ADDIS ABABA UNIVERSITY

COLLEGE OF SOCIAL SCIENCE

DEPARTMENT OF POLITICAL SCIENCE AND INTERNATIONAL RELATIONS

THE ROLE OF DEVELOPMENT PARTNERS ON THE ETHIOPIAN HEALTH SECTOR DURING HEALTH SECTOR DEVELOPMENT PROGRAM IV IMPLEMENTATION

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Advisor: Demeke Achiso (PhD)

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A Thesis Submitted to School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Art (MA) in International Relations

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Declaration

I declare that this thesis is my original work and has not been presented for a degree in any other university, and that all sources of materials used for the thesis have been duly acknowledged.

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Signature Date

Demeke Achiso (Dr _____ _____

Advisor **Signature**

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Acronyms

AIDS Acquired Immune Deficiency Syndrome

ANC Antenatal Care

ART Antiretroviral Therapy

Aus Aid Australian Aid

BEmONC Basic Emergency Obstetric and Neonatal Care

CAR Contraceptive Acceptance Rate

CDC Center for Disease Control

CIFF Children's Investment Fund Foundation

CPR Contraceptive Prevalence Rate

DFID Department for International Development

DP Development Partners

EPI Expand Program on Immunization

EU European Union

FMoH Federal Ministry of Health

GAVI Global Alliance for Vaccines and Immunizations

GF Global Fund

GTP Growth and Transformation Plan

HCT HIV Counseling and Testing

HAD Health Development Army

HEP Health Extension Program

HIV Human Immunodeficiency Virus

HSDP Health Sector Development Program

HSS Health System Strengthening

HIP	International Health Partnership
IRS	Insecticide Residual Spraying
ITN	Insecticide Treated Net
JFA	Joint Financial Arrangement
LLIN	Long Lasting Insecticide Treated Net
MDG	Millennium Development Goal
MDG PF	Millennium Development Goal Performance Fund
MoFED	Ministry of Finance and Economic Development
MTCT	Mother to Child Transmission
NHA	National Health Account
NGO	Nongovernmental Organization
OECD	Organization for Economic Cooperation and Development
PLHIV	People Living with HIV
PMTCT	Prevention from Mother to Child Transmission of HIV
PNC	Postnatal Care
RHB	Regional Health Bureau
SSA	Sub- Saharan Africa
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID US	Agency for International development
WHO	World Health Organization

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Abstract

The main purpose of this study is to examine the role of foreign aid on health development in Ethiopia during health sector development program IV that has been implemented from 2010/11 to 2014/15. The study focused on the International health compact signed between government of Ethiopia and development partners according to principles of Paris declaration 2005 and Accra Agenda for Action 2008 based on mutual accountability of the signing parties. Purposive sampling was used to collect the relevant data from UNFPA and Ministry of Health (Resource mobilization and utilization office, grant management office, plan policy office and offices of leads programs that were heavily financed by aid during this program implementation). Annual performance reports of health sector development program were used as secondary sources are for data collection. The study result shows that, the main focus areas of health in HSDP IV, those heavily financed by foreign aid, prevention and control of communicable diseases (HIV/AIDS, TB and Malaria), maternal health and child health. Aid has a significant positive impact on health development. However, limiting one fiscal year on utilization of foreign aid resulted in less performance in the sector. In addition complex bureaucracy of procurement and the process of agreement that have been taking long time period for construction are found to be other challenge. Based on the study finding the researcher recommended that government of Ethiopia must increase health per capita income, ministry of health is recommended to build the capacity of the workers through continuous training on how to utilize aid effectively, donors are recommended to contribute their donation through pooled fund mechanism and expand the time limit of using aid from one to two years can make health aid effective and efficient.

Keywords: *Foreign Aid, Pledged, Disbursement, Health Developmen*

Chapter One

1. Introduction

1.1.Background of the Study

Development assistance given to promote development, in diverse areas such as health, education, social inclusion, democratization, gender equality and sustainability in aid receiving countries is the social goal of foreign aid (Barratt, 2008). Developing countries were recommended by World Health Organization to scale up health services and health expenditure in their own countries by considering improved health of people as input for development (World Health Organization, 2004). The notion of scaling up is a process of expanding the coverage of health interventions by increasing necessary inputs required to expand coverage like financial, human and capital resources (Mangham and Hanson, 2009). In fact, a society burdened by a large number of sick and dying individual cannot escape from poverty, but scaling up necessary input for health service is not easy for developing countries because of their income is low and another service provider sectors need budget.

The Abuja commitment was signed in 2001 by 53 African states with intension of increasing health expenditure by allocating at least 15% of their annual government expenditures to the health sector. Despite the Abuja commitment most of Sub Saharan African states could not fulfill the commitment due to their income is low and financing health remains major problem in the continent (USAID, 2013). And seeking more foreign aid for health service development in developing countries became a mandatory. International aid is considered as the most effective weapons in the war against poverty (UNDP, 2005) and the UN Millennium Project also makes the link from expert plans to foreign aid. Increasing foreign aid and well designed and well implemented plans are considered as best input to reduce poverty in developing countries (Easterly, 2008).

Millennium Development Goals (MDGs) declaration, one of the global policies, which focused on world poverty reduction, gives prominence to the improvements in health in poor countries (Roberts, 2003). For the implementation of millennium development goals, a number of organizations, notably the Global Fund, the GAVI Alliance and UNITAID, have deemed innovative financing mechanisms which is a vital and increasingly important element of their resource mobilization and diversification strategies (World Health Organization, 2010).

The volume of aid for health dramatically increased from $5.7 billion in 1990s to $28.1 billion in 2012 (Moon and Omole, 2013). HIV/AIDS pandemic, and in particular to calls for additional resources to make antiretroviral therapy widely available and the adoption of the MDGs in 2000 and debt relief initiatives also helped to generate increased financial resources (Mangham and Hanson, 2009).

Ethiopia, one of the Sub Saharan Africa states, has been receiving aid from foreign donors for several purposes like health, education, humanitarian aid, and the like (Meyer, 2012). The aid history in Ethiopia dates back to 1950s, however, foreign flows in Ethiopia grew in substantial amount since 1980s (Alemayehu and Kebrom, 2011). Foreign aid has covered almost half of the health sector budget for Ethiopian health sector during HSDP IV implementation (National Health Account, 2014).

Ethiopia has given attention for the health sector since the last two decades. In 1993 the government formulated the first national health policy by focusing on the expansion of primary health care system and encouraging partnership and participation of non-governmental actors (Wamai, 2009). To implement this national health policy, four health sector development programs were developed which contains five years plan and strategy in one health sector development program (WHO, 2014). This study focuses on the last health sector development program (HSDP IV) implementation.

Health sector development program IV (HSDP IV) covered period from 2010/11-2014/15 which was the expression of the renewed commitment of Ethiopian government to achieve health millennium development goals. The national health policy and the most influential international commitments global declaration of MDGs, the African Health Strategy 2007-2015, the Paris Declaration on Aid harmonization (2005), Accra Accord on Aid effectiveness (2008) and the Abuja Declaration on health care financing in Africa taken in to account while designing HSDP IV. For the successful implementation of HSDP IV and in order to strengthen the Health Extension Program (HEP), the organization and mobilization of the Health Development Army (HDA) was started during the beginning year of HSDP IV implementation (2010/11). This has targeted capacitating families who are lagging behind in terms of adopting safe health practices (HSDP, 2011).

All implementation efforts of the HSDPs and the progress the sector making to advance the policies and institutional reforms in Ethiopia would not have possible without the dedicated support of development partners (National Health Account, 2014). Particularly, in HSDP IV implementation, multilateral and bilateral donors contributed a significant amount of money for Ethiopian health sector.

Table 1: Pledged and disbursed money during HSDP IV

Year	Pledged (USD)	Disbursed (USD)
2010/11	485,439,775	422, 351,726
2011/12	409,345,028.61	410; 996,784.23
2012/13	550,989,473.00	531,133,786.35
2013/14	538,327,539	612,865,345
2014/15	445,962,381.60	269, 070,132.35

Data source: HSDPs (2011, 2012, 2013, 2014 and 2015)

Even though the amount of commitment and actual donation increased during HSDP IV implementation, there was fluctuation. Hence, this study tries to deal with the significances of development partners' contribution to Ethiopian health sector and health outcomes in Ethiopia during the Health Sector Development Program IV implementation.

1.2.Problem Statement

Most of developing countries are looking for the rich countries and international development organizations to scale up their health services and reduce poverty. World Health Organization has recommended that developing countries to scale up and reach $34 per capita income per individual spend on health in 2001 and this will be revised to $60 for 2020. Accordingly the expected expenditure for health was $34*81, 9000, 00 however, by 2011 per capita income spent on health in Ethiopia was only $ 20.77 and the share of total government expenditure spending on health was not more than 5.6% of the total government expenditure (NHA, 2014). This is very low as compared to the Abuja Declaration commitment of African countries to raise the share of health expenditure to 15%, which shows the existence of wide gap from the benchmark.

Hence "Health is still underfinanced in Ethiopia and there is strong need to make more resources available to the sector to improve the health status of the population" (NHA, 2014). In HSDP IV

implementation period, development partners' contribution has covered 49.9% of the total health expenditure. During this program implementation, the financial commitment and actual donation of development partners to Ethiopian health sector has shown an increasing trend. In spite of its increasing trend, there was a variation between the pledged and actual disbursement amount of the donors during program implementation fiscal years. This is because of some development partners failed to actualize their commitments. For instance, CSO and ISS in 2010/11; global fund for malaria in 2011/12; UNFPA and USAID in 2012/13; Italian cooperation in 2013/14 and UNFPA, GAVI, global fund HIV/AIDS. DFID, Italian cooperation and UNICEF in 2014/15 were aid donors to Ethiopian health sector which totally failed to disburse their pledge during HSDP IV implementation (HSDP, 2011; HSDP, 2012 HSDP, 2013; HSDP, 2014; HSDP, 2015).

Irregular aid disbursement and uncertain financial flow on the future can undermine long term effort to build health system especially in the country like Ethiopia aid covers most of the sector's budget (Moon and Omole, 2013). The key areas of the health sector in Ethiopia heavily financed by donors (WHO, 2013). Since the spending of government is minimum on health and the donors' fund was the major sources of health care finance in Ethiopia, while the donors' commitment was not fully disbursed, this is a problem for Ethiopian health sector.

In 2009, Wamai (2009) has conducted research on health system development in Ethiopia and found that many of HSDPs objectives remained unachieved due to various reasons. The maximum cost for health service covered by household at that time challenged the health service utilization improvement. Imbalanced spending of health budget among regions and shortage of human resources for health listed as a major problem in his study. Similarly, In 2007, Amarech (2007) conducted study on the impacts of user fees on health services and she found that user fee cost recovery decrease health demand and exposed poor people for more problems because of their spending most of their income on health.

Despite the programmed aid to health play a significant role since HSDP III implementation, both studies did not discuss the contribution of development partners for Ethiopian health sector in depth. The purpose of this study is to fill the gaps which were not discussed in both investigations. The first one is the time gap, both of the previous studies deal with HSDP III implementation but this study deals with HSDP IV (2010/11-2014/15) which was the final program of HSDPs and finished in the same year with the millennium development goals. The

second one is the contribution of development partners to the health sector of Ethiopia was discussed in depth under this study.

1.3.Objective of the Study

1.3.1. General Objective

The overall objective of this study is to investigate the contribution of development partners for Ethiopian health sector and to identify the reasons of the gap between the amounts of money pledged by the development partners and the actually donated money during the implementation of HSDP IV.

1.3.2. Specific Objectives of the Study

Specific objectives of the research are:

1. To examine the areas of health financed by foreign aid
2. To assess the relation between foreign aid to health sector and health development in HSDP IV
3. To assess the gap between pledged and actually disbursed money in HSDP IV
4. To investigate how the sector uses foreign aid for health development in HSDP IV

1.4.Research Questions

The research paper aspires to address the following research questions

A. Which areas of health are financed by foreign aid?
B. What is the relation between foreign aid and health development in Ethiopia?
C. How development partners did disbursed their commitment for health sector in HSDP IV and what are gaps between their commitment and disbursement?
D. How did the sector use foreign aid for health development in HSDP IV?

1.5.Research Methodology

1.5.1. Methods of Data Collection

So as to come up with deeper and comprehensive understanding of the role of foreign aid in health sector development program IV in Ethiopia, the research adopted both qualitative and quantitative research approach. The total population of the study is 50 people from Federal Ministry of Health of Ethiopia and donor organizations. Of the total 13 (thirteen) were selected

as a sample by using purposive sampling technique based on their experience on the study area. Except grant management office workers most of the interviewees had more than ten year experience in the health sector.

This sampling technique helps the researcher to collet important data about the study from the key informants or right persons who can provide relevant data for the success of the study.

The researcher used both primary and secondary sources. The primary data used in this research were collected through interview from different departments in Federal Ministry of Health, which include Resource Mobilization and Utilization, Plan Policy Office, Grant Management Office, TB Case Team, Malaria Case Team, HIV/AIDS Prevention and Control Office, Maternal and Child Health Program and UNFPA country office.

Different Books, journals, and different reports on related topics were used as secondary data sources. HSDP IV annual performance reports were used to understand how the existence of foreign aid brought a change on the health areas heavily financed by foreign aid and how much of the pledged money were disbursed by donors in HSDP IV. Since the study was qualitative research, the data collected from the respondents were analyzed and summarized in text analysis. Tabulation, graphs and description were used to analyze and present the obtained data to make it easily understandable for readers of the research.

1.6. Significances of the Study

To sustain health development in a given country, the necessary resources should be available. However, least developed countries like Ethiopia need foreign aid for sustainable health development still their income capacity will be able to allocate the necessary expenditure for the health sector from the government budget. Foreign aid has played a crucial role for Ethiopian health sector during HSDP IV implementation. This study assessed the role of foreign aid to health development in Ethiopia during HSDP IV implementation and identified the problems related to foreign aid to the health sector. Therefore, the findings of this study will help Ethiopian health sector and the donors to examine the role and problems of foreign aid to health sector and to find solution by conducting further studies on the problems related to aid. Finally, this study will serve researchers as a source who wants to conduct further studies on the related study area.

1.7.Scope of the study

The health care finance in Ethiopia comes from variety of sources such as from government, house hold and International Development Partners. In all HSDP implementations, Ethiopian health sector has been supported financially by development partners. However, dealing with all HSDP implementation and all the sources of finance in the implementations of HSDPs are beyond the capacity of the researcher due to a limited time. Therefore, this research is limited to the role of development partners particularly channel II donors for Ethiopian health sector during HSDP IV implementation.

1.8.Structure of the Study

This paper is divided into four chapters: the first chapter deals with an introduction, which contains background, problem statement, and objectives of the study, scope of the study, research methodology and significance of the study. The second chapter deals with review of related literature and the third chapter discusses about an overview of health system in Ethiopia. The fourth chapter discusses the contribution of development partners to health development in HSDP IV implementation as well as the findings of the investigation and recommendations.

1.9. Limitation of the study

The nature of the research problem needs adequate data from donors and Federal Ministry of Health. However, the researcher has faced various problems like lack of interest to provide the primary data from donors except UNFPA country office.

Chapter Two

2. Literature Review

2.1.Review of Related Literature and Conceptual Framework

This chapter deals with certain review of existing literature about foreign aid. This research aimed at studying the issues of foreign aid pledged and actually donated money for Ethiopian health sector during health sector program IV implementation. By reviewing the previous finding the purposes of this chapter is to provide certain important idea to the reader about the study. In this respect specific important issues that associated with this study were discussed under this chapter.

Various scholars defined and classified foreign aid in different terms and different ways. There are strongly varied theoretical views on the purposes of aid: Liberals believe the purposes of aid for cooperation and realists believe the purposes of aid to facilitate donor interest that enhancing power and security of the donor this was also discussed in this chapter. Foreign aid and its effectiveness become an important issue since the global policy of MDGs declared, in this regard the international forums regarding aid effectiveness in order to achieve MDGs goals set out within specific role of donors and aid receivers deliberated. Despite its importance, foreign aid to the health sector has been irregularly disbursed; therefore the reasons of this fluctuation addressed in the chapter. Finally, the donors of Ethiopian health sector and supported areas reviewed in this chapter.

2.2.What is Foreign Aid?

Foreign aid is an official financial flow from the government of developed countries to the government of developing countries in grant form or loan at rate less than market interest rate (OCED, 2012). It include technical assistance, and commodities that are designed to promote economic development and welfare as their main objective thus excluding aid for military or other non-development purposes (Radelet, 2006). Foreign aid is the gift of public resources from one government to the other government, or an international organization and nongovernmental organization, for the purposes of improving humanitarian relief in aid receiving countries (Lancaster, 2007).

According to Moyo (2009), foreign aid can be classified in to three parts. These are: humanitarian or emergency aid, Charity based aid and systematic aid. Humanitarian or emergency aid is given in response to catastrophes and calamities. Charity-based aid is the aid disbursed by charitable organizations to institutions, or people on the ground; and systematic aid, is the aid payments made directly to governments either through government-to-government transfers or bilateral aid, or transferred via institutions such as the World Bank also known as multilateral aid. For Example within two year (2010-2012) $6 billion humanitarian aid was disbursed to Haiti (Ramachandran and Walz, 2012) lives). In response to the 2004 Asian tsunami which causing a loss of nearly 230 000 lives, a national and international aid program amounting in total to perhaps US$17 billion or more was organized to support relief, rehabilitation and reconstruction projects following the tsunami(Jaysuriya and McCawley,2010).

2.3.Theoretical and Conceptual Framework

Foreign aid is controversial and debatable issue among many scholars and politicians, in relation to its role as facilitator of development in aid receiving countries, or the policy game of the donors (Svensson, 1995). There are different international relations theoretical perspectives about the purposes of foreign aid prominently realism and idealism in strong debate either aid given to promote development in developing countries(helping the poor to escape from poverty or serve as policy tool of the donors(to maintain their power and security of the donor) (Lancaster, 2007). The following section explores the purposes of aid for different theory advocators and aid effectiveness.

2.3.1. Theoretical Views on Purposes of Aid

According to realist theory, the relations among states are best understood by focusing on the distribution of power among states (Griffiths et al, 2009). In this respect aid program primarily designed to facilitate donor interest that enhancing power and security of the donor (Van Belle et al, 2004). For the realist theory, however, foreign aid is the tool of foreign policy of the powerful states that originated in the Cold War to influence the political judgments of recipient countries in a bi-polar struggle (Hattori, 2010). During the Cold War period, policy makers imagined that foreign aid could create stability abroad, assumed that foreign leaders who received aid would be willing to support the United States in the international arena (Taffet, 2007). Political relationships between donors and receivers are the most important determinants of aid flows

rather than economic development (Radelet, 2006). Aiding developing countries has been a key tool of American economic statecraft since World War II, and the primary way for the United States to engage other nations in pursuit of its foreign policy goals (Milner et al, 2007). The US has targeted about one third of its total assistant to Egypt and Israel, France has given overwhelming to its former colonies and Japan aid is highly correlated with UN voting pattern. As a result, bilateral aid is weakly associated with poverty, democracy and good governance (Alesina and Dollar, 2000)

The Kyrgyzstan's geographical location is politically important for two competent states in the world. Since the attacks of September 11, 2001, in the United States; there was Russo-American competition over the use of Kyrgyzstan airfield. The Americans were able to maintain Kyrgyz air access for the Afghanistan campaign through a $150 million aid package, including $18 million in rent. This uneasy balance remained for a few years, with U.S. support buying access to the air base. While on a visit to Moscow in early 2009, the Kyrgyz president announced that the Americans had 180 days to vacate the base. Russia had offered Kyrgyzstan a $300 million loan for economic development, a $150 million grant for budget stabilization (Werker, 2012).

In contrast to the realist view, idealists claim that national interests should be minimized, or eliminated from aid calculations. Aid should instead be guided by transnational humanitarian concerns, targeted at improving the conditions of the broader populations within the recipient states. Idealists believe that progress, development and cumulative advances in the human condition can then be stabilizing, with the increasing satisfaction of individuals within the states that achieve such gains, reducing their willingness to put that comfort at risk through warfare and conflict (Van Belle et al, 2004).

Liberal internationalists and others of the liberal tradition in international relations see foreign aid as an instrument of states to cooperate in addressing problems of interdependence and globalization (Lancaster, 2007). Neoliberal discourse implies that by making aid allocations conditional on economic liberalization and democratization, aid is a means to better governance. Democratization and decentralization are thus valued for their ability to introduce political competition promoting accountability (Meyer, 2012).

For Marxist scholars, the purpose of foreign aid is to serve as a tool for dominant states at the center of world capitalism, and to help them control and exploit developing countries.

According to constructivists view, economic foreign aid cannot be explained on the basis of donor states' political and economic interests, and that humanitarian concern in the donor countries forms the main basis of support for aid. Support for aid is a response to world poverty, which arose mainly from ethical and humane concern and, secondly, from the belief that long-term peace and prosperity is possible only with a generous and just international order where all could prosper. As constructivists' interpretation, aid through the prism of ideas, norms, and values, especially the social democratic traditions prevailing in those countries (Lancaster, 2007)

Therefore, for realism theory advocators aid is minimally related to recipient economic development and the humanitarian needs of recipient countries. In contrast, idealist scholars are positive about foreign aid's ability to solve the problems of Third World poverty and underdevelopment. Thus, this theory also states that donors may give foreign aid to support the spread of democracy and human rights (Fuller, 2002).

2.3.2. Conceptual Framework

Liberals see international relations as a potential realm for cooperation, progress and purposive change (Griffiths et al, 2009). Regardless of other hidden objectives of the donors, in the recent world the main objective of foreign assistance, is reduction of world poverty specially in developing countries (Barder, 2009) that include a number of social goals health, education, social inclusion, democratization, gender equality and sustainability (Barrat, 2008).

Today, in many of the world's poor countries, activities funded by aid from foreign governments and international organizations are widespread and familiar. In line with this, aid facilitates a lot of development activities in developing countries. For instance, aid helped in the expansion of primary education in rural Uganda, supported girls' education in Peru, and helped in financing the budget of the Ministry of Education in Ghana, children in Guatemala, Indonesia, and Ethiopia and in numerous other countries are inoculated with aid funded vaccines (Lancastor,2007).

The world community agreed that aid should be targeted to reduce poverty and established the Millennium Development Goals (MDGs) for development. The millennium agenda of goal number eight deals with the global partnership that focused on donor countries rather than recipient countries in an attempt to encourage aid reform of the highly developed countries (UN, 2000).

In 2005, they agreed a series of targets for making aid more effective in achieving these results, as well as to sharply increase aid. Though these targets have not all been met, they have increased the volume and the quality of aid. Moreover, the MDG framework with its social sector focus has helped to make sure aid benefits to poor people. The Monterrey Consensus calls upon recipient and donor countries, as well as international institutions, to make aid more effective through improved harmonization and coordination.

In the recent time debate regarding foreign aid among many scholars is its effectiveness with its objective of poverty reduction in developing countries. Even though foreign aid is a centerpiece of development policy in Africa; it makes the poor poorer, and growth slower. Accordingly, foreign aid did not achieve the objective of reducing poverty and promoting development in developing countries, (Moyo, 2009).

The attention given to foreign aid since the declaration of millennium development goals especially in the health sector is due to most of developing countries depend on aid for their health service finance and in order to achieve health millennium development goals. The developing countries will not be able to achieve their numerous goals, targets and other objectives without additional international support in a variety of forms and the removal of external impediments to development (UN, 2007). In this regard in the following section the literature survey deal with the role of aid to health sector by considering international forum that agreed by donors and aid receivers like Paris declaration (2005) and Accra Agenda for Action

A large share of Western countries' aid to developing countries goes to sub-Saharan Africa. The region's share of Western Countries aid increased from 29% percent in 1978/79 to 41% in 2008/ 09 (Deaton and Tortora, 2015) Among the sectors that provide social services, the health sector has been an important recipient of global attention and external assistant due to health recognized as the key determinant of economic growth, labor force productivity and poverty reduction (World Health Organization, 2007).

Africa is the continent with the world's highest mortality rates, and it is the only continent where deaths from infectious disease still outnumber deaths from chronic disease. The high disease burden is further aggravated by poor health infrastructure in the region (African Medical and Research Foundation, 2012). Aid to sub-Saharan African countries has increasingly been targeted toward health (Deaton and Tortora, 2015). Health intervention in low-income countries,

considered as a means of reducing poverty has been common amongst all the main international donors (David et al, 2003).

Health aid has produced tangible results, saving the lives of millions of individuals and the livelihoods of their families (World Health Organization, 2008). Since 2005, with help from the US President's Emergency Plan for AIDS Relief (PEPFAR) and from the Global Fund to Fight AIDS, Tuberculosis, and Malaria antiretroviral therapy has become more widely available and out of nearly 30 million who were eligible in low- and middle-income countries, 9.7 million people were receiving antiretroviral therapy by December 2012(Deaton and Tortora, 2015)

In 1990, maternal mortality ratio in Rwanda and Burundi was 1400/100,000 and 1300/100,000 respectively. In the same period, under five mortality ratio was 151.8/1000 and 170.1/1000 in both country. From 1990 to 2010 Rwanda received $9.92 per capita and Burundi received $3.82 per capita, and Rwanda received 160% more health aid than Burundi. During 2010, maternal mortality ratio in Rwanda was 390/100,000 while in Burundi was 820/100,000. In the same period, under five mortality ratio in Rwanda was 63.6/10000 and 93.6/1000 in Burundi (Pearson, 2015). In this regard increasing the amount and quality of aid to the health sector can improve the health of people in aid receiving country.

2.3.2.1.Paris Declaration and Accra Agenda for Action

Paris declaration (2005) and Accra agenda for Action (2008) set out the principles how aid would be effective to meet health millennium development goals in aid reliant countries. Paris Declaration is an international agreement that endorsed on 2nd March, 2005, based on the following principles that obliged the donors and receivers in different way.

Ownership: Poverty in the poorest countries can be dramatically reduced only if developing countries put well designed and well implemented plans in place to reduce poverty and only if rich countries match their efforts with substantial increases in support (UN et' al, 2000) Accordingly, developing countries required to set their own strategies for development, improve institutions and need to invest in the development of results-oriented national health strategies, plans and budgets.

Development will be successful and sustained, when the recipient country takes the lead in determining its own development goals and priorities and sets the agenda for how they are to be

achieved. GHPs will contribute, as relevant, with donor partners to supporting countries fulfill their commitment to develop and implement national development strategies through broad consultative processes; translate these strategies into prioritized results-oriented operational programs as expressed in medium-term expenditure frameworks and annual budgets; and take the lead in coordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector. Civil society, including Parliament, is largely excluded from health policy decision making (Action for Global Health, 2010). Without the participation of civil society it will be difficult to prioritizing the program.

Alignment: For aid to be effective, partners must develop reliable national development strategies, and donors must support and use strengthened local systems. All development partners must aim to report in a timely manner the size and duration of commitments and timing of disbursements in order to support stronger countries budget and planning processes. Also, they must aim to report on alignment to program-based approaches in health and on using country systems. However, according (WHO, 2008) in most of developing countries alignment is a particular challenge in the health sector to undermine progress in health outcomes.

Using country systems in health sector is mechanisms such as sector-wide approaches and national planning, budgeting, procurement and monitoring and evaluation systems. To progressively rely on country systems for procurement when the country has implemented mutually agreed standards and processes; and to adopt harmonized approaches when national systems do not meet agreed levels of performance (2007). If the national government procurement system is complex, it will be difficult to the health sector to provide necessary health equipment on time and health outcome will be poor. Even curable disease can be the reason for death of many people since the necessary equipment and drug is not available for treating the patient on time. According to Alesina and Dollar (2000), the bureaucracy of the receiving countries has been making aid misused.

Harmonization: Donors' aid will be more effective if all donors would adopt common procedures to harmonize aid delivery, including coordinating their actions, simplifying procedures, using common approaches and rationalizing the division of labor to reduce fragmentation and duplication. Common arrangements at country level for planning, funding,

disbursement, monitoring, evaluating and reporting to government on Global Health Partners (GHP) activities and resource flows Collaboration at global level with other GHPs, donors and country representatives to develop and implement collective approaches to cross-cutting challenges, particularly in relation to strengthening health systems, including human resource management

Managing for Development Results: Both developing countries and donors need to focus on producing and measuring results. Donors and partner countries must manage and implement aid in a way that focuses on achieving results; this entails a shift in focus from inputs to the achievement of measurable outcomes.

Health Millennium development goals were measurable and the principles set out in Paris declaration were aimed at making foreign aid effective and achieving these measurable goals. Both partaker (donors and aid receiver) should measure development outcome. In order to realize managing aid for development result in Ethiopian health sector, Joint financial arrangement incorporated into International health compact signed between donor and Ethiopian government. It may be strengthen country capacities and demand for results-based management, including joint problem-solving and innovation, based on monitoring and evaluation.

Mutual Accountability: Donors and partners must be equally responsible for development results and work together to establish mutually agreed frameworks. To ensure timely, clear and comprehensive information on GHP assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries requiring GHP support.

According to this Paris declaration, donors should provide reliable indicative commitments of funding support over a multi-year framework and disburse funding in a timely and predictable manner according to agreed schedules (WHO, 2007).

Similarly, the Accra Agenda for Action (2008) set out the way how aid to health would be effective to meet health millennium agenda based the commitment agreed in the Paris declaration of 2005. It contains Predictability: Donors will provide three to five-year forward information on their planned aid to partner countries. Country systems: Partner country systems will be used to deliver aid as the first option, rather than donor systems. Conditionality: Donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the partner country's own development objectives. And Untying: Donors

will relax restrictions that prevent developing countries from buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.

According to this forum, all development partners must aim to report in a timely manner the size and duration of commitments and timing of disbursements in order to support stronger countries budget and planning processes (WHO, 2008).

The Millennium Development Goals (MDGs) focused on three global health issues: child health, maternal health, and infectious diseases including HIV/AIDS, tuberculosis (TB), and malaria and for each health indicators the measurable targets set out though foreign aid flow to developing countries considerably increased since MDGs declaration, according to World Bank survey (2005). There was no hope to achieve health MDGs by least developed countries specifically WHO African region for the dating day 2015. In order to make aid effective and help developing countries to achieve MDGs, Paris Declaration (2005) and Accra Agenda for Action (2008) adopted.

International Health Partnership (IHP) created in 2007, aims to improve delivery of MDG outcomes and universal access to health services. All IHP signatories, International organizations, bilateral agencies and country governments to strengthened country partnerships in line with the Paris Declaration and in a way that reflects the unique situation in each country, channels support in to country owned health plans, and secures fair and sustainable financing of health systems(WHO,2014)

In line with the effort to implement better harmonization and alignment with the national plan and monitoring and evaluation with the national system, Ethiopia signed IHP compact with key partners in the health sector on August, 26, 2008 in Addis Ababa. The IHP compact signed based on mutual responsibility between Ethiopia and partners. Development Partners share this responsibility in terms of commitment to increased aid and aid effectiveness, and the government is responsible for services that are on budget and that form part of an approved sector strategy. Partner contribute to the health sector through pooled funding mechanism like Millennium Development Goals performance pooled fund, Health Pool Fund, Protecting Basic Services (WHO, 2013).

Donors funding mechanism is applied through three channels of financial management. These are Channel I pooled and managed by government or earmarked by agencies with direct

disbursement or the fund which is given to Ministry of Finance and Development of the Country. Channel II, donor held financing directly provided to the sector and channel III direct donor programmed funds disbursed by development partners to finance contribution to HSDP through NGOS.

The MDG Fund is pooled funding mechanism managed by the FMOH using the Government of Ethiopia procedures. In the framework of the Ethiopia IHP compact, it provides flexible re-sources, consistent with the "one plan, one budget and one report" concept, to secure additional finance to the Health Sector Development Program. The partnership framework is founded on the vision of „one plan, one budget, one report' key agreements, mechanisms and strategies include: the Plan for Accelerated and Sustained Development to End Poverty (PASDEP); the Health Sector Development Program (HSDP); the HSDP Harmonization Manual (HHM); the Code of Conduct to Promote Harmonization in the Health Sector of Ethiopia; the International Health Partnership (IHP) Compact signed between Government of Ethiopia and Development Partners (DPs).

The harmonization and alignment process, reinforced by the International Health Partnership (IHP) Compact and the Joint Financing Arrangement (JFA), had supported the overall program implementation, making financial support more effective and flexible. The key principle underpinning the process of harmonization and alignment is the establishment of "One-Plan, One-Budget and One-Report" to provide predictable funding in support of results-oriented national plans and strategies. A critical step towards "One Budget" is the establishment of the MDG Performance Package Fund to facilitate resource pooling in order to finance the priorities under the HSDP. As per the JFA, the MDG Pooled Fund is used to fill the financial gap in four eligible funding areas: Health Extension Program; Health Service Delivery; Procurement of Health Commodities; and Health System Strengthening.

Based the above principles aid should achieve the expected health outcome. Therefore this paper analyzed how the country's health policy and the country's system are favorable to implement these principles and contributed for health development due to aid for health sector increased in HSPD IV implementation.

2.4.Health Millennium Development Goals Progress

The Millennium Development Goals (MDGs) are a powerful tool for focusing the world's attention on development issues, particularly those issues that need to change. Health is central to development, thus all of the eight MDGs set for 2015 involve health-related issues, but the following three refer directly to health: MDG 4 to reduce child mortality; MDG 5 to improve maternal health and achieve universal access to reproductive health,; and MDG 6 to combat HIV/AIDS, malaria and other diseases (World Health organization 2014)

Regarding maternal mortality, developing regions account for approximately 99% of the global maternal deaths in 2015, with sub-Saharan Africa alone accounting for roughly 66% (World Health Organization, 2015).The maternal mortality ratio dropped by 45% worldwide between 1990 and 2013, however, maternal deaths are concentrated in sub-Saharan Africa and Southern Asia, which together accounted for 86% of such deaths globally in 2013. Less than five age death of children declined by 50% from 1990 to 2015 worldwide. Sub-Saharan Africa carries about half of the burden of the world's under-five deaths 2015 (UN, 2015).

Concerning with reducing the prevalence and incidences of communicable diseases, new HIV/AIDS infection, falling from 3.5 million to 2.1 million from 1990 to 2013(WHO, 2015). Sub Saharan Africa burdened with 1.5 million new infections. AIDS related death declined by more than 50% globally, but it remains the number one killer of adolescents in Sub Saharan Africa. The gains in treatment are largely responsible for a 26% decline in AIDS-related deaths globally since 2010 Treatment coverage in Latin American and the Caribbean reached 55% in 2015. In the Asia and Pacific region, coverage more than doubled, from 19% in 2010 to 41% in 2015. Western and central Africa and the Middle East and North Africa also made important gains but achieved lower levels of coverage in 2015, 28% and 17% respectively. In Eastern Europe and central Asia, coverage increased by just a few percentage points in recent years to 21% 20–23%about one in five people living with HIV in the region (UNAIDS, 2016).

Between 2000 and 2015, the global malaria incidence rate has fallen by an estimated 37 percent, and the global malaria mortality rate has decreased by 58%. TB mortality rate has fallen by 47% since 1990 and TB incidence rate has been falling in all regions since 2000, declining by about 1.5% per year on average (UN millennium development goals report, 2015).

2.5.Condition of Aid Flow to the Health Sector

The agreement, adopted by heads of state at the International Conference on Financing for Development in Monterrey, Mexico, in March 2001, contains commitments by all countries for specific actions to help low-income countries achieve the Millennium Development goals. According to this monetary consensus donors committed to increasing the quantity of aid as well as improving the quality of aid. The main responsibility for accelerating development lies with the governments of poor countries was must put in place appropriate policy and institutional frameworks. Consequently after this monetary consensus several countries increased the size of their ODA disbursements significantly (Radelet, 2004).

Aid to health sector increased by more than double fold from 1990 to 2010 (Moon and Oomle, 2013). However, despite the various on commitment adopted, aid ineffectiveness challenging the sector and exposed for health poor output in the most aid reliant countries (World Health Organization, 2007). In many African countries, external resources account for a substantial proportion of total health expenditure. However, due to its mostly fragmented and unpredictable, it raises the question of sustainability (World Bank, 2013).

Aid disbursement is irregular it mean some donors did not disburse their commitment or pledged timely and information on future financial flows are uncertain, which is particularly damaging for aid dependent countries (Moon and Omole, 2013). Commitment or pledged is financially-backed written documents in which donors undertake to provide financial assistance to recipient countries directly or through multilateral organizations. However, disbursement is the actual donation or the amount of aid transferred from donors, in cash, in kind (valued at the cost to the donor) or in services (Maeles et al, 2013) Sub-Saharan Africa with 11% of the world's population, share the burden of sever and death due to these majors health problems by more than 50% (Harmonized Health for Africa, 2015,). Many factors contributed to the lack of progress: weak governance and accountability, political instability, natural disasters, underdeveloped infrastructure, health system weaknesses, and lack of harmonization and alignment of aid. Other key factors explaining limited progress have to do with how health systems are financed (Ibid)

Most of Sub Sahara states' health sectors are heavily reliant on external funding as well as user fees (USAID, 2010). Foreign aid covers 25.9% of total health expenditure in the low income

countries, where most of Sub Saharan states exist (Moon and Omole, 2013). However, in some of Sub Saharan states health sectors foreign aid covers more than 25.9% of their health expenditure for instance, foreign aid covered 49.9% of health expenditure in Ethiopia during HSDPIV implementation (NHA, 2014). The share of government, household and external assistance for health expenditure varied from country to country based on their level of income. For instance, Burundi, Democratic Republic of Congo, Liberia, Malawi, Serra Leone, Ethiopian, Nigeria, Madagascar, Eritrea, Central African Republic and Guinea are heavily dependent on external assistance for health expenditure. Especially Democratic Republic of the Congo (DRC), Ethiopia and Uganda are the countries remain with the largest health financing gaps even in 2020 (USAID, 2013).

Table 2 : African countries remain with large health financing gap for 2020

Countries	**Estimated health financing gap for 2020**
Democratic Republic of the Congo (DRC)	$3.9 billion
Ethiopia	$3.2 billion
Uganda	$1.2 billion

Source USAID, 2013:9

2.6.Why Foreign Aid was Irregularly Disbursed?

Out of various reasons that distort aid flow, one is global economic crisis which brought uncertainty and risk to all sectors in Africa, in particular concern for the health sector. Africa relies to a large extent on external funding of health care, so contraction in donor country economies may very well lead to reduced funding for health programs (USAID, 2010). The two-thirds of all HIV/AIDS expenditures in Africa come from external sources while international investments for HIV/AIDS dropped by 13% from 2009 to 2010 declined from US$ 8.7 billion to US$ 7.6 billion. In 2011, the Global Fund cancelled its next round of new funding proposals due to financial constraints arising largely from the failure of donors to meet their financial commitments to the Global Fund. Aid dependency creates enormous risks, since external aid remains unpredictable and can fluctuate considerably from year to year (UNAIDS, 2012).

Table 3: Aid to health development providers decrease involvement due to global economic crisis

Countries	Impacts on donors support
D.R Congo	DFID and The Belgian Cooperation decreased their involvement in health ,
Lesotho	Irish Aid limiting their contribution
Liberia	The drop in value of the British pound reduced the Pool Fund's (and other) DFID contributions by 25%.
Benin	Switzerland pull back from health sector support
East, Southern Africa Region	DFID has cut their regional HIV/AIDS annual budget. Irish Aid anticipates a major cut in their regional OVC budget, Swedish SIDA is anticipating particularly heavy cuts in its foreign aid

Source: USAID, 2010:5

The second factor is aid effectiveness; more effective aid can help to speed up progress in the health sector (Pereira, 2009). Donors' support for health sector in developing countries based on the Paris Declaration on Aid Effectiveness (WHO, 2012). Results oriented financing is an instrument that links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered. Linking payments to performance strengthens the governance of the system and allows ongoing monitoring of the results that government and partner resources are buying. It has been extensively tested in Africa as a promising approach to work towards Universal Health Coverage.

> Average per capita health spending is low in Africa, but higher than in South Asia. As of 2010, the Principal regions receiving aid to health by total amount were sub-Saharan Africa $8.07 billion, or 29% and South Asia $1.78 billion, or 6%.Yet South Asia, in general, has better health outcomes. So Africa not only needs more money for health, it also needs more health for the money (World Bank, 2013).

Another factor is political conditions in aid receiving countries: poor records on the practices of human rights decline the donors' interest to involve in financing health sector in developing countries. For instance, after 2005 election result reported most of international health partners declined their financial contribution due to human right violation (Periera, 2009). The pledge and

actual donation for health sector during HSDP III implementation was the best evidence (HSDP III, 2008, 2009 and 2010).

2.7.Global health Initiatives and Supported Areas

As part of the scaling up of international development assistance numerous health initiatives have been established. These initiatives focus on global partnerships, and are typically programs targeted at specific diseases work on different aspects of the health sector using varied modes of intervention. Some of them are targeted at specific diseases, such as AIDS, tuberculosis, malaria and immunization, as well as maternal and child health. Others are working on different aspects of health systems, for example health information systems, drug supply, human resources (WHO, 2014).

The Global Fund for the explicit purpose of providing financial assistance to low and middle income countries in their fight against tuberculosis, AIDS and malaria (OECD, 2012). GAVI Alliance contribute financing the cost of the vaccines in developing countries and Partnership for Maternal Newborn & Child Health (PMNCH) is a global health partnership to accelerate efforts towards achieving MDGs 4 and 5, reducing maternal and child death. The International Drug Purchase Facility (UNITAID) provides sustainable funding to boost the availability of affordable medicines and diagnostics for HIV/AIDS, malaria and tuberculosis.

Muskoka Initiative on Maternal, Newborn and Child Health, which also works to accelerate progress on MDGs 4 and 5, is a funding initiative announced at the 36th G8 Summit that commits member nations to collectively spend an additional US$ 5 billion between 2010 and 2015 to accelerate progress towards the achievement of MDGs 4 and 5, the reduction of maternal, infant and child mortality in developing countries (WHO, 2014).

Roll Back Malaria Partnership which was launched in 1998 is a global health initiative created to implement coordinated action against malaria. The initiative is composed of a multitude of partners, including countries endemic with malaria; bilateral and multilateral development partners; the private sector; nongovernmental and community based organizations, (WHO2014)**.** President's Malaria Initiative focuses on expanding coverage of four highly effective malaria prevention and treatment interventions to the most vulnerable populations: pregnant women and children less than 5 years of age.

These interventions are: insecticide-treated mosquito nets; indoor residual spraying with insecticides; intermittent preventive treatment for pregnant women; and prompt use of artemisinin-based combination therapies after malaria has been diagnosed (WHO, 2014). Civil society organization (CSO) is a key contributor to health care financing in Africa. Due the funding for the health sector is largely donor-driven in the region, several CSOs have had to focus on the management of health funds and advocacy for increased funding for the health sector. In SSA, the contribution made by non-profit organizations serving households has increased by almost 50% in the 5-year period from 2006 to 2010. The increased funding in the sector is largely HIV/AIDS-focused (AMREF, 2015).

2.8.Ethiopia and Global Health Partners

Apart from direct budget support to the different levels of the government through the Ministry of Finance and Economic Development, implementation through civil society organizations (CSOs) and self-implementation, partners channel their funds through various modalities. MDGs Performance Pool Fund set up under the framework of the IHP compact and its Joint Financial Arrangement (JFA). It is a pooled funding mechanism managed by the FMOH using Government's procedures, and provides specific federal grants for public goods and capacity building activities for health system strengthening. During HSDP IV implementation, various partners contributed under this channel. During the beginning year of HSDP IV DFID, WHO, UNFPA, Irish Aid and Spanish Aid disbursed under this channel (HSDP, 2011). In the next fiscal year three donors, namely Australian aid, Italian cooperation and UNICEF joined this channel (HSDP, 2012). In 2012/13, Netherland Embassy (HSDP, 2013), in the 2013/14, GAVI (HSDP, 2014) and in the 2014/15, European Union joined the channel (HSDP, 2015).

The technical assistant pooled fund was also one pooled funding scheme and supports implementation activities with focus on procurement of technical assistance. It was funded by Australian Aid, DFID, UNICEF and Italian Cooperation in HSDP IV and USAID contribute for this channel in 2013/14.

Protecting Basic Services (PBS): This is a basket fund for basic services (like health and education). It is managed and monitored using World Bank procedures. The World Bank and other international development partners (DFID and CIDA) provide funds, through government channels, targeted at protecting and promoting basic services for the poor.

Table 4: Programs supported by Foreign aid in Ethiopian health sector and donors

Health Programs	Multilateral	Bilateral
HIV/AIDS, Malaria and TB prevention and control	UN System/UNDAF, WB/EMSAPII, Global Fund	Italian Development Cooperation, , CDC, USAID CIDA, Irish Aid
Food and Nutrition, including promotion, relief, recovery and Development.	WHO, WFP, FAO, UNICEF, IOM, IAEA, UNFPA,WB, AfDB, IFAD, OCHA,UNHCR, UNESCO	USAID, SCF UK ,SCF US, ACF, World Vision, Goal, Concern ADRA, IMC, Care, Merlin
Health System strengthening, monitoring, HMIS and quality assurance.	WHO,UNICEF,UNFPA, WB, Health Metrics Network, GFATM, GAVI	CDC, Tulane University Ethiopia, GF, IDC, Irish Aid, IC, USAID
Support to Maternal and Child Health Services,	WHO, UNICEF, UNFPA. WB	USAID, SIDA, DFID, RNE Irish Aid, JICA, AEICD
Support to Health Extension Program	WHO, UNICEF,UNFPA	USAID, DFID
Strengthening health care referral system	WHO, UNICEF, UNFPA	Clinton Foundation, USAID
Capacity building for Human Resource Development in the health sector.	WHO, UNFPA	USAID, Tulane University, IC, Irish Aid
Strengthening control of vaccine-preventable and other major communicable diseases	WHO, UNICEF,GAVI	EU, JICA, CDC, Rotary, IFF, IM, Russian Global Fund, Irish Aid, AEICD
Capacity development for health laboratories and research performance	WHO	USAID, CDC, Irish Aid
Support to appropriate and widely disseminated IEC/BCC programs	WHO, UNICEF, UNFPA, GFATM	
Capacity building for health Commodity supplies.	WHO, UNICEF, UNFPA	Royal Netherlands Embassy, Irish Aid, DFID, USAID
Water, hygiene and sanitation	UNICEF, WHO	RNE, Irish Aid, AEICD, USAID

Data source, WHO, Regional office for Africa 2013:25

Almost all programs in the health sector in Ethiopia got financial support from development partners. The above table shows the list of major donor agencies with their areas of contribution/participation. Partners working in the interrelated areas of health, population and nutrition are bilateral, multilaterals, UN agencies, civil societies and none governmental organizations.

Chapter Three

3. Overview of Health Systems Development in Ethiopia

3.1.National Health Policy and Country's System

This chapter deals with Ethiopian health systems development. Even though shortage of money is the problem that hindering health development in developing countries, the flow of foreign aid to developing countries' health sector alone cannot promote health development. The national health policy and country's health system should be conducive to achieve the target in addition to flow of funds due to the donors support the country's system. In this respect, foreign aid effectiveness is one of Paris declaration principles that required developing countries to set their own development strategy. The purpose of this chapter is, therefore, to assess how much the country's system is favorable to advance health by using foreign aid in Ethiopia. Data used in this chapter collected from secondary sources including published and unpublished material that was documented by Federal Ministry of Health.

3.2.Mandate Analysis

Proclamation no 475/1995 of the Federal Democratic Republic of Ethiopia provides definition of Powers and Duties of the Executive Organs. This proclamation, in its part 3 No. 10 states the common Powers and Duties of the executive organs. Accordingly, initiating policies and laws, preparing plans and budget is the mandates given for them. In the same manner, Federal Ministry of Health of Ethiopia is mandated to prepare, review and implement national health policy, plans and budget. Since the donors support the country's plan, Federal Ministry of Health of Ethiopia should wisely prepare health development plan on Ethiopian health sector. Likewise, it should ensure the enforcement of laws, regulations and directives which The Federal Government of Ethiopia also gave for executive organs under this proclamation. In this respect, the health sector of Federal Ministry of health has authorized to enforce regions and woredas to accept and implement the national direction in the health sector (Federal Ministry of Health, 2010).

Undertaking studies and researches are also the mandate of Minister Offices. The Minister also enters into contracts and international agreements in accordance with the law; give assistance and advice as necessary to regions. This may encourage cooperation between Federal Ministry of Health, Regional Health Bureaus and Woreda Health Offices. Based on the above powers and duties commonly given for the executive organs, Ethiopian Federal Ministry of Health made an

international agreement with development partners in 2008 which was called International Health Compact. The agreement was signed between both signing parties regarding health financing improvement and health outcome improvement based on mutual accountability (Federal Ministry of Health, 2008).

Ethiopia has gone through two stages of decentralization: the first stage involves the decentralization of functions from the center to the regions and the second stage is from region to the woredas. The primary objectives of the political, administrative and economic decentralization policy are to increase local participation aimed at strengthening ownership in the planning and management of government services; to improve efficiency in resource allocation; and to improve accountability of government and public service to the population (Amarech, 2007).

3.2.1. Mandates of Federal Ministry of Health

The Federal Ministry of Health is vested with the following mandates (FMoH, 2010)

- Causing the expansion of health services;
- Establishing and administering referral hospitals as well as study and research centers;
- Determining standards to be maintained by health services, except in so far as such power is expressly given by law to another organ, issues licenses to and supervise hospitals and health services that are established by foreign organizations and investors;
- Determining the qualifications of professionals required to be engaged in public health services at various levels, provide certificates of competence for same;
- Causing the study of traditional medicines;
- Organize research and experimental centers;
- Devising strategies, means and ways for the implementation of prevention, control and eradication of communicable diseases;
- Undertaking the necessary quarantine control to protect public health; and
- Undertaking studies with a view to determine the nutritional value of food. Federal Ministry of Health is also responsible for referral hospitals and the national level study and research centers.

Moreover, key institutions such as Drug Administration and Control Authority, Health Education Center and Ethiopian Health and Nutrition Research Institute have specific mandates. These

mandates are related to ensuring safety, efficacy, quality and proper use of drugs; improving the knowledge, attitude, behavior and practice of the population on prevention and control of disease and health lifestyle; conducting researches and studies that will contribute to the improvement of the health of the population.

3.2.2. Mandates of Regional Health Bureaus

Regional Health Bureaus have the powers and duties to:

- Prepare, on the basis of the health policy of the country, the health care plan and program for the people of the region, and implement same when approved;
- Ensure the adherence of health laws, regulations and directives issued pertaining to public health in the region;
- Organize and administer hospitals, health centers, health posts, research and training institutions that are established by the regional government;
- Issue license to health centers, clinics, laboratories and pharmacies to be established by NGOs, OGAs and private investors; supervise same to ensure that they maintain the national standards;
- Ensure that professionals who are engaged in public health services in the region operate within the prescribed standards and supervise same;
- Ensure adequate and regular supply of effective, safe and affordable essential drugs, medical supplies and equipment in the region;
- Cause the application, together with modern medicine, traditional medicines and treatment methods whose efficiency is ascertained;
- Cause the provision of vaccinations, and take other measures, to prevent and eradicate communicable diseases;
- Participate in quarantine control for the protection of public health; and
- Ascertain the nutritional value of foods.
- They are also responsible for all types of hospitals in the region, health centers and health clinics as well as for health professional training institutions that are established by the regional government.

3.2.3. Mandates of Woreda Health Offices

The mandates of woreda health offices are to manage and coordinate the operation of the primary health care services at woreda levels. They are also responsible for planning, financing, monitoring and evaluating of all health programs and service deliveries in the woreda. Health Centers and Health Posts are responsible for primary health care services at woreda level. The division of duties and responsibilities between the federal, regional and woreda in the management and control of health providers help health sector to address health service for the local community in simple way and this contributes for health service expansion coverage in the country (FMoH, 2010).

3.3. Health Policies and Institutional Framework

The right to health for every Ethiopian has been guaranteed by the 1995 Constitution of the Federal Democratic Republic of Ethiopia (FDRE), which stipulates the obligation of the state to issue policy and allocate an ever increasing resources to provide public health services to all Ethiopians(FDRE constitution,1995, article, 41,(4)). The national health policy of Ethiopia that published in 1993 focused on expanding the primary health care system, and encouraging partnerships and the participation of nongovernmental actors as well as with the objective of contributing positively to the overall socio-economic development effort of the country (Wami, 2009). In this regard, the national health policy of Ethiopia designed and developed by centralizing cooperation with other actors in the health sector and by recognizing healthy people as development input.

3.3.1. Health Sector Development Programs

Federal Ministry of Health (FMOH) of Ethiopia had prepared a comprehensive strategic plan, and health Sector Development Program (HSDP) based on the national Health policy. The overall goal of the HSDP is to improve the health status of Ethiopian people through providing a comprehensive package of preventive, promotive, rehabilitative and basic curative health services by scaling basic infrastructure; providing standard facilities and supplies; and developing and deploying appropriate health personnel for realistic and equitable primary health delivery at the grassroots level.

The program under HSDP-I covered the first five years (1997/98–2001/02) and prioritized disease prevention and decentralizing health. The second program (HSDP-II) which runs

from2002/03–to 2004/05) was developed with an added aim of including NGOs in the implementation of a basic health package (Wamai, 2009). The third program (HSDP-III) covering periods from2005/06 to2009/10) fully reflects the commitment to the achievement of the Health Millennium development goals (MDGs) and also constitutes towards National Sustainable Development and Poverty Reduction Program-II.

The fourth program, HSDP IV, was implemented from 2010/11 to 2014/15. In the implementation of HSDP IV in order to strengthen the Health Extension Program (HEP), the organization and mobilization of the Health Development Army (HDA) was started in 2010/11 in order to capacitate families who are lagging behind in terms of adopting safe health practices; and training has been carried out in all agrarian regions (HSDP, 2011)

The phases of all HSDP have clear strategies for making targeted interventions against poverty related diseases which are HIV/AIDS, Malaria and Tuberculosis. Other focus areas of interventions are Child Survival, Reproductive Health and Maternal Health Care (FMHO, 2010/2011).

3.3.2. Growth and Transformation Plan

According to (2005) Paris declaration on aid effectiveness, one of the principles was ownership, which mandates developing countries to set their own strategy for development. GTP was a national development program as well as the main poverty reduction strategy document. GTP is inclusive of all the MDG relevant sectors and most of the targets for the sector programs are in line with MDGs. HSDP were the main medium of translating the health component of with minimum targets more or less similar with the MDGs. In addition, the GTP identified key sectoral measures and cross-cutting issues to focus on education, roads, water and sanitation, HIV/AIDS, health gender and development.

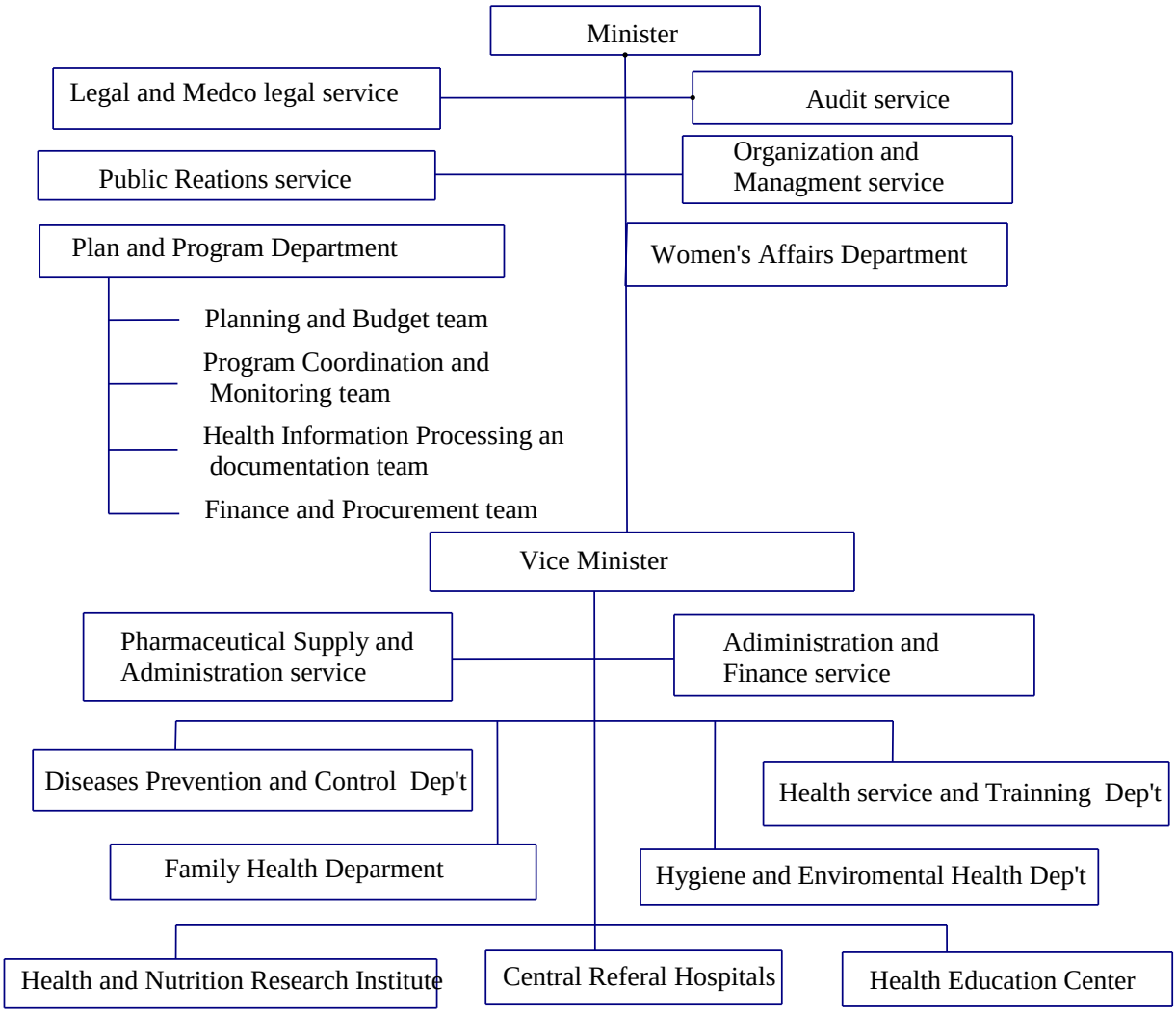
In health, in particular, it seeks to improve the balance between preventive and curative healthcare through a community-based healthcare delivery system aimed at creating a healthy environment and lifestyle. GTP will continue towards primary health care and preventive services and improving the effectiveness of services in relation to availability of drugs. Furthermore, the Government will strengthen its measures to improve the numbers, skills, distribution and management of health workers, through accelerated training of physicians (specialists and general practitioners). New systems of health care financing, including drug

revolving funds will be explored and implemented to overcome the bottlenecks in the sector (Ministry of Finance and Development, 2010). Revolving drug fund enhanced to ensure adequate supply of the essential pharmaceuticals and covers operational expenses; capital replacement; and expansion; while protecting against inflation and losses due to a number of factors including expiration of drugs. Health facilities will recollect and use user fee to procure pharmaceuticals FMoH, 2010)

3.3.3. Health Extension Program

The Health Extension Program (HEP) is an innovative community-based health care delivery system that aimed to expand primary health service coverage in rural area of the country due to majority of people live in rural part of the country. It is a family and community-based intervention, which target households to improve the health status of the families and their members by working on hygiene and environmental sanitation, family health, disease prevention and control and health education and communication. It has been also expanded to urban areas, with the aim of improving access and equity in the delivery of essential health services (HSDP, 2011).

In the HSDP IV, organization and mobilization of the Health Development Army (HDA) plan included to capacitate families who are lagging behind in terms of adopting safe health practices. HDA is the key strategy to scale up best practices by organizing and mobilizing families. The HDA will be a network created between five households and one model family to influence one another in practicing healthy life style. This network of families will be provided with technical support and training by Health Extension Workers (HEW) to implement the packages of HEP (Ibid).



Data source: Federal Ministry of Health of Ethiopia (2000)

Figure 1: Organizational Structure of Ministry of Health

3.3.4. Health Service Delivery Arrangement

The Ethiopian health service is restructured into three tier systems**.** The first tier is **p**rimary care level which has three kinds of service centers including health posts, health centers and primary hospitals. A health post is staffed with two health extension workers and serves 3,000-5,000 people and a health center is staffed with an average of 20 persons and serves 25,000 people in rural and up to 40,000 in urban areas. A primary hospital provides an inpatient and ambulatory services to an average population of 100,000 and is staffed with 53 people. The second tier is

secondary care level which comprised of general hospitals. A general hospital provides an inpatient and ambulatory services to an average of 1,000,000 people and is staffed by an average of 234 professionals. It serves as a referral center for primary hospitals. The third, tier is tertiary care level that comprised of specialized hospitals. A specialized hospital serves an average of 5,000,000 people and is staffed with an average of 440 professionals (FMoH, 2010).

3.3.5. Health Governance and Leadership

Ethiopia follows a decentralized health care system development of the preventive and curative health care delivery by public, private for profit and not -for profit players in the health sector. In this regard, government, development partners, NGOs, CSOs, participate in planning and implementation. FMOH, RHBs, ZHDs, WorHOs at all levels of the health system own the process, have the responsibility to organize and lead the planning sessions and other processes. Health development partners, NGOs, CSOs, private sector, etc take a part in consulting the plan. The plans should make sure that national priorities are addressed at all levels of the health system while taking the local priorities into consideration. The annual plans at all health systems represent the detailed operationalization of the five year strategic plan (FMoH, 2010).

3.3.6. Health Care Financing

There is a positive relationship between population growth, health demand and health expenditure. High rate of population growth increase the demand for health to expand health service coverage, which in turn increase health expenditures. Ethiopia is the second populous country with an estimated population of 81.9 million in 2011 and extremely rural country (82%) in Africa (USAID, 2012) and currently estimated the population is estimated reach 90 million. Total health expenditure of the country was increased from $1.2 billion in 2007/8 to$1.6 in 2010/11 and the estimated cost under base-case scenario for HSDPIV implementation was $8.83 billion. In order to reach health MDGs targets and to expand the health service coverage, the health sector expands the plan and the expanded plan need additional expenditure (FMoH, 2010).

3.3.7. Financing Sources of General Health Expenditures

I. Donors and international NGOs

Donors and international NGOs have been the major financial source for the health sector in Ethiopia and their contribution covers half of the total health expenditure of the country.

Development partners' contribution for the health sector increased from birr 4.4 billion of total health expenditure in 2007/08 to birr 13.2 billion in 2010/11.

II. Household

Households represent the second largest financing source, accounting for about 34% of total health expenditure in 2010/11 and also increased from birr 4.1 billion in 2007/08 to birr t 8.9billion in 2010/11.

III. Government

The share of government (federal, regional, and parastatals) accounted for close to 16% in 2010/10 and also increased from birr 2.5 billion in 2007/07 to birr 4.1 billion in 2010/11 and all other sources covers less than 1% (NHA, 2014).

3.3.8. Management of Health Resources

It refers to the various procedures and processes governing the flow of funds, through the stages of authorization, disbursement, payments, reporting, accounting and auditing. The government and household manage 49% and 34% of health resources respectively. All other financing agents together managed only 17% and insurance schemes managed less than 1% of total health expenditure. This is mainly because major donor programs including Global Fund grants, GAVI Health System Strengthening, PBS, and the MDG Performance Pool Fund are managed by the FMOH and other government agencies (NHA, 2014).

The management and control system aims to ensure accountability and transparency in the utilization of the funds so as to meet the objectives for which the funds have been provided. To facilitate this, Grant Management Unit has been established under the Finance and Procurement Directorate of the FMOH during HSDP IV implementation (HSDP, 2011).

Chapter Four

4. The Implementation of HSDP IV

4.1.Health Development and Development Partners' Contribution in HSDP IV

This chapter deals with the main part of the study. During Ethiopian health sector development program IV (HSDP IV) implementation, the substantially increased foreign aid pledged to the health sector was irregularly disbursed.

The data used in this chapter were collected through interview from federal ministry of health of Ethiopia and one donor called UNFPA. From ministry of health, 13 people were interviewed from different departments in the health sector those include Resource mobilization and utilization, plan policy of the sector, grant management office, HIV prevention and control office, malaria case team, TB case team and maternal and child health program. In addition to this, the health sector annuls performance reports and National health account was used as source of data for this chapter. Health sector development program IV implementation was started in 2010/11 with three strategic themes in the health sector (FMoH, 2010). The first strategic theme was the provision and management of curative, preventive, rehabilitative and emergency health services and the promotion of good health practices (personal hygiene, nutrition, environmental health) at individual, family and societal level. It includes provision of maternal, neonatal, child, youth and adolescent health services and public health emergency services. The second strategic theme refers to planning, monitoring, evaluation, policy formulation and implementation that is evidence-based. It also includes the development and implementation of a regulatory framework. It incorporates the equitable and effective resource allocation and leadership development within the sector and the community. The third strategic theme refers to the development, rehabilitation and maintenance of health facilities and medical equipment that meet standards and are accessible to communities being served by qualified and motivated health professionals (HSDP, 2011).

4.1.1. Health Areas Financed by Foreign Aid in HSDP IV

The researcher started data collection from Federal Ministry of Health grant management office in December, 2015. Mr. Getachew Mr. Solomon and Mr. Lakew were the workers of grant

management office in the health sector. The researcher started interview with grant management office workers on Thursday morning in grant management office.

Researcher: Which areas of health were financed by foreign aid in Ethiopian health sector during HSDP IV implementation?

According to the interview conducted with Grant Management Office of Federal Ministry of Health, all programs in the health sector were supported by foreign aid during HSDP IV implementation. According to the interview result, these programs include construction of health facilities, procurement of health equipments, drugs, health human power capacity building and etc. According to interview result, health MDGs got a priority and heavily financed by foreign aid. Data collected from grant management workers revealed that the main focus areas of health in HSDP IV were prevention and control of communicable diseases (HIV/AIDS, TB and Malaria), maternal health and child health due to its relation with the health Millennium Development Goals. In order to meet the target of MDGs set for health, these three main areas were heavily financed by foreign aid during HSDP IV implementation.

I. Diseases Prevention and control (HIV/AIDS, Malaria and TB)

The role of donors' aid in prevention and control of the major communicable and preventable diseases like HIV/AIDS, TB and Malaria were robust. They were largely financed by donors' contribution for the health sector during HSDP IV implementation. Their fund covered 83.3% of total expenditure for HIV/AIDS, 79% for malaria and 51% for TB prevention and control in 2011. The data obtained via interview also revealed that during the health sector development program IV implementation, development partners' contribution for these programs were even above the stated percentage. This is because of that development partners have supported NGOs financially which have done on this program, but that was not included when the national health account have done. Global fund was the largest contributor of all donors. Likewise, UNDAF, WB, CIDA, Italian development cooperation, CDC, USAID and Irish Aid were the financial sources of HIV/AIDS, TB and malaria prevention and control in Ethiopia the program implementation period (NHA,2014).

HIV/ADIS, TB and Malaria are the most serious public health and development challenges in Ethiopia (NHA, 2014). Of the total population, 1.5 percent of ages 15–49 are HIV positive (EDHS, 2011). The problem of malaria was the major cause of illness and death for many years.

75% of the country is malarious with about 68% of the total population living in areas at risk of malaria (NHA, 2014).

Due to this fact and the global attention given to reduce these major diseases, the health sector committed to reduce prevalence and incidences as well as death due to these communicable diseases. In line with reducing the burden of these major health problems, the health sector has developed the measurable plan for each disease in HSDP VI. In order to reduce HIV/AIDS's burden, the plan developed by Ethiopian health sector consists of increasing the proportion of eligible people who are receiving ART; reducing the incidence of HIV in adults from 0.28% to 0.14%, and increasing the proportion of population aged 15-49 years with comprehensive knowledge of HIV/AIDS from 22.6% to 80%. Regarding malaria prevention and control, the availability and use of Long-Lasting Insecticide-treated Nets (LLIN); implementing Indoor Residual Spray (IRS), expanding appropriate diagnostic testing and therapeutic management at all places of care to ensure that all patients with malaria receive prompt and effective treatment. Concerning TB prevention and control the main targets set in HSDP IV were: increasing the TB case detection, TB treatment success rate and TB cure rate from (HSDP, 2011).

II. Maternal and Child Health Service

Reducing maternal and child mortality ratio was one of the prominence health MGDs project. Less than five year population estimated to11.8 million (15%) of the total population and the mortality ratio accounted for 88/1000(88 death out of 1000 live birth) in 2011(EDHS, 2011). Maternal mortality ratio accounted for 676/100,000 in the same year (Ibid). In order to reduce maternal and child mortality ratio, donors' contribution covered 47% for maternal health and 27.1% for children health of total expenditure in 2011 .The donors of both Programs in HSDP IV implementation were WHO, WB, UNICEF, UNFPA, USAID, DFID, Spanish Aid and Irish aid (NHA, 2014).

4.2.The Relationship between Health MDGs and Foreign Aid

According to the interview conducted with one of grant management worker who manage MDGs performance pooled fund grant and the former resources mobilization an utilization director in Ministry of Health, foreign aid has been playing a significant role in Ethiopian health sector which have brought an important health outcomes. The followings are the selected health outcomes achieved during HSDP IV implementation period with the support of foreign aid.

4.2.1. The Role of Foreign Aid to Reduce HIV/AIDS in HSDP IV

The role of Foreign aid in preventing and controlling HIV/AIDS during the implementation of HSDP IV were outstanding, covering 83% of total expenditure for HIV prevention and control and the largest donor for HIV program was global fund (NHA, 2014). During the first year of HSDP IV implementation (2010/11), the global fund disbursed $129.0 million for HIV program, which increased to $ 130.6 million during 2011/12 fiscal year (HSDP, 2011/ 2012). During the next fiscal year (2012/13), the global fund disbursed $139.2 million which also increased to $ 1999 million during 2013/14(HSDP, 2013; 2014). This was the cash collected from global fund only for HIV prevention and control. In addition to this, various donors like CDC, Italian cooperation, Irish Aid, CIDA, UNDAF UNFPA, UNICEF and World Bank have contributed for HIV prevention and control under MDGs performance pooled fund for HIV program (NHA, 2014).

UNFPA is one of the development partner which works with Federal HIV/AIDS prevention and control office. According to the data obtained from the country office of UNFPA via interview, the office has been pledged $1million in each fiscal years of HSDP IV for MDGs performance pooled fund and combating HIV. Beside this, UNFPA works on areas of health Reproductive health and rights, Youth and adolescences health, population and development, health research, health human power capacity building according to the data obtained reveals.

Table 5: Antiretroviral Treatment (ART) Trends during HSDP IV implementation period

Activities	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Ever enrolled	473,772	580,919	666,147	744,339	805,948	871,334
Ever started	268,934	333,434	379,190	439,301	492,649	535,069
Currently on ART	207,733	247,805	274,708	308,860	344,344	375,811

Data source: HSDPs (2015:24)

Increasing the number of people who live with HIV in using Antiretroviral Therapy (ART) in order to sustain their life was the plan set in HSDP IV (HSDP, 2011). In this regard, as the data in above table 4 shows, the number of people ever enrolled or registered for ART increased from 473,772 to 871,334 and the number of people ever started ART increased from 268, 934 to

535,069 at the end of the program implementation. The number of people who live with HIV/AIDS and using ART was increased from 207,733 to 375,811 during the same period.

Antiretroviral Therapy (ART) is one of the instruments used to control HIV/AIDS, and the treatment is given for people who live with HIV/ AIDS without fee. According to data collected Federal Ministry of Health via interview, the drug is given without fee because of the existence of foreign aid and this significantly reduced the deaths due to HIV/AIDS. Furthermore, the interview result showed as every activity done to prevent and control HIV/AIDs has been funded by foreign aid during HSDP IV implementation. This helped majority of people to endure their life as they are poor they cannot afford to purchase the drug. Hence, the existence of foreign aid saved the life many who lived HIV/AIDs.

Table 6: The progress of health facilities in providing HCT, PMCTC and ART in (2009/10-2013/14)

Activities	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
HCT	2,184	2,309	2,881	3,040	3,447	NA
PMCTC	1,352	1,445	1,901	2,150	2,495	NA
ART	550	743	838	880	1047	NA

Data source: HSDP (2014:30)

Increasing the number of health facilities, counseling and testing service, prevention from mother to child control and ART service in order to serve all people in the country was used to reduce prevalence of HIV and sustain the life of people who live with HIV/AIDS.

As shown in the table 5 above, services of HIV counseling and testing given in 2,184 health facilities during 2009/10 increased to 3,447 in 2013/14. The number of health facilities which provides HVI prevention from mother to child increased from 1,325 during 2009/10 to 2,495 in 2013/14. In the same period, the number of health facilities that provide ART services increased from 550 to 1047 (HSDP, 2014).

Prevalence and incidence of HIV declined from 2.4% and 0.29% in the 2009/10 to 1.1% and 0.03% in the 2014/15 respectively. The proportion of pregnant women counseled and tested for the prevention of mother to child transmission (PMTCT) of HIV out of the eligible and reached 92.6% in 2014/15. Out of 2,937,814 pregnant women who received at least one ANC visit,

2,807,345 (95.6%) pregnant women tested for HIV. The percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV was estimated at 64.9% in the 2013/14 from 9.3% out of eligible in the 2010/11 due to increased number of health facilities providing the service. HIV prevalence among adult (15-49) declined from 1.4 %(1.0% male and 1.7% female) in the 2011 to 1.0(0.8% male and 1.4% female) in the 2015. The number of HIV positive population in all age declined from 846,700 in 2011 to 753,100 in 2015 and from this, the number of females represented 60%of the total. Among people who live with HIV, 72% was adult and 28% was children in 2011(Federal HIV/AIDS prevention and control office, 2014).

According to interview held with Mr. Tsegahun who works in resource mobilization and utilization of the health sector revealed, it is difficult even to think about preventing and controlling these major preventable diseases without foreign aid because of it need huge resource. For instance according Mr. Tsegahun if global fund continue as reported not to disburse in 2011, 39,000 ART users would lost their life in Ethiopia only in one fiscal year. This shows that HIV prevention and control methods were supported by foreign aid and all indicators shows improvement, one can understand as foreign aid played a significant role to reduce HIV burden in Ethiopia during HSDP IV implementation.

4.2.2. The Role of Foreign Aid in Reducing the Burden of Malaria in HSDP IV

According to the data obtained from Federal Ministry of Health, foreign aid has covered more than 79% of the total health expenditure for malaria prevention and control during HSDP IV implementation. Like HIV/AIDS, global fund was the largest contributor for this program and disbursed money continuously for this program except in 2011/12. Other development partners such as CDC, USAID CIDA, Italian Cooperation and Irish Aid have also contributed for the prevention and control of malaria. In order to prevent and control malaria various mechanisms implemented in HSDP IV implementation, including, long lasting insecticide treated nets distribution and indoor residual spray which was financed by foreign aid. Global fund contributed $32.8 million in 2010/11 and increased its contribution to $120,336,282 in the 2012/13 (HSDP, 2011; 2013). Moreover, during 2013/14 and 2014/15 again, the global fund contributed $ 86.7 million (HSDP, 2014) and $36.6 million respectively for malaria prevention

and control (HSDP, 2014; 2015). Even though there is a variation between pledged and disbursement, Global fund continuously disbursed a large amount of money for this program except in the last year of the program. In addition to global fund, CDC, USAID, World Bank, CIDA, Italian Cooperation, and Irish Aid have also been supported this program.

Table 7: Trends in Long Lasting Insecticide

Nets distribution (2009/10-2014/15)Years	**Planned to distribute**	**Distributed LLIN**	**Cumulative number reach**
2009/10	18,500,000	13,060,282	35,237,701
2010/11	11,091,890	4,279,165	39,516,866
2011/12	12,699,493	6,260,000	45,776,866
2012/13	12,562,286	1,200,000	46,976,866
2013/14	19,866,625	11,700,000	58,676,866
2014/15	NA	17,200,000	75,876,866

Source: HSDP (2015:26)

The data taken from HSDP IV annual performance reports in the above table shows as the cumulative number of long lasting treated nets for malaria prevention increased from base line 18,500,000 in the 2009/10 to 75,875,866 in 2015, yet the distributed amount in fiscal years were below the target set. With regards to vector control, HSDP reports showed that 4,636,787 households in the 2010/11; and, 4,383,819 households in the 2011/12 were sprayed. In the next fiscal years, 2012/13, and 2013/14, a total of 5,032,693 and 3,930,604 households respectively in malaria endemic areas were sprayed. During the final year of HSDP IV, a total of 5.3 million households living in the malaria endemic areas were sprayed.

According to the interview result obtained from Federal Ministry of Health, the distribution of long lasting treated net and indoor residual spray were financed by foreign aid and the service was given for people without fee. The interview result also clarifies the impossibility of giving and expanding prevention mechanisms and millions of people could be affected by malaria due to 75% of the country is malarious and 68% of the total population lives in malaria endemic areas. In addition to this, the drugs and medical equipments for malaria case treatment has been procured by foreign aid. Therefore, the role of foreign aid was very substantial to prevent and

control malaria during HSDP IV implementation and saved the life of millions of Ethiopian and significantly reduced death due to malaria.

4.2.3. The Role of Foreign Aid in Reducing TB Burden during HSDP IV Implementation

The role of foreign aid for TB prevention and control was relatively strong during HSDP IV in which 51% of expenditure was covered by foreign aid (NHA, 2014). Similar to HIV/AIDS and Malaria, global fund was the largest contributor for TB prevention and control. Other donors of Malaria and HIV were also donated for TB prevention and control (NHA, 2014). Global fund contributed $ 5,494,887 in the 2010/11 increased to $18,815,277 in 2011/12 (HSDP, 2011; 2012). In the2012/13 and 2013/14, it also disbursed $ 5,668,847, $22,483,878 respectively (HSDP, 2013; 2014) and finally, it disbursed $ 11,943,767 in the 2014/15 for TB prevention and control (HSDP, 2015).

Table 8: Trends of TB Detection, Treatment Success and Cure Rate in HSDPIV

Year	TB Detection Rate	TB Treatment Success Rate	TB Cure Rate
2009/10	35.8%	84.0%	65.0%
2010/11	36.8%	82.5%	66.5%
2011/12	NA	90.6%	68.2%
2012/13	58.9%	91.4%	70.3%
2013/14	53%	92.1%	69.1%
2014/15	67%	92.1%	77.9%

Source: HSDP (2015:46-47)

As shown in the above table the burden of TB has been reduced during HSDP implementation. The indicators of TB prevention and treatment such as TB detection rate, TB treatment success rate and TB cure rate during the implementation years of HSDP IV showed a significant progress from year to year. TB detection rate and TB treatment success rate increased from 35.8% and 84% in the 2010/11 to 67% and 92% respectively during 2014/15. In the same manner, TB cure rate increased from 65% to 77% in the same period.

In 2010/11, the prevalence of all forms of TB was estimated at 572/100,000, with the mortality rate due to TB being at 64/100,000 populations, while in 2014/15, a total of 135,831 TB cases

(all forms) were reported with a TB case notification rate of 151/100,000 populations in Ethiopia (HSDP, 2015). As the above data showed a significant reduction observed regarding TB prevalence and death was due to TB prevention and control program during HSDPIV implementation. Even though, there was a variation between pledged and disbursement of aid, global fund disbursed continuously and other donors contributed for TB prevention and control during the implementation program.

According to the interview result obtained from Federal Ministry of Health, the TB drug given for TB patient without fee was due to the existence of foreign aid and it significantly reduced TB prevalence and death due to TB case in Ethiopia. However, in the absence of foreign aid it would be difficult for the country as understood from the interview. The interviewee stated that, "If the prevalence of TB continued by 572/100,000, out of the 90 million at least 5 million would be affected and dead due to the TB prevalence which would be increased" However, due to the existence and increment of foreign aid millions of Ethiopians life was saved during HSDP IV implementation.

4.2.4. The Role of Foreign Aid in Reducing Maternal and Child Mortality during HSDP IV implementation.

Foreign aid has been played a crucial role in reducing maternal and child mortality ratio and it covered more than 47% of the total expenditure for both programs. The donors of maternal and child health service during HSDP IV implementation were DFID, WHO, UNICEF, UNFPA, USAID, GAVI, World Bank, Irish Aid and Spanish Aid (NHA,2014). DFID was the largest donor for maternal and child health development during HSDP IV implementation and continuously disbursed under MDGs pooled fund. DFID contributed under MDGs pooled fund $30,506,570 in the 2010/11 (HSDP, 2011); $81,577,543 in the 2011/12 (HSDP, 2012); $ 106,964,000 in 2012/13 (HSDP, 2013); $142,558,200 in the 2013/14 (HSDP, 2014); and $ 101,647,000 in the 2014/15(HSDP, 2015) It showed an increasing trend of DFID's contribution from year to year during HSDP IV implementation

Development partners such as World Health Organization, UNFPA, Irish Aid and AECID have contributed a total of $9,935,439 during 2010/11(HSDP, 2011). Likewise, in the 2012, WHO, UNICEF, UNFPA, Spanish Aid, Australian Aid and Italian cooperation have contributed $22, 277,231 under MDGs performance fund (HSDP, 2012). In the 2012/13, WHO, UNICEF,

Spanish Aid, Australian Aid, Irish Aid and Netherland Embassy have contributed $ 16,268,877 (HSDP, 2013). In the 2013/14 as well, the World Bank group, UNICEF, Spanish Aid, Australian Aid, Irish Aid Netherland Embassy, UNFPA, WHO and GAVI have disbursed $ 88,125,717 (HSDP, 2014). During the final year of HSDP IV implementation, $75,727,730 has disbursed by the World Bank group, Netherland Embassy, Irish Aid, UNICEF, Italian cooperation and European Union under MDGs pooled fund (HSDP, 2015).

The interview result obtained from Federal Ministry of Health, stated that large amount of donation were collected from various donors under MDGs performance fund and were allocated for maternal and child health. Health equipment used for maternal health, drug, vaccine, ambulance, and contraceptive, has been procured by MDGs pooled fund as understood from the interview. In addition to this, MDGs pooled fund used to facilitate training given to build the capacity of health man power regarding maternal and child health.

Similarly, the interview result of UNFPA country office revealed that foreign aid has played a crucial role in HSDP IV implementation with regard to maternal and child mortality reduction. The interview disclosed that the reproductive health and right components cover more than half of the budget (61.2 %), while the population and development, gender and program coordination components cover 38.8% of the total $ 85 million budget. Moreover, the trainers of maternal and child health services including health workers, medical doctors and midwiferies were supported by foreign aid and this was a big achievement and long last solution for Ethiopia regarding the reduction of the shortage of health man power.

In order to reduce maternal mortality rate and neonatal mortality rate, the ministry of health has made strong commitment through the implementation of the HSDP IV. This initiative, which is based on the principles of equity for women, primary health care and maternal care, and it, has four main pillars: family planning, antenatal care, clean & safe delivery, and essential obstetrics care. The progress of each indicators listed in the table 9 below taken from each year of HSDP IV annual performance reports and they directly contributed for the reduction of maternal death and all indicators show significant progress in HSDP IV implementation than the previous program (HSDP, 2011).

Maternal mortality ratio estimated to 676/100,000 during the beginning HSDP IV (EDHS, 2011). However, it reduced to 420/100,000 in the final year of HSDP IV implementation (HSDP, 2015).

This clearly shows the existence of foreign aid played a crucial role in improving maternal mortality ratio. The existence of foreign aid also aided to expand health service providing centers like, health posts, health centers and hospitals.

Table 9: Trends in Maternal and Neonatal Health Indicators Progress in HSDP IV

Indicators	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
ANC+1%	71.4	82.2	89.1	97.4	98.1	96.1
ANC+4%	_	_	_	_	_	67
PNC%	36.2	42.1	44.5	50.5	66.2	90
PDA by SP%	16.8	16.8	20.4	23.1	40	60.7
CAR%	61.9	61.7	60.4	59.5	63	69.9
C&SDC by HEW%	17	14.7	13.2	11.6	8.8	3.9
PWC&T HIV for PMCT %	_	33.4	36.7	54.9	57	92.6
PWHIV+ R ART%	_	9.3	25.5	42.9	60	64.9

Data source: HSDP IV, Annual Performance Report (2015:10-14)

As data presented in the above table shows, all of maternal health indicators improved except clean and safe delivery coverage by health extension workers in HSDP IV implementation. Antenatal care coverage at least one visit (ANC+1) and Antenatal care coverage at least four visit (ANC+4) reached 96.9% and 67% respectively in the 2014/15, from 71.4% and 0% in the 2009/10 respectively. In the same period, the percentage of deliveries assisted by skilled health personnel, increased from 16.8% in 2009/10 to 60.7% at the end of the program due to the number health personnels increased. Contraceptive Acceptance Rate (CAR) was near to stagnated 69% in 2009/10 and 69.9% in 2014/15. Clean and safe delivery coverage (by Health Extension Workers) declined from 29% in 2009/10 to 3.9% in 2014/15. The percentage of pregnant women counseled and tested HIV for prevention of HIV from mother to child transmission (PWC&THIV for, PMCT) increased from 33.4% to 92.4% and the percentage of pregnant women HIV positive that receiving ART increased from 9.3% to 64.9% in 2010/11 to 92.6% in 2014/15(HSDP, 2015).

The collective improvement of maternal health indicators that heavily financed by foreign aid have contributed to reduction of maternal and new born mortality indicating the role of foreign aid in contributing to save the life of millions of Ethiopian mothers and new born during HSDP IV implementation period.

Improving child health was one of the priorities in HSDP IV which set a target for the reduction of under-five mortality rates from 101 to 68/1,000 live births and the infant mortality rate from 77 to 31/1000 live births. In order to reduce child mortality, several activities were articulated in HSDP IV, including strengthening routine immunization, expansion of community and facility based Integrated Management of Neonatal and Childhood Illnesses (IMNCI), establishing newborn corners and NICUs, capacity building on program management for child health services, strengthening HEP and implementing locally relevant and effective child health interventions in pastoralist areas. Special emphasis was given to the Expanded Program on Immunization (EPI) (with campaigns supplementing regular routine programs when necessary) and IMNCI. Similar donors' support maternal and child health service but in addition to the donors listed above, GAVI disbursed a significant amount of money continuously for four year of HSDP IV implementation period. GAVI covers the cost of vaccine and different types of vaccine coverage increased instantly that directly contributes for child health (NHA, 2014). As a result, less than five mortality rate declined from 88/1000 in the 2010/11 to 64/1000 in the 2014/15.

Table 10: Trends in child Health in HSDP IV

Activities	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
P3VC%	86.0	84.7	84.9	87.6	91.1	94.4
MVC%	82.4	81.5	79.5	83.2	86.5	90.3
FIC%	72.3	74.5	71.4	77.7	82.9	86
PC3VC%	_	_	44	80	85.7	93.9
RV2VC	_	_	_	_	39	88

Data source: FOMH, Annual Performance Report (2015:16)

According to the above data in HSDP IV implementation, all types of immunization coverage have showed an improvement. Pentavalent 3 Vaccine and Measles Vaccine Coverage increased from 86% and 82.4% in the 2009/10 to 94% and 90.3% in the 2014/15 and to 90.3% in 2014/15 respectively. Pneumococcal conjugated 3 Vaccine which was started in 2011/12, increased from 44% in the 2011/12 to 93.9% in the 2014/15. And Rota Virus 2 Vaccine started in 2013/14, increased from 39% in the 2013/14 to 88% in the 2014/15. Full Immunization Coverage increased from 81.4% in the 2009/10 to 86 in the 2014/15.

The Integrated Management of Neonatal and child Illness (IMNCI) is the strategy to improve the quality of management of childhood illnesses, linking preventive and curative services so that programs, such as immunization, nutrition, and control of malaria and other infectious diseases are implemented in an integrated manner. It is, therefore, an integrated approach to child and neonatal health that focuses on the well-being of the whole child and the neonatal. IMNCI aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age by expanding service of IMNCI in health facilities and giving training of trainers for health professionals. In this regard, the number of HCs providing IMNCI increased from 1,267 in the 2009/10 to 3,033 in the 2014/15. The entire activities that contributed for the reduction of child mortality rate were financed by foreign aid indicating the role of the foreign aid in reducing the mortality rate of child.

4.3. Pledged and Disbursement during HSDP IV Implementation

Based on the principles of international health compact signed on August 26, 2008 between development partners and government of Ethiopia, development partners significantly increased the pledged and disbursement during HSDP IV implementation. In this regard, Federal Ministry of Health collected considerable amounts of cash from development partners only through channel II or cash transferred to Federal Ministry of Health account. However, there were several donors that contributed for health development of the country through Non-Governmental Organization (NGOs) and Ministry of Finance and Development (MoFD). For instance, USAID and CDC contributed a considerable amount of US dollar to support health service development through channel III (NGOs). The data presented below shows the amount of pledged and actually donated by various development partners during HSDP IV implementation (HSDP, 2011).

Table 11: Pledged and Disbursement of 2010/11

Sources of Fund	Commitment in USD	Disbursement in USD
1. MDG Pool Fund		
DFID	25,120,000	30,506,570
WHO	300,969	300,969
UNFPA	1,000,000	1,000,000
Irish Aid	1,442,392	2,217,960
AECID	6,416,510	6,416,510
2. Protection of Basic Service Sub Program B		
World Bank	22,300,000	10,000,000
Italian cooperation	10,739,000	10,739,000
Royal Netherlands Embassy	12,000,000	8,000,000
CIDA Canada	19,078,000	19,078,000
3. Global Initiative		
GAVI	23,496,345	19,600,000
CSO	1,336,345	0
ISS	2,560,000	0
Global Fund		
Malaria	71,153,810	32,793,810
HIV	143,000,000	129,700,000
TB	9,522,399	5,494,887
4. UN Partners		
UNICEF	103,979,859	111,444,578
UNFPA	14,244,663	11,395,730
WHO	9,658,645	19,471,217
5. Bilateral Donors		
US CDC	11,794,688	4,000,000
AECID/Spanish Aid	192,495	192,495
Total	485,439,775	422,351,726

Source (HSDP, 2011:89)

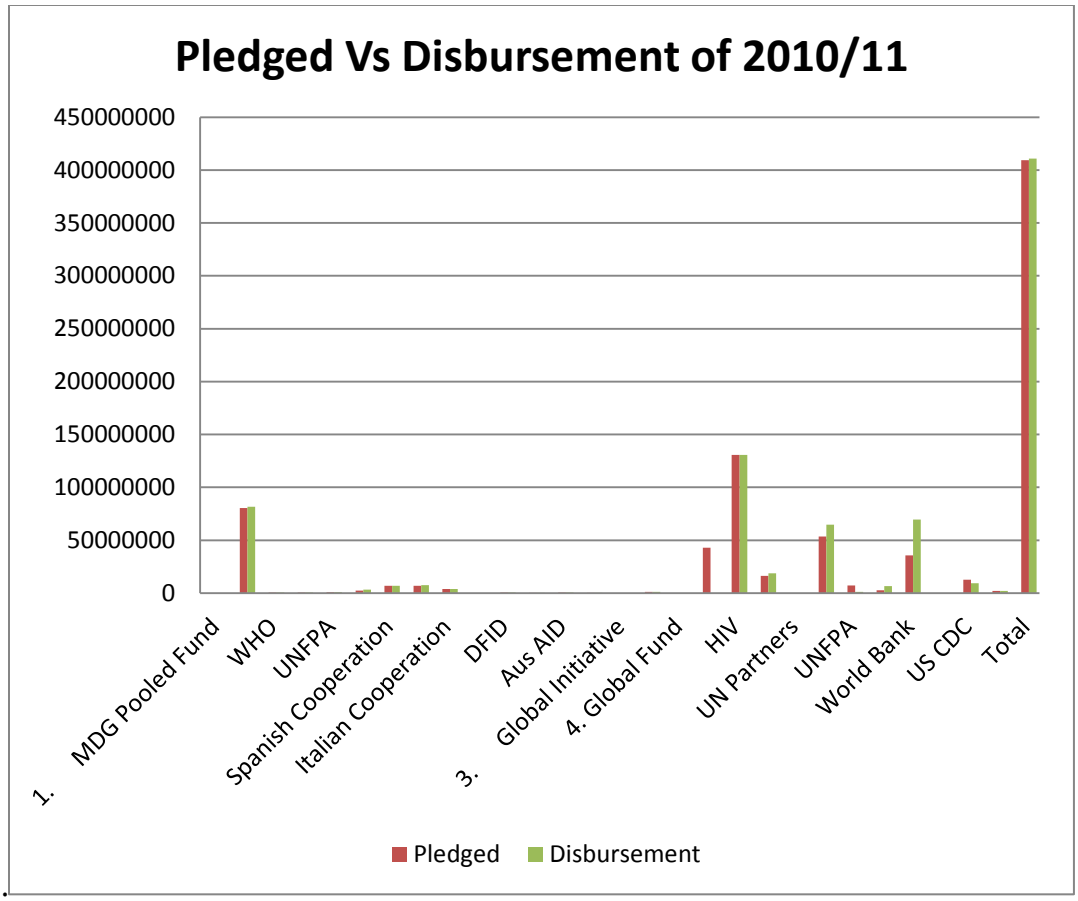
According to data in the table 10, during 2010/11 fiscal year, thirteen development partners pledged total amount of $ 485,439,775 for Ethiopian health sector, yet the disbursed amount was totaled to $ 422,351,726, which is 87% of the total pledged amount. From the total collected cash, 83% of it was collected only from five donors, namely Global Fund (GF) which disbursed 40% of the total disbursement followed by United Nations Children's Fund (UNICEF) which disbursed 26% of total disbursement. UK's Department for International Development (DFID) disbursed 7% followed by World Health Organization and Global Alliance for Vaccines and

Immunization (GAVI) in which each of them disbursed 5% of the total disbursement. CIDA, Italian Cooperation, UNFPA, World Bank, Netherland Embassy, AECID/Spanish Aid, and CDC contributed 16.6% of the total grant collected. As it is exhibited in the above table 10, , four donors: namely WHO, UNICEF, DFID and Irish aid have disbursed more than their pledge while Spanish Cooperation, CIDA and Italian Cooperation disbursed total amount of their pledge.

On the other hand, Netherland Embassy, World Bank, CDC, UNFPA, Global Fund and GAVI disbursed below their pledged and CSO and ISS not disbursed at all what they have pledged to donate.

In according to the Paris declaration principles, foreign aid was given based on the plan of the health sector and it was programmed during HSPD IV implementation. For instance, global fund finances the major communicable diseases and it is impossible to use the finance for other activities. If the sectors do not utilized for the prevention and control of communicable disease effectively in that fiscal year, the unutilized amount of money is transferred to the coming year. Indeed, the reason for global fund's disbursement of under the pledged amount was the underutilization problem of the health sector on the health areas that financed by global fund like HIV/AIDS, TB, and malaria. Likewise, the delays on the procurement of health commodities for these health areas are another reason for under disbursement. Unlike this, it was possible to use MDGs performance fund by reprogramming it and it was relatively effective. Some donors disburse more than their pledged, because of undisbursed commitment by them in the previous year and they disburse it in this fiscal year.

Despite the progress registered on the activities to achieve health MGs, the data obtained from Ministry of Health revealed that the achievement was below the plan set for the fiscal year. This shows that as the required health outcome did not achieve when compared to foreign aid given for health service most likely due to inactive system in the country.



Data source (HSDP, 2011:89)

Figure 2: Pledged and disbursement in 2010/11

The above figure (Figure2) shows the difference between pledged and actual donation of development partners for Ethiopian health sector during 2010/11.

Table 12: Pledged and disbursement in 2011/12

Sources of Fund	Commitment in USD	Disbursement in USD
1. MDG Pooled Fund		
DFID	80,620,000.00	81,577,543.68
WHO	698,772.65	698,772.65
UNICEF	500,000.00	500,000.00
UNFPA	1,000,000.00	1,000,000.00
Irish Aid	2,456,631.00	3,484,284.62
Spanish Cooperation	6,823,975.00	6,846,499.53

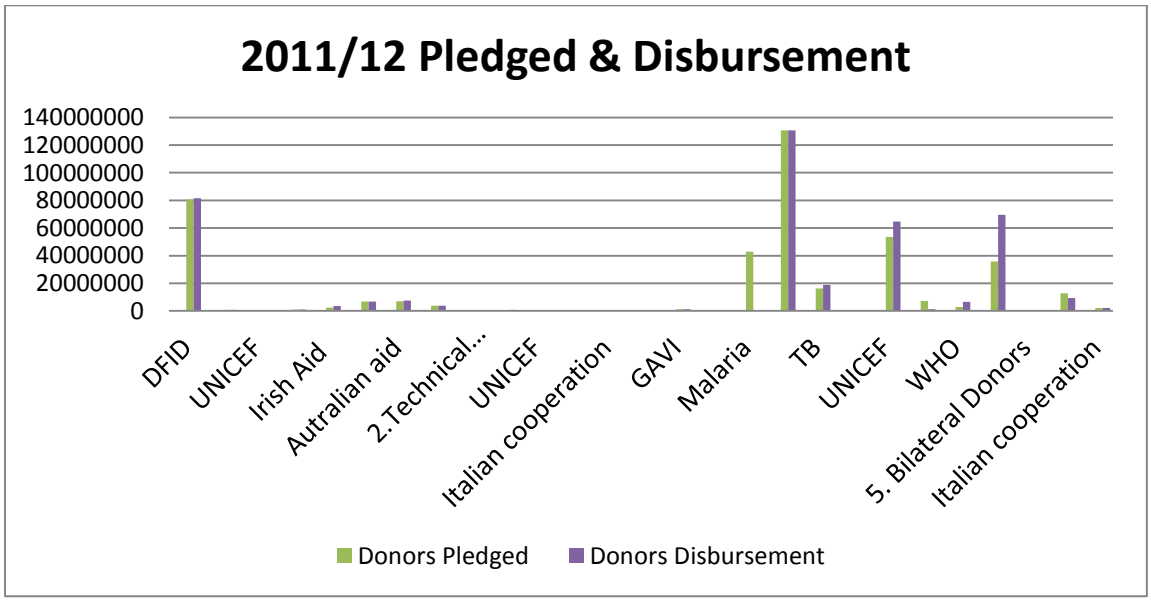
Aus AID	7,000,000.00	7,445,900.00
Italian Cooperation	3,797,853.45	3,797,853.45
2. Technical Assistance Pooled Fund		
DFID	487,314.29	703,125.00
UNICEF	153,000.00	153,000.00
Aus AID	500,000.00	500,000.00
Italian Cooperation	133,333.00	133,333.00
3. Global Initiative		
GAVI CSO	1,336,500.00	1,336,500.00
4. Global Fund		
Malaria	42,821,789.00	0
HIV	130,617,835.00	130,617,835.00
TB	16,243,298.00	18,815,277.00
UN Partners		
UNICEF	53,582,779.00	64,692,410.00
UNFPA	7,257,442.00	1,128,001.08
WHO	2,782,199.00	6,525,932.00
World Bank	35,699,898.00	69,522,568.00
5. Bilateral Donors		
US CDC	12,694,554.00	9,380,094.00
Italian Cooperation	2,137,855.22	2,137,855.22
Total	409,345,028.61	410,996,784.23

Source (HSDP, 2012:88)

Federal Ministry of Health collected $ 410,996,784.23 during 2011/12 fiscal year from different development partners. Of the total donor collected, 89.2% of it was collected from four donors. The contribution of global fund and DFID accounted for 36.4%and 20.0%,of the total grant respectively during 2011/12 fiscal year World Bank contribution followed DFID by accounting for 16.9%, and United Nations Children's Fund (UNICEF) follows which accounted for15.9%.

Four donors;namelyWHO, UNICEF, UNFPA and Italian cooperation) disbursed the total amount of their pledged while donors like DFID, Irish Aid, Spanish Cooperation and Australian aid disbursed more than their pledged. The donors of technical assistant fund DFID disbursed more than the pledged, yet the others such as UNICEF, Italian Cooperation and Australian Aid disbursed total of their pledged. Global initiatives (GAVI CSO) contributed total amount of pledged while global fund disbursed below pledged. Concerning UN partners, except UNFPA all of them including UNICEF, WHO and World Bank disbursed more than their pledged in the fiscal year. Among bilateral donors, Italian Cooperation disbursed total amount of the pledged and US CDC disbursed below pledged.

In the fiscal year(2011/12) three donors, namely UNICEF, Italian Cooperation and Asustralian Aid joined MDGs performance pooled fund. DFID and Irish Aid disbursed more than pledged like previous year and the others disbursed total amount of their pledge. The reason for variation between pledged and dibursement of foreign aid to the health sector was almost similar with the previous year. During the fiscal year of 2011/12, according to data obtained Federal Ministry of Health reveald that 43% of the collected grant in preveious year was not utlized. Hence, Since foreign aid is programed 43% of the grant given for the fiscal year was not utlized, in which one can predict as planned activities were also remained the same with the percentage.



Source (HSDP, 2012:88)

Figure 3: Pledged and disbursement in 2011/12

As shown in figure 3, there is a difference between pledged and actual donation for Ethiopian health sector during 2011/12, in which the total cash collected was greater than pledged though some donors disbursed below pledged and global fund for malaria did not disbursed at all. .

Table 13: Pledged and Disbursement of 2012/13

Sources of Funds	**Commitment in USD**	**Disbursement in USD**
1. MDG Performance Fund		
DFID	106,000,000.00	106,964,000.00
WHO		
UNICEF	1,000,000.00	1,000,000.00
UNFPA	1,000,000.00	0
Irish Aid	2,467,532.00	2,447,777.00
Spanish Cooperation	4,545,455.00	4,545,455.00
Australian AID	12,500,000.00	2,561,360.00
Italian Cooperation		
Netherlands Embassy	5,714,285.00	5,714,285.00
2. Technical Assistance Pooled Fund		
DFID	294,370.00	294,370.00
UNICEF		
Italian Cooperation		
Australian AID	516,530.00	516,530.00
USAID	1,000,000.00	0
3. Global Initiative		
GAVI HSFP	6,255,481.00	3,120,250.33
GAVI CSO (B)	1,289,578.01	1,289,578.01
GAVI ISS	80,222,000.00	79,753,500.00
4. Global Fund		
Malaria	75,481,650.00	120,336,282.00
HIV	111,759,350.00	39,238,000.00
TB	18,821,000.00	5,668,847.25
5. UN Partners		
UNICEF	71,249,658.00	107,683,723.38
UNFPA	18,958,057.00	501,137.92
WHO	6,182,000.00	5,706,233.30
World Bank	6,132,000.00	25,518,793.08
6.Other Partners		
US CDC	13,560,744.00	3,760,201.62
Italian Cooperation	2,272,727.00	2,272,727.00

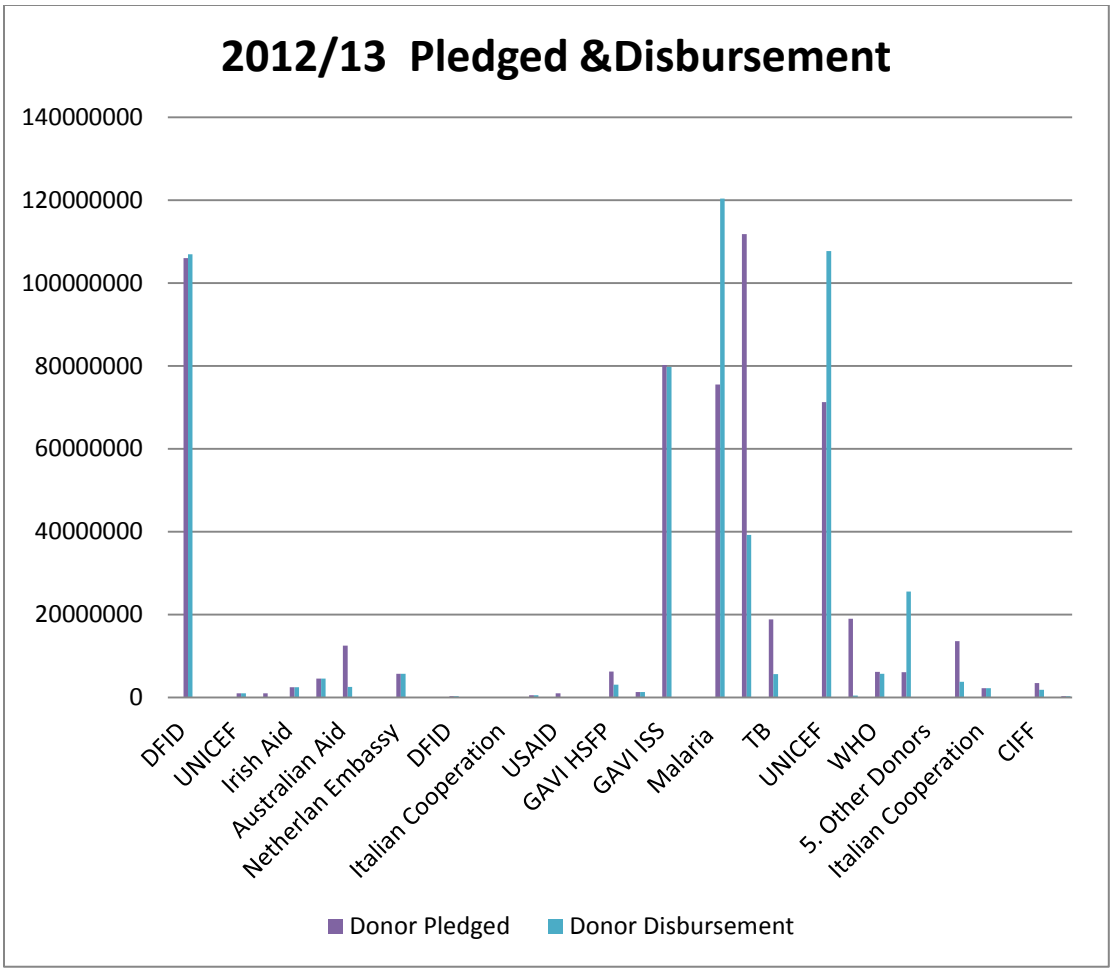
IGAD	_	67,459.46
CIFF	3,467,056.00	1,871,198.00
Imperial College of Sciences	300,000.00	300,000.00
Total	550,989,473.01	531,133,786.35

Source HSDP (2013:85)

During 2012/13 fiscal year, the total of fund of $ 531,133,786.3 was collected which represents 96.4%of the total pledge. Of the total disbursement, 86.9% was collected from four donors in which global fund alone contributed 31.1%, and UNICE, DFID and GAVI disbursed 20.5%, 20.2% and 15.8% of the total disbursement respectively. World Bank, Australian Aid, Netherland Embassy and WHO contributed 4.8%, 2.5%, 1.1% and 1.1% respectively and each of the remain donors contributed less than 1%.However, World Health Organization and Italian Cooperation have no pledge and disbursement.

Among technical assistance pooled fund donors, DFID and Australian Aid disbursed the total of their pledged for the fiscal year while USAID did not disbursed the pledge at all. According to the data collected from Ministry of Health, Italian Cooperation changed the channel. Global initiatives like GAVI and global fund disbursed 95.9% and 80.2% of their pledged respectively. UN partners such as UNICEF and World Bank disburse more than their pledged while WHO and UNFPA disburse pledged amount during the fiscal year. Bilateral donors such as CDC disbursed far less than pledged and Italian Cooperation disbursed the total of pledged. Other donors such as IGAD, CIFF and Imperial College also disbursed during this fiscal year.

According to data obtained from Ministry of Health, collected shows, during this fiscal year, only 24% of cash collected in the last year transferred to this year and reduced the actual donation of this year. However, the utilization rate of this year was high relative to last year



Data source: HSDP, (2013:85)

Figure 4: Pledged and disbursement in 2012/13

The above Figure 4 shows the difference between pledged and actual donation for Ethiopian health sector in 2012/13.

Table 14: Pledged and disbursement of 2013/14

Sources of Fund	Commitment in USD	Disbursement in USD
1. MDG Performance Fund		
DFID	110,769,231	142,558,200.00
AusAid	12,500,000	4,973,250.00
World Bank	36,000,000	35,393,073.00
Netherlands Embassy	7,142,857	7,142,857.00
Irish Aid	4,935,065	5,523,618.00
Spanish Aid	1,948,052	2,022,548.00

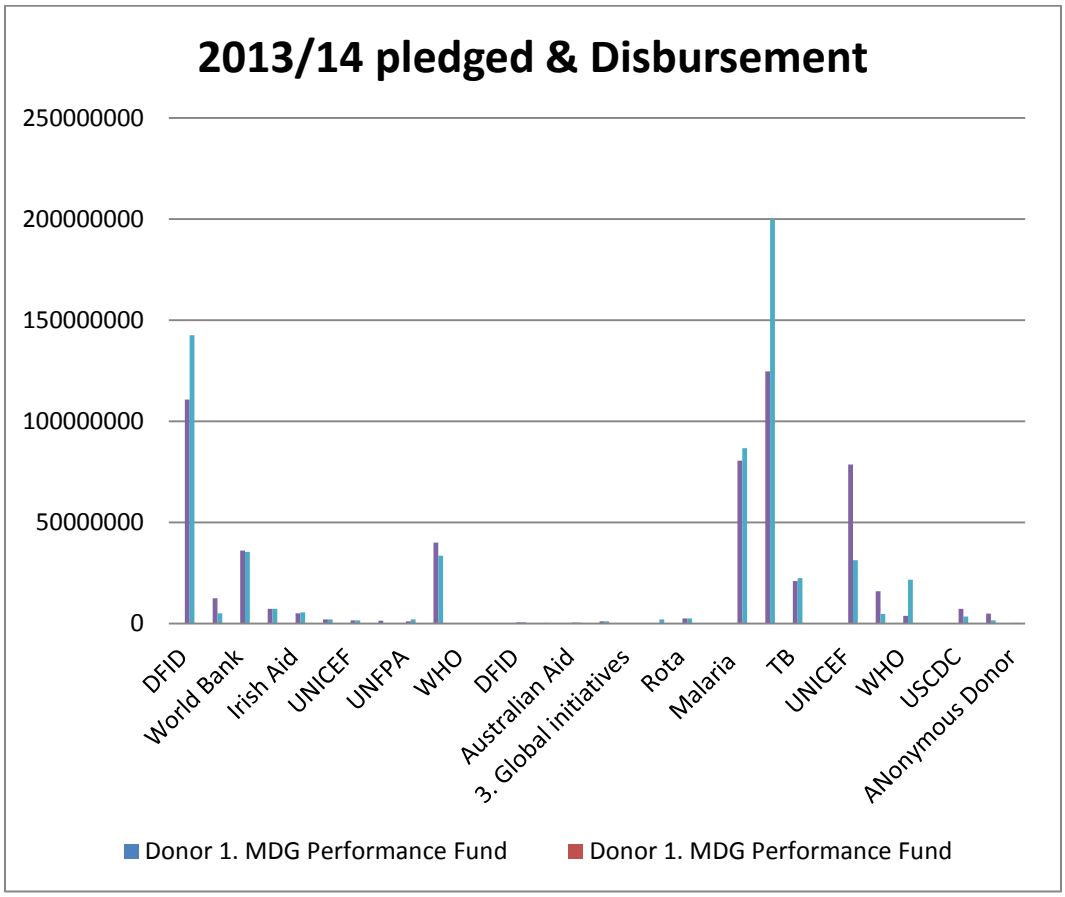
UNICEF	1,500,000	1,500,000.00
Italian cooperation	1,298,701.00	0.00
UNFPA	1,000,000.00	2,000,000.00
GAVI	40,000,000.00	33,420,034.00
WHO	0.00	148,337.00
2. Technical Assistant Pooled Fund		
DFID	563,465.00	563,465.00
Italian cooperation	194,805.00	0.00
Aus Aid	410,633.00	410,633.00
USAID	1,000,000.00	992,315.00
3. Global Fund		
Malaria	80,503,597.00	86,715,500.00
HIV	124,560,832.00	199,924,923.00
TB	20,971,909.00	22,483,878.00
4. UN Partners		
UNICEF	78,520,327.00	31,198,065.00
UNFPA	15,898,894.00	4,700,643.00
WHO	3,785,260.00	21,610,616.00
5. GAVI		
CSO		2,060,000.00
Rota	2,469,000.00	2,469,000.00
6. Foundations		
CIFF	4,866,067.00	1,573,940.00
Anonymous Donor	237,844.00	0.00
7. Bilateral Donor		
US CDC	7,251,000.00	3,480,480.00
Total	558,327,539.00	612,865,345.00

Source (HSDP, 2014:93)

In the 2013/14 fiscal year, federal Ministry of Health collected $ 612,865,345.00 from fourteen development partners how. The amount was greater than pledged during fiscal year in which the pledged amount stood at $ 558,327,539. Of the total disbursement, 91.1% was collected from five donors, which include Global Fund with the share of 50.4%:DFID with the share of 23.4%; GAVI with the share of 6.2%; World Bank with the share of 5.8% and UNICEF with the share of 5.3%. World Health Organization, Netherland Embassy and UNFPA contribution accounted for 3.6%, 1.2% and 1.1% of the total disbursement respectively during the fiscal year. The least shares held by Irish Aid with 0.9%; Australian AID with 0.9%; CDC with 0.6%: Spanish Aid with 0.3% CIFF, with 0.3% and USAID with 0.2%.

Five donors, namely GF, WHO, GAVI UNFPA, Spanish Aid and Irish Aid) disbursed greater than their pledged during the year and almost all of the remained donors disbursed below pledged. However, two donors (Italian cooperation and Anonymous Donor) did not disburse their pledged at all. Despite most of the donor disbursed below pledged and two donors failed to disburse, the total collected grant was beyond the pledged due to global fund and DFID contributed a large amount of money as observed on figure below.

As the data gathered from Ministry of Health shows, 37.75% of the last year collected money was not utilized. But, global fund disbursed more than pledged for three programs that were supported by global fund and DFID was also disbursed more than pledged as usual.



Data source HSDP (2014:93)

Figure 5: Pledged and disbursement in 2013/14

The above Figure 5 shows the difference between the pledged and the actual donated money for Ethiopian health sector in the 2013/14 fiscal year.

Table 15: Pledged and Disbursement of 2014/15

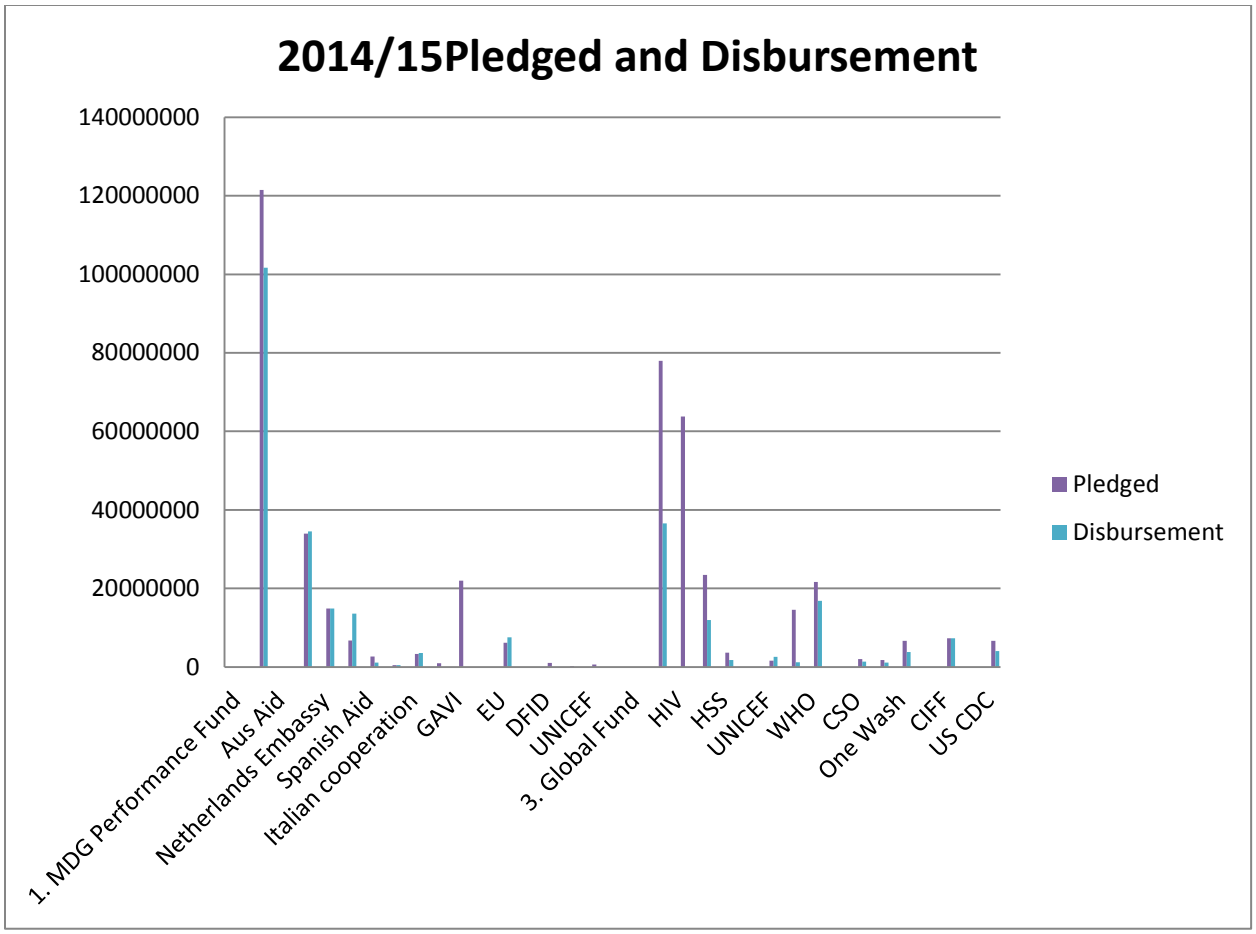
Sources of Fund	Commitment in USD($)	Disbursement in USD($)
1. MDG Performance Fund		
DFID	121,464,646.46	101,647,000.00
Aus Aid	0.00	0.00
World Bank	34,000,000.00	34,521,883.44
Netherlands Embassy	14,877,143.00	14,862,788.00
Irish Aid	6,709,610.00	13,620,725.80
Spanish Aid	2,683,844.00	1,112,199.24
UNICEF	500,000.00	500,000.00
Italian cooperation	3,354,804.08	3,544,798.00
UNFPA	1,000,000.00	0.00
GAVI	22,000,000.00	0.00
WHO	0.000	0.000
EU	6,200,000.00	7,565,337.00
2. Technical assistance pooled fund		
DFID	1,007,757.60	0.00
Italian cooperation	201,288.24	0.00
UNICEF	650,000.00	0.00
USAID	0.00	0.00
3. Global Fund		
Malaria	77,945,974.42	36,603,819.28
HIV	63,813,214.64	0.00
TB	23,467,531.42	11,943,767.76
HSS	3,680,982.00	1,812,002.00
4.UN Partners		
UNICEF	1,650,000.00	2,612,054.88
UNFPA	14,595,739.00	1,228,970.95
WHO	21,684,664.74	16,845,691.00
5.GAVI		
CSO	2,000,000.00	1,350,000.00

Global Sanitation	1,774,950.00	1,113,450.00
One Wash	6,704,522.00	3,807,684.00
6. Foundation		
CIFF	7,326,329.00	7,326,329.00
7. Bilateral Donor		
US CDC	6,669,581.00	4,051,632.00
Total	445,962,581.60	269,070,132.35

Data source HSDP (2015:80)

In the last year of HSDP IV implementation (2014/15), Federal Ministry of Health obtained $ 269,070,132 donations from thirteen donors however; the collected cash was far below than the pledged for the year, $ 445,962,581. Of the total donation obtained, 70.4% was collected from three donors, namely DFID, GF and WB contributions of 37.8%, 19.8% and12.8% respectively. World Health Organization, Netherland Embassy and Irish Aid also disbursed 6.3%, 5.5% and 5.1% of the total in their respective orders and the remaining 12.7% was collected from others in the fiscal year. As it was observed in the table above, all of technical assistance fund donors and four of MDGs pooled performance donors did not disburse their pledged in the year. Irish Aid and European Union disbursed greater than pledged, but the others including DFID disbursed below pledged amount of money.

The 2014/15 fiscal year was the last year of MDGs and HSDP IV implementation, there was unused 38.20% of disbursed money in the previous year. As the data in the above table shows, the fiscal year 2014/15 was the year that an extreme variation observed between pledged and actual donations.



Data source (HSDP, 2015:80)

Figure 6: Pledged and disbursement in 2014/15

Figure 6 shows the pledged and actual donation of 2014/15 fiscal year for Ethiopian health sector. It also shows that MDGs performance pooled fund donors were contributed their pledged continuously, except Italian Cooperation, UNFPA, WHO, GAVI and Australian aid. The technical assistance pooled fund donors except DFID and Australian aid disbursed continuously while USAID, UNICEF and Italian cooperation did not disbursed their pledged continuously. Even though the amount of pledged and disbursement varied; Global fund and UN partners disbursed continuously during HSDP IV implementation. This shows that there was a fluctuation between pledged and disbursement that directly affects health areas those financed by foreign aid**.**

Generally, Ethiopian health sector did not face the shortage of money in HSDP IV implementation rather it faced the problem of aid utilization. If the increased aids are properly

disbursed and utilized, it could further expand health service and improve the status of health outcomes.

4.3.1. Millennium Development Goals Performance Pooled Fund

The MDG PF was created based on those rules and regulations and the signed Joint Financial Arrangement (JFA) including planning, financial management, governance framework and decision making, reporting review and evaluation, audit and supply chain management. MDG PF came into existence in 2009 and has increased both in numbers of contributors and in volume of its contribution. According to the JFA, the MDG PF covers all program areas where there is funding gap.

Various partners including DFID, World Bank, Netherland Embassy, Australian Aid, Spanish Aid, Irish Aid, GAVI, Italian Development cooperation, UNICEF, UNFPA WHO and EU contributed their financial support for Ethiopian health sector under MDGs pooled fund. Indeed, the number of donors joined MDGs pooled fund contribution of donors increased from year to year in HSDP IV. As a result cash collected under MDGs pooled fund increased from $ 40.44 million in the 2010/11(HSDP, 2011) to $ 234. 68 million (HSDP, 2014) but declined to $177.37 million in 2014/15 due to most of the donors disbursed below pledged and four of them did not disburse at all (HSDP, 2015).

MDGs pooled fund was used to fill the identified financial gap areas in health sector. In this regard during 2010/11 fiscal year, of the collected $40.44 million, $384, 058.0 was allocated for health extension workers capacity building training to cover the financial gap and $ 4 million was allocated for maternal and child health services from MDG pooled fund. Furthermore, total of $27.7 million was allocated for the procurement of health commodities and health system strengthening and $7 million were allocated for filling the funding gap for HC construction (HSDP, 2011).

Likewise, in 2011/12 fiscal year, the total of $105.35 million was disbursed to the MDGs performance fund. In the same year, $ 8,111,456 for health extension and $ 22.1 million for maternal health including for the procurement of ambulance was allocated from MDG pooled fund. Likewise, for health system strengthening a total of $ 23.1million, for the health centers construction a total of $ 8 million and for the procurement of essential drug and HEP training on clean and safe delivery for HEWs and malaria control which includes: procurement of bendio

carb chemical for IRS a total of $ 23.4 million were allocated from MDGs performance fund in the same year (HSDP, 2012).

During 2012/13 fiscal year, a total fund disbursed to MDG fund reached to $133.23 million. From this fund, $4,907,400 was allocated for health extension program; $71,431,158 was allocated for maternal health; $14,357,011 was allocated for child health during the same fiscal year. Likewise, for the procurement of medical equipment's and disease prevention and control, a total of $31.8million and $20.178 million were allocated respectively from MDG pooled fund. Furthermore, a total of $6,857,175 was allocated for health system strengthening from MDGs performance fund in the same year (HSDP, 2013).

In the 2013/14 fiscal year, a total of $ 234,681,887 was disbursed to MDGs performance fund from different donors. From this, $7000, 000 was allocated for health extension program, $10,750,000 was allocated for maternal and child health and $7,389,838 was allocated from MDGs performance fund in the same year. Furthermore, a total of $55.1 million was allocated for various activities of health system strengthening. Addition to this, $107.4 millionwas allocated for health commodity procurement: $9.58 million was allocated for prevention and control: $50,000 was allocated for miscellaneous from MDGs performance fund in the same fiscal year (HSDP, 2014).

In the 2014/15 fiscal year, a total of $177,374,731.48 was disbursed for MDGs performance fund. Like in previous years, in 2014/15 fiscal year, MDGs performance fund allocated to various health areas. Accordingly, $13,000,000 was allocated for health extension; $21,044,479.00 for maternal and child health from MDGs performance fund. Moreover, $143,620,521 was allocated for health commodity procurement; $68,580,522 for health system strengthening from MDGs performance fund during the same year. Furthermore, $4,100,000 was allocated for prevention and control of disease and $819,321 for miscellaneous in the same year (HSDP, 2015).

A large amount of MDGs performance fund used for maternal and child health services during HSDP IV implementation due to most of the activities funded from MDGs performance fund linked with maternal and child health directly or indirectly. For instance, training of contraceptive and clean and safe delivery for health extension workers was delivered by MDGs performance fund which was allocated for health extension program. Furthermore, most of

health commodities for maternal and child health including ambulance, vaccines and EMONC drugs and supplies were also procured by MDGs performance fund. Likewise, in the health service delivery area, the budget was allocated to fill the gap for the implementation of maternal and child health activities and services. Despite the fluctuation existed on the flow of foreign aid to the health sector, there was no unfinanced program left due to the reason that MDGs pooled fund has secure them.

4.4.The Procedure of Health Aid Collections

The interview result obtained from federal ministry of health resource mobilization and utilization office director in 2015 revealed that development partners' support for health sector during HSDP IV implementation in various ways played a significant role. As the interviewee responded, the procedure of how the donors give the fund for the sector was, first, the sector prepared plan on each program and present to the donors' representative on a meeting, then the donors' representatives should confirm the plan and then health sector representatives also agree to meet the target. After the confirmation on the plan and agreement for the meeting the target donors committed to give the money based on the health sector plan. According to the interview result, the agreement signed between government of Ethiopia and donors' aid flow to the health sector depends on the plan and achievements of the health sector. Based on the above principles, the donors of health pledged and contributed their financial support for health even though; there was a variation between the pledged and actually donated cash.

As understood from the interview there was a variation between pledged and disbursement due to various reasons. The major problem was the health sector itself because of lack of timely utilization of the fund. The donors disburse money after they audited and checked the health sector account and how many of the last year's funds used. If the money was not used for the given fiscal year, the donors recommend the sector to use that fund which exists in the account of the sector for the next fiscal year so it has negative impacted on the budget of the next fiscal year. For instance Global fund for HIV, malaria and TB program disbursed below the pledged most of the time because of the given fund in the previous year was not timely utilized.

The data collected from UNFPA country office director Dr. Awoke via interview discloses lack of timely utilization of donors' fund was the major problem of Ethiopian health sector. In addition to this, UN partners collect fund from donors, for instance, the major donors of UNFPA

were, Sweden, United Kingdom, Norway, US, Japan, France and Spain and if those donors do not gave their fund, UNFPA cannot do anything. Likewise, global humanitarian disaster shifts the attention of the donors.

Another reason for variation between pledged and disbursement, according to the interview, was concerned with donors' economy. For instance, according to Mr. Tsegahun, in 2011 global fund dismissed the pledged for that year due to global economic crisis. However, it revised the case of the least developed countries due to least developed countries including Ethiopia were heavily shocked. Global fund was the largest contributor of HSDP IV implementation and funded three major communicable diseases such as HIV, TB and malaria.

The researcher interviewed two people from plan policy office of the sector in their office, in 2015. According to the interview result with plan policy office workers of the sector, financial aid given for the health sector before HSDP III was not planned and programed aid. Unlike in the previous HSDPs, in HSDP III and HSDP IV, the aid flowed to the health sector was programed or given based on the plan of the sector. The agreement signed between government of Ethiopia and donors determine the flow of aid from the donors to Ethiopian health sector.

The researcher asked Dr. Mekdem in 2015; in her office about the measurement taken by health sector. According to her response, the sector cannot enforce the donors, but in response to manage fluctuation of foreign aid to health, the health sector use two mechanisms to solve the problem. One is asking other donors to finance the areas of financial shortage happened due to the absence disbursement from donors of the program and the other is using MDGs performance pooled fund. From the above data, it is possible to understand that irregularity of aid flow from some donors is the main reason why some donors disburse more than their pledged for the fiscal year.

4.5. Health Aid Management and Utilization in HSDP IV

The management and control system aims to ensure accountability and transparency in the utilization of the funds so as to meet the objectives for which the funds have been provided. To facilitate this, Grant Management Unit has been established under the Finance and Procurement Directorate of the FMoH during HSDP IV implementation. This unit has a major objective of catalyzing the timely utilization and reporting of donor funded programs through regular monitoring of grants from both programmatic and financial perspectives.

Both recurrent and capital budgets audited and report was submitted to concerned bodies in each fiscal year by an external auditor on the accounting system that regards the recording and the reporting of the transactions of the grant funds, reliability of the financial reports for the accounts of the grant funds, authorization and authenticity in the utilization of the grant funds, proper documentation file, management system, safeguarding and proper utilization of assets that are purchased donated by the grant funds.

Grant management office submitted reports to all donors as their rules and principles since it started working in 2011/12. The data collected from documented sources of grant management office discovered regarding reports submitted to donors, a total of 6 report to Global fund for malaria, 12 reports to Global fund HIV and 6 to Global fund TB. In the same year 4 reports were submitted for MDGs pooled fund donors, 1 report to GAVI, 4 to UN agencies, 8 reports to CDC and 2 reports to Italian cooperation. In 2013/14, 6 reports were submitted to Global fund malaria, 6 to global fund TB and 12 to global fund HIV. In similar way with the previous year 4 reports were submitted to MDGs pooled fund donors, 1 report to GAVI, 4 to UN agencies, 8 reports to CDC and 2 reports to Italian cooperation. In the last year of HSDP IV, 5 reports were submitted to Global fund malaria, 11 reports to Global fund HIV and 5 reports to global fund TB. For MDGs performance pooled fund donors, 3 reports were submitted and also 3 reports to UN agencies, 1 to GAVI, 1 to Italian cooperation and 7 for CDC in a fiscal year.

According to the data gathered from grant management office in January 2016, regarding the utilization of granted fund in HSDP IV, of the total collected $ 422,351,726 in 2010/11only $236,516,966 (56%) of the collected grant was utilized in the fiscal year. In 2011/12 of the total collected fund $410,996,784 (75%) or $308,247,588 was utilized. In the next fiscal year 2012/13 the total collected cash $513,133,786 (62%) or $378750, 783) was utilized. In 2013/14 a total of $ 612,865,345 was collected but $ 378,750,783(61%) was utilized. During the final year of HSDP IV a total of $ 269,070,132 was collected but $ 200,537,969 was utilized. Donors gave the resource to be used for each fiscal year based on the plan of the health sector however; there was no year in which the donors fund totally used.

The maximum utilization rate of health aid was 75% used in 2011/12 and minimum utilization rate was 56% in 2010/11. According to grant management office workers of the sector, the reason for less utilization was the bureaucracy of procurement and construction.

According to data collected in January 2016 from Mr. Girma, finance director, in the health sector following this bureaucracy was mandatory in procurement because the procured commodities were bulky and used for long time. In the construction process of contract, agreement was time taken and mandatory to avoid corruption. The data clearly shows the problem of health sector on using the collected fund timely, which was taken as the major reason for aid fluctuation in the health sector.

Conclusion and Recommendation

Based on the collected and analyzed data, the researcher concluded the study and recommended the government of Ethiopia and development partners concerning the issues need improvement in the health sector financing as follow.

Conclusion

The study has examined the role of foreign aid on Ethiopian health sector during health sector program IV implementation with special emphases of aid funded programs in the sector. The study makes an effort to identify areas of health financed by aid, the relation between foreign aid and health areas financed by aid, the flow of aid and how aid was used in HSDP IV implementation. In line with this, found the following fact concerning development partners' contribution and health development in Ethiopia during HSDP IV implementation and forward the relevant recommendations.

Regarding the health areas financed by aid, even though the whole programs in the health sector got financial aid during HSDP IV implementation, the main focus areas of the program, health MDGs, were heavily financed by aid. The programs that heavily financed by aid were the major communicable disease prevention and control; these are HIV/AIDS, TB and Malaria, Maternal and Child health. Prevalence and death due to communicable diseases, maternal mortality rate and child mortality rate declined significantly in line with the raise of foreign aid. This shows that the relation between health MDGs and foreign aid was positive.

Regarding the flow of fund, fluctuation happened because of some donors disbursed irregularly, and some did not disburse the total amounts of their pledged but disbursed regularly during HSDP IV implementation. According to International Health Compact (IHC) signed between government of Ethiopia and donors, both donors and government were responsible for their part. However, this study find out as the problem of discharging their duties existed with both donors and health sector. The health sector charged to use the donated fund for each fiscal year effectively but the study showed as lack of effective utilization challenged health sector and donors charged to disburse regularly but some donors were disbursed irregularly.

The Grant management office in the health sector that is charged to manage huge grant and to report the status of utilization to development partners, submitted reports continuously to all donors based on the rules and principles of the donors. This study found that the joint financial

arrangement implemented in HSDP IV implementation avoided wastage and diverting aid from its purpose. Despite the fluctuation of aid flow existed and almost all programs in the health sector was financed by aid, there was no unfinanced program, due to the possibility of using MDGs performance fund for the identified program for which financial gap happened except salary by requesting reprogramming the aid. Therefore, MDGs performance pooled fund managed the fluctuation of aid flow in HSPD IV implementation.

Generally, this study found the chained problem regarding flow of aid and utilization in Ethiopian health sector during HSD IV implementation. Principles of Paris declaration advocated supporting the local system, using country systems in health sector is mechanisms such as sector-wide approaches and national planning, budgeting, procurement and monitoring and evaluation. The procurement system of the country found to be challenging the health sector to use foreign aid properly.

Limiting the time to one budget on using aid resulted in less performance on utilization of aid due to the bureaucracy of procurement and the process of contract agreement for construction take a long time. As a result aid disbursement fluctuated and undermined quality of health service and affect proper utilization of the development partners contribution for health sector during HSDP IV implementation.

Recommendations

Based on the above conclusion, the researcher forwarded the following recommendation for Government of Ethiopia and development partners.

- In order to increase health Expenditure Ethiopian government is suggested to implement community and social based health insurance. Community based health insurance is designed to serve people who do not have constant income monthly. Social based health insurance was designed to serve people who have monthly constant income

- Lack of effective utilization of foreign aid was seen as the major challenge of the health sector that resulted in the reduction or absence of actual donation of the pledged. To manage this problem ministry of health is recommended to build the capacity of the workers through continuous training on how to utilize aid effectively.

- Donors are recommended to contribute their donation through pooled fund mechanism because, if the shortage of budget happen, it is possible to use the grant that was given through pooled fund.
- There are so many bureaucracies that hinder the utilization of foreign aid on time. This need additional time expansion for effective utilization of aid. Therefore, expanding the time on using aid from one to two years can make health aid more effective and efficient.

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