Addis Ababa University

College of Business and Economics

School of Graduate Studies

Department of Public Administration and Development Management

The Contributions of Health Development Partners in the Health Commodities Management Information System of Ethiopian Pharmaceutical Supply Agency

A Thesis Submitted to the Department of Public Administration and Development Management of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Masters in Public Management and Policy (MPMP)

By

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This is to certify that the thesis prepared by Alemayehu Admasu Assefa entitled *The Contributions of Health Development Partners in the Health Commodities Management Information System of Ethiopia Pharmaceutical Supply Agency*, which is submitted in partial fulfillment of the requirements for the Degree of Master in Public Management and Policy (MPMP), complies with the regulations of the University and meets the accepted standards concerning originality and quality.

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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.

Alemayehu Admasu _____ _____

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Signature **Date**

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Acronyms

APTS	Auditable Pharmaceuticals Transactions and Services
EPSA	Ethiopia Pharmaceutical Supply Agency
HSDP	Health Sector Development Program
IPLS	Integrated Pharmaceuticals Logistics System
JSI	John Snow, Inc.
JFA	Joint Financial Arrangement
LMIS	Logistics Management Information Systems
PSCMIS	Pharmaceutical Supply Chain Management Information System
PLITS	Pharmaceutical information system
RRF	Combined Report Request Form
RDF	Regular Drug fund
RHIS	Routine health information systems
SDGs	Sustainable Development Goals
WHO	World Health Organization
USAID	U.S. Agency for International Development
UNFPA	United Nations Population Fund

Abstract

The study aims to examine the contribution of health development partners to The Health Commodity Management Information System (HCMIS) of the Ethiopian Pharmaceutical Supply Agency. A mixed research approach was used for this study. A questionnaire was used to gather quantitative data from 67 *Ethiopian Pharmaceutical Supply Agency (EPSA) employees and development partner (JSI) directors selected using used purposively sampling method for analysis of their views. Also, qualitative data through the key informant interviews and document reviews were analyzed. The respondents were made up of professionals from both EPSA and partners. The study revealed that lack of employment skills, absence of clear mutual accountability, absence of ownership rights of the agency in Health Commodity Management Information System (HCMIS), clear system and strategy/policy alignment and harmonization with health Development partners and EPSA during implementation to monitoring, and evaluation of Health Commodity Management Information System (HCMIS) resulted in hinders to achieve the intended results of health development for the agency. This study recommended both the Development partners and EPSA formulate common systems/strategies and policies they used in the implementation, monitoring, and evaluation of the Health Commodity Management Information System with clear individual and mutual accountability to achieve the extended goal of EPSA.*

Keywords: *ownership, alignment, and harmonization, mutual accountability.*

CHAPTER ONE

INTRODUCTION

1.1 Backgrounds' of the Study

A partnership is a key idea in current debates about global health and development assistance, and policy debates in recent years (Amy, Garret, and Sophie, 2016). The debate about whether partnerships represent a distinctive approach with unique advantage in practice. Critics have suggested that partnership discourse may be only a rhetorical veil, masking the perpetuation of power asymmetries and the exclusion or co-optation of certain stakeholders. (Louise, and Martin, 2013). The others it increases confidence among partners and generates more energy, increasing the area extent of effective individual and joint action (Kaseje, 2006). However, new development partners do not fit within the frame of the existing aid architecture (Kharas, Markino, and Jung, 2008)

The growing demand for aid effectiveness and donor harmonization at the country level, based on the principles of the Paris Declaration, reflects concerns about the system-wide effects of global health initiatives. The increase resources devoted to health worldwide, however, has focused more on inputs, especially human and financial resources rather than outputs or health effects such as effective coverage and improved health. Yet, there is limited evidence that previous attempts to achieve strong donor coordination through poverty reduction strategies and sector- wide approaches have helped to improve health system performance (Takemi and R. Reich, 2008).

The multifaceted nature of health systems and the spread of direct and indirect responsibilities across multiple sectors pose challenges in monitoring performance. In response, over the past several years, the World Health Organization (WHO) and its partners have been working to reach a broad-based consensus on key indicators and effective methods and measures of health systems capacity, including inputs processes, and outputs and to relate these two indicators of outcome (WHO,2010). It is widely known that there are many potential advantages of a harmonized approach to health systems monitoring and evaluation, including reduced transaction costs, increased efficiency, and diminished pressure on countries. However, there are also

identified practical issues to be addressed before greater harmonization can become a reality. The existence of multiple analytical and strategic frameworks for health system results in the considerable potential for duplication, overlap, and confusion (Shakerishvili G., WHO, 2010) where countries are stronger, assistance should focus on encouraging better policy strategies and not specific programmatic objectives. This is best done through arrangements that ensure that they align ODA objectives with national plans, such as through sector-wide agreements (Kexu et al.., n.d,Ravindra P.,Eliya, 2008).

Donors have difficulties aligning to priorities which have not been clearly articulated by the partner country, or which are not stated in national plans and strategies for development (OECD, 2012a, OECD, 2014). That they have difficulty aligning to countries' sector strategies when those strategies prioritized support to sectors with more direct or attributable impact on attainment of the Millennium Development Goals, at the expense of cross- cutting priorities. The MDG and the 2005 Paris Declaration on Aid Effectiveness focused attention on global health targets. These initiatives have led to a growing global emphasis on measurement and accountability in health, including what is being measured, how it is being measured, the quality of those data, and how they are being measured, how it is being measured, the quality of those data, and how they are being shared and used. (Strachan et al.., 2013)

The amount of data available from agencies and countries is rapidly increasing. (Takemi, and R. Reich, 2008) However, such data do not yet permit reliable monitoring of the trends of communicable and non- communicable disease burdens, evaluation of the impact of health initiatives and investments, or a compare assessment of performing health systems. This process surely comes with important limitations, including observation from national authorities that argue the estimates do not always reflect the reality in countries. This situation calls for effective and sustained action to strengthen national health information system, and reinforce the capacity of countries in generating, compiling, analyzing, disseminating, and reporting reliable data for the monitoring of health situations in countries (Ali et al., 2016) to achieve this, country institutions and management structures must be strengthened by adopting and adapting global health information standards that are aligned to broader efforts to improve the availability and quality of statistics.(WHO,2007).

from current researcher experience, there is a lagged view which the key actors understand health development partner's contribution to Ethiopian pharmaceutical supply health systems; whether those who are at different levels of governance see a partnership as a relation of equality or (as suggested above) as empty rhetoric; or how partnerships work from their perspective in practice. Likewise, the contributions of health development partners in the HCMIS of Ethiopia pharmaceutical supply agency are not well-known being a significant gap given the pervasiveness of partners on global health and development assistance agendas gap given the scope and scale of the challenges that remain within health systems.

1.2 Statement of the Problem

Major international agreements such as the 2005 Paris Declaration stressed the need to strengthen the country supply systems, rather than by pass them. Supply chain strengthening attempts to improve performance, reduce stock outs, and minimize costs and wastage in the local health supply chain. Although they have implemented many approaches to strengthen supply chains in the global health arena (UNCEF, 2016) However, Stock-outs of essential products at service delivery sites have been a consistent problem, hampering health services in developing country public health systems for decades and continuing until today. (UNCEF, 2016)

Ethiopian situation is not different from the rest of the developing world and the medicine supply chain has several problems including the inadequate supply of quality and affordable essential medicines, weak stock management, robbery of medicines and medical equipment along the supply chain, and forged procurement requests from health facilities resulted in high levels of waste and stock-outs (shewarega et al, 2015). To solve these problems, the Ethiopian Pharmaceutical Supply agency, with the support of its partners, has developed and implemented various innovative interventions to manage pharmaceuticals under various programs (Nigatu et al, 2018).

The Health Commodity Management Information System (HCMIS) is one of the major interventions to enhance the visibility of procurement and shipping data, to make better decisions, improve the availability of medicines, and reduce waste (Dowling,2017) however, in Ethiopia Pharmaceutical Supply Agency, the main problems that existed are inadequate registered medicines, data quality, non- coordinated forecast, poor inventory practice, lack of

logistic data visibility but Health Commodity Management Information System (HCMIS) and Integrated pharmaceutical logistic System (IPLS) have not yielded the results as mentioned above. Which further support this idea is health sector transformation plan (2015) showed that the gap in the existing automated Logistics Management Information System (LMIS) is that it doesn't link the agency's head office with branches and health facilities at other levels that handle/ monitor the supply of pharmaceuticals to have real-time stock status information at national level. Besides, the revised Pharmaceutical Supply Transformation Plan (2018) showed that the accuracy of supply chain data: with only approximately 20 % (percent) of health facilities operating a computerized inventory and reordering system, the Health Commodity Management Information System (HCMIS), and the balance of the health facilities using the manual version of the system, there is considerable opportunity for the recording and transmission of inaccurate data, Lack of accuracy and concerns of reliability for logistics data and reports generated from Health Commodity Management Information System (HCMIS) and underdeveloped institutional capacity for data utilization in decision- making processes.

This study is intended to assess the contributions of health development partners in the Health Commodities Management Information System of the Ethiopian pharmaceutical supply agency.

1.3. Research Questions

1. What is the implementation status of the Health Commodity Management Information System (HCMIS) in the Ethiopian Pharmaceutical Supply Agency?

2. How development partners are cooperating within Ethiopian Pharmaceutical Supply Agency in strengthening ownership through the institutionalization of the Health Commodity Management Information System (HCMIS) in the Agency?

3. How development partners align and harmonize their programs with the Ethiopian pharmaceutical supply agency in strengthening its Health Commodity Management Information System (HCMIS)?

4. How development partners are ensuring mutual accountability in the implementation of Health Commodity Management Information System (HCMIS) in Ethiopian Pharmaceutical Supply Agency?

5. What results (in relation to system strengthening) are documented due to the implementation of the Health Commodity Management Information System (HCMIS) in Ethiopian Pharmaceutical Supply Agency?

1.4. Objective of the Study

1.4.1. General Objective

The overall objective of the study is to evaluate the contributions of health development partners in the HCMIS of Ethiopia pharmaceutical supply.

1.4.2. Specific Objective.

1. To assess the implementation status of the Health Commodity Management Information System (HCMIS) in Ethiopia pharmaceutical supply agency.

2. To examine development partners are cooperating with the Ethiopian Pharmaceutical Supply Agency in strengthening ownership through the institutionalization of Health Commodity Management Information System (HCMIS) in the Agency.

3. To assess development partners align and harmonize their programs with the Ethiopian Pharmaceutical Supply Agency in strengthening its Health Commodity Management Information System (HCMIS).

4. To examine development partners are ensuring mutual accountability in the implementation of Health Commodity Management Information System (HCMIS) in Ethiopian Pharmaceutical Supply Agency.

5. To investigate results (in relation to system strengthening) are documented due to the implementation of Health Commodity Management Information System (HCMIS) in Ethiopian Pharmaceutical Supply Agency.

1.5. Significance of the study

Considering the contributions of health partners in the health development system of Ethiopia, and strengthening the Health Commodity Management Information System (HCMIS) under the jurisdiction of the study area; This study has the following significance:

- To increase the understanding of decision-makers on the contributions of health partners in the Health Commodity Management Information System (HCMIS) of the Ethiopian Pharmaceutical Supply Agency.
- To provide the policymaker and the study organization about the contributions of health partners in the Health Commodity Management Information System (HCMIS) Ethiopian Pharmaceutical Supply Agency.
- This study identified the factors affecting the contributions of health partners in the Health Commodity Management Information System (HCMIS) in the Ethiopian Pharmaceutical Supply Agency.
- It identifies problems arising from inadequate disengagement and the absence of a conducive environment for health partners in the Ethiopian Pharmaceutical Supply Agency.

1.6. Scope of the Study

Health development partners in Ethiopia contribute to a wide range of health sectors and areas. One of health sectors supported by health development partners is Ethiopian Pharmaceutical Supply Agency (EPSA) and Health Commodity Management Information System (HCMIS). This study will aim to analyze the contribution of health development partners in the Ethiopian Pharmaceutical Supply Agency (EPSA) in Health Commodity Management Information System (HCMIS). The study mainly focuses on the contribution of development partners involve in a different area of health which is financial support, technical support, human resource development and technology transfer and other support but this study focuses on one of technological support is Health Commodity Management Information System (HCMIS). Because of dealing with all others, the contribution of health development partners in the Ethiopian Pharmaceutical Supply Agency (EPSA) is beyond the capacity of the researcher due to

a limited time. Therefore, this research is limited to the contribution of health development partners in a specifics focus area.

1.7. Structure of the Study

This paper is divided in to five chapters: the first chapters' deals with an introduction, which contains background, problem statement, and objective of the study. The second chapter deals with a review of related literature and the third chapter discusses an overview of the structure of the Ethiopian Pharmaceutical Supply Agency (EPSA), research approach, and methodology. The fourth deals with data presentation and analysis. Chapter five covers the findings, conclusion and recommendations.

1.8. Limitation of the Study

This study was conducted at central Ethiopian Pharmaceutical Supply Agency (EPSA) and development partners (JSI) Ethiopia which did not include Ethiopian Pharmaceutical Supply Agency (EPSA) branches, health centers, hospitals, and suppliers. The time and resource constraints were the major challenges that limit the depth of coverage of the research work. Finally, a limited number of empirical literatures in similar study areas especially in Ethiopia made it difficult for comparing the results of the study.

1.9. Ethical Consideration

In this study permission was asked from PFSA management and workers and partners after getting consent from the management data collection will start. I will tell to each respondent that the information that will collect will be kept confidential.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter deals with a certain review of existing literature about the contribution of health development partners. This research aimed at studying the issues of health development partners supported in Ethiopian pharmaceutical supply agency in the deferent area of health one of the supporting areas of health is HCMIS (health commodity management information system). By reviewing the previous finding the purpose of this chapter is to provide certain important ideas to the reader about the study. In this respect, specific important issues associated with this study were discussed in this chapter.

2.2 Paris Declaration and Accra Agenda for Action

The Paris Declaration on Aid Effectiveness was endorsed in 2005 by over 150 countries and organizations, including donor countries, developing countries around the world, international development institutions such as the World Bank, the United Nations Development Group, and the Organization for Economic Co-operation and Development (OECD), as well as civil society organizations. (Patton & Dabelstein, 2013) The Declaration calls for donor countries to rationalize their activities. Rather than each trying to be active in numerous countries or sectors, they are encouraged to link together to limit the fragmentation of donors and to allow those with special experience and competencies to take the lead in specific aid efforts. (OECD, 2009) As the evaluation report notes in establishing the context for and significance of the Paris Declaration, it was considered a landmark international agreement and the culmination of several decades of attempts to improve the quality of aid and its impact on development. (Patton & Dabelstein, 2013)

The Paris Agenda addressed an expanded agenda. It added development results to Rome's two issues, as recommended by a Marrakesh meeting in 2004 (OECD DCD/DAC, 2005, Abdel-Malek, 2015). Paris experienced a visible increase in partner countries' engagement. Roundtables addressed concrete issues of aid effectiveness around five themes: ownership, alignment,

harmonization, managing for development results, and mutual accountability. The endorsement of these principles by signatory countries and the international community was recognized as a breakthrough in international development cooperation. (Patton & Dabelstein, 2013) Although partner countries were more vocal in the debate, the agenda and many contributions were led /made by aid providers, with the World Bank playing a substantial role. (Abdel-Malek, 2015)

2.2.1 Ownership

Ownership – one of the five pillars of the Paris Declaration on Aid Effectiveness is a field in which partial progress has been made but where areas for further progress have been identified. In 2005, the Paris Declaration emphasized ownership as referring primarily to developing country governments' abilities to exercise leadership over their development policies and strategies and co-ordinate development actions Commitments emphasized the articulation of development priorities through national development strategies, with partner countries taking the lead in co-coordinating aid at all levels in conjunction with other development resources. (OECD, 2011) Implementation of the HMN Framework should be based upon a set of common principles– empowerment, leadership, and ownership; a focus on the needs of individual states; building upon what already exists; broad-based consensus-building; and an incremental approach to health information system development. (World Health Organization, 2008)

The process of strengthening country health information systems is by its very nature focused on empowering countries to undertake broad health system strengthening activities it is therefore essential that any given national leadership is engaged and owns the implementation process. (WHO, 2008)

2.2.1.1 Principles of Country Leadership and Ownership

The process of strengthening country health information systems is by its very nature focused on empowering countries to undertake broad health system strengthening activities. It is therefore essential that any given national leadership is engaged and owns the implementation process. The role of partners will be to offer flexible support, information, and guidance, as well as to actively engage in the HMN harmonization process, which has been globally informed by country experience. (WHO, 2012)

2.2.1.2 Principle of Responding to Country Needs and Demands

Strengthening country health information systems should always begin with recognition of the need for this process by the country itself. The process should then focus on the needs of health information users. Implementation must take into account what can be achieved within available resources and capacities. A key step in this is the development of a comprehensive vision of health information: (WHO, 2012)

- addresses institutional and organizational constraints (including human and resources);
- financial serves as a coherent framework for international support in improving health information; and
- It is flexible enough to change in response to changing needs.

2.2.1.3 Principle of Building upon Existing Initiatives and Systems

Wherever possible the implementation process should build upon existing initiatives, systems, and knowledge. Strengthening country health information systems should not take place in a vacuum but should be linked to (and build upon) similar initiatives, especially national and international strategies for the development of statistics. (Health Metrics Network, 2006)

2.2.1.4 Principle of Building Broad-Based Consensus and Stakeholder Involvement

Broad-based consensus-building is a crucial first step because much of the data needed by the health sector is generated by other sectors, and comes from constrained national budgets. Although the inputs of external partners and donors are initially important to catalyze action, countries themselves must sustain the necessary longer-term investments. (WHO, 2012)

2.2.1.5 A Gradual and Incremental Process with a Long-Term Vision

The strengthening of country health information systems is best approached as a gradual incremental process. It need not entail an immediate and total overhaul of the whole health information system (although this may be necessary for countries where the system is completely dysfunctional) or major structural change. (WHO, 2006)

2.2.2 Leadership over development policy and strategy

The Paris Declaration emphasizes the importance of partner countries' efforts to exercise leadership in developing and implementing high-quality development strategies, and in ensuring that these are results-oriented and inform resource allocations. One of the indicators agreed in Paris (indicator 1) considers the extent to which partner countries have national development strategies with clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets. (OECD, 2011)

2.2.2.1 Prioritization

The assessment report provides the basis for strategic decision-making and framing a comprehensive future vision of health information. However, it also contains a long list of an issue to resolve. An important next step, therefore, is prioritization and the identification of action to be undertaken in the short, medium, and long terms. The underlying philosophy for priority setting should be that strengthening will be incremental, a staged roll-out of key action with a gradual scale-up as resources and capacities permit. (HMN, 2006)

The process of priority setting should be inclusive and transparent. (HMN, 2006) A development plan is likely to have several important stakeholders. Effective planning is done with the participation of these stakeholders. Stakeholders are the people who will benefit from the development activity or whose interests may be affected by that activity. Therefore, a simple stakeholder analysis is generally recommended for all planning processes. (UNDP, 2009)

The explicit recognition of a broader range of stakeholders as development actors in their own right implies that donors and partner country governments should provide an enabling environment to help maximize their contributions to development. This inclusive approach also involves a commitment from CSOs to look at how they can apply relevant aid effectiveness principles in their work. (OECD, 2011) Capacity development is essential for the achievement of sustainable development results. Developing countries need an enabling environment, strong institutions, systems, and local expertise to fully own and manage their development processes. (OECD, 2011)

2.2.2.2 Planning

once a broad agreement has been reached on an alimented set of priorities for the initial period of strengthening a national plane preferably with a long term perspective, typically 10 years should be prepared under the overall guidance and leadership of the steering committee each group identified as having specific responsibility in delivering the plan outputs should develop a detailed, activity-specific work plan. (HMN, 2006)

2.2.2.3 Action Plan and Budget

The national action plan should also be attuned to the calendar of health sector operational plans. Each strategic intervention identified should be accompanied by a defined product (output) to be delivered, with the specific responsibilities for ensuring delivery set out. Finally, the national action plan will need to be coasted and financing plans and resource-mobilization strategies discussed. Costing should cover both capital and recurrent costs, including the training of existing and new human resources. The costs of external technical assistance should also be included. (WHO, 2012)

2.2.3 Alignment and harmonization

As part of the follow-up to Monterrey, representatives of 74 donor and partner countries, bilateral and multilateral development institutions, and regional organizations met in Rome in February 2003 at the High-Level Forum on Harmonization to make plans for applying good practice principles at the country level. Donors are committed to align development assistance with partners' strategies and improve systems, harmonize donors' policies and procedures, and implement principles of good practice in development cooperation. (Patton & Dabelstein, 2013) Under the Declaration, a range of commitments supports the use of partner countries' national development strategies and country systems. Donors agree to align with partners' strategies, basing their support on them, and where possible, drawing conditions from the partner's strategy, and linking their funding to a single framework of conditions derived from this strategy. (Working Party on Aid Effectiveness, 2008) On harmonization, Donors have made a start in using simplified procedures and practices, joint analytical work, enhanced focus on the delivery of development results, delegated cooperation, common procurement and financial management procedures, and common arrangements for sector-wide approaches and budget support. (Patton,

2013) Global partners and countries have been working towards better harmonization and alignment in Support of a strong national health strategy. IHP+ has been focusing on achieving better health results by mobilizing donor countries and other development partners around a single country-led national health strategy. (WHO, 2011)

2.2.3.1 Aligning Conditions with Partner Countries' Development Policies

One specific area in which donors committed to improving the alignment of their aid programs was in drawing conditions, whenever possible, from developing countries' policies. When donors impose conditions on the provision of aid that is not aligned with partner countries' priorities, these can undermine efforts to implement domestic policies and hinder effective prioritization of activities. Through the Accra Agenda for Action, donors and partner countries committed to working together to agree on a limited set of mutually agreed conditions based on national development strategies. They also committed to specific actions to improve transparency around conditions. (OECD, 2011)

Donors base their overall support on partner countries' national development strategies, institutions, and procedures. Partner countries and donors jointly commit work together to establish mutually agreed frameworks that provide reliable assessments of performance, transparency, and accountability of country systems; and integrate diagnostic reviews and performance assessment frameworks within country-led Strategies for capacity development (OECD, 2005)

2.2.3.2 Aligning With Partners' Strategies

Basing support on partners' strategies the Paris Declaration Evaluation finds abundant evidence from partner and donor studies, that, as compared with 2005, at the broadest level donors are increasingly basing their activities on partners' national development strategies, medium-term expenditure plans, budgets, and sect oral and thematic strategies. (Quinn Patton and Dabelstein, 2013) Users comprise those delivering care as well as those responsible for the management and planning of health programs, including those financing healthcare programs, both within the country (health and finance ministries) and outside (donors, development banks, and technical support agencies). Users of health-related data are not confined to health-care professionals or statisticians. Indeed, decision-making around country health priorities necessarily involves the

wider community, including civil society, and policy-makers at the senior levels of government. (WHO, 2012)

Responsibilities for effective data generation go beyond that of ministries of health and involve other bodies, such as departments and agencies that handle health-related data, including national statistics offices, ministries of education, among others. There is a need for a strong coordinating body that brings together the various stakeholders and helps ensure the development of a comprehensive and integrated plan for health information and statistical system development. Such a plan should provide the basis for enhanced alignment and harmonization of technical and financial support from the development partners. (WHO, 2010)

2.2.3.3 Global Standards and Harmonization of Health Information

A sound health information system depends upon organized processes for gathering, sharing, analyzing, and using health-related data for decision-making.

the Accra Agenda for Action commits donors and partner countries to reduce the fragmentation of aid by improving the complementarily of donors' efforts and the division of lab our among donors, including through improved allocation of resources Fragmentation can be an important barrier to effective development co-operation: as the number of donors and initiatives increases in a given country or sector, so too do the risks of duplication, increased overhead costs for partner governments in managing aid coming through a multitude of channels and projects, and the cost of engaging in dialogue with multiple small donors. (OECD, 2011)

HMN is the first attempt to develop a unifying framework that facilitates the efficient coordination and joint action of all subsystems in a health information system. Health information systems involve complex processes and relationships that go beyond the responsibility of any single government agency. (WHO, 2012) The Development of the HIS must respond to the needs and requirements of the various institutions with one comprehensive plan and collaborative approach rather than being seen as existing within one single institution. (Lippeveld.J,2001,HMN,2006) with so many constituencies with important stakes that health information it is surprising that no unifying framework or standard has been established to facilitate how all health information systems sub-system fit and work together efficiently. (HMN, 2006)

2.2.3.4 Approaches to Health Information System Strengthening

Based on this conceptual approach, the first step in health information system strengthening is to undertake a broad-based assessment of the country health information system, examining not only the technical aspects of the information system but also the health system environment and organization, as well as the influence of relevant behavioral factor. The health information system should be assessed to (HMN, 2006) allow objective baseline and follow-up evaluation – assessment findings should, therefore, be comparable over time; inform stakeholders for example, of aspects of the health information system they may not be familiar with; build consensus around the priority needs for health information system restructuring, and mobilize joint technical and financial support for the implementation of a national strategic plan. HMN has developed a tool (HMN assessment tool, WHO, 2012) designed to guide such an assessment. All major stakeholders should participate in assessing and planning health information system strengthening. Stakeholders include finance providers and the producers and users of health information and other social statistics – at both subs national and national levels. (WHO, 2012)

2.2.3.5 Identifying Data Requirements and Indicators

The many types of data that a health information system should generate can appear overwhelming. But for policy-makers and planners, some types of information are more important than others. A key step in reforming health information systems is for stakeholders to identify the data needed for proper management, disease control, and response, strategic decision-making, and policy development. Such data must then be made available in a timely and reliable manner. The consensus is now needed on a core set of indicators that are meaningful, action-oriented, and appropriate to a particular country situation and collaborating partners. (WHO, 2012)

2.2.3.6 Matching Data Requirements to Data Sources

Matching the data item or indicator with the appropriate and cost-effective tool for generating it is an essential function of the health information system. The range of sources for health-related data comprises service-generated data, diseases and behavioral surveillance, vital statistics, financial and management information, household surveys, health facility, surveys, census,

modeling estimates and projection, and research. Each of these has its strength or weakness in generating health information. (HMN, 2006)

2.2.3.7 Synthesizing, Analyzing, and Using Information

Data alone do not reveal the full situation – meaning is only acquired when data are analyzed and interpreted. Data also need to be synthesized, analyzed, and interpreted within the overall context of the health system and delivery of health interventions. In this way, data is transformed into information, evidence, and knowledge for action. A vital aspect of the analysis is synthesizing data from multiple sources, examining inconsistencies and contradictions, and summarizing health situations and trends to produce consistent assessments. (WHO, 2012)

Capacity for data analysis is often lacking at peripheral levels where the data are generated and the results need to be used for planning and management. The development of such capacity warrants careful planning and investment by multiple stakeholders. (HMN, 2006)

2.2.3.8 Aligning Partners and Bringing Data and Users Together

Another essential step in strengthening health information systems is to link data production to data use. Users comprise care deliverers and those responsible for managing and planning health programs – including those financing healthcare programs inside countries (health and finance ministries) and externally (donors, development banks, and technical support agencies). Users of health-related data are not confined to healthcare professionals or statisticians. Indeed, decision-making around country health priorities necessarily involves the wider community, including civil society, and policy-makers at senior levels of government. (WHO, 2012)

2.2.3.9 The Power of Partnership – The Health Metrics Network (HMN)

HMN uses the strengths of a global network to stimulate the coordination and alignment of partners around a harmonized framework to develop and strengthen country health information systems. However, putting the recommendations of this HMN Framework into practice is not a simple matter. Existing health information systems are institutionally and historically complex, with multiple partners involved in different ways and at different levels in generating, analyzing, sharing, and using data. (WHO, 2012)

2.2.4 Results and Mutual Accountability:

Managing for Development Results: The Paris Declaration calls for stronger management for development results, committing developing countries and donors to work together to manage aid for the achievement of development results, using the information on results to improve decision-making Developing countries are expected to develop cost-effective results-oriented reporting and performance assessment frameworks, while donors commit to using any such arrangements and refraining from requiring separate reporting. The Accra Agenda for Action reiterates the importance of managing for results, emphasizing greater transparency and accountability for the use of all development resources. (OECD, 2011)

It is also important for donors and partners to ensure that mutual accountability relationships complement, rather than crowd out, national accountability between governments and citizens. (OECD/DAC et.al, 2008) There was wide agreement that the prevalent view of the Declaration as a technical, bureaucratic process needed to be shaken up and the key driver of high-level political support revitalized. The need to engage actors outside the executive branches of central government legislators, other levels of government, civil society, and the private sector came to the fore. The Forum reiterated the need to adopt the Declaration's application to fit different country circumstances and recognized that additional work will be required to improve the methodology and indicators of progress. (Patton & Dabelstein, 2013) Strong and balanced mechanisms that support accountability are required at all levels for aid to be most effective. (Jordan, 2012) The Paris Declaration calls upon donors and partners to be mutually accountable for development results. Individual and joint actions can create and reinforce shared agendas by building trust, shifting incentives towards results, embedding common values, deepening responsibilities, and strengthening partnerships. (Working Party on Aid Effectiveness, 2008)

Partner countries commit to strengthen the parliamentary role in national development strategies and/or budgets and to include a broad range of development partners when formulating and assessing national development strategies. For their part, donors commit to providing timely, transparent, and comprehensive information on aid flows. Partner countries and donors together commit to assessing country-level mutual progress in implementing agreed commitments on aid effectiveness, including the Partnership Commitments. (Working Party on Aid Effectiveness, 2008)

2.2.4.1 Key Elements of Transparency

The building block on transparency represents a unique opportunity to commit to further action on aid transparency and fiscal transparency for better predictability, engagement, and accountability. **Aid transparency** and **fiscal transparency** are intrinsically linked. Budgets in partner countries cannot be made fully transparent without aid transparency.(Busan High-Level Forum,2011) Also, transparency of aid flows and transparency of partner countries' resources are prerequisites for better accountability, which leads to sustainable and locally owned development results. The possibility for citizens to scrutinize the use of resources and government actions creates incentives for results throughout the aid chain. Governments need to support an enabling environment for parliaments, audit institutions, civil society, and media to access information and engage in processes of development in their own countries. (Busan High-Level Forum, 2011) As noted, Global Partnership monitoring of the transparency of development co-operation relies on the assessment of the extent to which information is made publicly available through each of the three reporting systems and standards. (OECD, UNDP, 2019)

The International Aid Transparency Initiative (IATI): IATI was launched at the Accra High-Level Forum on Aid Effectiveness in 2008, and is perhaps the most significant initiative at the global level aiming to improve the accessibility of aid information. Based on the OECD's CRS standards, IATI has developed additional features finalized in the IATI standard agreed in February 2011, such as more timely data (quarterly), information on forwarding spending plans, and documentary information (*e.g.* country strategies; conditionality and results in frameworks). (OECD, 2011)

2.2.4.2 Implementation of HIS Strengthening Activities

Using a country's institutions and systems, where these assure that aid will be used for agreed purposes, increases aid effectiveness by strengthening the partner country's sustainable capacity to develop, implement and account for its policies to its citizens and parliament. Country systems and procedures typically include but are not restricted to, national arrangements and procedures for public financial management, accounting, auditing, procurement, results in frameworks, and monitoring. (Working Party on Aid Effectiveness, 2008)

Diagnostic reviews are an important and growing source of information to governments and donors on the state of country systems in partner countries. Partner countries and donors have a shared interest in being able to monitor progress over time in improving country systems. They are assisted by performance assessment frameworks and an associated set of reform measures that build on the information set out in diagnostic reviews and relate analytical work. (Working Party on Aid Effectiveness, 2008)

Overall guidance on the implementation of the plan should be provided through the steering committee, where the continuing participation of high-level leadership and involvement of stakeholders will help maintain momentum and commitment. HIS strengthening is likely to require additional efforts by the many actors involved beyond their normal responsibilities. Any resulting stresses should be recognized and acknowledged. The action plan may consider identifying rewards for improved data collection, presentation, and use of information. ((WHO, 2006)

2.2.4.3 The National Health Strategy Specifies a Sound Monitoring

Monitoring means bringing together data from all relevant sources to analyze what is happening, where, and to whom. Monitoring uses a set of core indicators and targets to provide timely and accurate information to governments and partners' it informs progress and performance reviews, and policy dialogue. (WHO, 2011) Six-monthly reports on the progress of activities and disbursement of funds should be provided to the steering committee to enable corrective action and modifications to the plan, if necessary. The achievement of milestones and the difficulties encountered and addressed should be reviewed and discussed annually by stakeholders. (WHO, 2006)

Evaluation builds upon the monitoring data but the analysis goes much deeper, taking into account contextual changes, addressing questions of attribution, and looking at counterfactual situations. (WHO, 2011)

2.2.4.4 Evaluation and Reprogramming

A full evaluation of the implementation of the strengthening plan should be undertaken at intervals appropriate to the timescale of the plan. It may be helpful to undertake the first

evaluation within three years of the start of implementation. The evaluation should include a reassessment of the health information system, using the same HMN Health information system situation assessment tool to allow a comparison of improvements against the baseline. (WHO, 2006)

The evaluation will look specifically at the availability, quality, and use of important health information, and the extent to which there is an improved ability to measure and monitor inequalities in health and take action based upon these measurements. It should also permit an assessment of the degree to which there is improved coordination between country and external partners and greater coherence in the overall demands for information. (HMN, 2006)

Regular planned assessments of the M&E system are required to ensure that indicators are measuring what they are meant to, that data is generated according to standards that data analysis and communication of results give the information needed by decision-makers, and that data management includes an assessment of overall data quality. (WHO, 2011) The evaluation should lead to a renewed cycle of prioritization, planning, and implementation. A national workshop should be convened to finalize and endorse the reprogrammed plan of action. (WHO, 2006)

Reviews are based on the evidence gathered through monitoring processes and require national institutional mechanisms involving multiple stakeholders. Existing country health-sector review processes are a key entry point for assessing progress and performance and can influence priority-setting and resource allocation. Such reviews need to be systematically linked to actions in countries and provide the basis for mutual accountability. (WHO, 2011)

2.2.4.5 National Strategies for the Development of Statistics

At the Second International Roundtable on Managing for Development Results held in Marrakech, Morocco in 2004, the international community recognized that the provision of statistical data to inform, monitor, and evaluate national development plans requires, in turn, strategic planning process of its own. Participants endorsed a Marrakech Action Plan for Statistics, which promoted a process that has since become the benchmark in strategic statistical planning: the National Strategy for the Development of Statistics (NSDS). (OECD, 2011)

Partners collaborating with HMN include both producers of health information in the health, statistics, and research communities, and users of information such as the media, donor and development agencies, funds, and foundations. Other networks with mandates in the area of enhancing statistical capacities and building better health information systems include PARIS21 (http://www.paris21.org/, WHO, 2006)

2.2.4.6 Monitoring, Evaluation, and Review Regularly Assessed

Regular planned assessments of the M&E system are required to ensure that indicators are measuring what they are meant to, that data is generated according to standards that data analysis and communication of results give the information needed by decision-makers, and that data management includes an assessment of overall data quality. (WHO, 2011)

The indicators used for M&E must be 'fit for purpose'; that is, relevant to the needs of different users and sensitive to change. (If health priorities, strategies, or activities have changed, indicators should be reviewed to see if they are still relevant and revisions should be made as appropriate. The underlying data need to be accurate, complete, and timely. Quality is essential, both in terms of validity and reliability. Transparency is critical. (WHO, 2011)

Such assessments should be carried out every 2–3 years and the reports need to be made public and discussed during the annual review process. (WHO, 2011)

2.2.5 Challenges of Strengthening Health Information System

Strengthening of health systems has become a top priority of many global and national health agendas as a way to improve health outcomes. With the global health context becoming increasingly complex, national health systems are beginning to move away from a focus on disease-specific health responses to the comprehensive strengthening of health systems. The global community agrees that without a systems approach, health outcomes will not further improve and health-related development goals such as the United Nation's Millennium Development Goals (MDGs) for 2015 will not be met. (Nutley and W. Reynolds, 2014)

Learning from the experience of the Millennium Development Goals (MDGs), generation, availability, and accessibility of timely and quality information for key health indicators is essential for monitoring the progress towards achieving the targets of the health-related

Sustainable Development Goals (SDGs). Despite the progress made by many countries in monitoring health during the MDG era, the lack of reliable, timely, and comparable information in low- and most middle-income countries remains an issue (WHO,n.d, Ali et al,2016) and often hampers tracking and evaluation of progress.

There are two major sources for these problems in the field of health information. This is. Existing data are neither accessible nor presented in a coherent way (a problem of technical inefficiency); and Data, very often with limited utility, are collected and compiled in an uncoordinated fashion, hence at higher marginal costs (a problem of a locative inefficiency). (Shibuya, 2008)

The correction of such inefficiencies across agencies, institutions, and countries will make global health metrics more useful and reliable and leverage the comparative advantage of each stakeholder. The biggest challenge facing the global health community is developing the local capacity needed to collect, share, and analyze the high-quality data that are required to guide the ongoing reform of health systems. (Shibuya, 2008)

Capacity: A common challenge at all levels of the health system relates to human resource and technical capacity is affected by human resource capacity. Training of sub-national personnel across these technical skill sets has been undertaken; however, high turnover has destabilized these foundational steps. (Nemser et al, 2018)

Data quality: While not uniform, the perception of poor data quality existed for some data sources. For example, in LMIS, there is no routine audit mechanism for data quality. Supervisor visits are held to support capacity building and review data submissions; however, these visits. Moreover, funding shortfalls or 'push' supply systems often provide commodity replenishment that is inconsistent with current stock status or requested quantities, which creates less incentive to maintain accurate data submissions. (Nemser et al, 2018)

2.2.5.1 Technical Inefficiency

Data availability is the key to monitoring progress toward targets and evaluating the performance of health systems and programs. Many consumers of statistics overlook this fact because numbers—such as those representing progress toward the health-related MDGs—continue to be

published annually, and the assumption is that these represent meaningful data. Three prominent factors contribute to technical inefficiency in data collection and compilation: 1) the lack of a common database, 2) the lack of standardized metrics and data quality assurance, and 3) the lack of capacity and incentives to share data. (Shibuya, 2008)

Lack of A common database: As a general principle, common formats, definitions, and standards should be used to collect, compile, and store health information from countries. However, not all countries have achieved—nor are they likely to shortly—best international practice in this area. However, there can be considerable information content and value in nonstandard data sets (e.g., verbal autopsy-derived data on causes of death). Provided these data are well documented and understood, they should be made more widely available for comparative analyses and included along with more standardized compilations. (Shibuya, 2008)

2.2.6 Empirical literature

Today, the notion of partnership in North-South relationships remains the backbone of international development cooperation, as reflected in aid effectiveness principles, in the post-2015 debates, and the global public goods agenda. The very notion of North-South partnership has turned into yet another development buzzword (Cornwall, 2007, Carbonnier and Kontinen, 2014). Virtually everyone seems to agree with it in principle, but actual practice shows that implementing equitable partnerships is difficult: money flows tend to determine decision-making and actual division of lab ours. (Carbonnier and Kontinen, 2014) The rigidity of administrative procedures and practices of donor partners can only be addressed through a commitment to the partnership and willingness to revise existing organizational procedures and practices. In this respect, though often unrecognized informal donor policy and practice, most scholars and practitioners support the view that partnerships require start-up investments to establish internal support for partnership work (Brinkerhoff, 2004, Blagescu, and young, 2005). Therefore, one of the main challenges in partnership practice lies in coordinating partners' policies while promoting greater flexibility, responsiveness, and innovation. (Blagescu, and young, 2005)

According to the 2012 survey, while most donors do consider the country's policies and strategies when designing their interventions, it is not possible to determine if they are actually "aligned". The 2014 progress report indicated that even though country ownership continues to

strengthen, a stronger dialogue is needed to promote greater alignment with the priorities and systems of the partner countries. (OECD, 2014) One of the indicators agreed in Paris (indicator 1) considers the extent to which partner countries have national development strategies with clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets. The target was that at least 75% of partner countries have operational development strategies by 2010. (OECD, 2011)

The bilateral donors reviewed and the World Bank articulate their country's health sector support through 3- to 5-year plans or strategies, albeit with varying amounts of information on the level of financial support that will be provided over this period. These donors often try to align their support with national Poverty Reduction Strategies (PRSs) and Health Sector Strategic Plans. Thus if the planning horizon of recipients is limited, the duration of support provided by these partners is also likely to be constrained. (Dodd and lane, 2010)

Development partners reported that 831 country strategies were in place in 2018. Partner country governments were involved in the preparation of 94% of the strategies for almost three-fourths of the strategies, the partner country government signed off on the final document (73%), and/or the strategy includes results indicators that are drawn from CRFs, plans and strategies (72%). However, fewer (65%) use government data and statistics to report on the strategy's results indicators. Moreover, 24% of the strategies that plan an evaluation do not include the partner country government in either the evaluation of the country strategy or a discussion of the evaluation process and results. (OECD, UNDP b, 2019)

The Paris Declaration introduced the concept of mutual accountability – that aid is more effective when donors and partner governments are not only accountable to their respective publics for the use of resources to achieve development results but are also accountable to each other for better management of aid. The survey shows that the work to establish specific mechanisms for joint monitoring of aid effectiveness commitments at the country level is just beginning, and more efforts will be needed to achieve the target by 2010. (OECD, 2006)

Mutual accountability is evolving together with rapidly changing development co-operation modalities and coordination structures. Traditional mutual accountability structures are more prevalent and have strengthened, in partner countries for which official development assistance

remains important. More than half (52%) of the 42 least developed countries that reported on mutual accountability have quality mutual accountability mechanisms in place. (OECD, UNDP a, 2019)

In 2010, the amount of coordinated country analytical work has also decreased since 2007 levels. In 2007, 47% of analytical work in Jordan was undertaken jointly. By 2010, that number had decreased to 20%. The Government notes the use of government-donor working groups as an important step towards facilitating greater shared analytical work. However, Jordan is significantly below the 66% target for 2010. (JORDAN, 2012)

The challenge with such coordinated efforts for strengthening health systems is carefully monitoring how the country's plan is developed since no metrics have been developed to assess the impact of donor coordination. Efforts must be made to measure the extent to which donor coordination truly leads to improved health system performance. (Shibuya, 2008) In many countries, political commitment and priority given to HIS are inadequate due to the fragmentation of existing systems coupled with low capacity to collect, verify, and disseminate data and information.(Mohamed, et. al,2016) similarly, The overall HIS in Ethiopia is poorly developed. Formats for data collection have evolved as a result of decrees from the Ministry of Health (MoH) and vertical program managers and agencies. When new reporting formats have been issued, the old often continue to be used since they are owned" by a different agency, causing inconsistencies and "duplication. The information unit at the MoH has tried to create some order by issuing an overall compilation of required formats, but these efforts have not improved the situation. (Braa, et.al, 2007)

CHAPTER THREE

METHODOLOGY

3. RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter presents the research methodology that was used during the study. The chapter describes the research design, the target population, sample size and sampling procedure, research instruments, data collection procedures data analysis techniques.

3.2. Research Design

Creswell, (2009) Research designs are plans of all elements and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis. According to Kothari, (2004), it consists of the blue print for the collection, measurement, and analysis of data. The purpose of this study is to identify the role of development partners during the implementation of the Health Commodity Management Information System (HCMIS) has brought based on the perception of some selected employees of the central Ethiopian pharmaceutical supply agency (EPSA) also, it examined the factor that hinders the system from being effective. To serve this purpose, a descriptive study executed with a single case study research method was used. In addition, quantitative and qualitative data were employed.

The quantitative approach is selected to understand the overall perception of the Ethiopian Pharmaceutical Supply Agency on the contribution of development partners in the health Commodity Management Information System (HCMIS). Qualitative research is exploring and understanding the meaning individuals or groups ascribe to the contribution of health development partners in the Health Commodity Management Information System (HCMIS) problem. Thus; qualitative data were collected from purposively selected employees of Ethiopian Pharmaceutical Supply Agency and development partners for key informants due to their awareness/position in organization, knowledge, skill, interaction with issues, and/or rich information they have on the issues through developed semi-structured was collected.

3.3. Data Types and Sources

In this study, both primary and secondary source of data was used. Primary data was collected from the sample population through questionnaires distributed to Ethiopian Pharmaceutical Supply Agency employees and development partners directly involved. Also, relevant information was gathered from key informants because of their position and rich information they have on the contribution of development partners in the Health Commodity Management Information System (HCMIS). Also, written policies/strategies, minute meetings, and relevant documents for this study that are related to the contribution of development partners in Health Commodity Management Information System (HCMIS) were observed through the lens of the objective of the study to triangulate data and ensure reliability.

Secondary data was collected from published documents, article journals, books, internets, organizational publications, and related materials that have relevance to this study for both literature and analysis purposes was also used.

3.4. Sample Size and Sampling Procedure

3.4.1. Target Population

The study population refers to the total population from which the samples were selected. According to Kothari (2004), the study population refers to all cases of people and organizations or institutions which possess certain characteristics that reflect the purpose of the study. For this study, the study population consisted people, groups or organization/institutions have contributions for Commodity Management Information System.

3.4.2. Sampling and Sample Size Determination

3.4.2.1. Sample Methods

To achieve the object of this study the researcher applied the non-probability sampling (purposive sampling) method to select which enabled the researcher to choose a representative. Thus; Based on the information and data obtained and cleaned from Ethiopian Pharmaceutical Supply Agency headquarter directorates and development partners head office in Addis Ababa.

3.4.2.2. Sample Size Determination

The sample is the smaller portion of the study population or subgroup of the population from whom a researcher draws out information about the total population. The researcher was informed and observed by Ethiopian Pharmaceutical Supply Agency and its directorates have 245 individuals in the area that provides appropriate information concerning the objective of the study.

The sample size of this study was 70 individuals who were purposively selected and directly involved in this study from different Ethiopian Pharmaceutical Supply Agency directorates and health partners.

3.5. Data Collection Techniques

Data collection techniques are a process of collecting information from all the relevant sources to find a solution to the research problem and evaluate the outcomes. Two data collection instruments/questionnaires and semi-structured interviews /was used in this study for data collection.

Accordingly; Questionnaires were chosen as a research instrument in this study because relative to other tools is economical in terms of time and cost, it facilitates easy and quick response questions and gives freedom to respondents of any category to express their views or opinion. And allow greater uniformity in the way questions are asked by ensuring greater comparability in the response. A Likert scale was used for the closed-ended questions was prepared and used to collect relevant data from the target respondent. Brace (2003) cited in Thomas M.(2015); states that the Likert scale intends that the statements represent different aspects of the same attitude. The Likert scale is simple to construct and easy for the respondents to read, understand, and respond to statements put across.

In this research also a semi-structured interview was applied to collect qualitative data from key informants selected by using a purposive judgmental sampling procedure, based on the knowledge and experience regarding the subject under study to elicit the necessary data. A semi-structured interview provides greater flexibility in the order they are asked and the respondent has greater freedom to answer and expand on each question.

3.6. Data Analysis Techniques

In this study, the researcher begins with a quantitative data analysis collected from respondents using closed-ended questionnaires in which a theory or concept is tested using the Statistical Package for Social Scientists (SPSS) V.20.0 using tables, for analysis. Followed by a qualitative data analysis collected using semi-structured interviews from key informant individuals. Qualitative data were conducted from the key informant interviews also analyzed thematically through content analysis.

CHAPTER FOUR:

DATA PRESENTATION, ANALYSIS, AND INTERPRETATIONS

4.1 Introduction

This chapter discusses the presentation of data, interpretations and analysis of the study. It has two main parts: the first part is the background information of the respondents; the second part comprises of data collected from employees and directors through questionnaires and interviews, respectively. In this research 70 questionnaires were prepared and distributed to EPSA employees out of these questioners it filled 67 the rest 3 questioners were unturned.

The profile of respondents in terms of level of education, position and years of service is set out in the table.

4.2 Demographic Characteristics of Respondents

Table 4.1. Profile of the respondent

education level of respondents	Frequency	Percent
Diploma / TEVET/	17	25.4
First degree	32	47.8
Second degree and above	18	26.8
Total	67	100.0
Experience in the health sector general	Frequency	Percent
Less than or equal to 5 years	14	20.9
6 years to 11 years	39	58.2
12 years to 15 years	9	13.4
21 years and above	5	7.5
Total	67	100.0
Position of the respondent	Frequency	Percent
Officer	19	28.4
senior officer	28	41.8
Coordinator	19	28.4
Director	1	1.4
Total	67	100.0

Source: Field Survey (2020)

The above table shows the educational level, experience, and position of the 67 (sixteen, seven) respondents who filled in the questionnaire. The majority of respondents, 32 (47.8%), have a first degree in various fields of study, while 18 (26.9%) have a second degree. A relatively small number of the respondents, 17 (25.4%), have Diploma / TEVET/. Therefore, it showed that as a considerable number of the respondents, 50 (74.7%), have a first degree and above, then they can understand the contribution of development partners in the sector. In supplement to this, my respondents can better understand and answer questions based on their level of education. Regarding their experiences in the health sector, most of the respondents, 39 (58.2%), have served in the health sector 6 (six) years up to11 years and can better understand the context of international health support and the contributions of health development partners in the strengthening health information system.

4.3. Strengthening ownership trough, the institutionalization of HCMIS in the Agency

Table 4.2 Perception of respondents on strengthening the health commodity management information system.

(i.e. 1: Absolutely no 2: Mostly non 3: Nether yes nor no 4: Mostly yes 5: Absolutely yes)

N.O	**Section 1:- ownership**	1	2	3	4	5
1	HCMIS suited to the needs and priorities of the agency.	19 (28.4%)	17 (25.4%)	17 (25.4%)	9 (13.3%)	5 (7.5%)
2	HCMIS building has broad-based consensus and stakeholder involvement.	13 (19.4%)	22 (32.8%)	19 (28.4%)	7 (10.4%)	6 (9%)
3	System and procedure for HCMIS implementation and follow up are efficient (Including system for engaging staff).	23 (34.3%)	18 (26.9%)	11 (16.4%)	10 (14.9%)	5 (7.5%)
4	EPSA have the capacity of implementing HCMIS development policy (monitor and review)	19 (28.4%)	17 (25.4%)	19 (28.4%)	9 (13.3%)	3 (4.5%)
5	EPSA development strategies adequately address the issues of capacity and capacity utilization.	11 (16.4%)	20 (29.9%)	25 (37.3%)	10 (14.9%)	1 (1.5%)
6	Institutional arrangement of EPSA is available within the coordination of government strategies and development partners.	3 (4.5%)	20 (29.9%)	18 (26.9%)	19 (28.4%)	7 (10.4%)
7	EPSA has the action that has been taken to strengthen systems and procedures.	8 (11.9%)	23 (34.3%)	25 (37.3%)	7 (10.4 %)	4 (6%)

Source: developed by the author, 2020

As table 4.2 above shows, the majority (53.8%) of the respondent replied that the Health Commodity Management Information System (HCMIS) is not suited to the needs and priorities of the agency. While (20.9 %) reported that the Health Commodity Management Information System (HCMIS) is responsive to agency needs and priorities and (25.4%) of respondents did not justify it.

Based on the above table (52.2%) respondents and (19.4%) respondents replied that Health Commodity Management Information System (HCMIS) building has broad-based consensus and stakeholder involvement and (28.4%) neutral. In fact, by the information received during the interview, Health Commodity Management Information System (HCMIS) came to Ethiopian Pharmaceutical Supply Agency from individuals' approval rather than broad-based consensus and stakeholder involvement. Furthermore, Agency officers are not involved in the process of building and implementing Health Commodity Management Information Systems (HCMIS).

Regarding the implementation and monitoring of the Health Commodity Management Information System (HCMIS) majority of respondents (61.2%) are not efficient (including the system to engage staff) and (22.39%) of respondents indicate that the Health Commodity Management Information System (HCMIS) implementation are efficient (Including system for engaging staff); while a small number of respondents (16.41%) this was not justified/neutral. The interview made with directorates the participation of agency officers in the processor implementation and follow-up Health Commodity Management Information System (HCMIS) was very low/weak.

As observed in the above table 4.2, (53.8%) of respondents indicated that the Ethiopia Pharmaceutical Supply Agency (EPSA) has not the capacity to implement Health Commodity Management Information System development policy, and (28.4%) of respondents were neutral to the question. Small number (17.8%) of respondent indicated that the Ethiopia Pharmaceutical Supply Agency (EPSA) have the capacity implementing Health Commodity Management Information System (HCMIS). This showed that the Ethiopian Pharmaceutical Supply Agency (EPSA) system can officers monitor and adjust the system. However, Key informant interviewees agree that the Health Commodity Management Information System (HCMIS) system is operated by its development partners, system officers of the agency have never had the opportunity to manage, adjust, and collaborate with the system.

Similarly, table 4.2.Above indicates that 46.3% of respondents disagree that the Ethiopian pharmaceutical supply agency (EPSA) development strategies adequately address the issues of capacity utilization and (16.4%) respondents agree to the issues of capacity and capacity utilization. And the rest respondents (37.3%) were neutral. This showed that the capacity gap is not filled by strategy in internal employees. However, external employees according to during the 2006 E.C fiscal year, report of Ethiopia pharmaceutical supply agency (EPSA) training was given to 89 professionals from selected health facilities on the Health Commodity Management Information System (HCMIS) computer system and 83 professionals from Pharmaceutical Information Management System PLITS.

From the above table (38.8%) of respondents say Yes/agree, to the availability of government strategies and development partners coordination in (EPSA). While (34.5%) of respondents disagree with the government strategies and development partners coordination in (EPSA), and (26.9%) of the respondent become neutral/ not justify the issues. Key informant interviewees confirmed that the institutional arrangement issue is still under question/not addresses the organizational problems.

As table 4.2 shows the majority (46.2%) of the respondents replied that the Ethiopian Pharmaceutical Supply Agency (EPSA) does not take action to strengthen systems and procedures.37.3% of the respondents kept neutral; Whereas 16.4% of them said that the Ethiopian Pharmaceutical Supply Agency (EPSA) takes action to strengthen systems and procedures. This means that the agency has done less to correct the system. But the researcher confirmed with the key informant interviewee that the Ethiopian Pharmaceutical Supply Agency (EPSA) has nothing done in the system that has been improved.

4.4. Alignment and harmonization of Development partners' programs with EPSA priorities in strengthening its HCMIS

Table 4.3 Perception of respondents Development partners aligns and harmonize programs.

N.O	**Section 3:- Alignment and Harmonization**	1	2	3	4	5
8	HCMIS implementation is aligned with agency priorities.	9 (13.4%)	26 (38.8%)	16 (23.9%)	10 (14.9%)	6 (9%)
9	Partners in the implementation of HCMIS are using EPSA financial management system.	21 (31.3%)	19 (28.4%)	17 (25.4%)	9 (13.4%)	1 (1.5%)
10	Partners in the implementation of HCMIS are using the EPSA procurement management system.	24 (35.8%)	15 (22.4%)	15 (22.4%)	9 (13.4%)	4 (.6%)
11	Development Partners of HCMIS use agency development strategies and result framework.	10 (14.9%)	23 (34.3%)	19 (28.4%)	11 (16.4%)	4 (6%)
12	EPSA is involved in HCMIS development and reviews.	21 (31.3%)	28 (41.8%)	8 (11.9%)	6 (9%)	4 (6%)
13	EPSA and development partners give strengthen capacity HCMIS by co-ordinate support	14 (20.9. %)	7 (10.4%)	27 (40.3%)	18 (26.9%)	1 (1.5%)
14	Technical cooperation development partners regarding the implementation of HCMIS are aligned and coordinated.	6 (9%)	23 (34.3%)	16 (23.9%)	18 (26.8%)	4 (6%)
15	HCMIS budget support is linked to EPSA strategic policy priorities.	24 (35.8%)	24 (35.8%)	12 (17.9%)	6 (9 %)	1 (1.5%)
16	Development partners harmonize their system and procedure in EPSA.	5 (7.5%)	12 (17.9%)	23 (34.3%)	20 (29.9%)	7 (10.4%)
17	Harmonization has a negative impact on HCMIS effectiveness.	18 (26.9%)	11 (16.4%)	15 (22.4%)	15 (22.4%)	8 (11.9%)

Source: developed by the author, 2020

As shown in Table 4.3, the majority (52.2%) of respondents answered that the implementation of the Health Commodity Management Information System (HCMIS) is not aligned with agency priorities. While 23.9% stated that the implementation of the Health Commodity Management Information System (HCMIS) is aligned with agency priorities and the remaining 23.9% of respondents kept neutral. This indicated that there is a lack of alignment of project objectives with partners and country priorities decreased expected outcomes.

The study established that most of the respondents represented (59.7%) said that development partners do not use the agency's financial system and (25.4%) of the respondent did not justify it. On the other hand; (14.9%) of the respondents agreed that developmental partners used the agency financial management system. Regarding the agency procurement system (58.2%) of

respondents said development partners do not use the agency procurement system and (22.4%) of the respondent kept neutral; While (19.4%) of respondents agreed that the development partners using the agency procurement management system. Data gathered from key informants of concerned directorates partners in health development are not use agency financial systems. Similarly, Health development partners are not using national procurement systems.

As table 4.3 shows the majority (49.2%) of the respondents replied that the Development Partners of Health Commodity Management Information System (HCMIS) are do not use agency development strategies and result framework. Whereas 22.4% replied that development partners use agency development strategies and result framework and the rest 28.4% of the respondent did not justify it. Key informants with directorates indicated that Development partners are not using the Agency's development strategies and results framework.

Concerning the Ethiopian Pharmaceutical Supply Agency (EPSA) participation in the development of the Health Commodity Management Information System (HCMIS) and diagnostic reviews (73.1%) of respondents not agreed, and (15%) agreed; while (11.9%) respondents were neutral that Ethiopia's Pharmaceutical Supply Agency participates in the development of the Health Commodity Management Information System (HCMIS) and diagnostic reviews. Based on the respondents' results the Ethiopian Pharmaceutical Supply Agency (EPSA) is not involved in the development and diagnostic reviews of the Health Commodity Management Information System (HCMIS). Document review shows that routine meetings are held, at least monthly, to jointly review progress and track outcomes. The interviewee with the information technology coordinator of the agency confirmed monitoring and determining the gaps and changes in the relevant experts of the agency is weak.

As we observe from the above table most of the respondents (43.03 %) confirm that technical cooperation regarding the implementation of Health Commodity Management Information (HCMIS) is poorly aligned and coordinated. While 32.8% of Health commodity Management Information System (HCMIS) implementations were aligned and coordinated, the remaining 23.09% did not have a clue. The Agreement Provide technical assistance and support to PFSA, as agreed to the joint work plan, with USAID rules and regulations, and AIDS-free processes and procedures.

As shown in the table above, most respondents (40.03%) confirm that development partners are harmonizing their system and procedure in EPSA, and (34.3%) kept neutral. While (25.4%) respondents said development partners do not harmonize their system and procedure in EPSA. Key informant interviewee confirmed that development partners are not working together and signed Memorandum of understanding document.

As shown in the table above, most respondents (43.03%) agree that harmonization does not negatively affect the effectiveness of the Health Commodity Management Information System (HCMIS) while (34.3%) harmonization negatively impacts the effectiveness of the Health Commodity Management Information System (HCMIS). The remainder (22.4%) did not justify this. The results of collecting the questionnaire are described above. However, confirmed in an interview that development partners are not working together on the impact on the effectiveness of the Health Commodity Management Information System (HCMIS)

4.5. Development partners' mutual accountability in the implementation of HCMIS in EPSA

Table 4.4 Perception of respondents on mutual accountability

N.O	**Mutual accountability**	1	2	3	4	5
18	The monitoring and reporting systems and processes of HCMIS results are effective.	21 (31.3%)	19 (28.4%)	17 (25.4%)	9 (13.4%)	1 (1.5%)
20	HCMIS system and evaluation process are effective.	9 (13.4%)	26 (38.8%)	16 (23.9%)	10 (14.9%)	6 (9%)
21	Evaluation is used to improve HCMIS development effectiveness.	24 (35.8%)	15 (22.4%)	15 (22.4%)	9 (13.4%)	4 (6.%)
22	HCMIS activities are evaluated as cost/ resource-efficient.	10 (14.9%)	23 (34.3%)	19 (28.4%)	11 (16.4%)	4 (6%)

Source: developed by the author, 2020

Data, reports, analysis, and decisions based on monitoring evidence should be retained to make them easily accessible to evaluations (UNDP, 2009). Table 4.4 above indicates that (59.7%) of respondents said the Health commodity Management Information System (HCMIS) results in monitoring and reporting system and process are ineffective. On the other hand, 25.4% of respondents were neutral and (14.9%) of respondents indicated that the Health commodity Management Information System (HCMIS) monitoring and reporting system and outcome process are effective.

Evaluations are often carried out after the fact when multiple data gaps prevent a meaningful evaluation of what has worked and what has had the most impact (WHO, 2011). The table above shows that (52.2%) Respondents believe that the evaluation process of the Health commodity Management Information System (HCMIS) of the Ethiopian Pharmaceuticals Supply Agency is ineffective. On the other hand (23.9%) and(23.9%) of respondents respectively agree and kept silent on the efficiency of the Health commodity Management Information System (HCMIS) and the evaluation process.

Confirm that the above questionnaire received from the respondent indicates that the Health Commodity Management Information System (HCMIS) and evaluation process are not effective. This means that the purpose of the evaluation is not to enhance the effectiveness of the development of the Health Commodity Management Information System (HCMIS).

Similarly regarding the improvement of evaluation system of health commodity management information system (HCMIS); (58.2%) and (19%) of respondents respectively disagree and agree; were (22%) are neutral to the improvement of evaluation system of health commodity management information system (HCMIS). As indicated in table 4.5, the majority of respondents (49.2%) disclosed that health commodity management information system (HCMIS) activities are not evaluated cost/ resource efficiently. (22.4%) of respondents marked as health commodity management information system (HCMIS) activities are evaluated cost/ resource-efficiently and the remaining 28.4% kept neutral.

Generally based on the above information; it is possible to conclude that there is a lack of mutual accountability, effective monitoring, evaluating, and reporting system in cost/resource-effective way health commodity management information system (HCMIS) in the Ethiopian pharmaceutical supply system.

Results documented concerning system strengthening due to the implementation of HCMIS in EPSA.

Table 4.5 Perception of Respondents on Results Managing of HCMIS in EPSA

Section 5:- Managing results		**1**	**2**	**3**	**4**	**5**
23	Implementation of HCMIS has achieved the stated development objective and expected results.	19 (28.4 %)	19 (28.4%)	13 (19.4%)	12 (17.9%)	4 (6%)
24	HCMIS has resulted in positive benefits to the agency.	12 (17.9%)	16 (23.9%)	19 (28.4)	15 (22.4)	5 (7.5%)
25	Alternative measures are taken to bring a result-oriented HCMIS in EPSA.	13 (19.4%)	21 (31.3%)	17 (25.4%)	8 (11.9%)	8 (11.9%)

Source: developed by the author, 2020

As indicated in the table above, the majority of respondents (56.8%) did not implement the Health Commodity Management Information System (HCMIS) that achieved the stated development objective and expected results. With the statement that the Health Commodity Management Information System (HCMIS) has achieved the stated development objective and expected results (23.9%), yes, and (19.4%) remain neutral. This indicates that implementation Health Commodity Management Information System (HCMIS) has not achieved the stated development objective and expected results.

Table 4.5 above indicates that the implementation of the Health Commodity Management Information System (HCMIS) has not achieved the stated development objective and expected outcomes. Similarly, in Positive Outcomes for the Health Commodity Management Information System (HCMIS) for the Agency (29.9%) of respondents yes, (41.8%) absolutely, and especially none, and (28.4%) remains neutral. A conclusion that the Health Commodity Management Information System (HCMIS) is a health Commodity Management system does not produce positive outcomes for the Agency.

Based on the table above, most respondents (50.7%) indicated that corrective measures had not been taken. Whereas implementation Health Commodity Management Information System (HCMIS) has not achieved the stated development objective and expected results, (23.8%) respondents Yes, other measures are being taken to implement an outcome-based Health Commodity Management Information System (HCMIS). and the rest (25.4%) remain indifferent

to the issue. The results of the questionnaire conclude that no remedial action has been taken, except for the name change.

4.6 Contribution Development Partners to the Results

4.6.1 Strengthen the supply and contract management of development partners with the fiscal year 2006.

2006 E.C Budget Year on a regular budget birr 2,999,098,079.92 (two billion nine hundred and ninety-nine million ninety-eight thousand seventy-nine birr's ninety-two cents) and a health program of Birr 3,176,758,517.69 (three billion one hundred and seventy-six million seven hundred and fifty-eight thousand five hundred and seventeen birr's from sixty-nine cents) A total of 6,175,856,597.61 (six billion one hundred and seventy-five million eight hundred and fifty-six thousand five hundred and ninety-seven birr and sixty-one cents) as well as (in-kind) for health programs through partner organizations 3,773,919,329.29 (three billion seven hundred and seventy-three million nine hundred and nineteen thousand three hundred and twenty-nine birr from twenty-nine cents) and a total of Birr 9,949,775,926.90 (nine billion nine hundred and forty-nine million seven hundred and seventy-five thousand nine hundred and twenty-six birr nine cents) Valuable medicines and medical supplies provided. Vaccines (Birr 2,223,562,678.42) accounted for the largest share of the drugs offered by partner organizations. (2006, report)

4.6.2 Strengthening Distribution Development Partners 2006 E.C Fiscal year.

During the fiscal year, it is planned to distribute Birr 10,870,000,000.00 (ten billion eight hundred and seventy million birr's) worth of medicines and medical equipment in the regular budget of Birr 1,692,242,813.23 (one billion six hundred and ninety-two million two hundred and forty-two thousand eight hundred and thirty twenty- three cents) and the health program. Birr 8,768,329,249.44 (eight billion seven hundred and sixty-eight million three hundred and twenty-nine thousand two hundred and forty-nine birr's forty-four cents) Total birr 10,460,572,062.67 (ten billion four hundred and sixty million five hundred and seventy-two thousand sixty-two birr's sixty-seven cents) the distribution of valuable medicines and medical supplies. 96% of the plan has been achieved. The distribution of medicines and medical equipment is divided into regions as follows. (2006, report)

Table 4.6 Results in strengthening distribution development partners in Ethiopian Pharmaceutical Supply Agency (EPSA)

n.o	State / Government	Regular program	Health Program	Total
1	Oromia Region	426,713,094.4	2,302,799,710.62	**2,729,512,805.02**
2	Amhara Region	362,678,891.43	2,013,109,307.63	**2,375,788,199.06**
3	Addis Ababa City Administration	428,175,716.99	1,410,854,683.20	**1,839,030,400.19**
4	Southern Nations, Nationalities and Peoples' Region	262,448,745.72	1,418,666,989.55	**1,681,115,735.27**
5	Tigray Region	102,789,210.65	433,098,223.83	**535,887,434.48**
6	Afar Region	9,180,834.40	503,953,082.11	**513,133,916.51**
7	Benishangul-Gumuz Region	9,584,109.87	196,740,863.76	**206,324,973.63**
8	Dire Dawa City Administration	28,522,246.00	170,257,919.46	**198,780,165.46**
9	Somali Region	32,483,560.20	138,588,711.33	**171,072,271.53**
10	Harari Population Region	24,580,101.00	100,770,648.34	**125,350,749.34**
11	Gambella Population Region	5,086,302.57	79,489,109.61	**84,575,412.18**
	Total	**1,692,242,813.23**	**8,768,329,249.44**	**10,460,572,062.67**

Source: Ethiopian Pharmaceutical Supply Agency report (2006 E.C)

The distribution of medicines and medical equipment was 6.162.000.000.00 Birr in 2004 E.C and increased by 25 percent in 2005 E.C at Birr 7.699.261.228.00. The distribution also increased by Birr 10,460,572,062.67, up 36 percent compared to the prior year.

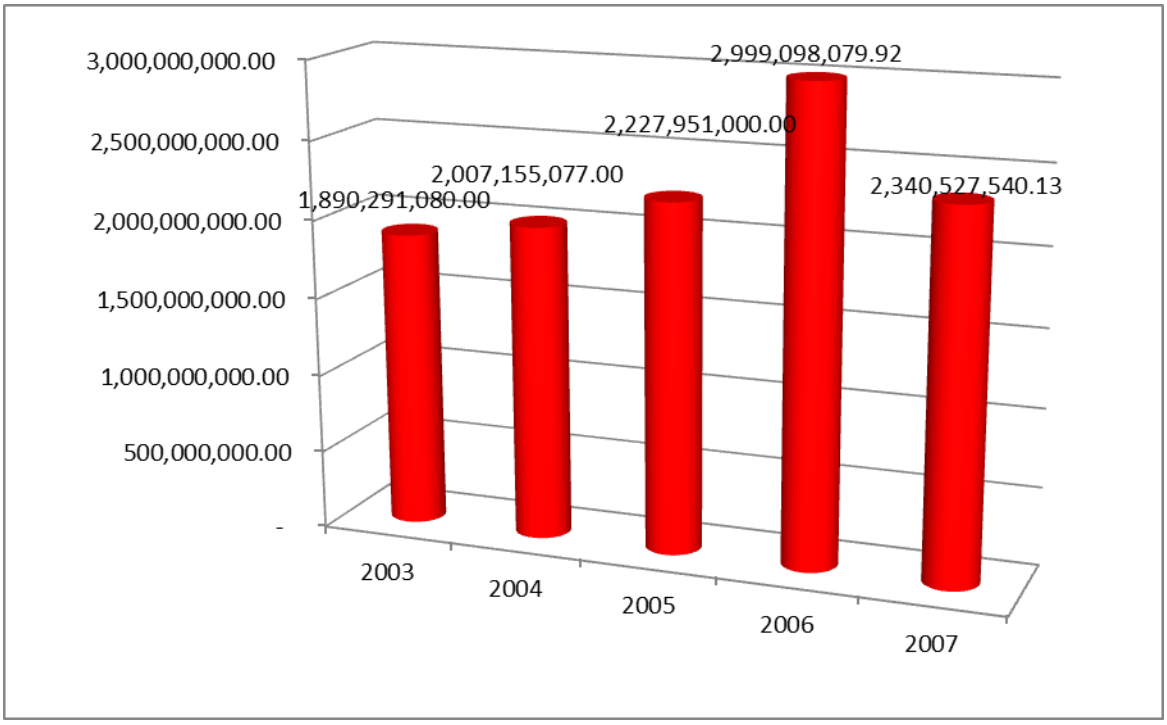
Of the Birr 8,768,329,249.44 worth of health program medicines and medical supplies distributed by the Agency during the fiscal year, Birr 496,112,547.50 was used to prevent the spread of HIV and to reduce the incidence and morbidity of AIDS, prevent mother-to-child transmission of the virus, and treat related diseases. In collaboration with the health bureaus, Birr 2,223,562,678.42 worth of pneumonia, polio, meningitis, rotavirus, etc., as well as Birr 22,123,808.44 worth of medicines and medical supplies for integrated health services is

available. Programs, anti-HIV, anti-malarial, TV and family planning, diagnostic kits, etc. Select health facilities and regimens health facilities and identify their needs in type and quantity in a coordinated manner monthly for 161 government hospitals and 21 private hospitals. Delivered directly to 1,460 health centers, 453 woreda health offices, and 49 zonal health departments. (2006, E.C report)

4.7. Strengthen procurement and contract management through contribution from development partners for fiscal year 2007.

During the fiscal year, 1,931,875,994.28 worth of medicines and medical equipment, Birr 1,200,000,000.00 worth of medical equipment, Birr 4,610,000,000.00 worth of medicines and medical equipment purchased through the Agency with the financial support of partner organizations, It is planned to deliver valuable medicines and medical equipment with a budget of Birr 2,340,527,540.13 and a total Birr 4,229,297,716.25 and Birr 6,569,825,256.38 medicines and medical equipment. Partners have provided Birr 6,907,355,790.72 worth of medicines and medical supplies for health programs, and a total of Birr 13,477,181,047.10 worth of medicines and medical supplies have been provided during the fiscal year. Out of these, Birr 2,535,991,733.98 worth of medical equipment and equipment was handed over. (2007, report)

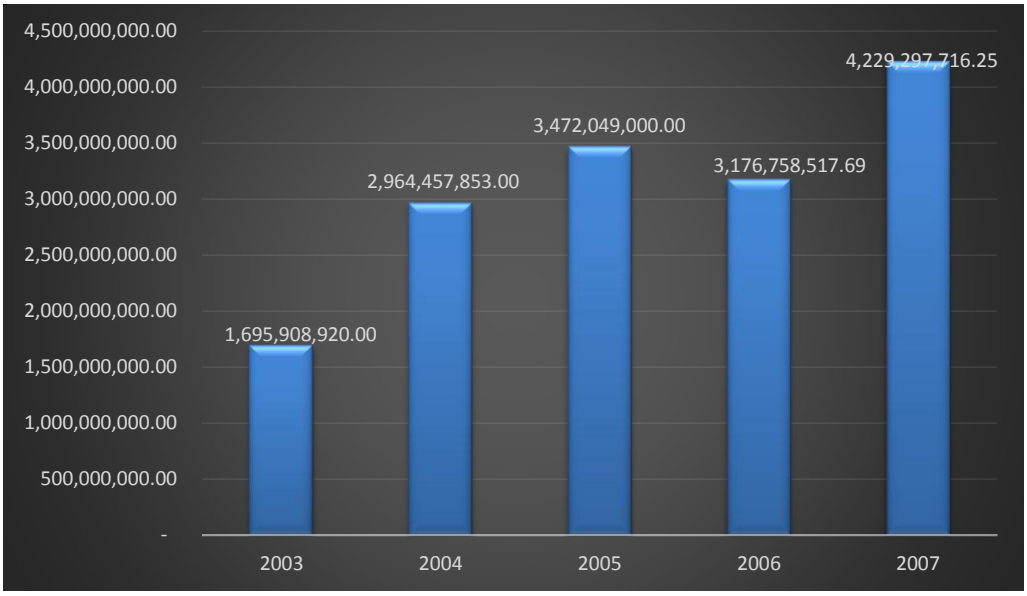
The purchase of drugs and medical equipment from the Regular Drug Fund was from Birr 1,890,291,080.00 in 2003 E.C., and increase by 6% in 2004 E.C., to Birr 2,007,155,077.00. It was 11% up on the previous year and reached Birr 2, 279, 510, 00.00. In 2006, supply was 35% higher than the previous year, reaching Birr 2,999,098,079.92. However, in 2007, the number of acquisitions decreased by 22 per cent compared to the previous year to Birr 2,340,527,540.13. Figure 1 below shows that the contribution of health development partners to the purchase of regular medicines and medical equipment is increase. (2007, E.C report)



Data Source: 2007 Ethiopian pharmaceutical supply agency report

Figure 1 Purchase of regular medicines and medical equipment.

Health program procurement of medicines and medical equipment was Birr 1,695,908,920.00 in 2003 E.C and increased by 75% in 2004 E.C to Birr 2,964,457,853.00. In 2005 E.C It increased by 17% compared to the previous year and reached Birr 3,472,049,000.00. However, in 2006 E.C, the procurement decreased by 9% over the previous fiscal year and Birr 3,176,758,517.69.in the 2007 E.C fiscal year, procurement increased by 33% over the previous fiscal year and reached Birr 4,229,297,716.25. (2007, E.C report)



Data Source: 2007 Ethiopian pharmaceutical supply agency report.

Figure 2 Procurement performances of health program medicines and medical equipment

The procurement of regular medicines and health program medicines and medical equipment was Birr 3,586,200,000.00 in 2003 E.C and increased by 39% in 2004 E.C to Birr 4,971,612,930.00. In fiscal year 2005 E.C, supply increased by 15% at Birr 5,700,000,000.00. During the 2006 Ethiopian fiscal year, supply increased by 8% to Birr 6,175,856,597.61. In the fiscal year 2007 E.C., procurement increased by 6% at Birr 6,569,825 256.38. (2007, E.C report)

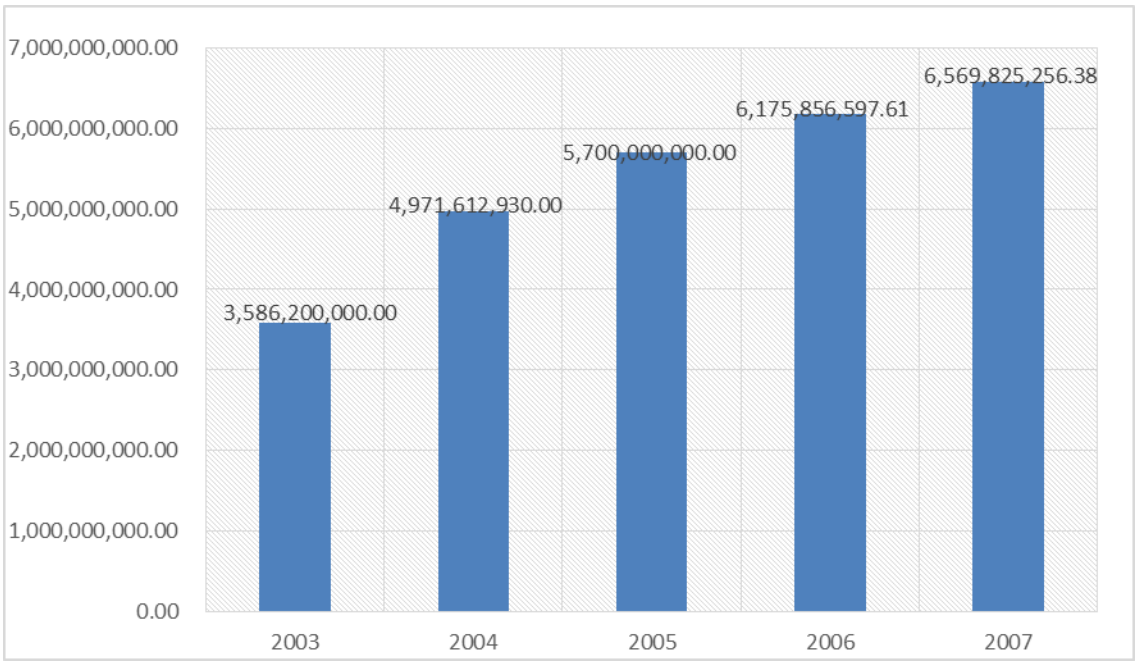


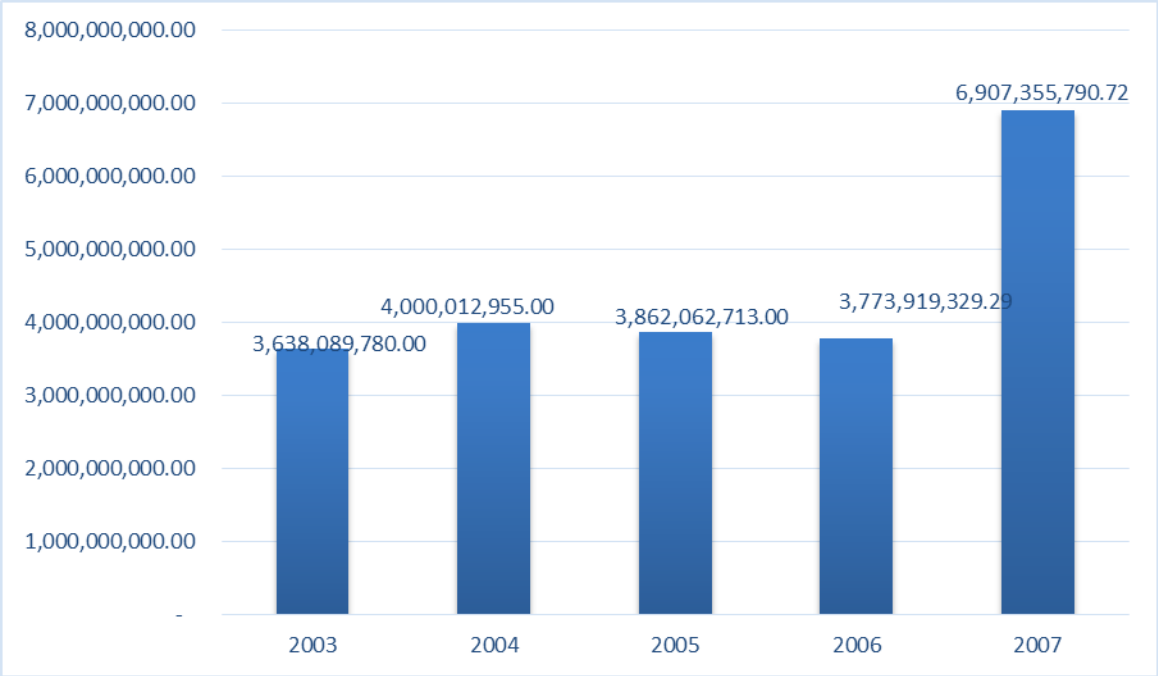
Figure 3 Procurement performance of regular and health program medicines and medical equipment.

Data Source: 2007 Ethiopian pharmaceutical supply agency report

4.7.1 In-kind medicines and medical supplies purchased by partner organizations

In the fiscal year 2003 E.C 3,638,089,780.00 Birr was purchased for health programs (in-kind) through partner agencies and 400,012,955.00 Birr increased by 10% in 2004 E.C. However, during the 2005 Ethiopian budget year, the amount of Birr 3,862,062,713.00 was reduced by 3 %. During the 2006 fiscal year, the partners purchased and submitted to the Agency a decrease of 2% to 3,773,919,329.29. During the 2007 Ethiopian budget year, partner organizations purchased Birr 6,907,355,790.72, 83% of which increased their purchases of medicine and medical supplies in kind. (2007, E.C report)

Over the last five years, the Agency has provided 7,224,289,780.00 Birr medicines and medical equipment under regular and health programs. During the last fiscal year, it increased by 24% in 2004 E.C at Birr 8,971,625,885.00. During the 2005 fiscal year, procurement increased 7% to 9,562,062,713.00 Birr. In the 2006 fiscal year in Ethiopia, supply increased by 4%, from 9,949,775,926.90 to 13,477,181,047.10. (2007, E.C report)



Data Source: 2007 Ethiopian pharmaceutical supply agency report

Figure 4: In-kind medicines and medical supplies purchased by partner organizations.

4.7.2 Strengthening of distribution with the contribution of development partners for the fiscal year 2007.

It is planned to provide a total of Birr 11,566,965,870.28 worth of medicines and medical supplies. Birr 2,340,527,540.13 in the regular budget and birr 4,229,297,716.25 in the health program and a total of birr 6,569,825,256.38 worth of medicines and supplies. Partners have provided (In- kind) Birr 6,907,355,790.72 worth of medicines and medical supplies for health programs, while Birr 13,477,181,047.10 worth of medicines and medical supplies have been provided during the fiscal year. Out of these, Birr 2,535,991,733.98 worth of medical equipment and equipment was handed over. (2007, E.C report)

4.8. Strengthen procurement and contract management in 2008

During the 2008 Ethiopian fiscal year, regular budget Birr 2,408,748,823.15 and health program Birr 4,001,088,319.59 general Birr 6,409,837,142.74 worth of medicines and medical supplies were provided, in the regular budget and Health Program. Additionally, health programs in the

form of partners provided (in-kind) Birr 7,639,933,197.80 and a total of Birr 14,049,770,340.55 values of medicines and medical supplies. (2008, E.C report)

4.8.1 Enhanced a distribution and freight management system in 2008

There are plans to distribute 15,314,798,600.00 Birr medicines and medical supplies during the fiscal year. The distribution of medicines and medical equipment in Ethiopia's 2008 fiscal year is divided into regional and city administrations as follows.

Table 4.7 Results in strengthening the delivery and freight management system.

n.o	State / Government	Regular program	Health Program	Total
1	Oromia Region	641,524,017.74	6,718,040,102.47	**7,359,564,120.21**
2	Amhara Region	571,904,550.20	3,965,367,618.98	**4,537,166,167.98**
3	Addis Ababa City Administration	309,052,397.56	2,781,854,941.77	**3,090,907,339.33**
4	Southern Nations, Nationalities and Peoples' Region	586,048,505.95	1,144,695,567.10	**1,730,744,073.05**
5	Tigray Region	129,106,964.05	611,736,336.90	**740,843,300.95**
6	Afar Region	55,732,437.20	368,319,464.19	**424,051,901.39**
7	Benishangul-Gumuz Region	45,747,216.54	383,112,998.83	**428,860,215.37**
8	Dire Dawa City Administration	21,588,935.71	223,060,192.26	**244,649,127.97**
9	Somali Region	11,770,521.16	174,938,294.34	**186,709,815.50**
10	Harari Population Region	27,382,379.42	54,369,073.29	**81,751,452.71**
11	Gambella Population Region	16,626,326.08	35,302,440.40	**51,928,766.48**
	total	**2,416,484,251.61**	**16,460,797,030.90**	**18,877,281,282.14**

Source: Ethiopian Pharmaceutical Supply Agency report (2008 E.C)

Out of the Birr 16,460,797,030.90 worth of health programs distributed by the Agency, prevention of HIV transmission and reduction of AIDS-related illness and death, prevention of mother-to-child transmission of the virus, integrated child health services, malaria, family planning, tuberculosis, and leprosy Used and used to treat related diseases and in collaboration with health bureaus and regular campaign vaccination supplies are valued at Birr 6,375,277,156.21. These inputs were distributed directly to 292 hospitals, 1473 health centers, 644 woreda health units, and 49 zonal health services, selecting health facilities, and identifying their needs. (2008, E.C report)

During the year, Birr 1,911,206,570.06 regular and health program Birr 7,091,511,796.12 total Birr 9,002,718,366.18 medicines and medical supplies were made in the Agency's warehouses. Out of this, Birr 86,461,623.31 is regular and 216,486,512.18 health program is the total cost of Birr 302,948,135.49 medicines and medical supplies have a shorter use period (six months or less) (2008, E.C report)

4.8.2 2009 E.C Strengthening procurement and contract administration;

Birr 3,740,372,659.39 in the regular budget as well as in the health program Birr 3,100,963,501.44 has been signed for the purchase of medicines and medical equipment worth a total of Birr 6,841,336,160.83. Medicine and medical supplies worth Birr 1,439,152,236.55 and Birr 3,345,436,545.73 were handed over to the Health Program. In addition to the above-mentioned supplies purchased by the Agency, Birr 5,177,784,479.84 worth of in-kind health programs were provided by the partners and a total of Birr 8,523,221,025.57 worth of medicines and medical supplies were provided during the year. (2009, E.C report)

4.8.3 2009 E.C Strengthening the Financial Management System;

During the fiscal year, the Federal Ministry of Health's Sustainable Development Goals (SDGs) collected 12,732,001.52 Birr from procurement services and 31,830,004.07 Birr from distribution services for a total of 44,562,005.59 Birr. A total of 14,600,735.03 Birr was collected from the Global Fund, 133,364,703.25 birr's from the distribution service and a total of 147,965,438.28 Birr from the CIFF-MOH, and 416,307.44 birr's from the distribution service. A total of 29,190,446.89 Birr was procured from the HIV / AIDS Prevention and Control Office and a total of 101,991,564.10 Birr was collected from the procurement service and 360,021,330.06 Birr was collected during the fiscal year.(2009,E.C report)

Table 4.8 Strengthening procurement of development partners during 2010 E.C.

Program	category	plan	total	Performance Percentage (100%)
In the health program (GF & SDG)	Medicines	5,000,000,000	2,090,608,768	57.6 %
	medical equipment		62,799,553.1	
	medical supplies		20,794,024.98	
	Chemical and Regent		703,454,382	
	total		2877656728.1	
In the health program (MOH & Unicef)	Medicines		4,919,494,814	
	medical equipment		33,218,386.52	
	Chemical and Regent		318,431,014.95	
			5,271,144,215	
Total			10,076,844,687	

Source: Ethiopian Pharmaceutical Supply Agency report (2010 E.C)

4.8.4. In the fiscal year 2010, development partners strengthening of distribution

During the fiscal year, Birr 4,262,570,640 worth of regular budget and Birr 2, 708, 836, 19301 (63.6%) worth of medicines were distributed in the Health Program, and Birr 13,513,615,277.04 (122.27%) worth of medicines and medical supplies were distributed in the Health Program. In total, 16,222,451,470.05 Birr (105.9%) of medicines and medical supplies were distributed.

Table 4.9. **Strengthening the financial management system for development partners in 2010 E.C.**

Service fee for the 2010 fiscal year

n.o	Development Partners	service fee		
		Procurement service (2%)	Storage and Distribution Service Payment (5%)	Total (7%)
1	Sustainable Development Goals (SDGs)	5,803,58597	16,931094.69	22,734,680.66
2	From the Global Fund	20,835,660.32	46,609,761.15	67,445,421.47
3	GF-Hapco	57,022,239.02	57,022,239.02	79,831,134.63
4	Moh IRSH AID	68,966.51	68,966.51	96,553.12
5	Moh CIFF	653,650.31	653,650.31	915,11031
Total		49,737,188.51	121,285,711.68	171,022,900.19

Source: Ethiopian Pharmaceutical Supply Agency report (2010 E.C)

CHAPTER FIVE

5. SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This part of the study summarizes and concludes the main findings obtained from the collected data from employees, reviews documents, and provides some recommendations to be implemented by concerned bodies to alleviate existing challenges and problems.

5.1. Summary of Findings

The following points are the major findings of the study:

- The Health Commodity Management Information System (HCMIS) does not address the Agency's needs and priorities.
- A strengthened development partner the Health Commodity Management Information System (HCMIS) certainly does not have broad consensus and stakeholder participation.
- Development partners of Health Commodity Management Information System (HCMIS) building and implementation process are not included for engaging staff especially, system officers.
- Ethiopia Pharmaceutical Supply Agency (EPSA) system officers have never had the opportunity to monitor and review the Health Commodity Management Information System (HCMIS).
- Health commodity Management Information System (HCMIS) partners have, not to use the Agency's finance and procurement system.
- Health Commodity Management Information System (HCMIS) partners have not used the Agency's development strategies and result framework.
- Technical cooperation development partners in implementing the Health Commodity Management Information System (HCMIS) are not aligned and coordinated.
- Monitoring and evaluation of the Pharmaceutical supply system Strengthening Framework of the Ethiopian Pharmaceutical Supply Agency (EPSA) are not implemented.
- The implementation of the Health Commodity Management Information System (HCMIS) has not met the stated development objective and expected results.
- According to the results and the objective of the Health Commodity Management Information System (HCMIS), no corrective action is taken, except for the modified name.

5.2. Conclusion

Development partners, the supply chain strengthening Ethiopian pharmaceutical supply agency is extremely important. For evidence, this is the 2006-2010 Development partners' five-year report, which shows that the agency contributed in contract management, procurement, and distribution 70% of the total agency in the supply chain. The contribution of development partners' in pharmaceutical supply procurement, distribution, capacity building, finance, and infrastructure complies with international conventions further research is needed. When to come to the developing partners contribution to Health Commodity Management Information System (HCMIS) international agreements, principles are not implemented. There is no ownership, alignment and harmonization, accountability, and managing the result, in the absence of such, there, development partners were not able to implement the system. Lack of agreement with a strong legal framework, failure to monitor and evaluate development partners and the agency systems this and other reasons the system does not contain all the necessary directions. In general, the contribution of development partners in the Health Commodity Management Information System (HCMIS) has not efficient and effective.

5.3. Recommendations

- Ethiopian pharmaceutical supply agency collaboration with development partners to identify the performance gap and the problems of Health Commodity Management Information System (HCMIS) a given priority for agency and users need to generate the strategic ideas from stakeholders.
- Establish a system in which the Ethiopian Pharmaceutical Supply Agency (EPSA) fully manages the Health Commodity Management Information System (HCMIS) and receives only the technical support required from development partners. (To do for this prepare strong legal frame work between agency and development partners)
- Development partners should develop their reinforcement system based on the needs and capacity gaps of the Ethiopian Pharmaceutical Supply Agency and its staff.
- Ethiopian Pharmaceutical Supply Agency and Partners in Implementing the Health Commodity Management Information System (HCMIS) are regular accountability measures for the submission of the Engagement and Evaluation Report.

- The Ethiopian Pharmaceuticals Supply Agency (EPSA) should take alternative action. Purchase a centralized system operated by agency officers. Always waiting for everything from the development partners.
- Development partners should use the agency's different systems within the framework of international agreements. And the appropriate government bodies should adjust the institutional arrangement to allow them to use the agency system.

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Appendix 1
Addis Ababa University
College of Business and Economics
Department of Public Administration Development Management
Master Program in Public Management and Policy

Research title: The Contribution of Health Development Partners in the Health Commodity Management Information System (HCMIS) of Ethiopia Pharmaceutical Supply Agency (EPSA)

Questionnaire Distributed to respondents to collect data from in the employees of Ethiopia Pharmaceutical Supply Agency (EPSA)

Introduction

Thank you for your willingness to participate in this study as a respondent. This Questionnaire is used to collect data for the Master Program in Public Management and Policy research title "The Contribution of Health Development Partners in the Health Commodity Management Information System (HCMIS) of Ethiopia Pharmaceutical Supply Agency (EPSA)" your experience will be significantly added value as an input for this paper. I assure you that the information you provide will be used only for academic research purposes and the anonymity of the respondent will be maintained thought the research process. Thank you for your cooperation. **If you have any questions about this study, please contact the investigator, AlemayehuAdmasu (aleayiti@gmail.com) or 251912489388**

1: BACKGROUND INFORMATION

1. Your level of education

☐ Diploma / TEVET/ ☐ First degree ☐ Second degree and above

2.Year of experience in the health sector in general

☐ Less than or equal to 5 years ☐ 6 years to 11years ☐ 12years to 15 years

☐ 16years to 20 years ☐ 21 years and above

3. Your current position

☐ Officer ☐ senior officer ☐ coordinator ☐ Director

4. for the following Questions, please put (x) mark in the box corresponding to your preferred response using the scale below

1: Absolutely no 2: Mostly non 3: Nether yes nor no 4: Mostly yes 5: Absolutely yes

Section 2:-ownership						
No	**Questions**	**Scale**				
		1	**2**	**3**	**4**	**5**
1	HCMIS is suited to the needs and priorities of the agency.					
2	HCMIS building has broad-based consensus and stakeholder involvement.					
3	System and procedure for HCMIS implementation and follow up are efficient (Including system for engaging staff).					
4	EPSA have the capacity of implementing HCMIS development policy (monitor and review)					
5	EPSA development strategies adequately address the issues of capacity and capacity utilization.					
6	Institutional arrangement of EPSA is available within the coordination of government strategies and development partners.					
7	EPSA has the action that has been taken to strengthen systems and procedures.					

Section 3:- Alignment and Harmonization						
8	HCMIS implementation is aligned with the agency priorities.					
9	Partners in the implementation of HCMIS are using EPSA financial management system.					
10	Partners in the implementation of HCMIS are using EPSA procurement system.					

11	Development Partners of HCMIS use agency development strategies and result framework.					
12	EPSA is involved in the HCMIS development and Diagnostic reviews.					
13	EPSA and development partners give strengthen capacity HCMIS by co-ordinate support					
14	Technical cooperation development partners regarding the implementation of HCMIS are aligned and coordinated.					
15	HCMIS budget support is linked to EPSA strategic policy priorities.					
16	Development partners harmonize there system and procedure in EPSA.					
17	Harmonization has a negative impact on HCMIS effectiveness.					
Section 4:- Mutual accountability						
18	The monitoring and reporting systems and process of HCMIS results are effective.					
19	HCMIS system and evaluation process are effective.					
20	Evaluation is used to improve HCMIS development effectiveness					
21	HCMIS activities are evaluated as cost/ resource-efficient.					
Section 5:- Managing results						
22	Implementation of HCMIS has achieved the stated development objective and expected results.					
23	HCMIS has resulted in positive benefits to the agency.					
24	HCMIS has been implemented to provide policy inputs that are arising out of feedback from information sharing and dissemination.					
25	Alternative measures are taken to bring a result-oriented HCMIS in EPSA.					

Appendix 2
Interview Guide for Key Informant Interviews
Addis Ababa University
College of Business and Economics
Department of Public Administration Development Management
Master Program in Public Management and Policy

Research title: "The Contribution of Health Development Partners in the Health Commodity Management Information System (HCMIS) in Ethiopia Pharmaceutical Supply Agency (EPSA): ***Ownership, align*** **and harmonize, managing results**"

In-depth structured interview to collect data from key informants in the management of Ethiopia Pharmaceutical Supply Agency (EPSA)

Location: _____

Qualification of the interviewee: _____ Year of experience: _____

Current Position: _____

Introduction:

Thank you for your contribution to this research as a respondent. This interview is conducted to collect data for Master Program in Public Management and Policy research title "The Contribution of Health Development Partners in the Health Commodity Management Information System (HCMIS) of Ethiopia Pharmaceutical Supply Agency (EPSA)" your experience and opinions will be significantly added value as an input for this paper. I assure you that the information you provide will be used only for academic research purposes and the anonymity of the respondent will be maintained thought the research process. Thank you for your cooperation.

1. To what extent can do we influence agency development strategy?
2. To what extent and how do you accommodate development partners' priorities?
3. What is the capacity you have for implementing HCMIS as development policy (Plan, Budget, implement, monitor, and review)
4. Who are your key stakeholder and what are their role strategy/ HCMIS development?
   4.1 What is their level of participation?
5. How far are development partners using agency financial management systems? (why/why not)
   5.1. What constraints in the agency's financial management system inhabit development partners from making use of it?
6. How far are development partners using agency procurement systems? (why/why not)
7. How and to what extent do development partner's procurement rules impact your procurement options?
8. What is being done to strengthen procurement standards and systems?
9. Have you requested development partners to harmonize there system and procedure?
10. What are the main constraints in development partners harmonizing their systems and procedure?
11. Are there any laws, rules, policies, or institutional factors that restrain the agency from adopting harmonizing practice?
12. Are there systems in place to provide policy inputs arising out of feedback from information sharing and dissemination?
13. How development partners supported efforts to improve results orientation in development work?

Appendix 3
Interview Guide for Key Informant Interviews

Addis Ababa University

Collage of Business and Economics

Department of Public Administration Development Management

Master Program in Public Management and Policy

Research title: "The Contribution of Health Development Partners in the Health Commodity Management Information System (HCMIS) in Ethiopia Pharmaceutical Supply Agency (EPSA):***implementation statuses, Ownership, align*** **and harmonize, managing results**"

In-depth structured interview to collect data from key informants in the health development partners of Ethiopia Pharmaceutical Supply Agency (EPSA)

Location: _____

Qualification of the interviewee: _____ Year of experience: _____

Current Position: _____

Introduction:

Thank you for your contribution to this research as a respondent. This interview is conducted to collect data for Master Program in Public Management and Policy research title "The Contribution of Health Development Partners in the Health Commodity Management Information System (HCMIS) of Ethiopia Pharmaceutical Supply Agency (EPSA)" your experience and opinions will be significantly added value as an input for this paper. I assure you that the information you provide will be used only for academic research purposes and the anonymity of the respondent will be maintained thought the research process. Thank you for your cooperation.

1. How do you ensure that your priorities have taken into account?
2. Do partners have the capacity to lead the aid utilization process?
3. What factors drive the development partners' agency assistance strategy?
3.1. What is the process?
3.2. Who participates?
4. How do you manage agency operations, oversee and report
5. What are the key constraints for better coordination?
6. How does the development partners determine strength (or weakness) of EPSA HCMIS systems
7. Are HCMIS capacity-building results measured
8. Are there any laws, rules, or operational procedures that restrain the health development partners from using the national system.
9. How far do you use partner budgeting, accounting, and auditing mechanisms?
10. When is the financial management system transparent in HCMIS PROJECT
11. What has been done to enable donors to harmonize aid activities?
12. How do you address issues of mutual accountability?