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ANNEX

of the Commission Decision on the individual measure in favour of the Federal Republic of Ethiopia

Action Document for Health Sector Budget Support in Ethiopia

INFORMATION FOR POTENTIAL GRANT APPLICANTS

WORK PROGRAMME FOR GRANTS

This document constitutes the work programme for grants in the sense of Article 128(1) of the Financial Regulation (Regulation (EU, Euratom) No 966/2012) applicable to the EDF in accordance with Article 37 of Regulation (EU) 2015/323 in the following sections concerning grants awarded directly without a call for proposals: 5.4.1, 5.4.2 and 5.4.6

1. Title/basic act/ CRIS number	Ethiopia Health Sector Budget Support – SBS CRIS No: ET/FED/038-386			
2. Zone benefiting from the action/location	Ethiopia The action shall be carried out at the following location: Ethiopia – Federal and in all Regional States			
3. Programming document	11th EDF National Indicative Programme (NIP) 2014-2020			
4. Sector of concentration/ thematic area	Focal Sector 2: Health	DEV. Aid: YES		
5. Amounts concerned	Total estimated cost: EUR 115 000 000 Total amount of EDF contribution: EUR 115 000 000 • EUR 100 000 000 for budget support • EUR 15 000 000 for complementary support			
6. Aid modality and implementation modalities	Budget Support - Project Modality (for the Capacity Development component) Direct management -Budget Support : Sector Reform Contract; grants – direct award; procurement of services Indirect management with World Bank Indirect management with Ethiopia			
7 a) DAC code(s)	Main DAC code 12110 - Health policy and administrative management			
b) Main Delivery Channel	10000 - Public Sector Institutions			
8. Markers (from CRIS DAC form)	**General policy objective**	**Not targeted**	**Significant objective**	**Main objective**
	Participation development/good governance	☒	☐	☐
	Aid to environment	☒	☐	☐
	Gender equality (including Women In Development)	☐	☒	☐
	Trade Development	☒	☐	☐
	Reproductive, Maternal, New born and child health	☐	☐	☒

	RIO Convention markers	Not targeted	Significant objective	Main objective
	Biological diversity	☐	☐	☐
	Combat desertification	☐	☐	☐
	Climate change mitigation	☐	☐	☐
	Climate change adaptation	☐	☐	☐
9. Global Public Goods and Challenges (GPGC) thematic flagships	None			
10. SDGs	Main SDG Goal(s) on the basis of section 4.1: Goal 3. Ensure healthy lives and promote well-being for all at all ages Secondary SDG Goal(s) on the basis of section 4.1: Goal 5. Achieve gender equality and empower all women and girls			

Acronyms

ANC	Antenatal Care
CBHI	Community Based Health Insurance
CCM	Country Coordination Mechanism
CD	Capacity Development
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Agency
DHS	Demographic and Health Survey
EFY	Ethiopia Fiscal Year
EHIA	Ethiopian Health Insurance Agency
EMCP	Expenditure Management Control Program
EPHI	Ethiopian Public Health Institute
ESPA	Ethiopian Service Provision Assessment
GTP	Growth and Transformation Plan
HC	Health Centre
FMoH	Federal Ministry of Health
HMIS	Health Management Information System
HSTP	Health Sector Transformation Plan
IBEX	Integrated Budget and Expenditure System
IFMIS	Integrated Financial Management Information System
JRM	Joint Review Mission
MoFEC	Ministry of Finance and Economic Cooperation
MDG	Millennium Development Goals
MDHS	Ethiopia Mini Demographic and Health Survey
MTEF	Medium Term Expenditure Framework
OFAG	Office of Federal Auditor General
ORAG	Office of Regional Auditor General
PBB	Program Based Budgeting
PBS	Promotion of Basic Service
PEFA	Public Expenditure Financial Accountability Framework
PFM	Public Finance Management
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendance
SBS	Sector Budget Support
SDS	Service Delivery Secretariat
SRH/FP	Sexual Reproductive Health and Family Planning

SUMMARY

The action aims at supporting the implementation of the Health Sector Transformation Plan (HSTP, 2016-2020) through Sector Budget Support (SBS) operation. Health is one of the pro-poor sector, as defined in the 2nd Growth and Transformation Plan (GTP II, 2016-2020) and one of the three focal sectors for EU-Ethiopia development cooperation (11th EDF-NIP, 2014-2020). The health sector has achieved encouraging results during the last 20 years through the implementation of its long term strategy – Health Sector Development Programme, which is aligned to the Millennium Development Goals (MDGs). This broader policy framework describing the sector goals of poverty reduction and inclusive growth gave coherence and context to initiatives and programmes in the sector. UN estimates and country level assessments and surveys confirmed that Ethiopia achieved impressive gains in indicators of health status - Under-five Child Mortality Rate (U5MR) has dropped from 204 per 1,000 live births in 1990 to 68 per 1,000 in 2012 - already achieved MDG 4 three years ahead of the time line; and similar achievements registered in family planning, immunization rates, etc.

Despite Ethiopia's progress in improving access to basic health services and achieving most of the health MDGs, it is from a low baseline and a huge challenge remains. In this context, the public policy assessment for this SBS operation has identified key challenges and issues: (i) improving quality and readiness of health facilities to provide the services – addressing quality of health care is a major concern in the sector (as defined in the HSTP) and relates to different dimensions including the need for competent and caring health professions, finance (limited operational budget at health facilities level), weak supply chain system, availability of equipment and utilities – water supply and power; (ii) inequalities (both vertical and horizontal) – health status indicators of national figures hide stark inequalities across regions, rural and urban areas, wealth groups and educational status of mothers; (iii) low domestic health sector financing – health spending is heavily skewed to 'rest of the world' – Development Partners support (50%) and out of pocket expenditure (34%) and, as a result, there is a risk in terms of sustainability and equity of service delivery; and (iv) the need to strengthen sector governance in terms of PFM and accountability - recurrent issues in this area are the weak follow up and correction of audit findings, transparency and efficiency of Pharmaceuticals Fund and Supply Agency and reinforcing coordination between the budget and the Sustainable Development Goals Performance Fund (SDG PF) - channel 2.

Cognizant of Ethiopia's experience in implementing long term health sector strategy and its ambition and commitment to become a lower middle income country by 2025, SBS as a more matured and adequate aid modality has the potential to engage with and support the Government of Ethiopia to better address the issues and challenges identified above. The use of SBS will also facilitate coordination between the health policy dialogue and the dialogue on decentralised service delivery by strengthening coordination between Ministry of Finance and Economic Cooperation (MoFEC) and Federal Ministry of Health (FMoH).

The main objective of this SBS is to enhance the implementation of the HSTP which aimed at improving equitable access and quality of healthcare across the decentralized service delivery system in Ethiopia. The implementation period of the SBS is three years (2016–2018) with a total support of EUR 115 000 000. The action includes SBS and complementary Capacity Development (CD) measures both integrated into one single and same intervention logic. It is expected to bring results on (i) increased quantity and quality of services – skilled human resources, health supplies/commodities and services at all levels; (ii) inequity addressed through strengthened health insurance system; (iii) increased domestic allocation and spending in the health sector; and (iv) improved PFM and oversight functions in general and health in particular.

1 CONTEXT

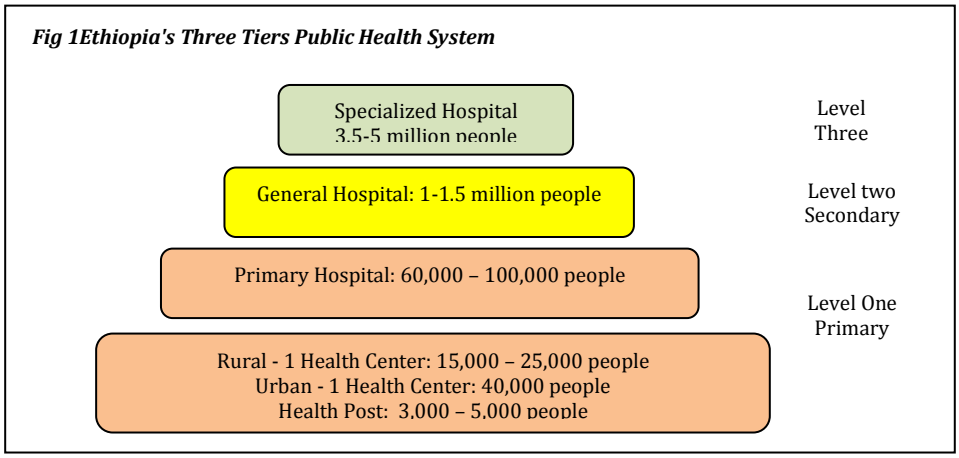
1.1 Country and sector context

Ethiopia has an estimated population of 96 million in 2014 (Index Mundi) and an estimated annual population growth rate of 2.9 % in 2014, with currently about 80% of the population living in rural areas. The UN estimates that its population will reach 130 million by 2025, becoming one of the world's ten largest countries in 2050.

According to official government data, Ethiopia had an average Gross Domestic Product (GDP) growth of 11% in the period 2004/05-2011/12[1] and according to the World Bank Poverty Assessment for 2014, this performance has helped reduce the share of the population living below poverty line from 38.7% in 2004/05 to 29.6% in 2010/11. Furthermore, Ethiopia has made good progress on the MDG goals; it has achieved MDG 4 target of reducing child mortality by two-thirds in 2012 and continues to make significant improvements on infant and maternal health. There has been progress in reducing underweight and stunting in Ethiopia, but the trend is not sufficient to reach the MDG 1 target of cutting hunger and malnutrition in half by 2015. Despite positive trends, Ethiopia remains a Low Income Country with a per capita income of USD 550 in 2014 – up from USD 377 in 2009/10, ranking 174 out of 188 countries at the Human Development Index (2014).

Ethiopia has a decentralised administrative structure, which includes federal, regions, zones and *woredas*[2]. It has opted for a decentralized model of basic service delivery. In the health sector, service delivery system has been organized in three levels linked by a referral system and managed by different administrative levels (Fig 1).

Fig 1Ethiopia's Three Tiers Public Health System



This structure is largely financed by the Federal Government through the use of the **Federal Block Grant**, whereby the Federal Government provides non-earmarked transfers to regional governments. The Federal government uses a pro-poor formula approved by the parliament to distribute grants to regions. Regions keep a share of the grant (approximately 40%) and redistribute grants to *woreda* administrations, where services are delivered. The Block Grant covers recurrent expenditures and is subject to audits by the Office of Federal Auditor General and the Office of Regional Auditor General (ORAG). Health and education take the lion's share of Block grant spending. This structure has provided timely and predictable financing to lower levels, contributing to the increase of services and sector outcomes, including in health. The steady increase of the budget share allocated to the federal block grant reflects strong government commitment.

1.1.1 Public Policy Assessment and EU Policy Framework

The FMoH has developed a visioning document entitled 'Ethiopia's path towards universal health coverage through primary health care' that guides the coming 20 years health sector investment, directions and priorities. It projects the health sector development on Ethiopia's economic development targets 2025/2035 and the expected demographic and epidemiologic transition. On the basis of this framework and GTP II, FMoH has also developed the next five-year plan - Health Sector Transformation Plan (HSTP, 2015/16 – 2019/20). The HSTP emphasizes the need to transform the sector in order to provide quality health services and address inequalities, which are growing challenges in the sector.

The HSTP is relevant, as it analyses the challenges and gaps in Health Sector Development Programme IV. HSTP proposes strategies to improve the quality of health services and address vertical and horizontal inequalities, which are two key challenges in the sector. The plan also recognizes the importance of citizen's engagement and ownership to ensure domestic accountability and responsive health services. However, HSTP sets out ambitious targets heavily stretched in achieving middle-income status by 2025.

[1] About 10% according to IMF/WB.

[2] A woreda is the third level administrative division in Ethiopia and is like a district

The HSTP is considered sufficiently credible based on Ethiopia's gains in improving health outcomes. In addition, its past track record is positive as regards the ability to implement health policies, to align donors and to achieve outcomes such as: i) implementation of consecutive five-year Health Sector Development Programmes since 1996; ii) promoting International Health Partnership (IHP) principles ('one plan, one budget, one report'); iii) successful donor alignment around the MDG Performance Fund harmonising; and iv) successful implementation of policies down to the community through the Health Extension Program and the Health Development Army.

In addition, HSTP includes a financing section that determines the costing estimate on the basis of One Health Tool. As regards health care financing framework, there are various funding flows to the sector. They include domestic resources channelled through the budget, SDG Performance Fund (channel 2), programme/project based support (channel 3) and off budget community contributions.

However the sector financing faces critical challenges to reach its ambitious targets, including: i) the medium term strategy is not fully aligned to the Medium Term Expenditure Framework (MTEF) (2014 PEFA); ii) the sector is highly dependent on external resources - nearly half of health spending is from the rest of the world (2011 National Health Account); iii) shortage of resources flowing to *woredas* and lack of financial and non-financial incentives for local health expenditures constrain the capacity to improve the quality of service delivery. Ethiopia needs to mobilize greater domestic resources to meet basic health care demands and ensure that sufficient resources flow to adequate levels to meet expenditure assignments.

There exists strong leadership at the federal level but the capacities at lower levels are variable and FMoH's role in coordinating multi-sectoral, inter-ministerial and inter-governmental action increases the demands on its leadership capacity. Competence of health professionals and a high turnover rate are key challenges across the board.

The HSTP has a well-defined results chain linking the inputs to the outcomes and the contribution of these outcomes to the GTP results. In addition, the sector has various performance review mechanisms, such as: i) the Annual Review Meeting supported by a Joint Review Mission; ii) Service Availability and Readiness Assessment carried out on annual basis with technical assistance from WHO; iii) Ethiopia Demographic and Health Survey (DHS) every five years; and finally, iv) the National Health Account conducted every three years.

There is a need to enhance accountability of the health system by shifting the emphasis from inputs to results. Data quality remains an important challenge. The FMoH has to accelerate the on-going efforts to institutionalize its Monitoring and Evaluation systems to provide reliable and timely information. To this aim, the ex-PBS component on system strengthening, including Social Accountability (SA) and the work of the Service Delivery Secretariat will be pursued.

The proposed intervention to support the health sector in Ethiopia is in line with the priorities of the EU Agenda for Change. The HSTP is linked to GTP II and is expected to contribute to inclusive and sustainable growth. It also provides space to enhance domestic and mutual accountability and transparency in the sector. The HSTP considers the development effectiveness agenda and the programme will enhance Development Partner coordination, particularly with budget support providers (World Bank and African Development Bank). Finally, this operation is an opportunity to better link the joint programming exercise in health and nutrition.

1.1.2 Stakeholder analysis

The FMoH and Regional Health Bureaus are responsible for policy formulation and technical support, while ***Woreda*** **Health Offices** manage service provision at district level. In addition, the health sector has **five agencies** directly accountable to the Ministry of Health[3]. **Service providers** are also key stakeholders and include **health facilities** and **health professionals** (incl. health extension workers). Over 93% of health facilities have governing bodies but only 52% of hospitals and 49% health centres' governing boards meet regularly[4]. This is a major challenge as these bodies are critical to decide plans, budget allocation, monitor progress and ultimately, ensure responsiveness to the needs of the communities.

[3] i) HIV/AIDS Prevention & Control Office (HAPCO) ; ii) Food, Medicine and Health Care Administration and Control Authority (FMHACA) ; iii) Pharmaceutical Fund and Supply Agency, responsible for the procurement of medical commodities ; iv) Ethiopian Public Health Institute (EPHI) ; v) Health Insurance Agency (HIA).

[4] HSTP (2016-2020), page 44.

Central Statistical Agency (CSA) and **Ethiopian Public Health Institute** (EPHI) are two key players as regards monitoring and evaluation of the health policy. **Central Statistical Agency** is responsible for generating national statistical data related to socio-economic trends (including the DHS). It also conducts Data Quality Assessment on sectoral Information Management Systems, including the Health Management Information System. **Ethiopian Public Health Institute**, undertakes research and conducts surveillance for the early identification and detection of public health risks. The Ethiopian Public Health Institute is tasked to conduct a Service Availability and Readiness Assessment aiming at strengthening data quality assurance.

Implementation of HSTP requires appropriate incentives and accountability relations between these different stakeholders. In Ethiopia, upward accountability relations are strong. Service providers are strictly accountable to local governments for producing results and in their turn, local governments are accountable to the regional and federal government for delivering basic services and reaching service delivery GTP targets. Yet, in line with HSTP and GTP II, there is room to improve downward accountability, notably through the implementation of social accountability tools.

The Ministry of Finance and Economic Cooperation (MoFEC) exercises oversight and coordination. It has the responsibility for supporting financial flows from the federal to the decentralized levels and for ensuring that public financial management systems work smoothly. Close coordination between the FMoH and MoFEC directorates and their involvement in policy dialogue are key for smooth implementation.

The **National Planning Commission** has been recently created and its role is expected to strengthen the link between planning and budgeting as well as the monitoring of the GTP II.

Office of Federal Auditor General, accountable to the parliament, is responsible for external audit of public bodies. Coverage and capacities are improving but more efforts are needed to improve external oversight (2014 PEFA). Bilateral and multilateral Development Partners coordinate their activities as described in section 3.2.

The **National Nutrition Coordination Body** chaired by the State Minister for Health should bring Ministries together to deliver a coordinated multi-sector response to under-nutrition however it has not been meeting regularly.

Civil Society Organisations are important complementary players in both service delivery, including through channel 3 funding (mostly USAID and EU financed projects), and in the governance of health sector such as i) Consortia/umbrella organizations that facilitate participation in health policy/strategy development, and ii) community based organizations – including the Women Development Army, that participate in village decision making, accountability and planning.

The Sustainable Development Goals Performance Fund contributors (Department of International Development (DFID), Irish Aid, Netherlands, and Spain) are the main actors in the health financing and policy dialogue. The SDG Fund is a pool funding mechanism managed by the FMoH using the Government of Ethiopia procedures. It is one of the Government's preferred modalities for scaling up Development Partners assistance in support of the health sector.

Global initiatives – Global fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Gavi, the Vaccine Alliance, whose combined support accounted for 46.9% of the ODA for health in the country in EFY 2005. The Global Fund is considering joining the Sustainable Development Goals Performance Fund using its Malaria and Health System Strengthening grants attached to trigger indicators similar to the World Bank - Performance for Results (P4R) Health program.

Basic Service Delivery Group: Since 2005 the multi-donor programme Promoting Basic Services has supported basic service delivery in five sectors, including in health. The group was renamed Basic Service Delivery Group. Development Partners are realigning their programmatic focus and shifting their support from the multi-donor trust fund towards a wider use of budget support. More concretely, the World Bank has launched a Program for Results (P4R) Enhancing Shared Prosperity through Equitable Services; AfBD is launching a budget support for basic service delivery in education, health and water and the EU is shifting its support towards budget with this action. Coordination mechanisms and joint dialogue mechanisms are being strengthened in this area.

1.1.3 Priority areas for support/problem analysis

The major challenges that remain in the health sector are listed below:

- **Improve quality and readiness of health facilities to provide the services**: During the last twenty-year span, Ethiopia constructed 16,440 Health Posts, 3,547 Health Centres, and 311 hospitals and made progress in improving access to services. However, despite improvements, additional efforts are required to improve the range and quality of the services, in particular as regards neonatal and maternal related services. For instance, Skilled Birth Attendance (SBA) is only 15% (Mini-DHS 2014). In addition, improving maternal health also requires prevention interventions, including provision of nutrition services, access to quality family planning services.

Challenges to improve the quality of health care relate partly to financial and human resources constraints. For instance, most of the block grant resources are used to pay salaries and little remains for operations and maintenance at local levels. To address this issue, MoFEC is committed to continue to increase the block grant per capita. The FMoH is also seeking to further strengthen the referral system and putting in place a health centre reform to improve the quality of services. Further, attrition rates, uneven deployment and competency of health professionals are major challenges. The Government is putting in place National Licence Examination for health professionals and FMoH is reviewing health extension workers career paths by putting in place a training scheme that would make it possible to upgrade Health Extension Workers to level 4.

- **Reduce vertical and horizontal inequalities**: National figures hide stark inequalities across regions, rural and urban areas, wealth groups and educational status of mothers. For instance, the difference between the national median and bottom 10% *woredas* percentage of deliveries assisted by SBA is 40%. Similar discrepancies are also observed across income/wealth quintiles with only 2% accessing SBA in the bottom quintile compared to 18% in the top quintile (DHS-2011). The FMoH is making efforts to reduce these inequalities, through the establishment of special support Directorate for Developing Regional States (DRS) and monitoring the progress through producing annual state of inequality reports.
- **Ensure appropriate financing for the sector***:* the HSTP is ambitious considering the current expenditure of USD 21 per capita, while the target was USD 32.2 under the HSDP IV. Budget allocation from domestic resources to the health sector remains low, though regional level allocations are increasing (average 10.3 % in 2013/2014). Subnational revenues are not increasing proportionately due to 1) shortage of block grant resources, 2) lack of capital budget at *woreda* level, 3) the near phase out of the SDG Support facility and 4) lack of financial and non-financial incentives for local health expenditures. As a result, service delivery relies strongly on community contributions and on out of pocket spending (35%), which entail risks in terms of sustainability and equity. To address this, the Government has placed increased emphasis on developing its health insurance system – Social Health Insurance (SHI) for the formal sector (employees) and Community Based Health Insurance (CBHI) scheme for the informal sector.
- **Strengthening sector governance on PFM and accountability***:* Making policy and planning processes more evidence based and responsive to inequalities is key to inform policy decisions and policy dialogue. To this aim, the programme will mobilise adequate expertise and strengthen regional forums where FMoH, MoFEC and Regional Bureaus dialogue and share knowledge on health performances and financing.
- Furthermore, a sound PFM system is essential for the implementation of public policies by supporting aggregate fiscal discipline, strategic allocation of resources, and efficient service delivery. Recurrent issues in this area are the weak follow up and correction of audit findings, the insufficient efficiency of the Pharmaceuticals Fund and Supply Agency and the insufficient coordination between funding flows to the sectors, notably between 'on treasury and on budget' donor resources (channel 1), 'off-treasury but on-system' Development Partner resources such as the Sustainable Development Goals Performance Fund (SDG PF channel 2) and 'off budget and off systems' resources (channel 3). Effective implementation requires close coordination between MoFEC, which is responsible to steer the PFM reform, and the FMoH, in charge of implementing and improving PFM in the health sector. Finally, there is room to improve financial transparency and social accountability at health facility level by building on the achievements of the Promotion of Basic Service (PBS) Program and the Ethiopian Social Accountability Program[5].

1.2 Other areas of assessment

1.2.1 Fundamental values

The Constitution establishes a federal and democratic state with a multi-party parliamentary government. In addition, Ethiopia adopted at the end of 2013 a National Human Rights Action Plan and underwent for the second time in 2014 the UN Universal Periodic Review. Furthermore, the impressive economic growth rate in the last years has had a positive influence on the fulfilment of Ethiopian's social and economic rights, as reflected by the reduction of poverty rates, increased life expectancy and improvements in access to basic services such as drinking water and education.

The points of the agenda between the EU, other Development Partners and the Government of Ethiopia include:

[5] The Ethiopia Social Accountability Program is financed through a Worldbank managed multi-donor trust fund and works with a Management Agency to implement capacity development, training, and support to civil society partners. The second phase of the program will end in September 2017 and a third phase is expected to continue after that date.

- **Civil and political rights**: The ongoing dialogue covers issues relating to the democratic level playing field for the opposition and the media and to the Government proclamations on civil society and anti-terrorism. Building also on the World Bank Panel Inspection Report recommendations, the budget support will support safeguard measures and social accountability.
- **Conflict**: recent unrest in Oromia, Gambella and some *woredas* in Amhara, as it may increase political and developmental risks.
- **Rule of law**: the representative and oversight institutions such as the Parliament, the Ethiopian Human Rights Commission and the Ombudsman have in the past years been strengthened and started to use the prerogatives provided by the constitution but still need to reinforce their action and also the need to strengthen, the professionalism and independence of the judiciary.
- **Position of the women** in the Ethiopian society and in the decision-making processes at political, social and economic levels still needs substantial improvement.

1.2.2 Macroeconomic policy

The year 2015 has registered a less favourable outlook with a forecasted Sub-Saharan Africa average growth down to 3.75%, commodity prices down and expected to further decline in 2016, growth deceleration of some emerging markets, and more restricted access to international capital markets. Despite these downsides, Ethiopia managed to maintain its position among favoured destination for investors on the continent.

The progress reported under GTP I is mixed yet the new GTP II is articulated around the primary objective for Ethiopia to become a lower middle income country by 2025 with the majority of its financing expected through domestic resources. A number of important challenges not clearly addressed in GTP II were raised by the Donor Assistance Group and the PM offered encouraging new avenues for dialogue. The International Monetary Fund (IMF) and the World Bank stressed the importance of structural reforms to foster export growth and export diversification to improve the business environment and private sector involvement. The impacts of the drought of 2016 are well managed but more government and Development Partners resources are needed.

Overall, the major trends in Ethiopia's economy remain "largely favourable", **while some important challenges remain. The government is actively engaged in addressing these specific development challenges that are discussed in various fora:**

On the basis of IMF Art. IV, the following issues have been raised by the Donor Assistance Group and the Macroeconomic Sector Working Group including: (i) very ambitious national planning to give direction and impetus but based on a financing capacity that still needs to develop, (ii) the Minister of Industry recognized that despite progress made, results in the manufacturing sector still need to reach expectations and that export revenue generation has been insufficient. The government's policy on industrial parks should help improve the situation, (iii) despite GTP II emphasis on private sector, logistics and unpredictable environment are still challenges for its development, (iv) shortage of foreign currency, (v) limited access to financing for local private investment, (vi) a highly concentrated, commodity dependent and underperforming export sector, (vii) an increasing current deficit, (viii) increasing public debt levels contracted by State-owned Enterprises (SoEs) and (ix) a financial market still dominated by the Central Bank of Ethiopia and maintained central government deficit financing through commercial banks.

Discussions during GTP II consultations and in regular dialogue with the Government and with other Development Partners point out the need to pay particular attention and monitoring to critical factors to achieve GTP II targets, including: (i) food inflation and market distortions which call for measures to support domestic agricultural supply as well as increased food aid to protect the most vulnerable; (ii) introduction of a prudent market-driven interest rate policy to encourage savings' mobilization and support investment financing as planned in GTP II; (iii) potential resurgence of social tensions which could potentially affect investments notably in the manufacturing sector; (iv) maturity of NBE bills purchased by the banks in 2011; (v) pace of foreign borrowing which should be assessed and prioritized together with policies designed to promote exports; (vi) assessment of tax expenditure and improved tax collection; (vii) full passing on of oil prices gain to ease current inflationary pressures; (viii) increase of net foreign assets to ease forex availability; (ix) effective take off of the newly introduced industrial policy designed around industrial parks; (x) effectiveness of the dialogue around interest rates and opening of services sector; and (xi) improvements in Global Competitiveness Index and Doing Business.

On every dialogue forum, the Government of Ethiopia has given explanations on the issues raised above and agreed to consider constructive inputs. It clearly indicated its development policies in order to dispel doubts of stakeholders on some of its policy directions and issues related to internal stability.

1.2.3 Public Financial Management (PFM)

Public Financial Management in Ethiopia has undergone significant improvements in the last decades, pushed forward by strong government leadership. The Government's 'basics-first' approach at federal level has been completed (good budget credibility, predictability and control in budget execution and accounting recording and reporting), paving the way for second-generation reform (such as Integrated Financial Management Information System (IFMIS), Programme Based Budgeting (PBB), accrual accounting). At regional level the situation varies and the first stage of the reform still needs further consolidation.

So far, the Government focused on improving service delivery: This has driven the prioritization of predictability and control in budget execution over other PFM dimensions. The fact that the first stage of the reform has been completed at federal level paves the way to gradually shift focus to accountability and oversight.

Although there is not a single and comprehensive PFM reform strategy, various complementary reform initiatives address different aspects of the budget. The Expenditure Management Control Program is steered by MoFEC and aims at ensuring that the general budget is planned and executed in a transparent, accountable and effective manner. The Ethiopian Revenue and Customs Authority steers the Revenue Reform Program with the aim of boosting domestic financing of the general budget. Finally, the Office of Federal Auditor General and Office of Regional Auditor General are in charge of external audit.

Past track record and strong political will confirm the credibility of the process. Successive PEFA assessments show a steady strengthening of PFM systems and Ethiopia has improved its performance as regards budget credibility, such as 1) bills are cleared on time, 2) there are no arrears, 3) payroll systems are robust, 4) the internal control system is comprehensive, 5) the inter-governmental fiscal transfer system works well, and 6) cash transfers are predictable up to local government level. Audit coverage at the federal level has also increased and audit reports are produced in a timely manner. In terms of fiscal reporting, at the federal and regional level, spending reports are prepared on a monthly basis with a delay of less than four weeks and quarterly reports are available after two weeks at the end of the quarter. Finally, Government's commitment to repeat PEFA also indicates the strong political will that drives the reform.

The Expenditure Management Control Program is judged *sufficiently relevant* as it adequately addresses key weaknesses in the Expenditure Management Control Program Action plan EFY 2008 (PEFA ratings C and D) and it has provided a solid platform to guide reform efforts and dialogue. In addition, the World Bank is preparing a PFM programme incorporating 2014 PEFA findings and DFID is implementing a programme in support to Tax Audit and Transparency. Further, the political will to improve PFM at all levels of government is strong. In 2015, repeat subnational PEFAs were carried out showing improvements but uneven capacities. Recognising this, MoFEC announced that it would develop regional tailor-made annual action plans. The *Woreda* Gap analysis shows that performance is mixed at *woreda* level. As regards audit, MoFEC's analysis shows that only around 5% of audit findings were fully addressed[6]. Given growing *woreda* responsibilities, there is need to urgently build their fiduciary capacities.

Over the years, dialogue on PFM has considerably improved. PFM is discussed in various platforms: the Development Partner PFM group, the Donor Assistance Group PFM Sector Working Group that is a key platform for government-donor dialogue and reports to the PBS biannual JRIS/JBAR, where PFM and the budget are high on the agenda.

Despite these achievements, progress has been slower than in previous periods and challenges remain:

- Firstly, 2015 PEFA findings point out the following weaknesses in the PFM system: i) budget document lacks information on extra-budgetary operations, public enterprises and previous year performance; ii) medium term

[6] Refer to the discussions in the PFM sector working group, PBS Joint Review & Implementation Support aide memoires and PEFA findings.

perspective in budgeting; iii) transparency and public access to budget information; iv) tax collection; v) in year predictability of budget execution and procurement. The health sector shows the highest budget variances and, according to DFID's Fiduciary Risk Assessment, the transparency and efficiency of procurement through the Pharmaceuticals Fund and Supply Agency are areas where improvement is urgently needed; vi) external audit, and more particularly low levels of correction of audit findings; vii) Parliamentary oversight. In addition health-financing challenges at all levels are acute. The EU Health SBS supports the Government's efforts in addressing some of these challenges.

- Secondly, general challenges for reform implementation are: i) the federal structures of Government can move to second generation reforms, but core functions need to be solidly rooted at subnational levels. In this context, discussions on IFMIS roll out are ongoing; ii) collaboration between MoFEC and other actors is required to ensure effective reform implementation. To this aim, the enlargement to new stakeholders of the Expenditure Management Control Program (EMCP) Steering Committee and Technical Committee has been agreed as part of the World Bank PFM standalone project. Further attention also needs to be given to coordination with the revenue side (MoFEC and Ethiopian Revenue and Customs Authority) and between MoFEC and the recently created National Planning Commission; iii) difficulty to attract and retain staff at all levels[7].
- Thirdly, the development of a comprehensive joint performance assessment framework has been agreed to further move to strategic and results oriented dialogue, strengthen coordination of the dialogue and support to different reform initiatives and ensure smooth budget support implementation, while at the same time reducing transaction costs. Finally, discussions on the budget are limited to the bi-annual PBS Joint Review and Implementation Support reducing the ability of Development Partners to react to financing challenges.

At sector level, health basic service delivery depends on 1) accurate planning and its costing as part of a medium term expenditure framework capable to credibly link budget to policies and 2) expenditure performance during annual implementation. Although the past track record in achieving health targets has been positive, major challenges remain, including:

- Resourcing, sustainability and equity of health financing at all levels of government: i) the medium term strategy is not fully aligned to the Medium Term Expenditure Framework (2014 PEFA), with a substantial financing gap of HSTP and with the health sector being dependent on external resources; ii) shortage of resources at service delivery levels, iii) lack of financial and non-financial tools to provide incentives for local health expenditures, and weak coordination of different sources of health financing, that impede adequate planning. As such, there is need to mobilize additional domestic resources to ensure that sufficient resources flow to meet expenditure assignments.

- Efficiency and effectiveness of spending: the FMoH is a pilot ministry for IFMIS roll out at federal level. However, challenges in budget execution remain, whereby the health sector shows the biggest budget variances, specifically at regional level. At subnational level, internal controls and audit need to be further strengthened. Inefficiency of procurement, through the Pharmaceuticals Fund and Supply Agency, causes shortages of drugs.

- Accountability: the trends of the external audits of the Ministry of Health accounts in the past years have been positive with unqualified audits and the challenge will be to maintain the positive trend. In addition, procurement and commodity audit remains a major pending issue.

Some of these general and sector challenges are being addressed through the EU Health SBS, notably:

- During the second half of 2016 a comprehensive PFM and transparency common performance assessment framework covering all PFM dimensions will be developed to guide joint dialogue and assess general conditions before each disbursement. This exercise is also carried out in the area of basic service delivery.
- Three trigger indicators address the shortage of domestic resources and the little coordination between different sources for health financing without distorting budget processes, namely: 1) per capita increase of Federal Block Grant transfer to regions; 2) % increase of allocation to National Sexual Reproductive Health/Family planning; and 3) % increase of actual expenditure in health. These indicators are instrumental to bring closer together MoFEC and FMoH and to strengthen coordination of expenditures between federal and regional levels. They are also strategic to strengthen the links between the dialogues taking place in the health platforms and in the Basic Service Delivery Group, where financing issues at all levels are discussed. Financing and sustainability will also be supported through dedicated capacity development measures – such

as 1) strengthening horizontal and vertical coordination and knowledge sharing on health performance and financing, 2) support to the health economic analysis capacity of the FMoH and the analytical works on health financing and sustainability to be carried out by the Service Delivery Secretariat (SDS), and 3) the European Commission will initiate a study on financing and incentivising health expenditures.

- Transparency and accountability challenges are addressed through: 1) the development of a joint PFM and the transparency annual monitoring plans; 2) a trigger indicator on external audit; and 3) various capacity development measures, such as social accountability, support to the M&E of the PFM reform and finally, the strengthening of the health sector financial and fiduciary management.
- Efficiency and effectiveness of spending will be addressed in the PFM annual monitoring plan, as well as through capacity development accompanying measures, such as 1) strengthening horizontal and vertical coordination and knowledge sharing on health performance and financing, 2) roll out of programme-based budgeting and support to the health sector financial and fiduciary management. The World Bank Program for Results (P4R) Health includes an indicator on procurement.

1.2.4 Transparency and oversight of the budget

The budgets for the fiscal years 2014/15 and 2015/2016 were approved by Parliament on time and according to law, and made available in hard and soft copies within a month of their approval. The most recent budget documentation can be downloaded from the web page of the MoFEC www.mofed.gov.et. The entry point for the fulfilment of the eligibility criterion on transparency and oversight of the budget is therefore met.

Although 2015 PEFA shows improvement in some areas (PI-7, PI-8, PI-26, PI-27), transparency and oversight is the eligibility criteria where progress has been slowest:

Comprehensiveness of budget documentation (PI-6): Although the direction of change at federal level remains positive (scoring B), pending weaknesses remain, notably: i) inclusion of actual budget outturns of previous year, without which, annual budgets reviewed and adopted by parliament and/or regional councils are not based on actual performance; ii) budget documentation and reporting omit operations by extra-budgetary funds (PI-7) and information on fiscal risk arising from public enterprises (PI-9). This can hamper comprehensive and sound parliamentary oversight (PI-27) due to unavailability of complete information. This is an issue that is still under discussion with the Government which considers at this stage that it would not be appropriate to report public enterprises activities in the budget for the following reasons; i) public enterprises are considered as any profit organisation; ii) the parliament has the right to ask the particular ministry responsible for monitoring these public enterprises; iii) the debt directorate of MoFEC issues the Quarterly Debt Bulleting on its website; iv) a Ministry of the Public enterprises has been created.

Public access to key fiscal information (PI-10): Limited access to fiscal information is one of the major PFM weaknesses in Ethiopia. Expenditure Management Control Program focuses on improving transparency at subnational levels, which is supported by the PBS Citizen's engagement subprogram. As a result, progress has been more important at regional level (with the exception of Southern Nations, Nationalities, and Peoples' Region (SNNPR) and Somali) than at federal level.

At federal level, overall fiscal transparency shows no progress since 2010 (C score). The Government produces all required budget documentation but only publishes three out of the basic six budgetary documents: In-year, mid-year and end-year reports are not published. The Government committed to publish them as part of the PFM Annual Monitoring Plan of the SPSP Roads but this has not materialised. Other initiatives contribute to improve transparency and accountability, such as: i) Financial Transparency and Accountability at regional level is part of Expenditure Management Control Program; ii) Creation of the National Audit and Accounting Board of Ethiopia; iii) The World Bank will implement the BOOST initiative as part of its PFM standalone programme. The EU Health SBS links to these initiatives and the Transparency Annual Monitoring Framework is being updated accordingly.

The above raises three main issues for follow up: firstly, while pursuing efforts at regional level, there is need to improve public access to fiscal information at federal level. Secondly, at regional level the focus has been more on the transparency rather than on the accountability side. Discussions need to be pursued to strengthen accountability. Finally, for transparency to be effective there is need for an enabling environment for civil society. Progress at subnational level has been possible because the Government granted an exemption to the law for civil society

organizations working under the Ethiopian Social Accountability Program. Continuing in this direction is necessary to yield the benefits of transparency.

External audit: coverage has improved from 30% in 2008 to 100% at federal level. Financial/performance audits are carried out according to international standards. Reports are submitted to the legislature within a reasonable time and published. The Office of Federal Auditor General follows up audit recommendations in consecutive audits. Key concerns relate to: i) uneven audit performance at regional level (such as weak audit quality and backlogs), mostly due to limited capacities; ii) weak implementation of recommendations by the different budget institutions. MoFEC has committed to improve the follow up process and is putting in place a series of initiatives to this aim.

Legislative oversight (PI-27 and PI-28) has only recently been introduced in Ethiopia – the Public Accounts Committee was established at the House of Peoples Representatives only around a decade ago. However, a number of good practices for accountability have emerged as regards budget oversight (PI-27), which improved at federal level (from D+ to B+) thanks to: i) legislature procedures are well established and the introduction of a procedure manual in EFY 2007 has improved compliance; ii) the Budget and Finance Committee has enough time to analyse the MTFF and annual budget proposals; iii) the scope of the scrutiny has improved and hearings are given more importance.

A number of challenges remain, notably: i) unclear incentives for the parliament to exercise effective parliamentary oversight, as both the legislature and the executive are controlled by the party in power. This, together with limited capacities, partly explains the fact that in practice, the parliament seldom requests the executive to introduce any change; ii) the challenges related to the comprehensiveness of budget documentation limit sound and comprehensive legislative oversight; iii) at regional level, there is a need to increase the time for the legislature to provide a response to budget proposals. The three-year expenditure framework of the Program Based Budget (PBB) will also require the Council to enlarge the scope of their scrutiny from an annual to a three-year perspective; finally, the **legislative scrutiny of audit reports (PI-28) remains weak and has deteriorated (from C+ to D+),** despite the improved quality and timely submission of Office of Federal Auditor General's reports. The Public Accounts Committee of the parliament reviews audit reports but does not provide its own recommendations. Finally, follow up of the implementation of performance audit recommendations is weak and a more active involvement of the Public Accounts Committee is required. Legislative scrutiny of audit reports is stronger at regional level where Councils directly issue recommendations.

2. RISKS AND ASSUMPTIONS

The summary of risks is derived from the latest Risk Management Framework. Some risks are substantial but mitigating measures are identified at political, policy and operational levels. Further, the costs of a non-intervention would be higher than the risks and would imply missing windows of opportunity. This means that the potential benefits of budget support outweigh the risks.

Risks	Level (H/M/L)	Mitigating measures
Political Major challenges as regards good governance and conflicts	**H**	**At operational level:** Support social accountability and safeguard initiatives as part of accompanying measures (Support to the Service Delivery Secretariat) Initiate and pursue discussions with the Government on social accountability and safeguards at higher and formal levels Involvement of civil society and EU to support to democratic governance as planned in the NIP **At political level:** Pursue EU and MS Art. 8 and technical dialogues AU peer review/EU demarches Donor Assistance Group dialogue and monitoring Government measures: Discussion forums involving different stakeholders; social accountability institutionalization.

Macroeconomic The development model pursued by the Ethiopian Government is generating good results on poverty reduction, economic growth and reduction of inflation risks. Yet, 2015 IMF Art. IV indicates that the private sector could be crowded out (p.12) and to the possible emergence of macroeconomic imbalances.	**M**	**Political level**: Discussions with the government in the framework of Article IV, Art. 8 and with the Donor Assistance Group (follow up of GTP…) **Policy level:** Pursue macroeconomic dialogue and EU business forum **Operational level**: EU Transformation Triggering Facility programme (TTF); Trade enhancement and Facilitation Programme (TeFAP)
Developmental High dependency of the health sector on external financing, weak statistical systems and overambitious targets, poor quality of services, vertical and horizontal inequalities.	**M**	**Policy level:** participation to the policy dialogue on health and on future PBS Joint Review & Implementation Support and finalise the development of a common performance / dialogue framework on basic service delivery and PFM **Operational level:** The SBS programme includes indicators and capacity development support to address each of these areas. Building on the Ethiopian Social Accountability Program-2 to further strengthen the participation of the population, including women in the decision-making processes.
Public Financial Management Whilst Ethiopia has a robust PFM system, weaknesses remain as regards unreported Extra Budgetary Operations, public access to key financial information, tax collection, external audit and legislative oversight of audit reports and more importantly, correction of audit findings.	**M**	**Policy level:** The Government is integrating PEFA findings in the annual ECMP Action Plan and developing regional action plans. Pursue dialogue in the PFM donor and sector working groups and develop a common performance framework for dialogue on PFM and on basic service delivery **Operational level**: Pursue PFM support through PBS subprogram B (Financial Accountability and Transparency and social accountability) The Health SBS integrates PFM/financing trigger indicators and capacity development support.
Corruption and fraud	**H**	Continuous monitoring, PFM support and policy dialogue Support to transparency and accountability measures

3. LESSONS LEARNT, COMPLEMENTARY MEASURES AND CROSS CUTTING ISSUES

3.1 Lessons learnt

Although this is the first budget support in health, the following lessons can be learned from past EU and other Development Partner support:

- EU support to the health sector has been provided indirectly through the Promotion of Basic Services programme. The Social Accountability initiative contributes to: 1) the health centre reform programme by improving service providers' responsiveness; planning processes as well as availability of basic medicines and staff at facility level; 2) reduce inequalities by encouraging gender responsive services and giving voice to vulnerable groups; 5) transparency and governance at service delivery level by engaging service providers and users in constructive dialogue and encouraging active community participation. Lessons relate to the need to address acute budget shortages at *woreda* level and further root public financial management, financial transparency, social accountability and data quality in the health sector at local level.

- The EU is supporting the health sector through the maternal health initiative – Enhancing Safe Delivery in Ethiopia (ESDE) project (EUR 40 million) which partly channelled resources to the MDG PF (EUR 21 million). As contributors to the MDG PF, the EU has joined the different policy dialogue – Joint Consultative Forum, Joint Core Coordinating Committee and Health, Population and Nutrition. From the dialogue at different fora so far, the lesson learnt is that the policy dialogue need to be further structured with a focus on key sector priority areas and defined performance indicators. To this effect, recently FMoH and Development

Partners revised the Joint Financing Arrangement (JFA) to enable to lift up the policy dialogue with active participation of MoFEC. The revision of the JFA has also provided the opportunity to initiate discussions with the Government and other Development Partners on the rationalisation and strengthening of the policy dialogue in the health sector.

- Relevant lessons from the three past phases of the EU Budget Support on the Road sector and from the formulation phase of the health sector budget support include:

  (i) At political level, there is strong Government demand for budget support. At operational level –MoFEC and FMoH - the concept, practice and internal coordination arrangements still need to be established to yield all the potential benefits of budget support. This may require training and support to stakeholders to design effective internal coordination arrangements, including ensuring appropriate involvement of actors in the policy dialogue as well as adequate and timely reporting for the budget support disbursement files. In addition, achieving trigger indicators in the Ethiopian federal and decentralised context also involves appropriate inter-governmental coordination and dialogue with the regions and *woredas*. A short term and intermittent technical assistant/independent assessor together with capacity development measures (such as regional conferences in health performance and health financing) will help facilitate these processes;

  (ii) Budget support, being based on strengthened coordination between MoFEC and sector ministries, allows addressing financing and sustainability issues that cannot be addressed through other modalities. This is complementary to other Development Partners' interventions as it helps reinforce the sustainability of their own operations in the medium term. To this aim, the use of dedicated trigger indicators and specific capacity development measures is proving instrumental;

  (iii) There is the need to strengthen and improve policy dialogue on health sector issues but also on basic service delivery and on sector budget support general conditions, particularly on PFM. Various Development Partners are placing more emphasis on results oriented modalities, which has triggered efforts to develop a common performance assessment framework in basic service delivery and in the PFM area. Pursuing efforts in this direction as well as bringing policy dialogue to higher levels to include all relevant stakeholders and ensure coordination between different dialogue fora is fundamental. In this context, and based on lessons from other countries (as per Budget support evaluations), a high level annual coordination platform including all budget support providers and all relevant stakeholders from the health sector, basic service delivery group and PFM would be an important milestone to yield the benefits of budget support. Ongoing work in this direction should be pursued and accelerated.

3.2 Complementarity, synergy and donor coordination

The management of a budget support operation requires a sector policy dialogue (health) as well as a dialogue on the general conditions (PFM and transparency as well as macroeconomic stability). In Ethiopia, there is no one single overarching platform. Therefore, the EU Delegation will continue to be engaged and to seek coordination between various existing platforms and in close coordination with other budget support contributors, notably:

- Two platforms are relevant for sector policy dialogue, namely: 1) the Joint Consultative Forum, which is the main health dialogue platform and 2) the dialogue on Basic Service delivery since health is one amongst the five decentralised sectors. Despite their complementarity and their respective added value, the dialogue on health and the dialogue on basic service delivery have barely coordinated.
- The dialogue on general conditions takes place in the PFM Sector Working Group, (that reports to the Donor Assistance Group and to the Basic Service Delivery Joint Review & Implementation Support), and the Macroeconomic Sector Working Group. So far the dialogue on general conditions for budget support has been relatively limited although over time it is improving.

A high level annual coordination forum for these different platforms should be envisaged to jointly review overall progress in all related areas (health, basic service delivery and PFM), avoid fragmentation and strengthen stewardship. This coordination platform could be established as an ad hoc annual basis or using the November JRIS/JBAR. Work is ongoing to design the specific details of the arrangements.

Dialogue platforms in the health sector: Development Partners active in Ethiopia coordinate their health related activities through the Health, Population and Nutrition Development Partners' forum, which meets with the Government (Ministry of Health) and one of the co-chairs together with the Minister of Health is co-chairing the Joint Consultation Forum.

The Joint Consultative Forum is the highest body for dialogue on sector policy and strategic issues between the Government and health and nutrition Development Partners. The Joint Core Coordinating Committee is the technical arm of the Joint Consultative Forum, responsible for follow up of all pool funds implementation and sector performance reviews. This high-level dialogue structure has not sufficiently involved MoFEC and discussions have been limited to mainly MDG PF activities/inputs.

Dialogue on Basic Service Delivery: In the federal and decentralised context of Ethiopia it is key to continue Development Partner harmonisation efforts and dialogue with the Government on basic service delivery, including in health, and irrespective of the aid modalities used by different Development Partners. In addition, the World Bank PFM standalone project and Performance for Results (P4R) Enhanced Shared Prosperity through Equitable Access (successor of PBS) as well as the African Development Bank budget support use PBS Joint Review & Implementation Support / Joint Budget and Aid Review to monitor and assess progress. This re-confirms the relevance to continue to be actively engaged in this platform. Agreement has been found to develop a common performance assessment framework, to coordinate findings emerging from the assessment of trigger indicators of the three budget support programmes and to create a high level steering committee to discuss issues that cannot be raised in the current format.

Dialogue on PFM: Upgrading the dialogue on PFM is key for the management of the budget support operation (assessment of general conditions) but also necessary in the context of the EU Sector Budget Support to Health, which includes PFM indicators and capacity development measures. To this aim, engagement will continue in the Development Partner PFM group and in the Donor Assistance Group PFM Sector Working Group (which reports to the PBS biannual Joint Review & Implementation Support / Joint Budget and Aid Review). So far the scope of the dialogue is relatively narrow as it only focuses on Expenditure Management Control Program, leaving off the agenda the revenue side, budget oversight and the budget. Agreement has also been found to develop a common performance-monitoring framework to structure the discussions around a set of common priorities and agenda and help better coordinate Development Partners' support programmes.

Macroeconomic framework: dialogue takes place in the macroeconomic sector working group and twice a year in the PBS Joint Review & Implementation Support. The efficiency and regularity of the macroeconomic sector working group needs improvement (in 2015 the group only met once). The agenda is issue based and dialogue has focused on exchange of information. Issues such as the impact of the drought or the budget have not yet been discussed.

Despite challenges still ahead, the Government is aware of all these coordination processes, has given its agreement to continue to move forward and is itself reflecting on the different options. All these dynamics represent a qualitative step forward in the way of managing budget support operations in Ethiopia

3.3 Cross-cutting issues

Gender - addressing maternal health, one of the priority areas of the HSTP and this SBS operation, saves women's lives, can improve the status of women and strengthen gender equality. Women's status and opportunities are enhanced by being able to live free from childbirth related disability and traumatic experiences. In line with this, the HSTP gives due attention in addressing gender issues through promoting gender equality and empowerment of women, improving women's information access (through the antenatal care services and supporting the establishment of adequate facilities and protocols in health centres to deal with women's health issues such as HTP, family planning and contraception, obstetric care), improving access to information about family planning, reproductive health issues, contraception and contraceptive methods for men and women that are the responsibility of Health Extension Workers, and increasing use of health services by women (provision of basic maternal health services for free).

The SBS will address gender issues in various ways: i) policy dialogue will address gender specific issues and will monitor trends in this area (such as women’s use of health services, improve quality of service delivery including

gender responsive services, the need to produce gender disaggregated data, implementation of the gender mainstreaming manual and its implementation as part of the health centre reform programme); ii) at operational level, the budget support component includes an indicator on the increase of the federal block grant. Indirectly this will address issues related to gender responsive preventive care as the block grant finances salaries of the Health Extension Workers who are responsible for preventive care (including improving knowledge of women on contraceptive use, impact of Harmful Traditional Practices including early marriage and expanding women and youth friendly health services responsive to the needs and customs of the community).

Environment and climate change - the most important issue related to the programme concerns the safe and appropriate management of health care waste, including the disposal of expired medicines. The FMoH has developed guidelines for health care waste management, which are incorporated into training programmes for health care workers. In addition, coordination will continue with the World Bank on the safeguard mechanisms and on social and environmental impact assessments and training of Government officials.

Nutrition contributes to achievement or acceleration of progress towards several MDGs. Ethiopia has one of the highest rates of malnutrition in Sub-Saharan Africa, and faces acute and chronic malnutrition and micronutrient deficiencies. Nutrition deficiencies during the first critical 1,000 days (conception to 2 years) put a child at risk of being stunted. While stunting has reduced over the last ten years, it still affects 40% of children in Ethiopia (DHS 2014) with dramatic impacts on the physical and mental development of individuals as well as the overall economy. The Cost of Hunger Africa study (WFP, 2013) estimated Ethiopia has lost about USD 4.7 billion as the result of under-nutrition in 2009 alone, an equivalent of 16.5% of GDP.

4. DESCRIPTION OF THE ACTION

The programme includes Health Sector Budget Support (SBS) and accompanying Capacity Development measures both integrated into one single and same intervention logic. This means that budget support funds and indicators and the capacity development support will be complementary and will together contribute to the same objectives, specific objectives, outcomes and outputs.

However, attention has been paid to 'de-link' trigger indicators from capacity development support in order to avoid disbursements delays due to potential delays in mobilising adequate expertise in time. Hence, appropriate division of labour between the two components will be ensured.

4.1 Objectives/results

This programme is relevant for the Agenda 2030. It contributes primarily to the progressive achievement of SDG Goal 3 - Ensure healthy lives and promote well-being for all at all ages, but also promotes progress towards Goal 5 - Achieve gender equality and empower all women and girls. This does not imply a commitment by the country benefiting from this programme.

The overall objective is to support the Government of Ethiopia to improve health and well-being of Ethiopian citizens.

As such, it aims at contributing to the efforts of the Government of Ethiopia to reduce poverty and engage in inclusive growth.

Specific objectives are:
SO 1: Improve quality and access to health service delivery at all levels with a particular focus on maternal and child health
SO 2: Reduce inequity in health service delivery both vertically and horizontally
SO 3: Improve the financial capacity at all levels of government to achieve HSTP objectives
SO 4: Improve governance, PFM and accountability in the health sector

Expected results:
Result 1: Increased quantity and quality of services – human resources, health supplies/commodities and services that are gender sensitive at all levels. This contributes to HTSP Strategic Theme 2 'Excellence in health service delivery', Strategic Theme 3 'Excellence in quality assurance' and Strategic Theme 4 'Excellence in health system capacity'. It consists of a mix of SBS trigger indicators and Capacity Development support.

Result 2: Equity addressed through strengthened health insurance system. This result directly contributes to HSTP Strategic 4 'Excellence in health system capacity'. It also consists of a mix of budget support indicators and capacity development support.

Result 3: Increased domestic allocation and spending in the health sector. This result directly contributes to HSTP Strategic Theme 3 'Excellence in leadership and governance'. It consists of a mix of budget support indicators and capacity development support.

Result 4: Improved PFM and oversight functions. This result directly contributes to HSTP Strategic Theme 3 'Excellence in leadership and governance', including a few selected budget support indicators on improvement of PFM in the sector and capacity development support in PFM and social accountability related areas.

4.2 Main activities

4.2.1 Budget support

The main activities of the SBS operation are:

- ***Disbursement of SBS funds*** on the basis of satisfactory assessment of eligibility criteria - progress in the implementation of the HSTP; maintenance of a stability-oriented macroeconomic policy; PFM reform; budget transparency and oversight functions (*fixed tranche*); and performance on the targets of trigger indictors (*variable tranche*);
- Conduct ***result oriented policy dialogue*** (together with other Development Partners) on the basis of agreed performance indicators.

4.2.2 Complementary support

Capacity development measures include:

- Strengthening the ***equity and quality reforms*** in the health sector - (i) support for Health Centres quality reform implementation; (ii) support for developing national licensing exam for health professionals; (iii) scaling up social accountability initiatives in the health sector; (iv) support for the creation of an IT system for claims processing management for the newly established Ethiopian Health Insurance Agency (EHIA);
- ***Strengthening sustainability of health care financing and enriching the policy dialogue*** through (i) support for health economics/financial and gender analysis; and (ii) strengthening existing forums particularly at regional levels (MoFEC, FMoH, Bureau of Finance and Economic Cooperation (BoFEC), and the Regional Health Bureaus) for knowledge sharing on health performance and financing; (iii) carry out analytical work on sustainability, pursue ongoing work on safeguards and system strengthening and support the internal audit of the health sector (training and update of audit manual);
- Strengthening of PFM and fiduciary management, including expenditure control, audit and policy based budgeting: (i) strengthening PFM Monitoring and Evaluation system; (ii) support for rolling out Performance Based Budgeting (PBB) at Regional States and City Administration level; (iii) strengthening health sector financial and fiduciary management (particularly at lower levels), including amongst others, internal audit function, commodity audits and audit of the Pharmaceuticals Fund and Supply Agency;
- Support the monitoring and management of the SBS operation using an independent assessor.

4.3 Intervention logic

The design of the programme takes into account that the identified priority areas (from the problem analysis) require building capacities at various levels of government involved in the health system as well as supporting social accountability and PFM in the sector.

The intervention logic is built on the activities identified (both SBS and accompanying Capacity Development measures) leading to defined results. **Result 1**: activities including (1) the policy dialogue on the trigger indicators (a) ANC+4; (b) SBA; (c) availability of services/utilities at Health Centres (essential drugs, water supply, power,

staff houses); (2) support Health Centres quality reform; (3) building capacities for National Licencing Exam; and (4) scaling up of social accountability initiatives in the health sector will lead to improved access and quality of services. **Result 2**: activities related to financial transfer and policy dialogue in addressing equity on SBA; follow up and strengthening of Community Based Health Insurance & Social Health Insurance coverage nationwide for risk pooling and financial protection for the poor; support for building FMoH's capacity on health economics and financial/gender analysis for informed policy design and decision making, and the support for developing Ethiopian Health Insurance Agency's IT system and automation of its claim management procedure will reduce inequity in health service delivery. **Result 3**: the discussions and dialogue on health financing (increased Federal Block Grant, enabling sub-national level's expenditure in health, allocation to Sexual and Reproductive Health/Family Planning programme from the domestic resources, overall increase of actual expenditure in health, the vertical and horizontal coordination mechanisms on health performance and financing and finally the support for programme-based budgeting (PBB) will improve the space for health financing from domestic resources and build capacities at all levels of the governance structures. **Result 4**: activities including the dialogue on the Office of Federal Auditor General audit findings of FMoH account, the support for FMoH internal audit capacity building, strengthening the national PFM Monitoring and Evaluation system will lead to improved governance, PFM, and accountability.

These achievement/results on 1) improved access and quality of care, 2) reduced inequity in health service delivery, 3) improved financial capacity and strengthening sustainable financing of health expenditure from the domestic resources, 4) overall improvement on the health governance, PFM, and ensuring accountability at all levels, will contribute to the overall objective of the programme - improved health and wellbeing of Ethiopian citizens.

5. IMPLEMENTATION

5.1 Financing Agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country, referred to in Article 17 of Annex IV to the ACP-EU Partnership Agreement.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which activities described in section 4.2 will be carried out and the corresponding contracts and agreements will be implemented, is 48 months from the date of entry into force of the financing agreement.

Extensions of the implementation period may be agreed by the Commission's Authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to this decision constitute non substantial amendment in the sense of Article 9(4) of Regulation (EU) 2015/322.

5.3 Implementation of the budget support component

5.3.1 Rationale for the amounts allocated to budget support

The amount allocated for budget support component is EUR 100 000 000, and for complementary support is EUR 15 000 000. This amount is based on the following grounds:

- Need to adopt adequate modalities to address key challenges in the sector and achieve proposed programme objectives: Ethiopia's good past track record together with the starting of a new policy cycle with the development of the HSTP are conducive factors to use budget support to further align to country mechanisms and to address challenges ahead. The Sustainable Development Goals Performance Fund (SDG-PF), to which of most Development Partners contribute, mainly focuses on procurement, which is only part of the health system. However, most challenges in the health sector are wider, go beyond the reach of the Sustainable Development Goals Performance Fund and require close coordination with MoFEC and with regions. For these reasons, the SBS is considered a more adequate modality as it has the potential to better discuss the entire HSTP and strengthen the coordination between MoFEC and FMoH and with regions and *woredas*, notably as regards coordination of financing sources and expenditures at various levels. This is necessary as financing to the sector involves the two ministries, who need to improve the coordination or the overall financing for the sector to ensure sustainability at all levels. The effects of a

sector budget support would also be beneficial to other Development Partners operations, as it would contribute to the sustainability of procurements processes now covered by external resources under the Sustainable Development Goals Performance Fund.

- Need to channel sufficient resources: the amounts allocated to the SBS and to the capacity development accompanying measures has been decided taking into account the following considerations: i) Government request and discussions; ii) the existence of a substantial financing gap to fully implement HSTP that is larger than the EU envelope and the need to increase domestic revenues to address identified challenges that EU BS aims to address. The EUR 100 000 000 SBS does not fill the gap (nor is it the intention) but helps address this in two ways. Budget support resources are considered as domestic resources and the successful negotiations between FMoH and MoFEC on trigger indicators confirm that they are substantial enough to create a space to consider mobilising additional domestic resources for health; and iii) capacity development envelope (EUR 15 000 000) has been decided on a needs-based approach that has also guided the split between the SBS and the capacity development envelope.
- Need to expand and improve policy dialogue and focus on results: due to its very nature, SBS focuses on results oriented dialogue and further strengthening of existing sector dialogue platforms with the participation of MoFEC. Some Development Partners are considering similar results oriented modalities in the health sector and in the basic service delivery group (World Bank - Performance for Results (P4R) health, Performance for Results (P4R) Enhanced Shared Prosperity through Equitable Access programme, and African Development Bank – Basic Service Transformation (BST) Program). This evolving Development Partner landscape provides an opportunity for a group of Development Partners to join forces and engage in a joint policy dialogue that addresses the entire HSTP and health care financing, while ensuring close coordination and building on the Sustainable Development Goals Performance Fund discussions.
- The allocation for the Capacity Development component is also on the basis of the analysis and needs identified for complementary measures that will further strengthen the equity and quality reforms across the different health service delivery tiers (described in section 1.1), PFM reforms, and scaling up of social accountability initiatives in the sector. The EU Delegation together with FMoH and MoFEC team (with the support of consultants recruited through the Framework Contract) has identified the areas for the Capacity Development that are key to achieve HTSP objectives.

5.3.2 Criteria for disbursement of budget support

a) The general conditions for disbursement of all tranches are as follows:

- Satisfactory progress in the implementation of the Health Sector Transformation Plan (HSTP 2015-2020) and continued credibility and relevance thereof;
- Implementation of a credible stability-oriented macroeconomic policy;
- Satisfactory progress in the implementation of the Expenditure Management Control Program;
- Satisfactory progress with regard to the public availability of timely, comprehensive and sound budgetary information.

b) The specific conditions for disbursement that will be used for variable tranches - a total of 12 performance/triggers indicators are selected and agreed with the Government on the definition, target, calculation and weighting of each trigger indicators. These performance indicators fall under the four priority areas identified and ensuring a mix of process, output and outcome indicators.

The chosen performance targets and indicators to be used for disbursements will apply for the duration of the programme. However, in duly justified circumstances, the Government of Ethiopia may submit a request to the Commission for the targets and indicators to be changed. The changes agreed to the targets and indicators may be authorised by exchange of letters between the two parties.

In case of significant deterioration of fundamental values, SBS disbursements may be formally suspended, temporarily suspended, reduced or cancelled in accordance with the relevant provisions of the financing agreement.

5.3.3 Budget support details

Based on the discussions with different stakeholders and decisions made on the Annual Action Plan, the budget support consists of EUR 100 000 000 over a three-year period with one disbursement per year combining a:

- A fixed tranche on satisfaction of eligibility conditions and pre-conditions;
- Variable amount linked to the satisfaction of performance/trigger indicators.

The split across years is EUR 34 000 000 in year one and EUR 33 000 000 in years 2 and 3. The table below illustrates the envisaged timing for the release of SBS funds, which will allow integrating the funds in EFY 2009 budget (2016 Gregorian calendar) and help avoid financial gaps in service. Having a variable tranche in the first year will also allow keeping up the momentum in policy dialogue.

1st tranche 4th quarter 2016		2nd tranche 4th quarter 2017		3rd tranche 4th quarter 2018	
FT 1	VT 1	FT 2	VT 2	FT 3	VT 3

The share between fixed tranche/variable tranche would be 60/40 in the first year (2016) with the objective of gradually increasing the share of the variable tranche - with 55/45 in 2017; and 50/50 in 2018. The indicative timeline below describes the disbursement schedule and the composition of each variable tranche:

- The first tranche in the fourth quarter of 2016 will be used for Drugs, Equity Skilled Birth Attendance, Community Based Health Insurance, Federal Block Grant, Sexual and Reproductive Health and Family Planning and the audits by the Office of Federal Auditor General.
- The second tranche in the fourth quarter of 2017 will be used for Ante-Natal care, Equity Skilled Birth Attendance, Drugs, Water and Energy supply, Federal Block Grant, Sexual and Reproductive Health and Family Planning, Actual Health Expenditures, and the audits by the Office of Federal Auditor General.
- The third tranche in the fourth quarter of 2018 will be used for Drugs, Water and Energy supply Equity Skilled Birth Attendance, Community Based Health Insurance, Federal Block Grant, Sexual and Reproductive Health and Family Planning, Actual Health Expenditures, and the audits by the Office of Federal Auditor General.

<u>Determining variable tranche payments</u>

The performance assessment for the health SBS shall be an inclusive process led by the Government, whereby performance results are also subject to stakeholder consultations and are made publicly available and feed into domestic accountability mechanisms. The results for variable tranche indicators can then be extracted from the overall policy review process, subject to EU Delegation views on the accuracy of the information. Where serious doubts exist about the quality of the data provided, data verification exercises will be carried out to inform payment decisions.

In view of this, determining the variable tranche payment involves attributing a score for each trigger indicator, and then aggregating these scores to determine the variable tranche disbursement. Specifically, the process involves:

i. Attributing a score to each indicator

A score shall be attributed (0, 0.5, and 1) depending on whether (a) less than 40% of the target was met (score 0), (b) 40-80% of the target was met (score 0.5), or (c) more than 80% of the target was met (score 1);

ii. Aggregating scores (with the weights) to determine the variable tranche disbursement

Disbursement will be made on the basis of the following performance categories: (i) 'unsatisfactory' (total score 0).

Capacity development supports mainly consist of providing adequate expertise, facilitating processes and reinforcing capacities at different levels. The priority Capacity Development areas (described above) fall and contribute to the overall intervention logic of the programme. There will not be purchases of goods and software, as this can be covered by the budget support funds according and in line with government priorities.

To this aim, the capacity development has been structured around different components to be implemented through a mix of modalities that the EU Delegation and Government agreed.

Finally, visibility, evaluation and audit activities will be implemented through procurement (direct management). Indicatively, one service contract is foreseen for the visibility part to be tentatively launched during the first quarter. Two service contracts are tentatively foreseen to carry out mid-term and final evaluation.

Budget support is provided as direct untargeted budget support to the national Treasury. The crediting of the euro transfers disbursed into Ethiopian Birr will be undertaken at the appropriate exchange rates in line with the relevant provisions of the financing agreement.

5.4 Implementation modalities for complementary support of budget support

5.4.1 Grant: direct award Support to the FMoH (direct management)

(a) Objectives of the grant, fields of intervention, priorities of the year and expected results
The grant to FMoH is expected to contribute to Result 1 'improved quality and access of services at all levels' of the proposed health programme. The specific objectives of the grant are to:

- Build the capacity of FMoH to enable successfully implement its health centre reform initiative for improving the quality of services at primary health care level
- Enable FMoH to design and implement licensing exams for the different cadres of health professionals

Detailed results and activities will be further designed jointly with the FMoH.

(b) Justification of a direct grant:
Under the responsibility of the Commission's authorising officer responsible, the grant may be awarded without a call for proposals to the Federal Ministry of Health.
Under the responsibility of the Commission's authorising officer responsible, the recourse to an award of a grant without a call for proposals is justified because the beneficiary is in a legal or factual monopoly situation; the action has specific characteristics requiring a specific type of beneficiary for its technical competence, specialisation and administrative power.

(c) Essential selection and award criteria
The essential selection criteria are the financial and operational capacity of the applicant.
The essential award criteria are relevance of the proposed action to the objectives of the call; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.

(d) Maximum rate of co-financing:
The maximum possible rate of co-financing for this grant is 80% of the eligible costs of the action.
In accordance with Article 192 of Regulation (EU, Euratom) No 966/2012 applicable in accordance with Article 37 of (EU) Regulation 2015/323 if full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. The essentiality of full funding will be justified by the Commission's authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative trimester to conclude the grant agreement
2nd Quarter of 2017.

5.4.2. Grant: direct award Support to the MoFEC (direct management)

(a) Objectives of the grant, fields of intervention, priorities of the year and expected results
This grant is expected to contribute to Result 4 of the proposed health programme 'Improved PFM and oversight functions'. The specific objectives of the grant are to:
Strengthen health sector financial and fiduciary management (expenditure control and audit in health)
Implementation of MoFEC Monitoring and Evaluation system of the PFM reform
Roll out of Programme Based Budget

(b) Justification of a direct grant
Under the responsibility of the Commission's authorising officer responsible, the grant may be awarded without a call for proposals to the Ministry of Finance and Economic Development.
Under the responsibility of the Commission's authorising officer responsible, the recourse to an award of a grant without a call for proposals is justified because the beneficiary is in a legal or factual monopoly situation; and because the action has specific characteristics requiring a specific type of beneficiary for its technical competence, specialisation or administrative power.

(c) Essential selection and award criteria
The essential selection criteria are the financial and operational capacity of the applicant.

The essential award criteria are relevance of the proposed action to the objectives of the call; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.

(d) Maximum rate of co-financing
The maximum possible rate of co-financing for this grant is 80% of the eligible costs of the action.

In accordance with Article 192 of Regulation (EU, Euratom) No 966/2012 applicable in accordance with Article 37 of (EU) Regulation 2015/323 if full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. The essentiality of full funding will be justified by the Commission's authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative trimester to conclude the grant agreement
2nd quarter of 2017.

5.4.3 Procurement (direct management)

Subject in generic terms, if possible	Type (works, supplies, services)	Indicative number of contracts	Indicative trimester of launch of the procedure
Independent assessor	Services	1	1 Q 2017

5.4.4. Indirect management with an international organisation

A part of this action may be implemented in indirect management with the World Bank in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012 applicable in accordance with Article 17 of Regulation (EU) 2015/323. This implementation entails to:

- mainstream and deepen social accountability in the health sector based on the achievements and lessons from the Ethiopian Social Accountability Program 2. This action will directly contribute to Result 1.

- support the Service Delivery Secretariat to: 1) strengthen vertical and horizontal coordination and knowledge sharing on health performance and financing; and 2) prepare analytical works and studies to inform dialogue on financing and sustainability, safeguards, system strengthening in the health sector and support to internal audit systems.

This implementation is justified because, in both cases, the World Bank has since 2006 been given the specific mandate as regards basic service delivery and social accountability and the World Bank has both the thematic expertise on the subject-matters and the logistical and management capacities.

The entrusted entity would carry out the following budget-implementation tasks: Management and supervision of the two multi-donor trust funds, one for social accountability (Ethiopian Social Accountability Program) and one for the Service Delivery Secretariat (such as financial management and annual single audit reports); Ensure appropriate leadership as permanent co-chair of the Basic Service delivery Group and social accountability in the dialogue and as regards oversight of operations.

The entrusted international organisation is currently undergoing the ex-ante assessment in accordance with Article 61(1) of Regulation (EU, Euratom) No 966/2012 EDF applicable in accordance with Article 17 of Regulation (EU) 2015/323. The Commission's authorising officer responsible deems that, based on the compliance with the ex-ante assessment based on Regulation (EU, Euratom) No 1605/2002 and long-lasting problem-free cooperation, the international organisation can be entrusted with budget-implementation tasks under indirect management.

If negotiations with the above-mentioned entrusted entity fail, that part of this action may be implemented in direct management in accordance with the implementation modalities identified in section 5.4.6.

5.4.5 Indirect management with the partner country

A part of this action, with the objectives of i) developing the Ethiopian Health Insurance Agency 's IT system and automating claim management procedure and ii) supporting FMoH health economics and financial analysis, may be implemented in indirect management with the Federal Democratic Republic of Ethiopia in accordance with Article 58(1)(c) of the Regulation (EU, Euratom) No 966/2012 applicable in accordance with Article 17 of Regulation (EU) 2015/3223, according to the following modalities:

The Federal Democratic Republic of Ethiopia will act as the contracting authority for the procurement and grant procedures. The Commission will control ex ante all the procurement and grant procedures.

Payments are executed by the Commission.

In accordance with Article 190(2)(b) of Regulation (EU, Euratom) No 966/2012 and Article 262(3) of Delegated Regulation (EU) No 1268/2012 applicable in accordance with Article 36 of Regulation (EU) 2015/323 and Article 19c(1) of Annex IV to the ACP-EU Partnership Agreement, the Federal Democratic Republic of Ethiopia shall apply procurement rules of Chapter 3 of Title IV of Part Two of Regulation (EU, Euratom) No 966/2012. These rules, as well as rules on grant procedures in accordance with Article 193 of Regulation (EU, Euratom) No 966/2012 applicable in accordance with Article 17 of Regulation (EU) 2015/323, will be laid down in the financing agreement concluded with the Federal Democratic Republic of Ethiopia.

5.4.6 Changes from indirect to direct management mode due to exceptional circumstances

Grants: call for proposals Health Sector Support (direct management)

(a) Objectives of the grants, fields of intervention, priorities of the year and expected results

mainstream and deepen social accountability in the health sector based on the achievements and lessons from the Ethiopian Social Accountability Program 2. This action will directly contribute to Result 1.

(b) Eligibility conditions

Public of semi public bodies with a strong experience in public administration.

(c) Essential selection and award criteria

The essential selection criteria are financial and operational capacity of the applicant.

The essential award criteria are relevance of the proposed action to the objectives of the call; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.

(d) Maximum rate of co-financing

The maximum possible rate of co-financing for grants under this call is 80% of the eligible costs of the action.

In accordance with Articles 192 of Regulation (EU, Euratom) No 966/2012, if full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100 %. The essentiality of full funding will be justified by the Commission's authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative timing to launch the call

1th trimester of 2017

5.5 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

5.6 Indicative budget

Modalities/contracts	**EU contribution (in EUR)**
5.3 Budget Support Sector Reform Contract	100 000 000
5.4.1 Result 1 and 2 Direct grant FMoH (direct management)	5 180 000
5.4.2 Result 4 Direct grant for MoFEC (direct management)	2 270 000
5.4.3 Result 1 Service Contract (direct management)	100 000
5.4.4 (or 5.4.6) Result 3 Administration Agreement WB (indirect management with international organisation)	700 000
5.4.4 (or 5.4.6) Result 1 Administration Agreement WB(indirect management with international organisation)	1 200 000
5.4.5 Result 1 Service contract (indirect management with Partner Country)	5 100 000
5.9 Evaluation, 5.10 - Audit	300 000
5.11 Visibility and Communication	150 000
TOTAL	**115 000 000**

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5.7 Organisational set-up and responsibilities

The organizational set-up for SBS operation shall be aligned with the existing institutional and operational arrangements developed for HSTP/GTP II implementation. While MoFEC has overall responsibility for the oversight and coordination of the budget support and capacity development support, FMoH and its health bureaus are the executing agencies. As regards the health sector, the Constitution provides for shared responsibility for policy, regulation, and service delivery between the FMoH, the Regional Health Bureaus and *Woreda* Health Offices. Accordingly, FMoH and the Regional Health Bureaus focus on policy formulation and provision of technical support, while *woreda* health offices retain primary responsibility for managing health system operations in their jurisdictions. The Pharmaceutical Fund and Supply Agency under the FMoH is responsible for procurement and distribution of medical commodities. In this context, it will be important that regions and *woredas* are involved and aware of their responsibilities in contributing to the achievement of budget support trigger indicators, notably through the regional summits (this refers to Capacity Development support on strengthening horizontal and vertical coordination and knowledge sharing on health performance and financing).

In addition, internal coordination and reporting mechanism need to be streamlined to make sure that all required information and data from the different stakeholders (different MoFEC departments and FMoH) is available on time for the assessment of the indicators and general conditions. To facilitate this, an independent assessor will be hired through a Service Contract.

Communities' involvement is key and enhancing the ownership is one of the strategic objectives of HSTP. Communities are represented in the governance boards of all public sector health facilities with due attention for gender balance. Moreover, local government councils, Health Extension Workers and the 'Health Development Army' have extensive responsibilities for social mobilization, increasing the community's awareness of their rights and responsibilities. The Health Development Army is engaged in promotion and prevention activities at community level, including the regular coordination of structured Community Dialogue Sessions, with guidance of the Health Extension Workers.

The sector has also established governance structures to effectively plan, coordinate and use development partners' support and/or resources. The **Joint Consultative Forum** chaired by the Minister of Health and co-chaired by Development Partners' representative is the highest body for policy dialogue. The Joint Consultative Forum discusses sector policy and strategic issues that impact resource allocation. The **Joint Core Coordinating Committee**, chaired by the Policy and Planning Directorate, FMoH, is a technical arm of the Joint Consultative Forum which provides operational oversight and monitors resources provided by partners to the health sector.

Apart from disbursing funding on a timely basis, the EU Delegation to Ethiopia will actively participate in the policy dialogue platforms (described in section 3.2) and engaged monitoring and review of sector performances. The EU will also conduct mid-term and final evaluation and audit using direct centralized management method.

Finally, the Basic Service delivery platform with its biannual Joint Review & Implementation Support / Joint Budget and Aid Review will be used to engage in joint dialogue on basic services, including in the health sector and appropriate linkages will be established with the Joint Consultative Forum and the Joint Core Coordinating Committee. The dialogue will be based on common performance framework. The dialogue on the PFM will be also pursued and work will be pursued to develop a common performance assessment framework in line with best practices in managing budget support and in line with the PFM indicators and capacity development activities identified in the SBS.

5.8 Performance monitoring and reporting

The Ministry of Finance and Economic Cooperation, implementing bodies and Development Partners will be conducting periodic monitoring, jointly and bilaterally.

The finalisation of a common performance assessment/monitoring framework for PFM and Transparency and oversight of the budget as well as the finalisation of the details of the policy dialogue mechanisms will be a condition for the disbursement of the first tranche in November 2016.

During implementation of the budget support component, MoFEC will be in charge of providing the required documents to the EU Delegation as well as of reporting progress against the PFM and Transparency annual monitoring plans in a consolidated manner. All performance reports prepared by the implementing partners are expected to be submitted to MoFEC and the EU Delegation.

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by the list of result indicators. The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

5.9 Evaluation

Having regard to the importance of the action, a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission.

A final evaluation will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the fact that a joint policy dialogue framework (as described in Figure 2 above) is to be further strengthened with a dialogue at sub-national levels through the organization of a Regional Summit to discuss health performance and financing and ensuring accountability at decentralized levels as well. The health SBS is also supporting new initiatives in addressing challenges related to quality of care and equity

issues; and also strengthening domestic health care financing through the recently developed Health Care Financing Strategy (HCFS) of the Government.

The Commission shall inform the implementing partner at least 30 days in advance of the date foreseen for the evaluation mission. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities. The evaluation is expected to be facilitated by MoFEC.

The evaluation report shall be shared with the partner country (MoFEC and FMoH) and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluation and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

Indicatively, one contract for final evaluation services shall be concluded under a framework contract in the second semester of year 3.

5.10 Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

Indicatively, two contracts for audit services shall be concluded under a framework contract in 2019.

5.11 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU. This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.6 above.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.

The visibility and communication activities together with other BS operations and related initiatives implemented through one service contract running for the project period. Specifically for this project, the service contract will be mobilized at any time to conduct visibility and communication activities using different events and forums, in particular at least twice a year (i) during annual assessment of the triggers/disbursements and (ii) take part in the organization of the Regional Summit; incorporating the views and opinions of the different stakeholders (including the communities). It is expected to launch the procedure for the service contract during the second quarter of 2017

Appendix - Indicative list of result indicators

Appendix - Indicative list of result indicators (for Budget Support)

The table below illustrates the intervention logic for both the SBS and Capacity Development component - indicators, baselines, targets and sources of verification. Only those indicators in *italic* are list of 'trigger' indicators for the release of SBS funds.

The inputs, the expected direct and induced outputs and all the indicators, targets and baselines included in the list of result indicators are indicative and may be updated during the implementation of the action without an amendment to the financing decision. The table with the indicative list of result indicators will evolve during the lifetime of the action: new columns will be added for intermediary targets (milestones), when it is relevant and for reporting purpose on the achievement of results as measured by indicators. Note also that indicators should be disaggregated by sex whenever relevant."

	Results chain	Indicators	Baseline	Targets	Sources of verification
Overall objective: impact	Improved health and wellbeing of Ethiopian citizens	(1) Maternal Mortality Ratio (MMR) *[8]	(1) 420/100,000 (2015)	(1) 199/100,000 (2020)	(1) Source: UN Report - analysis on the basis of DHS and other data sources. Verification: n.a
		(2) Neonatal Mortality Rate (NMR)	(2) 28/1000 (2015)	(2) 10/1000 (2020)	(2) Source: DHS Verification: n.a
		(3) Under 5 Mortality Rate (U5MR) *[9]	3. 64/1000 (2015)	(3) 30/1000 (2020)	(3) Source: DHS Verification: n.a
		(4) Stunting prevalence in children aged less than five years *[10]	(4) 40% (2014)	(4) 25% (2020)	(4) Source : DHS Verification: n.a
Specific objectives: outcomes	SO 1- Improve quality of services and access to service delivery at all levels	(1.1) Contraceptive Prevalence Rate (CPR) (**)[11]	(1.1) 42% (2015)	(1.1) 55% (2020)	(1.1) Source: DHS Verification: n.a
		(1.2) *ANC+4*	(1.2) *32 % (2014 MDHS)*	(1.2) *37% (2017)*	(1.2) *Source: DHS* *Verification: n.a*
		(1.3) *% of deliveries attended by SBA (**)*[12]	(1.3) *15 % (2014 MDHS)*	(1.3) *18% (2017)*	(1.3) *Source: DHS* *Verification: n.a*
		(1.4) Pentavalent 3 coverage of children 12-23 months (**)[13]	(1.4) 94% (2015 HMIS)	(1.4) 98% (2020)	(1.4) Source: HMIS Verification: CSA
		(1.5) % of new-born with neonatal sepsis who received treatment	(1.5) -	(1.5) 80% (2020)	(1.5 Source: HMIS Verification: CSA

[8] matching with EU RF #18 L1
[9] matching with EU RF #17 L1
[10] matching with EU RF #9 L1
[11] matching with EU RF #20 L2
[12] matching with EU RF #18 L2
[13] matching with EU RF #19 L2

	Results chain	Indicators	Baseline	Targets	Sources of verification
	SO 2- Reduce inequity in health service delivery both vertically and horizontally	(2.1) Gap in SBA deliveries between bottom and top quintiles	(2.1) 0.18 (2014 DHS)	(2.1) 0.21 (2017)	(2.1) Source: HMIS Verification: WB
		(2.2) Gap in SBA deliveries between bottom woredas/national median (excl. Addis Ababa)	*(2.2) 42 %*	*(2.2) 36% (2018)*	*(2.2) Source: HMIS* *Verification: EPHI – SARA*
		(2.3) Out of pocket expenditures	(2.3) 35%	(2.3) 15% (2020)	(2.3) Source: National Health Account Verification: n.a
		(2.4) % of woredas established Community Based Health Insurance (CBHI) scheme	*(2.4) 15%*	*(2.4) 46% (2018)*	*(2.4) Source: EHIA reports* *Verification: FMoH*
	SO3- Improve the financial capacity at all levels of government to achieve HSTP objectives	*(3.1) Per capita Federal Block Grant transfer to regions*	*(3.1) 641 ETB (EFY 2007)*	*(3.1) 829 ETB (EFY 2011)*	*(3.1) Source: IBEX* *Verification: OFAG*
		(3.2) Allocations to National Sexual Reproductive Health/Family Planning Program	*(3.2) 16 Million ETB (EFY 2008)*	*(3.2) Increased by 25% (EFY 2011)*	*(3.2) Source: IBEX* *Verification: OFAG*
		(3.3) Actual expenditure in health	*(3.3) 9.7 billion ETB (EFY 2006)*	*(3.3) Increased by 18% (EFY 2011)*	*(3.3) Source: IBEX* *Verification: OFAG*
	SO4- Improve sector governance and PFM, oversight and accountability in the health sector	*(4.1) OFAG audit on FMoH account*	*(4.1) Unqualified*	*(4.1) Unqualified*	*(4.1) Source: Internal Audit* *Verification: OFAG*
		(4.2) % HMIS report completeness	(4.2) 72%	(4.2) 90% (2020)	(4.2) Source: HMIS Verification: CSA
		(4.3) % HFs meet the data verification factor within 10% range for SBA	(4.3) 71%	(4.3) 85% (2020)	(4.3) Source: HMIS Verification: CSA
Induced outputs (per OS)	IO1- Increased quality and quantity of health supplies/commodities and services at all levels	(1.1.1) Proportion of laboratories of hospitals accredited with ISO 15189 and/or 17025	(1.1.1) 2%	(1.1.1) 100% (2020)	(1.1.1) Source: HMIS Verification: CSA
		(1.1.2) *Availability of utilities at HCs for quality of health care:* • 1.1.2(a) *Piped water at HCs* • 1.1.2 (b) *Reliable power source at HCs* • 1.1.2 (c) *# of in-compound staff houses at HCs*	1.1.2(a) *44% (2015)* 1.1.2(b) *57% (2015)* 1.1.2 (c) - *0*	1.1.2 (a) *52% (2018)* 1.1.2 (b) *75% (2018)* 1.1.2(c) *200 (2018)*	(1.1.2) *Source: HMIS* *Verification: EPHI – Annual SARA*
		(1.2.1) Availability of essential (life-saving MCH) drugs @ HCs	*(1.2.1) 87% (2015)*	*(1.2.1) 96% (2018)*	*(1.2.1) Source: UNFPA survey* *Verification: EPHI – Annual SARA*
		(1.2.2) % of children aged 6-59 months received Vitamin A supplementation	(1.2.2) 84%	(1.2.2) 95% (2020)	(1.2.2) Source: HMIS Verification: CSA

	Results chain	Indicators	Baseline	Targets	Sources of verification
	IO2- Equity addressed through strengthening the health insurance system	(2.1.1) # of Health Facilities (HFs) reimbursed as per processing time foreseen in the health insurance guideline	(2.1.1) (tbc)	(2.1.1) (tbc)	(2.1.1) Source: EHIA report Verification: facility survey
		(2.1.2) # of HFs by region linked to and use the health insurance IT platform	(2.1.2) (tbc)	(2.1.2) (tbc)	(2.1.2) Source: EHIA report Verification: facility survey
	IO3- Increased allocation to the health sector	(3.1.1) Guideline developed and approved for implementation of innovative sources of financing defined in the Health Care Financing Strategy (HCFS)	(3.1.1) On-going	(3.1.1) Finalized (2017)	(3.1.1) Source: FMoH report Verification: n.a
	IO4- Improved PFM and budget oversight functions	(4.1.1) % of Health Centres with functional Auditable Pharmaceuticals Transaction and Services (APTS)	(4.1.1) (tbc)	(4.1.1) (tbc)	(4.1.1) Source: HMIS Verification: EPHI - SARA
		(4.1.2) # of woredas applying social accountability tools	(4.1.2) (tbc)	(4.1.2) (tbc)	(4.1.2) Source: Admin report Verification: MA report
		(4.1.3) FMoH Plan of Action (PoA) to address both financial & procurement audit findings	(4.1.3) EFY 2006 audit findings PoA	(4.1.3) Every year	(4.1.3) Source: FMoH report Verification: n.a
Direct outputs	D01 - Increased size and share of external assistance funds made available through national budget	Share of external assistance funds available through national budget	(tbc)	(tbc)	*Source: IBEX* *Verification: OFAG*
	D02 - capacity development support better coordinated	Capacity of Resource Mobilization Directorate (Health Economics And Financial Analysis unit) further strengthened to coordinate Capacity Development support to the health sector		Health Economics And Financial Analysis Unit regularly conducts analysis on Development Partners' financial support to the sector;	FMoH report
				Health Pool Fund (responsible for TA support) evaluated	Evaluation report
	DO3- Policy dialogue focused with agreed key priority areas	Common/joint policy dialogue framework developed		ToR/MoU signed; Policy dialogue on agreed strategic issues	Joint PD minutes Service Delivery Secretariat reports