



USAID | **ETHIOPIA**
FROM THE AMERICAN PEOPLE

PROJECT APPRAISAL DOCUMENT (PAD)

HEALTH SYSTEM STRENGTHENING (HSS)

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ACRONYMS

AMR	Antimicrobial Resistance
CBHI	Community-Based Health Insurance
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CDCS	Country Development Coordination Strategy
CQI	Continuous Quality Improvement
CSA	Central Statistics Agency
CSO	Civil Society Organization
ECBH	Empowered Communities for Better Health (Project)
EFDA	Ethiopia Food and Drug Administration
EHIA	Ethiopian Health Insurance Agency
EPHI	Ethiopian Public Health Institute
EPI	Expanded Program on Immunization
EPSA	Ethiopia Pharmaceutical Supply Agency
EPT	Emerging Pandemic Threats
FBO	Faith-Based organization
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccine Initiative
GDP	Gross Domestic Product
GHSA	Global Health Security Agenda
GOE	Government of Ethiopia
G2G	Government to Government
HEI	Higher Education Institution(s)
HEP	Health Extension Program
HEW	Health Extension Worker(s)
HMIS	Health Management Information System
HRIS	Human Resource Information System
HRH	Human Resources for Health
HSS	Human Resources for Health
HSTP	Health Sector Transformation Plan (I and II)
IR	Intermediate Result
IRS	Indoor Residual Spraying
J2SR	Journey to Self-Reliance
LLIN	Long Lasting Insecticide Treated Net
LMIS	Logistics Management Information System
MDG	Millenium Development Goals
MDR TB	Multidrug Resistant Tuberculosis
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health

NGO	Non-Governmental Organization
NHA	National Health Accounts
OOP	Out-of-Pocket
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PS	Private Sector
RHB	Regional Health Bureau
SDGs	Strategic Development Goals
SOP	Standard Operating Procedures
TB	Tuberculosis
THE	Total Health Expenditure
USG	United States Government
QA/QI	Quality Assurance/Quality Improvement
XDR TB	Extremely Drug-Resistant Tuberculosis
WASH	Water, Sanitation and Hygiene

I. PROJECT PURPOSE

The purpose of the Health Systems Strengthening (HSS) Project is “*Improved Ethiopian health system performance for responsive, efficient, equitable and quality services.*” The HSS Project, henceforth referred to as “the project,” is led by USAID/Ethiopia’s Health Office, and will complement the USAID/Ethiopia’s Empowered Communities for Better Health (ECBH) Project.

USAID will accomplish the project purpose through three interdependent sub-purposes:

1. Increased health system responsiveness
2. Improved quality of essential services
3. Reduced health inequities

This project document is the result of extensive internal and external stakeholder consultations, evaluations, and assessments; it builds upon the work that USAID, the Government of Ethiopia (GOE) and its partners have achieved over the past decade, in the areas of health and nutrition. The total estimated funding for the project is \$310 million over five years.

Under this project, USAID/Ethiopia will partner with the GOE, other donors, the private sector, and non-governmental organizations (NGOs) for a coordinated approach to strengthen the health system. It will also depend upon the implementing partners under the ECBH Project to achieve their results. The project will engage at the federal, regional and woreda levels of the government and will contribute to achieving the Health Sector Transformation Plan (HSTP) II objectives.

II. CONTEXT

Problem Statement: The GOE does not have full capacity and sufficient resources to consistently and sustainably deliver equitable and quality essential health services, especially given growing demographic pressures and emerging health needs. According to the mid-term review of HSTP I, the following challenges were identified:

- Political, regulatory, and institutional barriers; inadequate accountability; and weak institutional and management capacity
- Poor quality of care throughout all levels of the health system
- Inequitable distribution and allocation of resources, particularly in “developing” regions and remote communities versus developed regions despite poorer health outcomes
- Inadequate transparency at all levels about sources, amounts of funding available, and expenditures for health (specifically at regional level down)
- Weak collaboration and partnership with the private sector
- Insufficient financing for the health sector leading to continued dependence on donor funding and high out-of-pocket payments
- Limited capacity to collect analyze and use quality data for decision making

A. Health Sector Context

The roots of the problem of low capacity and resources go beyond the health sector. As a low-income country, with a small middle class, FOREX problems, and insufficient tax revenue, the government simply does not have sufficient financial resources to meet all of its goals. Insufficient financial resources also drive low capacity in the health sector – for example, there is “brain drain” – educated staff who leave Ethiopia or the public sector for more lucrative salaries elsewhere; low morale and performance in the health sector due to low salaries and lack of incentives; and an inability to attract both the quantity and quality of expertise that the health sector needs. Poor or variable quality of pre-service education in the health sector, combined with lack of specialty knowledge, inadequate supplies, and poor morale generally, results in low quality health services. Further, the system is not set up to facilitate multi-sectoral collaboration, so not only are services within health often disjointed, the sector is unable to develop important relationships with other sectors such as nutrition and water/sanitation, which are underlying causes of poor health.

Over the past 50 years, the government has established strong relationships with donors to the health sector, including with USAID, and remains donor dependent. This is particularly true for procurement of medical and pharmaceutical supplies, and for technical expertise across the sector. Until there are more resources into the health sector, their system is not self-sustaining. Further, Ethiopia has been relatively slow, compared to other East African countries to embrace the opportunity within the private sector to advance its goals – meaningfully initiating such work only in the past two years.

The government is committed to providing equitable services across the country. This is particularly important politically as regional and ethnic conflicts continue to hamper Ethiopia’s development gains. In addition, lowland areas of the country, which frequently experience drought or disease outbreaks, and which have pastoralist populations and sometimes IDP populations, are unable to build and maintain good quality health services. These are difficult-to-staff areas, there are inadequate incentives for high-performing staff to serve in these areas, and due to the challenging environment, which often includes poor infrastructure and schools, staff turnover is high. There are concerted efforts to decentralize authorities to improve health services, and to ensure that all regions have the same opportunities, but as there are many factors external to the health sector driving inequity, this is still a work in progress.

With scarce resources, it is important to have high-quality data to drive informed decision-making and program scarce resources towards those technical and geographic areas where they are most needed. The government has recently expanded their health information system (DHIS2) and is also triangulating data from international sources (e.g., DHS, SPA, WHO/UNICEF data), to improve the quality of local data, and to use this to support decision-making. They are also more open to data-sharing with partners, and to utilizing information for policy and strategy decision-making. Such improvements are only since 2019, and quality, timeliness, and completeness all remain works in progress to have the right information to cost-effectively transform the sector.

There is high government commitment to improve the health sector, as evidenced in their strong donor partnerships, and the continuously increasing percentage contribution of revenue to the health sector (8.1% as of the last National Health Accounts Survey). While still below the 15% commitment made under the Abuja Declaration, it is growing, and is more than most sub-Saharan African countries. In February 2020, parliament approved a policy that 50% of the excise duties collected on tobacco and alcohol would go to the health sector – recognizing its need for greater investment. The government seeks to scale up community-based health insurance (CBHI) and develop a social health insurance plan as part of Universal Health Coverage (UHC), to reduce the out-of-pocket direct health expenditure of citizens relative to government spending. This will generate revenue, but expenditures could also increase, so there is need to expand the resource base to support UHC.

Underfinancing or inefficient use of funds to infrastructure (roads, facilities), telecommunications, WASH, and energy sectors are outside the scope of health sector, but public funds from the health sector are used to support these areas, drawing funds away from other health-specific programming. Macroeconomic strategies to increase government revenue and move towards FOREX resolution are core elements upon which a sustainable, high quality, equitable health sector depends.

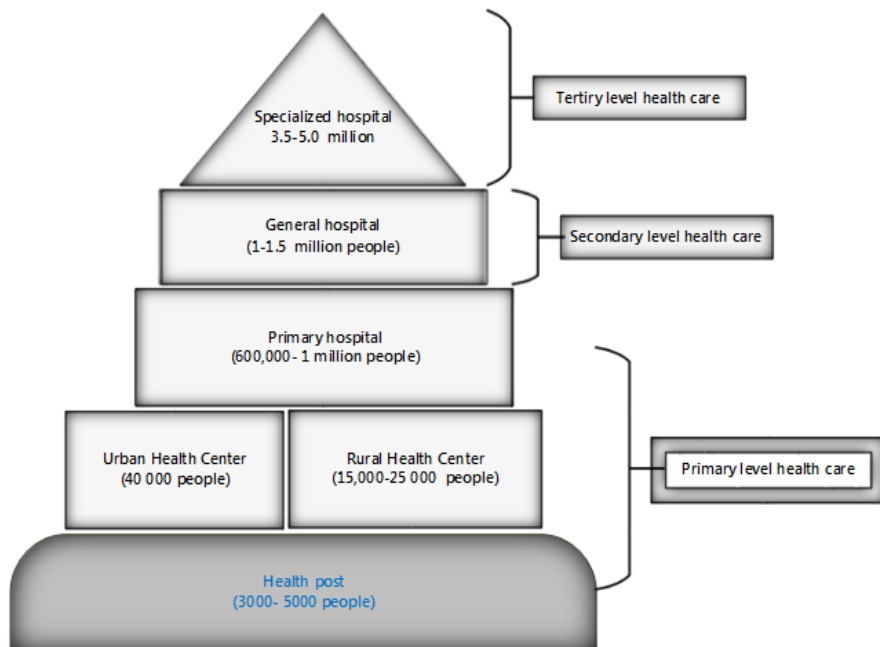
B. Health Status

The 2016 Ethiopia Demographic and Health Survey (EDHS) and 2019 mini-DHS shows tremendous progress over the past 20 years, while some areas have stagnated. From 2005 to 2016, maternal mortality rate (MMR) declined by 39 percent to 412 per 100,000 live births. Per the 2019 mini-DHS, under-five mortality (U5M) rate dropped by 55 percent; stunting by 21 percent; and use of modern family planning (FP) methods increased 193 percent. Global data shows TB incidence has decreased by 44 percent, and Ethiopia has nearly reached epidemic control status for HIV and is on its way to malaria elimination. Yet, challenges in Water, Sanitation and Hygiene (WASH) and nutrition continue to drive the burden of morbidity and mortality in Ethiopia, progress which has remained unchanged since 2007. Newborn mortality has increased from 2016 to 2019. Inequitable gender norms adversely impact health and health-seeking behavior with regard to FP, maternal, newborn, and child health, WASH, and malaria services. Service quality has begun to improve, but few facilities consistently meet the minimum standards outlined in the Ethiopian Health Center Reform Implementation Guidelines. National level progress masks wide geographic variation and inequity, and generally, urban areas have better outcomes than rural areas, where the majority of Ethiopia's population lives.

C. Health Systems

The health system is organized into a three-tier system: the Primary Health Care Unit (PHCU), consists of a primary hospital, a health center, and a health post, which together serve between 600,000 to 1 million people; Secondary Level Care, has a catchment population of 1.5 million; and

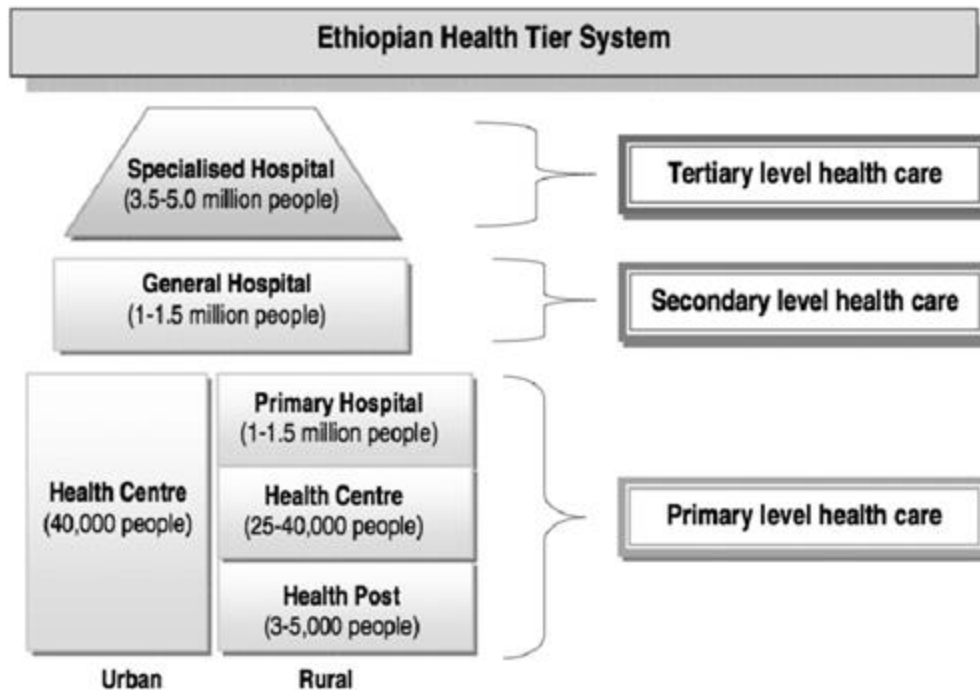
Tertiary Level Care has a catchment population of approximately 5 million people. (Image 1). The majority of public preventive, promotive, and basic curative health services are offered at the PHCU, where USAID support is focused.



Other health related services are managed by multisectoral platforms including the One WASH National Program. Health services cannot be of quality standard without adequate WASH infrastructure in health facilities, which will also help in ensuring infection prevention and control. Since the adoption of the National Nutrition Program (NNP), significant improvements have been reported including the endorsement of the

National Food and Nutrition policy. However, multisectoral coordination and supply chain issues remain a challenge. USAID is also a key contributor to the Global Health Security Agenda (GHSA) along with other USG and non USG actors to support GOE in preparedness, early warning, detection and response of pandemics including Ebola and Corona virus.

Image 1: Ethiopian Health Care Delivery System



D. Social, Cultural and Gender Norms

Ethiopia has over 80 diverse ethnic groups, with different languages, cultures and practices, and the relationship among them is affected by local dynamics. Complex social, cultural, and economic factors impair men and women’s full access to, participation in, and choice of healthcare. Literacy among females is lower than among males; the EDHS 2016 showed 42 percent of females were literate, compared to 67 percent of males. Women also have less exposure to mass media (newspaper, radio, television and internet), higher unemployment rates, and less control over household decision making.

In general, traditional norms and practices continue to exert strong influence in many areas of Ethiopian society. Women disproportionately deal with gender-specific harmful cultural practices, such as early marriage, heavy household duties (*e.g.*, collecting water and firewood), stigmatization, genital circumcision, and gender-based violence. These practices adversely affect women’s health status and that of their families, and place them at higher risk of communicable diseases and unintended pregnancies. Female circumcision rates are decreasing, but remain high; per the EDHS 2016, 65 percent of women were circumcised, with the highest rates in eastern Ethiopia. Women’s ability to decide to seek health care is often hampered by poor education, need for spousal consent, and limited financial autonomy. Public health initiatives have often sidelined men’s needs for participation and empowerment, albeit in different ways than for women, though men frequently act as gatekeepers of health services.

III. RELATIONSHIP TO MISSION’S CDCS

A. CDCS Results Framework

The HSS project will contribute to USAID/Ethiopia’s 2019–2024 CDCS (Annex 3): *Ethiopia transitions to a more democratic, prosperous, and resilient society, with accountable institutions and private-sector led growth* by improving the health system to be more responsive, efficient, equitable and higher quality in the services it provides to contribute for improved health outcomes. The project contributes to DO4: “Sustained improvement in essential service delivery outcomes, focused on women and girls,” and directly supports IR 4.4. “Utilization of quality health and nutrition services increased,” and IR 4.5: “Health and nutrition systems strengthened for greater self reliance.” Under DO4, Health, WASH, Education and Nutrition are interdependent sectors and all projects incorporate multi-sectoral approaches and activities. To fully realize its goals, the HSS project depends on improvements in WASH, education and nutrition. It responds directly to Strategic Principle 2: “More effective and accountable systems and institutions at all levels”. The HSS project will improve the health system to meet community and citizen demand and accountability for quality health services.

B. Linkages to Other DOs: The HSS Project also contributes to results under DO1, DO2, DO3, and the Special Objective.

Relationship to DO1: Disaster risk management strengthened. The project will contribute primarily to IRs 1.2, and 1.3 to develop a resilient health system that can function in spite of and respond adequately to shocks and health emergencies when they arise.

Relationship to DO2: Resilience of vulnerable populations to key shocks increased. The project will build household resilience for vulnerable groups (*e.g.*, poor, women, children, youth, orphans, pastoralist, urban slum, migrant workers) by minimizing financial hardship that they might experience due to routine illness and health emergencies. This primarily relates to IRs 2.2 and 2.4 to expand community-based health insurance (CBHI) and work with communities to identify bottlenecks on access to primary health services.

Relationship to DO3: Private sector-led economic growth promoted. The HSS Project links to IRs 3.1 and 3.5, developing private sector service delivery to expand the economy of the health sector. The project, by working through and with private health facilities and health enterprises as well as supporting the government to better regulate them will facilitate the expansion of these entities leading to a more developed private sector. It will also contribute to women’s economic empowerment through gender-forward activities promoting women in leadership roles in the health sector (HRH programs), and ensuring equitable and quality access for women and girls to the services they need.

Relationship to the Special Objective: Citizen responsive governance enhanced. The HSS Project will link to SpO IR 1, as it builds transparency, accountability, leadership, and management in the

governance of the health sector. The project will be supported by the DG framework for Participation, Inclusion, Transparency and Accountability (PITA).

IV. PROJECT DESCRIPTION

A. Theory of Change

The underlying assumption of this project is that a strong health system will contribute to sustainable reductions in health related morbidity and mortality particularly for children and women. Investments to increase the GOE's commitment and capacity to plan, manage, and finance the health system will contribute to its journey to self-reliance. With these investments, the GOE will increasingly be able to improve the health system in partnership with private sector, civil society, and empowered communities, so that it is responsive and accountable to population health needs; resilient in the face of emergencies; equitable; and able to deliver quality services. Therefore, the project's theory of change is:

If GOE increases its commitment to social inclusiveness and accountability; improves its capacity (in partnership with the private sector and civil society) to provide quality essential health services; and strengthens associated health system functions (governance, financing, human resources, pharmaceutical/medical technology and information systems); **then** health system responsiveness, equity, quality, efficiency, and resilience will increase.

B. What is New?

USAID/Ethiopia previously approached health sector support from an economic supply/demand perspective, with a strong emphasis on the supply side of health, and in close alignment with the GOE at all levels. While these elements still exist, under the new strategy, the Health Office seeks to be more intentional about the integration of democracy, rights and governance principles— participation, inclusion, transparency, and accountability.

This project will follow a systems approach, where we look at the interconnectedness and interdependence of the health system building blocks so that the different subsystems are holistically complementary to each other. In line with the J2SR principles of advancing capacity and commitment of the host government, the project will identify interventions that will gradually but fully transition to local partners. An example of such intervention is the transition of the procurement of all HIV commodities to be fully managed by the GOE after five years.

This project will also take an intentional approach to expand private sector opportunities in all areas of health system strengthening, and to develop government's regulatory capacity and contract management roles vis-a-vis the private sector.

C. Critical Assumptions and Risks

The HSS Project depends on certain critical assumptions. It assumes political stability that will allow full implementation of this project. It assumes GOE's political will to prioritize health and perform basic functions of health service delivery. Further, the project assumes that conflict, drought, outbreaks, and other "shocks and stresses" will continue; will be more effectively managed by GOE and its partners; and will not get significantly worsen in this time frame. Lastly, it assumes (and will include as a learning question) that multi-sectoral programming, geographic overlap of activities, and integrated programming will accelerate progress within this project (WASH, nutrition, education, and others).

D. Programming Principles

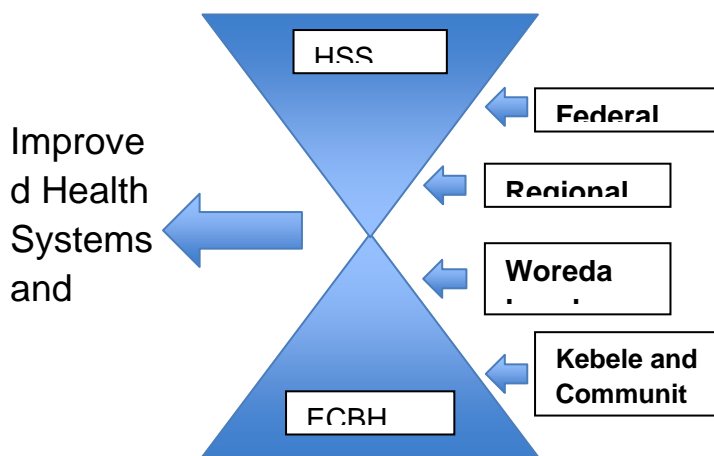
All activities within this project will adhere to specific guiding principles which represent the Agency's and Mission's strategic priorities. The project aligns strategic investments with country-owned and country-led national health, social, and economic plans to maximize cost-efficiency and increase sustainability. Activities under this project will use a variety of assistance models, including performance based-contracting and Government to Government (G2G) agreements. The project encourages risk-taking and innovative approaches, tools and techniques that have the catalytic potential to accelerate progress. As this project is housed under a women and girl-focused DO, we will require that all partners model gender equity through their own staffing pattern and leadership roles; incorporate gender issues at all levels of activity planning and implementation to support not only gender-equitable inputs but outcomes as well. The project will support inclusion of new partners on consortia and as direct partners, and will work with donor and private partners to leverage funding for more cost-effective approaches. The project will develop forums for dialogue and inclusion of relevant private sector providers and private businesses, to better engage them and consider their ideas.

E. Project Results and Illustrative Activities and Indicators

This HSS project will apply a systems approach, meaning it will go beyond the development of the six building blocks of the health system, to develop approaches that depend on the interactions among those building blocks that together create a strong health system. This approach will help to ensure that the country can plan, finance and implement health services on its own and will be on the Journey to Self Reliance (J2SR). It will also help to ensure that the health system is prepared to identify and respond to shocks, including outbreaks, without pressure on the routine services. A responsive, equitable health system that consistently provides quality health services can be achieved when there is a competent and motivated health workforce that is able to generate and utilize quality data for decision making supported by an accountable leadership with adequate and diversified financial resources and supplies. This project will help the government of Ethiopia have that system and will ultimately help the country to end preventable maternal and child deaths, and reduce the burden of infectious diseases.

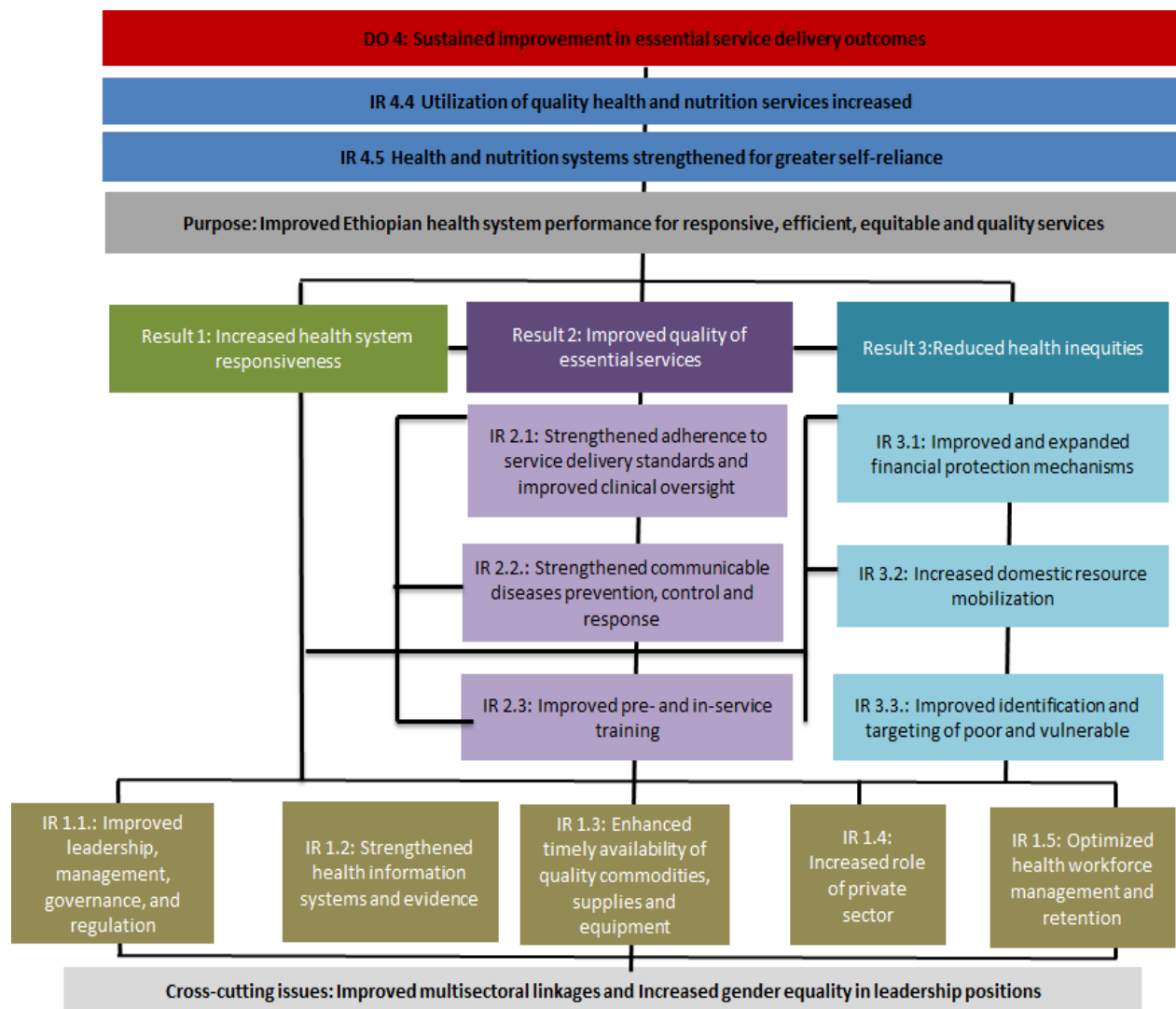
The health system of Ethiopia is largely federalized, with devolved power to the regional and woreda administration, and services are historically delivered through a top-down system. The HSS Project will work primarily in this context, however recognizing that for a system to truly offer quality to the end-user, support the personnel within the system, and be accountable, stronger systems from the community level upwards are needed. The HSS Project will therefore depend on the Empowered Communities for Better Health (ECBH) Project to fully realize its goals, as ECBH will support systems from the Woreda level and below, while HSS will support systems largely from the federal level and below.

Image 2: Project Linkages: HSS and ECBH



The HSS Project most directly supports IRs 4.4 and 4.5 of the CDCS, under DO4 (as described above). Under this, the three main results of the HSS Project are:

- Result 1. Increased health system responsiveness
- Result 2. Improved quality of essential services
- Result 3. Reduced health inequities



Result 1: Increased health system responsiveness

Health system responsiveness is an outcome of leadership and governance functions - where the health service needs of the population are met in a timely and effective manner. In order to achieve health system responsiveness, the leadership should track the emerging and existing epidemiologic, demographic and socio-economic trends and plan appropriate health (and other sector) policies and programs. Leadership also needs to mobilize, align and manage financial, human, pharmaceutical and medical, and information technology resources efficiently, effectively and transparently. The leadership also needs to deliver health services and resources equitably – including to the poor, vulnerable populations and marginalized groups. Intermediate Results (IR) under Result 1 are critical to achieve all of the results and IRs within the framework to be achieved and are therefore “cross-cutting” IRs. The project is based on the premise that opportunities exist to increase Ethiopian health system responsiveness by achieving the following intermediate results:

- IR 1.1 Improved leadership, management, governance, and regulation
- IR 1.2 Strengthened health information systems and evidence
- IR 1.3 Enhanced timely availability of quality commodities, supplies and equipment
- IR 1.4 Increased role of private sector
- IR 1.5 Optimized health workforce management and retention

IR 1.1 Improved leadership, management, governance, and regulation

There are capacity gaps in leadership and governance for planning and managing health programs, facilities and resources at different levels. Absence of adequate regulatory frameworks for health professionals, pharmaceutical companies, and service facilities has meant a corresponding absence of accountability. The governance problems are compounded by a low number of women in leadership positions, which hinders changing the social and gender norms directly related to health. Health is dependent on other sectors for its success – including WASH, nutrition, and infrastructure. Within the bounds of the CDCS, leadership, management, and governance (LMG) capacity and commitment will be developed within multi-sectoral areas including health, WASH and nutrition. Beyond the health sector, a wide range of actors are involved in governance rule-making such as the national parliament, the Council of Ministers, and the regional and woreda councils. Implementation of various rules and decisions passed by these entities impacts health, nutrition and WASH. Key non-health institutions upon which the health sector depends include: the Ministry of Science and Higher Education, the Ministry of Revenue, the Ministry of Agriculture, the Ministry of Construction and Urban Development, the Ministry of Finance and Economic Cooperation (MOFEC), the Customs Authority and the Civil Service Commission. This project will advocate for and work to develop these intersectoral linkages in support of improved health outcomes.

LMG Capacity will be developed primarily in government institutions including the Federal Ministry of Health, Ethiopian Food and Drug Administration (EFDA), Ethiopian Pharmaceutical Supply Agency (EPSA), Ethiopian Health Insurance Agency (EHIA), Regional Health Bureaus (RHBs), and Woreda Administration. The health sector needs to have enhanced capacity to advocate for governance rule-making and enactment within the health sector and beyond.

In regulation, the FMOH develops policy and leads and coordinates the institutions that support regulation within the health sector. These include the EFDA, EPSA, EHIA and the Quality Directorate (QD) within the Ministry. Technical assistance will be given to these institutions and directorates including establishing and/or operationalizing their regional structures as well as the health professionals' licensing and registration directorate to support their various roles in quality and regulation of health services as described below. The FMOH has a comprehensive National Health Care Quality Strategy 2016–2020. It is centered around four priority strategic areas: 1) Develop an integrated approach to planning, improving and controlling quality; 2) Activate key constituencies to advance quality; 3) Drive improvement in quality by explicitly linking Universal Health Coverage (UHC) strategy with quality; and 4) Support strong data system and feedback loops as the “backbone” of all improvement actions. The strategy suffered from implementation

weaknesses mainly because of the weak QD in the FMoH. The HSS Project will reinvigorate the QD and the Health Facility Regulation (Inspection) Directorate to oversee the development of the quality agenda at all levels. The project will support the health facility inspector body to have better autonomy and ensure a clear split between service provider and regulator at both federal and regional level, with legal powers for the whole sector.

The vision of EFDA is “Quality health services and products to all citizens.” and their goal is to protect public health by ensuring the safety, quality, efficacy and rational use and performance of regulated products which includes medicines, food, cosmetics and medical devices. This requires work on licensing, inspection, registration, laboratory testing, community participation and provision of up-to-date regulatory information to the public.. This project will systematically support the agency in getting the needed system and structure in place to address the regulatory gap.

The EPSA mandate is to establish a pharmaceutical procurement and distribution system; establish a modern storage management system; ensure the supply of essential pharmaceuticals of quality, safety and efficacy; and deliver pharmaceuticals directly to hospitals and health facilities via an effective transport network system. However, EPSA has a long way to go to fully realize its mandate. Issues remain in drug quality control, inventory management, warehousing and storage that need to be addressed.. With this project our support will ensure the agency will have the capacity and commitment to systematically implement the newly approved strategic plan that encompasses all the various levels of commodity management and the project.

The EHIA currently manages community-based health insurance schemes for the informal sector. However, currently it only covers around 20 percent of the population and needs to either be expanded or to be included in the creation of new financial protection schemes. The government has developed a new mandatory social insurance scheme for formal sector employees, which is expected to be launched during the life of this project. The HSS Project will support government initiatives, including the potential autonomous management of health insurance and implementing mandatory coverage, and will also support EHIA’s role in demanding implementation of accreditation standards.

Illustrative activities:

- Strengthen MoH (Directorates), Federal MoH Agencies and affiliated institutions to better realize their mandates
- Support government initiatives towards increased autonomy of health facility regulators towards an independent accreditation system

- Strengthen capacity of policy makers, healthcare providers, and regional, woreda and zonal level program managers for better planning and management of resources
- Increase private sector involvement in quality improvement policy and regulation
- Increase opportunities and pathways for women to reach and accept leadership positions in the health sector, in both public and private institutions.
- Enhance multi-sectoral collaboration at national and sub-national levels to better manage services during emergencies
- Strengthen public financial management and procurement systems

Illustrative indicators:

- Increased proportion of counterfeit drugs identified as a result of improved enforcement of pharmaceutical regulations
- Decreased proportion of drugs/vaccines wastage (rate).
- Number of policies and regulations jointly developed with the private sector.
- Increased proportion of senior leadership positions filled by women disaggregated by level of institutions, management structures, etc.
- Increased percentage of health institutions that have developed a monitoring plan, including annual work objectives and performance measures.
- Increased percentage of facilities/Woredas showing 80% of utilization with timely liquidation of allocated budget
- Improved transparency and accountability in procurement within the health sector
- Increased proportion of woreda health offices with functional multi-sectoral platform for emergencies, WASH, Urban Health, and GBV.
- Increased percentage of health facilities implementing the national healthcare facility standards.
- Increased government capacity to regulate the quality of health facilities
- Development of transparent processes for facility regulation, and development of autonomous body/ies to implement these.

IR 1.2 Strengthened health information systems and evidence

Timely and accurate data and information are essential to decision-making and tracking of health system performance. The Ethiopian Government has made strides in building health information systems by developing a national health information strategy and fully costed implementation plan. The digitization of major health functions is underway. However, the limited interoperability, scale and functionality of the existing information systems does not provide a holistic picture of health system performance and its underlying factors resulting in limited use of data for decision making. Shortage of skilled human resources and inadequate guidelines in analyses and interpretation additionally impedes use of information at different levels. In addition, there are limited organizational incentives to use information for better accountability. Under the Data Use Partnership (DUP), partners including USAID are supporting development of an electronic health

information systems architecture that will be interoperable and provide timely information. This project will support innovations and new technologies in the areas of information systems to facilitate ease of data capturing, compilation and utilization for decision making.

Illustrative activities:

- Improve digitization of health functions and clients records through developing Electronic Health Information Systems
- Strengthen Human Resource and Logistic Management information systems
- Increase standardization and integration of different HIS (DHIS2/LMIS/HRIS/UNIS) through interoperable Health Information Systems Architecture
- Improve organizational processes to promote a culture for the use use of quality data at federal and regional levels
- Support EPHI and CSA in their management, implementation and analysis of national surveys including the Demographic and Health Surveys (DHS), census, and other population-based surveys involving health such as prevalence surveys.
- Facilitate innovation and technology use for health information systems as well as piloting (testing) to learn if they can help us achieve data use for decision making
- Improved surveillance for infectious diseases including Malaria, TB, HIV, emerging infectious diseases, and neglected tropical diseases
- Build local capacity in data collection, cleaning, quality assessment, analysis, interpretation, and use (FMOH, RHB, Woreda, and other institutions)

Illustrative indicators:

- Increased proportion of health facilities implementing e-HMIS (DHIS2, LMIS, HRIS etc)
- Increased proportion of health facilities who regularly conduct Lots Quality Assurance Sampling (LQAS)
- Increased number of national surveys/census conducted by CSA with the support of USG
- Increased proportion of health institutions that met minimum information use standards/criteria by level of health care
- Existence of a functioning health information system governance mechanism (multi-stakeholder national committee)
- Increased percent of report fulfilling data quality standards by level of health care
- Increased number of innovations and technologies piloted and tested

IR 1.3. Enhanced timely availability of quality commodities, supplies and equipment

There is evidence of shortages of key health commodities at public and private facilities, including at the health post level. The logistics system is still characterized by a push system because of limited planning capacity at health facilities. The project will work with EPSA to improve its institutional capacity and identify opportunities for local manufacturing of essential medicines and or commodities. This sector is dependent on donors for the procurement of program commodities

(HIV, TB, Malaria and FP commodities), so the project will also support pathways to greater self-reliance in procuring and managing essential health commodities.

Illustrative activities:

- Improve implementation of auditable pharmaceuticals transactions system at all public health facilities.
- Increase use of LMIS data for nationwide policy and operational decisions.
- Develop skills of staff in public and private health facilities in the collection, analyses, interpretation and use of LMIS data
- Improve skills of providers at all levels of the health system (including HEWs at HPs and health providers in private health facilities) in forecasting, reporting and logistics management.
- Support good manufacturing practice (GMP) certification of local pharmaceutical manufacturers.
- Post-marketing surveillance of pharmaceutical products to monitor quality and safety
- Support innovation and technology to strengthen Supply Chain Management
- Support reverse logistics system for expired commodities Procurement of and support for improved local procurement and management of insecticides for indoor residual spraying and long-lasting insecticide-treated bed nets

Illustrative indicators:

- Reduced average stock-out rate of tracer medicines (FP, Malaria, TB, Nutrition, etc), commodities and equipments by level of health care
- Increased proportion of health facilities implementing auditable pharmaceuticals transactions system (APTS)
- Increased proportion of facilities who received the supplies timely per the distribution schedule in USG supported areas.
- Increased number of innovations and technologies for SCM piloted and tested, and/or implemented
- Increased post-market surveillance coverage of health products
- Increased proportion of essential medicines procured from local manufacturers

IR 1.4 Increased role of private sector

While healthcare delivery remains dominated by the public sector, the Ethiopian private health sector is growing in size and scope. According to an MoH assessment, private providers account for an estimated 20% of health facility visits nationally, with a significantly larger share in urban areas (35%), where private providers are heavily concentrated, than in rural areas (MoH, 2014). About a third of Ethiopia's Total Health Expenditures (THE) comes from out-of-pocket private spending by citizens (National Health Account-NHA-VII, MoH, 2017) – with an estimated fourth of it incurred at private facilities. However, the quality and availability of health services at private

facilities is perceived as uneven. Private sector is also a major player in the nascent but growing pharmaceuticals industry and the medical training area (Ethiopia Private Health Sector Assessment, Global Financing Facility, World Bank, October 2019 ppt presentation). This project will continue its work in strengthening and widening the provision of a number of priority public health services (such as HIV/AIDS, TB, Malaria and MCH-FP) through a network of private sector outlets and providers and identifying opportunities to support and advocate for private sector engagement in the health .

Illustrative activities:

- Private (corporate) sector roundtables for engagement on a variety of health matters
- Strengthen government policies and regulatory framework for better private sector engagement in health
- Facilitate availability of, and access to, financial resources for private health entrepreneurs (both men and women)
- Support the private sector's capacity to have better involvement in the areas of health workforce production, pharmaceutical, medical equipment and supply chain, information system and technology, quality improvement, as well as use of innovative approaches and technology
- Strengthen the GOE's capacity to effectively roll out public-private partnerships (PPP) in ancillary services related to health through contracting out and other approaches

Illustrative indicators:

- Percentage increase in investment by the private sector in the health sector as a result of project activities
- Increased number of private sector roundtables and any related commitments, MOUs or investments with the support of the project activity
- Increased number of private sector representatives included in the PSE policy and strategy formulation discussions and processes
- Increased proportion (number) of private facilities implementing supportive/ancillary health services through government PPP initiatives
- Increased innovation and technology for improved health systems piloted and tested or implemented by private sector
- Increased number of women in business engaged in these initiatives

IR 1.5. Optimized health workforce management and retention

Ethiopia is one of 57 countries identified by the World Health Organization (WHO) as having a critical shortage of health workers. Across the workforce, there are inadequate numbers of health graduates, particularly medical doctors, pharmacy and laboratory professionals, midwives, and anesthetists. The workforce shortage is compounded by health professionals not being adequately deployed to rural and remote areas leaving many facilities unable to meet staffing standards. Low

remuneration and difficult working conditions have resulted in a low retention rate, especially in rural areas and lowland areas. Shortage of health professionals is also caused by “brain drain” of health workers to more developed countries that offer better compensation, professional development and working conditions. There is a need to strengthen human resource planning, deployment and retention, including strengthening the human resource information system (HRIS) to track enrollment, deployment and retention alongside the measure of facilities meeting their staffing standards. This project will work with the government and private sector to improve human resource management in health in all of these areas. This IR links closely with IR 2.3.

Illustrative activities:

- Improve human resources in health (HRH) forecasting, projections, planning and management at national and sub-national levels (including focus on gender balance)
- Strengthen health labor market approach and advocate for increased employment of health professional graduates (including improved geographic distribution)
- Improve performance management systems and practices at all levels of health system (to increase performance/productivity of available workforce)
- Strengthen incentives for deployment and retention (with gender equity focus)
- Improve the work climate that fosters a safe, accountable and conducive working environment for men and women, with specific attention to reducing sexual discrimination and harassment in the workplace

Illustrative indicators:

- Reduced staff attrition rate (disaggregated by professional categories, gender mix, geographic locations)
- Increased percentage of facilities that have 95 percent of positions filled (a requirement of facility staffing standards) by geographic location
- Governance capacity score (to effectively manage its HRH) disaggregated by management levels, health facilities) against baseline
- Increased proportion of HRH budget against health sector spending (disaggregated by the 3 tier health care delivery systems, health facilities versus management structures, etc.)

Result 2: Improved quality of essential services

Health service utilization has remained low—at around 0.6 visits per person per year in 2018. Low utilization is caused not only by transportation and financial barriers, but also by poor quality of care. Many interrelated factors contribute to this, including inadequate processes of care such as flow of services, continuity of care, integration and/or coordination among different service providers, referrals, insufficient supply of medical equipment and supplies, and the shortage of skilled and competent health care providers and other health personnel. In addition, quality of care is compromised due to weak health infrastructure, deficiency or intermittent supply of electricity and water in facilities, and supply chain/distribution issues. Also regulatory bodies for services and

drugs are weak, which has implications on quality throughout the system. Further weakening the system is the inadequate coordination and collaboration with the FMOH Quality Unit and clear roles for quality planning, control and improvement. This includes work on rational medicine use in relation to antimicrobial resistance. This project will support the Quality Directorate at federal level and its counterpart at regional level in ensuring they have the capacity to update QA standards and operationalize them to ensure woredas and facilities are managing and providing services of high standard.

Compliance with standards and quality improvement (QI) processes occur at the sub-national levels—woreda, facility, and community. The interrelationship between woreda management, facilities, and community platforms ensures a strong backbone for continuous quality improvement (CQI). This project will support implementation, oversight and CQI processes primarily at the woreda and hospital levels, and will link with the ECBH project in its activities to do so at health center, health post and community levels through geographic overlap and coordinated efforts. Infectious disease prevention, control, and response will also be supported at all levels under this project, including some community work. Under this result there are three intermediate results:

- IR 2.1. Strengthened adherence to service delivery standards and improved clinical oversight
- IR 2.2. Strengthened communicable diseases prevention, control, and response
- IR 2.3. Improved pre- and in-service training

IR 2.1 Strengthened adherence to service delivery standards and improved clinical oversight

Most standards are already institutionalized in national policy and strategies. Facility administrators are responsible for identifying areas of non-compliance, and implementing quality improvement approaches to address these issues, and work towards full compliance. RHB and woreda health managers share oversight responsibilities through regular monitoring and supervision of facilities within their mandate. Additionally, health centers supervise and mentor health posts within their catchment areas. There are networks of hospitals mentoring health centers and higher level hospitals mentoring lower level hospitals. The project will support sub-national implementation of these standards, and oversight through self-evaluation, supportive supervision, and community engagement. The project will also support sub-national level split of regulatory and service provision functions with the regional bodies. This Project will also help ensure the government puts resources in the efforts of the hospital - health center as well as health center - health post mentorship and supervision.

Illustrative activities:

- Support the “Woreda Transformation” agenda and its linkages with other sectors at the Woreda level to create synergies with other development programs, such as water,

sanitation, electricity, transport, food supply chain, etc. as part of the “multi-sectoral woreda transformation” approach

- Strengthen the capacity of facility administrators and supervisors to oversee and implement adherence to standards and CQI approaches (gender-sensitive supervision)
- Provide support to implement comprehensive quality improvement interventions for performance measurement, monitoring and identifying performance gaps; plan for change ideas/performance improvement, and track progress for continuous improvement
- Develop capacity at woreda level for gender-sensitive supportive supervision, track progress, and provide feedback on facility performance at different levels of service delivery to support facility quality and performance improvement
- Work with the regional and/or woreda regulatory bodies to operationalize the national Quality Assurance (QA) standards and accreditation of health facilities
- With linkages to the ECBH Project, institutionalize forums for community feedback at the regional and woreda level.
- Institutionalize equitable patient-centered care practices and behaviors at facilities
- Support advocacy for institutional WASH facilities installation, use, and maintenance

Illustrative indicators:

- Increased percentage of facilities implementing comprehensive CQI approach
- Increased number or percent of Regional Health Bureaus or Woreda Health Offices which used supportive supervision findings for CQI
- Increased number or percent of Woreda health offices that have functional multi-sectoral review meetings/forums to support the Woreda Transformation agenda for health
- Increased number or percent of Woreda and/or Regional Health Bureaus supported to utilize QA standards and accreditation frameworks on health facilities

IR 2.2 Strengthened communicable diseases prevention, control and response

Ethiopia has achieved significant reduction in the burdens of HIV, malaria and TB in the past two decades due to scale up of interventions to detect, treat and prevent these diseases. There are vulnerable groups to these diseases like mothers, children, migrant and refugee populations, and other key populations. Some of the challenges faced by these disease programs are inadequate quality assurance of diagnostic tests, inadequate surveillance to identify vulnerable groups due to access for testing, data quality and completeness issues, absence of data for some vulnerable groups, monitoring of drug and insecticide resistance, and targeting of interventions. HIV, malaria and TB programs receive significant financial resources from the Global Fund, however, there are challenges in efficient utilization of these resources. The HSS project will improve diagnostic capacity and quality assurance, surveillance systems, and needs-based targeting of interventions based on high quality data.

Illustrative activities:

- Support quality assurance of laboratory diagnostic tests focusing on HIV, malaria and TB.
- Support quality assurance of clinical and pharmacy services focusing on HIV, malaria and TB
- Support surveillance, improved prevention, control and response processes for HIV, malaria and TB including MDR and XDR TB.
- Improve identification and management of women and vulnerable populations for HIV, malaria and TB using innovative approaches
- Support prevention of drug resistance of antimalarial, anti TB and anti-retroviral drugs
- Support private sector to provide HIV, malaria and TB services according to established standards
- Support FMOH and MOFEC to more effectively utilize Global Fund and other financial resources

Illustrative indicators:

- Increased number of people tested for HIV and received test results
- Increased number of patients diagnosed and treated by the private sector by programs according to standards
- Decreased rates of confirmed malaria cases disaggregated by age, sex and pregnancy status
- Increased number of TB patients identified and receiving confirmed diagnosis - all types (disaggregated by age and sex)
- Increased number of MDR-TB cases notified (disaggregated by age and sex)
- Increased treatment success rate disaggregated by “Drug Susceptible” and “Drug Resistant” TB
- Increased proportion of HIV positive people started on ART
- Increased proportion of HIV infected people on ART with adequate viral suppression
- Increased utilization of insecticide treated nets (ITNs) procured with USG funds
- Increased number of residents of sprayed houses
- Improved diagnostic capacity for all infectious diseases

IR 2.3 Improved pre- and in-service training

The Ethiopian Ministry of Health has recognized many gaps in the demand-driven production of a quality health workforce including availability of a variety of cadres, low quality of training, and gender inequity. There are also wide gender inequities in the number of women applicants and graduates. The low quality of pre- and in-service training of health professionals results in their limited performance competency and lower quality service delivery. Further, there is no federal licensing system that is linked to competency and continued education to maintain a modern high-competency workforce. This project will work with the government, professional associations, and private sector to address these issues. This links to IR 1.5—enhancing the role of the private sector in workforce development.

Illustrative activities:

- Strengthen pre-service education at higher education institutions, including competency-based training, especially for medical doctors, pharmacy and laboratory professionals, midwives, anesthetists and other identified areas with availability gaps
- Rationalize enrollment and training of community-based and mid-level health workers to meet the regional priorities
- Enhance and privatize in-service training of health professionals
- Develop the capacity of professional associations or similar bodies to develop and maintain licensing and continuing education standards
- Improve the capacity of pre- service training institutions to attract and retain students, especially women, through a more conducive and adaptive environment
- Institute approaches to achieve gender parity in the number of graduates in each health cadre
- Reduce gender bias and sexual harassment in pre- and in-service training institutions

Illustrative indicators:

- Increased percentage of graduates who pass competency-based testing after pre-service training (disaggregated by gender)
- Reduced attrition (drop-out) rate per student cohort, gender, cadre and health education institution (over a given period)
- Increased percentage of women graduates by health cadre (target: 50%)
- Increased number of private institutions engaged in in-service training to maintain licensing standards
- Increased number and percent of health training institutions accredited by the Higher Education Relevance and Quality Agency (HERQA)
- Support government to develop federal licensing standards in coordination with professional associations, higher education institutions, and in-service training institutions
- Increased number of professional associations or similar bodies supported to develop and maintain licensing and continuing education standards according to federal licensing standards

Result 3: Reduced health inequities

The GOE prioritizes equity in health care so that poverty, ethnicity, region, or location are reduced as barriers to care. Under HSTP I, one of the pillars of the health transformation plan was “compassionate, respectful care” recognizing that vulnerable individuals may not seek care if they feel they will be turned away or mistreated. Out-of-pocket (OOP) expenditure for patients remains high: 31% of Ethiopia’s Total Health Expenditure (THE) as of the latest National Health Accounts (NHA) and is considered a significant barrier to accessing health care, especially for the poor. The government contribution to the country’s THE in 2016-17 amounted to 32% (NHA-VII), indicating that the government needs to increase domestic financial resource mobilization (DRM) to adequately finance all areas of the health system and achieve its strategic health goals. This may include a public subsidy so that those populations unable to pay can still access essential health care

services. These targeted safety-net approaches are best integrated with other available means-test based household selection and social protection schemes, such as the Productive Safety Net Program (PSNP). This project will support the following intermediate results to enhance health equity:

- IR 3.1 Improved and expanded financial protection mechanisms
- IR 3.2 Increased domestic resource mobilization
- IR 3.3 Improved identification and targeting of poor and vulnerable groups with financial/poverty programs related to health

IR 3.1 Improved and expanded financial protection mechanisms

To address high OOP, the government is scaling up community-based health insurance (CBHI). Currently reaching only about 20 percent of the population, it still misses many of the most vulnerable people and communities. The government plans to have additional financial schemes to ensure all population sectors are covered. This project will support the Health insurance Agency to have better capacity at national and subnational level to expand the reach of CBHI and initiate the implementation of the Social Health Insurance (SHI) and strengthen the link between the insurance schemes and service provision outlets and mix.

Illustrative activities:

- Solidify and expand the Community-based Health Insurance (CBHI) program (for informal sector households) for nation-wide rollout with needed adjustments for urban cities and low-land areas
- Support initiation of Social Health Insurance (SHI) Program for public and private-sector formal employees
- Strengthen coordination, terms of reference, and role specification among FMoH, EHIA, and other related government agencies and bureaus at national and sub-national levels to develop a functional split between health service provision and purchasing
- Explore output-based provider payment approaches like capitation for primary health care and case-based payment for inpatient care (in place of the existing user-fee systems) that also allow the participation of private sector health providers and facilitate market competition for better efficiency.

Illustrative indicators:

- Increased proportion of eligible population enrolled in financial protection schemes as a result of USG support to the national health insurance programs (disaggregated by gender, wealth quintile, and geography)
- Increased number of health insurance schemes designed or established with USG support
- Increased proportion of eligible people (public and private-sector formal employees) enrolled in Social Health Insurance (SHI) Program
- Decreased OOP expenditure as a percentage of THE
- Increased per capita THE
- Reduced proportion of households with catastrophic out-of-pocket expenditure exceeding the threshold (40% of households' non-subsistence income)

IR 3.2 Increased domestic resource mobilization

Increased DRM is essential for the health sector's journey to self-reliance. The sector is heavily donor dependent so increasing the government's share is pivotal to sustaining the expanding health sector and to support its ambitious health goals. More cost-effective use of resources may also free up funds to expand services towards universal health coverage - more services for more people with reduced financial burden.

Illustrative activities:

- Advocate for and support the government to develop and implement strategies to increase domestic resource mobilization, including public budget and innovative financing sources (earmarked taxes, concessionary loans, debt swaps, community funds).
- Support increased private sector engagement, and support the government to pursue public-private partnerships and innovative financing approaches
- Support the government to adopt and institutionalize evidence-based tools for resource optimization
- Develop local capacity to analyze and identify cost-effectiveness of health programs and comparative schemes to deliver the best health services for outcomes relative to cost. (this links to IR 1.3)

Illustrative indicators:

- Percentage increase in general government expenditure on health as a percentage of total government expenditure
- Increased amount of financing invested by the private health sector
- Improved cost-effectiveness of government health system to prevent death and morbidity
- Increased domestic resource mobilization as percentage of GDP

IR 3.3 Improved identification and targeting of poor and vulnerable groups

To reduce barriers to services for the most poor and vulnerable and ensure that financial, geographical and cultural boundaries are not barriers to accessing health care, the targeting process needs to be streamlined to ensure appropriate and prioritized selection of the “poorest of the poor” households – as well as other vulnerable groups such as women, children, youth, orphans, pastoral, urban slum, and migrant workers for appropriate health services. A variety of effective outreach, mobile, and innovative approaches would also be used to link up these vulnerable groups with the health services of their needs.

Illustrative activities:

- Strengthen and expand identification of poor and vulnerable enrolled in CBHI, or sub-national social protection schemes/programs, as well as through other mechanisms of data collection
- Identify and link orphans and vulnerable children (OVC) in HIV/AIDS programs with care and treatment programs for all their health needs
- Engage and partner with NGO and CSOs to identify and provide services to poor and vulnerable groups
- Improved referral processes for poor and vulnerable groups

Illustrative indicators:

- Increased number of individuals and households enlisted in both CBHI and PSNP programs
- Greater number of NGO and CSO partners to identify and provide services to poor and vulnerable groups based on USG assistance
- Increased number of OVC receiving one or more services with the support of USAID
- Increased percentage of government allocations to subsidize health care for poor and vulnerable populations

F. Geographic Coverage

The HSS Project will work at national, regional, and woreda levels. National-level activities are those that will have impact across the country, such as work with federal institutions, federal policy and strategy development, and national resource mobilization. The project will work very closely with the ECBH Project to align implementation areas for sub-national work, and will consider the following criteria for woreda selection:

1. ECBH activities
2. Woreda Transformation candidate
3. Geographic overlap with education or WASH activities
4. Geographic overlap with lowlands resilience activities

5. Other partners' programs (avoiding duplication of efforts)
6. Equity – selection of Woreda in most or all regions, including lowlands and highlands, urban and rural
7. Selection of some secondary and tertiary cities – considering overlap with the Youth and Economic growth projects
8. Greatest need—the areas where there is no other programming, but need is high
9. Epidemiology—for malaria, TB, and HIV programs—where these programs are needed; for EPI, where rates are lowest, and others.
10. FMOH priorities

The HSS project will be able to reach into all 11 regions and will aim to work in up to 450 woredas, including secondary and tertiary city administrations.

V. OTHER LEVERAGED RESOURCES

Donors: USAID is a key member of the Health, Population and Nutrition Donor Group and will continue to use this platform to collaborate strategically with the donor community to ensure the efficient use of resources to maximize progress under this project. Major health development partners in Ethiopia include: multilateral organizations (UNICEF, UNFPA, WHO, UNAIDS, and the World Bank); bilateral donors (USG, DFID, JICA, CIDA, the Italian Cooperation, the Netherlands, Irish Aid, the French Cooperation, Spain, and Australia); global initiatives (GFTAM and GAVI); and private foundations (Bill and Melinda Gates, the Clinton Health Alliance Initiative, Packard, and Buffett). (See Annex for detailed description of donors and areas of investment).

Private Sector: The private health sector in Ethiopia is growing fast and it is currently estimated that around a quarter of the out-of-pocket health expenditure in the country goes to the private sector, which amounts to more than US\$200 million per year. The private sector (PS) appears to be a major source of outpatient care and nearly 90% of drug outlets are for-profit drug stores. Spurred by high economic growth, the growing private health sector market has attracted the attention of the Ethiopian diaspora and other foreign investors who have expressed interest to invest in the private health sector. The GOE has recognized the need to leverage non-state resources in order to reach its ambitious targets in health, but also recognizes that unregulated growth of the private health sector may do more harm than good. Appropriate engagement and regulation of the private sector will support its growth while ensuring a quality standard. USAID assistance will support private sector engagement in the delivery of health and nutrition services as well as in other health system building blocks, especially pharmaceuticals, medical equipment and supplies, production and training of health workforce, and information systems and technologies. USAID will support the GOE to integrate private sector data into the MOH data system to ensure comprehensive and quality information is used for analysis and decision making. USAID will use findings from the World Bank assessment on the PS and further assessments to identify concrete opportunities for engaging and leveraging the PS in strengthening Ethiopia's health care system through this project.

Local Non-governmental Actors: Sustainable and equitable country level reductions in maternal and child mortality depends on the contributions of multiple, interconnected actors. Therefore, the HSS Project will systematically engage the multiple local systems and actors that impact improvements in the health of Ethiopians and leverage their expertise and resources to improve the health system in Ethiopia. Some potential actors and groups include NGOs, CSOs, professional associations, and community groups.

Other USG/USAID Partners: USAID works closely with CDC on HIV, Malaria and EPI programming, and will continue to leverage their expertise in these areas. In addition, linkages with other offices and projects across the mission as described above in “Alignment with CDCS” will help leverage technical and management experience and activities across the mission.

Summary of Analyses:

Environmental Compliance: In accordance with 22 CFR and as part of USAID/Ethiopia New Country Development Cooperation Strategy (CDCS 2019-2024) formulation, Mission has developed umbrella Initial Environmental Examinations (IEEs) for IRs IR 4.4 and 4.5, the health related objectives. The Initial Environmental Examination gave a Categorical Exclusion threshold determination for most of the activities. Activities which have a negative determination with condition threshold decision, will develop an Environmental Mitigation and Monitoring Plan (EMMP) and implement the recommended mitigation measures and regular report on compliance status. A summary of the DO4 IEE is included in .

Climate Risk: The CDCS level climate risk assessment gave a “Low” climate change risk rating for activities under IR 4.4 and IR 4.5, and a “Low” rating for adaptive capacity. Ethiopia is one of the most vulnerable countries in the world to climate risks. The threat of extreme climate events is likely to generate higher demands for disaster assistance if adaptive capacity is not strengthened. The recommended climate change risk management actions include strengthening community systems for risk identification and preparedness, increasing access to and utilization of early warning information, building the GOE’s DRM capacities to improve the effectiveness of response and reliance on assistance, and strengthen contingency planning, emergency preparedness and disaster risk reduction. The recommended next step is to develop a monitoring system for assessing the effectiveness of early warning dissemination capacity. These recommendations have been incorporated into the project design and will be incorporated into the activity designs.

Gender Analysis: A project specific gender analysis was conducted in September 2019 that identified project specific gender issues, inequalities, and constraints impacting the use of health services and the practice of healthy behaviors in Ethiopia that could influence project outcomes. The findings and recommendations of the mandatory project level gender analysis have informed the design of this project. Gaps in information will be addressed through activity level gender analysis and will inform the design and implementation of interventions. A summary of the gender analysis is included in [Annex 2](#).

Private Sector Landscape Analysis: The World Bank conducted an initial private sector (PS) assessment. However, the project will conduct a more in-depth complementary PS analysis to provide critical information on the PS environment in Ethiopia such as mapping of private providers – who they are and what they are doing and their strengths and weaknesses. Findings will used to identify strategies for engaging and leveraging the private sector in health and nutrition services to strengthening the health system.

: A systems mapping exercise will be fundamental to understanding the actors (which include the Ethiopian Government, private sector, faith based facilities, religious and community leaders, civil society organizations (CSOs), and other community groups), their interrelationships, and the incentives that guide them in order to build a partnership and ensure shared responsibility, mutual accountability and achievement of lasting concrete results.

VI. PROJECT MANAGEMENT AND IMPLEMENTATION PLAN

A. Management Plan

The Project Management Team will be comprised of the Project Lead (Health Systems and Resilience Team Leader or Deputy) and a co-lead (Health Office Team Lead or Office Deputy), Contracts/Agreements Officer’s Representatives (CORs/AORs) from each activity, a representative from the Mission’s Program Office, a representative from the Mission’s Office of Acquisition & Assistance, and a Gender Advisor. The team will meet regularly with activity and project updates, and to find points of collaboration. Mission planning and reporting will be done by this team – including for portfolio reviews, and QFR and other required reports.

The Project Team lead and Deputy will represent the project at DO-level meetings, sharing information about the project and its activities with the other project leads and the DO lead. They will also meet regularly with the Mission front office with project updates.

The Project Manager will be responsible for the overall management of the project budget and team members, progress in achieving results, and adherence to Mission strategies and priorities. The Project Manager will oversee coordination with other USAID/Ethiopia projects and activities. The Project manager will take the lead and ensure collaboration with and/or directly engage national and regional government units, private sector, civil society, and other donors and international organizations to improve its management of its project. Collaboration with government and other donor partners will take different forms such as through technical meetings, quarterly and annual meetings at the national and decentralized level.

More detail can be found in the Mission Order on Roles and Responsibilities under the CDCS.

Ongoing/New	Activity Name	Start Date	End Date	TEC
Ongoing	Private Health Sector Project	10/09/15 -	10/08/20	
Ongoing	Strengthening Malaria	04/01/14 -	03/29/21	

	Monitoring and Evaluation Systems in Ethiopia (SMMES)			
Ongoing	Digital Health Activity	11/11/19	11/10/24	
Ongoing	Health Financing Improvement Project	10/25/18	10/24/23	
Ongoing	GH Supply Chain for the Procurement and Supply Management	04/20/15	11/23/23	
New	Eliminate TB from Ethiopia (ETBE) New Challenge TB	02/28/20	02/27/25	
New	G2G with EFDA			
New	Health Workforce Improvement Program (HWIP)	02/28/20	02/27/25	
New	Supply Chain Support			
New	Global Health Assistance Program			

New and follow-on activities over the life of the Project: All new procurements under the Project will be implemented through multiple awards and a mix of procurement mechanisms, including bilateral awards, Government to Government awards (G2G), utilization of USAID/Washington Central Awards, which the Mission will buy into through field support for commodities and specialized technical areas, and awards to new partners as part of the New Partner Initiative.

B. Ongoing HSS Activities

C. New Activities

VII. PROJECT MONITORING, EVALUATION AND LEARNING PLAN

USAID will monitor and evaluate the progress of the HSS project towards its overall indicators under IRs 4.4 and 4.5 as well as contributions to DO4 indicators. It will also evaluate progress on the journey to self-reliance (J2SR). A variety of monitoring and evaluation approaches will be utilized including “traditional” approaches as well as complexity-aware methods such as social network analysis, and stakeholder dialogue to understand the contextual factors that impact programming. These approaches will be detailed in . The HSS Project will include rigorous monitoring and evaluation to ensure that this and future projects benefit from lessons learned, and progressively effective programming. Some approaches and indicators will be jointly done with the ECBH Project.

A. Monitoring

USAID will support monitoring systems to gather timely and high-quality data. This data will feed into periodic analysis, learning and evaluation questions and decision-making. Both quantitative and qualitative data collection approaches will be utilized at the different levels of implementation to understand the inputs, outputs, context, and influencing factors. Data analysis and visualization techniques, including the use of GIS, will be utilized to better analyze and understand the data and generate new learning. The Project Lead will hold quarterly meetings with AOR/COR and IP staff to review project status and identify any corrective actions. Project Lead and team members will also conduct site visits in accordance with their AOR/COR role as well as combined project site visits to support project monitoring goals. In insecure areas not accessible to USAID staff, an external monitoring and evaluation contractor may be used for monitoring and data collection and for indicators for ongoing monitoring. The Project will comply with USAID’s Evaluation Policy by requiring monitoring of key indicators for each result

B. Evaluation

The Project evaluation strategy will be fully compliant with the USAID Evaluation Policy and will include one whole-of-project evaluation and one impact evaluation. of the budget will be allocated to support project evaluation. Though USAID will still look for opportunities for credible impact evaluations, the focus will be on learning activities that are fit for purpose and maximize the return on investment.

The recent 2018 mini DHS is a useful baseline for high level outcome and some demographic indicators, and a planned 2021 DHS will give useful mid-term results applicable to both the HSS and ECBH projects.

C. Collaboration, Learning and Adaptation

USAID seeks to promote learning across stakeholders involved in the implementation of this project through Collaborating, Learning, and Adapting (CLA). Project learning is intended to benefit all stakeholders.

CLA Objectives:

a. Generate Knowledge. The project team will generate new knowledge and evidence around learning questions identified together with USAID and other stakeholders, as well as questions that may emerge during the course of implementation. In filling these knowledge and evidence gaps, the project will identify reporting, data, and analysis processes and requirements and gather all stakeholders for inclusive reviews of the project and activity goals and results.

b. Share Knowledge. The project team will increase knowledge-sharing with stakeholders, including local organizations, national and local level MOH, sectoral experts, donors, regional and international organizations, and others through communities of practice to encourage more widespread learning across teams, mechanisms, and sectors. The project team will work together within a learning network to share information with implementing partners of other USAID activities, such as local stakeholders and other development partners. The project team will convene forums to share knowledge and will also use existing forums as available. Implementing partners will attend and participate in these meetings. This project will support the provision of case studies, lessons learned, success stories, and learning events to share among partners and stakeholders working in health systems strengthening. This includes working with USAID, MOH, CSOs, domestic and foreign academia, and other partners to identify lessons learned from previous and ongoing sector wide programming.

c. Incorporate Agile and Adaptive Processes. The project team will develop adaptive management and implementation processes to allow course corrections to respond to unintended effects, changing/emerging realities, and priorities. Together with the project team, each activity's work plan, quarterly reports, and periodic progress review meetings will provide a forum for an adaptive approach to change course or make corrections based on lessons learned and evolving country context.

Additionally, activity designs and annual work plans will allow for responding to windows of opportunity which include responding to national dialogues initiated by the government. The project team will stay abreast of political and economic shifts and recognize when there are windows of opportunity and moments of political and social change when reform is more likely to take root. If circumstances arise, activity designs can and will be altered to accommodate the window of opportunity, as long as the reprogramming does not incur additional costs (unless otherwise approved in writing by the Contracting Officer.)

Using the Collaborative, Learning and Adaptive Management approach outlined above the project will engage the GOE and other stakeholders in generating, analyzing, sharing and applying data. The project will put in place an iterative learning process that engages local actors and partners, and build flexibility to adapt best practices, and design for local conditions in order to attain the greatest impact. The following are learning questions that USAID looks to find answers to as it implements this project forward.

1. What is the effect of LMG intervention on performance of health workers or health sector?
2. Is LMG advanced more effectively as a discrete effort or within each building block or some hybrid? Work discreetly on service delivery?
3. What does effective cross-block collaboration look like and how do we support it?
4. In what way do we effectively crowd in private sector engagement?
5. How do we know the system is becoming a more responsive system?
6. How can we best collaborate/coordinate the building blocks with the vertical functions in FMOH?
7. What evidence is there on how to address urbanization?
8. Given limited resources, what are the most important priorities? (For USAID's theory of change)
9. How do we shift the locus of collaboration to the MOH, away from USAID?
10. What can we learn from other multi sectoral projects, example low land resilience
11. How has the HSS project informed and engaged community members (women and youth groups, government officials, youth, women, men, girls, boys, different, power structures, ethnic, religious or social groups, etc) in the health system programme cycle: assessment, design, implementation, monitoring and evaluation?

See the Project MEL Plan for further details.

VIII. FINANCIAL PLAN

The total estimated budget for this Project is \$310 million dollars over five years. USAID funds will include a mix of maternal and child health, malaria, HIV/AIDS, TB, family planning, nutrition, water and sanitation funds and GHSA funds.

ANNEXES:

Annex 1: Detailed Health Status Context

Data Table [to be included when final]

Maternal Mortality: Ethiopia has a pregnancy related mortality rate of 412 per 100,000 live births (DHS 2016)—one of the highest in the world. An estimated 12,000 women die from childbirth-

related causes every year, and over 50,000 women currently suffer from obstetric fistula. Major drivers of maternal death are: obstetric hemorrhage (37 percent), eclampsia (19 percent), and sepsis (12 percent). Ninety percent of deaths due to maternal hemorrhage occur during or within 42 hours of birth, 56 percent at hospitals and 19 percent en route to a facility for delivery. Delay in deciding to seek care and delay in actually seeking care contribute to 67 and 38 percent of mortality respectively (National Maternal Death Surveillance and Response 2017). Rates of women receiving any antenatal care (ANC) have increased from 28 percent to 74 percent in 2019, however women do not seek ANC in early pregnancy and only 43 percent of women had at least four ANC visits. The quality ANC is generally poor as few women receive all requisite tests during pregnancy. Assisted delivery has increased from five percent in 2005 to 48 percent in 2019. Women who report higher gender equity were more likely to deliver in a facility, and all indicators for maternal health are lower in rural areas than urban areas.

Under-Five Mortality: Ethiopia is one of five countries that account for half of the global U5M. According to the 2016 DHS, the U5M rate in Ethiopia has reduced to 67 per 1000 live births, however, wide regional variation exists (39 deaths per 1000 live births in Addis Ababa, versus 125 per 1000 in Afar). Mini-DHS 2019 results indicate that the U5M has reduced to 55 per 1000 live births nationally, but neonatal mortality increased from 29 to 30 deaths per 1000 live births from 2016; mortality is higher among rural areas than urban. While immunization rates have improved, they remain low, and the data is poor. The proportion of fully vaccinated children under one year increased from 39 percent in 2016 to 43 percent in 2019; however, the number of never-vaccinated children also increased from 16 percent in 2016 to 19 percent in 2019. Wide regional variation exists in vaccine coverage. Increase in outbreaks of vaccine-preventable diseases (VPD)—including measles and polio—in 2018 and 2019 demonstrate poor vaccine coverage. Ethiopia had 63 confirmed measles outbreaks in 2019, and 2,532 lab-confirmed cases; one-third of those cases had never been vaccinated. Vaccine coverage is higher in urban areas than rural areas.

Malaria: According to the 2018 World Malaria Report, between 2015 and 2018, the malaria incidence declined by 57 percent decline, and mortality due to malaria reduced by 54 percent. Similarly, a recent study using vital registry and population surveys showed malaria morbidity had reduced by more than 88 percent and mortality by 97 percent in the past 25 years. Based on this progress, the GOE declared their intention to eliminate malaria in 239 select woreda by 2022, with a target to completely eliminate malaria from Ethiopia by 2030. However, the National Malaria Control Program does face significant budget shortages, resulting in most long-lasting insecticide treated nets procured by the external sources, and significant assistance to indoor-residual spraying. Approximately 60 percent of the total population lives in areas at risk of malaria, and transmission is typically higher in rural areas than urban.

Family Planning and Reproductive Health: The proportion of women using modern FP methods is increasing; however, the unmet demand for FP by women of childbearing age is 25 percent. Modern FP use increased from six percent in 2000 to 41 percent in 2019. Urban women, and women with at least a secondary school education are more likely to use FP. Financial barriers and spousal permission to use FP are cited as barriers for women who want to access but do not use FP. Although the fertility rate has decreased to 4.6 (EDHS 2016), years of high fertility rates and low contraceptive prevalence contribute to an annual population growth rate of 2.5 percent, with 42 percent of the population under 15 (Population Reference Bureau, 2019). Fertility rates are higher among rural women (5.3 compared to 2.5). The increasing population puts pressure on arable land and on social services, including education, health, and employment.

Malnutrition: Ethiopia remains the seventh most undernourished country in sub-Saharan Africa. Stunting rates have dropped from 51 percent in 2005 to 37 percent in 2019, but have stagnated over the past three years. While rates of wasting have dropped from 12 percent in 2005 to seven percent in 2019, pockets of Amhara, Tigray, SNNP, and Somali regions have rates as high as 25 percent. Food insecurity, high disease burden, low health service utilization, poor hygiene, and poor feeding practices contribute to high malnutrition rates. In addition, exclusive breastfeeding for infants under six months is 59 percent, but only seven percent of children have a minimally acceptable diet (2016 EDHS). Rates of malnutrition are significantly higher in rural areas than urban areas. In addition to health consequences, studies have shown that malnutrition affects school performance and retention, work productivity, and potential income.

Water and Sanitation: While Ethiopia has made significant strides in water and sanitation access, both indicators are low compared to the world average, and African peer countries. Only seven percent of Ethiopia's population have access to basic sanitation; 41 percent have access to basic water supply; and only 30 percent of facilities have access to a basic water source (JMP 2019). Insufficient access to clean water and sanitation remains a key driver of morbidity and mortality. While access to water and improved sanitation is higher in urban areas than rural, rates of urbanization are outpacing the capacity of municipalities to ensure consistent water supply, and adequate sanitation management.

HIV/AIDS: Ethiopia has significantly decreased new HIV infections and all-cause mortality among HIV-infected individuals; the country is on the brink of achieving HIV epidemic control. Adult HIV prevalence has decreased to 0.9 percent, with new infections concentrated in urban areas (EDHS 2016). The 2018 Ethiopian urban-focused population-based HIV impact assessment (EPHIA 2018) showed that 72 percent of the HIV-infected population knows their HIV status; the likelihood of this group to receive antiretroviral therapy (ART) services, and achieve HIV viral suppression, is at 99 percent and 90 percent respectively. Over 469,000 people are enrolled into the national ART service and receive treatment.

TB: According to the 2019 WHO Global TB Report, Ethiopia is among the 30 “high TB, TB-HIV and MDR-TB burden countries.” Estimated incidence of all forms of TB is 155 per 100,000 population, with MDR TB estimated to be 0.71 percent among new TB cases, and 14 percent among retreatment cases. TB is a major opportunistic infection among people living with HIV/AIDS, and seven percent of all TB cases are co-infected. TB Every year, 33 percent of drug sensitive TB and 79 percent of MDR-TB cases go undetected, which fuels transmission to the community. Ethiopia has an approximate 56 percent annual budget gap.

Annex 2: Donor Coordination and Alignment with GOE

One of over 20 donor partners in Ethiopia, this project works in collaboration and partnership with other donors through a government and partner-established framework of coordination, including the HPN Donor Coordination group, the Joint Committee for Coordination and Cooperation (JCCC), and a wide array of technical working groups.

The HSS project is aligned with the HSTP I, and as the HSTP II is being developed, under the reforms of the new government, will also align with the priorities of this strategy. [Note: more detail to be added once the HSTP is in a more final stage]. USAID partners closely with the Ministry of Health at the federal (FMOH) and regional levels (at RHBs), and other related ministries including the Ministry of Water, Industry and Energy (MOWIE), the Civil Service Commission, and the Ministry of Science and Higher Education (MOSHE). It also works closely with affiliated health institutions including Ethiopia Pharmaceutical Supply Agency (EPSA), Ethiopian Food and Drug Administration (EFDA), Central Statistics Agency (CSA), Health Insurance Agency (HIA), and the Ethiopian Public Health Institute (EPHI). It will also work with professional associations, and independent accreditation bodies as they are developed.

This project will also work with private sector service providers, associations, and corporations engaged in the health sector.

Annex 3: CDCS result framework

Disasters		Demographics		Democracy
Goal: Ethiopia transitions to a more democratic, resilient, and prosperous country with accountable institutions and private sector-led growth				
DO 1 : Disaster risk management strengthened	DO 2: Resilience of vulnerable populations to key shocks increased	DO 3: Private sector -led economic growth promoted	DO 4: Sustained improvement in essential service delivery outcomes focused on women and girls	SpO: Citizen responsive governance enhanced
IR 1.1: Communities are empowered to mobilize, mitigate and act on shocks	IR 2.1: Household food security increased	IR 3.1: Ethiopia's economic reform agenda supported	IR 4.1: Sustainable WASH services improved, with an emphasis on women and girls	IR 1: Host government democratic and governance reforms advanced
IR 1.2: Institutional risk management capacity strengthened	IR 2.2: Shock-resilient livelihoods are increasingly adopted and maintained	IR 3.2: Agriculture transformation accelerated	IR 4.2: Skills and abilities of children and youth improved	IR 2: Civil Society Organizations and media strengthened
IR 1.3: Emergency response provided more effectively	IR 2.3: Natural resource and water management improved	IR 3.3: Inclusive market systems promoted	IR 4.3: Education systems enhanced for greater effectiveness	IR 3: Rule of law and democratic institutions strengthened
Crosscutting Issues/Approaches <ul style="list-style-type: none"> • Governance • Conflict Sensitivity • Gender • Youth • Resilience 	IR 2.4: Barriers to social services reduced	IR 3.4: Women's economic empowerment enhanced	IR 4.4: Utilization of quality health and nutrition services increased	
	IR 2.5: Socio-political stability improved		IR 4.5: Health and nutrition systems strengthened for greater self-reliance	
	Strategic principle 1: Improved citizen empowerment and household and community resilience and well-being.		Strategic Principle 2: More effective and accountable systems and institutions at all levels.	