **Implementation Support and Post-Review:** Contracts not subject to prior review will be subject to Post review by the Bank as per procedures set forth in "Procurement Oversight" of the Procurement Regulations. The Bank will also carry out regular procurement supervision missions on annual basis.

52. **Monitoring by STEP:** Through mandatory use of Systematic Tracking of Exchanges in Procurement (STEP) by the Borrower, the Bank will be able to consolidate procurement/contract data for monitoring and tracking of all procurement transactions. Using STEP, comprehensive information

of all contracts for goods, non-consultancy services and consultants' services awarded under the sub-component, for all contracts subjected to the Bank's prior-review as well as post-review, will be available automatically and systematically on an annual basis and/or whenever required, including but not limited to: (i) reference number as indicated in the Procurement Plan and a brief description of the contract; (ii) estimated cost, (iii) procurement method; (iv) timelines of the bidding process, (v) number of participated bidders, (vi) names & reasons of rejected bidders, (vii) date of contract award; (viii) name of awarded supplier, contractor or consultant; (ix) final contract value and (x) contractual implementation period, etc.

Table 9: Selection Methods and Thresholds

Method	Market Approach	Procurement method threshold [USD]	Prior review threshold [USD]
Goods / Non Consultancy Services			
Request for Bid (RFB)	Open National	< 1,000,000	≥ 1,500,000
	Open International	≥ 1,000,000	
Request for Proposal (RFP)	Open National	< 1,000,000	≥ 1,500,000
	Open International	≥ 1,000,000	
Request for Quotation	Limited National	< 100,000	NA
Arrangement through UN Agencies	As per Paragraphs 6.47 and 6.48 of Procurement Regulations for IPF Borrowers		
Consulting services			
QCBS	National	< 200,000	≥ 500,000
	International	≥ 200,000	
LCS	National	< 200,000	NA
CQS	National	≤ 100,000	NA
	International	≤ 200,000	
Individual Consultant (IC)	Open / Limited / International / National	NA	≥200,000
	Direct	NA	≥100,000
Arrangement through UN Agencies	As per Paragraphs 7.27 and 7.28 of Procurement Regulations for IPF Borrowers		

53. **Procurement Plan:** VERA has prepared and submitted to the Bank draft Project Procurement Strategy for Development using simplified version. According to the PPSD, the Procurement Plan under the sub-component will include the main activities below. The Borrower shall submit the Procurement Plan through STEP, and it will be disclosed by the Bank to the public - on the World Bank website - when the detail plan is approved by the Bank through STEP. The Procurement Plan will be updated on an annual basis or as needed throughout the project duration to reflect the actual project implementation needs and improvements in institutional capacity. The updated Procurement Plan, as agreed between the Bank and the Borrower, will specify procurement methods and their applicable thresholds, as well as activities that will be subjected to the Bank's prior review, for all packages.

Table 10: Procurement plan for major procurements for Sub-Component 1 and 2 activities

Contract Title, Description and Category	Estimated Cost US$	Bank Oversight	Procurement Approach/Competition	Selection Methods	Evaluation Methods
Technical Assistance and Capacity Building to Support National Nutrition Program II	5,000,000	Prior review	Direct	UN Agency (UNICEF)	Negotiation
Technical Assistance to VERA	800, 000	Prior Review	Direct	UN Agency (UNICEF)	Negotiation
Consulting services for system design to establish web based connectivity at all level, interoperability and software development and training	2,000,000	Prior Review	Open - International	QCBS	Shortlisting
File Cabinet for 18,506 Kebeles in 9 regions and 2 city administrations	4,900,000	Prior Review	Open- National	RFB	Lowest Evaluated Bid
Motorcycles (1000 no)	4,500,000	Prior Review	Direct	UN Agency (UNOPS)	Negotiation
CRVS Specialist – Project Coordinator	120,000	Post Review	Open- National	IC	CV Comparison
Procurement Specialist	120,000	Prior Review	Open- National	IC	CV Comparison
IT Consultant	120,000	Post Review	Open- National	IC	CV Comparison

Annex II: Results Matrix for IPF Component

Sub-Component 1: Civil Registration and Vital Statistics

Indicator	Unit of meas.	Baseline	Target values				Freq.	Data source	Responsibility for data collection
			Year 1	Year 2	Year 3	Year 4			
Percentage of births in a given year registered	%	TBD	5 percentage points from baseline	15 percentage points from baseline	25 percentage points from baseline	40 percentage points from baseline	Annual	VERA administrative data; HMIS & CHMIS / CSA population estimates	VERA, MOH, CSA
Percentage of all deaths in a given year registered	%	TBD	0	0	5	10	Annual	VERA administrative data; HMIS & CHMIS / CSA population estimates	VERA, MOH, CSA
Functional centralized electronic CRVS system	%	0	-	-	-	1	Once	Independent testing of the system	Contractor
Proportion of kebeles visited by woreda supervisors per month	%	TBD	15	25	50	80	Annual	VERA administrative data	VERA
Proportion of documentation cabinets procured, delivered and used for storage of CRVS forms	%	0	0	50	100		Annual	World Bank implementation support	World Bank

Sub-Component 2: Support to National Nutrition Program II

Indicator	Unit of meas.	Baseline	Target values				Freq.	Data source	Responsibility for data collection
			Year 1	Year 2	Year 3	Year 4			
Proportion of woredas with nutrition coordination platform	%	No data	15	30	45	60	Annual	NNCB administrative reports	NNCB (FMOH is secretariat)
Proportion of woredas reporting multisectoral nutrition information to national level	%	No data	15	30	45	60	Annual	NNCB administrative reports /HMIS/ UNISE	NNCB (FMOH is secretariat)
Number of nutrition operational research studies conducted	Number (cumulative)	0	1	2	3	4	Annual	FMOH administrative reports	FMOH (nutrition case team)
Completion of NNP evaluation	One-time	N/A	No	No	No	Yes	Once	FMOH administrative reports	FMOH (nutrition case team)
Number of joint reviews of NNP II carried out	Number (cumulative)	0	1	3	5	7	Annual	FMOH administrative reports	FMOH (nutrition case team)

Annex III: DLI Disbursement and Results progress to date

No	Disbursement Linked Indicator	Total ($ m)	Allocated Credit (SDR m)	Disbursed (SDR m) For results achieved *	Allocated Grant ($ m)	Disbursed ($m) For results achieved*	Progress in DLIs
1.	Deliveries attended by skilled birth provider (%)	20.00	9.8	6.5	5.0	5.0	DLI achieved (SBA=10% in 2011; 16.0% 2014 DHS; 28% DHS 2016). Total disbursement for DLI (SDR 6.5m and USD 5m).
2.a	Children 12-23 months immunized with Pentavalent 3 vaccine (%)	19.00	3.3	3.3	1.00	1.0	Establishment of a baseline for 2013 (=65.7%) achieved for DLI2a. DLI 2a fully disbursed (SDR 3.3 m and USD 1m).
2.b	Children 12-23 months immunized with Pentavalent 3 vaccine (%)		7.2	0.00	2.0	0.00	DLI 2b disbursed SDR 1.79m and USD 250k for prior results. Next disbursement will be completed after the next Cluster survey.
3.	Pregnant women receiving at least one antenatal care visit (%)	14.3	7.8	7.8	2.3	2.3	DLI exceeded the final target of 56% (43% in 2011 to 58.5% in 2014). Total Disbursement for DLI: SDR 7.8m and USD 2.3m. ANC1 = 62 2016 DHS.
4.	Contraceptive Prevalence Rate (%)	20.5	11.7	11.7	2.5	2.5	DLI exceeded the final target of 35% (27% in 2011 to 40.4% in 2014 DHS). Total Disbursements (SDR 11.7m and USD 2.5m). CPR 2016 DHS: 35.
5.	Health Centers reporting HMIS data in time (Average number for 4 quarters)	5.0	3.3	2.0	0.00	0.00	DLIs for both years have been achieved (55% in 2013 to 68% in 2014), disbursed SDR 1.95m.
6.a	Development and implementation of Balanced Score Card approach to assess facility performance and related institutional incentives	20.2	2.0	0.00	2.00	0.00	No disbursement against results for this DLI. Disbursements made to date have been advances (6a: SDR 325k, USD 250k; 6b: SDR 1.95m, USD 500k). Progress was delayed due to decision taken by the Government to change roll out modality for the BSC.
6.b	Upon initial implementation, review and decision on national scale up based on impact evaluation and scaling up to 20 Woredas as envisaged by the Program and		7.8	0.00	3.20	0.00	

	satisfactory to IDA						
7.a	Development and implementation of Annual Rapid Facility Assessment to assess readiness to provide quality MNCH services	14	1.3	1.3	2.0	2.0	The 2013 target met. Total disbursements under DLI 7a consist of SDR 1.3m and USD 2m (DLI7a was for prior result and it was disbursed upon development of assessment protocol).
7.b	Undertaking surveys and disclosing results with actions to address weaknesses		6.5	2.9	0.00	0.00	DLI 7b - a total of SDR 2.9m was disbursed for SPA+ and action plan. SARA undertaken in 2016.
8.a	Upon launching the website disclosing agreed procurement information	7.0	1.3	0.98	0.00	0.00	DLI 8a measures progress in transparency including the launch of a website which would disclose agreed procurement information; and DLI 8b measures the updating of the website procurement information, including issuing open call for pre-qualification of suppliers issued as per the Recipient's Law, and producing price tracking reporting. The 2014 target of a website disclosing agreed procurement information has been achieved. The Bank has cleared disbursement of US$2m. To date, disbursements have been SDR 977k under DLI 8a for results and SDR 813.8k under DLI 8b for advances.
8.b	Upon updating the website with procurement information, issuing open call for pre-qualification of suppliers and producing price tracking report		3.3	0.00	0.00		Website has been updated periodically.
	TOTAL	**120**	**65.1**	**36.4**	**20.0**	**13.8**	

- Total disbursed from IDA including advances is SDR 41.6m; Total disbursed from HRITF including advances is US$ 13.8m.

Annex IV: Program Action Plan Progress to date

	Action Description	Progress Made
1.	Developing and implementing balanced score card approach to assess facility performance and related institutional incentives.	The implementation of the BSC tool has been fully rolled out to all levels, but without a piloting approach that would allow identification of lessons on the impact of incentives on performance at the various levels. These actions under the Program were linked to achievement of DLI#6. Discussion on efforts to link payment to performance show little interest in the Government to expand on this policy direction hence the need to restructure the DLI.
2.	Implementing annual rapid facility assessments to understand health facility readiness to provide essential maternal and child services.	The Service Availability and Readiness Assessment (SARA) survey was undertaken in 2016, after the 2014 Service Provision Assessment Plus (SPA+), and this provided a comprehensive overview of health service delivery. The SPA+ report is finalized and the results were shared during the JRIS (April 2015). The Plan of Action has been developed to address weaknesses identified by the survey in line with Government priorities.
3.	Pharmaceutical Fund and Supply Agency (PFSA) launching/updating its website populated with procurement information including measures to increase competitive bidding.	PFSA has launched a website and is starting to upload procurement information, progress that greatly contributes to improvement in its transparency. Independent verification indicated that the website is launched and most of the agreed information is posted in the first year. However, a previous mission found that the website is not fully complete and during the second year PFSA disclosure was not as expected. The Bank team continues to work with PFSA on further developments of the site.
4.	PFSA launches an open call for pre-qualification bidders as per the Recipient's law at least once.	Actions were agreed in order to improve share of competitive bidding at PFSA. First is to launch an open call for prequalification to establish suppliers list for limited bidding procedures during the second year of program implementation period. The first open call is linked with the DLI and the 2015 payment will be disbursed after confirmation of the open call. The MTR mission discussion with the PFSA procurement directorate was informed that this action is planned in second half of 2016, a committee is established to resolve bottlenecks.
5.	PFSA introducing procurement timelines and price tracking system.	One of the agreed actions under the program is to establish a timely price tracking system at PFSA. Two aspects of data collection are envisaged under this action: (i) procurement process time disaggregated into the different stages of procurement up to final delivery of contract, and (ii) regular recoding of price of items. Previous missions had observed that the establishment of the price tracking system was under progress, and the price tracking was established at a basic level. The procurement directorate has developed a contract register format and had started recording contract details including prices of items and when procurement occurs. The MTR noted the data on price is more advanced and includes data starting from 2010. PFSA will continue to collect price data as a streamlined process, and was advised to produce useful analytical reports to guide decision making during planning and award decision making.
6.	Separating the procurement and distribution process for purposes of improving advance settlement & processes accountability; aging analysis to be prepared every quarter to monitor delays; once the procurement cycle is completed and goods are delivered at PFSA the advances will be liquidated in the books of account. A monitoring mechanism of delivery to ultimate beneficiaries will be developed separately.	A monitoring mechanism of delivery to ultimate beneficiaries will be developed separately. Supervision has confirmed that the procurement and the distribution processes have now been separated and advances are now being settled with MOH once the procurement process is finalized. However, according to the performance audit conducted by OFAG, the distribution mechanism needs further strengthening.
7.	Exchange rate will be applied on the basis of actual rate of transfer while reporting expenditures to minimize reported exchange losses. A reconciliation will be completed to adjust actual foreign exchanges losses/gains and accounting losses/gains.	The Bank has confirmed that there is no actual gain /loss that arises in the transactions of PFSA with MOH since all payments and transfers are made in foreign currency. The gains/losses that are shown in books are not actual gains and losses, rather currency translation differences which arise due to differences in currency of reporting. Accordingly, there will be no more action required from both MOH and PFSA in this regard.
8.	Audit Services Corporation completing the pending audits of PFSA.	The backlog audits of PFSA have only been partially cleared despite extensions of their due date. The Audits for EFY 2001, 2002, 2003, and 2004 are completed and

		the reports were shared with the Bank. As this continues to be a challenge, the Bank technical and FM teams will support the Government in identifying other options for completing the audit including use of alternative auditors.
9.	PFSA and FMOH having adequate professionally qualified and trained staff for internal audit.	PFSA has prepared a skills and training needs list; however, previous missions confirmed that limited resources are a main concern. PFSA needs to acquire the required resources towards procurement skill development of its staff. Various efforts to boost the skills at the Internal Audit Directorate of the MOH have not been able to sufficiently fill the gaps, and despite the deployment of additional staff, the workload remains quite large. The quick turnover of the civil servants remains a challenge in all sectors.
10.	FMOH through appropriate consultation to consider establishing Fiduciary Subcommittee of JCCC to monitor budget performance of SDGPF, advances, reporting, procurement and audit issues.	There is consensus among SDG PF partners that there is no need to establish standing subcommittees under the Joint Core Coordinating Committee (JCCC) as the JCCC deals with operational and technical issues.
11.	FPPA undertaking annual procurement audit and Finance FMOH and Bank team to consult OFAG on the feasibility of undertaking financial and value for money audits for SDGPF.	The Financing Agreement stipulates that procurement activities under the program should be audited annually and the audit reports should be shared with the Bank not later than six months after the end of each fiscal period. Since the start of the project, the Bank has received the first audit report done on PFSA for FY2011/12 (ET 2004) which was sent on 14 March 2014. The report was, however, written in Amharic and so it was not possible to do a formal review. The Government was informed about the need to send to the Bank the audit report written in English. Since then the Government has shared procurement audit report on procurements during FY 2013/14 and FY 2014/15 (ET 2006 and 2007)
12.	PMU, FMOH awarding civil works contracts for construction of the health centers through competitive bidding and FMOH improves tracking and recoding system for procurements undertaken through UN agencies.	The fiduciary assessment for the project had noted that civil works contracts for construction of health centers were being awarded through direct contracts to selected contractors. As part of the Project Action Plan, it was agreed that civil works contracts for health centers will thenceforth be awarded through competitive bidding procedure. The FMOH counterparts reported during the past mission that the practice of direct contracting has ceased and currently works contracts for construction of health centers are awarded through open competition bidding by respective regional health bureaus.
13.	Federal Ethics and Anti- corruption Agency (FEACC) sharing allegations of fraud and corruption and actions being taken with the Bank.	The MTR mission noted that the Bank is not aware of allegations of corruption that have been raised in relation to the SDGPF.As part of the ACG of the agreed PforR program, Federal Ethics and Anti-Corruption Commission (FEACC) and Federal Ministry of Health (FMOH) is committed to fulfil the governance requirement. These commitments include: (i) sharing of information on fraud and corruption allegations with the Bank on the program; (ii) adhering to the Bank's debarment list of firms and individuals; and (iii) the Bank's independent right to investigate corruption under the program.
14.	All Health facilities establishing and operating infection prevention and patient services committees. 15. Availing appropriate temporary storage facilities for collection of hazardous wastes till final disposal is done. 16. Documenting consultations and participatory nature of discussions where communal land is used for construction of health centers and where applicable compensation for land and livelihood paid. 17. Documenting outreach and specific actions focused on providing services to all vulnerable persons.	The Directorate for Pastoral Health Promotion and Disease Control, is responsible for coordinating health initiatives in the four regions that need additional attention (i.e., Afar, Benishangul-Gumuz, Gambella, and Somali) as well as for environmental health, hygiene and sanitation activities at the national level including joint initiatives with the Ministry of Environment, Forest and Climate Change. It is important to note that the functions of this Directorate have now been distributed across various units including HSS, WASH and CASH teams that are responsible for the original actions. Due to the fact that Afar, Benishangul-Gumuz, Gambella, and Somali meet the characteristics of the groups noted in Core Principle 5, it was agreed that to preclude any environmental and social risks, the Program will provide more information on how the program's activity is linked to equity goals of this Core Principle and/or how the program is paying special attention to the cultural appropriateness of, and equitable access of the Program benefits to these groups, considered as underserved groups. The lack of an effective institutional mechanism for coordination and reporting on environmental and social safeguards remains a challenge The MoH will designate a focal person/unit responsible for coordination and reporting on environmental and social safeguards, and it is included as specific action in the PAP for this AF.

Annex V: Summary of Technical Assessment Update

1. The update to the Technical Assessment builds on the original assessment prepared in 2012 and addresses additional areas to be supported by the Additional Financing (AF) for the Ethiopia Health Millennium Development Goals Program for Results (PforR). The assessment focusses on the strategic relevance of this support, the technical soundness, and the governance structure including the country partnership platform and utilizes the most recent data.

Changing Sector Context

2. Ethiopia is one of a few countries in Sub-Sahara Africa that has made consistent progress towards the achievement of the Health Millennium Development Goals, in particular in child and maternal health. While significant challenges remain, between 2000 and 2016, child and maternal mortality have significantly improved (see Table 1). Among other indicators, the proportion of women assisted by skilled birth attendants during delivery is low but increasing (5 percent in 2000 to 16 in 2014 and 28 percent in 2016). The proportion of births that take place in a facility has also steadily increased, from 16 in 2014 to 26 percent in 2016.

3. The progress is a result of two decades of a continued strategic framework, implemented through the Health Sector Development Program 1996 – 2015, followed by the ongoing HSTP. This framework is a key component of the overall development agenda of the country, established in Ethiopia's Growth and Transformation Plans (GTPI and II). The Government has committed to prioritize human development and allocate resources to high-priority primary health care interventions. Current health achievements have also relied on a robust community-based approach built upon an extensive network of health workers- the Health Extension Program and the Health Development Army.

Table 1. Progress of Key Health Indicators

Key Indicator	2000 DHS	2005 DHS	2011 DHS	MDHS 2014	2016 DHS
Infant Mortality Rate (per 1000 live births)	97	77	59	-	48
Under Five Mortality (per 1000 live births)	166	123	88	-	67
Total Fertility Rate (per woman)	5.9	5.4	4.8	4.1	4.6
Maternal Mortality Ratio (per 1000 live births)	871	-	676	-	412
Antenatal Care from a skilled provider (%)	26.7	27.8	33.9	41.2	62
Antenatal Care from a Skilled Provider 4 visits (%)					32
Children receiving penta3 by 12 months of age (%)			34.7	-	53
Children under 6 months exclusively breastfed (%)	55	49	52		58
Children under five stunted (% below 2 SD)		51.3	44.4		38
Contraceptive Prevalence Rate (%)		13.9	27.3		35

5. However, rapid population expansion sets significant challenges for the health system and the economy. In spite of increasing contraceptive prevalence rate (from 8 percent to 35 percent between 2000 and 2016), and declining fertility (from 5.9 to 4.6 children per woman between 2000 and 2016), the population is expected to increase to over 140 million people by 2050 (of which young people are expected to comprise over 50%), mostly due to previous high fertility rates. The population growth must be matched with a stronger capacity to respond to a higher demand for health and education services in order to produce healthy and skilled young workers, and to generate job opportunities accordingly.

6. Given that age at sexual debut is still quite young, and married adolescents have the highest unmet need for contraception for spacing purposes and are among the highest proportion of women with total demand for family planning, focused and need based services for adolescents are critical.

Therefore, readiness of facilities and skills of health care workers to be sensitive to and provide services for this age group is critical.

Equitable Access to Quality Services

7. The Government's Health Strategy notes that despite notable sector achievements, access to quality health services remains unequal, both geographically and socio economically. For example, for skilled birth delivery, a gap of 50 percentage points remains between the poorest and the wealthiest. In 2016, the national level of skilled birth attendance is at 27.7 percent nationwide but ranges from 16.4 in Afar to 97 percent in Addis a difference of about 80 percentage points. With respect to regional differences, the current use of contraception in Addis Ababa is 64.1 percent while in the Somali Region it is 1.7 percent (which reflects the combined effects of demand side barriers to family planning as well as availability of services), while data show also high inter-woreda inequalities especially in SNNP, Amhara and Oromia.[41]

8. The quality of services, partially measured by availability of basic equipment, drugs and range of services provided, remains a major challenge. For example, assessment of the availability of the 8 tracer items in facilities, such as trained staff and guidelines, equipment, medicines and commodities, shows that only 7 percent of facilities have all eight. Only 23% of the facilities have the capacity to conduct Hemoglobin test, a basic test during Antenatal Care visits, with significant geographical differences (2 percent in Gambela vs. 54 percent in Addis Ababa).

Women and Children's Nutrition Outcomes

9. Malnutrition continues to be high due to limited improvements on key multisectoral determinants such as food security, diversity of diets, feeding practices, healthcare services, water and sanitation. In 2016, 44 percent of children under the age of 5 suffer from chronic undernutrition and 24 percent are underweight. Although stunting decreased from 58% to 40% between 2000 and 2014, it remains highly prevalent, particularly in rural areas (40 percent versus 25 percent in urban areas). Micronutrient deficiencies are high due to poor dietary diversity, high incidence of infectious diseases, and sub-optimal child care and feeding practices (only 52 percent of children under 6 months were exclusively breastfed). Chronic malnutrition among women (15–49 years) is relatively high, with no significant progress over the last decade.

10. Poor nutrition has impacted negatively educational attainment, workforce productivity and economic progress. A recent study showed that 16 percent of all repetitions in primary school are associated with stunting and that stunted children achieve 1.1 years less in school education compared to non-stunted children. Child mortality associated with undernutrition has reduced Ethiopia's workforce by 8%. The annual costs associated with child undernutrition are estimated at 55.5 billion Ethiopian birr (ETB), the equivalent to 16.5% of GDP.[42]

11. In 2013, the Government revised the first National Nutrition program to take into account the multidimensional nature of nutrition, and it was endorsed by the Ministry of Agriculture, the Ministry of Health, and other eight line ministries. The Government of Ethiopia has developed the second phase of the National Nutrition Program (2016-2020), with the goal of ending child undernutrition by 2030. It includes strategic objectives to strengthen implementation of nutrition-related interventions across multiple sectors, such as agriculture, water, and social protection, and to improve nutrition coordination and capacity building.

[41] Mekkonen Y; Family Planning in Ethiopia: An Analysis of Successes, Challenges and Future Direction; World Bank, Ethiopia, May 2016 (Draft)
[42] WFP2012: The Cost of Hunger in Ethiopia.

Gender Dimensions Affecting Health Outcomes

12. Ethiopian women are vulnerable to harmful traditional practices such as early marriage, abductions, forced marriages, female genital mutilation, as well as economic, physical, psychological, and sexual violence. Domestic violence in Ethiopia has been acknowledged to be of great concern. DHS 2016 shows that more than 35 percent of ever married women have experienced physical, emotional or sexual violence from their husband or partners – 24 percent experienced emotional violence; 25 percent physical violence and 11 percent sexual violence. This is higher among older women; formerly married women; living in rural areas and with a regional variation (higher in Oromia, Amhara and Harari).[43.]

13. The legal age at marriage in Ethiopia is 18 years for both males and female but in 2016, 30% of women aged 25-49 are still married by age 15. Female Genital Mutilation persists across socio-economic groups and an estimated 23.8 million Ethiopian girls and women are subjected to the practice.[44] In recent years, the Government, along with Civil Society Organizations working in the country, has made a concerted effort to address the widespread practice, including several legal and policy changes such as the revision of the Criminal Code in 2005, which explicitly outlawed Female Genital Mutilation and tracks information through the Demographic Health Survey and the Multiple Cluster Indicator Survey. Obstetric Fistula is another condition widely affecting women in Ethiopia. The World Health Organization estimates that at least 8,000 Ethiopian women develop new fistulas every year. This is a result of multiple factors such as prolonged and/or obstructed labor, practices like early marriage and teenage pregnancy, low socio-economic status and high illiteracy rate among women, malnutrition, scarcity of healthcare units in rural areas and a low rate of skilled care during and after pregnancy and delivery. In 2014, a five-year strategy to eliminate obstetric fistula was launched by the Government of Ethiopia in collaboration with NGOs both local and international.[45]

Health Financing

14. Insufficient health financing continues to be a barrier to Universal Health Coverage. Government Health expenditure has been increasing but remains low as share of total Government expenditure (5.6 percent), and total health expenditure (15.6 percent). Although per capita health expenditure has increased from US$16.9 in 2007/08 to US$28.4 in 2013/2014, it is below the US 32.2 target set out in the Strategy and the WHO-recommended target of US$ 86 required to provide a basic package of health services in low-and-middle income countries. Out-of-pocket payments remain higher (34 percent of Total Health Expenditure in 2013/14) than most countries in the region and constitute a major access barrier for the poor and present elevated risk of impoverishment. According to LSMS 2016, 56 percent of those that did not seek care cited cost of care as the reason for not consulting a care giver.[46] [47]

15. The Government has developed the draft of the second health financing strategy which proposes a major shift in the health financing architecture. This will entail a move away from out-of-pocket payments to health insurance for all Ethiopians. This requires: completion of a Health Care Financing strategy, rolling out of Community Based Health Insurance and Social Health Insurance; building institutions and capacity in health insurance functions such as purchasing, targeting, resource mobilization, economic analysis, health care management, financing, at all levels and engaging the

[43] Ethiopia DHS, 2016; Key Indicators
[44] Bayene H; Final Report; National Assessment: Ethiopia Gender Equality and Knowledge Society; SIDA December 2015
[45] Sonny I; Married as Children, Women with Obstetric Fistulas Have No Future: PRB
[46] Reference period is four weeks before the survey
[47] Central Statistical Agency. Living Standards Measurement Survey. 2016. LSMS Integrated Surveys if Agriculture Ethiopia Socioeconomic Survey (ESS).

private sector and civil society organizations in support of the efforts of mobilizing domestic financing and improving access to quality health services.

The Government's Program

16. Similar to other countries undergoing epidemiological transitions, Ethiopia is facing a triple burden of diseases consisting of communicable and non-communicable diseases, and injuries. This burden, coupled with the ever increasing demand for health services, urges the Government to be increasingly focused on addressing equity in access to health care, quality in health services provision and in strengthening community engagement. On the supply side, key health system barriers are: Shortage of Human Resources for Health; inequitable distribution of health facilities, with the majority located in urban areas; poor quality services, including insufficient medicines and supplies; and inadequate and unsustainable financing. On the demand side, challenges relate to socio-cultural beliefs and practices, knowledge gaps, affordability barriers (attributed to poverty and relatively high costs of services) particularly in the most remote areas of the country. To address these challenges, the HSTP proposes a shift in the status quo to drive improvements at the national scale over the next five years. To that effect, a national health care quality strategy will guide investments towards safer, more effective, accessible, and equitable care. It sets ambitious targets for nutrition, maternal and child health outcomes to be achieved by 2020.

The Health Sector Transformation Plan 2015-2020

17. The Government has shown steadfast commitment to improve the health of its population as a core pillar of the overall country development process. In line with its overarching development strategy, the Governments' program defined under the HSTP identifies key challenges facing the sector and strategies to address systemic bottlenecks. It sets out ambitious targets on key health outcomes as well as directions on how to attain health goals under the GTPII. The HSTP has a well-defined results chain linking the inputs to the outcomes envisaged and how these outcomes contribute to the Sustainable Development Goals and GTP II results.

18. The HSTP renews the strong priority given to Reproductive, Maternal, and Child Health and Nutrition. It sets ambitious targets for nutrition, maternal and child health outcomes to be achieved by 2020, which would ensure it is on track to achieve its commitments under the SDG agenda. One of the strategic initiatives identified to help achieve the outputs is high impact interventions of Reproductive Maternal and Child Health, nutrition, prevention and control of communicable and non-communicable diseases.

19. A cornerstone of HSTP is the focus on quality and equity- planned as an iterative process requiring careful supportive supervision and tracking of performance. The HSTP establishes goals in terms of improving equity, coverage and utilization of essential health services, quality of health care, and enhancing implementation capacity of the health sector at all levels of the system. The focus on quality and equity requires a shift in the status quo to drive improvements at the national scale over the next five years. To that effect, a national health care quality strategy will guide investments towards safer, more effective, accessible, and equitable care.

20. The HSTP also aims to achieve Universal Health Coverage[1] through a combination of health systems strengthening and financial protection measures to cover the majority of households by 2020. The Government's Universal Health Coverage agenda aims to ensure that sector financing transitions in a responsible manner from donor financing to a sustainably financed domestic system. The Government has recently developed a second Health Financing Strategy to guide the country's progress towards Universal Health Coverage and Sustainable Development Goals. The draft Health Financing

Strategy proposes Social Health Insurance for the formal sector and Community-based Health Insurance for the informal sector, as the main mechanisms to increase financial risk protection and contribute towards increasing domestic resources for health. The Government plans to launch the Social Health Insurance implementation among the formal sector in the near term and has developed a strategy to scale up Community Based Health Insurance among the informal sector and rural residents. Community Based Health Insurance schemes were first piloted in 13 woredas and the country aims to scale up Community Based Health Insurance coverage to 80 percent of the woredas by 2020.

21. The Strategy was prepared with the joint participation of all stakeholders including Regional Health Bureaus, Civil Society Organizations, academia and partners and it was extensively discussed in the Joint Assessment of National Strategy, with the participation of all health partners supporting Ethiopia's health sector (May-June 2015).

22. The identified program continues to effectively harmonize support from its development partners, as a signatory of International Health Partnership Compact is an exemplar in mobilization of resources in support of Government priorities. The Sustainable Development Goals Performance Pooled Fund continues to be supported by 11 development partners under the management of the Federal Ministry of Health.

23. The HSTP continues the strong focus on results and sector goals as defined under previous Government priorities and the latest GTPII which has put greater emphasis on equitable access to quality health services. The HSTP addresses the country's ambition to ensure universal access to health care and building a health system that is able to meet the needs of a middle income country. Over the years, strong leadership of the FMOH has resulted in strong support from the partners. Their participation in the review of the draft HSTP in June 2015, and their continued participation in the Joint Core Coordination Committee and Joint Coordination Forum as well as other fora is a testimony to that commitment.

24. To achieve these targets, the HSTP defines specific strategic: 1) High impact interventions of Reproductive Maternal Neonatal Child Adolescent Youth Health, nutrition, prevention and control of communicable and non-communicable diseases, 2) Initiatives to improve quality and equity, 3) Education and information to build culture of health, safety and resilience at all levels; regular risk assessment and early warning; emergency preparedness for effective health system response and recovery at all levels; 4) Roll out the second generation health extension program, certificate of competency evaluation of households based on Health Extension Program standards; self-reliance movements; health literacy and health systems literacy of the public; rollout and expansion of the Health Development Army; 5) Financial management, transparency and accountability development program; regular financial and performance audits; efficiency gain; efficient facility revenue utilization; implementation of Social Health Insurance and Community Based Health Insurance; 6) Strengthening multisectoral coordination and regional and global partnership; and, 7) Enhancing leadership capacity; establishing public health leadership incubation center; accountability and transparency; community representation at health facility governing boards and regular town hall meetings and public conferences.

25. Accompanying the overarching HSTP are various sub-sector guiding documents such as the: 1) The Human Resources Strategy (specific guidance on human resources challenges, including paths towards enhanced equitable, quality and universal coverage of high-impact interventions and focusing on reaching remote, vulnerable and poorest population); 2) The draft National Reproductive Health Strategy 2016-2020 (focused attention on reproductive health initiatives); and, the draft, National Adolescent Health Plan- Priorities and Actions in Adolescent Health: Health Service Landscape in Ethiopia

Costing of the Government's Program

26. The Government's Program is guided by the HSTP (Health Sector Transformation Plan) that aims to address a comprehensive list of challenges in the sector including: i) Quality of Care; ii) Equitable Access to Health Care Services; iii) Non Communicable Diseases; iv) Health Management Information System; etc. The costing of the Program was prepared under two scenarios: i) The base case scenario costing assumes achievement of comparatively more modest but realistic targets set in Government Program for the coming five years; and ii) The best-case scenario which has more ambitious targets and requires much higher human resources capacity and infrastructure requiring higher investment.[48]

27. Under the base case scenario, the total cost of implementing the Government Program between 2015 and 2020 is an estimated US$15.6 billion; while under the high case scenario the cost is US$22 billion, the difference between the two estimates is due to the higher costs of infrastructure; human resources and medicines supply under the high case scenario. Projected Government allocation to its program is US$8 billion and Development Assistance is US$4.3 billion, there is an estimated gap of US$3.3 billion under the base cost scenario. The funding gap on Reproductive Health (2016-2020) requires US$2.35 billion, this shows the need for intensified efforts to mobilize resources for Reproductive Maternal and Child Health to address preventable maternal and child deaths and reduce inequalities. The proposed AF will include the GFF in support of the HSTP.

28. The Government has identified various channels to address the financing gap under its Program, including the roll out of health insurance schemes that could raise a total of US$409 million through social health insurance, while Community Based Health Insurance could generate US$376 million. Other channels that could be used to address the financing gab are listed in Table 1 and include resources flowing through channel 3 that are managed through implementing partners which is a substantial part of health financing. As part of its Health Financing Strategy the Government is also exploring innovating financing mechanisms; enhancing efficiency gains especially on procurement, supply management and human resources productivity and evidence based planning.

Program Strategic Relevance and Technical Soundness

Strategic Relevance

29. The programme supported by the AF to the PforR operation has a strong strategic rationale as it aims to address priority health concerns as established in the HSTP. One of the key concerns is the lack of equitable access to basic priority health care services for women and children. As a signatory of International Health Partnership Compact, Ethiopia's program continues to effectively harmonize support from its development partners. The Sustainable Development Goals Performance Pooled Fund (the Pooled Fund) continues to be supported by 11 development partners under the management of the Federal Ministry of Health.[49] The HSTP continues the strong focus on results and sector goals as defined under previous Government priorities and the latest GTP II which has put greater emphasis on equitable access to quality health services. Their participation in the review of the draft HSTP in June 2015, and

[48] Base Case scenario for MMR=420/100,000 by 2020 compared to 199/100, 000 by 2020 in the high case scenario. CPR targets under Base Case scenario is 55% by 2020 compared to 65% under HC scenario. Reduce IMR from 46.4/ 100, 000 to 19.33/100, 000 compared to reduction to 16.7/ 100, 000 live births by 2020 under high case scenario.

[49] UK DFID, UNICEF, EU, GAVI, Netherlands Government, Spanish Development Cooperation, UNFPA, Irish Aid, WHO, Italian Cooperation and the World Bank. Millennium Development Goals Pool Fund was renamed Sustainable Development Goals Pool Fund.

their continued participation in the Joint Core Coordination Committee and Joint Coordination Forum as well as other fora is a testimony to that commitment.

Soundness of Technical Approach

30. The design of the HSTP is based on international experience of factors and strategies to effectively tackle the identified challenges, adapted and refined from the experience of the past decades of implementing previous strategies. The HSTP has three key features - quality and equity, universal health coverage, and transformation- and four pillars of excellence which are designed to help the sector to achieve its mission and vision by building excellence in: 1) Health service delivery; 2) Quality improvement and assurance; 3) Excellence in leadership and governance; and 4) Excellence in health system capacity. These four areas of excellence are further decomposed into fifteen strategic objectives categorized under two driver perspectives (Business Process; Learning and Growth) and two results (community perspective and financial stewardship).

31. The HSTP reaffirms that Primary Health Care remains at the core of the health system, it also builds on the success gained and strives to meet increasing demand of the population as well as coverage of high impact interventions through the second generation of Health Extension Program.

32. The HSTP has the critical building blocks required for a program that can deliver results:

- A technically sound and costed strategic plan well aligned with Ethiopia's Growth and Transformation Plan II and Sustainable Development Goals, and validated by Joint Assessment of National Strategy tool developed under the International Health Partnership Plus –WHO. It also has well-established processes and tools for evidence-based planning and efficient use of resources on a sustained basis;
- Clearly defined and costed set of evidence-based interventions supported by a results framework with a multi-year financing plan (two scenario developed for estimating resource requirements for the implementation of the HSTP);
- Highest level political commitment to achieve health Sustainable Development Goals;
- Clearly-defined governance structures involving key stakeholders; and strong donor coordination and aid harmonization governed by the International Health Partnership Plus compact; previous Sector Strategies harmonization manual, and Joint Financing Arrangement.

Human Resources for Health

33. The shortage of skilled human resources for health (especially for child, maternal and reproductive health), its uneven distribution, and rapid turnover are major barriers to achieve Sustainable Development Goals. The ratio of Health professionals to population has increased from 3 per 10,000 population in 2009 to 7.6 per 10,000 in 2014 (WHO recommends more than 23 health care professionals per 10000 population). Ethiopia has given priority attention to addressing the human resource shortages through greater number of universities, and hospital based colleges (both public and private). Specifically, the number of medical schools has risen to 33 and public midwifery schools have reached 49. Such shortages are more acute for medical doctors, midwives, nurses and specialists, especially obstetricians and anesthetists. The population ratio stood at one for 58, 290 which is quite low compared to World Health Organization standard of 1for 10,000 population. (Health and health indicator 2013/2014). Further, health staff, particularly doctors, unevenly distributed favoring urban areas than are rural and pastoral areas. The FMOH is using several strategies to motivate and retain health staff. These include: (a) Public service after graduation; (b) Financial incentives for highly critical staff including housing, salary top-ups; and (c) Training opportunities for those working in rural and pastoral

areas. Skills gaps are being addressed through competency based training in midwifery and introduction of new training in emergency obstetric and surgical care for health officers.

34. Part of the skills shortage has been compensated through alternative approaches. Through the Health Extension Program and the Health Development Army which brings together groups of women to mobilize the community to promote healthy behavior, access to Primary Health Care services has significantly improved, particularly for the rural poor. Currently, 40, 000 Health Extension Workers provide services, mostly in rural areas, complemented by 440, 000 Health Development Armies groups. Under the HSTP, the Government plans to expand the network of Health Extension Workers and the Health Development Army to reach a larger rural population, especially in emerging regions where pastoralist and migratory populations require a tailored approach and modality.

Institutional Environment

35. The proposed AF to the PforR operation will use existing institutional and implementation arrangements under the original program. Ethiopia follows a decentralized Federal structure of administration and the Constitution provides for shared responsibility for health policy making, regulation and service delivery between the FMOH, Regional Health Bureaus and woreda Health Offices. The FMOH restructured its functional departments and directories following the nationwide health sector reform and Business Process Reengineering (BPR). The three General Directorates were disbanded and function based new Directorates established under the Office of the Minister and the State Ministers. Policy, planning and M&E, Medical Services General Director, Public Relations, Audit and Compliance under the Office of the Minister.

36. There are five authorized agencies under the FMOH with specific mandates and they are appointed by the Prime Minister and report to FMOH, MOFEC, and Board of Directors. These include: i) The Food, Medicine and Health Care Administration and Control Agency (FMHACA); ii) The HIV/AIDS Prevention and Control Office (HAPCO); iii) The Ethiopian Public Health Institute (EPHI) under which the International Institute for Primary Health Care in Ethiopia is currently placed; it is mandated for short term training courses for designing and strengthening Primary Health Care programs, carry out needs based implementation research on Primary Health Care and community based health programs; and serve as a resource center to Ethiopia health sector and beyond; iv) The Pharmaceutical Fund and Supply Agency; and v) The Ethiopia Health Insurance Agency.

37. For certain priority issues, the Government of Ethiopia has established multisectoral coordination mechanisms. Nutrition policy issues are coordinated and monitored by the National Nutrition Coordinating Body, chaired by the State Minister of the Federal Ministry of Health and co-chaired by the State Ministers of Agriculture and Education. Additional sectors in the National Nutrition Coordinating Body include Finance and Economic Development; Water and Energy; and Women, Children and Youth affairs. This nutrition coordination structure extends from sub-district level up to Regional level through layers of coordination bodies consisting of representatives across several key sectors.

38. The FMOH will be responsible for planning, budgeting and reporting funds released from the Pooled Fund, through which IDA funding will be disbursed under the AF to the PforR operation. The Joint Consultative Forum chaired by the FMOH and co-chaired by one of the partners in the sector will continue to be the highest body for dialogue on sector policy and reform issues between Government of Ethiopia its partners and wider stakeholders.

Governance Structures and Institutional Capacity

39. There are well established governance structures at different levels of the Ethiopian health system to effectively plan and use resources. The Government's strategies have aimed to rationalize these structures and improve overall governance in the health sector to ensure effective harmonization as well as better accountability. The International Health Partnership Plus also provides strong impetus for this. The Joint Consultative Forum chaired by the Minister of Health and co-chaired by the lead partner in the sector is the highest body for dialogue on sector policy and reform issues between Government of Ethiopia, its partners and wider stakeholders (with representation of Regional Health Bureaus). It oversees the allocation, implementation and use of the Pool Fund and non-pool fund resources to ensure the effective linkages between programs. The Joint Core Coordinating Committee is the technical arm for the Joint Coordination Forum and provides operational oversight and monitor the implementation of all pooled and non-pooled funds provided by partners to the health sector. It is also responsible for supporting the Policy and Planning Directory in organizing and coordinating monitoring and evaluation of the program as well as facilitating relevant meetings and missions including technical assignments recommended by Joint Coordination Forum.

Citizens Engagement in the Health Sector

40. The HSTP puts citizens at the center of the Government's strategy to improve health service delivery at the community level. The Technical Assessment Update carried out for the AF shows that citizen engagement and social accountability mechanisms exist in several aspects of service delivery in health. Patients, communities, providers and health authorities engage on a continuous basis and some beneficiary feedback is flowing between the different stakeholders. However, the assessment found that while systems are in place and cover both upstream and downstream engagement, these are ad-hoc and mostly conducted orally. The lack of documentation on functionality of engagements between service providers and the citizens, as well as management of related grievances and acknowledgement of agreements reached during these engagements makes it difficult to assess the nature and the extent to which grievances are resolved, or potential problems are left undiscussed or unresolved at every level (national, regional, zonal, woreda, Kebele level). Therefore, one of the key area for improvement is to systematically record discussions, grievances and agreements at every level and the way these are addressed with some basic performance measurement of monitoring grievances management.

41. Although targeting all basic sectors including the health sector, current social accountability tools and other citizens' engagement mechanisms supported through PBS3 (FTA, GRM and ESAP II) and ESPES are contributing to achieve significant results to address quality and equitable access issues in health service delivery in woredas where the health sector is covered. The power of these approaches lies in their complementarity as they address both the supply and demand side of citizen engagement. In the health sector, preliminary results of ESAP II have shown that such mechanisms have initiated a behavioral change for citizens and providers (more respectful and ethical patient-health worker relationship); they have strengthened patients and providers' ownership of health facilities based on a better understanding of budgets, service standards, linkages with policies; and they have contributed to better service delivery (greater availability of essential drugs, higher staff attendance, joint community-Government mobilization of resources for the renovation of facilities, etc.). Posting of budget and expenditure information which includes basic service sectors including health has continued in more than 95 percent of woredas. The pre-budget discussion forum which has been designed to identify and prioritize community needs at the local levels before budget is allocated and help citizens to voice their concerns during the planning and budgeting process of basic services including health have started in 37 percent of woredas in FY 2008 (2015/2016) and this is expected to increase in the coming years. More than 60 percent of basic service facilities including health centers are now posting their plans and performances to enable citizens understand the type of services that they provide.

Assessment of Monitoring and Evaluation Arrangements

42. Assessment of the Monitoring and Evaluation arrangements found that Ethiopia has multiple data sources that can be used to effectively monitor and evaluate results under the PforR. The proposed AF will draw on most of the original data sources used to monitor results, and will add sources of data that will become available during the course of implementation: Health Management Information System; population-based surveys (Demographic and Health Surveys) and population censuses; health facility surveys (Service Availability and Readiness Assessment; and SPA+); disease and behavioral surveillance systems; a newly launched civil registration and vital statistics system; financial and management information systems; and research studies. Part of the Government's agenda (supported by various partners) includes advancing data collection, aggregating reporting and analysis, and promoting the use of information for decision making, harnessing IT and improving access and feedback systems, in particular community Score Cards.

Civil Registration and Vital Statistics (CRVS)

43. Prior to 2012, Ethiopia did not have a legal and administrative structure to undertake civil registration of births, deaths and other vital events, though the 2005 DHS established that 6.6% of children had their births registered, only 1.3 percent had birth certificates. The legislative framework governing civil registration in Ethiopia, was issued in 2012, making the registration of vital events compulsory in the country. Through the Ministry of Justice, Ethiopia has subsequently established the Federal Vital Events Registration Agency (VERA). VERA became operational in 2013 and the official registration of vital events in the country was launched in August 2016. Registration takes place at kebele, the lowest administrative area in the country. There are a total of 16,475 kebeles, some of which have weak physical infrastructure, particularly those in rural areas. The registration process started with a manual paper-based system, to be computerized progressively from the federal office to the regional and local offices.

44. To date the registration of vital events is still very low and no vital statistics has been generated from the civil registration system. Ethiopia has prepared a costed strategic plan to guide improvements that are required to strengthen CRVS in Ethiopia. The key strategic areas include - the establishment and development of the registration of vital events and associated services at all administrative levels; effective coordination mechanism among stakeholders; information, education and communication program; demand creation programs for vital events records; improving and strengthening data collection, production and use of vital statistics; building sustainable institutional capacity for a CRVS system; establishing effective technological environment; and managing, coordinating and monitoring the implementation of the Strategy and Action Plan. The Additional Financing will support CRVS activities undertaken by VERA and FMOH for notification of events.

Health Management Information System, Surveys and Censuses

45. Several information sources are used in the country. Ethiopia has maintained a comprehensive electronic Health Management Information System since 2008 to capture and provide core health indicators used to improve the provision of health services, with the ultimate goal of improving the health status of the population. In 2014, almost all public hospitals (98 percent) and 87 percent of health centers had implemented the HMIS in the country.[50] However, in 2014, only 72 percent of source

[50]http://www.moh.gov.et/documents/26765/0/Health+and+Health+Related+Indicators+2005+E.C/1b5b2a9f-a960-4024-8d92-519195364023?version=1.0

documents were available of which 5 percent were completely recorded. There was an HMIS focal person in 62 percent of facilities and computers were available in 75 percent of facilities. Since 2000, Ethiopia has been undertaking standard DHSs almost every five years (2000, 2005, 2011 and 2016), but to meet demands for data, the Government has undertaken a mini DHS in 2014 and will do so again in 2018, which will allow for the monitoring of progress made in the DLIs. The 2016 DHS results have been used as baseline data source for several DLIs (on deliveries, pregnancy care, immunization, contraception, etc.) for the AF. Health facility surveys have been undertaken in Ethiopia in 2005, 2014 (SPA+), and most recently in 2016 (SARA) and the results will be used to complement information from the DHS.

46. Finally, Ethiopia has undertaken three population and housing censuses in 1984, 1994 and 2007, following the United Nations standards for undertaking censuses. Census will provide key information for health, including population data required for the calculation of health indicators, and will provide sampling frame for surveys such as the DHS. Plans are underway to undertake another census in 2017.

Technical Risks

47. The overall risk rating for Ethiopia is rated high due to the current political situation in the country that could impact the country program more broadly. Since the Health Millennium Development Goals PforR disburses directly into a Pool Fund managed at the Federal level, the current situation might not have an immediate effect on the implementation of the program itself as the Government still has flexibility to shift resources. However, if current crisis continues or there is an escalation and spread, the current outcomes and results of the health sector will not be sustained, and the implementation of the program as well as the related disbursements will be affected.

48. The technical risks for the program are rated moderate and include: 1) Human resources for health: distribution and skill mix of Human Resources for Health continues to be uneven with high turnover exacerbating inequalities; 2) Inconsistent Data Quality undermines the reliability of program progress and impact, as well as disbursement; 3) Fiduciary risk including completeness, timeliness and quality of financial data challenges, as well as delay in internal audits for entities such as Pharmaceuticals Fund Supply Agency; 4) Environmental risks such as medical waste management; and, 5) Introduction of new activities focused on Health Care Financing and efforts towards fast roll out of Community Based Health Insurance and Social Health Insurance with limited capacity in place.

Annex VI. Program Economic Evaluation

Health sector Expenditure

1. Total Health Expenditure in Ethiopia has steadily increased, however, Government health expenditures as a percent of total Government expenditure have remained low and large regional variations in terms of proportion of Government spending on health exist. Between 1999/2000 FY, the share of health expenditure relative to total Government expenditure averaged 3.7 percent, while Government spending accounted for 30 percent of total health expenditure in 2013/14 FY. Harrar region allocated the highest share of its regional budget to health (15.7 percent), while Addis Ababa allocated only 2.8 percent. As of 2011/2012, per capita capital spending on health at regional level ranged between 7 and 108 birrs; while per capita recurrent spending on health ranged between 42 and 153 birrs. A comparison of total health expenditure as a share of GDP and some key outcomes shows that Ethiopia has been more efficient in its use of resources that are allocated compared to other low income SSA countries.

2. Data also show that Government budget execution rate is fairly high, an average of 93 percent for recurrent and 75 percent for capital expenditure, with slight variation between federal and regional levels. As expected, execution rates for recurrent expenditure are high as the majority goes to salary payment. Execution rate of capital expenditure at federal level has increased from a low 42.1 percent in 2005/06 to 87 percent in 2013/14, reflecting the heavy investment in infrastructure. Execution levels for capital expenditure at the regional and woreda levels are slightly lower, over the years. Regional differences in budget execution for capital expenditure ranged from 27 percent in Gambela to over 90 percent in a number of regions, but execution rates for recurrent expenditure were high and more comparable across regions.

Rationale for public sector intervention

3. The proposed AF is strongly justified in the case of Ethiopia on the grounds of equity. Public provision of activities directly supported by this PforR operation are justified on the grounds of equity, public good, externality, public sector reliance and efficiency, because the SDG PF targets financing gaps in priority areas including maternal health, child health, capacity building and health systems strengthening. Furthermore, DLIs are linked to public investment in key areas such as those dedicated to addressing inequity (Skilled Birth Attendance; CBHI, rural CPR, etc.), with targets designed to make sure there will be concerted efforts to enhance coverage among the poor.

4. The use of public resources to address the project objectives is justified for the following reasons: i) The public sector is the main provider of health services in Ethiopia, but these facilities are severely underfunded and often understaffed. Wide socioeconomic and geographic inequities in access to services exist between and within regions, which cannot be addressed through the private sector. Investing in RMNCAH is not only a sound economic decision, but a moral issue that cannot be left to the private sector. ii) Some of the interventions proposed under the project such as vaccination have positive externalities. Providing these services through the free market may lead to under-supply, undermine herd immunity, and pose public health risks.

Impact of the proposed AF on the PDO

5. The proposed AF will contribute to saving health care costs through focus on cost-effective, high impact preventive and curative interventions that will reduce the economic burden related to maternal and child morbidity and mortality.

Cost effectiveness of the Program

6. Table 1 below shows the estimated Cost-effectiveness (US$/DALY) that accrues from interventions that will lead to the results under the PforR. By reducing maternal mortality and morbidity, women will be more productive in the labor force, will support their children through the critical development stages and contribute to other non-income generating activities.[51] It is estimated that one maternal death in the African region reduced GDP by US$ 0.42 per capita per year. [52]

Table 1: Neglected Low-Cost Opportunities in Sub-Saharan Africa

Neglected low-cost opportunities in Sub-Saharan Africa	Cost per DALY averted a (US$)	Thousands of DALYs averted a, b per 20% increase in coverage	Burden of target diseases a (millions of DALYs)
Childhood Immunization: Second opportunity measles vaccination c Additional coverage of traditional Expanded Program on Immunization (tuberculosis, diphtheria-pertussis-tetanus, polio, measles)	1–5	n. e.	13.5–31.3
Childhood Illness: Integrated management of childhood illnesses Case management of non-severe lower acute respiratory illnesses at the community or facility level Case management package including community- or facility-based care for non-severe cases and hospital-based care for severe lower acute respiratory illnesses Breastfeeding support to prevent underweight children	9–218	at least 1.2	9.6–45.1
Maternal and Neonatal Care: Increased primary care coverage Improved quality of comprehensive emergency obstetric care Improved overall quality and coverage of care Neonatal packages targeted to families, communities, and clinics	82–409	at least 2.8	29.8–37.7

n.e. = not evaluated.
a. Ranges represent variation in point estimates of cost-effectiveness, DALYs averted, or burden of disease among the different interventions listed in each group. Point estimates of cost-effectiveness and DALYs averted were obtained directly from the relevant chapters or calculated as the midpoint of range estimates reported in the chapters. Burden of disease were obtained from the relevant chapters and from Mathers and others 2006.
b. Avertable DALYs per 20% increase in treatment coverage in a Hypothetical sample population of one million people.
c. Only evaluated for Sub-Saharan Africa

Project Development Impact

7. The World Health Organization estimates that annually 42 percent of women who give birth experience at least mild complications during pregnancy and 15 million women annually develop long-term disabilities attributable to pregnancy related complications. About 50 to 80 percent of pregnant women in developing countries develop acute health problems, and between 8 and 29

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[52]Kirigia et al (2014). Indirect costs of maternal deaths in the WHO African region in 2010. BMC Pregnancy and Childbirth (14): 299

percent develop chronic health problems as a result of pregnancy. About 830 die from preventable causes related to pregnancy and child birth every day. Approximately 99 percent of maternal deaths occur in developing countries and more than half occur in Sub- Saharan Africa.

8. In Ethiopia, 412 out of 100,000 women die during pregnancy and child birth, and 29 in 1,000 babies die before their first birthday. Neonatal mortality accounts for 67 percent of mortality in children under five years of age. Cost-effective interventions to reduce maternal and childhood deaths exist but they are not always available to those who need them most. The additional AF will contribute towards addressing these challenges, economic growth and development through the following pathways:

- The project will contribute to improved child survival and development by supporting a range of high impact cost-effective interventions to address the major causes of child morbidity and mortality, including increasing vaccination coverage and nutrition interventions. A recent study showed that 28 percent of all child mortality in Ethiopia is associated with undernutrition; 16 percent of all repetitions in primary school are associated with stunting; stunted children achieve 1.1 years less in school education; child mortality associated with undernutrition has reduced Ethiopia's workforce by 8percent; 67 percent of the adult population in Ethiopia suffered from stunting as children, and that the annual costs associated with child undernutrition are estimated at Ethiopian birr (ETB) 55.5 billion, which is equivalent to 16.5 percent of GDP.[1] By addressing causes of childhood mortality, more children will survive into adulthood, will be healthier, have higher cognitive development, complete education and actively participate in the labor force.
- Contributing to saving health care costs related to maternal and child morbidity. For every death, there are a number of women and children who survived, with long-term disability that require constant medical care. In addition, the high level of unmet need for family planning (which the project aims to address) leads to high incidence of unintended pregnancies and abortions (estimated as 101 per 1000). The most recent available data suggests and increase in the number of induced abortions from 382,000 in 2008 to 620, 296 in 2014. [3][4] About 52,600 and 103,648 women were treated for abortion related complications in 2008 and 2014 respectively. Reducing unplanned births potentially saves public spending on social services, contributing to social and economic development.
- The project will contribute towards long-term economic benefit in the form of high GDP arising from increased labor force participation and productivity. Healthier communities give rise to increasing investment in human and physical capital, generating higher rates of economic growth. By reducing maternal mortality and morbidity, women will be more productive in the labor force, will support their children through the critical development stages and contribute to other non-income generating activities. It is estimated that one maternal death in the African region reduced GDP by US$ 0.42 per capita per year. [2] In addition, indirect costs of maternal deaths in Africa amounted to US$ 4.5 billion in 2010. With the high number of maternal deaths in Ethiopia, the costs of maternal deaths to the economy can be substantial.

Value Added of World Bank and Partners support to the Government Program

- The Bank and partners bring the following additional value in support of the Government's HSTP: (i) Technical expertise and international experience in supporting health systems strengthening; reforms in health care financing and roll out and strengthening of CRVS; (ii) its strong track record

[1]WFP. 2012. The Cost of Hunger in Ethiopia.
[4]Moore A et al (2016). The Estimated Incidence of Induced Abortion in Ethiopia, 2014: Changes in the Provision of Services Since 2008. International Perspectives on Sexual and Reproductive Health, Vol. 42, No. 3
[2]Kirigia et al (2014). Indirect costs of maternal deaths in the WHO African region in 2010. BMC Pregnancy and Childbirth (14): 299

in mobilization of resources and working in harmonized partnerships; iii) capacity in fiduciary management which in the context of a PforR helps to strengthen the overall system.

Financial Sustainability

- The program aims to support the Government's Health Financing Strategy, in particular the roll out of CBHI which addresses a key concern in how health is financed. Overall, the program is deemed to be financially sustainable given the smaller percentage of the Government's overall program that it finances. Overtime, Government's expenditure on health is projected to increase as per its commitments under the HSTP.

Annex VII: Summary of Integrated Fiduciary Assessment

1. An Integrated Fiduciary Assessment (IFA) for the additional financing to the Health PforR was carried out at the Federal Ministry of Health and a sample of participating Regions and woredas, as well as PFSA which will implement the proposed operation consistent with Operational Policy/Bank Procedure (OP/BP) 9.00, Program for Results Financing.

2. The fiduciary assessment entailed a review of the capacity of the sample participating entities on their ability to: (a) record, control, and manage all Program resources and produce timely, understandable, relevant, and reliable information for the borrower and the World Bank; (b) follow procurement rules and procedures, capacity, and performance focusing on procurement performance indicators and the extent to which the capacity and performance support the program development objectives and risks associated with the Program and the implementing agency; and (c) ensure that implementation arrangements are adequate and risks are reasonably mitigated by the existing framework.

Financial Management

3. The 2014 PEFA assessment has been completed for the Federal Government as well as regions which noted good improvements in areas of budget credibility and internal control systems. Weaknesses continue to remain in internal audit function, high staff turnover and capacity constraints in Procurement and internal audit, delay in reports etc.

4. Since Bank funding is to flow to the Sustainable Development Goal Performance Fund and through it to PFSA, this update to the IFA also assessed the performance of the fund as well as the beneficiary entities. The SDG PF is financed by a pool of 11 donors who have signed the Joint Financing Agreement (JFA). The fund follows a Joint Annual work plan, quarterly report and annual audit report.

Key Finding of the Fiduciary Assessment

5. Overall the main challenges observed in the financial management system are: (i) the audit backlog of the PFSA accounts; (ii) lack of integrated automation at PFSA to meet the demands of PFSA; (iii) the need for Strengthening the existing monitoring mechanism of delivery of items to ultimate beneficiaries; (iv) the need to strengthen the current rollout of the APTS to ensure existence of adequate monitoring mechanism for delivered health goods; (v) weak internal audit unit of PFSA due to capacity and structural constraints and (vi) the need to prepare detailed action plan on how to address the audit report findings for the years EFY 2001-2004. Based on this challenges, DLIs and Actions for the PAP are recommended. The financial management arrangements for the AF P4R is described below.

6. *Planning and Budgeting:* A specific plan for the SDG Performance Fund will continue to be extracted from the comprehensive plan and will be discussed and agreed among FMOH and contributors. Approvals of the annual plan, priority setting, and review and appraisal of the draft plans will be done after consultations between FMOH and all donor partners. Budget utilization/execution will be monitored and reviewed through the consolidated HSTP annual performance report, quarterly reports, and the joint review mission.

7. *Budget Monitoring:* The Grant Management Unit at FMOH will continue to be responsible for the budget monitoring activities. Monthly, the case team produces budget monitoring report and circulates to the relevant directorates. In addition, the quarterly IFRs will continue to compare budget with actual expenditure with relevant explanations.

8. *Accounting and Financial Reporting:* The existing basis of accounting (modified basis at FMOH and accrual basis at PFSA) will continue in the additional financing of the program. The FMOH along with the RHBs and the woredas will continue to use the Government's finance manual for the program. Quarterly accounting reports, as outlined in the existing Joint Financing Arrangement, are produced from PeachTree software and Excel; and shared with SDGPF signatory partners. Program financial reports will be produced from the existing system and their production will be the responsibility of the FMOH.

9. *Automation:* Although IFMIs is rolled out at FMOH, due to the customization required to accommodate donor funded projects, it will continue to use PeachTree accounting software in parallel with the IFMIs. PFSA will continue to use Peachtree accounting software - Sage 50 Enterprise edition for transaction recording and financial reporting. The challenges in this area and the proposed mitigating measure is discussed below.

10. *Staffing*: FMOH, the RHBs, woredas and the PFSA have adequate number of finance staff although there is a high staff turnover particularly at PFSA. The FMOH and PFSA will monitor their level of staffing and ensure that there is adequate staff at all times to look after the SDG PF.

11. *Funds Flow.* Disbursement of program funds will continue to be made upon achievement of the disbursement-linked indicators (DLI). An initial advance can be made through agreement with the World Bank for up to 25 percent of PforR financing for one or more DLIs that have not yet been met following effectiveness. Funds will flow from World Bank to the SDG PF foreign currency nominated account. The previously established sub account in the original credit is no longer needed hence fund will flow to the pool account already established by FMOH. Any remaining balance in the sub account can be transferred into the pool account and used as per the requirements of the program. Transfers will be made from this pooled account to PFSA and any other implementing agencies as determined by FMOH.

12. *Internal Controls and Internal Audit.* The internal controls, which follow the Government's system, were found to be adequate at the FMOH, PFSA, visited RHBs, woredas and PFSA branches. Noted weaknesses were incomplete fixed asset registers for donor funded assets at RHBs, delay in preparing bank reconciliations, and the need to strengthen the follow up of goods receiving notes from health facilities. Internal audit departments at FMOH and PFSA exist to monitor weaknesses in internal control although the structure and the capacity of the latter could be further strengthened. The two internal audit departments will develop separate annual risk-based audit plans that will be the basis of their internal audit work. Weaknesses in the operation of the SDG Performance Fund will be identified, and mitigation measures proposed to reduce the impact of the identified risk. All internal audit reports with respect to the SDG Performance Fund will be sent to the Minister of Health within 30 days of completion together with a proposed action plan to deal with identified risks. PFSA internal audit reports will be sent to the Director General of PFSA and its Board. Strengthening the capacity of the internal auditors at all levels is required. Assigning additional experienced auditors; assigning seconded Technical Assistant in the finance section and providing continuous practical training would enhance the capacity of the auditors at PFSA.

13. *Program Audit*. The Office of the Federal Auditor General (OFAG), or an auditor to be assigned by it, will conduct the annual audit of the financial statement of the SDG Performance Fund in accordance with terms of reference agreed upon by all SDG PF donor partners. The resultant audit report and management letter will be submitted to the SDG PF partners and FMOH within nine months after the end of the Government of Ethiopia fiscal year. Performance audits and value-for-money audits will be conducted by OFAG or a delegated audit firm following the terms of reference agreed upon by all

signatory partners and FMOH as required. In addition to the program audit, the entity audit report of PFSA is essential given that most resources of the program are managed by the agency. Accordingly, the submission of the audit backlog for the entity audit report of the PFSA will be DLI against which disbursement will be made for its achievement.

14. *Transparency and Accountability.* The HSTP budget is disclosed to the public as part of the Growth and Transformation Plan II (GTP II) of the Government. Given that the Bank has requirement to disclose audit, the annual audit report of the SDG PF will be disclosed on the Ministry's website. Furthermore, the Bank will also make the audit reports public through its website.

Procurement

15. According to PO data in PFSA, the maximum value of single contracts committed using the SDG PF are US$ 35.5 million for malaria (including bed nets insecticides), US$ 11.7 million for laboratory regents, and US$4.5 million during for medical supplies during FY 2006, FY2007 and FY 2008 respectively. It is noted that likelihood of single contract amounting to more than 25% of program expenditure is low. Furthermore, outside of PFSA, large value procurement using the SDG PF is undertaken by FMOH when doing procurement through UNOPS. The assessment found maximum value for procurements still under process with UNICEF valued at US$50 million for procurement of hospital equipment and US$45 million for procurement of Solar Direct drive from the SDG PF. The assessment also found a maximum contract value of US$17 million with UNOPS for procurement of vehicles.

16. *Overall, the main challenges observed in the procurement system are*: (a) PFSA need to strengthen data management and performance monitoring; (b)The PFSA website needs improvement in terms of data entry and capacity while availing procurement information; (c) The SBD under use by PFSA need review and improvement; (d) There is no comprehensive and standard bid evaluation report template that provides all the required information consistently for all procurement operation; (f) Staff in the Procurement Directorate at PFSA need procurement skills upgrading that should be fulfilled through a dedicated procurement skills-upgrading program; (g) There is a need to improve the procurement planning system at PFSA; (h) Packaging items based on product category for efficient procurement processing and for better competition is a challenge; (i) There is too much repetitive approach to the market for similar products thereby reducing efficiency and increasing the transaction load on the PFSA procurement unit; (j) Procurement records at PFSA are kept with high risk of exposure of documents to unauthorized access and tampering; (k) tracking and recording system for procurements handled by UN Agencies at FMOH need improvement and award information need to be publicly disclosed.

17. To address these identified risks and to further increase the reliability of the procurement system, a number of suggestions have been made for implementation either as part of the Program through a DLI/ incorporated in the Program Action Plan. The assessment recommends to keep the existing DLI that targets transparency of PFSA, and to add new DLIs that incentivizes PFSA to measure its performance through procurement Key Performance Indicators (KPIs).

18. **Main recommendations to improve the procurement system include**: (a) maintain the existing DLI#8 with strengthened requirement that ensures dependable posting of procurement information that can be easily accessed and referred; (b) PFSA to introduce performance measurement through KPIs and methodology developed by FPPI; (c) upgrade the HCMIS system to include procurement process data capturing modules so that the PFSA Management System will provide integrated information and data; (d) strengthen the procurement timeliness and price tracking system with the above action and produce report as agreed under fourth year deliverable of DLI #8; (e) Prepare

annual procurement plan with complete information and disclose in the website; (f) Undertake assessment study and develop coding and categorization system of procurable items; (g) finalize the action agreed to introduce Framework contracting method for common and repetitively procured items, and also finalize the agreed action under second year deliverable of DLI#8 to undertake prequalification evaluation based on open competition; (h) Plan and implement dedicated procurement skills-upgrading program; (i) Review and improve the SBD and agree with FPPA, and also review current Bid Evaluation reporting methods and develop a template that keeps and records all relevant evaluation information; (j) Provide adequate space for procurement records so that they are kept away from access from unauthorized persons and develop document retrieval directory; (k) FMOH to improve procurement tracking and recording system for procurements handled by UN agencies and to publicly disclosed award information.

19. As a procurement fiduciary oversight assurance the PforR program will continue to rely on the country system whereby FPPA is mandated to undertake procurement audit on federal institutions. Hence FPPA will undertake annual procurement audit on PFSA and FMOH procurement activities and the report will be shared with the Bank annually.

Fraud and Corruption

20. In terms of fraud and corruption, Ethiopia has robust legal framework for addressing Fraud and Corruption risks. The Federal Attorney General has been established for the duty of investigating offenses and prosecuting public corruption cases in a centralized manner in a bid to materialize the country's interest to 'good governance' and enforce laws to the fullest. It harmonizes investigation and prosecutions responsibilities dispersed in different public institutions under a single entity.[53] FEACC concentrates on the preventive side, on expanding and promoting ethics and anti-corruption education, and preventing corruption while the Federal Attorney General deals on the curative side, on prosecution of alleged corruption offences. Since 2007, all the nine Regional Governments have established their own Regional Ethics and Anti-Corruption Commission (REACC) as per the regional laws.

21. Corruption in the health sector is not pervasive compared to other sectors. The FEACC annual performance reports from 2012 to 2015 indicated the top 20 to 25 public institutions having high number of corruption allegations each year; and the health sector institutions were not included in the list indicating a relatively low level of corruption in the health sector.[54]

Complaint-handling Mechanisms: Fraud and Corruption; Maladministration Complaints / tip-offs

22. Federal and Regional Governments have a well-defined complaint handling mechanism as per the laws of FEACC and REACCs for controlling Fraud and Corruption and maladministration. The proclamation and regulation provides for the establishment and functioning of Ethics Liaison Units across public offices and public enterprises in the country with the objectives of preventing corruption, impropriety and exposing and investigating offences for appropriate actions against perpetrators.[55] The scope of FEACC driven Ethics Liaison Units covers all sectors including the health sector from Federal to facility levels. The Health MDGs PforR is designed to take advantage of built-in measures to address

[53] The Federal Attorney General took over investigation and prosecutions duties previously given to FEACC under Proclamation No. 433/2005 (as amended by Proclamation No. 880/2015) and the revised Anti-Corruption Special Procedure and Evidence Proclamation No.434/2005 amended in 2015 as well as other investigation and prosecutions responsibilities in the Revenue and Customs Authority, Consumers' Protection Authority, responsibilities within other public offices and most of the responsibilities of Ministry of Justice.
[54] Annual Performance Reports, FEACC, 2013, 2014, 2015.
[55] FEACC Establishment Proclamation No.433/2005 and 433/2005 and "the Functioning of Ethics Liaison Units Council of Ministers Regulation No. 144/2008".

fraud and corruption that may occur during implementation. Fraud and Corruption related complaints/ tip-offs are principally addressed to Ethics and Anticorruption Liaison Directorates /Officers/focal persons in the FMOH, in all the seven agencies accountable to the Ministry particularly in the PFSA as well as in the health sector public bodies at Regional State, Zone, woreda and facility levels. Complaints are lodged using suggestion box, remarks ledger book and retrieved or filed in person, in writing, through telephone, E-mail, and using a Hotline.

23. However, the complaint handling system has gaps that prevent it from functioning effectively. It is necessary to strengthen the structure, capacity of complaint handling staff and improve the tracking, recording and reporting of Fraud and Corruption at federal, regional and woreda levels. FMOH should play an overarching role in coordinating complaint handling functions under the Ethics and Anticorruption Liaison Directorates /Officers of the agencies accountable to the Ministry and the PFSA regional Hubs.

Fraud and Corruption Control Performance and Significant Risks

24. Encouraging results have been witnessed in the performance of FEACC and REACCs. From 2013 to 2015, FEACC and REACCs investigated 5605 Fraud and Corruption cases (22.3 percent of the total 25, 187 tip offs), and 2, 301 cases (41.1 percent out of the total investigated cases) were prosecuted leading to the highest 3-16 years' imprisonment and the lowest 2 months -2 years' imprisonment. This performance has almost been doubled compared to the 2, 483 investigated offences and 1, 188 prosecuted cases between 2012 and 2013. The conviction rate between 2013 and 2015 was 86.1 percent in terms of files or 78.7 percent in terms of accused persons. Among the cases investigated and prosecuted were those involving high-ranking Government officials, including former officials and employees of the Revenues and Customs Authority and some business persons, ruling party members, CEOs and Government owned public enterprises. [56] In relative terms, court ruling on procurement offences is significant. In 2013, 2014 and 2015, the share of court decision made on large public procurement and sales were significant. They accounted for 16.2 percent (812), 18.3 percent (989) and 11.1 percent (517) out of the total tip-offs received (5, 020; 5, 394 and 4, 663) respectively. In magnitude, the share of decisions on land administration or revenue and tax came second.

Based on the assessment findings, the key challenges for effective system of complaint handling which particularly lead to Fraud and Corruption, maladministration are the following:

(a) *Structure for the control of Fraud and Corruption at PFSA Regional Hubs level requires strengthening:* There are still gaps in tracking and addressing complaints and control of Fraud and Corruption and maladministration in PFSA Regional Hubs. In most PFSA regional Hubs, Ethics and Anticorruption Officers are not assigned; and the existing assigned officers serve clusters. The proposed mitigation measure is, therefore, to strengthen the structure through human resource and building capacity for the control of Fraud and Corruption at PFSA and its Regional Hubs.

(b) *Lack of full time assigned Ethics and Anticorruption Liaison Officer in woreda Health Offices:* Complaint handling function for the health sector needs strengthening at woreda level. Full time personnel are not placed in woreda health offices unlike other seven woreda sector offices which have assigned Ethics and Anticorruption Liaison Officers (Officers are placed in WOFED, Office of Agriculture, Education, Revenue, Police, Justice and Administration). The proposed mitigation measure is to ensure the deployment of Ethics and Anticorruption Liaison Officer and experts at all levels (PFSA; PFSA regional Hubs; RHBs, offices).

[56] FEACC Annual Reports, 2011, 2012, 2014, 2015, Publication Volume 13 No. 4 June, 2014.

(c) *Gaps related to accessing, tracking, recording, organizing and reporting of Fraud and Corruption incidents and complaints in health institutions for effective complaint handling:* The gaps are evident in health institutions involved in complaint handling at Federal, Regional and woreda levels including in Ethics and Anticorruption Directorates/Offices and in grievance handling /disciplinary committee. Effective complaint handling system is expressed by the availability and quality of records and data base. Its absence hinders the disclosure, transparency and accountability to combat Fraud and Corruption, and to defeat conflict of interest. The functions of tracking, monitoring Fraud and Corruption as well as future planning and research in this area has to be informed by reliable and organized data. It is necessary to track and report the response for priority actions/ indicators of complaints. The proposed mitigation measure, therefore, is to strengthen capacities and support the provision of Information Technology for systematic accessing, tracking, recording, organizing and reporting of Fraud and Corruption incidents and complaints in health institutions.

(d) *Low capacity of complaint handling staff, including Ethics and Anticorruption officers/ Directors and experts:* Capacity of complaint handling staff is low compared to the demanding tasks of FMOH, PFSA and regional Hubs, Bureaus of Health, Zones and woredas. The vertical and horizontal functional relationships need to be strengthened. The proposed mitigation measure is to provide capacity building support/training to fulfill human resource gaps in addressing complaints in the FMOH and its 11 agencies, 17 PFSA regional hubs, 12 health bureaus, Zones and most woreda offices. The existing assigned experts have different professional discipline and this requires bringing them to par with others and upgrading professional skills including training on complaint handling, investigation and research.

(e) *Lack of common understanding and consultation on oversight/ management of Fraud and Corruption incidents, priorities, complaint responses:* Weaknesses were pointed out on oversight/management of Fraud and Corruption, governance risks due to lack of common understanding and approach on managing Fraud and Corruption risks and complaints among FMOH and regional and decentralized health institutions. This leads to inadequate information sharing and also Fraud and Corruption risks could be overlooked. The proposed mitigation measure is to ensure inclusiveness of Fraud and Corruption and complaint handling performances or priority actions in FMOH and RHBs joint forum discussions semiannually (including issues on realization of Anti-Corruption Guidelines (ACG) in discussion forums).

(f) *In general, there is low level of capacity in tracking misrepresentation and coalition in procurement, and fraudulent action, misuse and embezzlement of distribution, and dispensing of pharmaceuticals:* Different initiatives are under way in Ethiopia to strengthen the institutional arrangements for combating Fraud and Corruption. Under this program, the governance and anticorruption Action has been selected for risk mitigation purposes is provision of quality and timeliness biannual Fraud and Corruption complaint handling performance reporting, information sharing of Fraud and Corruption related procurement offences, complaints and priority action.

25. Arrangements to handle the risks of fraud and corruption, including providing complaint handling mechanisms are in place but should be refined, strengthened and sustained in the course of the program implementation. Based on the assessment, the Fraud and Corruption risk is rated as Moderate.

Alignment with Anti-Corruption Guidelines for PforR Operations

26. Agreement is reached with the Government to ensure the Bank's Anti-Corruption Guidelines (ACGs) applicable to PforR Operations are met and to address fraud and corruption issues associated with the key challenges of system of complaint handling which particularly lead to fiduciary risks.

Sharing of information on Fraud and Corruption Allegations

27. In line with the PforR ACGs, the Government, FEACC in collaboration with the Federal Attorney General, will consolidate and share information with the Bank and participating Donor Partners on all allegations and investigations of fraud and corruption received from the general public including on procurement and actions taken on the Program, specifically from activities conducted by PFSA. The FEACC in collaboration with the Federal Attorney General has agreed to share information on corruption allegations with the Bank immediately while at the same time conducting its own internal investigations. The structure of collecting and sharing information on fraud and corruption including procurement offences on the program goes beyond the Federal Government and would involve the concerned regional, zone and local level institutions as well. Consequently, information on fraud and corruption and complaints regarding the Program will be collected at the Regional level by REACCs and shared with the FEACC which will in turn will be shared with the Bank. The FEACC collects monthly reports from the REACC and the Federal Attorney General, compile and share information on fraud and corruption with the Bank every six months. The details of this reporting includes the types of allegations and the status of actions taken.

Sharing of List of Debarred Firms and Individuals

28. The Government of Ethiopia commits to use the Bank's debarment list to ensure that persons or entities debarred or suspended by the Bank are not awarded a contract under the Program during the period of such debarment or suspension. The Government also agreed that they would include some disclosure measures in bidding documents for works, goods and services to be financed under the program, including insisting that the firms and/or individuals declare they have not been debarred or suspended and/or have any links with a debarred entity or individual. This self-disclosure of firms or individuals bidding for contracts will be a way of strengthening enforcement. The Federal Public Procurement and Property Administration Agency (FPPA) has a website and will provide a link to the Bank debarred list for use by implementing agencies. The use of the debarment list is supported by pooling partners and the disclosure will be strengthened. Companies and individuals debarred by the Bank and the FPPA will be posted and updated regularly on FPPA's and PFSA's website and advertised publicly by FMOH. The FMOH will take responsibility in ensuring that the website is updated regularly with information on the list of debarred firms and individuals and share this information with all participating donors, PFSA regional Hubs, regional Health bureaus in the Program, instructing them to comply.

Investigation of fraud and corruption allegations

29. The Federal Ethics and Ani- corruption Commission, the Federal Attorney General (FEACC) and Regional Ethics and Anti-Corruption Commissions (REACCs) are established with powers to prevent, expose, investigate and prosecute corruption offences and impropriety and encouraging investigation results were recorded. Encouraging results have been witnessed in the performance of FEACC and REACCs.[57]

Fiduciary Risks and Mitigation Measures

30. Based on the findings noted above, the fiduciary risk assessed for this operation is classified as substantial. Overall, the fiduciary assessment concludes that the examined program financial management and procurement systems are adequate to provide reasonable assurance that the financing proceeds will be used for intended purposes, with due attention to principles of economy, efficiency, effectiveness, transparency and accountability, and for safeguarding Program assets once the proposed

[57]Annual Performance Reports, FEACC, 2013, 2014, 2015.

mitigation measures have been implemented. Appropriate systems to handle fiduciary risks including the fraud and corruption, including effective complaint-handling mechanisms, have been agreed on and established. Risk mitigation measures for the identified risks will be discussed and agreed with Government. The risk mitigation measures have three approaches: First a Disbursement Linked Indicator will be provided in the Financing Agreement to support transparency aspects of the Program. Second specific actions have been proposed that will support the DLI and help improve efficiency and performance monitoring are indicated in the Program action plan. Third, activities that can be supported through the capacity building budget or ongoing other initiatives have been clearly identified.

The proposed DLIs and PAP based on the IFA are summarized below:

(a) *Financial management:* (a) PFSA is fully automated including the branches to accommodate for the complex transaction and control levels required; (b) PFSA clears all the audit backlogs and submits subsequent audits timely without "adverse" or "Disclaimer opinion" (timeliness and quality starting in EFY 2011)

(b) *Procurement:* (a) PFSA launches the Website disclosing information by December 2013 on procurement plan and its revisions, specific procurement advertisement, award decisions (product, bidders, contract amount, and scope of contract, winning agency, and country of winning agency), Standard Biding Documents; and Proceedings of annual meetings with suppliers. Furthermore, Periodic open call to allow interested suppliers to pre-qualify as per the Recipient's law. (b) PFSA introduces procurement performance measurement through KPIs developed by FPPI, and reported progress on selected KPI. PFSA upgrades the HCMIS system to include procurement process data capturing modules so that the HCMIS will provide integrated information and data.

(c) *Fraud and corruption:* FMOH provides quality and timely biannual report on Fraud and Corruption related offences, complaints and priority actions.

Other actions discussed and agreed with Government to be included in the PAP are the following:

#	Action	Pre-Start	FY-1	FY-2	FY-3
Financial Management					
1	**Automation** -Prepare a clear roadmap for the automation of PFSA -Initiate the automation process as per the roadmap (sign agreements, finalize all preparatory works, that may be required) -for the short run, enhance the existing system to address the challenges				
2	**Commodity distribution process** -Strengthen the existing monitoring mechanism of delivery to ultimate beneficiaries at the reconciliation of head quarter and branch level. -The monitoring mechanisms of the FMOH needs to be strengthened regarding the usage of the health commodities already delivered to health centers. The current rollout of the APTS should be continued and progress updated to ensure existence of adequate monitoring mechanism		X	X	X
3	**Internal audit** -Develop continuous training program for both FMOH and PFSA internal audit units. Amend the structural issues of PFSA internal audit directorate to report to the board and branch auditors to the directorate and Provide access to the accounting and stock management software to the auditors.		X	X	X
4	**External audit** -Prepare detailed action plan on how to address the audit report findings for the years EFY 2001-2004		X	X	X
Procurement					

#	Action	Pre-Start	FY-1	FY-2	FY-3
5	Prepare annual procurement plan with complete information like estimate, quantity, method, milestone dates etc. (PFSA)		X	X	X
6	Undertake assessment study and develop coding and categorization system of procurable items (PFSA)		X	X	
7	Introduce Framework contracting method for common and repetitively procured items. (PFSA)			X	X
8	Review and improve the SBD and agree with FPPA; and review current Bid Evaluation reporting methods and develop a template that keeps and records all relevant evaluation information. (PFSA)		X		
9	Improve tracking system of monitoring contracts with UN agencies and disclose award decisions to the public (FMOH)		X	X	X
Fraud and Corruption					
10	MOH Provides and FEACC verify and submit to the Bank quality and timely biannual report on Fraud and Corruption complaints and priority actions related to the program		X	X	X
11	Strengthen the structure through human resource and build capacity for the control of Fraud and Corruption at PFSA and regional Hubs.		X		
12	Ensure the deployment of Ethics and Anticorruption Liaison Officer and experts at all levels (PFSA; PFSA regional Hubs; RHBs, offices);		X	X	
13	Strengthen capacities and support the provision of IT related equipment for systematic accessing, tracking, recording, organizing and reporting of Fraud and Corruption incidents and complaints in health institutions			X	
14	Ensure inclusiveness of Fraud and Corruption and complaint handling performances or priority actions in FMOH and Regional Health Bureaus joint forum discussions semiannually (including issues on realization of Anti-Corruption Guidelines (ACG) in discussion forums).		X	X	X

Annex VIII: Summary of Environmental and Social System Assessment (ESSA) Update

1. The ESSA Update examined existing environmental and social management systems relevant to the health sector, based on the review of the original ESSA, and recommends actions to address any risks or challenges identified. The exercise undertook performance assessment of the existing country systems in relation to the needs of the proposed AF, in relation to: (a) The environmental and social management systems defined in the country's policies, legal and strategic frameworks; and (b) The capacity and experience of the health sector in applying the environmental and social management systems associated with the program's potential environmental and social effects.

2. The Update considered the strengths and gaps in the system with respect to five of the six core principles outlined in the OP/BP 9.00: (i) General Principle of Environmental and Social Management; (ii) Natural Habitats and Physical Cultural Resources; (iii) Public and Workers Safety; (iv) Land Acquisition and loss of Access to Natural Resources; (v) Indigenous Peoples and Vulnerable Groups; and (vi) Social Conflict. These principles establish the policy and planning elements that are generally necessary to achieve outcomes consistent with the Program for Results objectives. They are intended to guide the assessment of the borrower's systems and of its capacity to plan and implement effective measures for environmental and social risk management.

3. This Update is intended to ensure that the AF to the Health SDG Program will be implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes, or mitigates adverse environmental and social effects and risks.

4. This Update includes the following: (a) a review of relevant policy, legal, and institutional frameworks to identify the strengths and weakness of the system as related to the six core principles; (b) a description of the potential environmental and social effects associated with the Program activities; (c) an assessment of institutional roles and responsibilities; and (d) a description of current capacity and performance to carry out those roles and responsibilities. More specifically, the Update reviewed the Government's regulatory and administrative framework and the capacity and experience of the health sector in managing environmental and social effects that are likely to be associated with the AF.

5. With regard to the methods of the assessment, the following documents were reviewed: (a) Federal and regional policies, strategies and laws related to environmental and social management and assessment; (b) ESSAs undertaken for the original Health SDG PforR and the ESPES PforR; and (c) Relevant regional reports from Benishangul-Gumuz, one of the emerging regions. A Field visit to Benishangul-Gumuz was undertaken in October 2016 to get an insight on what is happening at on the ground with regards to the environmental and social management. Results of the field visit are not representative of the situation across the country. Government officials and technical experts, at all levels, and other stakeholders involved in environmental and social management of the health sector were also consulted.

6. On the basis of the findings of the analysis, the Update proposes a set of actions for inclusion in the Program Action Plan to strengthen the existing system. These actions are expected to contribute to achieving the program's results and to enhance institutional performance. The selected actions are coordinated with the support provided through other operations such as ESPES and ESAP II.

Assessment of Borrower's Systems relative to the Six Core Principles

7. The Update reviewed the changes made since the 2012 ESSA:

- Strengths of the system, or where it functions effectively and efficiently and is consistent with OP/BP 9.00
- Weaknesses (or gaps) between the principles espoused in OP/BP 9.00 and capacity constraints, examined at two levels: (i) the system as written in applicable laws and regulations, and (ii) how the system functions in practice.
- Opportunities to strengthen the existing system.
- Threats (or risks) to the proposed actions designed to strengthen the system.

Core Principle 1: General Principle of Environmental and Social Management

8. The national standard set for health facilities in the Health Sector Transformation Plan (HSTP) on average, targets a *woreda* to have 20 health posts, 4 health centers and a primary hospital by the year 2020. These new health facilities are planned to be constructed, each with a physical foot print of about one hectare, which includes placenta pits and incinerators. Facilities that receive health products and equipment under the AF need effective medical waste management, including hazardous materials such as expired pharmaceuticals. Furthermore, Pesticides used in vector control programs (bed nets) require appropriate storage, distribution, use and disposal mechanisms.

Core Principle 2: Natural Habitats and Physical Cultural Resources

9. Activities funded through the AF could generate limited impact on natural habitats and physical and cultural resources, though civil works are limited in number and have a small physical footprint that facilitates appropriate siting, thus limiting adverse impacts on natural habitats and any chance- finds. Construction of facilities such as health centers and disposal of medical wastes may pose some risk to natural habitats and physical cultural resources if not sited appropriately and if procedures are not embedded in general construction contracts and supervised appropriately.

Core Principle 3: Public and Worker Safety

10. Rehabilitation, construction and operation of health centers could expose the general public as well as health service providers and construction workers to risks such as exposure to infectious waste, toxic or hazardous materials including pesticides and expired medicines, operational risks (needle pricks) at health facilities and civil works construction phase associated adverse environmental and social impacts.

Core Principle 4: Land Acquisition

11. Given the size of land required for each health facility, it poses a relatively limited risk of displacement or potential loss of access to natural resources, and could be mitigated with early screening, good siting practices, and appropriate compensation, if any. It is important to note that the risk of land acquisition and displacement is likely to be higher in urban and highland areas where population density is generally high.

Core Principle 5: Indigenous Peoples and Vulnerable Groups

12. The Government has identified four emerging regions (Afar, Benishangul-Gumuz, Gambella, and Somali) that require special attention. The HSTP aims to have regionally tailored approaches

that ensure distributional, gender balanced and culturally appropriate access to health services, as well as technical support to these regions to ensure coverage and provision of health services is on par with the rest of the country.

Core Principle 6: Social Conflict

13. The proposed program will not exacerbate social conflict nor will it operate in a fragile state context, a post-conflict area or in areas subject to territorial disputes. The program is designed to yield significant social benefits to all citizens and to improve distributional equity of health services, particularly in the four regions that require special attention.

Recommendations

14. The ESSA Update identifies a key set of recommendations based on the status of the implementation the 2013 ESSA Action Plan:

Site Screening for new Health Centers:

- Relevant documents should be updated to incorporate environmental impact and risk criteria in the site selection screening forms for all health facilities.
- Engaging people in the process of site selection should be as per the Laws and Regulations as indicated in environmental laws of the country.[58]

Equipment and Resources for Regulatory Purposes of Health Facilities:

- Almost all the standards and guidelines are prepared in English. When these are sent to the woredas without being translated to the local languages or Amharic, health workers may find it difficult to fully understand the contents. Translating to relevant languages may facilitate access to information.
- Adequate transport support, especially for zone and woreda offices, for inspection work is an area that needs attention.
- Capacity building of the regulatory body on areas of health care facilities regulatory work.

Healthcare Worker Retention, Incentive Packages, Training and Capacity Building:

- Review the health worker retention and incentive package and identify areas of improvement.

Establishment and operationalization of Infection Prevention and Patient Safety Committees (IPPS) to facilitate the implementation of facility level Medical Waste Management (MWM):

- A continuous supply and ensuring availability of IPPS supplies and commodities should be given attention;
- Transfer best practices observed in well performing health facilities to other health facilities (including public health facilities to private health facilities).

Temporary storage facilities for collection of hazardous wastes until final disposal:

- Efforts have to be made to encourage health facilities constructed before the Medicines Waste Management and Disposal Directive was adopted should comply with the Directive.
- Refresher training in standard hazardous waste disposal including disposal of expired medicines; and

[58] For instance, see Environmental Protection Organs Establishment Proclamation No.295/2002. In its Article 15 (1), this Proclamation states that: "Each national regional state shall establish an independent regional environmental agency or designate an existing agency that shall, based on the Ethiopian Environmental Policy and Conservation Strategy and *ensuring public participation in the decision making process*." (Emphasis added).

- In most places the basic hazardous waste disposal facilities exist but when they are damaged due to various reasons, proper maintenance is not done because of budget constraints. As this could be the last thing that will be done when there is budget constraint, earmarking a budget for this kind of activity may help.

Consultations with affected people when land is used for construction of health centers:
- Staff members who carry out consultation should be made aware of the importance of documenting the process.
- Forms that guide the consultation process should be prepared by the responsible Government Agency and provided to the regions.

Outreach and specific actions focused on providing services to vulnerable people:
- Staff involved in the service provision should be made aware about the importance of the documentation process.
- Prepare forms that guide the documentation process (disaggregation by vulnerable persons) and provide to regions, which can be part of the monitoring and evaluation (M&E) process.

Institutional Arrangements

15. It is recommended to have a focal person in the Environment Case Team of the ministry to coordinate the activities and commitments including documentation of environmental and social management and assessment reports. The focal person could work with the Ministry of Environment, Forest and Climate Change (MEFCC) and the Ministry of Labor and Social affairs to ensure that regulatory bodies are involved in the implementation of agreed actions.

Action Plan

16. The Proposed actions to be included in the Program Action Plan (PAP) to address some of the recommendations above are presented in the Table below.

No.	Action	Responsibility	Timeframe
1	Strengthen the coordination and reporting on environmental and social safeguards in FMOH	FMOH	Year 1-3
2	Update relevant documents to incorporate environmental impact and risk criteria in the site selection screening for all health facilities.	FMOH	Year 1
3	Capacity building of staff of the regulatory body on areas of health care facilities regulatory and inspection work	FMHACA	Year 1-3
4	Enforce compliance with the Medicines Waste Management and Disposal Directive on health facilities constructed before the issuance of the directive	FMOH/ FMHACA	Year 1-3
5	Document consultations with communities on land acquisition for construction of health facilities	FMOH	Year 1-3

Annex IX: Results Framework and Monitoring Indicators

PDO/Outcome Indicators (KI measuring achievement of PDO statement)	Type of Indicator	DLI #	Unit of Meas.	Original Baseline	2013	2014	2015	2016	Baseline AF 2016	2017	2018	2019	End Target AF 2020	Rationale for Changes from Original
PDO level Results Indicators														
PDO Indicator 1: Deliveries attended by Skilled Birth Provider[59]	Original	1	%	10%		14%		18%						Result exceeded by 10 percentage points from the end target
PDO Indicator 1a: Deliveries attended by Skilled Birth Provider	Scaled	1	%						18%	28%	34%		40%	DLI is scaled for further results
PDO Indicator 1b: Deliveries attended by Skilled Birth Provider for the bottom 3 performing Regions (Afar, Oromia and Somali)[60]	New	1a	%						Av. For the three regions = 19%	National Health Equity Strategy Endorsed by FMOH	Av. For the three regions = 25%		Av. For the three regions = 28%	According to DHS 2016 skilled provider delivery= 16.4% in Afar; 96.8 % in AA.
PDO Indicator 2b: Children 12-23 months Immunized with Pentavalent 3 vaccine	Restructured	2	%	Baseline to be established	59.6*						65.7%			Original target for setting baseline was met. Follow up Cluster survey has not been undertaken.
PDO Indicator 2c: Children 12-23 months Immunized with Pentavalent 3 vaccine	Scaled	2	%										75.7%	The DLI is restructured to give more time for targets achievement.
PDO Indicator 3: Pregnant women receiving at least one antenatal care visit	Original	3	%	43%		48%		56%						The original indicator target is achieved
PDO Indicator 3a: Pregnant women receiving at least four antenatal care visits	New	3a	%						32%		36%		38%	New DLI added to spur results in four antenatal care visits.

[59] SBA result for 2016 to be updated upon release of full 2016 DHS in order to ensure that the SBA definition remaining the same as per the original definition.
[60] Based on the 2016 Demographic and Health Survey
*Baseline established as a prior result

PDO/Outcome Indicators (KI measuring achievement of PDO statement)	Type of Indicator	DLI #	Unit of Meas.	Original Baseline	2013	2014	2015	2016	Baseline AF 2016	2017	2018	2019	End Target AF 2020	Rationale for Changes from Original
PDO Indicator 4: Contraceptive Prevalence Rate	Original	4	%	27.3%		31%		35%						DLI Targets achieved.
PDO Indicator 4a: Contraceptive Prevalence Rate (for Rural Women only)	New	4	%						32%		35%		38%	New DLI to spur results in rural areas after achievement of national CPR targets (DLI#4).
PDO Indicator 10a: Percent of Children 6-59 months receiving Vitamin A Supplements	New	10a	%						53% (DHS 2011)		4 percentage points from 2016 DHS		8 percentage points from 2016 DHS	
PDO Indicator 10b: Percent of Woredas in non-emerging regions delivering Vitamin A Supplements to children through routine systems (i.e. health facilities)[61]	New	10b	%						48%	50%	55%	60%	80%	
PDO Indicator 11: Percent of pregnant women taking iron and folic acid (IFA) tablets	New	11	%						17% (DHS 2011)		4 percentage points from 2016 DHS		8 percentage points from 2016 DHS	
Intermediate Results Indicators														
Intermediate Result Indicator 5: Health Centers reporting HMIS data in time	Original	5	%	50%	55%	60%	70%	75%		80%				The original targets for 2014 was met but subsequent targets were not met.
Intermediate Result Indicator 5a: Health Centers reporting HMIS data in time	Restructured	5	%						68%	75%	80%	84%	86%	The DLI is restructured to give more time for achievement of goals.

[61] Routine systems for delivery of Vitamin A means non-campaign delivery of Vitamin A, children receiving Vitamin A at a health center or facility.

PDO/Outcome Indicators (KI measuring achievement of PDO statement)	Type of Indicator	DLI #	Unit of Meas.	Original Baseline	2013	2014	2015	2016	Baseline AF 2016	2017	2018	2019	End Target AF 2020	Rationale for Changes from Original
Intermediate Result Indicator 6: Development and implementation of Balanced Score Card Approach to assess performance and related institutional incentives	Dropped	6	N/A	Upon development of Protocol	Implemented in 20 woredas	Implemented in 20 woredas	Review and decision on national scale up	Scale up to 200 woredas across the country						Implementation modality changed when the Government rolled-out the BSC country wide in a manner that would not make it possible to measure the impact of the approach on service delivery.
Intermediate Result Indicator 7b: Development and Implementation of Annual Rapid Facility Assessment	Original	7	Y/N		Survey protocol developed by EHNRI and agreed with IDA	Survey undertaken and result disclosed with proposed action to address weaknesses	Survey undertaken and result disclosed with proposed action addressing weaknesses	Survey undertaken and result disclosed with proposed action addressing weaknesses		Survey undertaken and result disclosed with proposed action addressing weaknesses				The target of developing the survey protocol was met and a facility survey has been undertaken every two years.
Intermediate Result Indicator 7c: Development and Implementation of Rapid Facility Assessment	Scaled/ Restructured	7	Y/N						-	-	Survey undertaken and results disclosed with proposed actions to address weaknesses		Survey undertaken and results disclosed with proposed actions to address weaknesses	The DLI is scaled to ensure facility surveys continue to be undertaken every two years.
Intermediate Result Indicator 8: Transparency of PFSA Procurement Processes	Original	8	Y/N	No website disclosing information	Website launched disclosing agreed Procurement information	Procurement information on website regularly updated and first open call for prequalification of suppliers made as per the recipient's law	Procurement information on website regularly updated	Procurement information on website regularly updated. PFSA produces price tracking report		Procurement information on website regularly updated				The target of launching the website was met. Some information is being posted on website.
Intermediate Result Indicator 8c: Transparency of PFSA Procurement Processes	Scaled	8	Y/N						Website launched disclosing some agreed Procurement information.		Procurement information on website regularly updated	Procurement information on website regularly updated	Procurement information on website regularly updated	The DLI is scaled to ensure comprehensive information is disclosed on website for increased transparency.
Intermediate Result Indicator 9 (1): Introduction of Procurement	New	9	Y/N						Procurement KPIs not yet in use	Commence procurement process data recording,	PFSA produces annual performance	PFSA produces annual performance report based on	PFSA produces annual performance report, based on	

PDO/Outcome Indicators (KI measuring achievement of PDO statement)	Type of Indicator	DLI #	Unit of Meas.	Original Baseline	2013	2014	2015	2016	Baseline AF 2016	2017	2018	2019	End Target AF 2020	Rationale for Changes from Original
Key Performance Indicators (KPIs) developed by Federal Public Procurement Agency (FPPA) at PFSA										introduction of procurement key performance indicators using format and guidelines developed by FPPA.	report based on such Key Performance Indicators using data recorded under result 9a above PFSA continues recording procurement process data.	such Key Performance Indicators using data recorded in previous year. PFSA continues recording procurement process data	such Key Performance Indicators using data recorded in previous year. PFSA continues recording procurement process data.	
Intermediate Result Indicator 9 (2): Automate the PFSA core business fiduciary system using Selected Software in PFSA HQ and Addis Ababa City [62]	New	9	Y/N						No core business fiduciary system		Contract for Automation of core business fiduciary system software installation signed with vendor		Automate using selected software at PFSA HQ and Addis Ababa City Branch	
Intermediate Result Indicator 9 (3): PFSA submission of backlog audit reports and timely quality[63] audit reports thereafter	New	9	Y/N						Backlog from EFY 2005-2007	Submit audit reports backlog from EFY 2005 and 2006 by December 2017	Submit audit reports backlog from EFY 2007 and 2008 by December 2018	Submit audit reports backlog from EFY 2009 and 2010 by December 2019	Submit timely and quality audit report for EFY 2011 by December 2020	
Intermediate Result Indicator 12a: Percent of Children 0-23 months participating in Growth Monitoring and Promotion (GMP)	New	12a	%						38% (HMIS End EFY 2008 Report)	6 percentage points increase from baseline	12 percentage points increase from baseline	18 percentage points increase from baseline	24 percentage points increase from baseline	
Intermediate Result Indicator 12b: Percent of woredas in emerging[64] regions transitioning from	New	12b	%						0% (HMIS)	10 percentage points increase from baseline	20 percentage points increase from baseline	35 percentage points increase from baseline	50 percentage points increase from baseline	

[62] At a minimum, the system should be able to reconcile balance between headquarters and branches, reconcile inter-fund balances; control bank balances; reconcile the stock; monitor advances, provide clear system over the income of the PFSA and overall consolidation of the fund managed by PFSA.
[63] Quality audit reports have non-adverse or disclaimer audit opinion.
[64] Emerging regions are: Afar, Somali, Gambella and Benishangul-Gumuz

PDO/Outcome Indicators (KI measuring achievement of PDO statement)	Type of Indicator	DLI #	Unit of Meas.	Original Baseline	2013	2014	2015	2016	Baseline AF 2016	2017	2018	2019	End Target AF 2020	Rationale for Changes from Original
EoS[65] to Community Health Days (CHD)														
IR Indictor 13 (1): Percent of PHC facilities having all drugs from the MOH list of essential drugs available	New	13a	%						42%	By December 31, 2017 Develop Quality Standards for PHC facilities [66]	Increase in PHC facilities having all drugs from MOH list of essential drugs from baseline up to 44.5%	By December 31, 2019 Revise and update the Quality Standards for PHCs developed in 2017	Increase in PHC facilities having all drugs from MOH list of essential drugs from baseline up to a max of 47%	
IR Indictor 13 (2): Develop and implement postnatal care services directive to improve the quality of postnatal services	New	13b	Y/N						N/A	By December 31, 2017 Develop a Postnatal Care Directive[67]	By December 31, 2018 Implement Postnatal Care Directive in all PHCs	By December 31, 2019 Monitor the implementation of the Directive by reviewing the use of the Directive at Facilities	Assess the effectiveness of the implementation of the directive and document lessons through a report on the experience	
IR Indictor 13 (3): Improve quality of adolescent health services	New	13c	Y/N						N/A	By December 31, 2017 Publication of the Government Endorsed Adolescent and Youth Health Strategy	By December 31, 2018 Develop a Standard Package of Health Services for Schools	By December 31, 2019 Develop a training manual for healthcare providers to build their competencies in providing the minimum health services package to adolescents	By December 31, 2020 Increase in PHCs providing adolescent health services from baseline 60% to 75%	
IR Indictor 14 (1): Percent of woredas with functional Community Based Health Insurance (CBHI) schemes[68]	New	14a	%						N/A	Baseline Established (Prior Result)	20 percentage points increase from baseline	25 percentage points increase from baseline	30 percentage points increase from baseline	
IR Indicator 14 (2): Undertake CBHI schemes	New	14b	Y/N						N/A	By December 31, 2017 undertake review of the	-	By December 31, 2019 undertake review of the	-	

[65] EOS= Enhanced Outreach Services

[66] PHC Quality guidelines define the standards of health care at Primary Health Care units.

[68] A woreda will be considered to have established a scheme when the woreda has set up a Board and General Assembly for the scheme, hired appropriate staff, initiated registration of members and collection of premium, and members start benefitting from the scheme.

PDO/Outcome Indicators (KI measuring achievement of PDO statement)	Type of Indicator	DLI #	Unit of Meas.	Original Baseline	2013	2014	2015	2016	Baseline AF 2016	2017	2018	2019	End Target AF 2020	Rationale for Changes from Original
review every two years										implementation of CBHI schemes for the period January 2016-December 2017, and developing actions on areas that need improvement, and disclosure of results with remedial action plan.as needed.		implementation of CBHI schemes for the period January 2016-December 2017, and developing actions on areas that need improvement, and disclosure of results with remedial action plan.as needed.		
IR Indicator 15 (1) Devise and implement a mechanism for documenting consultations when communal/ private land is used for construction of health facilities	New	15a	Y/N						N/A	By December 31, 2017 Devise a mechanism for systematically documenting consultations validated by communities when communal/ private land is used for construction of health facilities	By December 31, 2018 Implement the mechanism for documenting consultations for land use and acquisition in 10%. of woredas	By December 31, 2019 Implement the mechanism for documenting consultations for land use and acquisition in 50%. of woredas	By December 31, 2018 Implement a mechanism for documenting consultations for land use and acquisition in 70%	
IR Indicator 15 (2) Development and implementation of Health Sector Community Score Card (CSC)[69]	New	15b	Y/N						N/A	By December 31, 2017 Develop Health Sector CSC Directive setting out the CSC Mechanism	By December 31, 2018 Pilot the implementation of the Health Sector CSC in 56 agrarian and pastoralist woredas from a baseline of 0.	By December 31, 2019 Review the pilot and implement the Health Sector CSC in up to 56 woredas	Implement the Health Sector CSC in 400 woredas including woredas in 4 emerging regions	

[69]The Community Score Card (CSC) approach is a process used to promote participation, transparency, accountability and informed decision-making with the involvement of the community in following up on quality improvement.

Annex X: Disbursement Linked Indicators, Disbursement Arrangements and Verification Protocol[70] [71]

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
DLI 1. Deliveries attended by Skilled Birth Provider	Original		10%		14%		18%				
Disbursement Amount: (US$ mil)		20.00			10.00		10.00				
DLI 1a. Deliveries attended by Skilled Birth Provider	Scaled						18%	28%	34%		40%
Disbursement Amount: (US$ mil)		45.43						25.00	11.00		9.43
DLI 1b. Deliveries attended by Skilled Birth Provider for the bottom 3 performing regions (Afar, Oromia and Somali)	New		Av. For the three regions = 19%					National Health Equity Strategy Endorsed by FMOH	Av. For the three regions = 25%		Av. For the three regions = 28%
Disbursement Amount: (US$ mil)		20.00						1.00	10.00		9.00
DLI 2b. Children 12-23 months Immunized with Pentavalent 3 vaccine	Restructured		Baseline to be established	59.6%					65.7%		
Disbursement Amount: (US$ mil)		11.73		0					11, 73		
DLI 2c. Children 12-23 months Immunized with	Scaled		65.7%								75.7%

[70] Once level of disbursement has been verified by the Bank, disbursements will be made in equal proportions from all sources of financing allocated to the DLI.

[71] The Table shows the DLIs for the full GFF amount of US$60 million (of which $40m is lagged financing, i.e., the grant agreement will be signed for a grant $20 million to be followed by an amendment in 2018 to increase the grant by $40 million), Power of Nutrition US$20 million; IDA US150 million.

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Pentavalent 3 vaccine											
Disbursement Amount: (US$ mil)		8.13									8.00
DLI 3: Pregnant women receiving at least one antenatal care visit	Original		43%		48%		56%				
Disbursement Amount (US$ mil)		14.3			5.50		8.80				
DLI 3a: Pregnant women receiving at least four antenatal care visits	New		32%						36%		38%
Disbursement Amount (US$ mil)		20.00							12.00		8.00
DLI 4: Contraceptive Prevalence Rate	Original		27%		31%		35%				
Disbursement Amount (US$ mil)		20.5			9.85		10.65				
DLI 4a: Contraceptive Prevalence Rate (for Rural Women only)	New		32%						34%		38%
Disbursement Amount (US$ mil)		17.00							10.00		7.00
DLI 5: Health Centers reporting HMIS data in time	Original		50%	55%	60%	70%	75%	80%			
Disbursement Amount (US$ mil)		5.00		1.00	1.00	1.00	1.00	1.00			
DLI 5a: Health Centers reporting HMIS data in time	Restructured		68%					75%	80%	84%	86%

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Disbursement Amount (US$ mil)		7.77						1.77	2.00	2.00	2.00
DLI 6. Development and implementation of Balanced Score Card Approach to assess performance and related institutional incentives	Dropped			Upon development of Protocol	Implemented in 20 woredas	Implemented in 20 woredas	Review and decision on national scale up	Scale-up to 200 woredas across the country			
Disbursement Amount (US$ mil)		20.2		5.0	4.0	4.0	5.0	2.2			
DLI 7. Development and implementation of Annual Rapid Facility Assessment	Original			Survey protocol developed by EHNRI and agreed with IDA	Survey undertaken and result disclosed with proposed action to address weaknesses	Survey undertaken and result disclosed with proposed action addressing weaknesses	Survey undertaken and result disclosed with proposed action addressing weaknesses	Survey undertaken and result disclosed with proposed action addressing weaknesses			
Disbursement Amount (US$ mil)		14.00		4.0	4.0	2.0	2.00	2.00			
DLI 7c: Development and implementation of Rapid Facility Assessment	Scaled/ Restructured							Target achieved to be disbursed in 2017	Survey undertaken and results disclosed with proposed actions to address weaknesses		Survey undertaken and results disclosed with proposed actions to address weaknesses
Disbursement Amount (US$ mil)		10.95						4.95	4.00		2.00
DLI 8: Transparency of PFSA Procurement processes	Original		N/A	Website launched disclosing agreed Procurement information	Procurement information on website regularly updated and first open call for	Procurement information on website regularly updated	Procurement information on website regularly updated. PFSA produces	Procurement information on website regularly updated			

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
					prequalification of suppliers made as per the recipient's law		price tracking report				
Disbursement Amount (US$ mil)		7.00		2.00	2.00	1.00	1.00	1.00			
DLI 8c: Transparency of PFSA Procurement processes	Scaled		Website launched disclosing agreed Procurement information					Procurement information on website regularly updated	Procurement information on website regularly updated	Procurement information on website regularly updated	Procurement information on website regularly updated
Disbursement Amount (US$ mil)		10.86	-					4.86	2.00	2.00	2.00
DLI 9 (1): Introduction of Procurement Key Performance Indicators (KPIs) developed by Federal Public Procurement Agency (FPPA) at PFSA	New	N/A						Commence procurement process data recording, introduction of procurement key performance indicators using format and guidelines developed by FPPA.	PFSA produces annual performance report based on such Key Performance Indicators using data recorded under result 9a above PFSA continues recording procurement process data.	PFSA produces annual performance report based on such Key Performance Indicators using data recorded in previous year. PFSA continues recording procurement process data	PFSA produces annual performance report, based on such Key Performance Indicators using data recorded in previous year. PFSA continues recording procurement recording data.
Disbursement Amount (US$ mil)		2.00						.50	.50	.50	.50
DLI 9 (2): Automate the PFSA core business fiduciary system using Selected Software in PFSA HQ and	New		No core business fiduciary automated system at PFSA						Contract for Automation of core business fiduciary system software installation signed with vendor		Automate using selected software at PFSA HQ and Addis Ababa City Branch

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Addis Ababa City [72]											
Disbursement Amount (US$ mil)	-	7.00							3.50	-	3.50
DLI 9 (3): PFSA submission of backlog audit reports and timely quality audit reports thereafter	New		Backlog from EFY 2005-2007					Submit audit reports backlog from EFY 2005 and 2006 by December 2017	Submit audit reports backlog from EFY 2007 and 2008 by December 2018	Submit audit reports backlog from EFY 2009 and 2010 by December 2019	Submit timely and quality audit report for EFY 2011 by December 2020
Disbursement Amount (US$ mil)		6.00						2.00	2.00	1.00	1.00
DLI 10a: Percent of Children 6-59 months receiving Vitamin A Supplements	New		53% (DHS 2011)						4 percentage points from 2016 DHS		8 percentage points from 2016 DHS
Disbursement Amount (US$ mil)		5.00						-	2.5		**2.5**
DLI 10b: Percent of Woredas in non-emerging regions delivering Vitamin A Supplements to children through routine systems (i.e. Health Facilities)	New		48%					50%	55%	60%	80%
Disbursement Amount (US$ mil)		5.00						2.00	2.00	0.5	0.5
DLI 11: Percent of Pregnant women taking	New		17% (DHS 2011)						4 percentage points from the 2016 DHS		8 percentage points from the 2016 DHS

[72] At a minimum, the system should be able to reconcile balance between headquarters and branches, reconcile inter-fund balances; control bank balances; reconcile the stock; monitor advances, provide clear system over the income of the PFSA and overall consolidation of the fund managed by PFSA.

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
iron and folic acid (IFA) tablets											
Disbursement Amount (US$ mil)		5.00							2.50		2.50
DLI 12a: Percent of Children 0-23 months participating in Growth Monitoring and Promotion (GMP)	New		38% (HMIS End EFY2008 Report) *					6 percentage points increase from baseline	12 percentage points increase from baseline	18 percentage points increase from baseline	24 percentage points increase from baseline
Disbursement Amount (US$ mil)		15.00						5.00	5.00	2.50	2.50
DLI 12b: Percent of woredas in Emerging regions transitioning from EoS to Community Health Days (CHD)	New		baseline: 0% (HMIS)					10 percentage points increase from baseline	20 percentage points increase from baseline	35 percentage points increase from baseline	50 percentage points increase from baseline
Disbursement Amount (US$ mil)		5.00						1.50	1.50	1.50	0.50
DLI 13 (1): Percent of PHC facilities having all drugs from the MOH list of essential drugs available	New		42%					By December 31, 2017 Develop Quality Standards for PHC facilities [73]	Increase in PHC facilities having all drugs from MOH list of essential drugs from baseline up to 44.5%	By December 31, 2019 Revise and update the Quality Standards for PHCs developed in 2017	Increase in PHC facilities having all drugs from MOH list of essential drugs from baseline up to a max of 47%
Disbursement Amount (US$ mil)		7.00						2.00	3.00	1.00	1.00

[73]PHC Quality guidelines define the standards of health care at Primary Health Care units.

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
DLI 13 (2): Develop and implement postnatal care service directive to improve the quality of postnatal services	New		N/A					By December 31, 2017 Develop a Postnatal Care Directive[74]	By December 31, 2018 Implement Postnatal Care Directive in all PHCs	By December 31, 2019 Monitor the implementation of the Directive by reviewing the use of the Directive at Facilities	Assess the effectiveness of the implementation of the directive and document lessons through a report on the experience
Disbursement Amount (US$ mil)		5.00	-					1.00	2.00	1.00	1.00
DLI 13 (3): Improve quality of adolescent health services	New	-	N/A					By December 31, 2017 Publication of the Government Endorsed Adolescent and Youth Health Strategy	By December 31, 2018 Develop a Standard Package of Health Services for Schools	By December 31, 2019 Develop a training manual for healthcare providers to build their competencies in providing the minimum health services package to adolescents	By December 31, 2020 Increase in PHCs providing adolescent health services from 60% to 75%
Disbursement Amount (US$ mil)		6.00	-					1.00	3.00	1.00	1.00
DLI 14 (1): Percent of woredas with functional Community Based Health Insurance (CBHI) schemes	New	-	N/A					Baseline established (Prior Result)	20 percentage points increase from baseline	25 percentage points increase from baseline	30 percentage points increase from baseline
Disbursement Amount (US$ mil)		19.50						9.50	5.00	2.50	2.50
DLI 14 (2): Undertake CBHI schemes review every two years	New		N/A					By December 31, 2017 undertake review of the implementation		By December 31, 2019 undertake review of the implementation	

			Indicative Timeline for DLI Achievement (Original)					Indicative Timeline for DLI Achievement (AF)			
Indicator	**Type of indicator**	**Total financing**	**Baseline and means of measurement**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
								of CBHI schemes for the period January 2016-December 2017, and developing actions on areas that need improvement, and disclosure of results with remedial action plan.as needed.		of CBHI schemes for the period January 2016-December 2017, and developing actions on areas that need improvement, and disclosure of results with remedial action plan.as needed.	
Disbursement Amount (US$ mil)		5.00	-					3.00		2.00	
DLI 15 (1): Devise and implement a mechanism for documenting consultations when communal/ private land is used for construction of health facilities	New		N/A No/Yes					By December 31, 2017 Devise a mechanism for systematically documenting consultations validated by communities when communal/ private land is used for construction of health facilities	By December 31, 2018 Implement the mechanism for documenting consultations for land use and acquisition in 10%. of woredas	By December 31, 2019 Implement the mechanism for documenting consultations for land use and acquisition in 50%. of woredas	By December 31, 2018 Implement a mechanism for documenting consultations for land use and acquisition in 70%
Disbursement Amount (US$ mil)		4.50						1.00	1.00	1.50	1.00
DLI 15 (2): Development and implementation of Health Sector Community Score Card (CSC)	New		N/A					By December 31, 2017 Develop Health Sector CSC Directive setting out the CSC Mechanism	By December 31, 2018 Pilot the implementation of the Health Sector CSC in 56 agrarian and pastoralist woredas from a baseline of 0.	By December 31, 2019 Review the pilot and implement the Health Sector CSC in up to 56 woredas	Implement the Health Sector CSC in 400 woredas including woredas in 4 emerging regions
Disbursement Amount (US$ mil)	-	5.00	-					1.00	2.00	1.00	1.00

Summary Indicator Description and DLI Verification Protocol Table

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
Indicator 1: Deliveries attended by Skilled Birth provider	Original	Numerator: Number of women having a live birth during prior 5 years who were assisted by a skilled provider (medical doctor, nurse and midwife) in their most recent birth Denominator: Women 15-49 having a live birth during the prior 5 years, excluding women who delivered by C-section	Yes	Three times during the program period	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results
Indicator 1a: Deliveries attended by Skilled Birth provider	Original	Numerator: Number of women having a live birth during prior 5 years who were assisted by a skilled provider (medical doctor, nurse and midwife) in their most recent birth Denominator: Women 15-49 having a live birth during the prior 5 years, excluding women who delivered by C-section	Yes	Three times during the program period	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results
Indicator 1b: Deliveries attended by skilled birth provider for the Bottom 3 Performing Regions	New	Upon development and endorsement of the National Health Equity strategy by FMOH	No	2017	National equity strategy disseminated and posted on FMOH website	MOH, RHB and respective technical working group	Technical Partners (excl. Bank)	Develop the strategy and disseminate to stakeholders

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
Indicator 1c: Deliveries attended by Skilled Birth providers for the bottom 3 performing regions (in DHS 2016) (Afar, Oromia and Somali)	New	Numerator: Number of women in Afar, Oromia and Somali that had a live birth during prior 5 years who were assisted by a skilled provider (medical doctor, nurse and midwife) in their most recent birth Denominator: Women15-49 in Afar, Oromia and Somali Regions that had a live birth during the prior 5years, excluding women who delivered by C-section	Yes	Two times during the program period	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results
Indicator 2c: Children 12-23 months Immunized with Pentavalent 3 vaccine	Restructured	Numerator: Children age 12-23 months who received the Penta3 vaccine at any time before the survey, with the information from either a vaccination card or mother's report Denominator: All children 12-23 months at the time of the survey	Yes	Two times during the program period	Household Cluster Surveys	EPHI/CSA supported by Partners	EPHI/CSA supported by Partners	Undertake survey and disclose results
Indicator 3a: Pregnant women receiving at least four antenatal care visits	New	Numerator: Women 15 - 49 who had a live birth in the five years preceding the survey, who received antenatal care at least four times from a skilled provider (including HEW) for the most recent birth Denominator: All women 15-49 who had a live birth in the five years preceding the survey	Yes	Two times during the program period	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results
Indicator 4a: Contraceptive Prevalence Rate (for Rural Women Only)	New	Numerator: Currently married women (rural) 15-49 years of age who are currently using a modern method of contraception Denominator: All currently married women15-49	Yes	Two times during the program period	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results
Indicator 5a: Health Centers reporting HMIS data in time	Restructured	Numerator: Sum of number of Health Centers submitting their Quarterly Reports on time	Yes	Annual	HMIS Regional Annual Report:	Collection of HMIS by MOH HNP partners	Annual data validation of HMIS	Undertake Data Quality Assessment

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
		Denominator: Number of Health Centers				excl. Program partners	by technical partners	
Indicator 7c: Development and implementation of Rapid Facility Assessment	Scaled	Upon undertaking of Rapid Facility Assessment to assess facility readiness for delivery of key maternal and child health services.	No	Every two years	Survey undertaken and results disclosed with proposed actions to address weaknesses	EPHI/CSA with technical support	EPHI/CSA with technical support	Random data quality check with TA from Partners/IDA
Indicator 8: Transparency of PFSA procurement processes	Scaled	Completion of actions as per schedule. Website procurement information regularly updated disclosing information on: 1) Procurement Plan and its revisions; 2) Specific procurement advertisement; 3) award decisions (product, bidders, contract amount, scope of contract, winning agency, and country of winning agency); 4) Standard Bidding Documents; and 5) Proceedings of annual meetings with suppliers. Periodic open call to allow interested suppliers to pre-qualify as per the recipient's law.	No. Completion of actions year-wise. Website procurement information regularly updated and first open call for pre-qualification of suppliers as per the recipient's law issued. Website procurement information regularly updated.	Annual	Annual Report of FPPA indicating the progress. PFSA produces price tracking report.	Independent consultant employed by Government	Independent consultant employed by Government	Review of website
Indicator 9 (1): Introduction of Procurement Key Performance Indicators (KPIs) developed by Federal Public Procurement Agency (FPPA) at PFSA	New	(a) PFSA commences the procurement process data recording using procurement key performance indicators using format and guidelines developed by FPPA.	No. Completion of actions year-wise.	Annual	Procurement process data recording commenced using the format and guideline developed by FPPA	Independent consultant employed by Government	Independent consultant employed by Government	Review of reports
		(b) (c) (d) PFSA measures its procurement performance and monitoring through KPIs developed by FPPI and reports progress on KPIs	No. Completion of actions year-wise	Annual	PFSA produces annual performance report based on KPIs pertaining to analyzed data	Independent consultant employed by Government	Independent consultant employed by Government	Review of Information at PFSA and preparation of Report

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
					captured during the previous year			
Indicator 9 (2): Automate the PFSA core business fiduciary system using Selected Software in PFSA HQ and Addis Ababa City	New	(a) Contract for Automation of core business fiduciary system software installation signed with vendor[75]	No. Completion of action as per the schedule.	Annual/ Once	Report shared by PFSA	Independent consultant employed by Government	Independent consultant employed by Government	Review of Information at PFSA and preparation of Report
		(b) Upon software utilization by PFSA headquarters and Addis Ababa City Branch	No. Completion of action as per the schedule.	Annual/ Once	Report shared by PFSA	Independent consultant employed by Government	Independent consultant employed by Government	Review of Information at PFSA and preparation of Report
Indicator 9 (3): PFSA submission of backlog audit reports and timely quality audit reports thereafter		i) Submitting the audit backlog of the PFSA for the years EFY 2005- 2006 by December 2017; (ii) Audit report for EFY 2007-2008 is submitted by December 2018 (iii) Audit report for EFY 2009-2010 is submitted by December 2019; iv) Audit report for EFY 2011 is submitted timely and with quality by December 2020.	No, completion of audits as per the schedule	Annual	PFSA and Report from Audit Service Corporation.	Audit Service Corporation	Audit Service Corporation	Review of Information at PFSA and Branches; and preparation of Report
Indicator 10a: Percent of Children 6-59 months receiving Vitamin A Supplements	New	Numerator: Children age 6-59 months who received the Vitamin A Supplement in the six months before the survey, with the information from either a vaccination card or mother's report Denominator: All children 6-59 months at the time of the survey.	Yes	Two times during the program period	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results

[75] At a minimum, the system should be able to reconcile balance between headquarters and branches, reconcile inter-fund balances; control bank balances; reconcile the stock; monitor advances, provide clear system over the income of the PFSA and overall consolidation of the fund managed by PFSA.

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
Indicator 10b: Percent of Woredas in non-Emerging Regions delivering Vitamin A Supplements to children through routine systems (i.e. Health Facilities)	New	Numerator: Woredas providing Vitamin A Supplements through a health post and health center Denominator: Total number of woredas in Agrarian Regions/non Emerging Regions	Yes	Annual	HMIS Regional Annual Report:	MOH	Joint review mission with Nutrition partners excl. Program partners and support of Technical Assistance	Data is collected and results disclosed
Indicator 11: Percent of Pregnant women taking iron folic and acid (IFA) tablets	New	Numerator: Women who took iron and folic tablets during the pregnancy of the most recent birth in the past five years Denominator: All women who had a birth in the past five years	Yes	Twice during implementation	Regular/ interim Demographic and Health Survey	CSA and EPHI with technical assistance from ICF Macro	CSA/ ICF Macro	Undertake survey and disclose results
Indictor 12a: Percent of Children 0-23 months participating in Growth Monitoring and Promotion (GMP)	New	Numerator: Number of children aged 0-23 months that participated in Growth Monitoring and Promotion (GMP) in a year excluding woredas receiving CIFF support for nutrition Denominator: Number of children aged 0-23 months in a year excluding those woredas receiving CIFF support for nutrition	Yes	Annual	HMIS and annual progress report of MOH/RMNCH	MOH	Joint HPN Review Mission (excl. Program partners) with Technical Assistance	Analyze data and report prepared
Indictor 12b: Percent of woredas in Emerging regions transitioning from EoS to Community Health Days (CHD)	New	Numerator: Woredas in Emerging regions (Afar, Benishangul-Gumuz, Gambella, and Somali) delivering nutrition services through CHD Denominator: Number of woredas in Emerging regions	Yes	Annual	HMIS and annual progress report of MOH/RMNCH Directorate	MOH	Joint review mission with Nutrition partners excl. Program partners and support of Technical Assistance	Data analysis and report prepared

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
Indictor 13 (1): Percent of PHC facilities having all drugs from the MOH list of essential drugs available	New	(a) (c) Develop and revise quality improvement manual (including standards) for PHCs	No	Every two years	Program report of MOH/RMNCH	MOH/ Quality Directorate	Technical Working Group/ relevant technical partners	TWG to review the developed quality improvement manual (including standards)
		(b) (d) Numerator: number of facilities with essential drugs (20 tracer drugs) at the time of the survey in required adequate amounts and in the appropriate dosage forms. Denominator: number of functioning health facility	No	Annual	Regular Facility Survey by EPHI and CSA. Mean availability of essential drug to be measured	EPHI / CSA with Technical Assistance	EPHI / CSA with Technical Assistance	Random data quality checks with TA form Partner/IDA
Indictor 13 (2): Develop and implement postnatal care service directive to improve the quality of postnatal services	New	(a) Develop the postnatal care service Directive	No	2017	Program report of MOH/RMNCH	MOH/RMNCH	Technical Working Group/ relevant technical partners	TWG to review the developed quality improvement manual (including standards)
		(b) Implement the Postnatal Care Directive in all PHCs		2018	Program report of MOH/RMNCH	MOH/RMNCH and RHB	Technical Working group with Technical Assistance	TWG to review the implementation report of the postnatal care directive
		(c) Monitor the implementation of the Directive by reviewing the use of the Directive at Facilities	No	2019	Annual report of MOH/RMNCH	MOH/RMNCH and RHB	Joint Review Mission including RMNCH partners excl. Program Partners	Desk Review and Field Visits
		(d) Assess the effectiveness of the implementation of the directive and document lessons through a report on the experience		2020	Review of the implementation of the directives in facilities.	TWG with support of Technical Assistance	Technical Working group with support of Technical Assistance	Desk Review and Field Visits

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
Indictor 13 (3): Improve quality of adolescent health services	New	(a) Upon publication of the Government endorsed Adolescent and Youth Health Strategy	No	By December 31, 2017	Adolescent and youth health strategy developed and endorsed by MOH and shared to respective stakeholders	MOH with support of Technical Assistance	Review dissemination process with relevant technical partners.	Strategy disseminated
		(b) Upon development of a Standard package of health services for Schools	NO	By December 31, 2018	MOH Report	MOH with support of Technical Assistance, respective line ministries and technical partners	Technical Working group with support of Technical Assistance	Development of basic package
		(c) Develop training manual for health care providers to build their competency in providing Adolescent friendly health services	No	By December 31, 2019	Annual progress report	MOH and respective partners	Technical Working group with support of Technical Assistance	Desk Review
		(d) Numerator: Number of PHCs providing adolescent Health Services Denominator: Number of PHCs	yes	By April 31, 2020	SARA	EPHI /CSA with Technical Assistance	EPHI /CSA with Technical Assistance	Data collected and results disclosed
Indicator 14 (1): Proportion of woredas with functional Community Based Health Insurance (CBHI) schemes	New	(a) Baseline Established	No	Once	Report of EHIA validated by Health Care Financing Partners Excl. Program Partners	EHIA	Health Care Financing Partners Excl. Program Partners	Desk and Field Review
		(b) Numerator: Number of woredas with functional CBHI Schemes Denominator: Number of woredas	Yes	Annual	Annual Progress report of EHIA and Branch Office report And validated by services	EHIA	Joint review mission with support of technical assistance	Desk review and field visit

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	**Responsibility for Data Verification**	**Procedure**
					availability and readiness survey			
Indicator 14 (2): DLI 14b: Undertake CBHI schemes review every two years	New	Review of CBHI schemes every two years.	No	Twice during the program period	Government and Partners Joint Review Mission report	MOH, EHIA-HCF partners with technical assistance including validation of report	Relevant Technical Partners with Technical Assistance	Desk Review and Field Visits
Indicator 15 (1): Devise and implement a mechanism for documenting consultations when communal/ private land is used for construction of health facilities	New	(a) Develop a standard template for documenting consultations validated by communities when communal/ private land is used for construction of health facilities	No	Annual	MoH Annual Governance and E&S Report	MOH/ Reform Directorate	Technical Working Group	Desk Review and experience sharing from other sectors
		(b) and (c) Implement such developed mechanism in (a) above in 10%; 50% of woredas and 70% of woredas	No	Annual	MoH Annual Governance and E&S Report	MOH/ PFSA/Reform Directorate	Joint review mission with the support of Technical Assistance	Desk Review and Field Visits
Indicator 15 (2): Development and implementation of Health Sector Community Score Card (CSC)	New	(a) Develop Health Sector CSC Directive setting out the CSC Mechanism	No	2017	MOH PPD Annual Report	MOH /Reform Directorate	Development Partners (excluding Bank) members of Technical Working Group	Desk Review and Field Visits
		(b) Pilot the implementation of the Health Sector CSC in up to 56 woredas including agrarian and pastoralist	No	2018	MOH PPD Annual Report	MOH /Reform Directorate	Development Partners (excluding Bank) members of Technical Working Group	Desk Review and Field Visits
		(c) Review the pilot and implementation of the Health Sector CSC in up to 56 woredas in (b) above	No	Annual	Government and Partners Joint Review Mission report	TWG with support of Technical Assistance	TWG with support of Technical Assistance	Desk Review and Field Visits

DLI	*Type of indicator*	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Frequency/ Expected Timing of Achievement	Data Source/ Methodology	Protocol to evaluate achievement of the DLI and data/result verification		
						Responsibility for Data Collection	Responsibility for Data Verification	Procedure
		(d) Implement Health Sector CSC in 400 woredas including in 4 emerging regions	Yes	Annual	Government and Partners Joint Review Mission report	TWG with support of Technical Assistance	TWG with support of Technical Assistance	Desk Review and Field Visits

Allocation of the Credit and Grants per Category and ceiling amounts for Advances and Prior Results

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
Indicator 1: Deliveries attended by Skilled Birth Providers	Original	Increase in delivery attended by skilled birth provider from baseline 10% up to a maximum of 18%. US$2.5 million from HRITF Grant; SDR 1.6275 million from Credit No. 5209, for each 1% increase	SDR 3,262,669.19	SDR 0.00	SDR 3,262,669.19	0.00	0.00	0.00	Allocation to the DLI (SDR0.407834mil) Maximum DLI increment for disbursement (8%)
Indicator 1a: Deliveries attended by Skilled Birth Providers	Scaled	Increase in delivery attended by skilled birth provider from baseline 18% up to a maximum of 40%. US$2.6 million from HRITF Grant; thereafter US$558,250 from GFF Grant, thereafter SDR 1.395 million from Credit No. 5209, and thereafter SDR 1.139 million from AF Credit, for each 1% increase	SDR 9,765, 000	SDR 12, 530, 000	SDR 22, 295, 000	5,200,000.00	5,000,000.00	0.00	Allocation to the DLI ($45.43 mil) Maximum DLI increment for disbursement (22%)
Indicator 1b: Deliveries attended by Skilled Birth providers for the bottom 3 performing regions (in DHS 2016) (Afar, Oromia and Somali)	New	Upon endorsement of an equity strategy that addresses least performing regions	0.00	SDR 750, 000	SDR 750, 000	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 1c: Deliveries attended by Skilled Birth providers for the bottom 3 performing regions (in DHS 2016) (Afar, Oromia and Somali)	New	Increase in delivery attended by skilled birth provider for the bottom 3 performing regions from baseline 19% up to 29%. US$ 0.558250 million from GFF Grant; thereafter SDR 1.4743 million from AF Credit, for each 1% increase	0.00	SDR 10, 320, 000	SDR 10, 320, 000	0.00	5,000,000.00	0.00	Allocation to the DLI ($19mil) Maximum DLI increment for disbursement (10%)
Indicator 2b: Children 12-23 months Immunized with Pentavalent 3 vaccine	Restructured	Increased immunization up to a maximum of 6 percentage points from baseline (determined by (2)(a) as 59.6%) to reach a maximum of 65.7%	SDR 7, 161, 000	0.00	SDR 7, 161, 000	2,000,000.00	0.00	0.00	Allocation to the DLI ($7 mil) Maximum

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
		US$1 million from HRITF Grant; thereafter SDR 1.746 million from Credit No. 5209 for each 1% increase							DLI increment for disbursement (6%)
Indicator 2c: Children 12-23 months Immunized with Pentavalent 3 vaccine	Scaled	Increased immunization by 10 percentage points from baseline of 65.7% to a maximum of 75.7% US$.446 million for 1% increase from the GFF grant thereafter SDR equ. of SDR 0.516 from IDA Credit AF	0.00	SDR 3, 050, 000	SDR 3, 050, 000	0.00	4,000,000.00	0.00	Allocation to the DLI ($8 mil) Maximum DLI increment for disbursement (10%)
Indicator 3a: Pregnant women receiving at least four antenatal care visits	New	Increase in pregnant women receiving at least four antenatal care visits up to a maximum of 38% from baseline of 32% US$ US$ 0.55825 million from GFF Grant; thereafter SDR 2.764 million from AF Credit, for each 1% increase	0.00	SDR 11, 056, 000	SDR 11, 056, 000	0.00	5,000,000.00	0.00	Allocation to the DLI $20 mil. Maximum DLI increment for disbursement (6%)
Indicator 4a: Contraceptive Prevalence Rate (for rural women only)	New	Increase in Contraceptive prevalence rate in rural women up to a maximum of 38% from baseline of 32% US$ 0.55825 million from GFF Grant; thereafter SDR 2.211 million from AF Credit, for each 1% increase	0.00	SDR 8, 844, 000	SDR 8, 844, 000	0.00	5,000,000.00	0.00	Allocation to the DLI ($17 mil) Maximum DLI increment for disbursement (6%)
Indicator 5: Health Centers reporting HMIS data in time	Original	Increase up to a maximum of 80% from baseline 50% SDR 108,500 for each 1% increase	SDR 1,302,000	0.00	SDR 1,302,000	0.00	0.00	0.00	Allocation to the DLI ($5 mil) Maximum DLI increment for disbursement (30%)
Indicator 5a: Health Centers reporting HMIS data in time	Scaled	Increase up to a maximum of 86% from baseline of 68% US$ 0.223 million from GFF Grant; thereafter SDR 0.1844 million from AF Credit, for each 1% increase	0.00	SDR 2, 950, 000	SDR 2, 950, 000	0.00	2,000,000.00	0.00	Allocation to the DLI ($7.77 mil) Maximum DLI increment for disbursement (18%)
Indicator 7b: Development and implementation of	Original	(b) Upon undertaking Annual Rapid Facility Assessment and disclosing results with actions to	SDR 3,643,644	0.00	SDR 3, 643, 644	0.00	0.00	0.00	Achievement of agreed milestones

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
Annual Rapid Facility Assessment		address weaknesses as envisaged by the Program.							
Indicator 7c: Development and implementation of Annual Rapid Facility Assessment	Scaled	Upon undertaking Rapid Facility Assessment and disclosing results with actions to address weaknesses as envisaged by the Program, for each of the calendar years ending December 31, 2018 and December 31, 2020 SDR 2.948 million by December 2018, and SDR 1.592 million by December 2020 from AF Credit	0.00	SDR 4,540,000	SDR 4,540,000	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 8a: Transparency of PFSA Procurement Processes	Original	(a) Upon launching the website disclosing agreed information	SDR 323, 973.41	0.00	SDR 323, 973.41	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 8b: Transparency of PFSA Procurement Processes	Scaled	(b) Upon updating the website with procurement information, issuing open call for pre-qualification of suppliers issued as per the Recipient's procurement law and proclamations, and producing price tracking report, as envisaged by the Program for each of the calendar years ending December 31, 2016 and December 31, 2017 SDR equivalent of US$ 1.6275million from Credit No. 5209, for each of the calendar years	SDR 3,255,000.00	0.00	SDR 3,255,000.00	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 8c: Transparency of PFSA Procurement Processes	Scaled	Upon updating the website with procurement information, issuing open call for pre-qualification of suppliers issued as per the Recipient's procurement law and proclamations, and producing price tracking report, as envisaged by the Program for each of the calendar years ending December 31, 2018,	0.00	SDR 4, 570, 000	SDR 4, 570, 000	0.00	0.00	0.00	Achievement of agreed milestones

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
		December 31, 2019 and December 31, 2020. SDR 1.5233 million from AF Credit, for each of the calendar years.							
Indicator 9 (1): Introduction of Procurement Key Performance Indicators (KPIs) developed by Federal Public Procurement Agency (FPPA) at PFSA	New	(a) Upon commencement of process data recording, introduction of Procurement KPI using formal and guidelines developed by FPPA.	0.00	SDR 370, 000	SDR 370, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(b) PFSA produces annual performance report for calendar years ending December 31, 2018, December 31, 2019, and December 31, 2020 December based on such key performance indicators using data recorded under result 9a above SDR 0.37 million from AF Credit IDA, for each of the calendar years.	0.00	SDR 1, 110, 000	SDR 1, 110, 000	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 9 (2): Automate the PFSA core business fiduciary system using Selected Software in PFSA HQ and Addis Ababa City [76]	New	(a) Upon contract signing for software installation by December 2018	0.00	SDR 2, 580, 000	SDR 2, 580, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(b) Upon software utilization by PFSA headquarters and Addis Ababa City Branch by December 2020	0.00	SDR 2, 580, 000	SDR 2, 580, 000	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 9 (3): PFSA submission of backlog audit reports and timely quality audit reports thereafter	New	(a) Submit audit reports backlog from EFY 2005 and 2006 by December 2017 (b) Submit audit reports backlog from EFY 2007 and 2008 by December 2018 (c) Submit audit reports backlog from EFY 2009 and 2010 by December 2019	0.00	SDR 4, 420, 000	SDR 4, 420, 000	0.00	0.00	0.00	Achievement of agreed milestones

[76] At a minimum, the system should be able to reconcile balance between headquarters and branches, reconcile inter-fund balances; control bank balances; reconcile the stock; monitor advances, provide clear system over the income of the PFSA and overall consolidation of the fund managed by PFSA.

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
		(d) Submit timely and quality audit report for EFY 2011 by December 2020							
Indicator 10a: Percent of Children 6-59 months receiving Vitamin A Supplement	New	Increased Vitamin A supplementation up to a maximum of 8 percentage points from 2016 DHS baseline US$ 0.23 million from PN Grant; thereafter SDR equivalent of US$0.625 million from AF Credit, for each 1% increase	0.00	SDR 1,840,000	SDR 1,840,000	0.00	0.00	2,500,000.00	Allocation to the DLI ($5 mil) Maximum DLI increment for disbursement (8 percentage points)
Indicator 10b: Percent of Woredas in non-emerging regions delivering Vitamin A Supplements to children through routine systems (health facilities)	New	Increased delivery of Vitamin A supplementation using routine systems in Woredas in Non-Emerging Regions up to a maximum of 80 % from a baseline of 48% US$ 0.156250 million from PN Grant; thereafter SDR equivalent of 0.115 million from AF Credit, for each 1% increase.	0.00	SDR 1,840,000	SDR 1,840,000	0.00	0.00	2,500,000.00	Allocation to the DLI ($5mil) Maximum DLI increment for disbursement 32 percentage points increase
Indicator 11: Percent of Pregnant women taking iron and folic acid (IFA) tablets	New	Increased use of iron and folic acid tablets among pregnant women up to a maximum of 8 percentage points from 2016 DHS baseline US$ 0.625 million from PN Grant; thereafter SDR 0.46 million from AF Credit, for each 1% increase.	0.00	SDR 1,840,000	SDR 1,840,000	0.00	0.00	5,000,000.00	Allocation to the DLI ($5 mil) Maximum DLI increment for disbursement 8 percentage points increase
Indictor 12a: Percent of Children 0-23 months participating in Growth Monitoring Promotion (GMP)	New	Increased children's participation in Growth Monitoring Promotion up to a maximum of 62% from a baseline of 38% US$ 0.625 million from PN Grant; thereafter SDR 0.46083 million from AF Credit, for each 1% increase.	0.00	SDR 5,530,000	SDR 5,530,000	0.00	0.00	7,500,000.00	Allocation to the DLI ($15 mil) Maximum DLI increment for disbursement (24 percentage points

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
Indictor 12b: Percent of Woredas in emerging regions transitioning from EoS to CHD	New	Increased percent of woredas using Community Health Days in Emerging Regions up to a maximum of 50% from a baseline of 0% US$ 0.1 million from PN Grant; thereafter SDR 0.0736 million from AF Credit, for each 1% increase.	0.00	SDR 1,840,000	SDR 1,840,000	0.00	0.00	2,500,000.00	Allocation to the DLI ($5 mil) Maximum DLI increment for disbursement (50%)
Indictor 13 (1): Percent of PHC facilities having all drugs from the MOH list of essential drugs available	New	(a) Upon development of the quality standard for PHCs by December 2017.	0.00	SDR 1, 470,000	SDR 1, 470,000	0.00	0.00	0.00	Achievement of agreed milestones
		(b) Increased availability of all drugs from the MoH list of essential drugs in PHC facilities up to a maximum of 45% from a baseline of 42% SDR 0.7367 million from AF Credit, for each 1% increase	0.00	SDR 2, 210,000	SDR 2, 210,000	0.00	0.00	0.00	Allocation to the DLI ($3 mil) Maximum DLI increment for disbursement (3%)
		(c) Upon revision of the quality standard for PHCs developed in 2017 by December 2019	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(d) Increased availability of all drugs from the MoH list of essential drugs in PHC facilities up to a maximum of 47 % from 45 % SDR 0.37 million from AF Credit, for each 1% increase	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Allocation to the DLI ($1 mil) Maximum DLI increment for disbursement (2%)
Indictor 13 (2): Develop and implement postnatal care service directive to improve the quality of postnatal services	New	(a) Upon development of the postnatal care services directives by December 31, 2017 (b) Upon implementation of the Postnatal Care Directive in all PHCs by December 31, 2018 (c) Monitor the implementation of the Directive by reviewing the use of the Directive at Facilities by December 31, 2019	0.00	0.00	0.00	0.00	5,000,000.00	0.00	Achievement of agreed milestones

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
		(d) Assess the effectiveness of the implementation of the directive and document lessons through a report on the experience by December 31, 2020							
Indictor 13 (3): Improve quality of adolescent health services	New	(a) Upon development, and endorsement of Adolescent and Youth Health Strategy by December 31, 2017	0.00	0.00	0.00	0.00	1,000,000.00	0.00	Achievement of agreed milestones
		(b) Upon development of a package of Health Services for Schools by December 31, 2018	0.00	0.00	0.00	0.00	3,000,000.00	0.00	Achievement of agreed milestones
		(c) Upon development of a training manual for healthcare providers to build their competencies in providing the minimum health services package to adolescents by December 31, 2019	0.00	0.00	0.00	0.00	1,000,000.00	0.00	Achievement of agreed milestones
		(d) Increase in PHCs adolescent health services from baseline 60% to 75% By December 31, 2020 US$0.029773 from GFF Grant for each 1% increase	0.00	0.00	0.00	0.00	1,000,000.00	0.00	Allocation to the DLI ($1 mil) Maximum DLI increment for disbursement (15%)
Indicator 14 (1): Percent of woredas with functional Community Based Health Insurance (CBHI) schemes	New	(a) Upon establishment of a baseline for the percent of woredas with functional CBHI schemes (prior result)	0.00	SDR 4, 800, 000	SDR 4, 800, 000	0.00	3,000,000.00	0.00	Achievement of agreed milestones
		b, c, d) Increase in the proportion of Woredas with functional community-based health insurance schemes up to a maximum of 30 percentage points from baseline	0.00	0.00	0.00	0.00	10,500,000.00	0.00	Allocation to the DLI ($10.5 mil) Maximum DLI increment for disbursement (30 percentage points)
Indicator 14 (2): Undertake CBHI schemes review undertaken every two years	New	Upon undertaking review of implementation of CBHI schemes for the 2 calendar years ending December 31, 2017 and December 31, 2019, and developing actions on areas that need improvement, and	0.00	SDR 3, 690, 000	SDR 3, 690, 000	0.00	0.00	0.00	Achievement of agreed milestones

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
		disclosure of results with remedial action plan.as needed. SDR 2.2110 million by December 2017 and SDR1.474 million by December 2019 from AF Credit, for each review period							
DLI 15 (1): Devise and implement a mechanism for documenting consultations when communal/ private land is used for construction of health facilities	New	(a) Upon devising a mechanism for systematically documenting consultations validated by communities when communal/ private land is used for construction of health facilities by December 31, 2017	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(b) Upon Implementation of the mechanism for documenting consultations for land use and acquisition in 10% of woredas by December 31, 2018	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(c) Upon Implementation of the mechanism for documenting consultations for land use and acquisition in 50% of woredas by December 31, 2019	0.00	SDR 1, 110, 000	SDR 1, 110, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(d) Implement a mechanism for documenting consultations for land use and acquisition in 70% by December 31, 2020	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones
Indicator 15 (2): Development and implementation of Community Score Card (CSC)	New	(a) Develop Health Sector CSC Directive setting out the CSC Mechanism by December 31, 2017	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(b) Pilot the implementation of the Health Sector CSC up to 56 agrarian and pastoralist woredas base line from zero by December 2018	0.00	SDR 1, 470, 000	SDR 1, 470, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(c) Review the pilot and implement the Health Sector CSC in up to 56 woredas by December 31, 2019	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones
		(d) Implement CSC in 400 woredas including woredas in 4 emerging regions by December 31, 2020	0.00	SDR 740, 000	SDR 740, 000	0.00	0.00	0.00	Achievement of agreed milestones

Category Disbursement Linked Indicators	Type of Indicator	Disbursement Linked Result and corresponding value (New/AF)	Amount of IDA Credit Allocated from Original (Balance of Original Credit in SDR)	Amount of IDA Credit Allocated from AF	Total Amount of IDA Credit Allocated (SDR)	Amount of HRITF Grant Allocation (expressed in US$)	Amount of GFF Grant Allocation (expressed in US$)	Amount of PN Grant Allocation (expressed in US$)	Determination of Financing Amount to be disbursed against achieved and verified DLI values
		Total	**39,000,000.00**	**110,600,000.00**	**120,365,000.00**	**7,200,000.00**	**51,500,000.00**	**17,500,000.00**	
							Prior result	**25,000,000.00**	
							Advance from Credit AF only	**34,750,000.00**	
							Advance from GFF	**12,875,000.00**	
							Advance from PN	**4,375,000.00**	
							Total Advance + prior result	**77, 000,000**	

Annex XI: Revised Program Action Plan

1. The proposed program action plan addresses the key gaps identified by the technical, fiduciary and environment assessments and supports program implementation. The major gaps in the system are: (a) improve the implementation and coordination capacity of the health sector (system and technical capacity of the staff); (b) putting in place an information mechanism to inform about health facility readiness to deliver the essential health services required to achieve the SDGs. One DLI and list of activities under the IPF component are proposed to address these important technical needs.

2. Ensuring timely availability of health products is critical for delivering quality services. The Government is using significant part of donor support through the SDG fund for supply of health products and essential equipment. Despite its strengths, the assessments noted some weaknesses in PFSA fiduciary systems, especially in the areas of transparency, improving competition contract management and complaint redress. It is proposed that PFSA implements the agreed actions to address the identified weaknesses to achieve its vision to become a world class procurement and distribution agency in the health sector. Timely submission of the quarterly financial and activity reports is a requirement of the JFA. This requirement needs to be strictly enforced to regularly update the pooling partners about the program.

3. Finally, the program requires a strong institutional framework to improve the environmental and social systems related to delivery and expansion of health services giving priority attention to regions requiring special attention. The health sector with decentralized nature of functioning is prone for governance and accountability challenges. It is therefore important to ensure that the program has effective mechanisms to deal with fraud and corruption.

	Action Description	**DLI**	**Due Date**	**Responsible Party**	**Completion Measurement**
1.	Development of a Postnatal care Directive/policy, Implementation of the directive/policy and Monitoring of the policy/directive.	☒	2018	FMOH RMNCH Directorate	Manual/policy and implementation report available
			2020	Ethiopia Public Health Institute with TA from the Bank	Evaluation report available
2.	Commodity distribution process - Roll out of APTS and provide progress update to ensure existence of adequate monitoring mechanism of delivery to ultimate beneficiaries at the branch level		Annually	Regional Health Bureaus and PFSA	MOH report

	Action Description	DLI	Due Date	Responsible Party	Completion Measurement
3.	PFSA launches an open call for pre-qualifications bidders as per the Recipient's law at least once and introducing Framework Contracting Methods for common and repetitive procurement items.	☒	Once every three years.	PFSA	Open call made.
4.	Ensure a system of recording fraud and corruption complaints at all levels including woredas; Ensure the deployment of Ethics and Anticorruption Liaison Officer and experts at all levels (PFSA; PFSA regional Hubs; RHBs, offices); Build capacity for the control of Fraud and Corruption at all levels (PFSA; PFSA regional Hubs; RHBs, and woreda offices).		By Dec, 2018	FMOH, PFSA	FMOH Governance Report
5.	Automation of PFSA	☒	Annual	PFSA	Annual Report.
6.	FPPA undertaking annual procurement audit and FMOH and Bank team to consult OFAG on the feasibility of undertaking financial and value for money audits for SDGPF		Annual	MOH Audit Directorate and Financial Resource Mobilization Directorate	Annual Audit Reports available
7.	Review and improve the SBD and agree with FPPA; and review current Bid Evaluation reporting methods and develop a template that keeps and records all relevant evaluation information		Annual	FMOH and PFSA	PFSA Annual Report
8.	Improve tracking system of monitoring contracts with UN agencies and disclose award decisions to the public.		Annual	FMOH Logistics Unit and Finance and Procurement Directorates	Annual Report
9.	Undertake assessment study and develop coding and categorization system of procurable items		Annual	PFSA	PFSA Annual Report
10.	Gender based violence strategy for the health sector is prepared and implemented and analytical		Annual	MOH Gender Mainstreaming Directorate	FMOH PPD and Gender Mainstream

	Action Description	DLI	Due Date	Responsible Party	Completion Measurement
	in gender disaggregated HMIS data is conducted.				ing Directorate
11	Conduct Training and regular implementation support of health workers at the facility level on cause of death as per national disease notification codes, registration of births and other VE registration requirements.		Annual	FMOH PPD	FMOH PPD Report
12.	MoH Provides and Federal Ethics and Anti-corruption (FEACC) verify and submit to the Bank quality and timely biannual report on Fraud and Corruption complaints and priority actions related to the program		Continuous	FMOH & FEACC	Reports shared by FEACC
13.	Ensure inclusiveness of Fraud and Corruption and complaint handling processes or priority actions in FMOH and Regional Health Bureaus joint forum discussions semiannually (including issues on realization of Anti-Corruption Guidelines (ACG) in discussion forums).		Continuous	MOH	FMOH/ PPD and Governance Report
14.	Availing appropriate temporary storage facilities for collection of hazardous wastes until final disposal, enforce compliance with MWM and Disposal Directive in HF constructed before issuance of the Directive.		Continuous	Medical Service for health centers and hospitals; Health systems for health posts	Annual reports
15.	Update relevant documents to incorporate environmental impact and risk criteria in site selection screening for all health facilities, strengthen the coordination and reporting mechanism on social and environmental safeguard in MOH. Implement the national joint plan of action (FMOH and FEPA)		Year one	FMOH and FEPA	Annual reports

	Action Description	DLI	Due Date	Responsible Party	Completion Measurement
16.	Documenting consultations and participatory nature of discussions where communal land/ private is used for construction of health centers and where applicable compensation for land and livelihood paid	☒	Continuous	Infrastructure Directorate, FMOH	Documentation of consultations and compensation
17.	Documenting outreach and specific actions focused on providing services to all vulnerable persons	☒	Continuous	FMOH PPD and HSS Directorate	Annual reports of the HSS Directorate

Annex XII: Ethiopia - Global Financing Facility in Support of Every Woman and Every Child

Background

1. The Global Financing Facility (GFF) in Support of Every Woman and Every Child (EWEC) is a multi-stakeholder partnership aimed at supporting the scaling up of country-led efforts to improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH). This country-driven financing partnership brings together, under national leadership and ownership, stakeholders in RMNCAH, to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths by 2030 and improve the health, nutrition and well-being of women and children. It is underpinned by the collaborative principles of the International Health Partnership (IHP+) and serves to harmonize fragmented RMNCAH approaches, using existing structures and processes.

2. At the heart of the GFF approach is a rigorous focus on achieving and measuring results. At the country level, it uses an integrated approach that looks for the best solutions for better RMNCAH outcomes through results oriented smart, scaled up and sustainable financing. The Facility provides results-focused financing to drive progress toward ending preventable maternal, adolescent, and child deaths, while also supporting the systems—particularly civil registration and vital statistics—needed to monitor progress and measure results.

3. The GFF acts as a pathfinder in a new era of financing for development through a model that shifts away from focusing solely on official development assistance to an approach that combines external support, domestic financing, and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way. Specifically, it uses grants from a multi-donor trust fund (the GFF Trust Fund) to mobilize additional funding from the International Development Association (IDA), Government, and other development partners, including the private sector.

Health Sector Transformation Plan and RMNCAH Investment Case

4. Ethiopia is one of the front runner countries to be supported by the Facility to strengthen the utilization and quality of reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAH) services as laid out in the Health Systems Transformation Plan (HSTP-2015-2020). The HSTP is a continuation of 20 years of Health Sector Development Programs (HSDPs) that have provided strong guidance in key areas leading to consistent progress in health outcomes over the last decades. The HSTP is aligned with Ethiopia's Second Growth and Transformation Plan (GTPII 2015/16-2019/20), which sets ambitious targets for Ethiopia to become a lower middle income country by 2025. Ethiopia, being an IHP+ country, used the Joint Assessment of National Health Strategies (JANS) process to ensure stakeholder buy-in and quality of the HSTP.

5. A cornerstone of the HSTP is the focus on quality and equity, planned as an iterative process requiring careful supportive supervision and tracking of performance. It establishes goals in terms of improving equity, coverage and utilization of essential health services, quality of health care, and enhancing implementation capacity of the health sector at all levels of the system. The HSTP renews the strong priority given to Reproductive, Maternal, and Child Health and Nutrition. It sets ambitious targets for nutrition, maternal and child health outcomes to be achieved by 2020, which would ensure it is on track to achieve its commitments under the SDG agenda. One of the strategic initiatives identified to help achieve the results is high impact interventions of RMNCAH, nutrition, prevention and control of communicable and non-communicable diseases. The HSTP also identifies the importance of making gains in adolescent health, particularly in the context of reproductive health and nutrition, for the longer term economic and social progress of the country.

6. Ethiopia's HSTP was unanimously endorsed by Government and partners as the document that lays out the RMNCAH Investment Case and formed the basis for investment from GFF, IDA and Power of Nutrition for the following reasons: i) the costed strategic plan is evidence-based, prioritized and well aligned with Ethiopia's Growth and Transformation Plan II and Sustainable Development Goals and is validated by Joint Assessment of National Strategy tool; ii) there is a clear results framework that covers RMNCAH and is accompanied by a multi-year financing plan that has two scenario resource requirements for implementation of the HSTP depending on available resources; iii) there is the highest level political commitment to achieve the health Sustainable Development Goals including the RMNCAH goals; and the Government and key financiers of RMNCAH have aligned their funding of the HSTP.

Multi-stakeholder Platform for Policy and Programmatic Oversight

7. The GFF's requirement of having a multi-stakeholder platform that includes key stakeholders (Government, bilateral and multi-lateral financial agencies, foundations, civil society, private sector, etc.) exists in the current governance structures with the Joint Consultative Forum (JCF) and Joint Core Coordinating Committee (JCCC). The JCF is the highest governing body and serves as a joint forum for dialogue on sector policy and reform issues between the Government and key stakeholders and to oversee the implementation of the Sustainable Development Goal (SDG) performance fund, and other donor-supported projects. This ensures effective linkages between operations supported by different partners and reduces duplication. It is chaired by the Federal Minister of Health and co-chaired by the Chair of Health Nutrition and Population (HNP) Partners group. The JCCC, chaired by the Director General of Policy, Plan and Finance General Directorate, serves as the technical arm of the Joint Consultative Forum. Technical Working Groups (TWGs) created by the JCF support the implementation of the Sector Strategy as well as sub-sectors including the RMNCAH sub-sector strategy. Ethiopia has committed to use this existing system, and these structures, combined with strong donor coordination and aid harmonization governed by the International Health Partnership Plus (IHP+) compact, previous Sector Strategies harmonization manual, and Joint Financing Arrangement provide opportunities for partners to monitor program progress and discuss complementary financing.

Health Financing Strategy on Universal Health Coverage (UHC)

8. The HSTP aims to achieve UHC through a combination of health systems strengthening and financial protection measures to cover the majority of households by 2020 and ensure that sector financing transitions in a responsible manner from donor financing to a sustainably financed domestic system. This requires a shift in various aspects, including: developing a comprehensive implementation roadmap for the Health Care Financing strategy, rolling out of Community Based Health Insurance (CBHI) and Social Health Insurance (SHI); building institutions and capacity in health insurance functions such as purchasing, targeting, resource mobilization, economic analysis, health care management, financing, at all levels; and engaging the private sector and civil society organizations in support of the efforts of mobilizing domestic financing and improving access to quality health services.

9. The Government, with technical support from key health care financing partners including the World Bank, USAID, and Gates Foundation, and GFF is working on ways to increase domestic resource mobilization, efficiency in use of resources and building health financing capacity within the public health sector. Partnerships under the GFF will also enable the Bank (through Bank Executed Trust Funds) to help build institutions and capacity in health insurance functions such as purchasing, targeting, resource mobilization, economic analysis, health care management and financing at all levels; and engage the private sector and civil society organizations in support of the efforts of mobilizing domestic financing and improving access to quality health services.

10. The second Health Financing Strategy proposes SHI for the formal sector and CBHI for the informal sector, as the main mechanisms to increase financial risk protection and contribute towards increasing domestic resources for health. The Government is already implementing select areas of the draft health care financing Strategy while refining remaining areas to be rolled out later. The Government plans to launch the SHI implementation among the formal sector in the near term. CBHI schemes were first piloted in 13 woredas and the country aims to scale up CBHI coverage to 80 percent of the woredas by 2020. The Government is also exploring innovating financing mechanisms; enhancing efficiency gains especially on procurement, supply management and human resources productivity and evidence based planning.

Additional Financing (AF) to the Health SDGs Program for Results

11. The proposed AF to the P4R operation, is well aligned with the GFF approach, and together with other key partners supporting the Sustainable Development Goals Performance Fund, will contribute to the agreed RMNCAH outcomes, as well as the move towards UHC and a more sustainable health care financing system by addressing specific gaps in priority program areas for women, children and adolescents, while also addressing critical health system bottlenecks. The AF will also help in the roll-out of the CBHI while providing technical support and building capacity to implement the country's health financing strategy. The emphasis that GFF places on strengthening data systems to monitor and improve RMNCAH outcomes has led to including support for the Federal Vital Events Registration Agency in building a Civil Registration and Vital Statistics (CRVS) system through technical assistance, capacity building and procurement of equipment. This will greatly strengthen the country's data revolution agenda by making the CRVS system more robust and able to provide the necessary data, on births, maternal and child deaths (including causes of death) and age at marriage, which are critical to monitor and improve RMNCAH outcomes.

12. The proposed AF will support the Government's efforts to expand options for financing its development efforts. It will allow the Government to strategically combine and leverage sources of financing including domestic, private, and international resources in line with the conclusions of the Financing for Development Conference held in Addis Ababa in 2015. The proposed AF, in partnership with the GFF, is working to intensify efforts to mobilize resources for Reproductive Maternal and Child Health to address preventable maternal and child deaths and reduce inequalities. The Government has identified various channels to address the financing gap which includes the roll out of health insurance schemes that could raise close to $800 million. Other channels that could be used to address the financing gap include resources flowing to the sector that are managed through implementing partners which is a substantial part of health financing.