BRE Operational Research: Assessing the efficiency and effectiveness of emergency health financing mechanisms in Ethiopia

Phase 2: In-Depth Context Analysis

(updated with regional findings)

Donna Harris, Edom Betru, Esther Namukasa, Betelhem Merra Tegegne, Zoma Mesfin, Israel Mitiku, Biniyam Tadesse, and Ageazit Teka (Oxford Policy Management); Ermias Dessie and Tesfaye Mesele (Partnership and Cooperation Directorate, Ministry of Health)

May 2023

BRE BUILDING RESILIENCE IN ETHIOPIA

A technical assistance programme implemented by Oxford Policy Management (OPM) in partnership with:

UKaid from the British people

USAID FROM THE AMERICAN PEOPLE

About Oxford Policy Management

Oxford Policy Management (OPM) is committed to helping low- and middle-income countries achieve growth and reduce poverty and disadvantage through public policy reform.

We seek to bring about lasting positive change using analytical and practical policy expertise. Through our global network of offices, we work in partnership with national decision makers to research, design, implement, and evaluate impactful public policy.

We work in all areas of social and economic policy and governance, including health, finance, education, climate change, and public-sector management. We draw on our local and international sector experts to provide the very best evidence-based support.

Oxford Policy Management Limited
Registered in England: 3122495

Level 3, Clarendon House
52 Cornmarket Street
Oxford, OX1 3HJ
United Kingdom

Tel: +44 (0) 1865 207 300
Fax: +44 (0) 1865 207 301
Email: donna.harris@opml.co.uk
Website: http://www.opml.co.uk
Twitter: https://twitter.com/OPMglobal
Facebook: @OPMglobal
YouTube: @OPMglobal
LinkedIn: @OPMglobal

Acknowledgements

We are grateful for the support provided by the Health Economics and Financing Analysis Case Team (HEFA) within the Partnership and Cooperation Directorate (PCD) of the Ministry of Health (MoH), and by the Ethiopian Public Health Institute (EPHI). We are also grateful for the time that all of the respondents provided to us during the key informant interviews.

Executive summary

Background

This Operational Research has been commissioned under **the Building Resilience in Ethiopia (BRE) Technical Assistance (TA) programme**, which is co-financed by the UK Foreign, Commonwealth, and Development Office (FCDO) and the United States Agency for International Development (USAID). The aim of this Operational Research (OR) is to gain a better understanding of how emergency health and nutrition financing can be most effectively allocated and spent in the medium and long term in Ethiopia. In conducting this research, we have worked very closely and collaboratively with the Government of Ethiopia (GoE), particularly the Partnership and Cooperation Directorate (PCD) within the Ministry of Health (MoH) and the Minister's Office within the MoH, as well as receiving support from the Ministry of Finance (MoF) and the Ethiopian Public Health Institute (EPHI), in order to ensure that our research is aligned with the GoE's priorities, and to ensure that the evidence generated by this research will help contribute to the overall outcomes and impacts of the BRE TA (to 'save lives and promote well-being through better shock responses').

Objectives and scope

This Operational Research is taking place over three phases. The scope of the research is limited to the health sector and the time boundary is the past five years (2015–2020, or Ethiopian Calendar Year 2008–2012). Case studies conducted as part of the research cover malaria, cholera, nutrition shocks, COVID-19, and trauma and injuries (as permitted by the availability of data). The first phase of the research was formative research that reviewed existing literature, reports, and policy documents, to help us map the emergency health and nutrition financial landscape in Ethiopia.

The main objective of the current phase (Phase 2) is to build on the first phase by conducting **an in-depth context analysis** at the federal and regional levels **to understand the sources of emergency financing for health and nutrition, the allocation processes, and the financial flows, in order to identify the strengths and weaknesses of the emergency funding mechanisms**, gaps in terms of resources, and bottlenecks in terms of decision-making/reporting processes for emergency financing for health and nutrition.

Methodology

We utilised a mixed-methods research approach involving both primary and secondary data collection. For primary data, key informant interviews (KIIs) were conducted with stakeholders within the government at federal and regional levels, donors, development partners, non-governmental organisations (NGOs), and implementing agencies. The methodology used for the analysis of primary data was innovative in that it embedded value for money (VfM) analysis within the analysis framework, building on the previous VfM analysis study by the MoF and MoH, and the performance standards set out in the World

Health Organization's (WHO's) Health Financing Progress Matrix (HFPM) Assessment,[1] which is the WHO's standardised qualitative approach for assessing country health financing systems, in terms of both the development and implementation of health financing policy. The focus was on emergency aspects of the HFPM, which was incorporated into the analysis framework and performance standards that were used to assess the current emergency financing for health and nutrition in Ethiopia in this phase of the operational research.

Secondary data on health expenditure and health emergency incidence came from the MoH and EPHI and were used to analyse the trends in health financing and the incidence of different types of health emergencies over time.

Key findings

This phase of the Operational Research has attempted to assess the efficiency and effectiveness of the emergency financing for health and nutrition across eight dimensions: (i) predictability; (ii) adequacy/flexibility; (iii) allocative efficiency; (iv) timeliness; (v) good coordination; (vi) accountability/transparency; (vii) impact (reach/coverage); and (viii) resource use/cost-effectiveness.

(i) Predictability: between 'progressing' and 'established' at federal level but only 'progressing' at regional level

Based on the available evidence, the predictability of resources for emergency health financing falls between the categories of 'progressing' and 'established overall'. This means that although revenue and expenditure scenarios exist through some form of planning, predictability of the level of funding for emergency health and nutrition still requires improvement. While the sources of emergency funding for health and nutrition are known across all stakeholders, there is a lack of a functional budgeting process that allows for an accurate estimate of the required funding for a given emergency event (the 'established' category).

At regional level, the major source of funding is the regional contingency budget. Other sources of financing include regular regional budgets, the federal government, country offices for regional NGOs, donors, and an emergency preparedness fund in Sidama. Generally speaking, there is no budget line earmarked for emergency responses, and the contingency budget is not earmarked for any specific emergency.

Generally speaking, regional health and disaster risk bureaus prepare Emergency Preparedness and Response Plans (EPRPs), which outline the technical and financial (budgeting) components that forecast, quantify, and estimate the magnitude of emergencies and the resources required to address the problems. Also, risk and vulnerability assessments are prepared to support the EPRPs. However, there is no earmarked or prepositioned budget allocated by the government to the corresponding emergency preparedness and response activities, as per the annual plan. In most cases, the plans do

[1] www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix#:~:text=The%20Health%20Financing%20Progress%20Matrix,of%20health%20revenues%20and%20expenditures.

not get financed until a disaster happens. Overall, the sector annual emergency planning does not ensure the predictability of resources. Some regional Disaster Risk Management Commissions (DRMCs) participate in the preparation of the national Humanitarian Response Plan (HRP) prepared by the federal government. Though the HRP ensures the predictability of resources, there is no resource mobilisation to ensure the availability of prepositioned resources/supplies before the occurrence of emergencies included in the HRP.

Additionally, there is no functional budgeting process to accurately estimate the financial resources needed for emergency responses. The resources allocated for preparedness and response activities are not allocated proportionally based on the expected level of public health and nutrition emergencies. It seems that the budget for responding to emergencies is allocated in a haphazard way, and there is no procedure for estimating the required funds.

(ii) Adequacy: 'emerging' at both federal and regional levels

Overall, emergency funding is insufficient to address the magnitude of need that exists in Ethiopia. The government's budget allocated for emergencies is reported to be low and not earmarked or put aside for health and nutrition emergency needs. Most emergency responses are donor dependent, and even donors and implementing partners (IPs) referred to funding limitations when it comes to addressing increasing needs caused by protracted conflicts and health and nutrition crises across the country. There is some flexibility to move funds across programmes and adjustment to secure additional resources from within government institutions, but less so on the donors' side, due to accountability and transparency requirements.

At regional level, based on the available evidence, the adequacy of resources for emergency health financing is 'emerging'. Overall, emergency funding is insufficient to address the magnitude of the need in all the regions and city administrations included in this study. Moreover, the government's budget allocated for emergencies is reported to be low and is not earmarked or put aside for health and nutrition emergency needs. Similarly, IPs report funding limitations in regard to addressing increasing needs caused by protracted conflicts and health and nutrition crises across the country. Overall, there is some flexibility in government budget use to accommodate cases where more resources are needed, in all of the regions included in this study, though flexibility in the Amhara region is relatively limited. Donor funds seem to be less flexible, and adjustment of these funds is highly donor dependent.

(iii) Allocative efficiency: '**established' at both federal and regional levels**

Overall, evidence is used in resource allocation, and decisions on emergency resource allocation are assessed against established criteria among the federal government institutions, donors, and IPs. In most cases, risk assessments are conducted to generate evidence on magnitude/volume and negative impacts/consequences of the potential emergency, and the findings are used as an input for resource allocation and planning. For unplanned emergencies, resources are mobilised and allocated appropriately according to need.

At regional level, evidence is used in resource allocation. In most cases, risk assessments are conducted to generate evidence on the magnitude or volume and negative impacts/consequences of the potential emergency, and the findings are used as an input for

resource allocation and planning. For unplanned emergencies, resources are mobilised and allocated appropriately according to need. Decisions on emergency resource allocation are assessed against established criteria in most regions. Resources can also be mobilised from other programmes and sectors, following appropriate approvals.

(iv) Timeliness: 'progressing' at both federal and regional levels

Within the government institutions, there are existing systems to facilitate a timely allocation of resources, conditional on the availability of adequate resources and proper documentation. Issues pertaining to bureaucratic administrative procedures, communications chains, and procurement act as barriers to the public financial management (PFM) system offering timely resource allocations. The timely allocation of resources among donors depends on the type of emergency, and when it occurs, and differs from donor to donor. Also, from the donors' side, resources for nutrition are allocated on time for the required needs, but may be slower to arrive compared to resources for other types of emergencies.

At regional level, the timescale of resource allocation does not allow for the timely provision of emergency response and health services to beneficiaries (people affected by emergencies) in all regions and in the city administrations. Emergency funding from partners/donors and the federal government, which are the major sources of funding, is reported to suffer the biggest delays because of the longer time taken for approval and disbursement. On the other hand, the budget allocation at the regional level, through shifting budgets from other programmes and/or from contingency budgets, seems to be the quickest and most timely source of funding for immediate and lifesaving emergency responses/interventions. However, the funding from regional sources is inadequate to cover the full-scale implementation of emergency response.

The Integrated Budget and Expenditure System (IBEX) is a PFM system that is commonly used in government offices/sectors across the country. The importance of the PFM system/IBEX in facilitating the timeliness of emergency response was cited by most of the respondents. However, other factors were reported to be more important in determining the timeliness of resource allocation for emergency response in general, and the effectiveness of the PFM system in particular.

There is relatively quick and timely resource allocation for emergencies that are perceived to be more important in terms of severity (causing mortality and morbidity) and magnitude. Moreover, the timeliness of resource allocation is affected by different factors, which include the lack or absence of adequate prepositioned or earmarked budgets for emergencies, and the time involved in completing procedures for funding requests, approval, and disbursement.

(v) Good coordination: 'progressing' at both federal and regional levels

Some roles and responsibilities are defined across the different actors, with the National Disaster Risk Management Commission (NDRMC) being the principal coordinator of stakeholders and resource mobilisation for emergency responses. There are established communication strategies, such as taskforces, technical working groups, and humanitarian clusters between and within the government and development partners. There are contradicting claims on the status of coordination: some government institutions claim

donors do not coordinate well with the government and among themselves, and, on the other hand, donors claim they coordinate well with the government. This is a sign that the existing communication strategies are not very functional, and that better coordination is required. IPs seem to coordinate and communicate well with both the government and donors.

At regional level, there are established communication strategies, such as technical working groups, humanitarian clusters, taskforces, and emergency coordination committees, across regions. Clear roles and responsibilities across the different actors are less evident from regional research findings. The existing communication strategies are not very functional due to the lack of commitment to consistently convening and sharing information among actors. Other consequences of weak coordination that were reported were duplication of efforts and resources.

(vi) Accountability and transparency: 'progressing' at federal level and between 'established' and 'progressing' at regional level

Some forms of accountability mechanism exist within the government, donors, and IPs. IPs demonstrate some public performance accountability to beneficiaries. Standardised reporting systems seem to exist within the GoE, donors, and IPs, but whether these are functioning well, especially within the government, is not clear. Regular tracking of resource allocation and use seems consistent in MoF and among donors but is not clear for other government institutions and IPs. According to some respondents, especially donors, information is available publicly, but the overall information is not public.

At regional level, across nearly all regions, funds received from various sources are tracked and monitored using the government PFM system (IBEX). In Amhara and Southern Nations, Nationalities, and Peoples' Region (SNNPR), reports are also collated from woredas, to zones, to the region, and all the way up to their federal counterparts as well, following an emergency response. In Harari, there is a PFM team that controls and monitors budgets. In Somali, there is an emergency bank account and withdrawals are only made with the approval and signature of authorised personnel. Supportive supervision, review meetings, joint monitoring visits, and after-action reviews are some of the accountability mechanisms in place to ensure proper budget utilisation across woredas, in Afar, Benishangul-Gumuz, and Gambela. Regional IPs share their independent tracking systems with donors and government counterparts. There is limited transparency and accountability to the public, except for IPs in Gambela and Somali, which ensure accountability to beneficiaries.

Across regions, reporting for expenditure of emergency funding allocated by the government is integrated with the regular reporting system – commonly through IBEX. There is thus no separate reporting on emergency health financing within the government system. There are separate reporting mechanisms and formats for donors; these tend to be standardised and vary according to the donor. In SNNPR, Afar, and Benishangul-Gumuz, the regularity and timelines of reporting needs to be improved as emergency reports are delayed due to various logistical issues. Statements of expenditure or expenditure reports are some reporting mechanisms that are used in Harari, depending on who provides the funds. In Gambela reports are made accessible to the public following formal requests and approvals.

Overall, some accountability mechanisms are in place but these remain weak. There is some form of a standardised reporting system, for resource allocation and use, but information is not consistently available to the public

(vii) Outcomes achieved: 'progressing' at both federal and regional levels

Outcomes are often achieved, and beneficiaries are often reached, especially in the case of donors and IPs who have systems for tracking and measuring outcomes. For the government, there is a limitation in tracking and measuring outcomes and it cannot be concluded with certainty that funding reaches the most vulnerable and that the desired outcomes are achieved. There is a form of beneficiary prioritisation by the GoE, donors, and IPs, with prioritisation being stronger among the latter two. However, the research findings are silent on whether benefits and entitlements, and conditions of access, are communicated to the masses, and whether beneficiaries are aware of them.

At regional level, there are indicators to measure or track the achievement of outcomes for emergency health interventions and routine programmes in most regions. However, it cannot be concluded with certainty that funding reaches the most vulnerable and that the desired outcomes are achieved. In regard to IPs, it is evident that outcomes are often achieved and beneficiaries are often reached, given their systems for tracking and measuring outcomes.

There is some form of beneficiary prioritisation across all regions, except Harari, with various criteria for beneficiary entitlement for emergency support. In general, the research findings are silent on whether benefits and entitlements, and conditions of access, are communicated to the masses, and whether beneficiaries are aware of them.

(viii) Resource use: 'N/A' at federal level and 'emerging' at regional level

Ascertaining whether the cost of each input translates into the maximum desired impact is a challenge due to the lack of mechanisms and the limited ability to measure or assess the same. With the available evidence, it is not possible to say whether the resources are commensurate with the level of outcomes achieved or not.

Across the eight criteria, we find that current emergency financing for health and nutrition in Ethiopia is 'progressing' overall – which means that while some of the fundamental building blocks are there, there is still significant room for improvement. The criterion with the strongest performance is allocative efficiency: there is a well-established evidence-based resource allocation mechanism that is used by the government, donors, and IPs. The sources of funding are known to all those involved in emergency responses, but there is a lack of a functional budgeting process that allows for an accurate estimate of the required funding for a given emergency event. A contingency budget is generally used to 'fill the gaps' but since this is not specifically dedicated for health and nutrition emergency responses the total available contingency budget is small. Given the competing needs in other sectors, it is unclear to what extent and in what proportion the contingency budget is actually allocated to emergency health and nutrition expenditures.

At regional level, there are few or no mechanisms to assess the cost-effectiveness of emergency response interventions. Action reviews, mid-term and end-term evaluations, and regular monitoring and evaluation (M&E) systems were often cited as mechanisms that are used to assess effectiveness. However, these do not link outcomes with the resources invested. As a result, unit costs per beneficiary, or costs of key inputs for a particular

intervention, could not be ascertained. As such, a judgement on whether the invested resources are commensurate with the level of outcome or impact achieved cannot be reached.

This updated report (updated)

This report incorporates findings from the KIIs across all regions in Ethiopia. We have interviewed 49 key informants from Regional Health Bureaus (RHBs), Regional Finance Bureaus (RFBs), NDRMC, IPs, and donors who are active in the regions. We have used the same analytical framework to assess the evidence and have incorporated the regional findings into the analysis and findings.

In addition, a workshop was organized to validate the results and major findings. The expected outputs of the validation workshop were to draw some potential recommendations and plans for phase 3, where the OR team, in collaboration with other BRE work streams, are expected to design and deliver an adapted strategy/framework for emergency health and nutrition financing mechanism based on the challenges identified in Phase 2. Key federal and regional level government stakeholders and development partners participated in the validation workshop.

Table of contents

Lists of tables, figures, and boxes

List of abbreviations

AWD	Acute watery diarrhoea
BRE	Building Resilience in Ethiopia
CRRF	Comprehensive Refugee Response Framework
DALYs	Disability adjusted life-years
DHIS	District Health Information System
DRMC	Disaster Risk Management Commission
EDHS	Ethiopian Demographic Health Survey
EFY	Ethiopian Fiscal Year
ENCU	Emergency Nutrition Coordination Unit
EPHI	Ethiopian Public Health Institute
EPRP	Emergency Preparedness and Response Plan
EPSA	Ethiopian Pharmaceutical Supply Agency
ETB	Ethiopian Birr
EU	European Union
GoE	Government of Ethiopia
HFPM	Health Financing Progress Matrix
HRP	Humanitarian Response Plan
IBEX	Integrated Budget and Expenditure System
IDPs	Internally displaced persons
IFMIS	Integrated financial information management system
IP	Implementing partner
IPD	Inpatient department
IRB	Institutional Review Board
KII	Key informant interview
M&E	Monitoring and evaluation
MEAL	Monitoring, evaluation, accountability, and learning
MoF	Ministry of Finance

MoH	Ministry of Health
NDRMC	National Disaster Risk Management Commission
NGO	Non-governmental organisation
NHA	National Health Accounts
OPD	Outpatient department
OPM	Oxford Policy Management
PCD	Partnership and Cooperation Directorate
PDM	Post-distribution monitoring
PFM	Public financial management
PHEM	Public Health Emergency Management
RFB	Regional Finance Bureau
RHB	Regional Health Bureau
SAM	Severe acute malnutrition
SDGs	Sustainable Development Goals
SHA	System of Health Account
SNNPR	Southern Nations, Nationalities, and Peoples' Region
TA	Technical assistance
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UN-OCHA	United Nations Office for the Coordination of Humanitarian Affairs
VfM	Value for money
WHO	World Health Organization
YLL	Years of life lost

1 Introduction

1.1 Country profile/context

Ethiopia has the second largest population in Africa and is the 12th most populous country in the world, with a total estimated current population of over 120 million.[2] About one-fifth of the Ethiopian population is urban, and the majority of the population is young. Ethiopia operates under a federal system of government. Administratively, the country is divided into regional states, zones, woredas (districts), and kebeles.

Ethiopia is classified as a low-income country and has a predominantly rural, agriculture-based economy. Over the past 15 years, Ethiopia's economy has been among the fastest growing in the world (at an average of 9.5% per year), and in recent years the Ethiopian economy has continued to grow steadily. However, though the country is still one of the fastest growing economies in the region, with 6.3% growth in financial year (FY) 2020/21, it is also one of the poorest, with *per capita* gross national income of US$ 890.[3]

1.2 The Ethiopian health system

Ethiopia has made significant progress on health indicators according to the mini-Ethiopian Demographic Health Survey (EDHS)[4] and on managing humanitarian crises. It is now recognised globally for its leadership in delivering progress on the development and humanitarian nexus.

Over the last decade, health expenditure *per capita* has increased considerably. In 2019, health expenditure *per capita* was US$ 27. It increased from US$ 5 in 2000 to US$ 27 in 2019, growing at an average annual rate of 9.54%.[5] Moreover, total health expenditure increased from US$ 1.20 billion in 2007/08 to US$ 3.1 billion in 2018.

However, despite this growing expenditure on health it still remains significantly lower than the US$ 86 *per capita* the WHO recommended spending for the delivery of essential health services in 2015. In Ethiopia, household out-of-pocket healthcare expenditure accounts for one-third of total healthcare expenditure, which is one of the highest levels in the world, and this continues to create barriers and difficulties for households in regard to accessing healthcare, and may lead to them delaying or forgoing needed healthcare use.[6] Life expectancy has consistently increased over time in Ethiopia, from 46.9% in 1990 to 67.4 years in 2022.[7]

[2] www.worldometers.info/world-population/ethiopia-population/#:~:text=The%20current%20population%20of%20Ethiopia,of%20the%20total%20world%20population
[3] www.worldbank.org/en/country/ethiopia/overview#1
[4] dhsprogram.com/pubs/pdf/PR120/PR120.pdf
[5] https://knoema.com/atlas/Ethiopia/topics/Health/Health-Expenditure/Health-expenditure-per-capita
[6] Ethiopia Federal Ministry of Health (2019) *Ethiopia's Seventh National Health Accounts 2016/2017*, Addis Ababa.
[7] www.macrotrends.net/countries/ETH/ethiopia/life-expectancy

The government has implemented four successive five-year Health Sector Development Programmes and Health Sector Transformation Plans since 1997 and is currently implementing the Sixth Health Sector Transformation Plan (2020–2025). These have guided the government and development partners' coordination and investment in cost-effective primary healthcare.[8]

Nevertheless, Ethiopia remains vulnerable to humanitarian crisis. The COVID-19 pandemic has created severe health risks across the globe and is having a drastic impact on the already strained Ethiopian health system, with devasting social consequences. Health workers are struggling to deliver basic services and to respond to the pandemic, which has impacted routine services, including growth monitoring and immunisation.

The GoE wants to manage its recurrent and unexpected humanitarian crises more effectively and to maximise results for those affected by crises. Empowering the country to do this would also be consistent with the Grand Bargain commitments (see Box 1) to improve the efficiency and effectiveness of humanitarian funding, and to work more directly with local actors. Building national health systems that are able to respond to shocks is critical to delivering sustainable and continued health improvements in Ethiopia.

Box 1: The Grand Bargain[9]

The Grand Bargain is an agreement between the largest donors and humanitarian agencies who have committed to **improving the effectiveness and efficiency of humanitarian action**. The Grand Bargain was launched in 2016, in light of the increasing humanitarian financing gap (a 45% shortfall in 2015). The Grand Bargain is based on the concept of a 'quid pro quo'*: if donors and agencies accept changes, aid delivery will become more efficient, freeing up human and financial resources for the benefit of affected population.* For example, donors should reduce earmarked funds, while aid agencies should increase their transparency. The objective is to generate efficiency gains, which will be used to save more lives, not to reduce aid budgets. The Grand Bargain has 61 signatories (24 states, 11 United Nations agencies, five inter-governmental organisations and Red Cross and Red Crescent movements, and 21 NGOs) and represents 80% of all the humanitarian contributions donated in 2017 and 76% of the aid received by agencies.[10]

The Grand Bargain has nine workstreams with 51 commitments:

1. Greater **transparency.**

2. More support and funding tools to **local and national responders.**

3. Increase the use and coordination of cash-based programming.

4. **Reduce duplication** and management costs, with periodic functional reviews.

5. Improve joint and impartial **needs assessments.**

6. A **participation** revolution: include people receiving aid in making the decisions which affect their lives.

7. and 8. Increase collaborative humanitarian **multi-year planning** and funding and **reduce the earmarking** of donor contributions.

9. Harmonise and **simplify reporting** requirements.

[8] MoH and IPE Global Limited (2020) 'Sub-National Public Expenditure Review (PER) in Health', draft inception report.
[9] OPM (2019) 'Support to EPHI on financing health-related emergencies', BRE Programme, Oxford.
[10] Inter-Agency Standing Committee (2019), as cited in OPM (2019) 'Support to EPHI on financing health-related emergencies.

1.3 Building Resilience in Ethiopia Technical Assistance (BRE TA) Programme

In order to assist the GoE in achieving these objectives**, the Building Resilience in Ethiopia (BRE) Technical Assistance (TA) programme** component was initiated and is co-financed by the UK Foreign, Commonwealth, and Development Office and the United States Agency for International Development. The programme covers all aspects of humanitarian assistance provided to Ethiopians affected by climate and humanitarian shocks. It is intended to contribute to the objective of an 'Ethiopia that is more resilient to climate and humanitarian shocks'. OPM is the Managing Agent for the provision of TA across four workstreams: health, disaster risk management, scalable safety net, and finance.

Under the BRE TA component, **Operational Research** has been commissioned with the aim of understanding how emergency health and nutrition financing can be most effectively allocated and spent in the medium and long terms in Ethiopia. In conducting this research, we have worked very closely with GoE, particularly the PCD within the MoH, the Minister's Office within the MoH, the MoF, and EPHI, in order to ensure that our research is aligned with the GoE's priorities and to ensure that the evidence generated by this research will help contribute to the BRE TA's overall outcomes and impacts ('save lives and promote well-being through better shock responses').

The overarching aim of this research is to review emergency health and nutrition financing in the country and to identify a system through which emergency resources can be most effectively allocated, and to generate evidence to support and inform a transition to a more proactive planning strategy that will deliver sustainable financial mechanisms for emergency health and nutrition financing. The Operational Research reviews existing strategies (government as well as donor) and considers what plans are required for different types of humanitarian crises, how those plans should be financed, through which channels the finance should be allocated and at which level (federal, regional, or woreda), and who needs to be able to make decisions to allow for rapid and effective responses to emerging health crisis. In-depth context analysis (including KIIs with donors, key stakeholders at national and regional levels and national and international NGOs is the focus of this report (Phase 2). A VfM analysis of the channels through which the financial flows would be most appropriately deployed is conducted as part of this Operational Research and is build on the latest VfM study carried out by MoF and MoH in July 2019.

The ultimate goal of this research is to identify more sustainable and timely options for delivering international and domestic resources for health-related emergencies. Therefore, in the final phase of the Operational Research (Phase 3), a pilot of a new or adapted approach to channelling donor and domestic resources will be reviewed and evaluated, based on evidence generated and in consultation with the government and donors. This research examines disaster risk management processes, accountability, and financial arrangements within the government system that may require strengthening to address donor fiduciary concerns.

Because the focus of the Operational Research is on emergency financing, it provides cross-cutting inputs to all of the other BRE TA workstreams mentioned above. Thus, the

evidence generated will be used to inform policy design and the implementation of health emergency responses.

1.4 Overall objectives and scope of the Operational Research

1.4.1 General objective

The general objective of this study is to examine the efficiencies and effectiveness of the existing emergency health financing system and to identify sustainable and timely options for delivering international and domestic resources for health-related emergencies.

1.4.2 Specific objectives

- To map the emergency health and nutrition financial landscape in Ethiopia.
- To conduct an in-depth context analysis of health financing at regional, woreda, and health facility levels to understand the financial flows and to identify the gaps in terms of resources, as well as bottlenecks in terms of decision-making/reporting processes.
- To pilot and evaluate an adapted approach for emergency health financing.

This research is being carried out across three phases. The research **scope** is limited to the health sector and the time boundary is the past five years (2015–20, or Ethiopian Calendar Year 2008–12). Case studies conducted as part of the research cover malaria, cholera, nutrition shocks, COVID-19, and trauma and injuries (as permitted by the availability of the data).

The first phase involved carrying out a desk review of academic, grey literature, and reports on the current financing mechanisms, and of resource-mapping and tracking for health and nutrition produced by the PCD/MoH, MoF, and the World Bank. The aim was to map out existing emergency health and nutrition financing systems and to examine the public health finance landscape in Ethiopia with respect to specific case studies over the past five years. We examined historical evidence of recurring humanitarian shocks, and where possible the processes around emergency health and nutrition financing. We also examined the early responses to the COVID-19 pandemic.

Phase 2 (this phase) has involved conducting an in-depth context analysis, involving conducting KIIs with stakeholders within the government at federal and regional levels, donors, development partners, NGOs, and implementing agencies. We also conducted field visits to health facilities/centres, hospitals, and health posts, as well as in-depth interviews with finance officers and exit interviews with key beneficiaries. In this stage, we undertook resource-mapping of emergency financing, drawing on the work carried out by MoH, paying particular attending to off-budget emergency financing of health and nutrition. We also carried out in-depth VfM analysis, building on the previous VfM analysis study by MoF and MoH, including – where this was possible – modelling of the potential economic costs and benefits of different approaches to reducing the parallelism of the financing mechanisms.

Phase 3 will aim to build on the findings of Phase 2 by piloting and evaluating an adapted approach for emergency health financing and documenting the findings, i.e. what works and

what does not work, and proposing policy recommendations. This phase will also look at strategies around uptake and dissemination of the recommendations.

The following research questions will be addressed during the third phase:

- What is the optimal arrangement between the different emergency financing channels?
- What are the risks and challenges that need to be mitigated before the new/adapted approach can be adopted? What are the strengths and weaknesses of the current emergency financing systems?
- What is the indicative long-term impact in terms of health service delivery and outcomes?

We will also explore the extent to which donors' requirements can be harmonised, such as the potential of extending and/or adapting the Sustainable Development Goal (SDG) pooled fund. The pilot approach will involve formalising and strengthening a number of the processes that are already in place. This will include procedures for how funds are requested, allocated, disbursed, and monitored at federal, regional, and woreda levels. It will also examine ways to strengthen and build capacity at local level (regional and woreda) in order to improve the timeliness and effectiveness of crisis management in the long run. The findings and recommendations will be presented to the government and donors and, if appropriate, the tested approach may be considered for potential scale-up.

This report is structured as follows. The next section (Section 2) summarises the key findings from the previous formative research (Phase 1) and highlights the knowledge gaps which provide the building blocks for the research objectives and scope of the present Phase 2. Section 3 sets out the detailed research objectives, scope, research questions, and methodology of the Phase 2 study. Section 4 reports they key results both of the quantitative research (financial and incidence data) and the qualitative research (KIIs at federal level) using the proposed analytical framework and performance standards outlined in Section 3. Section 5 provides concluding remarks and outlines plans for the next steps.

2 Key Findings from Phase 1: Formative Research

The key research questions addressed in the formative research (Phase 1) were as follows: (i) What does the financial landscape for emergency health and nutrition look like? (ii) How do resources flow from different sources during emergencies? (iii) How do resources get allocated to the federal sector ministries, regions, and woredas? (iv) To what extent can we observe allocative efficiency of the current mechanisms? (v) To what extent does evidence already exist in regard to tracking emergency health and nutrition funding allocations and spending within the government channels and among humanitarian agencies?

2.1 Methodology

The formative research reviewed grey and academic literature and government reports, and analysed secondary data collected from the MoH PCD, EPHI, MoF, National Health Accounts, the Sub-national Public Expenditure Review, the COVID-19 Resource Mobilisation Dashboard, and resource-mapping exercises carried out by MoH. The research involved carrying out a simplified allocative efficiency analysis using four case studies: cholera/acute watery diarrhoea (AWD) outbreak, malaria outbreak, nutrition shocks, and the COVID-19 pandemic (where data were available).

2.2 Key findings

The formative research highlighted the fact that examining and summarising Ethiopian health sector financing is challenging due to complexities around the ways resources are channelled through on- and off-budget mechanisms. This is particularly difficult for emergency financing for health and nutrition, which seems to be *ad hoc* and to adopt a 'response' mode, as there is currently no health emergency budget at federal, regional, or woreda levels. The fragmented reporting mechanisms also add to this difficulty.

2.2.1 Public Health Financing in Ethiopia

Like other developing countries, Ethiopia faces critical resource constraints in terms of adequately meeting its healthcare financing needs, and thus Ethiopia's health sector is heavily dependent on donor financing, which flows through three main channels in Ethiopia, as follows:

Channel 1 is for funds that flow directly through the MoF system and covers both government and donor funds. Within this, Channel 1a represents funds that flow to the regional governments as formula-based block grants, with those formulae approved by the House of Federation. Channel 1b funds are those that are earmarked for specific projects, outcomes, and activities agreed between the government and donors. The flow of funds is on-budget, on treasury, and on account.

Channel 2 is the funds managed by MoH. Channel 2a funds are unearmarked resources that are largely managed through the SDG Pooled Fund. The regional/district health bureaus

receive direct funding through this channel and maintain separate accounts with separate direct reporting to MoH (and MoH reports to MoF and donors at the end of the year); however, these funds do not go through the treasury. These resources are used to centrally procure commodities and supplies, or in-kind contributions, with minimum flow of actual funds. The SDG Pooled Fund is a flexible fund allocated to filling programme financing gaps and for activities agreed between donors and MoH and is the preferred channel for the MoH for donor funds.

Channel 3 is for funds that directly flow to development partners or their implementing agencies. They are planned, budgeted, and reported independently of government procedures, i.e. off treasury and off account. The funding under this channel has declined considerably over the past 10 years. Apart from voluntary reporting through the resource-mapping exercise carried out by MoH, there seems to be no systematically organised and comprehensive data available on a regular and consistent basis regarding the trends of aid flows to the health sector – either at MoF or MoH. As far as we know, data sourced from budget documents/MoF do not reflect the exact amount of aid used in the health sector.

Tracking of the financial resources from these channels does not follow the same structure: each channel utilises different structures at all government levels. Additionally, government financing is not based on programme financing, and thus tracking of resources to evaluate the level of funding going towards programmes such as those that aim to address nutrition shocks or malaria outbreaks does not capture the full picture of the extent to which the resources and funds get allocated and spent at different government levels. While resource tracking by donors is indicated based on programme financing, due to the methodology employed in the resource-mapping exercises information and data gathered through these exercises have limitations in terms of showing the full funding amounts provided by all stakeholders annually.

Increasing on-budget support can help build the capacity of the public systems, but there are limitations, such as the following: weak coordination between the channels; an absence of sufficient financing mechanisms within MoH, particularly for the nutrition programme; the fact that the policy of some development partners requires a set proportion of funding to be directed to non-governmental implementing agencies; Ethiopia's use of the Ethiopian calendar, which is different from the Gregorian calendar used by donors; the unpredictability of the exact funding basket of some development partners; and the lack of a transparent national budget, against which all players report routinely and which is publicly available.

2.2.2 Emergency Health and Nutrition

For health-related emergencies, MoH and Regional Health Bureaus (RHBs) are the main actors involved in the delivery of emergency health services through permanent and temporary health facilities and the network of Health Extension Workers. NGOs and United Nations agencies support government health bodies in filling human and logistical capacity gaps and enhancing the quality and coverage of the response. The health cluster in Ethiopia supports the provision of essential health services and supplies, in the form of health kits, referral and outreach services, routine immunisation, and emergency reproductive healthcare services, to internally displaced persons and other vulnerable groups.

For **nutrition-related emergencies**, the assessment of risk for nutrition emergencies in all woredas of the country is performed by a platform known as the Emergency Nutrition Coordination Unit (ENCU), which is housed in the Early Warning and Response Directorate of NDRMC, under the Ministry of Peace. ENCU coordinates the efforts for four United Nations agencies (WHO, the United Nations Children's Fund (UNICEF), the World Food Programme, and the United Nations High Commissioner for Refugees), and 15 national and international NGOs working on the prevention and management of acute malnutrition in Ethiopia. ENCU collects information about emergency nutrition activities from NGOs located in different woredas. One of the key challenges faced by ENCU is the lack of clear guidelines outlining the roles and responsibilities of different players (e.g. the Nutrition Case Team at MoH, NDRMC, EPHI, and the Ministry of Agriculture, which co-manages moderate acute malnutrition together with NDRMC). As a result, there is a lack of a coordination structure for nutrition emergency management at regional, woreda, and zone levels.

Responsibility for conducting surveillance and risk analysis to prepare for, respond to, and recover from public health emergencies is given to EPHI. EPHI is in charge of three main tasks: (i) generating and disseminating scientific and technological knowledge on priority health and nutrition issues; (ii) surveillance for the early identification and detection of public health risks and to prevent public health emergencies through adequate preparedness, alerts, and timely information during a public health emergency, to respond effectively and in a timely manner, and to ensure rapid recovery of the affected population; and (iii) referral diagnostic and analytical tests and support capacity building of health and food science laboratories at the national level. In 2009 EPHI established Public Health Emergency Management (PHEM), with the primary aim of identifying unusual public health events on a timely basis, promptly responding to arising public health emergencies, and ensuring recovery in the aftermath of an incident.

Challenges with PHEM include the fact that while there is capacity at the central level, there are minimal structural arrangements at lower levels of government to actually execute PHEM activities. There is currently no permanent high-level incident management structure specifically for health emergencies. Instead, there is a committee that is formed every time a health and nutrition emergency is detected. This approach results in delays in the response and limits recovery capacity since the committee becomes inactive soon after the response activities end. The central PHEM team has no formal linkage with health facilities and consequently encounters serious difficulties in organising timely responses.

In terms of the health workforce, the key challenges are a lack of human resource plans for health emergency management, a lack of databases of staff trained in emergency management, and the absence of clear procedures for integrating national and international volunteers into service delivery during an emergency. **For medical and non-medical emergency commodities and supplies**, although the Ethiopian Pharmaceutical Supply Agency (EPSA) identifies the procurement of emergency supplies and equipment as its responsibility, clear mechanisms and guidelines are not in place to ensure it can carry out its function during emergencies. There is no dedicated channel for managing the logistics required to execute health emergency operations.

On health information, national integrated disease surveillance currently captures 20 priority diseases from the level of health posts up to the highest level of health facilities. However, there is no event-based surveillance, which would be helpful in the early detection

and announcement of public health and nutrition emergencies. This lack of real-time surveillance systems for health emergency preparedness and response is identified as one of the key challenges for the health system.

2.2.3 Financing for Emergency Health and Nutrition

For emergency financing, similar to non-emergency health and nutrition financing, the majority of emergency resources come from bilateral and multilateral donor countries, in the form of grants, loans, and in-kind assistance that flow through the three main funding channels. Domestic resources raised from taxes and other public revenues also contribute to emergency health and nutrition programmes, but less significantly so.

In the case of emergency resource mobilisation, unlike regular resource flows, more Channel 3/off-budget resources are mobilised either through IPs or through direct community resource mobilisation. These off-budget resources are directly transferred to health facilities and/or health offices, which means that the involvement of the federal and regional finance offices is limited. Depending on the size and scope of the emergency, the mobilisation of resources and the flow of funds may vary.

There is no emergency budget at any government level, although there is a contingency budget (around 2–3% of the total budget) at the respective levels that is deemed to serve unspecified economic/financial challenges and/or for emergency responses within a particular fiscal year. Currently, contingency funding is practised at woreda level, but it is very limited and since it is not specific to health and nutrition emergencies it can be used by any sector that is deemed necessary by the woreda council.

The key challenge is the lack of finance for EPRPs at all levels of the health system. Currently, available funding channels are neither responsive enough to deal with sudden-impact and rapidly evolving emergencies, nor flexible enough to cater to pre-emptive preparedness and containment measures. Domestic financing for health emergency management is almost non-existent. During emergencies, resources are mobilised through budget reallocation/reprogramming – for instance, from lower-priority areas within and/or outside health sector, depending on the severity of the emergency.

In the case of COVID-19, resource mobilisation mechanisms differ from health emergency responses relating to malaria and nutrition, due to the levels and nature of the pandemic. In Channel 1, government revenue and donor funding are the two sources of financing for its own operations for the COVID-19 responses. Funds from donors for COVID-19 prevention are either channelled directly to MoH or through MoF. In addition to the funds channelled to MoH, MoF also allocate funds directly to the regions.

There are growing additional resources that come from the community (usually in-kind) and the private sector, particularly during emergencies. These usually go directly to health facilities, hospitals, or individual households. However, these resources are not captured within the standard channels

The results from our preliminary allocative efficiency analysis of the case studies indicated that funding for emergency programmes (particularly malaria and nutrition shocks, for which we currently have data) are not aligned with the severity of incidents (i.e. the number of cases). However, these results are only indicative and are based on the resource-mapping

data (for Channels 2 and 3), which are self-reported and voluntary by donors and IPs. Moreover, the multisectoral nature of some of the programmes, such as those related to nutrition, creates additional difficulties in tracking the flows of funds and how they are spent, which might underestimate the magnitude of resources invested.

- Overall, several factors inhibit response capacity for emergencies at federal and sub-national level: the lack of multisectoral coordination; delays in sharing reports or announcing reportable diseases; limited capacity for preparedness due to lack of clear planning and the insufficient budget allocated for emergencies; inadequate communication infrastructure – particularly in the most remote districts or woredas, which tend to also be the most affected in emergencies; as well as lack of transport resources in most woredas.[11]
- There is frustration among government and development partners that, despite the largely predictable annual humanitarian needs, beneficiaries rely on underfunded appeals. Furthermore, as the response system is largely administered through United Nations agencies and international NGOs, the transaction costs are considered high, and the six- to 12-month planning and reprogramming are costly and inefficient. There are also tensions between externally driven and administered humanitarian systems and government-administered services, such as competition for logistics and staff time.[12] The current humanitarian funding context (terms, duration, scope, etc.) is not conducive to resilience-building and to prevention programmes in chronically vulnerable woredas.[13]
- **There is clearly a need for longer-term funding through treasury and sector-specific pooled funding for vulnerable areas and populations**, rather than short-term and less cost-effective funding models that have high transaction costs. Longer-term financing and implementation of nutrition security programming need to be tracked and mapped to better understand coverage, scope, and scale, and how treatment and prevention programmes overlap and complement each other.
- The PHEM Strategic Plan was recently developed at federal level through the BRE TA programme (in 2020) and is a road map for building public health emergency systems that prevent, detect, and respond to both infectious disease outbreaks and other public health emergencies. It also encompasses non-infectious conditions, such as emergency nutrition and mass casualty management, and can foster the linking of the Emergency Critical Care Directorate of MoH and the PHEM Directorate of EPHI. The PHEM Strategic Plan is currently being adapted at regional level, starting in Amhara region.

The findings of the formative research provided the basis for Phase 2 of the Operational Research. Through primary data collection, in the form of KIIs and secondary financial data at regional and woreda levels, the second phase has examined the existing preferences and strategies of both government and donors. The detailed research questions and methodology of Phase 2 are described in the next section.

[11] MoH (2015) *Ethiopia. Health Sector Transformation Plan*.
[12] *Ibid*.
13 Emergency Nutrition Network (2020) 'Strengthening the Humanitarian Development Nexus for Nutrition in Ethiopia: An analysis of nutrition programming and the enabling environment'.

3 Phase 2: In-depth context analysis – objectives, scope, research questions, and methodology

3.1 Objectives and Scope

Building on the findings of the formative research (Phase 1), which reviewed the literature, reports, and available secondary data on emergency health financing for health and nutrition**, the main objective of Phase 2** (as reported on here) was to conduct an in-depth context analysis at federal and regional levels to understand the sources of emergency financing for health and nutrition, the allocation processes, and the financial flows, in order to identify the strengths and weaknesses of the emergency funding mechanisms, gaps in terms of resources, and bottlenecks in terms of decision-making/reporting processes for emergency financing for health and nutrition.

This phase involved conducting both primary and secondary data collection. To obtain primary data, KIIs were conducted with stakeholders within the government at all levels (federal and regional), donors, development partners, NGOs, and implementing agencies. Secondary data on health expenditure and health emergency incidence came from MoH and EPHI and were then used to analyse the trends in health financing and the incidence of different types of health emergencies over time. Through primary data collection and secondary financial data at federal and regional levels, the second phase of this research has examined existing preferences, processes, and strategies of both government and donors and addresses the following questions:

- Do emergency health and nutrition programmes receive sufficient funds and resources? Do we have enough funds/resources for what is needed?
- Are funds and resources allocated appropriately/according to the needs (allocative efficiency)? How does the decision-making process work in terms of emergency budget allocation?
- Are funds and resources distributed in a timely manner to respond to emergencies?
- What is the cost per beneficiary for different types of emergencies (resource use)?
- Are funds and resources impactful? Do we see the desired outcomes (i.e. do we see more lives saved, are people able to access the health treatments they need)?
- How are the financial flows and utilisation monitored and tracked? Is there any monitoring dashboard/framework?

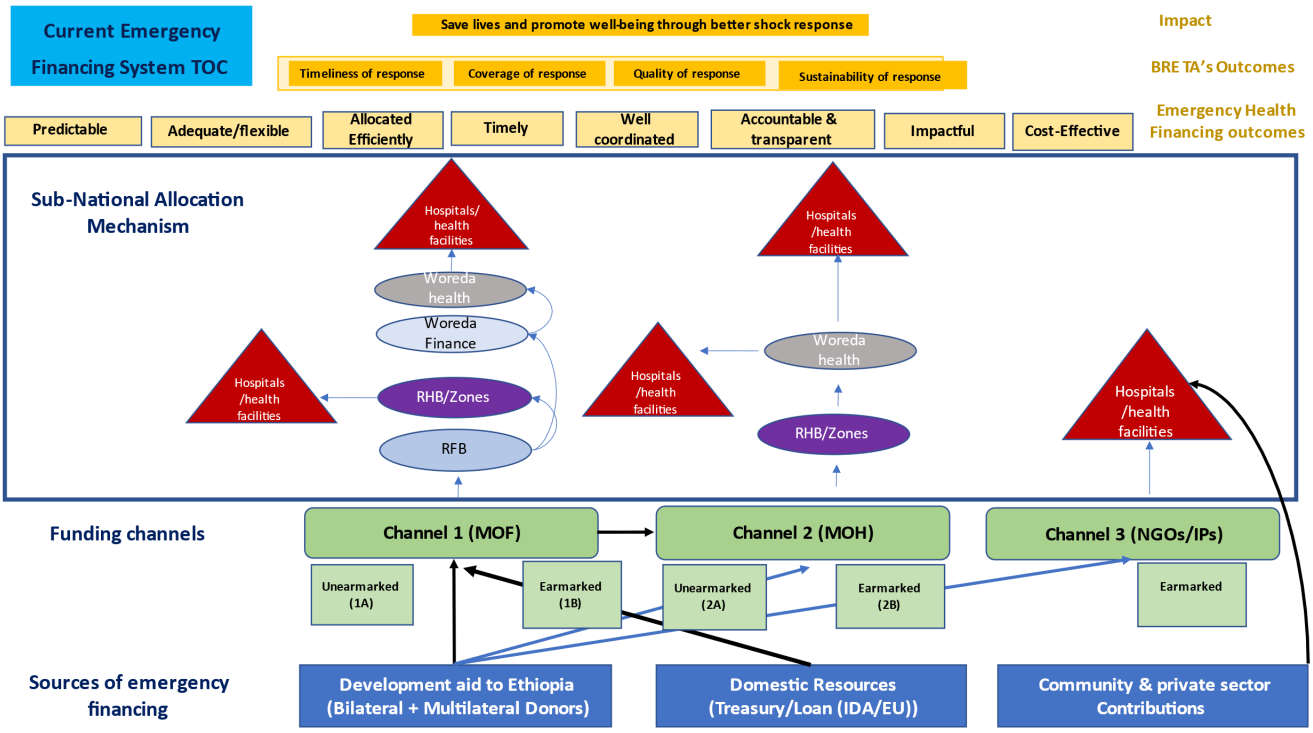
The methodology applied was innovative in that it embedded VfM analysis within the analysis framework, building on the previous VfM analysis study by MoF and MoH and the performance standards set out in the WHO's HFPM assessment, which is the WHO's standardised qualitative approach for assessing country health financing systems, in terms of both the development and implementation of health financing policy. The focus was on emergency aspects of the HFPM, which was incorporated into the analysis framework and the performance standards that were used to assess the current emergency financing for health and nutrition in Ethiopia.

The results from Phase 2, together with those from Phase 1, will be used to formulate ideas on how emergency health and nutrition financing can be most effectively allocated in the medium and long term in Ethiopia, and to generate primary evidence to support and inform a transition to a more proactive planning strategy that will deliver sustainable financial mechanisms for emergency health and nutrition financing. The aim is to work with key GoE and donor stakeholders to pilot and evaluate a potential new/adapted approach to emergency financing for health and nutrition, in Phase 3.

3.2 Theory of Change and Detailed Research Questions

We developed a theory of change to guide our research framework and our understanding of the emergency financing mechanisms for health and nutrition.

Figure 1: Theory of change for current emergency financing for health and nutrition



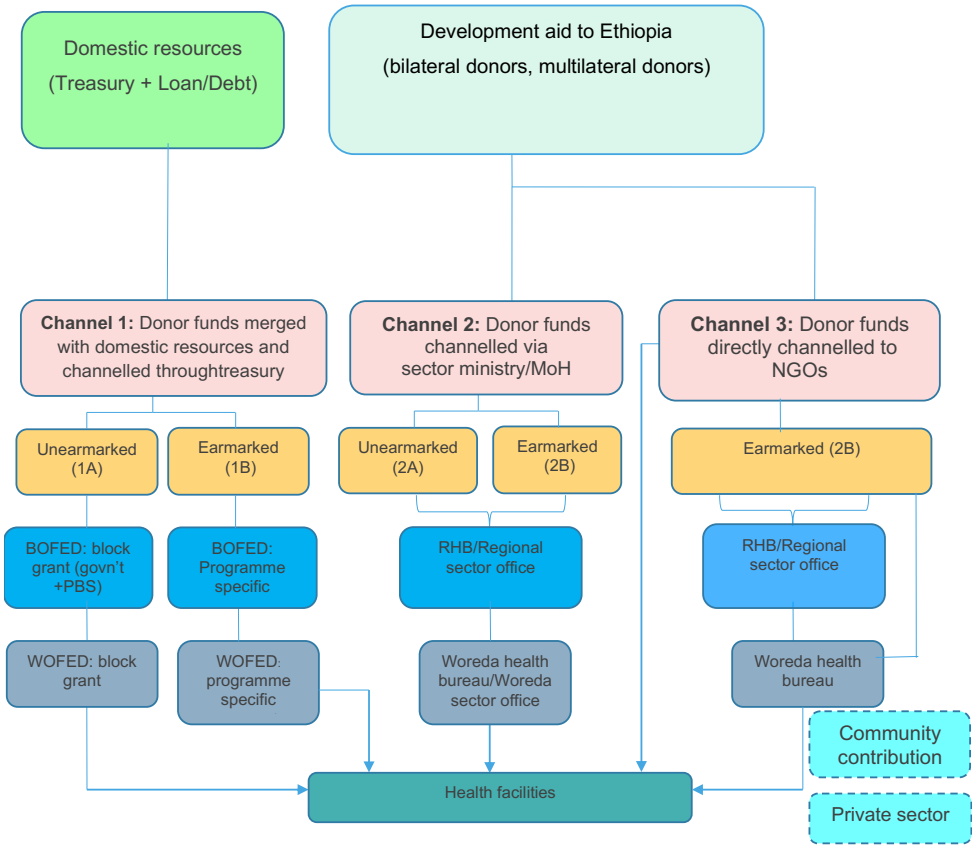
The bottom of the figure starts with the sources of emergency financing, namely donors, domestic resources (treasury/loans), and contributions from the community and the private sector. These resources are channelled through the three main funding channels: Channel 1 (MoF); Channel 2 (MoH); and Channel 3 (NGOs/IPs). In the middle section, we sketch out the sub-national-level financial flows from Regional Finance Bureaus (RFBs) to Regional Health Bureau (RHBs) to Woreda Finance Offices and Woreda Health Offices, and finally to hospitals/health facilities.

These are then linked to the key outcomes for emergency health and nutrition outcomes, which we use as the building blocks for the analysis framework: (**i) predictability; (ii) adequacy/flexibility; (iii) allocative efficiency; (iv) timeliness; (v) good coordination; (vi) accountability/transparency; (vii) impact (reach/coverage); and (viii) resource use/cost-effectiveness.** These outcomes then feed into the overall outcomes and impacts of the BRE TA programme (the yellow boxes), which include the timeliness of the overall

emergency response (not just the financial allocation), good coverage of the response, good quality of the response, and a response which is sustainable (i.e. that can lead to recovery and then preparedness for future emergencies and crises). These outcomes lead to the overall impact that the BRE TA programme aims to achieve, which is to 'save lives and promote well-being through a better shock response system'.

Figure 2: Funding flows for health and nutrition emergency financing (embedded in the ToC in Figure 1)

Figure 1: Health emergency financing in Ethiopia – Funding flow



Source: MoH

In accordance with the ToC for emergency financing for health and nutrition (Figure 1) above, the detailed research questions addressed in Phase 2 (this phase) are outlined below; these are in line with the following eight assessment criteria or desirable attributes, which reflect a desirable or ideal situation with respect to emergency financing for health and nutrition. Some of these attributes can be linked to the seven desirable attributes in the HFPM[14]. While the HFPM assesses the overall health financing system, we focus specifically on emergency health financing, and thus we adapt some of the questions that are suitable for our eight assessment criteria/desirable attributes (we make note of the questions from the HFPM below):

[14] www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix#:~:text=The%20Health%20Financing%20Progress%20Matrix,of%20health%20revenues%20and%20expenditures.

(1) Predictability

Operational definition: the sources of funds are known, and estimated amounts can be earmarked for emergency preparedness, response, and recovery.

- What are the sources of emergency financing for health and nutrition?
- How predictable are the funds/resources for emergency financing for health and nutrition? (A*dapted from HFPM Q2.2*)
- How are the risks of different types of emergencies assessed and quantified by different actors (the government, donors, NGOs/IPs)?
- Does there exist a national plan for emergency financing for health and nutrition?
- Does the Humanitarian Response Plan (HRP) help improve the predictability of emergency financing for health and nutrition?
- Is there a strategy for pooling revenues from different sources to finance emergency health and nutrition? (*Adapted from HFPM Q3.1*)
- What measures are in place to address problems arising from multiple and/or fragmented pools? (*From HFPM Q3.3*)

(2) Adequacy/flexibility

Operational definition: Resources are sufficiently allocated to specific health and nutrition emergency needs.

- Are the funds allocated to all channels sufficient/adequate? (How are fund allocations and needs aligned across the three channels? Is the funding for emergencies sufficient for the magnitude of need?)
- How flexible are the resources (if more is needed, is there room to adjust/increase?)
- At the federal level (MoH and EPHI), is there a health emergency budget? How do MoH and EPHI receive their resources and funds during an emergency from the Government Treasury? What are the processes for requesting a budget, getting it approved, and receiving the funds? How long does it take? Is this sufficient?
- At the sub-national level, is there a health emergency budget? How do resources/funds get allocated to the regions and woredas? What are the processes for requesting a budget, getting it approved, and receiving the funds? How long does this take? Is it sufficient?

(3) Allocative efficiency

Operational definition: Resources are allocated appropriately and in line with the emergency needs.

- Are the resources allocated as per the magnitude of emergency needs?
- What drives the decision-making process regarding health spending at federal, regional, woreda, and health facility levels, both on- and off-budget?
- Are specific criteria used for emergency resource allocation?

- How do resources get mobilised (from other programmes) to fund health and nutrition emergency interventions?

(4) Timeliness

Operational definition: Resources are allocated in time for the required needs (or before).

- Are PFM systems in place to enable a timely response to public health emergencies? (*HFPM Q7.4)*
- What is the timeline for funding requests?
- What is the timeline for funds to come through from donors to MoF/MoH?
- Once MoH/EPHI have received the funds/resources, how long does it take for them to transfer money (the approved budget) to regional health offices, and to the woreda level?
- When more than one region requests support how does the federal government allocate resources? How long does it take for the regional government to receive the requested support from the federal government?
- What is the process that regional governments (RHBs and RFBs) and woreda health offices follow to request support from the federal government (money, equipment, medical supplies, human resources) and how long does it take? How does the federal government respond to regional governments' and woreda health offices' requests? What kind of processes are in place?
- Does the timescale of the resource allocation allow for the timely provision of emergency health services to the beneficiaries?

(5) Good coordination

Operational definition: All actors involved (the government at all levels, donors, IPs) agree in advance what their roles are and there is a clear division of labour and responsibilities, a clear workplan, and good communication between actors before, during, and after the emergency (recovery), which helps in preparing for the next emergency/crisis.

- Do the actors involved have a clear understanding of who does what?
- Are good communication strategies in place?
- Is there duplication of effort?
- How do NDRMC and MoH collaborate and work together at the federal level, and at sub-national levels?
- When and how is MoF involved when a health and nutrition emergency happens? How does the information (the need for more money) reach MoF?
- How does EPHI work with MoH and regional health offices? How do they coordinate? Do they have an agreement? What does the PHEM system look like at sub-national level? Do regional PHEM teams report to EPHI? Does EPHI support regional PHEM teams when emergencies happen? What kind of support do they give? How does EPHI support regions and woredas?
- Do the current emergency financing (including pooling and mobilisation of resources) arrangements and structure promote coordination across the different actors involved in

health emergency preparedness, response, and recovery programmes/interventions? (*Adapted from HFPM Q7.2)*

(6) Accountability and transparency

Operational definition: There is a clear and standardised reporting system that can help track and trace resource allocation and expenditures, and this information is available to the public.

- Is there a specific reporting system for emergency health financing which can help track how the funds are spent at all levels (beyond the standard reporting of health financing)? Is there a written document (standard operating procedures)?
- Is the reporting system transparent and standardised across channels?
- Is information shared appropriately between government departments, international NGOs, and donors?
- Is the emergency health expenditure reporting comprehensive, timely, and publicly available? (*Adapted from HFPM Q6.5)*
- Do reporting and data meet expected quality standards?

(7) Outcomes achieved (reach/coverage, equity)

Operational definition: The outcomes are achieved in terms of reach/coverage, and in terms of who benefits from the resources (equity).

- How many people have the resources been able to reach/be distributed to?
- What are the key outcome indicators used to measure achievement/success?
- Who has benefited and who has not? Have the most vulnerable benefited? (How are the most vulnerable defined?)

(8) Resource use (cost)

Operational definition: The cost of each input translates into the maximum impact achieved.

- Does there exist an approach for examining the cost per beneficiary of emergency financing for health and nutrition?
- What is the unit cost per beneficiary for a particular type of emergency intervention?
- What are the costs of key inputs which yield the most impact (for each type of emergency)?
- What is the *per capita* emergency health expenditure for the outcomes achieved?

It is worth noting that we did not carry out a cost-effectiveness analysis in this phase, due to uncertainty around data availability (more time is required to investigate this). We aim to undertake a more rigorous cost-effectiveness analysis in Phase 3. In this phase, we focused on the question of how resources are used and the costs of key emergency interventions, drawing on the costing methodology of the Working to Improve Nutrition in Northern Nigeria

Programme.[15] For example, some inputs may have a lower cost when financed through the government channels due to economies of scale or lower staff costs, or the cost could be higher due to procurement procedures – although slightly higher costs might be translated into a lower cost per beneficiary if there are other efficiencies in delivering the emergency interventions. We also take trade-offs into account: for example, higher costs to reach populations that are 'harder to reach' (e.g. getting health services to remote populations).

Other more general questions leading to Phase 3

- What are more effective and efficient ways by which it would be possible to finance and manage health and nutrition emergency activities at federal and sub-national levels? (For example, an emergency pooled fund).
- What do donor-/NGO-led investments in emergency health and nutrition deliver in terms of humanitarian outcomes? Are there duplications with the emergency health interventions delivered by the GoE?
- How does non-government-led expenditure on emergency health and nutrition help strengthen Ethiopia's health and nutrition delivery systems for the short- and medium-term future?

3.3 Methodology

3.3.1 Judgment for Performance Standards

We created an analysis framework with the eight assessment criteria/desirable attributes mentioned above. The broad methodological steps we followed are as follows:

- *Step 1:* Listing important assessment criteria/desirable attributes.
- *Step 2:* Producing a description of the current emergency health financing system (based on KIIs and secondary data analysis).
- *Step 3:* Analysing the current system – setting out performance standards to assess the performance of the current emergency financing system for health and nutrition. These standards were qualitatively judged based on the KII responses, as well as available secondary data. As much as possible, we tried to assess (through both primary and secondary data analysis) whether the responses differed for different types of emergencies, i.e. malaria, cholera, COVID-19, nutrition, and trauma and injuries.
- *Step 4:* Developing initial recommendations. Based on the analysis/assessment, we developed recommendations for overall emergency financing for health/nutrition more broadly. As this report only covers the results from KIIs conducted at the federal level (the regional-level interviews are still ongoing), we refrain from making specific recommendations at this point.

In the first step, we analysed the characteristics and trends for overall budget allocation, expenditure, and utilisation, the composition of spending, intra-sectoral allocation, and outputs/outcomes at national and sub-national levels (regional). We also attempted to

[15] Vargas, P., and S. Keen. (2017) 'Full Costing of the WINNN Programme', Operational Research and Impact Evaluation (ORIE).

capture the institutional structure and budgetary processes of the different levels, including how the health plans and fund estimates are made and consolidated at various levels; how the decisions on allocations are made; how funds are released and utilised; how these are tracked and reported; and how lessons are learned. By combining data from KIIs with key stakeholders, alongside secondary financial and incidence data, we aim to be able to comprehensively outline the current emergency health financing mechanisms, along with specific challenges and bottlenecks the system encounters.

In the second step, we assessed the current emergency financing mechanisms based on the pre-determined performance standards, which build on the HFPM framework, and the evidence and literature reviewed in the Phase 1. The innovative aspect of our analysis framework is that the VfM analysis was fully nested as the eight assessment criteria/desirable attributes can be mapped onto the 4E (economy, efficiency, effectiveness, and equity), and were used to assess the performance of emergency health financing (Steps 3–4) (described in more detail below).

How we make and report judgements against the performance criteria

We use the rubrics approach to make transparent judgements about the performance of the emergency health financing system in Ethiopia. The rubrics described in Table 1 below set out an agreed basis for interpreting the evidence.

Judgements are made holistically based on all of the evidence presented for each criterion. We review the evidence for each criterion against the relevant standards. In principle, performance standards are cumulative, so (for example) to reach a judgement of ‘advanced’ performance all criteria should be met at the ‘emerging’, ‘progressing’, and ‘established’ levels. However, exceptions may be made, based on the researcher’s professional judgements. Where this is the case, the rationale is clearly explained.

Table 1: Performance Standards

Criteria	Emerging	Progressing	Established	Advanced
Predictability	There are no clear sources of funds and there is no planning for emergency health financing. There is little or no forward budgeting, and there are large year-to-year fluctuations in funding emergency health and nutrition.	Although revenue and expenditure scenarios exist through some form of planning, the predictability of the level of funding for emergency health and nutrition remains poor.	The level of funding for emergency health financing is relatively predictable due to well-functioning budgetary processes and planning.	There is a clear annual plan for emergency financing for health and nutrition based on risk assessments and an effective early warning system, leading to predictable sources. The sources of funds are known, and estimated amounts can be earmarked for emergency preparedness, response, and recovery.
Adequacy/flexibility	Resources are not sufficiently allocated to specific health and nutrition emergency needs. Emergency funding is insufficient for the magnitude of the need.	Resources are relatively allocated to some aspects of health and nutrition emergency needs, but resource allocations remain scant overall by comparison to the magnitude of the need.	Resources are relatively allocated to all aspects of health and nutrition emergency needs, with minimal requirements for additional funding given the magnitude of the need.	Resources are sufficiently allocated to all specific health and nutrition emergency needs. Emergency funding is sufficient for the magnitude of the need and there is flexibility in regard to additional funds if required.
Allocative efficiency	Resource allocation is not evidence-based. There are no criteria defined as the basis for decisions on emergency resource allocation.	Some evidence is used in resource allocation. Some decisions on emergency resource allocation are assessed against selected criteria as a formal process for decision-making.	Evidence is relatively used in resource allocation, and decisions on emergency resource allocation are relatively assessed against established criteria.	Resources are allocated appropriately based on evidence and are subject to systematic risk assessments and deliberation against established criteria.

Criteria	Emerging	Progressing	Established	Advanced
Timeliness	Resources are not allocated in time to meet the required needs.	Resources for some aspects are allocated in time for the required needs but are slow in regard to other aspects.	Resources are relatively allocated in time for the required needs, with minor improvements required.	Resources are consistently and significantly allocated in time for the required needs.
Good coordination	Roles and responsibilities are not clearly defined among the actors involved in emergency health financing, and there is no clear division of labour and responsibilities (across government at all levels, donors, IPs); there is poor coordination among actors, and there are no clear communication strategies.	Some roles and responsibilities are defined and divided across actors for emergency health financing, but poor coordination remains. Some communication strategies are in place, but they remain weak.	Roles and responsibilities are clearly defined and divided collectively among actors in emergency health financing, although better coordination is still required. Communication strategies are in place and function relatively well.	Actors' roles and responsibilities are clearly defined for the emergency financing system overall. All actors are systematically involved, and communication strategies function very well.
Accountability and transparency	Accountability is weak. There is no clear and standardised reporting system that can help track and trace resource allocation and use, and this information is not available to the public.	Some accountability mechanisms are in place, but they remain weak. There is some form of standardised reporting system, but resource allocation and use are not regularly tracked, and information is not consistently available to the public.	Accountability mechanisms function relatively well. There is a standardised reporting system and standardised resource allocation, and use is regularly tracked, with minor improvements required. Information is publicly available but still needs improvement.	Accountability mechanisms are highly functional, and stakeholders are publicly accountable for performance. There is a clear and standardised reporting system that can help track and trace resource allocation and expenditures, and this information is consistently and openly available to the public.
Impact	Outcomes/impacts are not achieved in terms of	Some outcomes/impacts in terms of reach and	Outcomes/impacts, in terms of reach and	The outcomes/impacts are significantly achieved in

Criteria	Emerging	Progressing	Established	Advanced
	reach/coverage. There is no prioritisation of vulnerable population groups and benefit entitlements; conditions of access are implicit and not clearly defined, and people do not understand them.	coverage are achieved. There is prioritisation for relatively well-off groups, and benefit entitlements and conditions of access are clear for some part of the population but remain uncertain for most; some efforts are made to communicate, but these are limited.	coverage, are relatively achieved. Measures are taken to universalise certain benefits, and significant action is taken to make benefit entitlements and conditions of access explicit for most of the population, but these remain unclear for many.	terms of reach/coverage. Benefits entitlements are explicitly defined for the entire population, with provisions for vulnerable groups, and conditions of access are clearly communicated and understood by the population.
Resource use	Invested resources are not commensurate with the level of outcome/impact achieved.	Invested resources are fairly commensurate with the level of outcome/ impact achieved, but there is a significant room for improvement.	Invested resources are commensurate with the level of outcome/impact achieved.	Invested resources are significantly commensurate with the level of outcome/impact achieved.

3.3.2 Primary and secondary data collection

Primary data collection (updated)

Sampling and respondents for KIIs

Primary data were collected using KIIs with relevant stakeholders (virtually, by phone, and occasionally in person). The purposive sampling method was employed to select respondents, including government officials, donors, and IPs at the federal level.

During Phase 1 of the study, the research team started engaging intensively with government counterparts (from the PCD/MoH, MoF, EPHI, and NDRMC) to explain the objectives and potential benefits of the research and to understand how to best collaborate with each stakeholder to ensure that the direction of the Operational Research would be aligned with the GoE's strategies and objectives. At the completion of the formative research in Phase 1, the Operational Research team organised a one-day validation workshop where we invited stakeholders across the government, donors, and IPs to present our findings and to introduce the second phase. During this workshop, the team was able to communicate to stakeholders that we would be getting in contact with them for KIIs in the next phase. Having already fostered this relationship, we were able to leverage this collaboration to obtain our respondent lists for the Phase 2 KIIs. Our counterparts at the PCD played a key role in putting us in contact with respondents from MoH and EPHI. Additionally, the team was able to secure the participation of donor and IP respondents by maintaining contact with the participants from the workshop.

Of those participants, we employed selection criteria to pick those who were most relevant to our research objective in Phase 2. The main criteria for selecting the key informants included the following: degree of knowledge about financing or financial tracking as a whole and for the four case studies; degree of knowledge of and engagement in decision-making processes on mobilising and allocating financial response and recovery funds; and general availability and readiness to share pertinent information. By employing these parameters, we were able to narrow down our respondent list and we conducted 31 interviews at the federal level – 19 with government stakeholders, eight with donor organisations, and four with IPs.

The respondents were asked questions related to the predictability, adequacy, and allocation of funding, budgetary allocation, utilisation, and institutional mechanisms for coordination and accountability. Through the KIIs conducted at the federal level, we attempt to understand and capture the process behind the formulation of the emergency health budget, the allocation formulae, and decision-making processes across the multiple stakeholders that play a major role in emergency health and nutrition responses in Ethiopia. During this in-depth context analysis, we were able to gather an in-depth understanding of how the existing emergency financial system works, and its strengths and weaknesses, and to fill any missing gaps from the formative research in Phase 1. Moreover, the KIIs were also used to understand the political economy around decision-making processes for emergency financing for health and nutrition at different levels, as well as the interplay and coordination between different stakeholders.

The study employed two sampling techniques – namely, purposive sampling and snowball sampling – to identify and contact potential respondents.

At the federal level **32 KIIs** were conducted with different relevant government and non-government stakeholders (including donors and IPs).

Respondents from the organisations listed below participated in the primary data collection, based on the key selection criteria stated above.

Table 2: Organisations that participated in the federal-level data collection

Level	Organisations and number of participants
Federal, government	MoH – six participants
Federal, government	EPHI – two participants
Federal, government	MoF – five participants
Federal, government	NDRMC – three participants
Federal, government	EPSA – two participants
Federal	Donors – nine participants
Federal	IPs – five participants

At the regional level, KIIs were conducted with RHBs, RFBs, regional public health institutes, DRMCs, and IPs. Similar to the approach at the federal level, the regional interviews employed purposive as well as snowball sampling techniques. In total we interviewed 49 respondents at regional level, as shown in Table 3:

Table 3: Organisations that participated in the regional-level data collection

Region	Organisations and number of participants
Addis Ababa	Addis Ababa City RFB – one participant Addis Ababa RHB – one participant
Afar	Afra DRMC – one participant Afar RHB – three participants Afar Public Health Institute – one participant IP – one participant
Amhara	Amhara RHB – one participant Amhara RFB – one participant Amhara Public Health Institute – one participant IP – one participant
Benishangul-Gumuz	Benishangul-Gumuz RHB – two participants Benishangul-Gumuz RFB – two participants Benishangul-Gumuz DRMC – one participant IP – one participant
Dire Dawa	Dire Dawa RHB – one participant Dire Dawa RFB – one participant Dire Dawa DRMC – one participant
Gambella	Gambella RHB – two participants Gambella RFB – one participant Gambella DRMC – one participant IP – one participant

Region	Organisations and number of participants
Harar	Harar RHB – two participants Harar RFB – one participant Harar DRMC – one participant
Oromia	Oromia RHB – one participant Oromia RFB – one participant Oromia DRMC – one participant IP – one participant
Sidama	Sidama RHB – one participant Sidama RFB – one participant Sidama DRMC – one participant Sidama Public Health Institute – one participant
SNNPR	SNNPR RHB – one participant SNNPR RFB – one participant SNNPR DRMC – one participant SNNPR Public Health Institute – one participant IP – one participant
Somali	Somali RHB – one participant Somali RFB – two participants Somali DRMC – one participant IP – one participant
South West*	South West RHB – one participant

Note: * This is a new region and thus they are just setting up the institutions and infrastructure around emergency preparedness and responses.

Secondary data collection

a. Financial data (updated)

The quantitative analysis of financial data was conducted mainly based on the MoH's periodic health spending data, reports, and estimations of programme total spending and per capita at federal and regional level for the period from Ethiopian Financial Year (EFY) 2009 to 2012.

To evaluate the spending on the case studies, annual government budget allocation programmes (Channel 1), donor allocation on programmes (Channel 2), and off-budget IP spending (Channel 3) were reviewed at federal and regional levels. The government programme budget (Channel 1) is only available at federal level, while the regional-level budget utilises line budget items, so no data on programme health spending are available at regional level. Channel 2 and Channel 3 programme spending data are available both at federal and regional levels, from the annual resources mapping exercise.

Channel 1 expenditure estimation process

Federal-level health spending data

Expenditure data for Channel 1 health spending for EFY 2008–2012 are filtered in terms of programmes. Spending clearly related to the health programmes is identified. Spending related to multiple programmes, but not clearly assigned to one single programme, is also filtered. However, the latter is marked as needing further validation to identify the exact spending on a single programme within the department/programme spending to which it is assigned. These steps were conducted in relation to the nutrition and malaria programmes since the programme budget for these two programmes is based on the MoH programme/department, and is clearly defined in the budget allocation process. We encountered some issues with nutrition programmes due to the structural change within the MoH, which changed the placement of the nutrition programme within the departments. However, for cholera/AWD, there is no clearly defined expenditure linked to AWD disease/programme category. Thus, what was done is that expenditures that are related to hygiene and environmental programmes were marked as potential spending that might be related to AWD, but which needs further investigation and for data to be pulled from the actual MoH financial expenditure report on each programme. Therefore, we focus the analysis on malaria, nutrition, and injuries, for which data are clearly identified and available.

Regional-level health spending data

Due to the existing budget planning approach in the health sector, to estimate the regional-level programme expenditure for Channel 1, a methodology referred to as 'distribution key' was applied. This methodology, which is used in the production of National Health Accounts (NHA), was employed to estimate all the national- and regional-level spending by major diseases and health conditions for the study period. During the estimation process, for most regions, EFY 2008 data were not complete, and thus in order to have a similar data period across all regions, the period from EFY 2009 to EFY 2012 was considered for the distribution key estimations for all regions. The activities carried out to develop the methodology included the following:

1. The research team received a brief introduction on the steps and data needs in the estimation process for the distribution key, with continuous hands-on support from MoH throughout the estimation process.

2. The basic data used to work on the distribution key were shared from District Health Information Systems (DHIS) 2: i.e. regional outpatient departments (OPDs) and inpatient departments (IPDs) and prevention services health facility visits by provider type in all regions from EFY 2008 to 2012. In addition, prevention services for certain programmes, such as maternal health, vaccines, nutrition, HIV/Aids, malaria and TB, were collected from the health and health-related indicator report. However, the report was not fully available for the study period, thus to fill in the gaps, the data for the TB programme for EFY 2012 were estimated based on the available data for the previous year (EFY 2011).

3. OPD and IPD data (facility visits) and prevention services for the four years (EFY 2008 to 2012) were filtered, sorted, and organised per region for further processing. Thus, data for each region were organised as per the DHIS disease category and mapped with the System Health Account (SHA) disease category for all health facilities: i.e. health post, health centre, and hospital. The majority of the health posts did not have much data and thus the data for health posts were merged with the health centre data. In addition, the unit cost per health facility was estimated at health post level. Following the mapping, the unit cost for each visit, as per the SHA category, was obtained from MoH for health

centres and hospitals, and was used for producing the latest NHA. Accordingly, the total cost as per the SHA disease category list was calculated for the study period for both IPDs, OPDs, and prevention services for health centres and hospitals for each region. The unit costs for OPDs and IPDs were available at health centre and hospital levels. However, the unit costs for prevention services were only provided either at health centre or health post level, and thus the total cost for prevention services was calculated at health centre level.

4. To summarise the total costs per each disease category, a pivot summary of all the total costs for each DHIS disease category was produced as per the SHA major disease and health conditions per region for the three departments (OPD, IPD, and prevention). Prevention services are provided in OPDs and thus the total cost summary of these services for the selected programmes based on the SHA category summary were merged with the OPD total cost summary with the respective programmes. This process captured all the costs related to each programme within the OPDs.

5. Then, the total cost by health provider, by unit by year, and the total cost by unit by year for all regions were summarised (see Table 4 and Table 5).

Table 4: Government health cost at federal level per year by facility by unit

Facility	Unit	Total cost per year by facility by unit				
		EFY 2008	EFY 2009	EFY 2010	EFY 2011	EFY 2012
Health centre	OPD	0	4,052,965,025	12,969,243,181	13,046,030,131	14,451,258,236
Health centre	IPD	0	6,440,287	20,425,284	20,029,709	19,672,441
Hospital	OPD	0	753,266,847	3,774,882,418	3,968,085,697	3,438,246,102
Hospital	IPD	0	192,562,703	872,418,732	973,425,541	1,033,979,244

Table 5: Government health cost at federal level by facility

Facility	Total cost by facility				
	EFY 2008	EFY 2009	EFY 2010	EFY 2011	EFY 2012
Health centre	0	4,059,405,312	12,989,668,465	13,066,059,840	14,470,930,678
Hospital	0	945,829,550	4,647,301,150	4,941,511,238	4,472,225,347

Once the total cost by health provider was summarised (Table 4 above), the share of the total cost by health provider was estimated accordingly (Table 6). To estimate the spending by health provider, the proportion of expenditure by provider was calculated from the total actual expenditure (Table 7) for each year.

Table 6: Government federal level health cost share by health provider

Facility	Expenditure share by facility (%)				
	EFY 2008	EFY 2009	EFY 2010	EFY 2011	EFY 2012
Health centre	0	81%	74%	73%	76%
Hospital	0	19%	26%	27%	24%

Table 7: Government national health expenditure by year

National	EFY 2008	EFY 2009	EFY 2010	EFY 2011	EFY 2012
Health expenditure	20,481,853,918	28,091,426,345	26,083,188,231	32,074,534,016	40,038,122,741

Following the estimation of total spending (table 7 above) to further calculate the spending breakdown at a per capita level, total spending of each region was divided by the respective total population in each year.

Table 8: Government national health expenditure share by health provider

Facility	Total expenditure share by facility				
	EFY 2008	EFY 2009	EFY 2010	EFY 2011	EFY 2012
Health centre	0	22,783,043,846	19,210,327,795	23,272,865,562	30,585,658,373
Hospital	0	5,308,382,499	6,872,860,435	8,801,668,455	9,452,464,369

Then, to identify the share of spending by programme, the total cost of each major disease and health condition was divided to the total cost of all diseases per year. Then, to estimate the proportion of spending for each disease by health provider, the percentage share of each major disease was multiplied by the health expenditure for each health provider (Table 8 above). The expenditure by health provider was added for each programme and the total spending per major disease and health condition were estimated per year. The process was replicated for every region to estimate programme spending at regional level.

Channel 2 expenditure estimation process

Channel 2 data sourced from annual resource mobilisation exercises were collected for the four-year period from EFY 2009 to 2012. The data were cleaned and sorted based on the programmes for each year; thus, malaria and nutrition programme expenditures are clearly marked. Since Channel 2 data from resource mobilisation exercises are self-reported data, in order to verify the expenditures on each programme, actual reports were obtained from MoH. However, the reports show the expenditure by source of donor only. The expenditures are not linked to a specific programme, but rather give a total expenditure amount per year. Thus, further communication was conducted. However, detailed expenditure for Channel 2 resources is not yet accessible. The only available data for Channel 2 spending by programme are data on the expenditures organised in and drawn from the resource-mapping exercise. These expenditures do not indicate the regional allocation but only the total amount by programme.

Channel 3 expenditure estimation process

Similar to Channel 2 expenditure, Channel 3 expenditure data for the four years (EFY 2009 to 2012) were obtained from the annual resource-mapping exercises. Channel 3 expenditure was off-budget and the only way to evaluate the expenditure on emergency programmes was based on IP reporting in the resource-mapping exercises. The expenditure data, in addition to their programme allocation, entail geographic-level expenditure allocation based on the programmes as well. Channel 3 expenditure are available from the resource-mapping exercises only. Thus, due to the fact that the data are self-reported, definite analysis was not

concluded and trends identified based on the data are limited to those reported, and do not necessarily indicate the entire Channel 3 expenditure.

COVID-19 expenditure estimation process

COVID-19 resource mobilisation activity was established soon after COVID-19 cases were first reported in Ethiopia. Thus, a resource mobilisation dashboard was developed by MoH to monitor resource commitment from different partners, based on the pillars developed to mitigate the pandemic. The resource mobilisation dashboard is dynamic, and we have utilised the data to identify available resources, resource needs, commitments by donor category, and the resource gap. However, the dashboard only shows the resource allocation/commitment at national level. No regional distribution of resources is reported (including expenditure).

Thus, actual COVID-19 spending data, which are only available at federal level, were accessed from the latest NHA 2022 report.

Incidence data

Incidence data for each of the four case studies are accessible from EPHI. The incident data for the malaria, AWD, and nutrition programmes are available at regional level, while for COVID-19 the detailed case reports are available on a monthly basis, starting when the first COVID-19 case was reported in Ethiopia.

In addition, EDHS 2016 and 2019 reports, and the Regional Health Atlas on Burden of Disease, are used in the study as well.

Data cleaning

The incidence data cleaning process included the following steps:

***Step 1*: Removing duplicate or irrelevant observations.**

When we first received the raw data from EPHI, the dataset included duplicated entries, data from outside the five-year period, and other irrelevant observations and disaggregation. The team proceeded to remove the duplications and irrelevant entries and aggregated the remaining data into manageable categories. The malaria and cholera datasets were then organised by year and region because we sought to analyse incidence trends across all 11 regions over the years 2015 to 2019. The COVID-19 data were organised by month and by region. Since the COVID-19 data we have were only across 2020 and 2021, it was more appropriate to analyse monthly trends across the regions.

Removing duplicated and irrelevant observations made the analysis more efficient and created a more manageable dataset.

***Step 2*: Fixing structural errors**

The next step was to fix structural errors. After removing duplications and disaggregating the data by year and region, the team was able to see that there were numerous typos, incorrect naming conventions, and inconsistent abbreviations and capitalisations. In order to be able

to convert the data into pivot tables for further analysis, all these structural errors had to be corrected and names and abbreviations had to be made consistent throughout the dataset.

***Step 3*: Handling missing data**

The next step we took before making pivot tables and graphs was tackling missing data. Across all three datasets, there were some blank cells in the Excel files. The team operated on the assumption that if a particular month or year had blank cells it meant there were no cases recorded for that month or year. For the sake of convenience and to ensure the accuracy of the pivot tables, we went through every dataset and replaced the blank cells with the number '0' so that the Excel algorithm would accept those blank cells as null values.

***Step 4:* Validating and quality assurance**

At the end of the data cleaning process, the team circulated the clean datasets internally for feedback and review. As part of the basic validation, we asked ourselves the following questions:

- Do the data make sense? Do the data follow the appropriate rules for the respective field?
- Do they bring any insights to light?
- Could we find trends in the data to help us form our next theory?

Once we were satisfied with the answers to these questions, we proceeded to create pivot tables for efficient and manageable analysis, along with graphs and visualisations to demonstrate incidence trends of cholera and malaria during the years 2015 to 2019, and a trend analysis for COVID-19 from June 2020 to December 2021.

Ethical clearance

Ethical clearance was obtained through EPHI, through its Institutional Review Board (IRB), on 25 February 2021, with an approval period from 25 February 2021 to 24 February 2022. Both EPHI's IRB chairperson and EPHI's director signed and approved the certificate (Protocol number: EPHI-IRB-319-2020). The IRB approval was only valid for one year, so we filed an extension with the EPHI-IRB and on 12 May 2022 we were granted an extension until August 2022.

4 Results

4.1 Quantitative Results (updated)

4.1.1 Health Expenditure Trend Analysis

Health programme budgeting

The Ethiopian health sector utilises programme budgeting at national level, while regions and woredas implement line budgeting. As a result, an evaluation of programme-level expenditure trends at regional level is not feasible using budget line items. In order to assess health emergency programme expenditure at regional level, having the programme budget at regional level is needed. As mentioned in the previous section, the study employs a methodology referred as 'distribution key' to estimate the health expenditure breakdown by programme/disease at regional level. The disease categories applied to estimate the programme expenditure can only be applied to programmes such as malaria, nutrition, and injuries, and hence the expenditure trend analysis is limited to these programme disease lists. The detailed step by step regional expenditure estimation process using the distribution key methodology was explained in the methodology section.

Health programme spending trends

The total health expenditure on major diseases and health conditions as per the Ethiopian NHA report for EFY 2012 indicated that 46% of the health spending went to the prevention, management, and treatment of infectious parasitic diseases (Table 9). The spending is lower than the previous NHA reports: 51% in EFY 2006 and 49% in EFY 2009. As shown in Table 9 below, in 2019/20, out of the 46% spending on infectious and parasitic disease, neglected tropical diseases accounted for 18.3%, followed by vaccine-preventable diseases (17.6%), unspecified infectious and parasitic diseases (14.9%) and COVID-19 (11.3%). COVID-19 has changed the spending share particularly within the infectious and parasitic disease category and beyond. In the previous two successive NHA reports, in EFY 2006 and 2009, the share of spending within the infectious and parasitic disease category indicated that HIV/Aids, malaria, and neglected tropical diseases were among the diseases which accounted for the top spending shares. However, in the latest NHA report the share indicated that HIV/Aids and malaria dropped from 17% and 16% to 13.2% and 11.6% in EFY 2012, respectively. As indicated in the NHA EFY 2012 report, in EFY 2012 the spending share for COVID-19 and malaria out of infectious and parasitic diseases was 11% for both.

In addition, in regard to other major disease classifications, the latest NHA report, for EFY 2012, indicated that nutrition deficiencies and injuries have seen a significant spending reduction from EFY 2009 to 2012. Nutrition deficiencies dropped from 11% in EFY 2009 to 3.8% in 2012, while injuries decreased by a little more than 50% from 3% in the previous round of NHA in EFY 2009 to 1.3% in EFY 2012 (Table 9).

Table 9: Summary of spending share on major disease and health conditions (NHA EFY 2006, 2009, and 2012)

Descriptive	Share by disease and conditions			Major classification	Percentage %		
	2013/14	2016/17	2019/20		2013/14	2016/17	2019/20
	EFY 2006	EFY 2009	EFY 2012		EFY 2006	EFY 2009	EFY 2012
HIV/Aids and other STDs	10%	17%	13.2%	Infectious and parasitic disease	49%	51%	46.1%
Tuberculosis (TB)	2%	4%	7.7%				
Malaria	9%	16%	11.6%				
Respiratory infections		10%	3.1%				
Diarrheal disease		5%	2.3%				
Neglected tropical disease	7%	16%	18.3%				
Vaccine-preventable disease		12%	17.6%				
Leprosy		0.04%	0.0%				
COVID-19			11.3%				
Other and unspecified infectious and parasitic disease	20%	20%	14.9%				
Maternal conditions	3%	24%	43.7%	Reproductive health	9%	8%	12.5%
Perinatal conditions	2%	4%	13.6%				
Contraceptive management (family planning)	4%	40%	29.4%				
Unspecified reproductive health conditions		32%	13.2%				
National deficiencies	13%	11%	3.8%	Nutritional deficiencies	13%	11%	3.8%
Neoplasms		15%	5.6%	Non-communicable disease	12%	12%	24.7%
Endocrine and metabolic disorders		6%	5.5%				
Cardiovascular diseases		13%	47.0%				
Mental behavioural disorders and neurological conditions		2%	5.2%				

Descriptive	Share by disease and conditions			Major classification	Percentage %		
	2013/14	2016/17	2019/20		2013/14	2016/17	2019/20
	EFY 2006	EFY 2009	EFY 2012		EFY 2006	EFY 2009	EFY 2012
Respiratory diseases		1%	8.2%				
Digestive diseases		10%	13.3%				
Diseases of the genital-urinary system		32%	5.1%				
Sense of-organ disorders		8%	4.8%				
Oral diseases		4%	2.0%				
Other and unspecified non-communicable diseases		7%	24.7%				
Injuries	3%	3%	1.6%	Injuries	3%	3%	1.6%
Non-disease specific	15%	9%	3.6%	Non-disease specific	15%	9%	4%
Other and unspecified disease/conditions		7%	7.9%	Other and unspecified disease		7%	8%
Total					100%	100%	100%

Source: Ethiopian NHA EFY 2006, 2009, and 2012

Government Health program spending trends by case study programme

Malaria

The national-level government per capita spending on malaria showed a decreasing trend from EFY 2009 to EFY 2011, with the lowest per capita spending recorded in EFY 2011 and the highest spending in EFY 2012 (see figure 3). As indicated in Figure 3 below, malaria incidence showed a steady decreasing trend over the study period (EFY 2009–2012). The highest per capita expenditure recorded was in EFY 2012, yet during the same year the incidence for malaria was the lowest recorded within the study period.

Figure 3: National government malaria programme per capita spending trend EFY2009–EFY2012 (in Ethiopian Birr (ETB))

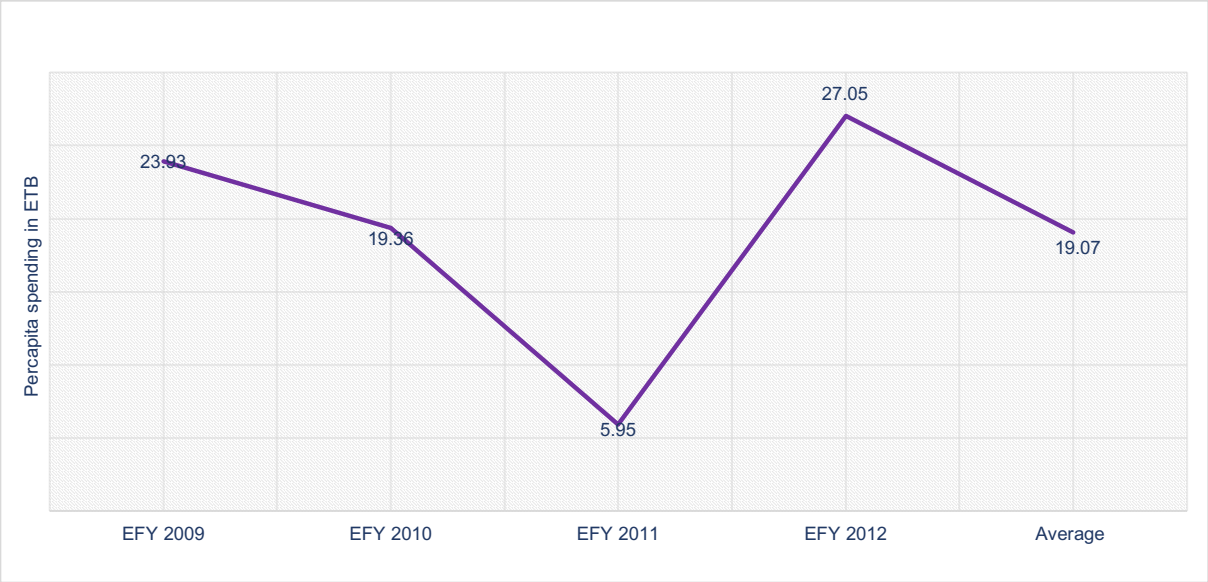
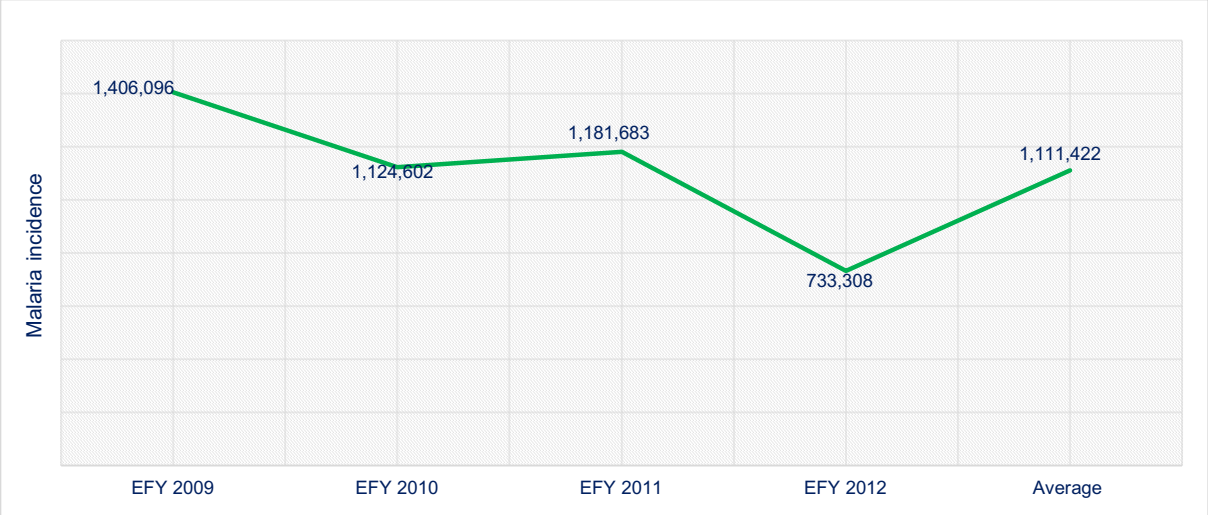


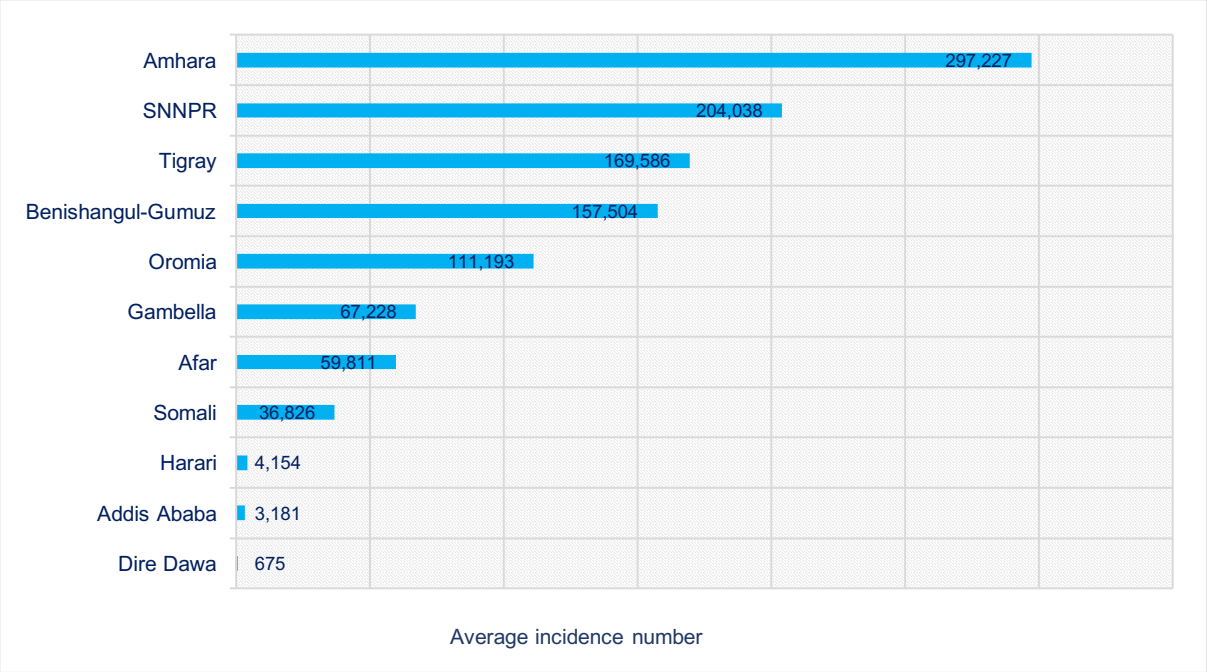
Figure 3: National malaria incidence trend EFY 2009–2012



Regarding the regional malaria prevalence, on average during the same period, the highest average incidence was recorded in Amhara region, followed by SNNPR and Tigray regions (see Figure 4). The average malaria per capita spending indicated in (see figure 5), the top

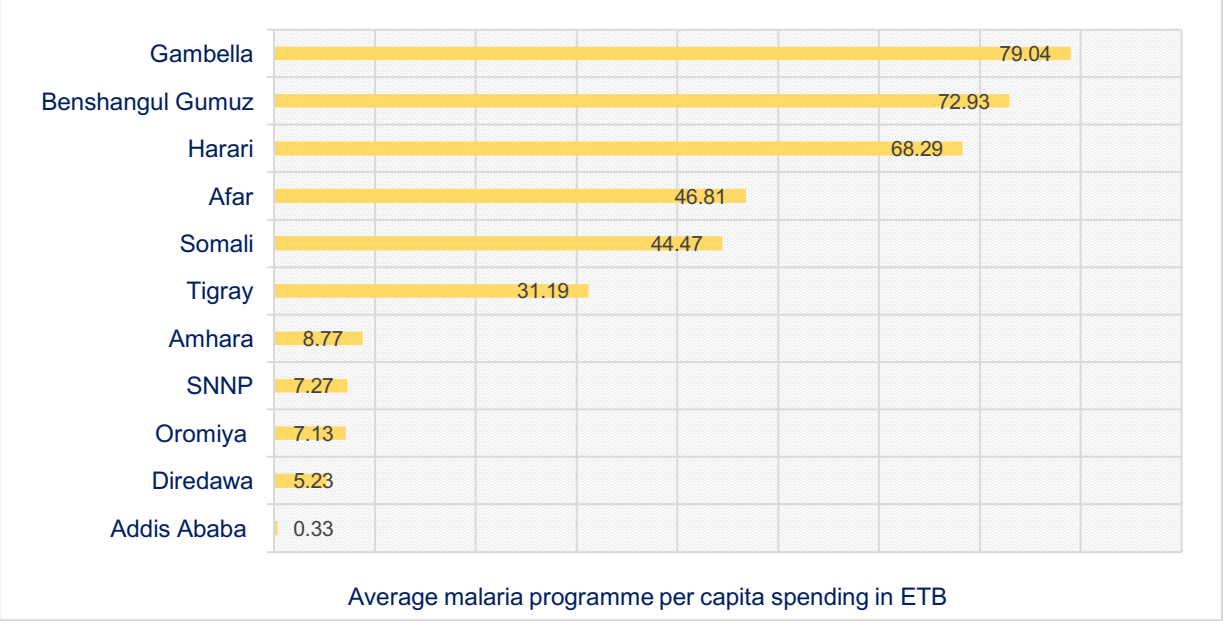
three regions with highest per capita spending are Gambella, Benishangul Gumuz, and Afar regions while the regions with least per capita spending are Addis Ababa, Diredawa and Oromia.

Figure 4: Average malaria incidence by region EFY 2009 – EFY 2012



Source: EPHI

Figure 5: Government average malaria programme per capita spending by region EFY 2009–2012 (in Ethiopian Birr (ETB))



In addition, as can be seen from Figure 4 above, the regions with the average top three malaria incidences from EFY 2009 to 2012 were Amhara, SNNPR, and Tigray regions. While malaria was declared a public health emergency in Amhara and SNNPR regions in EFY 2008/09 and 2011/12, no emergency was declared in Tigray region (see Table 10). Regardless, Tigray was among the top three regions during the same period in regard to average malaria incidence and average spending on malaria.

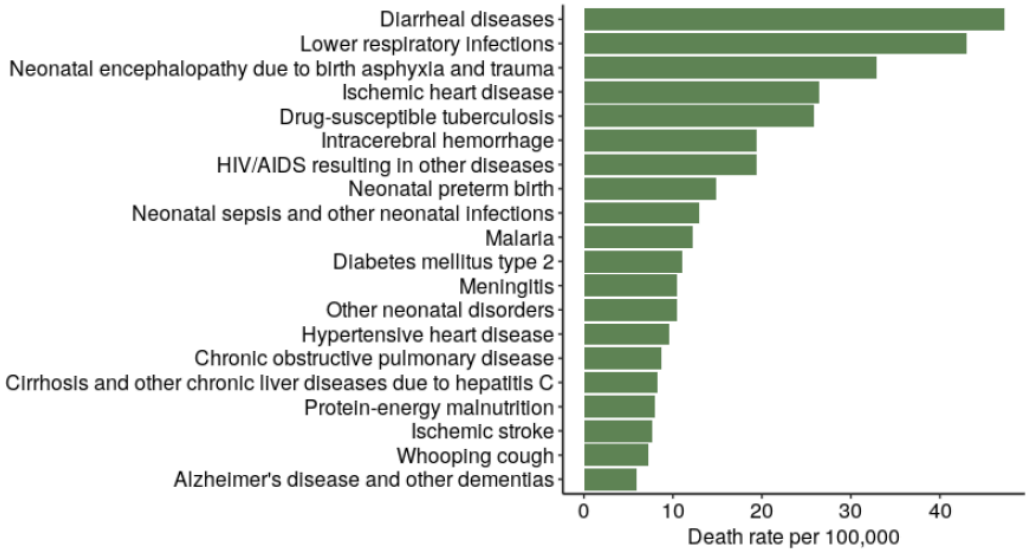
Table 10: Annual malaria incidence declared as public health emergency by region

Regions	EFY 2008/2009	EFY 2009/2010	EFY 2010/2011	EFY 2011/2012
Addis Ababa	3,778	732	-	-
Afar	-	4,201	5,182	-
Amhara	11,413	-	-	70,851
Benishangul-Gumuz	40,977	-	-	39,604
Dire Dawa	-	-	-	380
Gambella	34,425	31,550	-	4,331
Harari	7,378	5,198	-	-
Oromia	135,652	-	-	87,921
SNNPR	151,931	-	-	212,319
Somali	-	-	-	7,312
Tigray	-	-	-	-

Source: EPHI

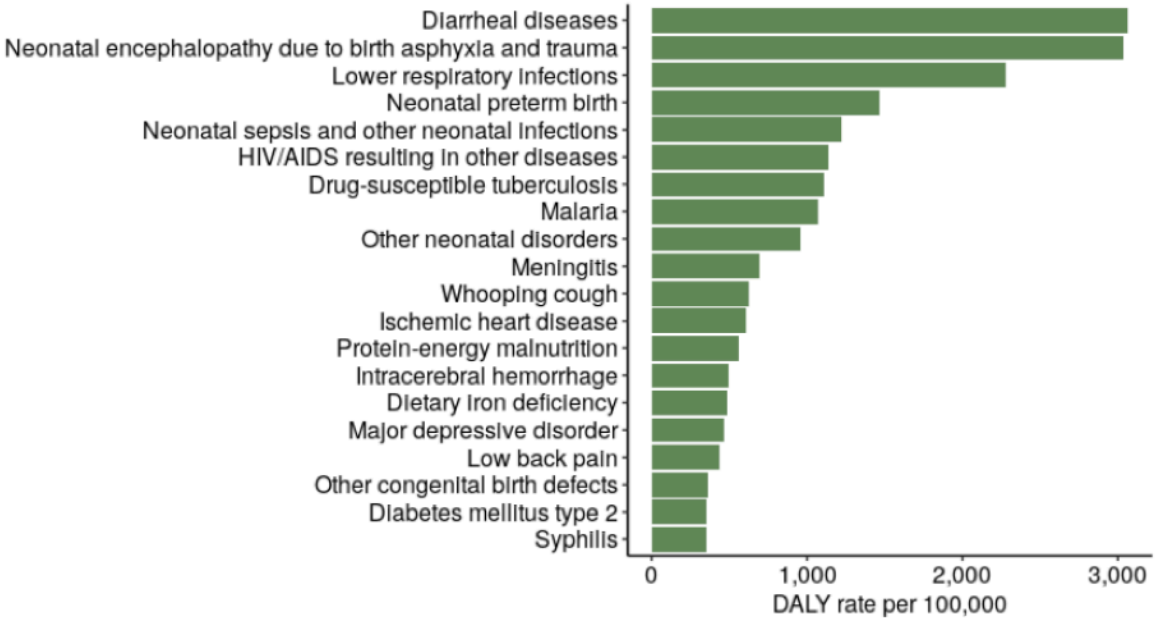
In line with the spending on major diseases and conditions, the National Health Atlas 2021 (EFY 2012/13) report indicates (see Figure 6) that the 20 leading causes of death in terms of total number of lives lost are mainly associated with non-communicable diseases, maternal disorders, communicable diseases, injuries, neonatal disorders, birth trauma, neonatal sepsis and infections, and pre-term birth complications. Thus, death due to malaria is in the top 20 leading causes of death. Furthermore, regarding the leading causes of disability, in regard to key drivers of an increasing burden in the number of disability adjusted life-years (DALYs) in 2019 (EFY 2011/12), malaria was among the top 20, as seen in Figure 7.

Figure 6: Top 20 leading causes of death in Ethiopia, all ages, 2019 (EFY 2011/12)



Source: Regional Health Atlas, 2021 (EFY 2013/14)

Figure 7: Age-standardised 20 leading causes of DALYs in Ethiopia, 2019 (EFY 2011/12)



Source: Regional Health Atlas, 2021 (EFY 2013/14)

Nutrition

In regard to the nutrition programme spending, as indicated in Figure 8 below, from EFY 2011 onwards the per capita spending saw a continues increasing trend. Simultaneously, according to the Ethiopia Mini Demographic and Health Survey 2019 (EFY 2011/12), the overall nutrition status of children has improved over the last two decades. Within the study period, as illustrated in Figure 9, in regard to the trends in nutritional status among children under the age of five, the percentage of wasted children decreased from 10% in 2016 (EFY

2008/09) to 7% in 2019 (EFY 2011/12), the prevalence of underweight children also declined from 23% to 21% and prevalence of stunted decreased from 38% to 37%.

Figure 8: National government nutrition programme per capita spending trend EFY 2009–12 (in ETB)

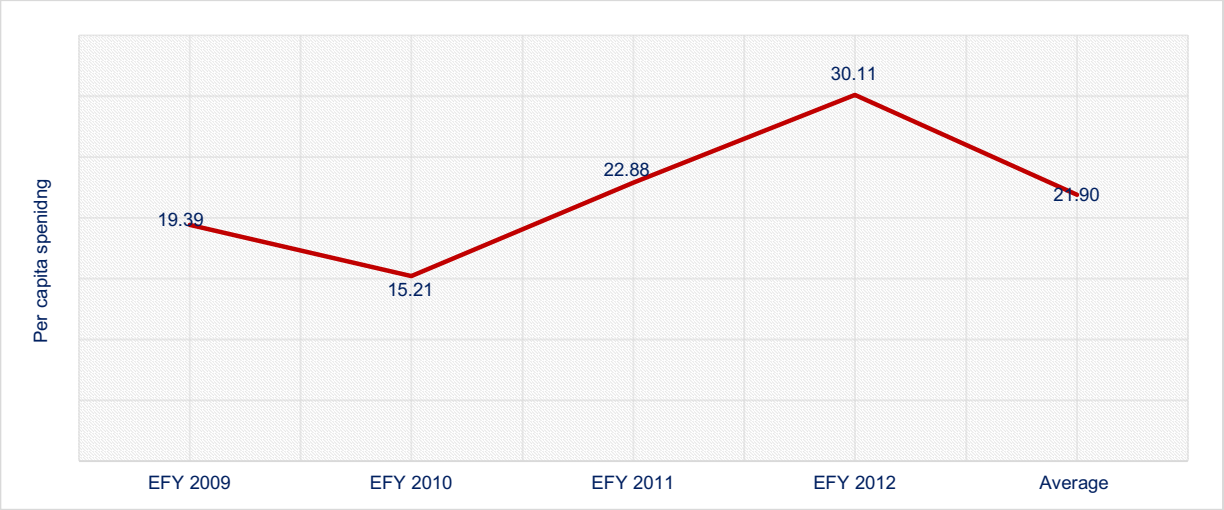
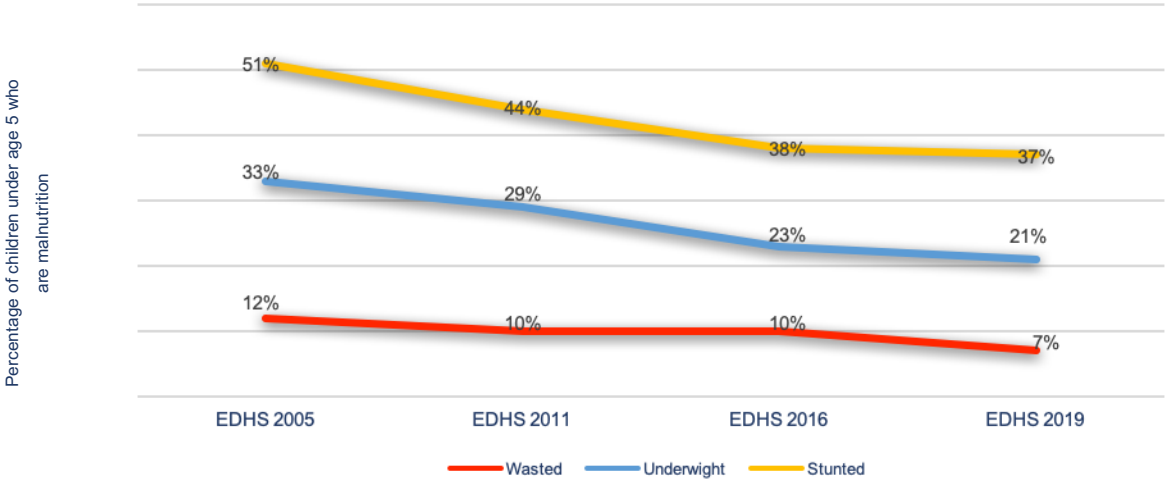


Figure 9: Trends in nutritional status of children



Source: EDHS 2019 (EFY 2011/12)

In regard to the regional distribution of the nutritional status of children, as reported in EDHS 2019 (EFY 2011/12), the highest number of malnourished (stunted, wasted, and underweight) children were in Oromia, followed by SNNPR and Amhara regions. The regions with the least number of malnourished children were Harari, Gambella, and Dire Dawa, as shown in Figure 10. As also indicated in Figure 13, the trend from EDHS 2016 (EFY 2008/09) to 2019 (EFY 2011/12) showed a decrease in the number of total malnourished children (stunted, wasted, and underweight).

Similarly, for the period EFY 2009–12, the top five per capita spending on nutrition deficiencies was in Somali (27 ETB), Benishangul Gumuz (24 ETB), Gambella (21 ETB) Oromia (19 ETB), followed Amhara region (14 ETB), while the least per capita spending was in Addis Ababa (8 ETB), SNNP (9 ETB), and Harari region with (9.2 ETB) (Figure 13).

Figure 10: Nutritional status of children by region, EDHS 2019 (EFY 2011/12)

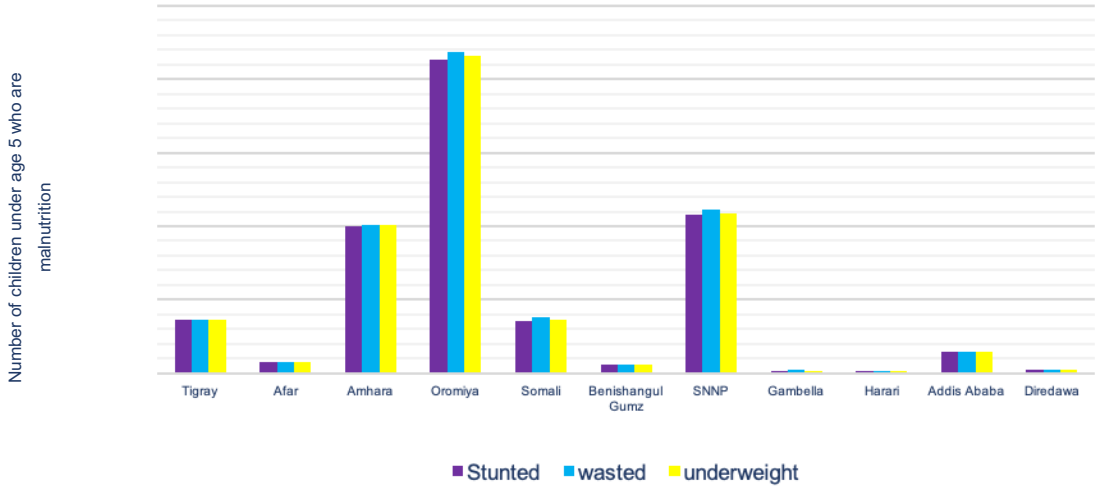


Figure 11: Total number of malnourished children trend: EDHS 2016–19 (EFY 2011/12)

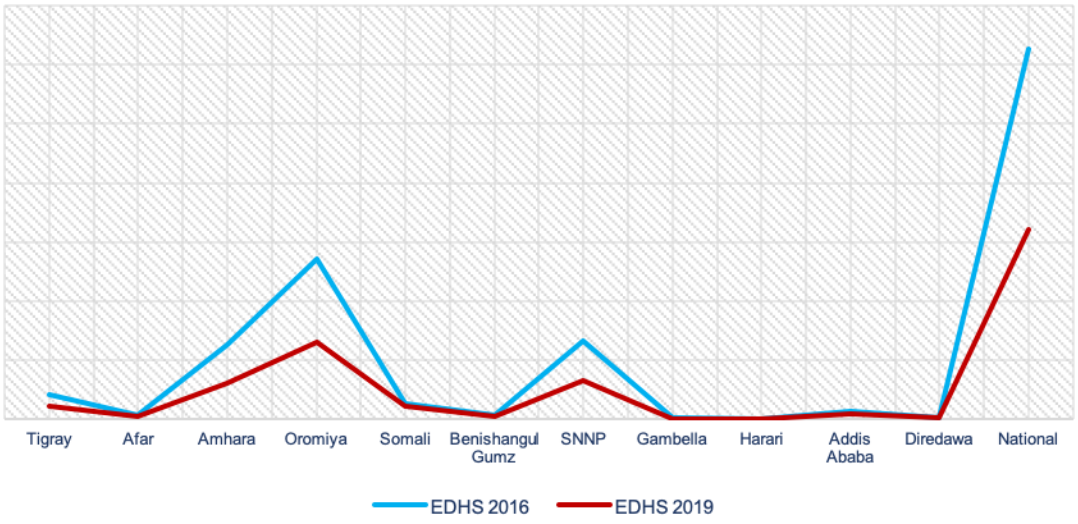
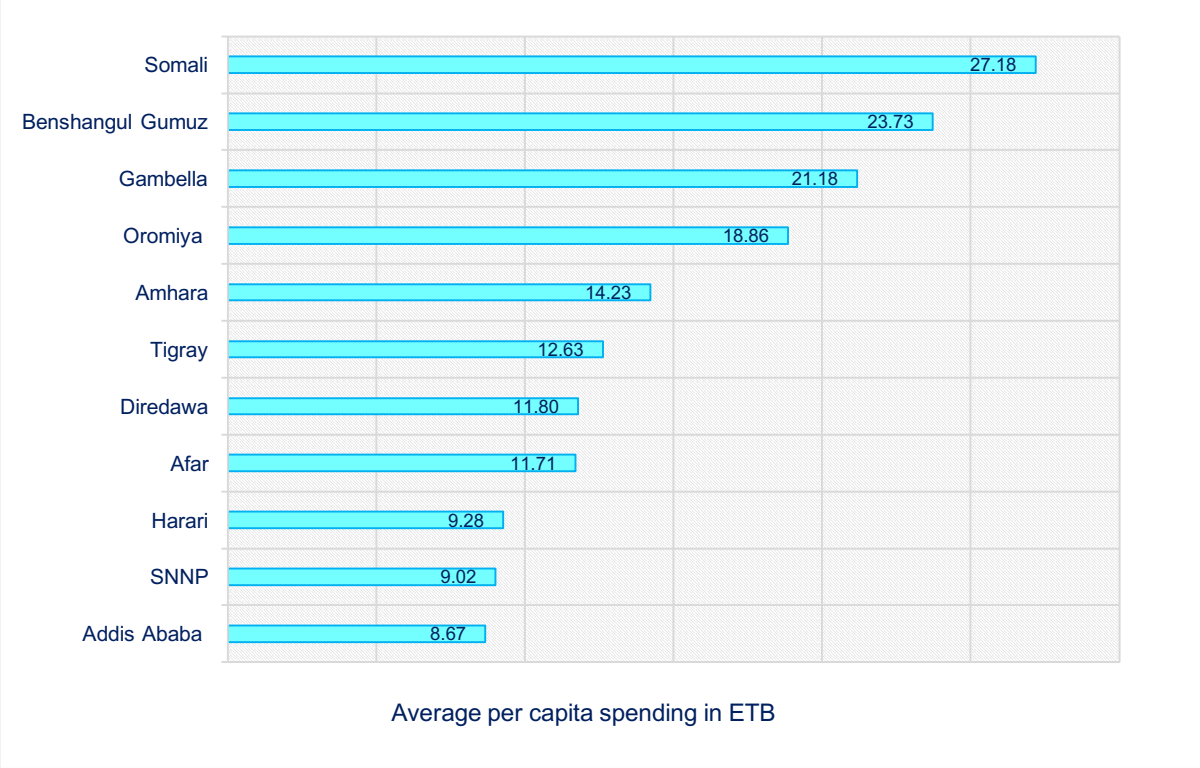


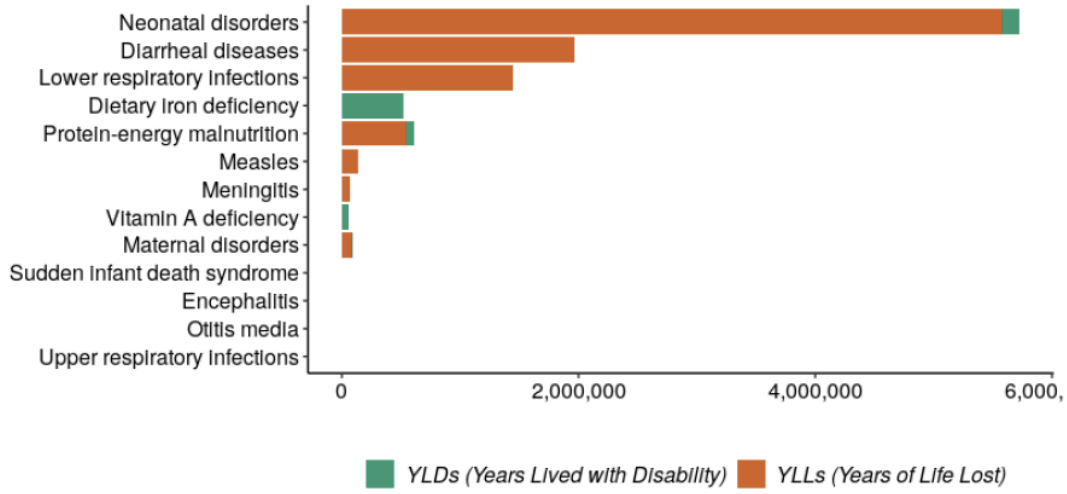
Figure 12: Government average nutrition programme per capita spending by region EFY 2009–12 (In ETB)



Furthermore, based on attributable risk[16] factors for mortality and disability, estimated attributable DALYs, deaths, and years of life lost (YLLs) as a risk factor of child and maternal malnutrition in Ethiopia are very high. Nearly 28% of total DALYs, 20% of deaths, and 34% of YLLs in Ethiopia were attributable to child and maternal malnutrition in 2019 (EFY 2011/12) (see Figure 15 and Figure 16). During the same year, child and maternal malnutrition caused a total of 10,600,000 DALYs, 114,000 deaths, 9,810,000 YLLs, and 818,000 Years Lived with Disabilities (YLDs) (National Health Atlas, 2021) (EFY 2012/13).

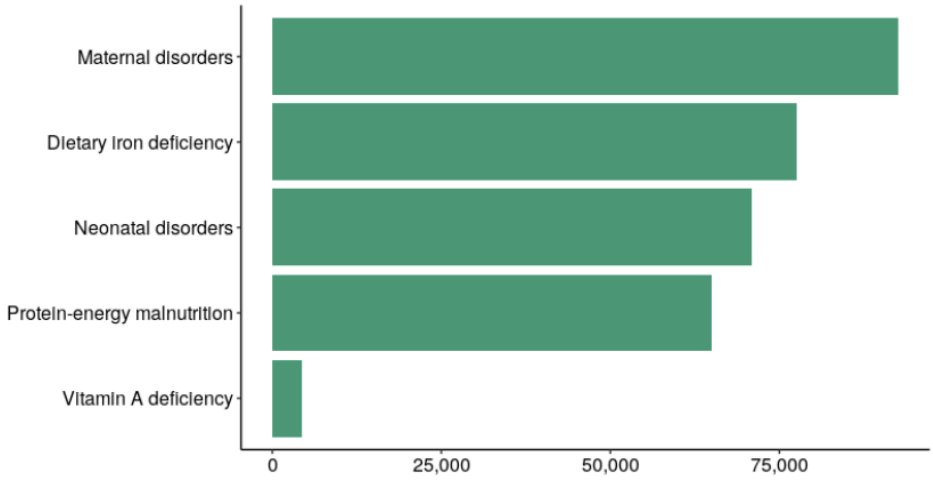
[16] An attributable factor is the portion of an outcome rate attributable to the exposure factor in the epidemiological context.

Figure 13: YLLs and YLDs attributable to child and maternal malnutrition in Ethiopia, both sexes, all ages, 2019 (EFY 2011/12)



Source: Regional Health Atlas, 2021 (EFY 2013/14)

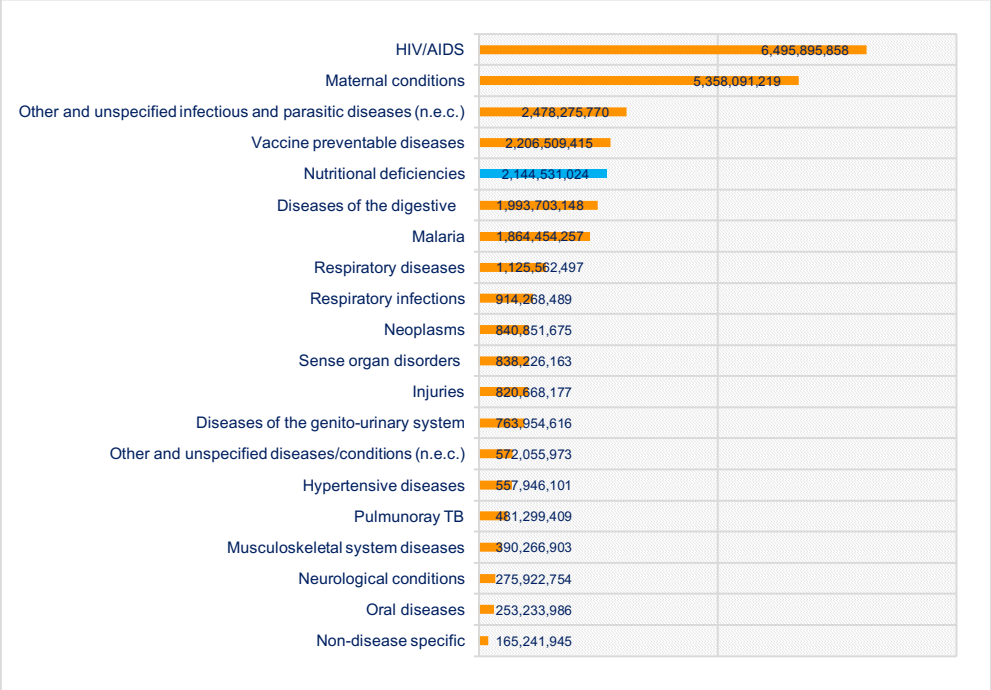
Figure 14: DALYs attributable to child and maternal malnutrition in Ethiopia, both sexes, ages 15 to 64, 2019 (EFY 2011/12)



Source: Regional Health Atlas, 2021 (EFY 2013/14)

This implies that nutrition deficiency contributes significantly to the burden of diseases and causes of death, either directly or as an attributable risk factor – mainly for child and maternal health – at the national level. On the other hand, the spending on nutrition deficiencies over the last four years has declined sharply, from 11% in EFY 2009 to 3% in EFY 2012, as indicated in the NHA report EFY 2012 report. Prior to this decline in spending on nutrition deficiencies, based on the spending for the period EFY 2009–12, nutrition deficiencies were among the top 15 areas of spending, ranking fourth highest spending area, as shown in Figure 16.

Figure 15: Government average spending by disease condition EFY 2009–EFY 2012 (in ETB)



Injuries

Injuries per capita spending over the study period from EFY 2009 to 2012 saw an average ETB 8 per capita spending and showed an increasing trend for the study period from EFY 2009 to 2012, reaching ETB 11 per capita spending in EFY 2012, the highest for the period, as shown in Figure 16. On the hand, causes of death by injures from EFY 2008/09 to 2011/12 showed an increasing trend, as indicated in Figure 17. In EFY 2011/12, injury was among the top 10 causes of death, ranking sixth (see Figure 18).

Figure 16: Government injuries program per capita spending trend EFY 2009–EFY 2012 (in ETB)

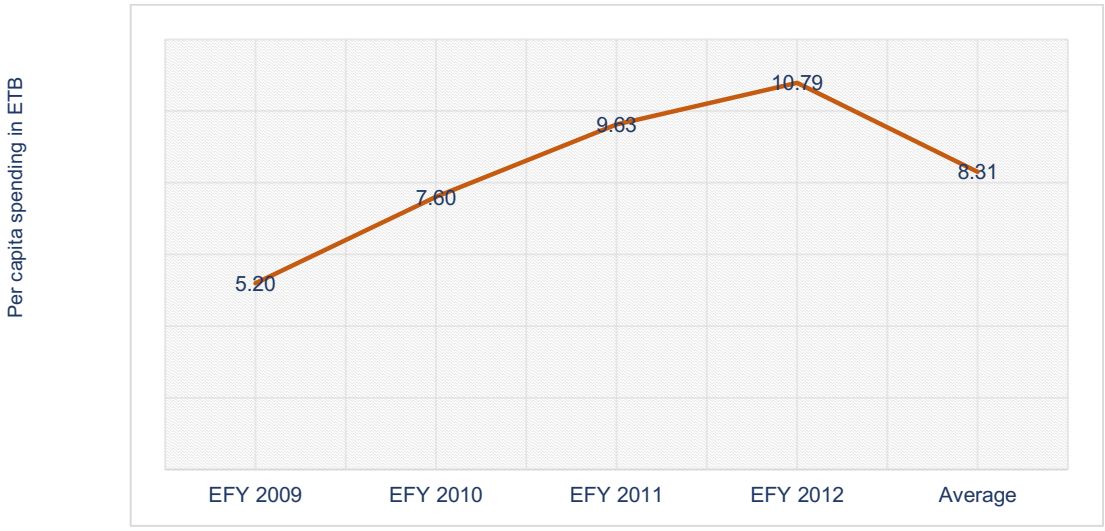
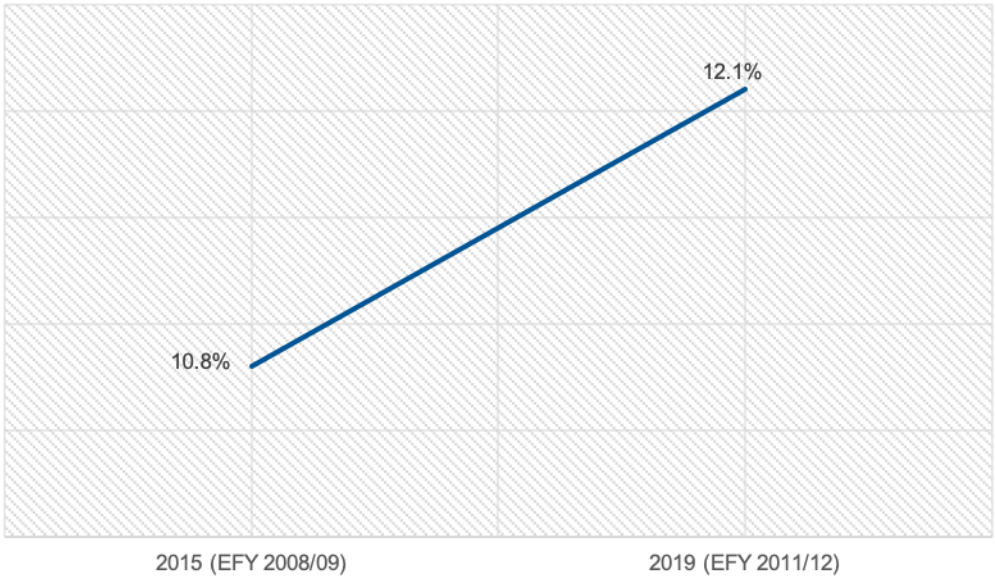
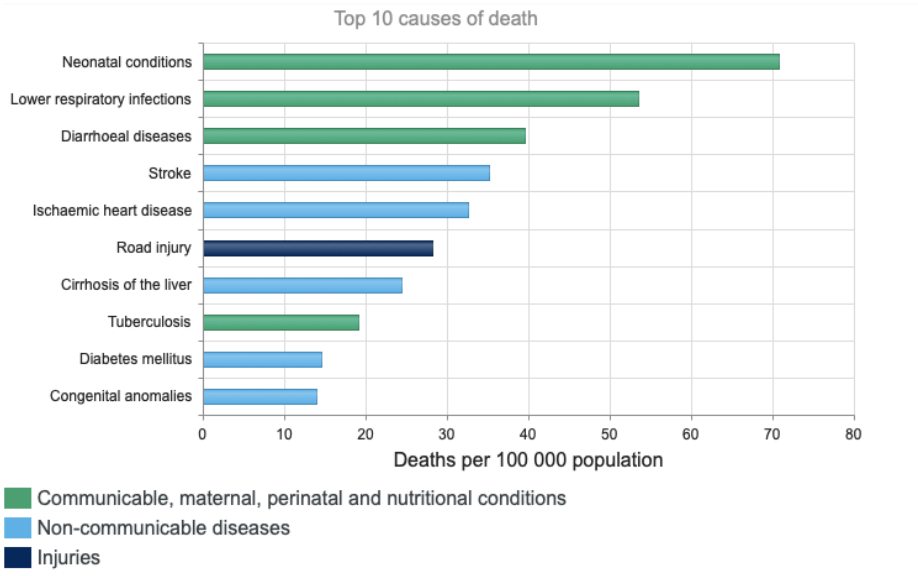


Figure 17: Death by injuries (% of the total) trends



Source: World Bank data

Figure 18: Top 10 causes of death, 2019 (EFY 2011/12)

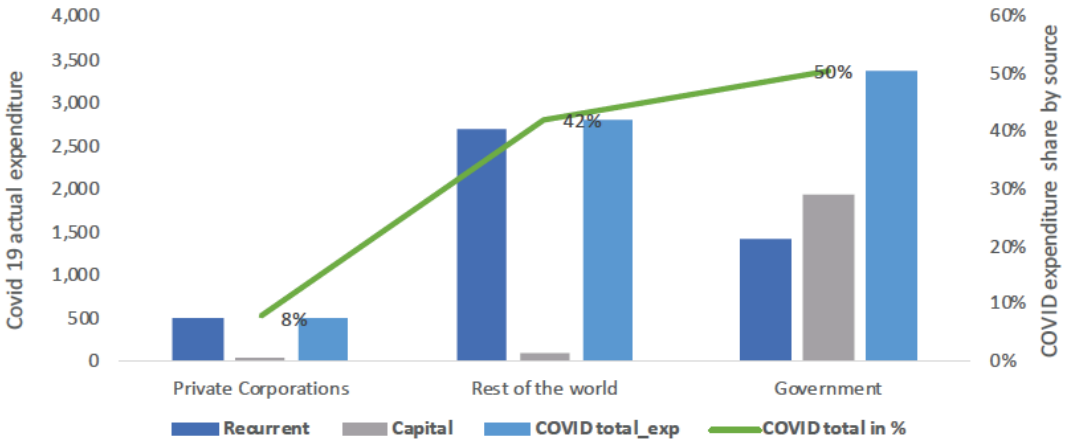


Source: WHO

COVID-19

As indicated in the NHA EFY 2012 report, the COVID-19 pandemic has diverted resources from health system strengthening to emergency response. The COVID-19 pandemic disrupted the health system and created challenges in regard to maintaining the achievements of the last few years. On the other hand, over the past two years, preparedness efforts have been strengthened, and a national preparedness and response coordination mechanism has been set up. The NHA report for EFY 2012 further points out that COVID-19 pandemic response finances are made available through domestic funds from the state budget, the private sector, and bilateral and multilateral donors (see Figure 19). In addition, resources were also mobilised from within the health sector by repurposing existing resources from other programmes.

Figure 19: COVID-19 prevention and management financing sources

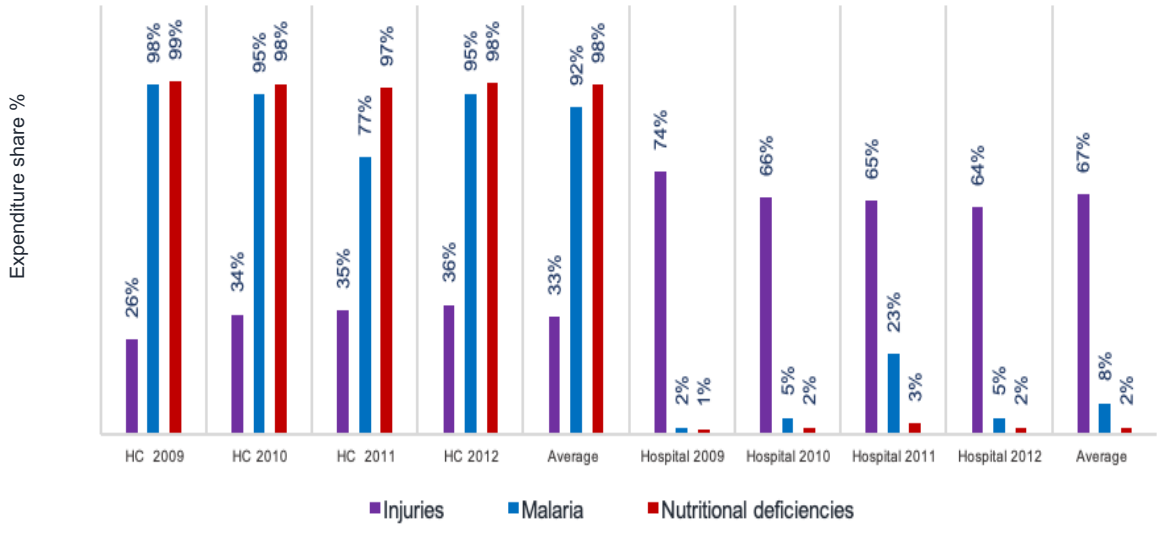


Source: NHA EFY 2012

Government health programme spending share by provider

When we look at the national spending by health provider, out of the total health programme expenditure from EFY 2009 to EFY 2012, on average, 92% of the spending on malaria and 98% of the spending on nutrition programme was at the health centre and health post level. On the other hand, for injuries, on average, 67% of the spending was at hospital level during the period (see Figure 20).

Figure 20: Government programme spending % share by health provider trend EFY 2009– EFY 2012



4.1.2 Government regional health programme per capita spending trend

Regional-level spending for the period from EFY 2009 to EFY 2012 for each programme was estimated based on the distribution key methodology. The spending trend is explained in relation to malaria incidence per region by year, while for the nutrition and injuries

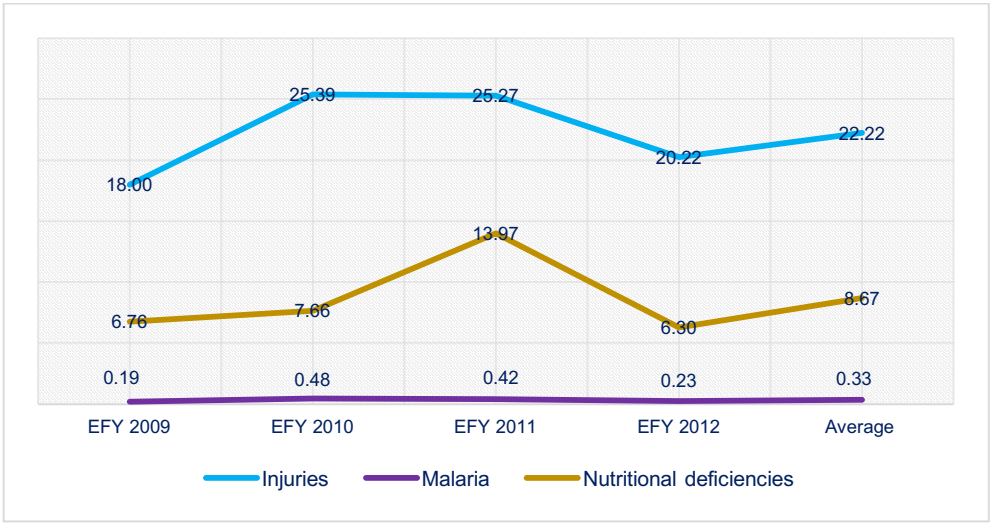
programmes the spending trend is only explained in relation to the course of the study period.

Addis Ababa

Government per capita spending by health programme

The disaggregated per capita spending data at regional level indicate that in Addis Ababa, among the three programmes, over the study period injuries received the highest average per capita spending among the three programmes, followed by the nutrition programme. The lowest average per capita spending was on malaria programme (see figure 12). This could be due to the fact that Addis Ababa was among the regions with the lowest malaria incidence (Figure 4). Nevertheless, malaria was declared a public health emergency in EFY 2008/09 and 2009/10 (Figure 23).

Figure 21: Addis Ababa government health programme per capita spending trend EFY2009–EFY 2012 (in ETB)



Average annual malaria incidence over the period EFY 2009–12 was 3,181. There was a sharp decline from 5,464 cases in EFY 2009 to 1,119 in 2012 (Figure 22). As indicated in Figure 23, in EFY 2008/09 and 2009/10 malaria was declared a public health emergency, with an annual incidence of 3,778 and 732 at national level and in Addis Ababa, respectively. Accordingly, as can be seen from figure 21 above, the highest spending per year was recorded in EFY 2010, at ETB per capita of 25.

Figure 22: Addis Ababa total malaria incidence trend EFY 2009–12

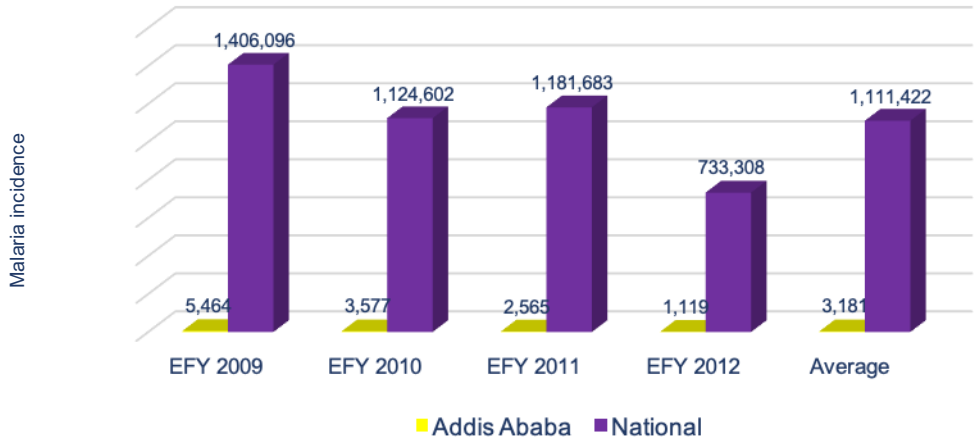
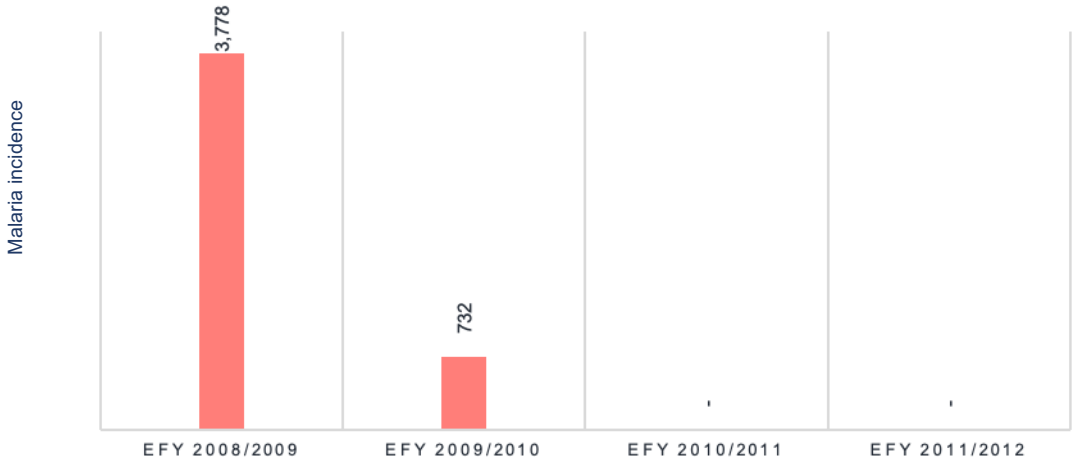


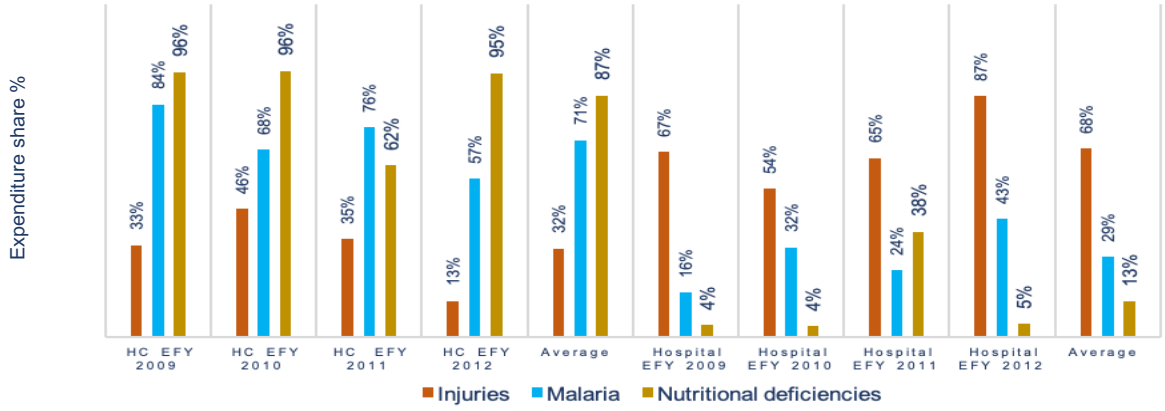
Figure 23: Addis Ababa malaria incidence declared a public health emergency by year



Government spending share by health provider

The data on spending by health provider in Addis Ababa indicate that for the nutrition and malaria programmes, the majority of spending was at the health centre level, accounting for an average of 87% and 71% of spending for nutrition and malaria, respectively. For injuries, on average 68% was spent at hospital level (Figure 24).

Figure 24: Addis Ababa programme spending % share by health provider trend EFY 2009–12



Afar region

Government per capita spending by health programme

Afar has very hot and dry weather and the region is not malaria-prone. Nevertheless, the average per capita spend on malaria was the highest among the three programmes, at an average spend of ETB 47 per capita. This was followed by nutrition and injuries (Figure 25). As shown in Figure 26, EFY 2012 had the lowest recorded incidence of malaria, which was in line with the per capita expenditure. By contrast, while EFY 2010 saw the highest recorded malaria incidence, the per capita spend in the same year was among the lowest over the period. The nutrition programme had ETB 22 million and injuries had ETB 8 million average per capita spending. The per capita spending of the three programmes seem to have seen a very similar trend, starting higher in EYF 2009, particularly for malaria and nutrition, with a sharp decline, and then rising again for the rest of the years (Figure 25).

Figure 25: Afar region government health programme per capita spending trend EFY2009–12 (in ETB)

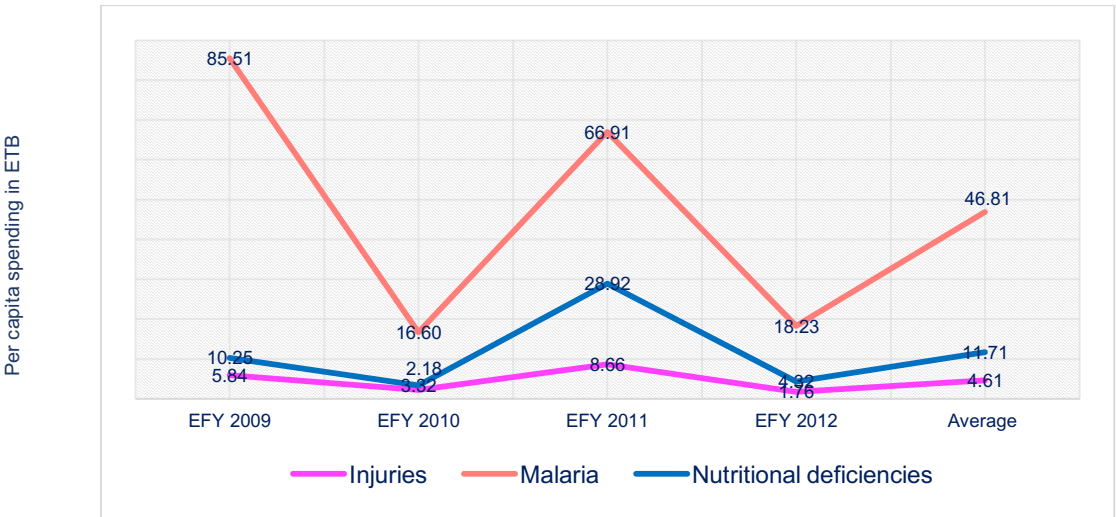
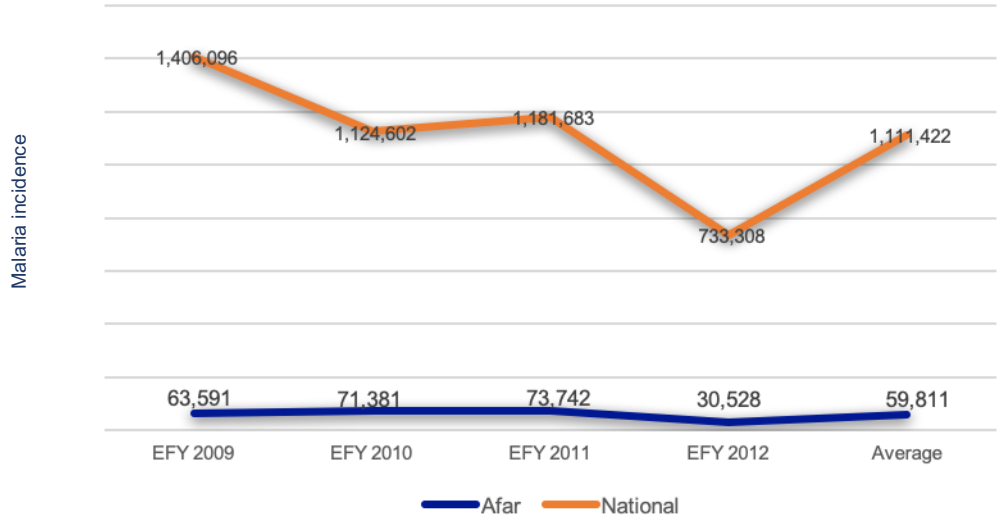
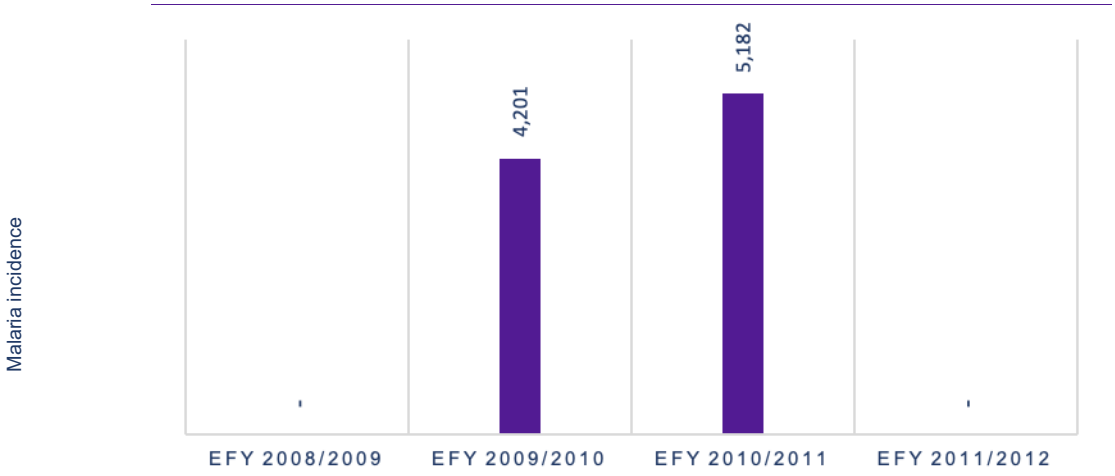


Figure 26: Afar region total malaria incidence trend EFY 2009–12



In EFY 2009/10 and 2010/11 malaria was declared a public health emergency in Afar (Figure 27). During the study period, the incidence recorded from EFY 2009 to EFY 2011 was in the top three highest incidences for the period (Figure 26 above). At the same time, the per capita spend on malaria, as indicated in Figure 25 above, was higher in EFY 2009 and EFY 2011, and was lowest in EFY 2010.

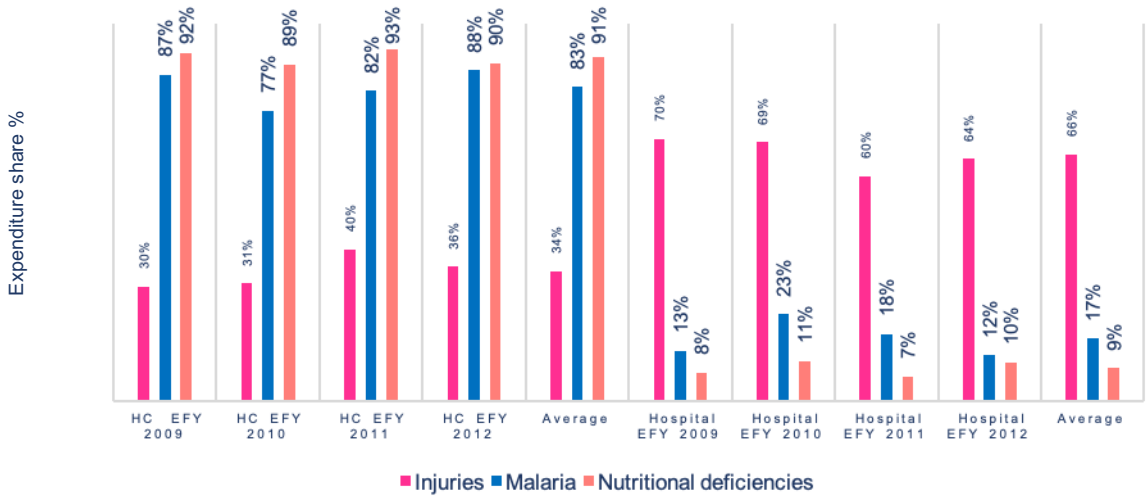
Figure 27: Afar malaria incidence declared a public health emergency by year



Government spending share by health provider

The data on the spending share by health provider in Afar region indicate that on average 91% and 83% was spent at health centre and health post level for nutrition and malaria, respectively. For injuries, 66% of the spending was made at hospital level (Figure 28).

Figure 28: Afar region health programme spending % share by health provider trend EFY 2009–12



Amhara region

Government per capita spending by health programme

In Amhara region, the average per capita spending on nutrition programme was the highest among the three programmes, at 14 ETB, followed by malaria nearly ETB 9 (Figure 29). At the same time, Amhara region had the highest malaria incidence among the regions from EFY 2009 to EFY 2012. Figure 30 below shows that on average malaria incidence of 297 million was reported per year during the period.

Figure 29: Amhara region government health programme per capita spending trend EFY 2009–12 (in ETB)

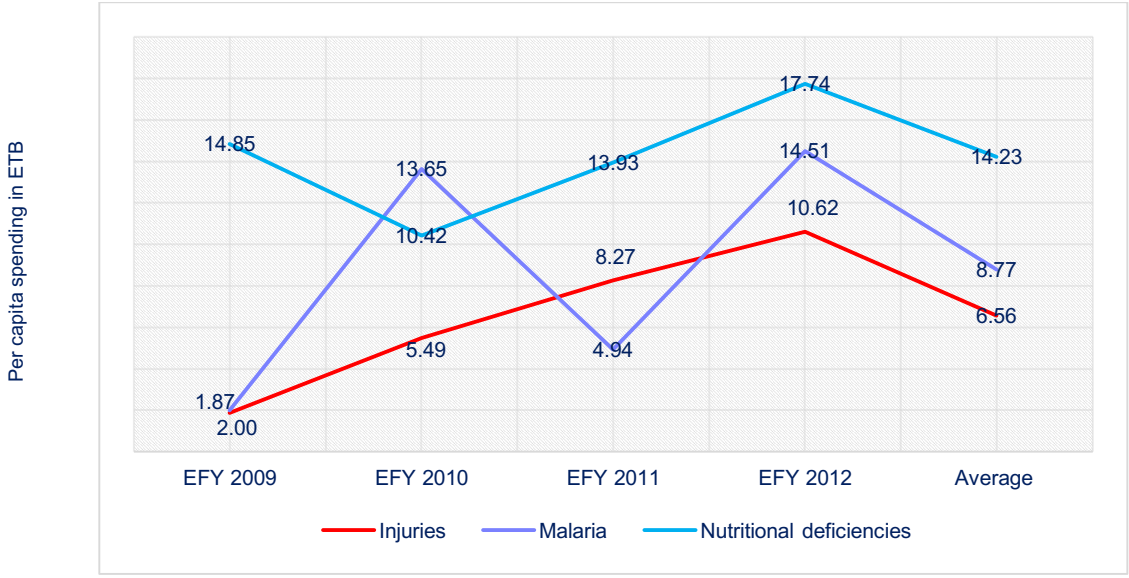
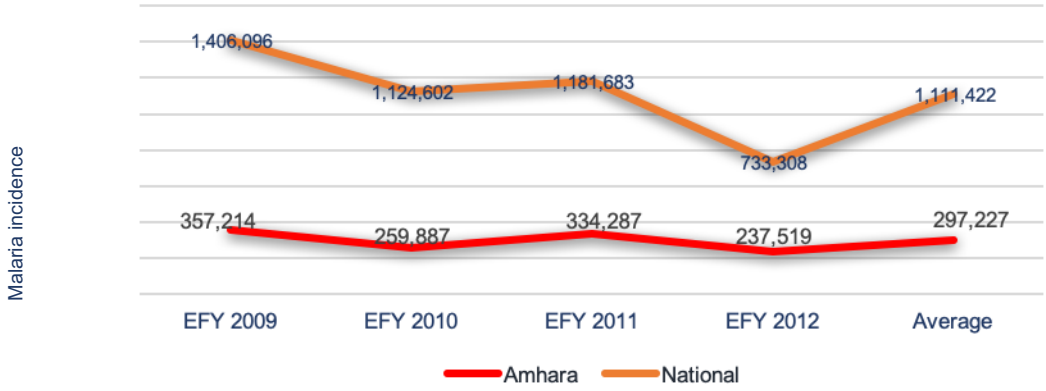
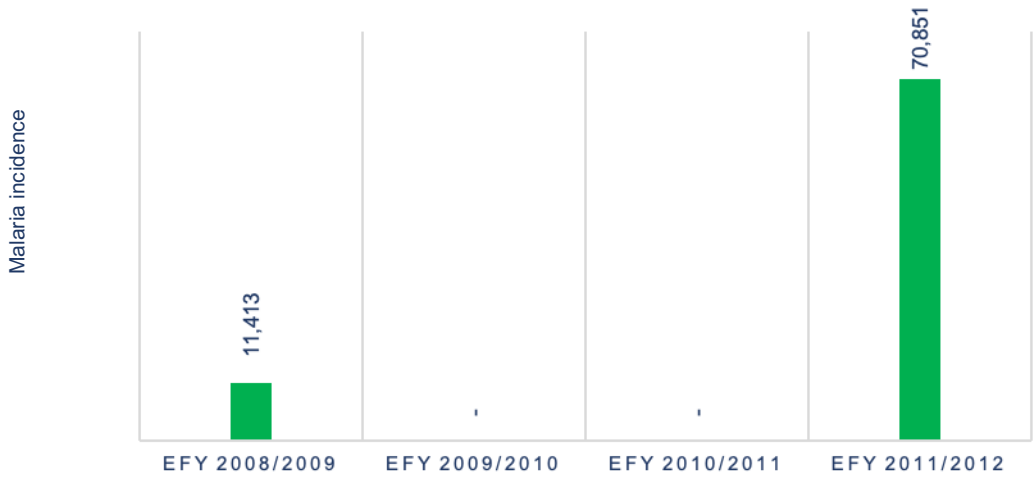


Figure 30: Amhara region malaria incidence trend EFY 2009–12



The region had the highest average malaria incidence from EFY 2009 to EFY 2012. As indicated in Figure 31, malaria was declared a public health emergency in 2008/09 and 2011/12 as well. However, the annual spending during this period was among the lowest in the period from EFY 2009 to EFY 2012 (see Figure 29 above).

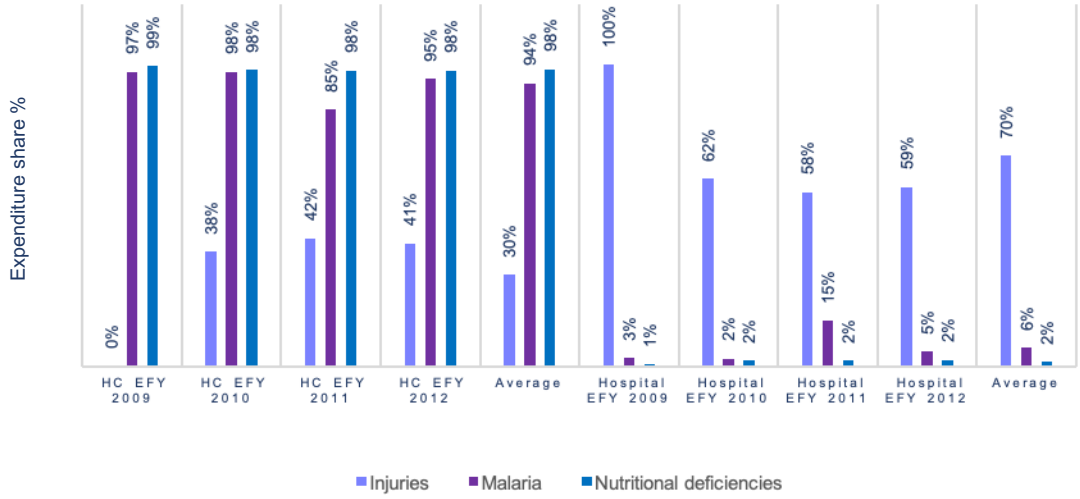
Figure 31: Amhara region malaria incidence declared a public health emergency by year



Government spending share by health provider

In Amhara region, the majority of spending on nutrition and malaria were at health centre and health post level during the period, while for injuries 60% of the spending was at hospital level (Figure 32).

Figure 32: Amhara region health programme spending % share by health provider trend EFY 2009–12

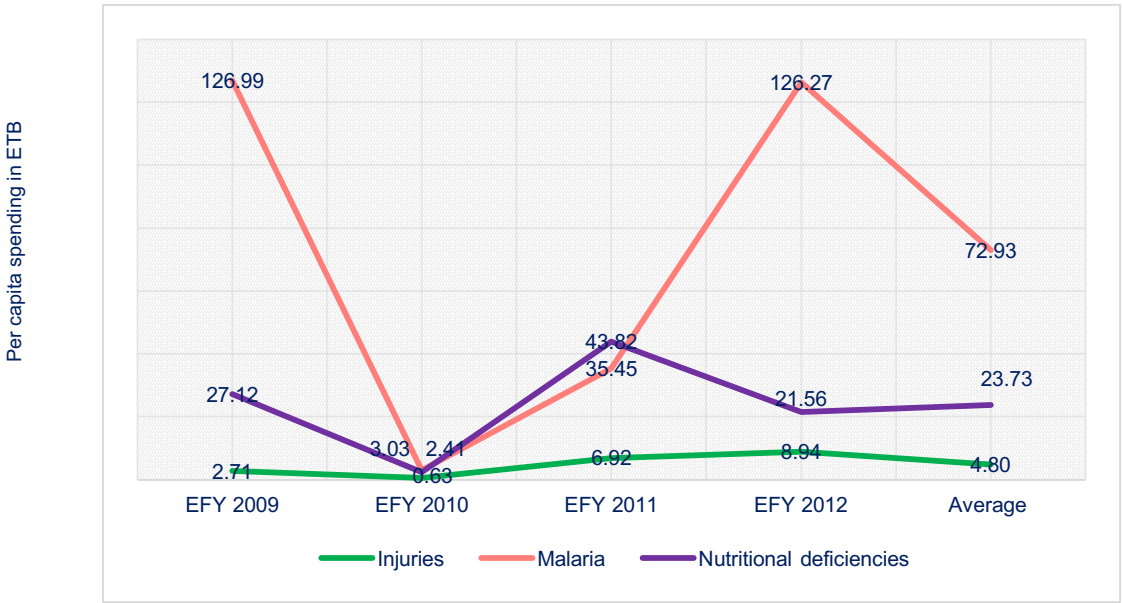


Benishangul-Gumuz region

Government per capita spending by health programme

In Benishangul-Gumuz region from EFY 2009 to EFY 2012, the average annual per capita spending ETB 73 for malaria, followed by ETB 24 for nutrition and ETB 5 for injuries. Within this period the lowest spending recorded for all programmes was in EFY 2010, as indicated in Figure 33.

Figure 33: Benishangul-Gumuz region government health programme per capita spending trend EFY 2009–12 (in ETB)



Benishangul-Gumuz average malaria incidence from EFY 2009 to EFY 2012 ranked fourth among the regions with the highest incidences. During this period, the highest incidence was recorded in EFY 2009, as can be seen in Figure 34. As indicated in Figure 33 above, the

spending in that year was the second highest in the period. In addition, as indicated in Figure 35 below, malaria was declared a public health emergency in EFY 2008/09.

Figure 34: Benishangul-Gumuz region malaria incidence trend EFY 2009–12

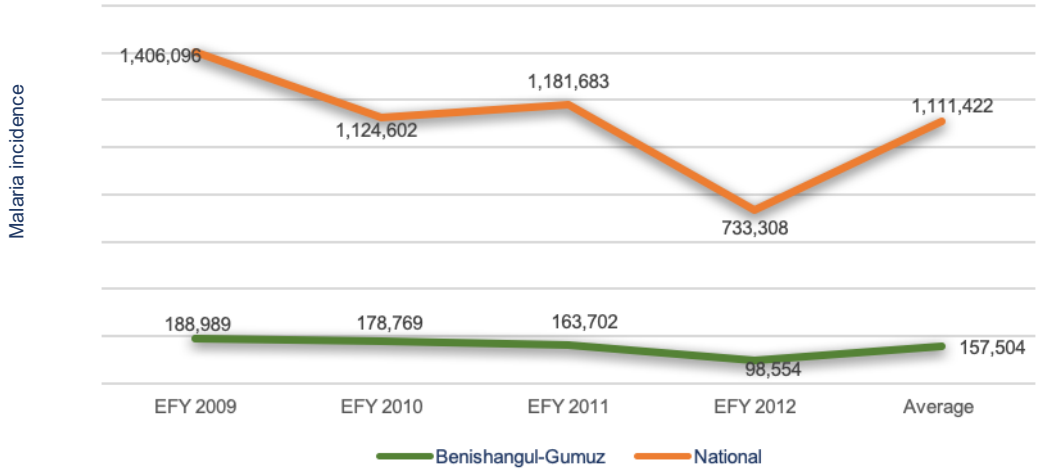
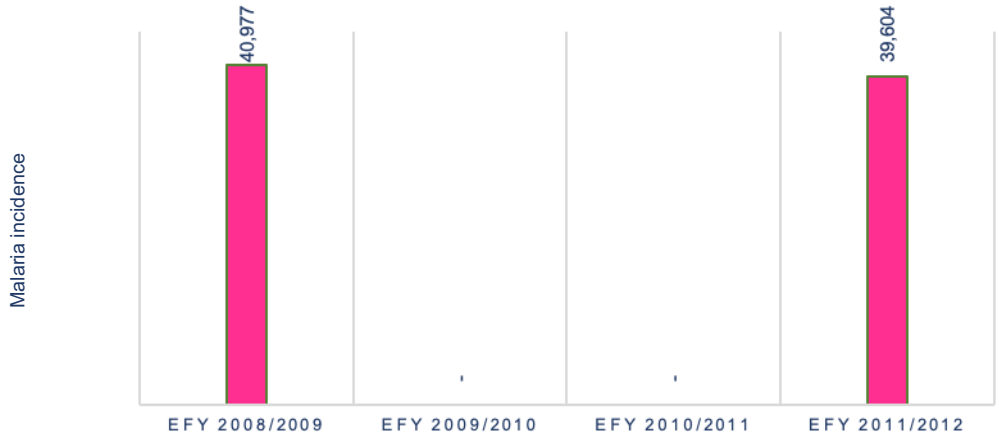


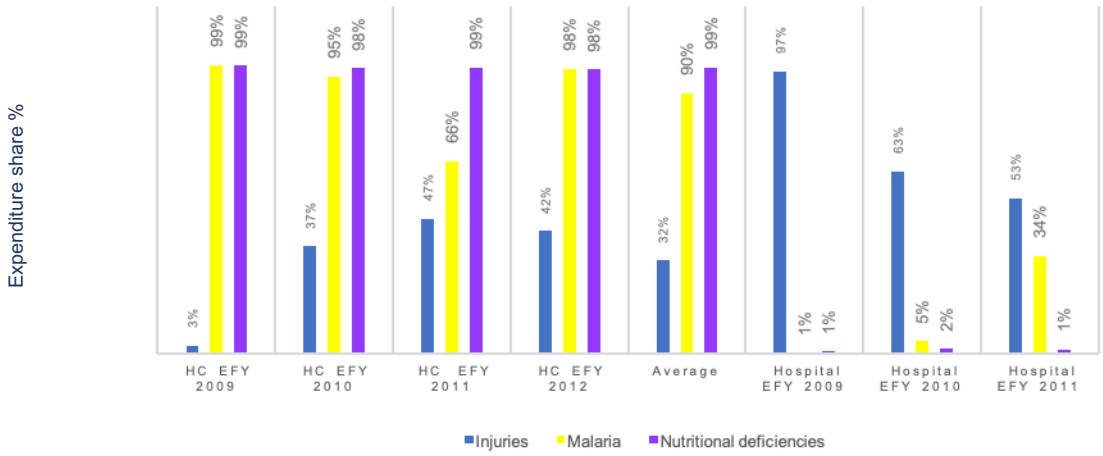
Figure 35: Benishangul-Gumuz region malaria incidence declared a public health emergency by year



Government spending share by health provider

The data on spending by health provider in Benishangul-Gumuz indicate that more than 90% of the spending for nutrition and malaria was at health centre and health post level, while 97% of the spending on injuries was at hospital level (Figure 36).

Figure 36: Benishangul-Gumuz region health programme spending % share by provider trend EFY 2009–12

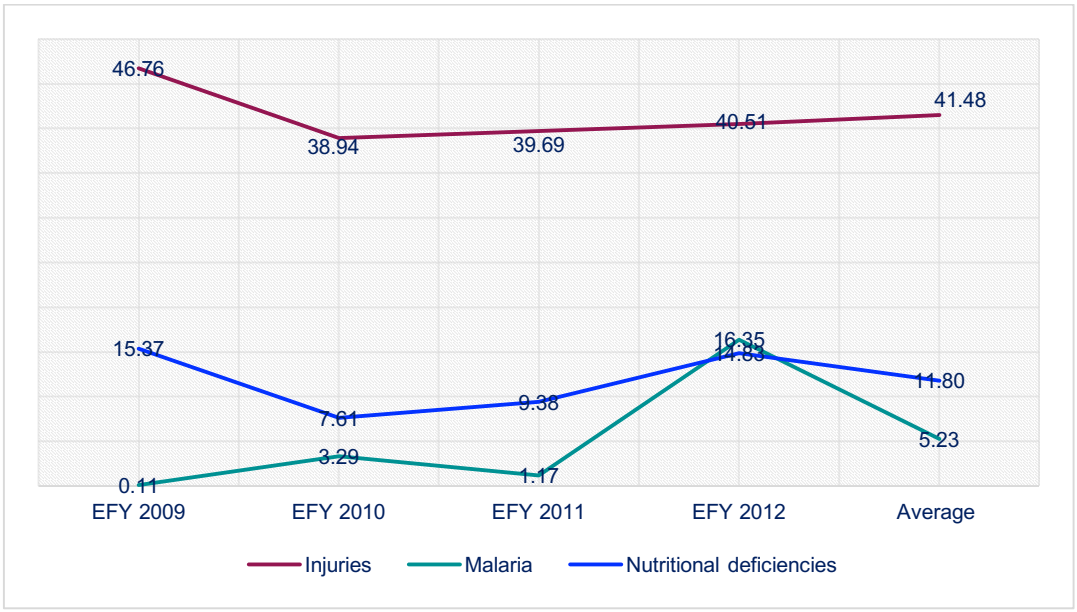


Dire Dawa region

Government per capita spending by health programme

In Dire Dawa city administration, from EFY 2009 to EFY 2012 the average per capita spending for injuries was ETB 41, which was the highest among the three programmes. This was followed by an average ETB 12 on nutritional deficiencies and ETB 5.2 on the malaria programme, as can be seen in Figure 37.

Figure 37: Dire Dawa region government health programme per capita spending trend EFY 2009–12 (in ETB)



Malaria incidence in Dire Dawa in the period, at 675 annual average prevalence, was the lowest in Ethiopia (see Figure 38). In line with the prevalence, the average spending on

malaria programming was not within the top 20 spending by major diseases and health conditions in the region, while spending on injuries and nutrition were among top 20: ranking third and 17th, respectively (see Figure 40 below). Regardless of the low regional prevalence, malaria was declared a public health emergency in EFY 2012/12, and it was during this year that spending on malaria was at its the highest for the period EFY 2009 to EFY 2012, as indicated in Figure 37 above.

Figure 38: Dire Dawa region malaria incidence trend EFY 2009–12

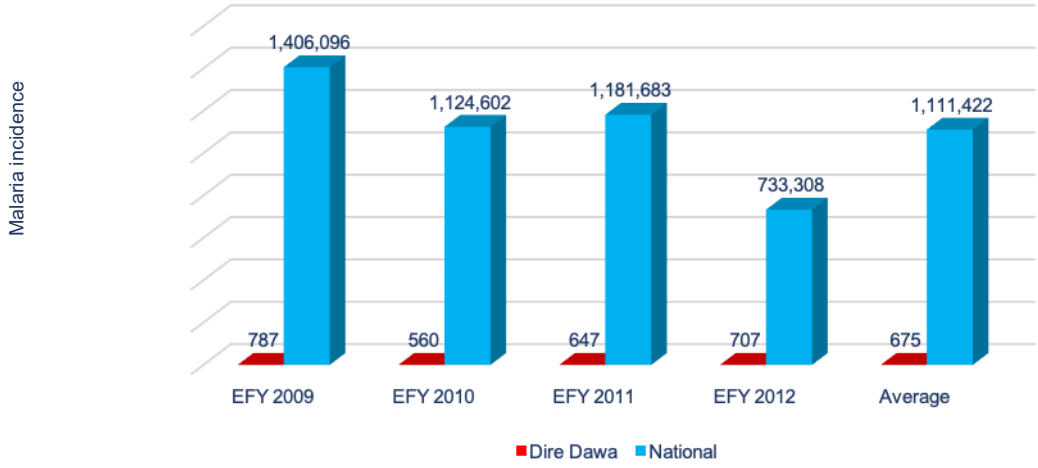


Figure 39: Dire Dawa region malaria incidence declared a public health emergency by year

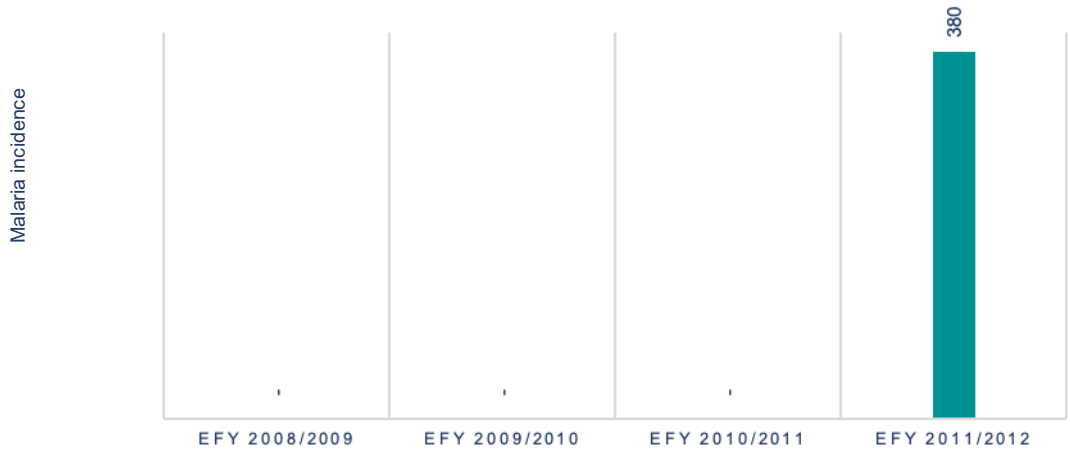
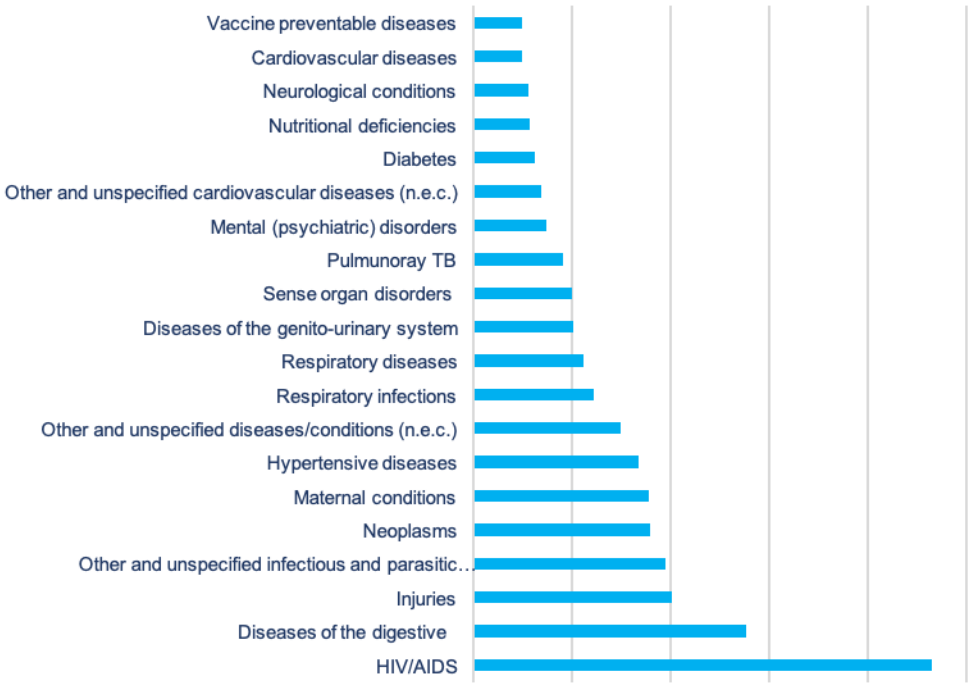


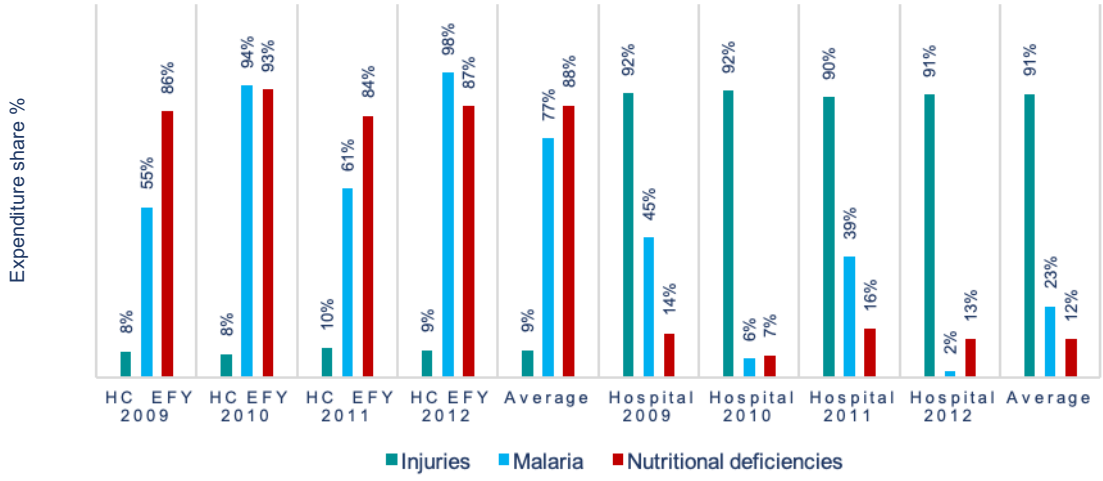
Figure 40: Dire Dawa region government average government spending by major disease and conditions EFY 2009–12



Government spending share by health provider

Data on the average spending share by health provider for Dire Dawa indicate that 88% and 71% of the spending was made at health centre and health post level for nutrition deficiencies and malaria, respectively, while for injuries 91% was spent at hospital level from EFY 2009 to EFY 2012 (see Figure 41).

Figure 41: Dire Dawa region health programme spending % share by health provider trend EFY 2009–12

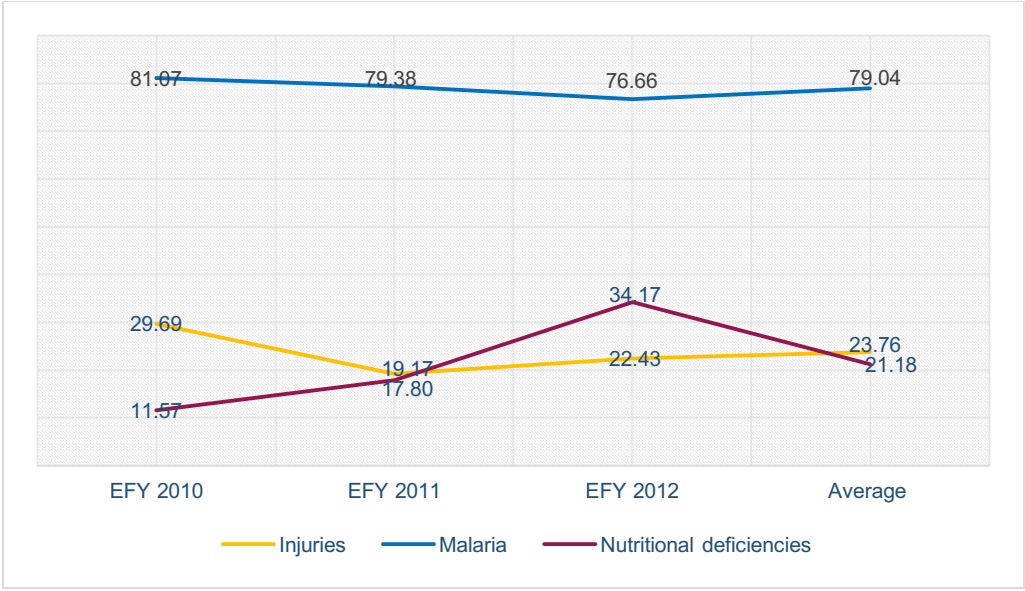


Gambella region

Government per capita spending by health programme

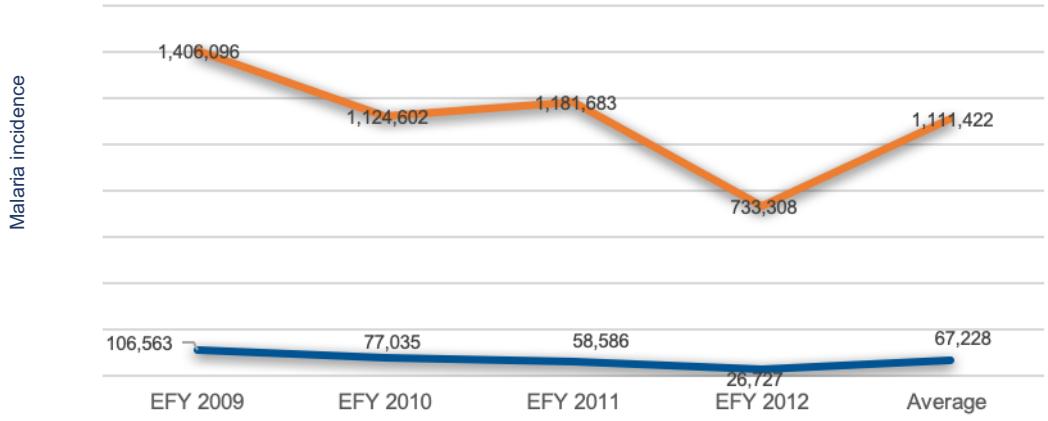
Data on health spending in Gambella region show that average per capita spending on malaria was the highest of the three programmes, at ETB 37, followed by injuries at ETB 11 and nutrition deficiencies at ETB 10 per capita, for the period EFY 2010–12 (Figure 42).

Figure 42: Gambella region government health programme per capita spending trend EFY 2010–12 (in ETB)



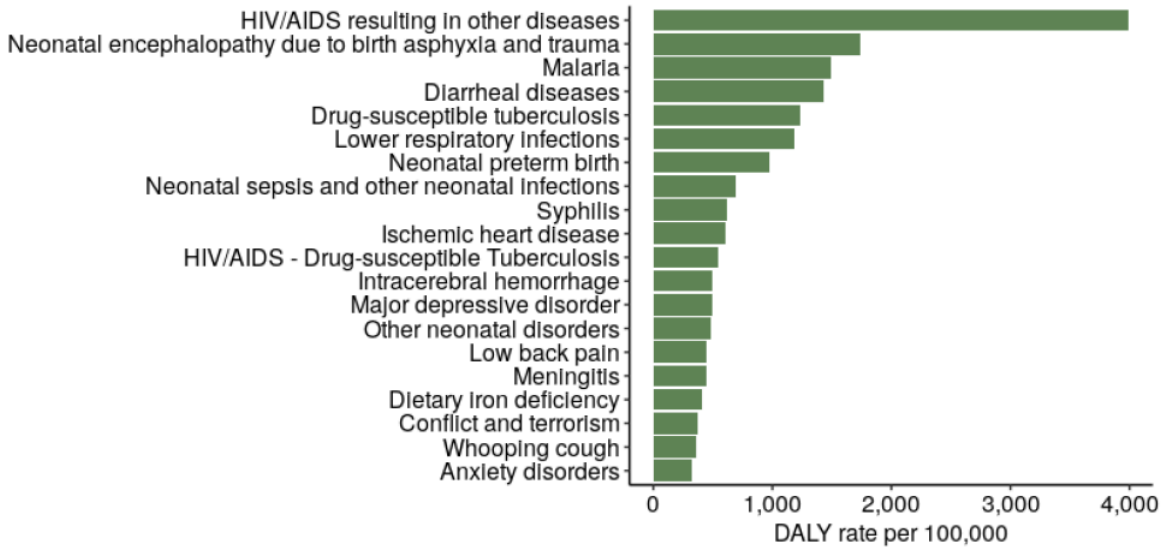
In Gambella, on average, malaria incidence per year from EFY 2009 to EFY 2012 was 67,000. The trend over this period showed a marked decrease from the annual 100,000 incidences recorded in EFY 2009 to 26,000 in EFY 2012 (Figure 43).

Figure 43: Gambella region malaria incidence trend EFY 2009–12



As indicated in the Regional Health Atlas, in 2019 (EFY 2011/12), in Gambella among the 20 most important drivers of an increasing burden of DALYs for both genders, malaria was among the top three for all ages (see Figure 44).

Figure 44: The 20 leading causes of DALYs in Gambella, all ages, 2019 (2011/12)

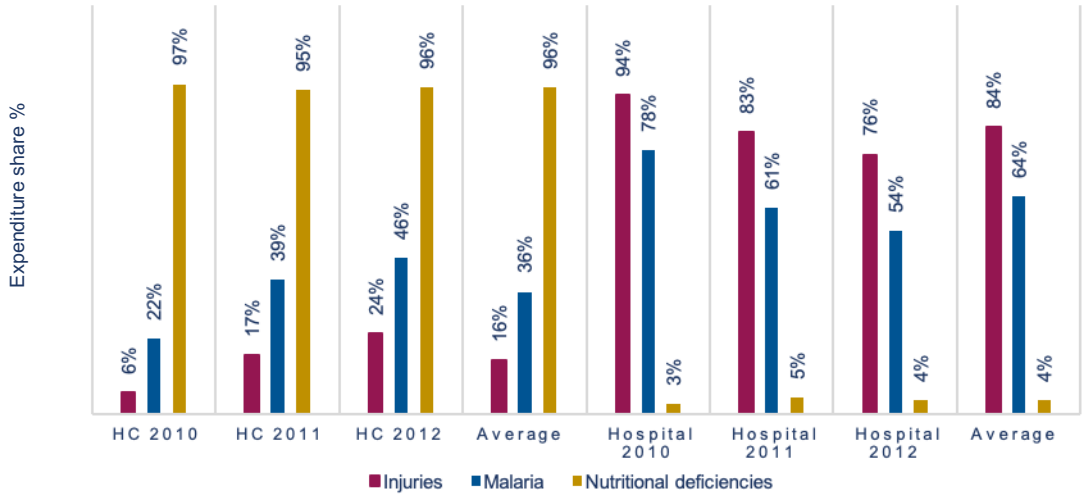


Source: Regional Health Atlas, 2021 (EFY 2013/14)

Government spending share by health provider

Data on the average spend from EFY 2010 to 2012 by provider in Gambella region indicate that the majority (96%) of the spending on the nutrition programme was at health centre and health post level, while on average 84% and 64% was spent at hospital level for the injuries and malaria programmes, respectively (see Figure 45).

Figure 45: Gambella region health programme spending % share by health provider trend EFY 2010–12



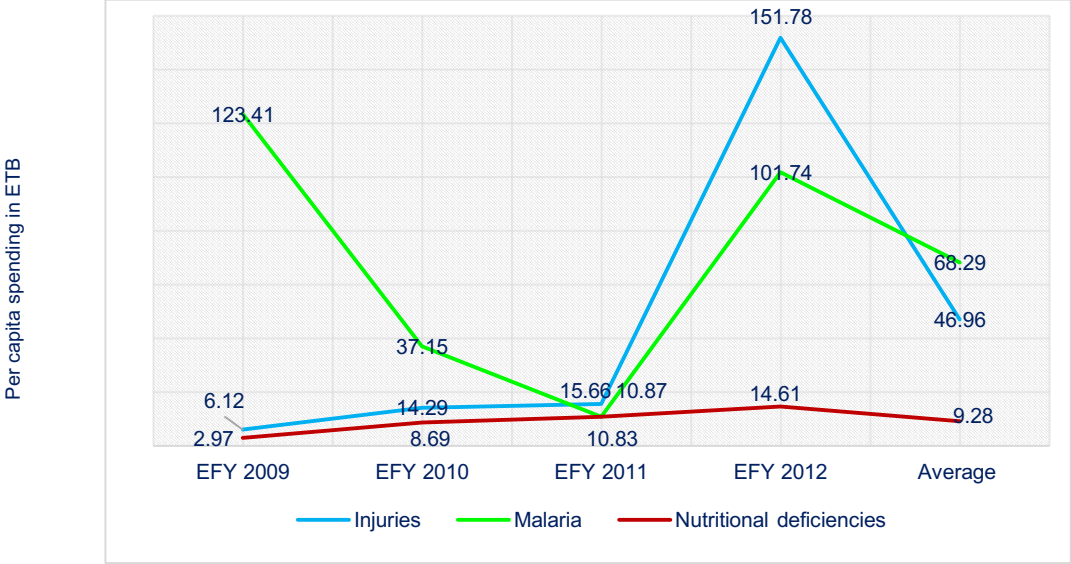
Harari region

Government per capita spending by health programme

Data on the health spending trend in Harari region for the four study-period years indicate that per capita spending on injuries experienced a marked rise form ETB 6 in EFY 2009 to ETB 152 in EFY 2012, with annual average per capita sending of ETB 47. During the same

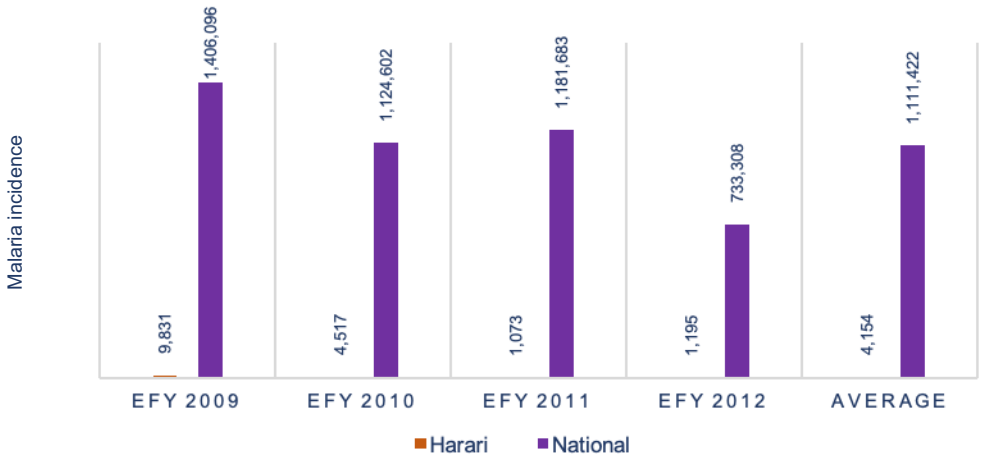
period, malaria dropped from per capita ETB 123 to ETB 26 million annual spending, resulting in ETB 17 million average spending per year. The nutrition programme, which had the lowest spending among the three programmes, showed a slight, steady increase from per capita spending of ETB 3 EFY 2009 to ETB 11 in EFY 2012, with an average per capita spend of ETB 9 (see Figure 46).

Figure 46: Harari region government health program per capita spending trend EFY 2009–12 (in ETB)



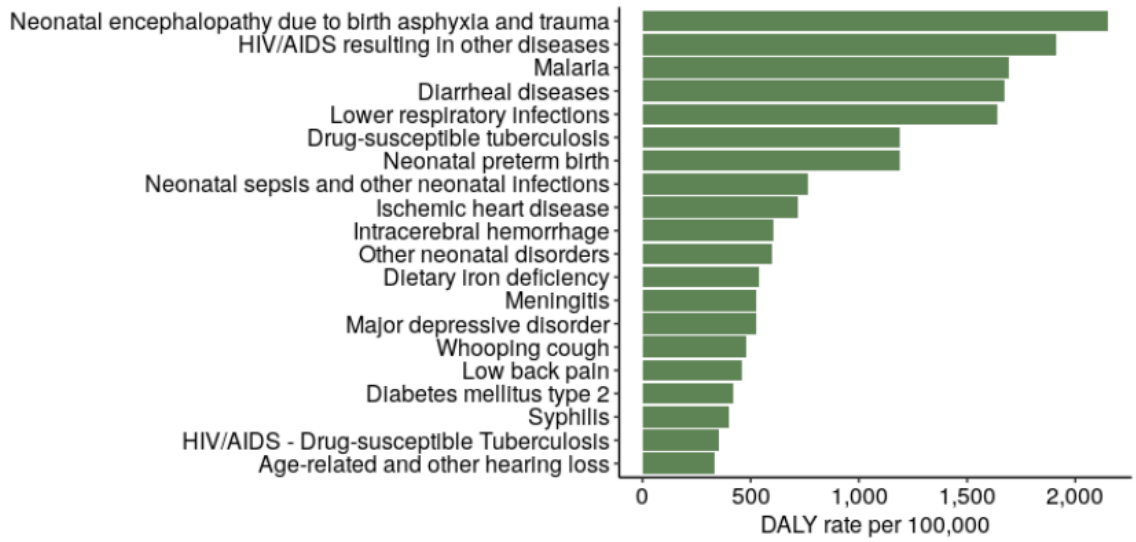
As can be seen in Figure 47, malaria incidence experienced a declining trend in the period, from 9,000 annual prevalence in EFY 2009 to 1,000 in EFY 2012, with an average annual incidence of 4,000. Within the four-year study period, the incidence was among the two lowest recorded in EFY 2012. However, the spending in that year was the second highest during the period. On the other hand, in EFY 2009 the highest incidence was recorded, and a public health emergency was declared, while the spending, at ETB 30 million, was the highest for the period.

Figure 47: Harari region malaria incidence trend EFY 2010–12



In Harari, as indicated in the Regional Health Atlas 2021, regardless of the low incidence, malaria was among the three top most important drivers for increasing the burden of DALYs for both genders in 2019, and was among the 20 leading causes of DALYs for all ages in 2019 (Figure 48).

Figure 48: The 20 leading causes of DALYs in Harari, all ages, 2019 (EFY 2011/12)

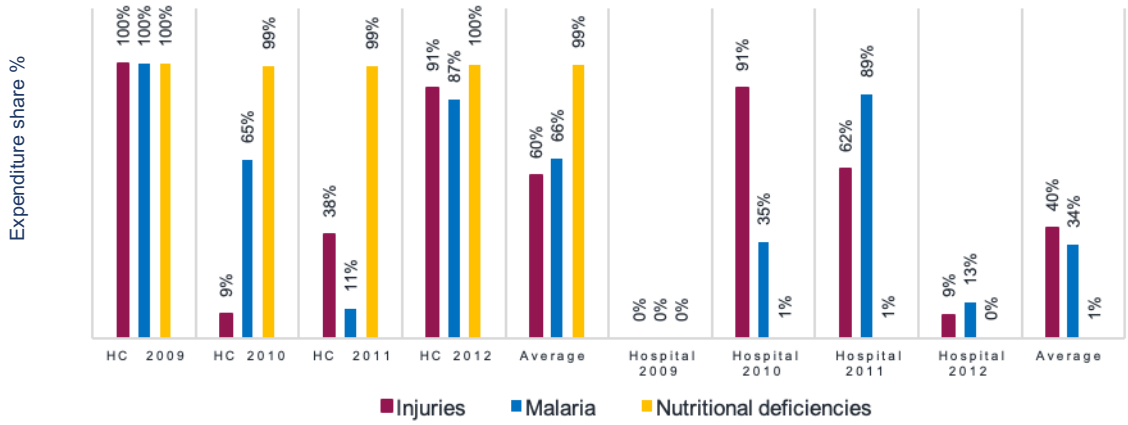


Source: Regional Health Atlas, 2021 (EFY 2013/14)

Government spending share by health provider

In Harari, on average, nearly 100% of the spending on the nutrition programme was at the health centre and health post level, while 66% of malaria spending and 60% of injuries spending was at health centre and health post level. The remainder, 40% and 34% for injuries and malaria, respectively, was spent at hospital level (Figure 49).

Figure 49: Harari region health programme spending % share by health provider trend EFY 2009–12

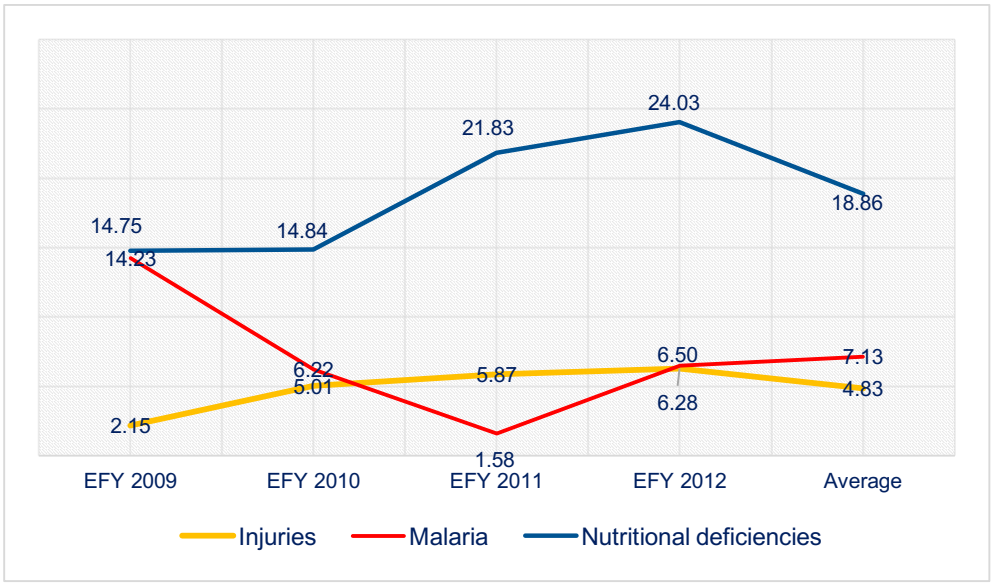


Oromia region

Government per capita spending by health programme

In Oromia region, the data on per capita spending on nutrition and malaria indicate the programmes had almost similar spending in EFY 2009, at ETB 15 and ETB 14, respectively. However, afterwards the trend for spending until EFY 2012 shows they took a differing spending path. While the per capita spending for nutrition continuously increased, reaching ETB 23 in EFY 2012, the highest per capita spending recorded during the period, the per capita spending for malaria showed a marked decline, reaching the lowest amount in EFY 2011, at ETB 2 per capita spending, and then increased to ETB 6 in EFY 2012. On the other hand, with an average per capita spending of ETB 5, per capita spending on injuries showed a steady increase over the four-year period (see Figure 50).

Figure 50: Oromia region government health programme per capita spending trend EFY 2009–12 (in ETB)



Malaria incidence in Oromia region, as indicated in Figure 51 below, was an average 111,000 per year. The incidence showed a decreasing trend from 144,000 in EFY 2009 to 83,000 in EFY 2012. The highest spending was in EFY 2009 and EFY 2012. During the period, malaria was declared a public health emergency, with incidence of 135,000 in 2008/9 and 2011/12, as can be seen in Figure 52. Generally, spending on malaria in Oromia was among the highest out of the regions.

Figure 51: Oromia region malaria incidence trend EFY 2009–12

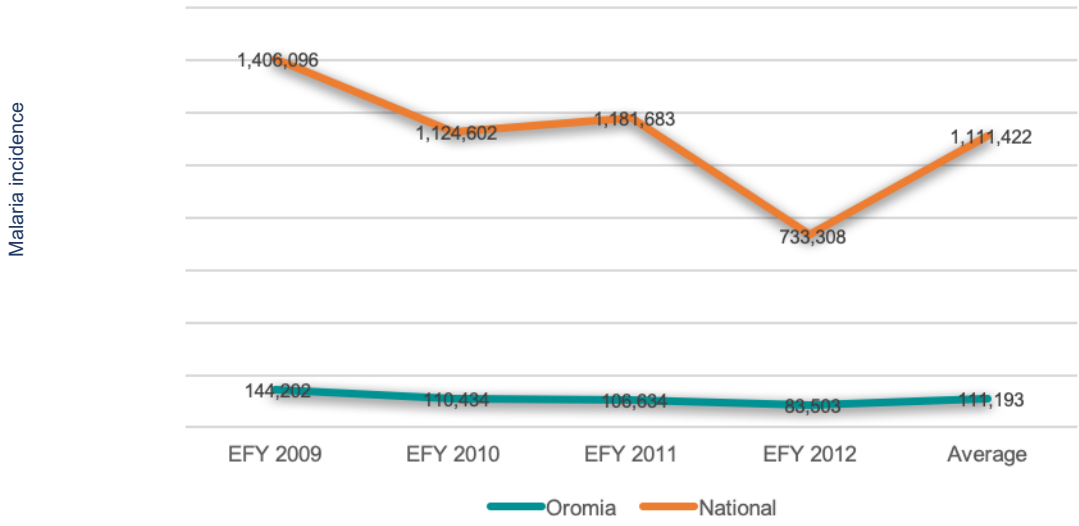
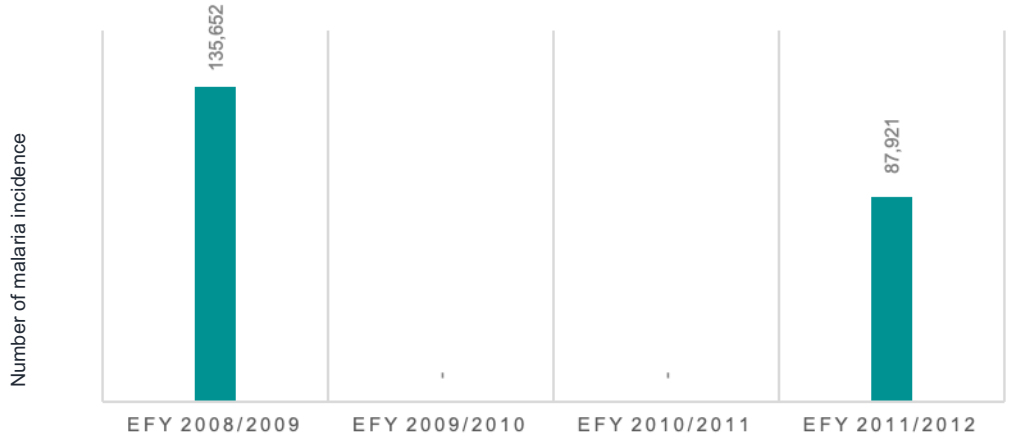


Figure 52: Oromia region malaria incidence declared a public health emergency

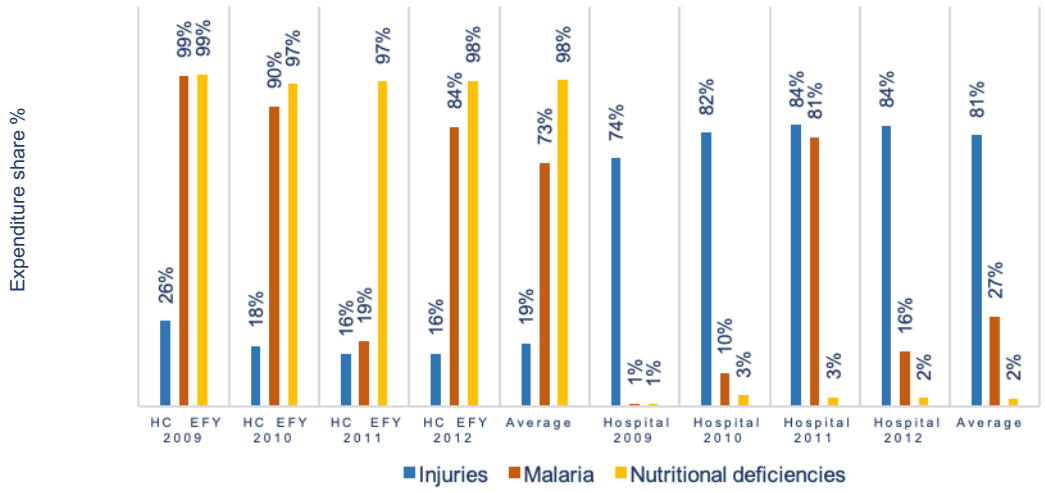


Source: EPHI

Government spending share by health provider

The data on the average spend by health provider in Oromia region indicate that of the total nutrition deficiency spending, 98% was made at health centre and health post level, while for malaria the figure was 73%. By contrast, the majority of spending on injuries was made at hospital level, which accounted for an average 81% of the spend (see Figure 53).

Figure 53: Oromia region health programme spending % share by health provider trend EFY 2009–12

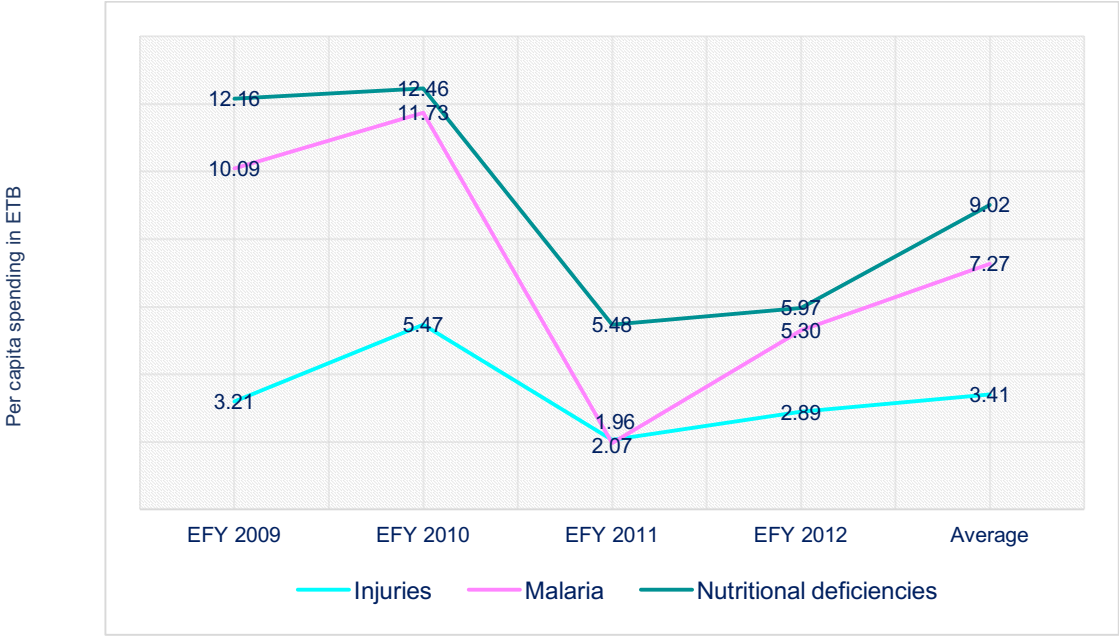


SNNPR

Government per capita spending by health programme

In SNNPR, the average per capita spending was ETB 9 for nutrition, ETB 7, for malaria, and ETB 3 for injuries, for the period from EFY 2009 to EFY 2012. Within this period, the highest per capita spending for all three programmes was recorded in EFY 2010 (Figure 54).

Figure 54: SNNP region government health program per capita spending trend EFY2009–12 (in ETB)



Malaria incidence in SNNPR was the second highest average, after Amhara region, with 204,000 annual incidence from EFY 2009 to EFY 2012 (Figure 55). In EFY 2008/09 and EFY 2011/12 malaria was declared a public health emergency, with incidence of 151,000 and 212,000, respectively (Figure 56). On the other hand, the spending on malaria was the highest in EFY 2010, although no public health emergency was declared during that year. Incidence was 216,000 in that year, which was higher than the regional average.

Figure 55: SNNPR malaria incidence trend EFY 2009–12

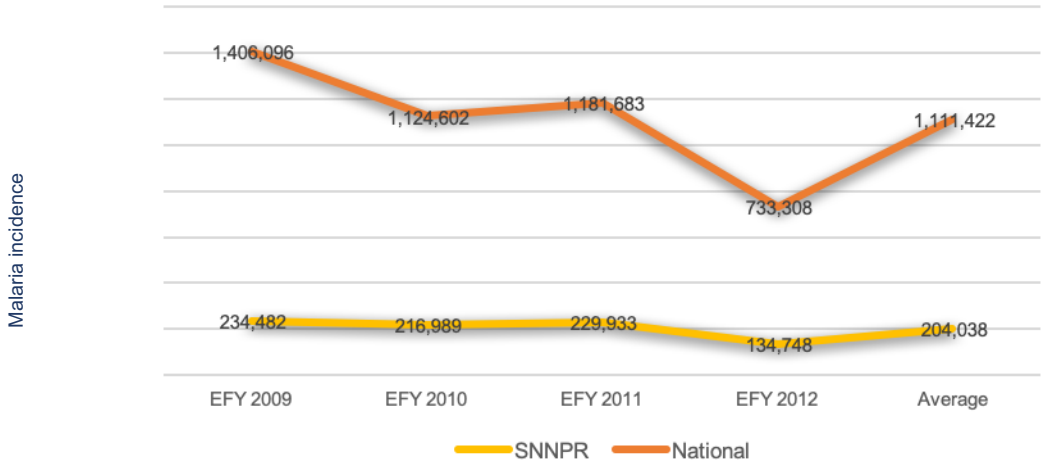
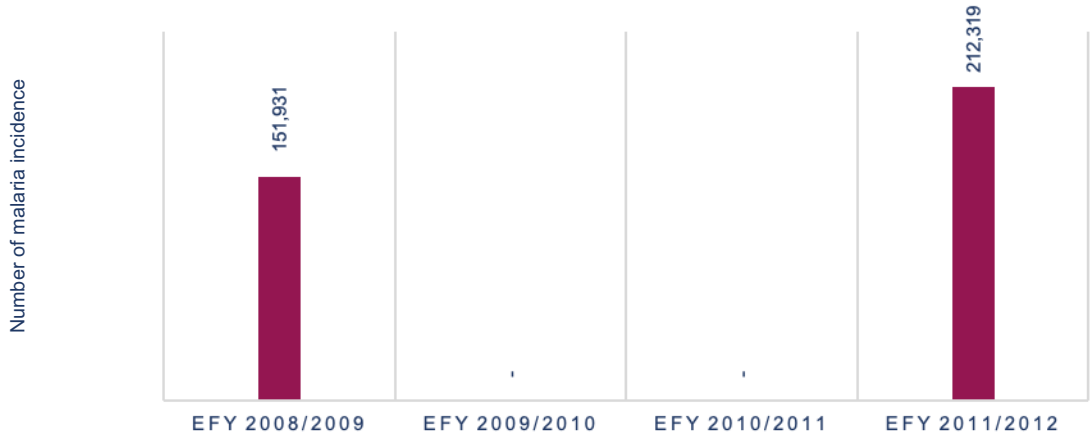


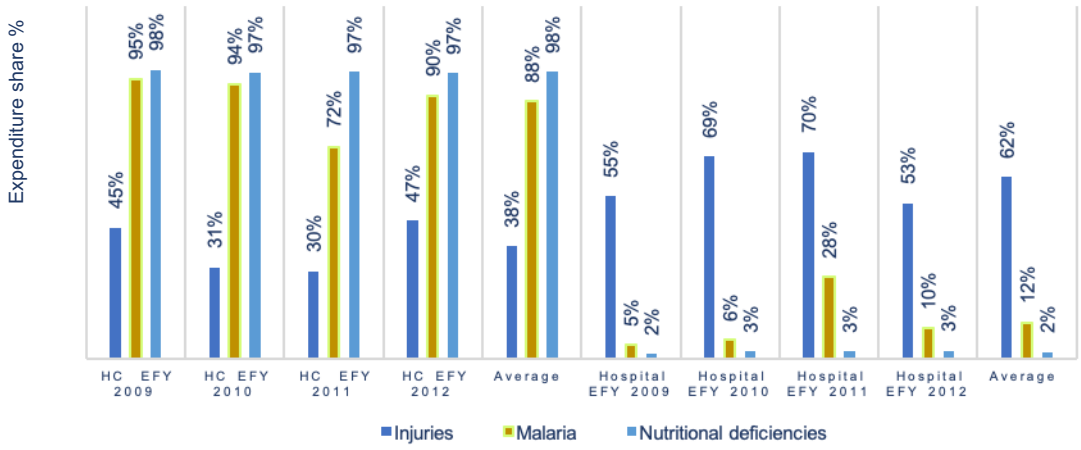
Figure 56: SNNPR malaria incidence declared a public health emergency



Government spending share by health provider

In SNNPR, as indicated in Figure 57, from EFY 2009 to EFY 2012 on average 98% and 88% of the spending for nutrition deficiencies and malaria, respectively, was made at health centre and health post level. For injuries, the majority of spending (62%) was made at hospital level.

Figure 57: SNNPR health programme spending % share by health provider trend EFY 2009–12

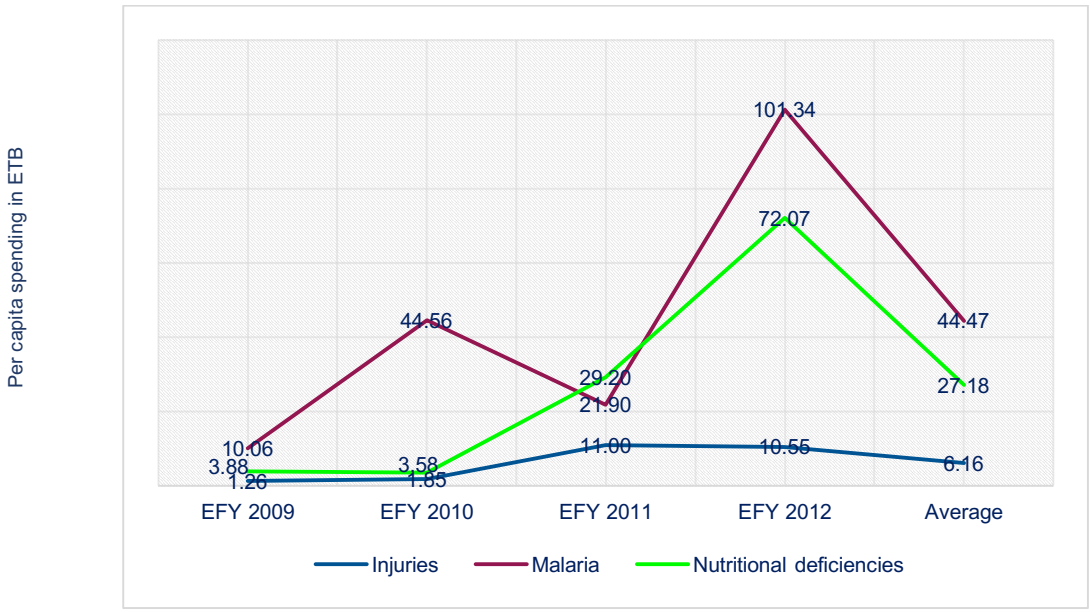


Somali region

Government per capita spending by health programme

In Somali region government health per capita spending for the malaria programme, at an average of ETB 44, was the highest among the programmes, followed by nutrition deficiencies with an average per capita of ETB 27 million and then injuries, with ETB 6. The per capita spending on all programmes saw an increasing trend, reaching the highest per capita spending in EFY 2012 (Figure 58).

Figure 58: Somali region government health programme per capita spending trend EFY 2009–12 (in ETB)



Malaria incidence in Somali region, as indicated in Figure 59, was the highest in EFY 2011, at 50,000. On average, Somali was not among the regions with the highest malaria incidence during the period. However, the average spending on malaria from EFY 2009 to EFY 2012 was among the highest across the regions. Malaria was declared a public health emergency in EFY2011/12 only (see Figure 60) and, similarly, the highest spending was made in EFY 2012.

Figure 59: Somali region malaria incidence trend EFY 2009–12

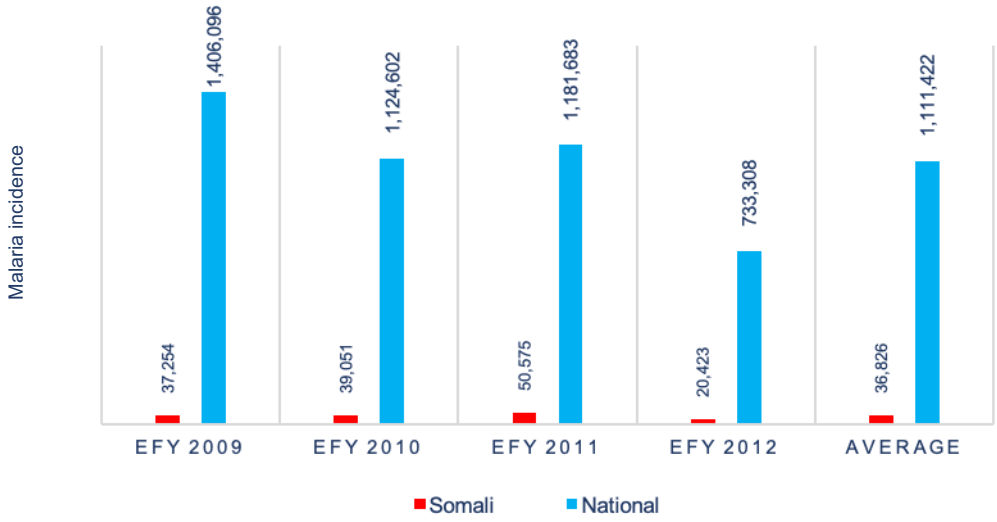
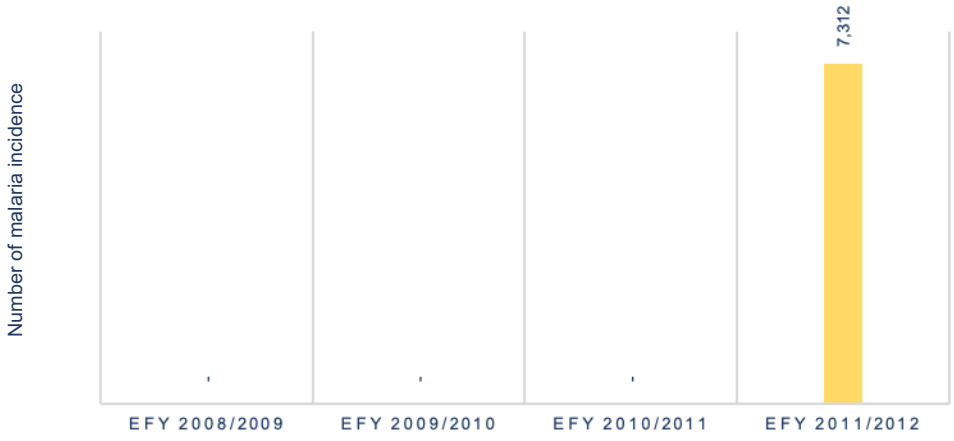


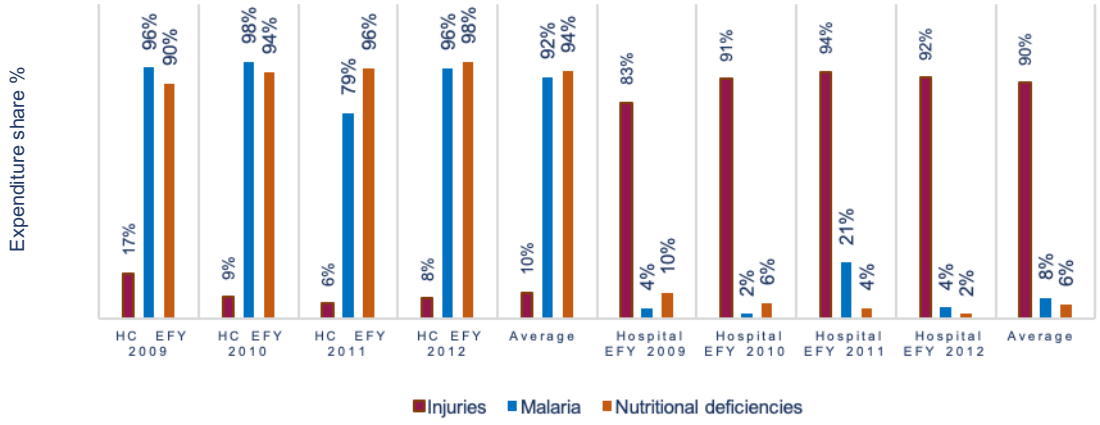
Figure 60: Somali region malaria incidence declared a public health emergency



Government spending share by health provider

In line with the national average, more than 90% of malaria and nutrition programmes' spending was made at health centre and health post level during EFY 2009–12, while on average more than 90% of the spending on injuries was made at hospital level during the same period (Figure 61).

Figure 61: Somali region health programme spending % share by health provider trend EFY 2009–12

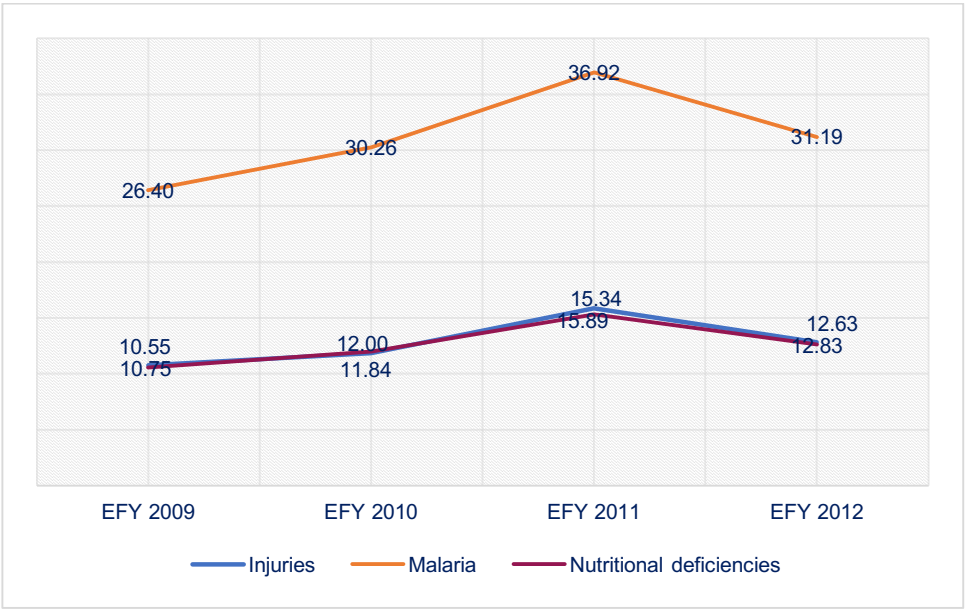


Tigray region

Government per capita spending by health programme

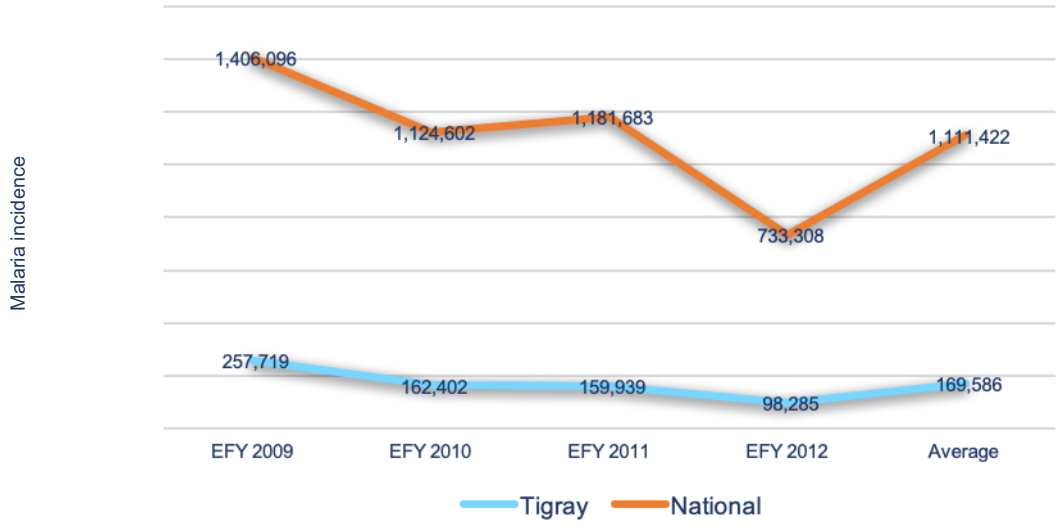
In Tigray region spending on malaria saw an increasing trend from EFY 2010 to EFY 2012. The highest per capita spending among the programmes, at an average ETB 31, was on the malaria programme. This was followed by an average ETB 12.6 and ETB 12.8 for injuries and nutrition deficiencies, respectively (Figure 62).

Figure 62: Tigray region government health programme per capita spending trend EFY 2010–12 (in ETB)



As indicated in Figure 63, malaria incidence showed a declining trend from 257,000 in EFY 2009 to 98,000 in EFY 2012. The average incidence during this period was 169,000. By contrast, the spending on malaria indicated a clear increasing trend, starting in EFY 2010, reaching the highest spending in EFY 2012 (even though in that same year malaria incidence was the lowest recorded). In Tigray, malaria incidence was never declared a public health emergency in the period from EFY 2009 to EFY 2012.

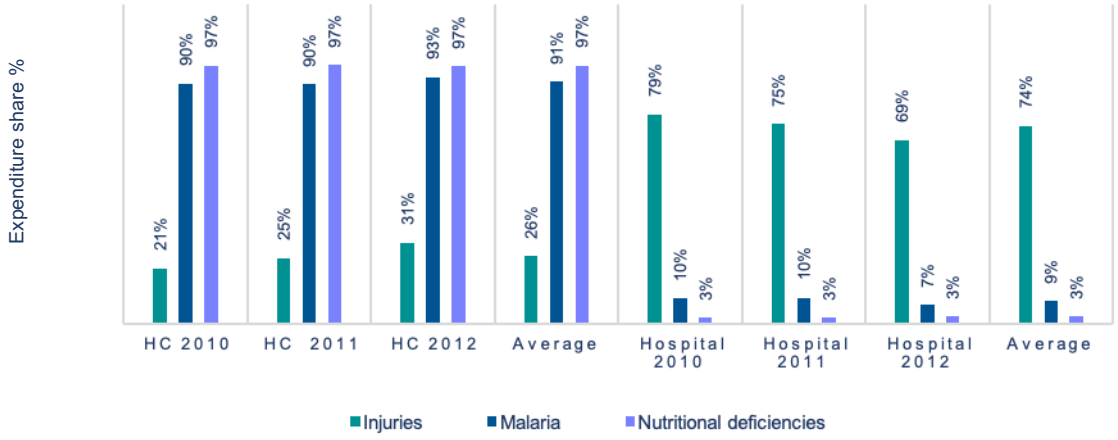
Figure 63: Tigray region malaria incidence trend EFY2009–12



Government spending share by health provider

Data on health spending by provider level in Tigray indicate that, similar to most regions, on average, 97% and 91% of the spending on nutrition and malaria, respectively, was at health centre and health post level. The majority (74%) of the spending on injuries was at hospital level (Figure 64).

Figure 64: Tigray region health programme spending % share by health provider trend EFY 2010–12



4.2 Qualitative results (updated)

The section provides preliminary findings for the performance criteria, based on **the federal- and regional-level KIIs**. The rubric for each criterion is presented, setting out the standards of performance. After the rubric, a box is presented that summarises the overall judgement, and what standard is met for each criterion. We then present a more detailed account of the evidence leading to the judgement.

Predictability of resources

Operational definition: The sources of funds are known, and estimated amounts can be earmarked for emergency preparedness, response, and recovery.

Research questions:

- What are the sources of emergency financing for health and nutrition?
- How predictable are the funds/resources for emergency financing for health and nutrition? (*Adapted from HFPM Q2.2*)
- How are the risks of different types of emergency assessed and quantified by different actors (the government, donors, NGOs/IPs)?
- Does there exist a national plan for emergency financing for health and nutrition?
- Does the HRP help improve the predictability of emergency financing for health and nutrition?
- Is there a strategy for pooling revenues from different sources to finance emergency health and nutrition? (*Adapted from HFPM Q3.1*)
- What measures are in place to address problems arising from multiple and/or fragmented pools? (*From HFPM Q3.3*)

Table 11: Predictability performance standards

Standard	Definition
Advanced	There is a clear annual plan for emergency financing for health and nutrition based on risk assessments and an effective early warning system, leading to predictable sources. The sources of funds are known, and estimated amounts can be earmarked for emergency preparedness, response, and recovery.
Established	The level of funding for emergency health financing is relatively predictable due to well-functioning budgetary processes and planning.
Progressing	Although revenue and expenditure scenarios exist through some form of planning, predictability of the level of funding for emergency health and nutrition remains poor.
Emerging	There are no clear sources of funds and there is no planning for emergency health financing. There is little or no forward budgeting, and there are large year-to-year fluctuations in funding for emergency health and nutrition.

Federal level: between 'progressing' and 'established'
Based on the available evidence, the predictability of resources for emergency health financing is found to lie between 'progressing' and 'established' overall.

While the sources of emergency funding for health and nutrition are known across all stakeholders, there is a lack of a functional budgeting process that allows for an accurate estimate of the required funding for a given emergency event.

There is no annual budget for health and nutrition emergencies. However, funds can be requested from contingency budgeting within MoF. However, the contingency budget is not explicitly tied to emergency health and nutrition financing. This means that, while some forms of revenue and expenditure scenarios exist, these are not always utilised to outline an annual plan for emergency health financing. Stakeholders across all categories stated that they conduct risk and hazard assessments and use the findings to prepare annual plans for health and nutrition emergencies. The IPs and donors emphasised that their financial plans and actual amounts earmarked for emergency preparedness and response are based on the results of risk/hazard assessments. Because IPs directly receive funds from donors or other specialised agencies, they are clear about their sources of emergency funding and their funds are typically earmarked for specific emergency interventions, including health and nutrition.

Regional level: Progressing

Overall, the major source of funding is the regional contingency budget. Other sources of financing include regular regional budgets, the federal government, country offices for regional NGOs, donors, and an emergency preparedness fund in Sidama. Generally speaking, there is no budget line earmarked for emergency responses, and the contingency budget is not earmarked for any specific emergency.

Generally speaking, RHB and DRMC prepare EPRPs that outline the technical and financial (budgeting) components that forecast, quantify, and estimate the magnitude of emergencies and the required resources to address the problems. Risk and vulnerability assessments are also prepared to support the EPRPs. However, there is no earmarked or prepositioned budget allocated by the government to the corresponding emergency preparedness and response activities as per the annual plan. In most cases, the plans do not get financed until a disaster happens. Overall, each sector's annual emergency planning does not ensure the resources' predictability. Some regional DRMCs participate in the preparation of the national HRP prepared by the federal government. Though the HRP ensures the predictability of resources, there is no resource mobilisation to ensure the availability of prepositioned resources/supplies before the occurrence of emergencies included in the HRP.

Additionally, there is no functional budgeting process to accurately estimate the financial resources needed for emergency responses. The resources allocated for preparedness and response activities are not allocated proportionally based on the expected level of public health and nutrition emergencies. It seems that the budget for responding to emergencies is haphazardly allocated, and there is no procedure for estimating the required funds.

Detailed evidence

1.1 Sources of emergency funding for health and nutrition

Federal level

The respondents mentioned multiple funding sources. The contingency budget allocated by the federal government was identified as the major and most immediate source of funding for emergency health and nutrition responses. The contingency budget is a pooled budget, equivalent to 2% of the national budget for the fiscal year, which is mobilised from internal sources, such as tax/revenue collection and treasury bond sales. According to the respondents from the MoF, NDRMC, EPHI, and MoH, more than half (50%) of the budget for emergency response is obtained from the federal government, mainly the contingency budget. However, there is no budget allocation mechanism whereby the contingency budget is tied to or earmarked for a specific emergency (i.e. there is no earmarked budget specifically allocated to and reserved for emergency health and nutrition).

Moreover, respondents from all categories mentioned the significant contribution of donors/development partners in supporting the health sector, including for health and nutrition emergencies. Similarly, the respondents from EPSA stated that the SDG fund, UNICEF, and the Global Fund were the major sources of funding for the procurement of drugs and medical supplies for emergency health and nutrition. Another source of funds for EPSA is a revolving fund. For example, there is always an expectation that there could be a malaria outbreak every September, therefore the drugs that will be needed are known ahead of time. The Procurement Directorate takes this into account when making purchasing plans from the revolving fund.

The respondents from donor organisations also mentioned the existence of a reserved budget at their organisation to ensure the availability of funding for prompt emergency responses, if necessary. A respondent from one of the United Nations agencies described their contribution as follows:

> *Our health and nutrition teams are the major supporter for the response of health and nutrition emergencies. … I am not sure about the exact amount, but it's quite substantial. Health and nutrition are the largest section providing support.*

The donors/development partners, as well as the private sector, are also major sources of funding for emergency health and nutrition response interventions implemented by IPs/NGOs.

Overall, the funding sources for emergency health and nutrition responses are clearly known among the respondents. The contingency budget allocated by the federal government is the major source of funding for emergency responses in the country. Nevertheless, there is no budget allocation mechanism whereby the contingency budget is earmarked for or assigned to a specific emergency. Furthermore, donors/development partners were said to make significant contributions to the availability of resources for emergency health and nutrition responses.

Regional level

In Amhara, Harari, Sidama, Addis Ababa, Oromia, Afar, Benishangul-Gumuz, Gambella, Somali, and Dire Dawa, the main emergency fund source is each region's contingency budget. The region's contingency budget is reserved and used for any and all regional emergencies. The regional contingency budget is not earmarked for any specific emergency (i.e. no earmarked funding is specifically allocated and reserved for emergency health and nutrition).

> *Contingency budget is our main source. We also transfer budget. For example, during the COVID emergency response we used all our contingency budget, and we were forced to use the regular budget of different institutions and projects. We transferred their budget to COVID response.* (RHB, Harari)

> *If there is an emergency, we use the contingency budget and our regular budget. we are able to mobilise funds from the DRMC, and through partners if the above two sources are insufficient.* (RHB, Sidama)

> *The contingency budget is not specifically assigned for emergency response. Rather, it is small portion of the regional budget reserved for any problem, including security, natural disasters, and disease outbreak.* (RHB, Afar)

> *… it is a total* [not earmarked] *contingency budget for unforeseen emergencies or any other sort of budget shortage while doing development works in the region.* (RFB, Afar)

> *The regional government allocates a contingency budget that is used to respond to emergencies when it happens. The contingency budget is not just earmarked for health emergencies only. It could be used for other emergencies, including flooding and conflicts.* (RFB, Gambella)

> *There is a contingency budget at the regional level to respond to all kinds of emergencies that would happen in the region.* (DRMC, Somali)

In Gambella, Somali, and Dire Dawa, donor organisations and IPs (NGOs) are also among the major sources of resources for public health and nutrition emergency response activities. Donors and IPs support emergency response activities through the provision of in-kind contributions, capacity-building training, and other logistical support. The SNNPR RFB reported that their regular regional budget is their major source of funding and that, if it is insufficient, they also tap into the contingency budget and funds from the federal government. Additionally, SNNPR and Oromia mentioned local civil society organisations and partners/donors that use their funds and directly intervene in the emergency response. According to Sidama respondents, an emergency preparedness fund at the regional level can be used as an immediate source of funding for health and nutrition emergencies in the region. Upon request by the regional public health institute, donors and the federal government also provide resource for emergency response in Sidama, Afar, and Benishangul-Gumuz.

> *We get financial support from different NGOs like UNICEF and Save the Children. We also get support from the federal government. For example, we got financial support from EPHI for cholera response. They are also institutions that support us in our malaria response both in cash and in-kind. There are specific districts that these institutions have already promised to assist in cases of particular emergencies. Based on this agreement, they intervene and provide financial support. These supports are not proactive, rather they are reactive based on the plans that will prepared. The plan shows the already existing emergencies and the possibility of their expansion.* (Regional Public Health Institute, Sidama)

> *UNICEF has been allocating a budget from year to year to support emergency responses. The reason that I have mentioned UNICEF is that they react more quickly since they already have the budget for this activity.* (Regional Public Health Institute, Oromia)

In Harari, Afar, and Benishangul-Gumuz, the RHB also mobilises resources from different sources, including investors, various institutions, and wealthy businesspeople.

> *What makes our region different is we have an association called Harari's People Diaspora. They have their office in Harari. They also mobilise resources through their office. We collaborate with them as well.* (RHB, Harari)

> *Two or three years ago, we as a region had prepared and passed a proclamation – 'Mobilisation of Resources for Emergency Preparedness' – to gather and assimilate emergency resources within the region. The article was designed to respond to emergencies swiftly with the available resources. It would allow us to respond quickly to emergencies until we go through the processes of receiving the emergency supplies needed. But we could not collect the necessary emergency resources due to the political instability and the strain caused by increasing inflation.* (RHB, Harari)

The respondents in Addis Ababa also mentioned that sectors could reach out to aid organisations for aid, but that this is a tiny part of the total budget: aid and loans account for between 1% and 2% of the total budget. The city administration therefore focuses on domestic revenue. Specifically for emergency internally displaced person (IDP) cases, there has been resource mobilisation under the Trust Fund led by the Mayor's office, which collects resources from wealthy individuals and private organisations. In some instances, in-kind resources are also accepted. These include the use of ambulance services.

> *If there are emergencies with mass causalities or multiple injuries, then we do use additional resources. Like in the case of the school I spoke about earlier where the children needed to be transported in ambulances to the hospital the ambulances in the area could not respond quick enough, we even tried to use the fire department. We had to use private ambulances that were in the area, the ambulance services provided their services in-kind.* (RHB, Addis Ababa)

It is also a common practice to mobilise resources by shifting resources from routine health programmes within the health sector, as well as from other programmes and sectors, to facilitate emergency response activities in Gambella and Afar and Benishangul-Gumuz. In Amhara region, pooling resources also tends to be done within the emergency operation centre and technical working groups that are established during emergency response.

> *There is a mobilisation of resources from non-emergency programmes to respond to emergencies. If there is an emergency, we use the health and nutrition budget to respond. For this, we are expected to make a budget amendment and let the donor know about it. We have a budget and planned to provide capacity-building training. Meanwhile, there could be a cholera outbreak. We could plan to provide training, but you have no budget dedicated to this purpose. In this situation, we do a budget amendment and request the donor for approval to shift the budget from other programmes to provide capacity-building training.* (IP, Gambela)

For expected outbreaks, like malaria, where the seasons for outbreaks are known and expected, the regional EPRP in Amhara and Sidama will have planned a response fund. If this proves insufficient they will also tap into the region's contingency budget.

Through their regional offices, IPs in Amhara and Gambela obtain their emergency health funding from donors through their country offices. There are known donors that fund health and nutrition emergency-related activities. One of the respondents (an IP) in Afar and Benishangul-Gumuz mentioned the existence of an internal funding mechanism in which the contingency budget labelled 'price modifier' is reserved for quick emergency response action. This acts as a bridge to resource gaps created due to delays in getting donor approval and disbursement of additional funding.

1.2 A clear annual plan for emergency financing, leading to predictable sources

Federal level

The respondents were asked about the existence of a clear annual plan for emergency financing which is based on evidence from a risk assessment and/or early warning system. The results were mixed. Some respondents from government institutions/ministries (primarily from NDRMC, MoH, and EPHI) stated that their sector has an annual plan for emergency financing; however, they believe that their annual plan is unclear as it lacks an earmarked budget (i.e. the contingency budget) for each type of emergency. According to respondents from NDRM, there is no clear financial plan for risk financing, which they believe is essential for the early identification of risks (before they happen). The respondents from EPSA, on the other hand, reported that there is a clear annual procurement plan that specifies the type and amount of emergency health and nutrition commodities.

The majority of respondents from federal government institutions cited the use of risk/vulnerability assessments to predict the incidence and scale of emergencies (like drought, flooding, and health emergencies). They also referred to estimating the amount of emergency financing for the fiscal year, including the contingency budget, based on the assessment findings and information from the early warning system.

Most of the respondents from donors and IPs/NGOs mentioned the existence of a clear annual plan for emergency financing in their respective organisation. They also referred to the use of evidence from risk/vulnerability assessments and gap assessments to forecast the magnitude of emergencies, and the required budget for the emergency responses.

> *The result from the assessment will help to develop a risk informant emergency preparedness response plan. This is plan is a part of the preparedness activity, which is one of the pillars in public health emergency management.* (Donor respondent)

Furthermore, some of the respondents from development partners reported aligning their emergency financing plan with the Ethiopian HRP. They also explained the importance of the HRP in improving the availability of funding through effective and efficient resource mobilisation and mapping.

Overall, the respondents indicated the absence of a clear annual plan for emergency financing at government institutions, mainly due to a lack of clear and earmarked budget allocation. On the other hand, donor organisations and IPs have a clear annual plan for emergency financing. The government and non-governmental institutions (donors and IPs) use the findings of assessments to forecast the occurrence and magnitude of emergencies, and to estimate the required budget for the emergency response.

Regional level

The regional EPRP is prepared in Amhara, SNNPR, Harari, Sidama, Oromia, Afar, Benishangul-Gumuz, Gambela, Somali, and Dire Dawa, and gets shared with the EPHI and MoH. The plan contains technical and financial (budgeting) components that forecast, quantify, and estimate the magnitude of emergencies, and the required resources to address the problems, if they occur. The EPRP also outlines the resources and financial plan for each of these emergencies. However, there is no earmarked or prepositioned budget

allocated by the government to the corresponding emergency preparedness and response activities as per the annual plan. Often, the plan does not get financed, either by the regional governments or by donors, unless an emergency occurs.

> *There is EPRP prepared and updated annually. It is prepared by including professionals across all sectors like agriculture, health, and water and food security. Each sector will put in their emergency forecasts into the plan. For example, the health sector puts in its emergency plan with regards to malaria, cholera, or COVID. The plan is prepared by professionals taken from each sector.* (DRMC, Harari)

> *We usually don't have budgets that align with our annual EPRP. The budget request depends on the severity of the outbreak. We only get additional budget increases if the Health Bureau cannot handle the outbreak with its limited budget. The EPRP usually stays as a document. It is not transferred to an actual financial budget. We use the EPRP as a reference to allocate resources in case an emergency happens. We usually don't get the amount we planned for in the EPRP. There is no sufficient budget to respond to an outbreak at the Bureau level.* (PHEM, Harari)

> *When we prepare the EPRP, we will outline where in the region we are at risk for a specific type of outbreak. We will also outline the communities that will be at risk and the number of people that will be affected. We will also include the amount of funding that is required to address this possible emergency. Once this plan is validated by different sectors of the regional government, the regional EPRP plan is then shared with stakeholders at both the regional and federal level – RFB, DRM, Food Security Commission etc. These stakeholders will then look at the financial plan of the EPRP and pledge whatever amount they plan to give to address the challenges.* (PHI, Amhara)

> *In the EPRP, we outline the financial plans along with the risk and vulnerability assessments and priority concerns to look out for in the region. The EPRP financial plan is largely donor-funded and supported.* (PHI, Amhara)

> *The EPRP is shared with all the stakeholders, including the federal government and IPs, and it is one way of mobilising resources*. (DRMC, Gambela)

> *We prepare separate plans for each emergency we might encounter. We have EPRP – Emergency Preparation and Readiness Plan. The EPRP includes separate plans for every possible emergency and disaster that might occur.* (PHEM, Dire Dawa)

Risk and vulnerability assessments are also conducted in Amhara, SNNPR, Harari, Sidama, Oromia, Afar, Benishangul-Gumuz, Gambela, Somali, and Dire Dawa, with the support and participation of the RHBs. These assessments are conducted bi-annually or annually, and their results are used in preparing the EPRP and other financial and intervention plans. The risk assessments are conducted with the aim of forecasting potential public health emergencies, and the magnitude of emergencies, and estimating the required resources to mitigate the crises if they happen. All relevant stakeholders, including IPs, take part in the risk assessments. Though resources are forecast based on the findings of the risk assessments, the government respondents believe that their annual plan lacks earmarked resources. In Sidama and Gambela, it was reported that there is no mechanism to allocate budget, taking risk assessment results into consideration.

> *Yes, we do conduct risk assessment but the budget allocated doesn't support that. We actually requested for specific budget taking risk assessment results into consideration. Especially at woreda levels, budget does not take risk assessment into consideration. So far, we are only allowed a 1 million birr budget. The plan is already there. We prepared the plan in collaboration with the Health Bureau, Disaster Risk Management Commission, the Peace and Security Bureau, and other institutions. I don't know about the budget allocation for other bureaus, but we were allowed, as I mentioned, only 1 million birr last year. The Health Bureau received 5 million birr by taking the risk assessment results into consideration.* (PHI, Sidama)

> *There is a bi-annual assessment. Hotspot woreda classification is done based on the assessment findings. All the stakeholders are involved in the assessment and the assessment is led by the regional DRM* [DRMC]*. Emergency Preparedness and Response Plan* [EPRP] *is prepared based on the findings of the assessment. The assessment indicates the type of hazards in each woreda. The resources needed for each woreda are estimated and included in the plan.* (DRMC, Somali)

> *We do vulnerability assessments. We then prepare a plan based on the assessment findings. We collect data. After each seasonal rain, we conduct post-rain assessments to do woreda hotspot classification. We collect data and do an analysis. The assessment is conducted twice a year. We conduct belg and meher assessments. We use the findings for woreda prioritisation* [hotspot classification]*. We use the assessment findings to prepare the EPRP. We also use findings from other routine nutrition assessments to inform the EPRP.* (RHB, Somali)

A regional IP in Amhara also reported that they conduct vulnerability risk assessments whenever required by the country office. Risk assessments identify the most at-risk communities and determine how to address them. The IP also reported that they prepare their own version of a HRP within Amhara region, based on the regional government's recovery plan. They are also involved in the development of the national HRP, through their participation in the health cluster forums.

> *We involve the local woreda administrations when we do these assessments. However, one of the challenges we encountered was a resistance from the regional government because they insisted that they already know what the hazards and risks were in the region and did not see the point in conducting a new assessment. They also had already prepared a response plan. However, on our end, when we approach donors, we need to provide a detailed and up-to-date assessment of the risks and vulnerabilities, as well as a market analysis. However, the regional government sees it from a perspective of timeliness and wants us to use the recovery plan they already have prepared.* (IP, Amhara)

The HRP is another approach to planning and financing emergency response activities that improves the predictability of resources. The HRP is a cluster-based coordinated planning approach, in which key stakeholders (government sectors and partners/NGOs) are involved in preparing an emergency response plan. The partners and sector offices are grouped under eight clusters, corresponding to their scope and intervention area/focus. Resource-mapping and assignment of roles and responsibility takes place during the joint planning. Therefore, unlike the government plan, the HRP ensures the predictability of resources, availed by the corresponding stakeholders to whom the specific task or responsibility is

assigned. The regional DRMC in Harari also participates in preparing the HRP. Respondents in Oromia and Dire Dawa also stated that the HRP has improved the predictability of funds, because of the integral role government partners play in preparing the plan.

> *The federal HRP is prepared based on the information gathered from the regional states. It is prepared twice in a year – in Meher and Belg (spring and autumn) seasons. The regional Early Warning Taskforce will conduct a study of the situation on the ground and produce the results. This result serves as input in producing the HRP.* (DRMC, Harari)

Nevertheless, respondents mentioned the absence of resource mobilisation to ensure the availability of prepositioned resources/supplies before the occurrence of emergency situations that are included in the HRP.

On the other hand, the regular planning of IPs/NGOs in Afar, Benishangul-Gumuz, and Somali was reported to be more effective in terms of ensuring predictable funding for emergency responses, as the planning is done based on the pre-defined budget approved by the donors. The respondents mentioned the existence of a monthly budget and resource forecasting and monitoring mechanism, which makes it possible to avoid interruption of emergency response interventions due to stockouts of supplies.

1.3 Functional budgeting process for emergency financing

Federal level

The interview findings reveal the absence of a functional budgeting process that accurately estimates the amount of emergency financing at federal government institutions. Most of the respondents from federal institutions reported that there is no budgeting mechanism whereby the estimated amount of the budget is proportionately earmarked for the expected magnitude/extent of emergency preparedness, response, and recovery. Rather, the emergency financing is based on the occurrence of emergencies, with the 2% contingency budget reserved by the federal government requested and then used to respond. Some of the respondents mentioned better allocation of resources for emergency health and nutrition both by the government and donors. Furthermore, some of the respondents pointed to the inadequacy of the budget due to inaccurate estimation/planning and forecasting of emergencies.

Despite the lack of an accurate budgeting process, the contingency budget remains the most predictable emergency funding across government institutions/ministries. Moreover, respondents from MoF described the existence of a budgeting mechanism whereby an additional budget can be requested from the national treasury and approved to fill a resource gap for emergency response. The respondents also mentioned flexibility in terms of revising their emergency financing plan to fit with changing needs, which could arise due to inadequate planning and/or increased demand. For instance, respondents from EPSA mentioned quarterly or bi-annual procurement plan revision to adjust (increase or decrease) the quantity based on the actual demand and to accommodate emergency requests.

On the other hand, the result indicate there is a functional budgeting process across NGOs (donors and IPs). Most of the respondents mentioned the use of assessment findings to

ensure the accurate estimation of budget allocations (emergency financing) for forecasted emergencies. At the same time, most of the IPs are able to predict the amount of budget allocated by donors for emergency response activities. One of the IPs elaborated that donors have an allocated amount and percentage for each thematic area they support, and there is usually no significant difference between the committed and actual amount of the budget.

Furthermore, the respondents from donor organisations mentioned the important role of the HRP in enhancing the functionality of the budgeting process and helping improve the availability and predictability of emergency funding through coordinated planning and resource mobilisation for emergency financing.

For most donors, the amount of emergency funds allocated depends on the results of assessments, the number of people affected, and the potential impact that the crisis could have on the overall health situation. For some, the funds used to respond to emergencies are haphazardly allocated, and there is no procedure to estimate the required funds. One donor respondent pointed out that they developed and used their Humanitarian Action Plan for the year as their resource mobilisation tool. This Action Plan outlines key areas of priority for the year and allows their headquarters to start mobilising resources in accordance with the plan. Similarly, another donor stated that evidence based on a cross-sectoral and comprehensive assessment (the HRP) helped to predict the source of funds and to estimate the earmarked budget for emergency responses. Another donor mentioned that they conducted a bi-annual planning exercise with MoH to align their budget with the needs of the government – this applies to both their regular programme budget as well as emergency needs.

EPSA respondents also reported that although procurement for an emergency is incited by MoH, the quantification is made in collaboration with the Quantification and Market Shaping Directorate. The quantification parameters account for additional quantity as a contingency. The contingency aims to fill gaps or shortages due to increased demand arising due to emergencies or other unforeseen reasons. Respondents from EPSA also reported that they have a flexible budgeting process whereby they are able to revise their annual procurement plan to accommodate emergency requests. These types of revisions to the annual plan allow the agency to adjust the number of requested items, by adding the requested amount for emergencies to the number of items specified in the annual procurement plan.

Regional level

According to respondents from Harari, Afar, Benishangul-Gumuz, Gambela, Somali, and Dire Dawa, the government has no functional budgeting process for allocating and reserving the required budget as per the annual emergency planning. They all said there is no mechanism in place whereby a budget is allocated for emergency response. This leads to a failure to address emergency situations in a timely and effective fashion.

> *We put budget request for cases we think might occur in our plans. We activate these when the cases happen. The budget is not received to the level predicted in the Early Preparedness Plans. It is hard for us to predict the frequency of budget supports. Budget support from EPHI or WHO might not arrive on the timeframe of the EPRP. Sometimes there are instances where the budget support is received six months after the emergency has taken place. We use budget from other pools within*

> *the bureau to respond to emergencies. We then replace it with the support budget obtained.* (PHEM, Harari)

> *No, we don't have designated budget for health-related emergency response. We put in a request to the region. There is a contingency budget set for any emergencies that may happen in the region.* (PHEM, Dire Dawa)

Gambela reported significant differences between the committed budget and the actual amount of budget allocated by donors and IPs to support emergency responses. Procedural issues and donors'/partners' areas of interest were cited as among the causes of the observed differences. The government respondents explained that shifting a budget is one of the strategies used to fill the gap.

> *It is common to observe a difference between committed amounts and the actual amount we receive from partners. There are different reasons for the difference. Some of the reasons include lack of approval by a top manager and procedural issues. To fill the gaps, we shift the budget. The directors make decisions to shift the budget from different programmes to emergency responses. For example, during the COVID-19 pandemic, we did budget shifting from all the programmes. We shifted financial resources and manpower and committed all our time to COVID-19 prevention and control-related activities.* (RHB, Gambela)

By contrast, Sidama reported that there is a functional budgeting process for emergency finance, even though the allocated budget is inadequate. Respondents reported that they prepare an EPRP and it helps with planning because if every sector knows what emergencies can happen, they give it enough attention. Furthermore, if an emergency does happen, they already have a budget prepared.

> *For those diseases that we know of we are able to plan for them we also include an area in the plan for unexpected health crisis emergencies, there is a budget for these types of emergencies. We don't do it by disease like just for malaria and just for cholera but, during the fiscal year, we plan for recurrent health emergencies, we map where these emergencies have been seen before and what population could be affected by this. We use this as first line for our budget planning. We cannot know ahead of time which disease will happen this year, but what we do is plan for emergencies in general.* (RHB, Sidama)

> *We are not operating to what we have anticipated based on data, but within the budget we have. We are not working according to our plan because of limited budget.* (PHI, Sidama)

> *If it has already been budgeted for then we can have the funds when we need it. At the beginning of the fiscal year the DRMC office will plan their budget for emergency response, then around 20 million birr will be put aside. This is very predictable, this is for emergency response, non-salary. If there are IDPs then we buy food and or shelter – for medication the RHB would do that. They are the only ones who plan for medication we focus on food and non-food items.* (DRMC, Sidama)

In Somali, a respondent from the RFB described the existence of a budgeting mechanism in which an additional budget can be requested from the national treasury and approved to fill a resource gap for emergency response.

On the other hand, a respondent from an IP operating in Gambela region mentioned the existence of a budgeting process to ensure accurate estimation of budget allocation (emergency financing) for expected public health emergencies. The respondent further explained that the organisation is able to predict the amount of budget to be allocated by the donors for emergency response activities.

> *The amount of funds provided by BPRM* [Bureau of Population, Refugees, and Migration] *each year is known. Each year, it has been donating US$ 2 million for over a couple of years. We know that will not give you more than this. Each donor has a funding limit. So, you know it ahead.* (IP, Gambela)

4.2.1 Adequacy/flexibility

Operational definition: Resources are sufficiently allocated to specific health and nutrition emergency needs.

Research questions:

- Are the funds allocated to all channels sufficient/adequate? (How are fund allocations and needs aligned across the three channels? Is the funding for emergencies sufficient for the magnitude of the need?)
- How flexible are the resources (if more is needed, is there room to adjust/increase?)
- At the federal level (MoH and EPHI), is there a health emergency budget? How do MoH and EPHI receive their resources and funds from the Government Treasury during an emergency? What are the processes for requesting a budget, getting it approved, and receiving the funds? How long does this take? Is this sufficient?
- At sub-national level, is there a health emergency budget? How do resources/funds get allocated to the regions and woredas? What are the processes for requesting a budget, getting it approved, and receiving the funds? How long does this take? Is it sufficient?

Table 12: Adequacy performance standards

Standard	Definition
Advanced	Resources are sufficiently allocated to all specific health and nutrition emergency needs. Emergency funding is sufficient for the magnitude of the need and there is flexibility in regard to additional funds, if required.
Established	Resources are relatively allocated to all aspects of health and nutrition emergency needs, with minimal requirements for additional funding given the magnitude of the need.
Progressing	Resources are relatively allocated to some aspects of health and nutrition emergency needs, but scant resource allocations for the magnitude of the need remain overall.
Emerging	Resources are not sufficiently allocated to specific health and nutrition emergency needs. Emergency funding is insufficient for the magnitude of the need.

Federal-level judgement: 'emerging'

Based on the available evidence the adequacy of resources for emergency health financing is 'emerging'. Overall, emergency funding is insufficient for the magnitude of the need in Ethiopia. The government's budget allocated for emergencies is reported to be low and not earmarked or put aside for health and nutrition emergency needs. Most emergency responses are donor dependent, and even donors and IPs reported funding limitations when it comes to addressing increasing needs caused by protracted conflicts and health and nutrition crises across the country. There is some flexibility to move funds across programmes and to make adjustments for additional resources from both the government and donors.

Regional-level judgement: 'emerging'

Based on the available evidence, the adequacy of resources for emergency health financing at regional level is 'emerging'. Overall, emergency funding is insufficient for the magnitude of the need in all the regions and city administrations included in this study. Moreover, the government's budget allocated for emergencies is reported to be low and not earmarked or put aside for health and nutrition emergency needs. Similarly, IPs reported funding limitations in regard to addressing increasing needs caused by protracted conflicts and health and nutrition crises across the country. There is some flexibility in government budget use, to accommodate cases where more resources are needed in all the regions included in the study, but flexibility in the Amhara region is relatively limited. Donor funds seem to be less flexible, and adjustment is highly donor dependent.

Detailed evidence

2.1 Adequacy of funding for health and nutrition emergency needs

Federal level

Resources allocated by the government and donors for public health and nutrition emergencies were reported to be inadequate, particularly in the light of increasing demands. Increasing humanitarian assistance due to increasing and recurrent conflicts across the country and the COVID-19 pandemic were reported to have exacerbated the need for emergency funding. The myriad of conflicts and emergency situations across the country are forcing donors to stretch their resources and are preventing them sufficiently allocating resources.

> *The needs in Ethiopia are much higher than what the resource envelope is able to provide. The government is not in a fiscally strong place to provide the necessary support for emergency health and nutrition.* (Donor respondent)

Moreover, it was explained that the lack of evidence-informed planning, inefficient use of resources, and duplication of efforts contributes to the inadequacy of funding to respond to health and nutrition emergencies.

> *There is a spike in emergencies in Ethiopia. The existing budget is inadequate to provide a prompt response and to detect early and give a response. The existing budget is not adequate to respond to the increasing magnitude of emergencies in different parts of the country.* (EPHI respondent)

Government respondents also pointed out that due to incorrect estimation and measurement of risks, the allocated budget for public health emergencies is usually inadequate. This points to the lack of a functional budgeting process, which requires additional allocation from the Treasury's safety budget.

Respondents reported an increasing trend in the amount of funds allocated to health and nutrition emergencies. However, the increase in the amount of funds is still inadequate to address the ever-increasing needs across the country. A respondent from EPSA explained that the budget allocated by the government for the procurement of drugs and supplies needed for emergency responses increases from time to time. Moreover, the government subsidises the procurement of commodities needed for emergency response.

A donor respondent explained that better funding is allocated for nutritional interventions compared to other health emergencies, while other health programmes that indirectly affect the outcomes of nutrition interventions are underfunded.

We asked respondents about the mechanisms in place to ensure the adequacy of funding for emergency health and nutrition responses in the country. Government respondents explained that domestic resource mobilisation and increasing the government's health expenditure are the main mechanisms to ensure sustainable and adequate resources for public health and nutrition emergencies. In addition, avoidance of duplication of efforts and efficient use of resources are reported to be essential for sustainable and adequate emergency funding.

All respondents agreed that there is increasing demand for financial resources to respond to the increasing humanitarian crises attributed to conflicts and natural disasters. However, the amount of emergency funds from donor organisations and partners to support emergency responses is decreasing. Government respondents across the board stated that resources are not allocated sufficiently to respond to emergencies. MoF respondents also stressed that funding for emergencies is not adequate to respond to the existing needs/problems. There is increased demand for emergency funding, mainly attributed to the humanitarian response required due to the Northern Ethiopia conflict and the COVID response. EPSA also reported that there is not an adequate budget for emergency procurement. Additionally, the agency reported that due to the decreasing trend for emergency funding from donors and NGOs, MoF has started allocating a budget to subsidise the procurement of commodities for emergencies by providing 10% of the total cost. The government is trying to fill the budget gap, and thus the government contribution for emergency funding has increased.

Government respondents made a number of suggestions to improve funding availability and fill the funding gap, as follows: increasing domestic resource mobilisation; increasing the government's general health expenditure; increasing resource utilisation efficiency; implementing cost-effective programmes; and working on procurement-related efficiency.

Overall, there has been an increase in the amount of funds allocated for health and nutrition over time, but this has not been enough to address the ever-increasing needs across the country. Funding is reported to be better for nutritional interventions than for other health emergencies. IPs also agreed that their organisations' funding for implementing emergency health and nutrition programmes is insufficient. IPs further reported that resource limitations among donors, and the myriad of conflicts and emergency situations across the country, stretch donors' resources and prevent them sufficiently allocating resources. The competing priorities between conflicts and disease outbreaks also prevent IPs sufficiently allocating resources across all needs.

Regional level

We asked respondents if the funding for emergency responses is sufficient for the magnitude of the need. Government respondents and IPs from all the regions and the two city administrations included in this study expressed their concern regarding the inadequacy of resources allocated by the government and donors/IPs for public health and nutrition emergencies, despite increasing demands due to humanitarian crises and natural disasters.

> *There is always a discrepancy between the available resources and the magnitude of the need. We prepare a plan based on the magnitude of the problem. We always prepare the estimation. However, lack of sufficient resources is always an issue.* (RHB, Somali)

> *There is a significant increase in emergency support provided by partners. However, we always face shortages due to frequent and persistent emergencies and an increased number of IDPs from conflict-affected areas.* (RFB, Benishangul-Gumuz)

A few respondents explained that the amount of funds allocated by the donors and IPs to support emergency responses is decreasing, despite increasing financial demand attributed to natural disasters and conflicts.

> *The resource is not sufficient because of the competing and increasing demands. The country office sends funds in its assessment and allocation procedures. But it usually does not satisfy all the demands in the region. Looking at our portfolio, the amount of funding we receive is significantly decreasing in recent years.* (IP, Amhara)

Insufficiency of emergency funding was reported to be due to several factors. Competing needs and priorities due to increasing and recurrent conflicts resulting in an influx of IDPs and natural disasters like drought and flooding across the country were reported to have exacerbated the need for emergency funding. Lack of evidence-informed planning was repeatedly mentioned as contributing to the inadequacy of emergency funding in SNNPR, Sidama, Oromia, and Gambela regions. Respondents from Addis Ababa, Harari, Afar, Benishangul-Gumuz, and Sidama regions explained that there are few IPs/donors that are supporting public health and nutrition, which the respondents believe has exacerbated the inadequacy of emergency funding in the regions.

Limited government budget allocation for the health sector in general, and public health and nutrition emergencies in particular, was believed to have contributed to insufficient emergency funding in some regions. Respondents from Gambela, Afar, Benishangul-Gumuz, and Harari regions believe that health emergencies are less prioritised as compared to other emergencies. Some respondents from Afar and Benishangul-Gumuz explained that more funding is allocated for politically sensitive public health emergencies, like cholera, as compared to other health emergencies like child malnutrition and malaria outbreaks.

> *The public health emergencies that have political implications are given due attention by the government and resources will be availed immediately. For instance, if adult people die due to adult malnutrition (starvation), which is politically sensitive, there will be immediate and adequate resource allocation by the government.* (RHB, Benishangul-Gumuz)

Decreased government revenue, which is one of the sources of emergency funding, due to a reduction in economic activities following conflicts, was believed to have exacerbated the insufficiency of emergency funding in some regions like Afar and Benishangul-Gumuz. According to the respondents, the amount of tax collected in the past two years has decreased.

Moreover, government respondents from Gambela region explained that the allocated budget for public health emergencies is usually inadequate due to duplication of efforts. A respondent from an IP operating in the region partially attributed resource duplication to the Comprehensive Refugee Response Framework (CRRF). According to the CRRF, all partners operating in the refugee camps are expected to support the host community.

> *Duplication of efforts is common. Different partners could provide similar training in the same woreda. For example, we allocate a budget to support health and nutrition activities. On the other hand, UNICEF gives funds to support health and nutrition activities in the region. The RHB could use the fund for capacity building. It could provide the same training. All partners operating in the refugee camps are expected to also support the host community according to the CRRF.* (IP, Gambela)

Respondents from Gambela, Afar, and Benishangul-Gumuz regions believe that the lack of well-established resource mobilisation mechanisms and reserved resources have contributed to the insufficient funding for public health and nutrition emergencies in these regions. The absence of a resource mobilisation mechanism to ensure the availability of prepositioned resources (as per the emergency response plan) is one of the factors contributing to the inadequacy of emergency funding. Despite having a clear emergency funding plan with clearly defined roles, responsibilities, and sources of funding, none of the regions have established a resource mobilisation system to secure and ensure sufficient funding for emergency responses. As a result, the resource mobilisation effort, which starts after the occurrence of an emergency, fails to gather adequate and timely funding from partners/NGOs and other sources.

Continuing this assessment, respondents also described the mechanisms that are in place to fill funding gaps for health and nutrition emergencies. IPs mentioned the use of 'shared cost', where projects are supported by different organisations and implemented in consortiums, to fill funding gaps for emergency responses. Moreover, requesting support from the federal government and donors/partners, budget shifting within and across sectors, and resource mobilisation from the community and private sector were repeatedly mentioned as mechanisms used to fill funding gaps.

We asked respondents about the mechanisms in place to ensure the adequacy of funding for emergency health and nutrition responses. The respondents suggested several mechanisms that are used to improve funding availability. Increasing domestic resource mobilisation, increasing the efficiency of resource utilisation, increasing the government's health expenditure, and reducing duplication of efforts were repeatedly mentioned to be essential to ensuring resource adequacy for emergency responses. Moreover, respondents from Oromia explained that the government is working on income-generating activities to ensure resource availability through the construction of commercial buildings and community mobilisation initiatives. Improved donor engagement, improved evidence-informed planning, and partner mapping were believed to contribute to the efforts to ensure resource availability for emergency health and nutrition responses. Respondents from Benishangul-Gumuz

explained that the HRP and strong coordination mechanisms are essential to ensure resource availability and adequacy of emergency funding.

> *The HRP enabled us to collaboratively plan under the leadership of UN-OCHA* [United Nations Office for the Coordination of Humanitarian Affairs] *and pool funds from various sources. Since the government do not dedicate budget for emergency responses, the HRP helps to mobilise and avail resources.* (RHB/PHEM, Benishangul-Gumuz)

2.2 Flexibility/adjustment for additional resources

Federal level

We asked respondents if there is flexibility in emergency funding/budget use to accommodate more resources if needed. With approval from the managing authority, both the government budget and partners' fund were reported to be flexible. The government's contingency budget is used to respond to public health and nutrition and is more flexible compared to the regular budget.

However, respondents reported that emergency funding from some donors is less flexible, as they have to follow strict procedures that focus on accountability and transparency.

Within the GoE, if required, there are additional mechanisms to reallocate additional funding for a health and nutrition emergency. The first mechanism is the reallocation of budgets within the organisation, in which the programme budget is shifted for an emergency. Each ministry/sector has the authority to shift the budget within the organisation. With prior approval by MoF, there is flexibility in shifting budgets from other programmes or organisations for emergency funding.

Respondents from EPSA explained that there is flexibility in shifting resources from regular programmes to fill a shortage of budget to purchase drugs and supplies needed for emergency responses. Flexibility plays an important role in ensuring the availability of resources for emergency responses.

However, while internal processes are flexible, the agency faces strict approval requirements from the regulatory body that could affect flexibility, even for emergency response.

> *We have relatively flexible working procedures for procurement of commodities. However, we have strict procedures after the commodities arrive to our warehouses and the data* [product description] *is fed into our system. There are a lots of accountability issues. For instance, it will be impossible to distribute products if there is discrepancy in the unit of measurement information on the document submitted by the contract management and supplier. This kind of documentation problem could result in delay. Nevertheless, our system and working procedure is more flexible for emergency than the routine programme.* (EPSA)

Respondents from donor organisations explained that there is limited flexibility of emergency funds and limited adjustment to reallocate additional resources for emergency responses, due to their strict procedures, which focus on accountability and transparency. Emergency funding reallocation and shifting is subject to prior approval. Respondents from a donor

agency explained that a crisis modifier is in place to allow IPs to flexibly use emergency funding. Nevertheless, flexibility or adjustment for additional resources for health and nutrition emergencies is subject to approval, in line with organisational objectives and priorities.

IPs also mentioned that flexibility is highly dependent on the donor and on specific circumstances. Some donors are very flexible with IPs, while others have more limited flexibility, i.e. within a specific range. IPs can also flexibly move resources within their programming according to priority needs. However, there is no room for overspending in the overall budget.

Regional level

We asked respondents if there is flexibility in emergency funding/budget use to accommodate cases where more resources are needed. Overall, government budgets were reported to be flexible in all the regions included in the study, though flexibility in Amhara region was reported to be relatively limited. According to the respondents, more contingency budgets could be allocated to respond to public health and nutrition emergencies depending on the magnitude of the crises. Moreover, there are additional mechanisms to allocate additional funding for a health and nutrition emergency. One of these mechanisms is shifting budgets from other programmes within the government structures for emergency funding within the sector. Each sector has the authority to shift the budget within the organisation without seeking approval from the RFB. As a result, shifting a budget from other programmes to emergency funding within sectors is easier and takes less taxing than requesting a new budget. The other mechanism used to allocate additional funding for a health nutrition emergency is shifting budgets from other programmes for emergency funding between sectors, which requires prior approval by the regional cabinet and each sector.

Overall, donor funds were reported to be less flexible and adjustment of these funds was reported to be highly donor dependent. Relatively better donor fund flexibility and adjustment were reported in Benishangul-Gumuz, Afar, Dire Dawa, Somali, Gambela, and Sidama regions. Respondents from Afar and Benishangul-Gumuz regions explained how the existence of a crisis modifier allows IPs to use emergency funding flexibly. Nevertheless, flexibility for additional resources for health and nutrition emergencies and budget shifting needs budget amendment and is subject to approval.

> *Budget flexibility is donor dependent. Some donors give top-up funds. For example, UNHCR* [United Nations High Commissioner for Refugees] *makes a mid-year revision to the budget it provides. You make a request if there is a discrepancy between the required budget and the budget provided and if there is budget inadequacy. The UNHCR team looks into the case and makes decisions.* (IP, Gambela)

4.2.2 Allocative efficiency

Operational definition: Resources are allocated appropriately and in line with the emergency needs.

Research questions:

- Are the resources allocated as per the magnitude of emergency needs?
- What drives the decision-making process for health spending at federal, regional, woreda, and health facility levels, both on- and off-budget?
- Are specific criteria used for emergency resource allocation?
- How do resources get mobilised (from other programmes) to fund health and nutrition emergency interventions?

Table 13: Allocative efficiency performance standards

Standard	Definition
Advanced	Resources are allocated appropriately based on evidence and subject to systematic risk assessments and deliberation against established criteria.
Established	Evidence is used in resource allocation, and decisions on emergency resource allocation are assessed against established criteria.
Progressing	Some evidence is used in resource allocation. Some decisions on emergency resource allocation are assessed against selected criteria as a formal process for decision-making.
Emerging	Resource allocation is not evidence-based. There are no defined criteria that act as the basis for decisions on emergency resource allocation.

Federal-level judgement: 'established'
Overall, evidence is used in resource allocation, and decisions on emergency resource allocation are assessed against established criteria among federal government institutions, donors, and IPs. In most cases, risk assessments are conducted to generate evidence on the magnitude/volume and negative impacts/consequences of the potential emergency; and the findings are used as an input for resource allocation and planning. For unplanned emergencies, resources are mobilised and allocated appropriately according to need.
Regional-level judgement: 'established'
Overall, evidence is used in resource allocation in regions. In most cases, risk assessments are conducted to generate evidence on the magnitude or volume and negative impacts/consequences of the potential emergency, and the findings are used as an input for resource allocation and planning. For unplanned emergencies, resources are mobilised and allocated appropriately according to need. Decisions on emergency resource allocation are assessed against established criteria in most regions. Resources can also be mobilised from other programmes and sectors following appropriate approvals.

Detailed evidence

3.1 Resources allocated based on the evidence/specific criteria

Federal level

The participants from all categories (i.e. government and non-government institutions) mentioned the existence of evidence-based resource allocation for emergency responses. The risk and vulnerability assessments are the main sources of information that forecast the occurrence of emergencies, and the level of anticipated crisis or negative impact on vulnerable individuals/communities. The information obtained from these assessments is

used to determine the number of resources for risk mitigation activities (prior to the occurrence of emergency), emergency responses, and rehabilitation interventions (post-emergency interventions). In addition, respondents from NDRMC and EPHI mentioned the use of information gathered through early warning information systems and disease surveillance systems as additional criteria for resource allocation at the federal and regional levels. Furthermore, the nature of the emergency (severity, magnitude, fatality level, etc.) is used as a prioritisation criterion for resource allocation.

Different departments mentioned different criteria used for the allocation of funds for emergency health/nutrition:

> *Regarding health emergencies, we have criteria that might be based on the risk. First, we identify the risk then prioritise the problem and allocate the proportional budget, based on the identified risks. The first criteria concern the spread of the disease: is the disease confined in one woreda, or will it spread to other woredas? What is its severity? How many cases will there be? How many deaths will there be? What socio-economic crisis will it have when it occurs? Based on the four criteria, the disease will be categorised as severe or of public health concern and the budget allocated appropriately. If the disease causes trade restrictions, if its morbidity and mortality are high, if it has public health significance, if it has a poor or unknown mode of transmission, if nothing is known about it, the budget you will allocate will be high.* (EPHI respondent)

> *EPRP is prepared at the national level, and the budget will be allocated. If it is a pandemic, though, the budget is distributed to each region based on its population size. Otherwise, the allocation will be based on needs and locations.* (EPHI respondent)

> *At NDRMC, we use the national hotspot classification tool. The tool is split by region, zone, and woreda; and has six sections – namely nutrition, health, agriculture, market, water, education, and protection – whose priority is rated between 1 and 3. We check the priority that is given to each section to classify a woreda as priority 1.* (NDRMC respondent)

According to the respondents from MoF, the allocation of the domestic budget (i.e. contingency budget) is based on the priorities and focus areas of the national strategic plan (10-year master plan) and the five-year micro plan (which forecasts five years of government funding). The master plan is a strategic document that specifies government priorities based on their level of importance for the economic growth and development of the country.

Similarly, the micro plan is developed based on government expenditure patterns for each sector (health, education, agriculture, etc.). Likewise, the funding from donors is aligned with the identified government priorities. In addition to the above evidence, the MoF uses budget allocation parameters to determine the amount of funding for federal and regional entities. The parameters are determined by the house of federations to ensure an equitable and fair allocation of the budget to the regional states and city administration.

Similarly, the allocation of resources for emergencies across donors/development partners is based on evidence from risk/vulnerability assessments, trend analysis of disease occurrence, and results from routine monitoring/reports. In addition, the magnitude of the

problem and the urgency of responding to the need are among the requirements for allocating resources for emergency responses. Moreover, fund availability, the country's capacity to respond to a crisis, and the alignment of the need with donors' priorities determine how resources are allocated. The most mentioned criteria were the number of people in need. Secondly, some respondents also stated that the existence of partners on the ground and their capacity to deliver the support and services is also a determinant when deciding to allocate funds for an intervention.

Most IPs mentioned multiple criteria for determining interventions and resource allocation, including the needs of the HRP, the outcomes of needs assessments, the government's ability to respond, and the availability of other support in the affected area. The vulnerability of the existing health system in the operational area also determines how much funding is allocated in a particular area. A previous operational presence for that targeted area and the affected population, and their vulnerability status, are also determinant factors for resource allocation and interventions. Vulnerable population groups, such as children under the age of five, pregnant/ lactating women, disabled people, the elderly, and adolescent girls, are among the most affected in most health and nutrition emergencies, and IPs tend to align humanitarian emergencies with a specific selection criterion that gives due emphasis to those affected and to the most vulnerable people.

Overall, there is evidence-based decision-making for the allocation of resources among federal government institutions, donors, and IPs. In most cases, risk assessments are conducted to generate evidence on the magnitude/volume and negative impacts/consequences of the potential emergency; and the findings are used as an input for resource allocation and planning.

Regional level

All respondents reported the existence of evidence-based planning, in which forecasting of emergencies and quantification needs is prepared based on the findings of risk/vulnerability assessments, which also inform the regional EPRP. Moreover, using evidence generated through rapid assessments (conducted when the emergency occurs) for the development of emergency response plans and budget proposals is widely practised in most regions. However, the respondents mentioned an absence of resource allocation based on the quantified need or magnitude, mainly due to a shortage of funding, and the absence of prepositioned budget allocation mechanism prior to the occurrence of emergencies.

The participants also described how emergency response plans are revised, before or during an emergency, based on assessment findings (like hotspot classification, nutrition surveys, and rapid assessments) and information obtained through routine monitoring of the emergency response. The resource mobilisation and allocation efforts aim to fit the changing needs throughout the emergency response time. Moreover, the resource mobilisation effort aims to avail adequate resources for the magnitude (number of affected individuals and the geographical coverage) and severity (fatality, hospitalisation rate, etc) of the emergency.

Respondents also reported that a risk assessment is conducted twice a year and this is done with the involvement of multiple sectors and stakeholders across the region.

3.2 Decision-making process for emergency health and nutrition spending/emergency finance

According to the GoE respondents, MoF is primarily responsible for authorising and controlling domestic and international funding for emergency health and nutrition. The MoF works with all government sectors and regional states to coordinate the planning and budgeting activities. The international partnership department (within MoF) oversees all funding activities from external sources (i.e. donors and international agencies). The amount of the contingency budget for each sector and region is determined based on the budget allocation parameters approved by the House of Federation.[17]

The decision-making process for health and nutrition emergency finance usually takes place at the woreda level. In most cases, the woreda administrations are responsible for allocating the budget, from their contingency budget to emergency responses within their territory: that is, if their capacity can manage it, with no requirement for more resources and high-level coordination at the regional/federal level. The emergency funding/budget allocation is planned at the beginning of the fiscal year, along with the regular budget at the federal level.

Regarding the decision-making process for health and nutrition spending/emergency finance, there is no specific process or procedure to determine funding for emergency health and nutrition from the government budget, according to MoF. Once the contingency budget (which is 2% of the annual budget) is determined, MoH and other sectors can submit proposals and the required documents to request the emergency funding, and MoF will approve and disburse the budget. Emergency funding for health and nutrition is not directly provided to the regions: rather, it is channelled through MoH. Furthermore, when there is a shortage of a budget due to an inadequate contingency budget for the emergency response, MoF shifts/reallocates an unused budget from other programmes to avail the budget or it requests a supplementary budget. A request for a supplementary budget requires the approval of the parliament, the highest decision-making body in the country.

Some IPs stated that the vulnerability of the affected community and the healthcare system are the main factors they consider when deciding on health and nutrition spending.

> *We tend to align humanitarian emergency response with specific selection criteria that give due emphasis to the most vulnerable. … Another aspect of the selection criteria is the existing health system in the operational area, the nature of the people being supported. If there are IDPs and if there is a weak health system, we tend to give focus to those area, and allocate more resources to these areas, as opposed to other areas who have more established health systems. These are some of the aspects of the response that we consider as far as resource allocation and selection criteria is concerned.* (IP respondent)

Regional level

The decision-making process for emergency health and nutrition emergency funding applies several criteria. The most commonly reported decision-making factor is the impact on human life.

IPs in Amhara region and SNNPR both reported that the community's need is the first and main criterion used to determine areas of intervention. This is determined using a needs/gap

[17] The House of Federation is the upper house of the bicameral Federal Parliamentary Assembly in Ethiopia.

assessment of the community. The second criterion used to determine intervention is a government request. The third criterion involves looking at the organisation's own thematic focus, as well as their capacity and ability to do the work.

APHI also reported that the first step is to focus on the current and most pressing issue.

> *For example, in the case of malaria, we focus first on woredas where the case numbers are the highest. And within that we also prioritise on mothers and children and other vulnerable groups.* (APHI)

The SNNPR Public Health Institute emphasised that, based on the risk assessments they conduct, they outline the priorities based on the community's vulnerabilities and the size of affected populations. While echoing this method, the respondent from SNNPR RHB also added that for nutrition emergencies they identify the woredas with the highest number of mothers and under-five children and they start their interventions in those woredas.

The PHEM team in Harari, together with the technical working group, identify the problems, along with what should be done. They then present their resource requests. The financial decision is then made by the bureau management. In the case of an outbreak the resource request is immediately accepted without any questioning. The management decides which funds to pull to financially support the outbreak response. The decision is then passed down to the RFB.

Afar and Benishangul-Gumuz respondents reported that, despite the enormous challenge due to the shortage of resources, the decision-making process for emergency health and nutrition financing is not based on objective criteria. The participants from both regions mentioned the absence of standard procedures guided by well-defined criteria and prioritisation parameters that ensure proper allocation of the budget for emergency preparedness and response activities. The respondents criticised the decision-making process for being haphazard and being driven by political interests. One of the study participants from Benishangul-Gumuz region said:

> *The public health emergencies that have political implication are given due attention by the government and resource will be availed immediately. For instance, if adult people die due to adult malnutrition (starvation), which is politically sensitive, there will be immediate and adequate resource allocation by the government.* (RHB, Benishangul-Gumuz)

Some of the participants from Afar region mentioned the existence of inappropriate contingency budget allocation criteria applied by the federal government, which results in unfair distribution and shortages of emergency funding. They also stated that the federal budget allocation is based on population size, and does not account for the magnitude of the emergency and variation in the contextual factors across regions (i.e. determinants of emergency response, like access and coverage of health services).

> *For instance, out of 8 billion birr allocated for COVID response from federal government, Afar region was given only 2%, based on the population size. But in reality, Afar is highly exposed region as it is the main entrance though which the national economic transactions are made via Djibouti port…and we were conducting 30,000 – 40,000 COVID testing per day. Regions with more vulnerability should get higher proportion of resources, as the demand will be higher… For your surprise, the*

> *budget we get from the federal government was not enough to cover one month expenditure related to COVID response.* (RHB, Afar)

On the other hand, a few respondents from Afar and Benishangul-Gumuz mentioned the existence of a prioritisation approach in which more budget is allocated for woredas with a higher number of affected people and geographical coverage. Moreover, allocating a higher proportion of the government budget for woredas that have no partner support (i.e. NGOs operating in the area) was mentioned as a decision-making criterion.

Gambella and Somali respondents reported that the decision-making process for emergency finance is usually determined by the management of sectoral offices, the emergency coordination unit (led by the regional vice president), and the regional cabinet, depending on the magnitude of the crisis. In Gambella, the RHB and DRMC are responsible for using the budget they have to respond to emergencies and for mobilising resources from donors and IPs. The senior management body of each sectoral office can make decisions regarding shifting a budget from other programmes to emergency financing. If the emergency is beyond their capacity, the RHB and other sectors can submit proposals and the required documents to request the emergency budget, and the regional cabinet will approve and disburse the budget. The respondents also explained that the RFB takes a lead in shifting or reallocating unused budget from other programmes inf different sectors to avail more budget for emergency responses in the case where the regional contingency budget is inadequate.

In Somali region, the RHB and DRMC are responsible for using the budget they have to respond to emergencies and for mobilising resources from donors and IPs. The senior management body of each sectoral office can make decisions regarding shifting the budget from other programmes to emergency financing. If the emergency is beyond their capacity, the RHB and other sectors can submit proposals and the required documents to request the emergency budget, and the regional cabinet and parliament will approve and disburse the budget. When there is a shortage of budget due to an inadequate contingency budget for the emergency response, the RFB requests the MoF to allocate more budgets, with the approval of the regional president. Moreover, the RFB takes the lead in shifting or reallocating unused budget from other programmes of different sectors to avail more budget for emergency responses if the regional contingency budget is inadequate.

> *After using the entire contingency budget, we postponed the implementation of new projects and used their budgets to respond to the drought. These projects included the construction of new hospitals and roads. The regional cabinet presented to the parliament and postponed these projects. The budgets allocated for the new projects were shifted to emergency funding*. (RFB, Somali)

A respondent from an IP operating in the region explained that the magnitude of the emergency (including its prevalence), underlying factors related to an emergency, and the government's capacity, together determine the decision to allocate resources for public health and nutrition emergencies.

> *The criterion is the magnitude of a problem. I mean the prevalence, the number of people affected. The other that we suppose is a regional appeal like food security, factors that are contributing to food insecurity, and factors related to malnutrition cases like drought, migration, and displacement.* (IP, Somali)

3.3 Resource mobilisation from other programmes to fund emergency health and nutrition

Federal level

According to the GoE, for pre-prepared emergencies there is no need to mobilise and reallocate resources. In the case of other unplanned emergencies, there may be a need to reallocate and mobilise resources from other programmes towards the emergency. This depends on the available resources and the use of resources by programmes. Respondents across the board gave the example of how reallocation took place during the Tigray conflict:

> *For example, in Tigray Region, after the war, there was a taskforce established to work on the reallocation of funds from developmental programmes towards more emergency response activities. Even some COVID-19 resources were being reallocated towards the rehabilitation efforts in Tigray.* (MoH respondent)

> *We mobilise funds in different ways. First, we develop a project proposal and submit to different supporting partners to give us a budget. Another way is by asking the government to shift budget from one programme to the other.* (EPHI respondent)

On the donor side, one donor noted that whenever they tackle an emergency response, they usually plan and mobilise resources in an integrated approach – meaning they mobilise funds towards multiple sectors at once. This allows them to leverage support from different sectors because they tackle an emergency response by looking into all its related sectors as well. In some cases, they mobilise funds from developmental programmes, but there is also a commitment to deliver regular programmes, so it is not something they do often. Another donor explained that it depends on where the specific funds are coming from. If they come from member state contributions, there is greater flexibility and funds can be mobilised from one programme to another. But if funds come from voluntary contributions, from bilateral agencies and donors, directly to the organisation, then they cannot move these funds to another programme. A different donor respondent mentioned the possibility of mobilising funds from other programmes if an emergency occurs in the area targeted by the organisation.

> *There has been a strong call within* [the organisation] *to increase member state contributions to WHO so that we have that level of flexibility to be able to respond more appropriately adequately and timely to different situations, including emergencies.* (A donor respondent)

IPs highlighted that there are cases where resources get mobilised from other programmes to fund emergency response. There is the possibility of shifting programme budgets from developmental programmes to emergency programmes, with the approval of the donors. For example, during the Tigray crisis, the Growth Through Nutrition programme implemented in Tigray, and processed through nutrition programmes, had to be shifted. This is a developmental nutrition programme but due to the current context it is not possible to continue this programme so the IP requested the donor of the programme to shift funds towards an emergency programme, and they are now working on an emergency nutrition programme in that area, using the funds from the original developmental programme. Also, there is a contingency budget in every developmental programme, especially in large

programmes, which will be used for emergency conditions. Resource mobilisation is possible if there is appropriate situational analysis that supports the need to shift focus.

Regional level

Both IPs interviewed in Amhara and SNNPR indicated that while their country offices may be able to shift resources from other programmes for emergency funding, this is not the case at the regional offices. At the country office level, there may have been a process of moving funding from other programmes towards COVID-19 response. But this was not the case at the regional office. At the regional office, funding sent from the country offices are all earmarked and the regional offices are not able to use funding outside of the assigned activities for a specific budget. The respondent from Save the Children reported that when the COVID-19 pandemic was declared in Ethiopia, they had to ask for new funding because they were not able to shift funding from other programmes towards the COVID-19 response.

Respondents from Harari stated that, according to the protocol budget, budget revision occurs in the region. It is a continuous process. Transferring the budget from unused sectors to another is the task of budget administrators.

> *If we have emergency, we have budget revision every six months and if there is no emergency then we have no revision. Very likely, there is pandemic so I can say we have budget revision every six months. We have budget shortage in general, so budget revision is common*. (Harari)

Similar to the Amhara and SNNPR government responses, Sidama and Dire Dawa respondents also reported that while resource mobilisation from other programmes is not typical, it can be performed with the approval of the regional cabinet. In both Dire Dawa and Sidama, during the COVID-19 pandemic, funds were shifted from other projects that were no longer in progress.

An Oromia respondent from an IP stated that funds are not easily transferred between programmes, because they need to be used for their intended purpose. The RHB, however, stated that it is a common practice to shift both recurrent and capital budgets from one sector to another during emergencies. The shifting of budgets is proposed by the RFB and approval is granted by the bureau head following a presentation.

Resource mobilisation from other programmes to fund emergency health and nutrition emergency is also widely practised in Afar, Benishangul-Gumuz, Gambella, and Somali regions. According to the respondents there, this practice is common for both planned and unplanned emergencies, as there is no earmarked budget in either scenario. Mobilising resources from other health programmes remains the first coping mechanism use to avail immediate and lifesaving supplies during emergencies.

> *Whenever emergencies occur, we immediately mobilise and shift government budget and other resources from the routine health programmes* [budget allocated by the government for non-emergency programmes]*. We also align the emergency response activities and interventions with the routine programme activities. But this is a temporary solution to immediately avail resources for emergency response.* (RHB/PHEM, Benishangul-Gumuz)

Similarly, the NGOs/IPs and partners mobilise resources from other programmes (i.e. from routinely implemented projects) to fund emergency health and nutrition. The respondents from IP/NGOs described the importance of mobilising resources from other programmes or internal sources in ensuring timely emergency response.

> *Since the request and approval process to obtain funding from donors require time, as it should be based on comprehensive proposal developed using assessment findings, we use our internal resource at initial step…for immediate and lifesaving supports.* (IP, Benishangul-Gumuz)

In general, resource mobilisation/pooling from government and non-government sources is the major emergency funding approach in both regions. Respondents from all categories mentioned the application of a resource pooling mechanism in which each stakeholder/partner avails the required resources (either cash or in-kind), as per the assigned responsibility in the agreed joint EPRP. Nevertheless, the budget (money) allocated by most NGOs is not pooled into a single channel/account, mainly because of the financial requirements and regulations of the organisations. Hence, the budget allocated by NGOs will be managed by themselves, in line with their financial regulations and requirements.

4.2.3 Timeliness

Operational definition: Resources are allocated in time for the required needs (or before).

Research questions:

- Are PFM systems in place to enable a timely response to public health emergencies?
- What is the timeline for funding requests?
- What is the timeline for the funds to come through from donors to MoF/MoH?
- Once MoH/EPHI have received the funds/resources, how long does it take for them to transfer money (the approved budget) to regional health offices and to the woreda level?
- When more than one region requests support how does the federal government allocate resources? How long does it take for the regional government to receive the requested support from the federal government?
- What is the process that regional governments (RHBs and RFBs) and woreda health offices follow to request support from the federal government (be that money, equipment, medical supplies, or human resources) and how long does it take? How does the federal government respond to regional governments' and woreda health offices' requests? What kind of processes are in place?
- Does the timescale of the resource allocation allow for the timely provision of emergency health services to the beneficiaries?

Table 14: Timeliness performance standards

Standard	Definition
Advanced	Resources are consistently and significantly allocated in time for the required needs.

Standard	Definition
Established	Resources are allocated in time for the required needs, with minor improvements required.
Progressing	Resources for some aspects are allocated in time for the required needs but are slow for other aspects.
Emerging	Resources are not allocated in time for the required needs.

Federal-level judgement: 'progressing'
Within the government institutions, there are existing systems to facilitate a timely allocation of resources, conditional on the availability of adequate resources and proper documentation. Issues pertaining to bureaucratic administrative procedures, communications chains, and procurement are a barrier to the PFM system offering timely resource allocations. The timely allocation of resources among donors depends on the type of emergency, and when it occurs, and differs from donor to donor. Also, from the donors' side, resources for some aspects – particularly nutrition – are allocated on time for the required needs but may be slower in relation to other aspects.
Regional-level judgement: 'progressing'
Based on the evidence, the timeliness of emergency funding in all regions is 'progressing', as the resources for some aspects (lifesaving interventions) are allocated in time but are slow for full-scale implementation of emergency responses. Overall, the timescale of resource allocation does not allow for the timely provision of emergency response and health services to the beneficiaries (people affected by emergencies) in all regions and city administrations in the study. The emergency funding from partners/donors and the federal government, which are the major sources of funding, is reported to be the most delayed because of the longer time taken for approval and disbursement. On the other hand, the budget allocation at the regional level, through shifting budgets from other programmes and/or from the regional contingency budget, seems to be the quickest and most timely source of funding for immediate and lifesaving emergency responses/interventions. However, the funding from regional sources is inadequate to cover the full-scale implementation of emergency response. The IBEX is a commonly used PFM system in government offices/sectors across the country. The importance of the PFM system/IBEX in facilitating the timeliness of emergency response was cited by most of the respondents. However, other factors are reported to be more important in determining the timeliness of resource allocation for emergency response in general, and the effectiveness of the PFM system in particular. There is relatively quick and timely resource allocation for emergencies that are perceived to be more important in terms of severity (causing mortality and morbidity) and magnitude. Moreover, the timeliness of resource allocation is affected by different factors, which include the lack or absence of an adequate prepositioned or earmarked budget for emergencies, and the existence of lengthy procedures for funding requests, approval, and disbursement.

Detailed evidence

4.1 The PFM system in Ethiopia enables a timely response to public health emergencies

Federal level

First, respondents explained that an integrated financial management information system (IFMIS) and the IBEX are the two financial management systems used in the country. The IFMIS was reported to be used by federal government offices and IBEX by the regional and

woreda-level (as well as the zonal-level)[18] government offices. We asked if these financial systems facilitate a timely response to public health emergencies. GoE respondents explained that these systems were reported to be essential in facilitating documentation, budget request processing, approval, and disbursement of emergency funding to the requesting organisations (federal or regional governments), and thus they play a role in the timely distribution of the resources needed for emergency responses. Moreover, these financial systems aim to enhance accountability, ensure efficiency and effectiveness, and assist budgetary control.

> *IFMIS and IBEX are systems that are in place that are used to disburse funds through banks. Almost all government organisations use IFMIS. It helps facilitate a timely response to public health emergencies, especially IFMIS.* (MoF respondent)

> *When the financial management system works well, every activity, be it an emergency or routine activities, works properly and efficiently. It will also be easy to control. Both IBEX and IFMIS are essential for recording expenses and transactions. We use it to tighten the budgetary control.* (MoH respondent)

However, the availability of adequate resources and proper documentation determines the time it takes to distribute resources for emergency responses.

> *If the budget request comes to us* [MoF] *with the necessary documentation and information, we will process it within two days.* (MoF respondent)

> *There might be an emergency, but the request must include all the necessary documents. … If the institution has prepared all of the necessary documents, then it is possible to finance within a week.* (MoF respondent)

By contrast, according to EPHI respondents, the IFMIS/IBEX is not commonly used. One respondent from EPHI pointed out the problem with accessing these systems:

> *It is troublesome. It doesn't facilitate anything. In IFMIS, someone who is going to approve maybe just be one person. In our section, it is a person who works in finance and general service, i.e. the person who will finally approve the IFMIS for you when you want to do something. This means that I don't have the authority over my budget.* (EPHI respondent)

MoH respondents, on the other hand, stated that the IFMIS and IBEX systems are in place and are very much in use:

> *You can't withdraw money without using the IBEX system or the IFMIS system. There are priorities and there will be an allotted budget for different activities, and as per that responsible finance bureau, health bureau, the regional health bureau, regional finance bureau, or any finance worker on the health sector effects the payment.* (MoH respondent)

Other respondents pointed out that while the systems help financial management in the health sector as a whole, their use for emergency response is not fully clear to them. IFMIS

[18] http://hiwotethiopia.blogspot.com/2010/08/ibex-integrated-budget-and-expenditure.html)

was described by some respondents as a system with limited importance in regard to resource mobilisation and availing emergency funding.

On the other side, donors mentioned that the existing PFM system does not enable a timely response to public health emergencies. Lack of resource allocation dedicated to emergency responses and bureaucratic financial systems were the reasons given for untimely responses to public health emergencies.

> *I don't think so. We are already seeing outbreaks of measles, dengue etc. – we are seeing very slow response time for those. What we are seeing is that after the outbreak, donors are having to step in and finance the response. This has shown to take some time.* (Donor respondent)

Regional level

The IBEX is a commonly used PFM tool/system across all regions and is used to manage budgets allocated through federal and regional governments. The study participants were asked if the PFM system/IBEX facilitates a timely response to emergencies. Most of the respondents believe it does so. They explained the importance of IBEX for tracking/controlling emergency funding, facilitating emergency fund request processing (i.e. request, approval, and budget disbursement/transfer), accurate and timely financial reporting, and documentation of government budgets/expenditures. The importance of IBEX as a data visualisation tool in regard to ensuring the visibility of financial transaction data across government structures (health facility, woreda, and region) was described by respondents from RFBs. Furthermore, some of the respondents mentioned the role of IBEX in ensuring efficient resource allocation and facilitating resource mobilisation for emergency response (shifting the regular budget for a timely emergency response).

> *The system-based approach IBEX has introduced has definitely facilitated and made fund mobilisation efficient. It has definitely made our response timely. It is rare to face delays when it comes to emergency fund disbursement.* (RFB, SNNPR)

> *…knowing the remaining amount of budget under each programme could help to identify budget lines from which budget should be shifted to fund emergency. So, it eases the budget transfer* [shifting] *process.* (RHB, Afar)

> *I believe the existing system facilitates timely response to emergencies. IBEX allows making corrections, adding additional budget, and making modifications. The system is easy to respond to emergencies. Even budget release is made without sticking to the financial bureaucracy.* (DRMC, Somali)

> *IBEX has definitely made a huge difference. Everything is interconnected now and it has really improved our efficiency. It allows us to track both our budget and expenditures simultaneously. Now even woredas are part of the system, which means we can monitor the woredas' budget and expenditure remotely from the RFB.* (RFB, Amhara)

> *IBEX clearly shows where resources can be found. IBEX shows where budges are available. It is not only limited to health sectors. It clearly shows unused budget in any sector in the region. We take that information to the cabinet and prioritise emergency areas*. (XXX, Harari)

On the other hand, a few respondents from Gambella, Sidama, Addis Ababa, and Dire Dawa (mostly from RHBs) said the PFM system/IBEX does not guarantee timeliness. According to these respondents, the timeliness of the emergency response is mainly determined by other factors, such as the availability of earmarked or prepositioned budget or supplies, the adequacy of resources, the urgency of the problem (i.e. the magnitude and severity, and the degree of political concern), and the level of attention and commitment given to the emergency response.

> *The financial management system is really challenging. One thing is that there is no budget dedicated to emergency response that we manage*. (RHB, Gambela)

Furthermore, a respondent from Benishangul-Gumuz expressed his concern regarding the absence of an integrated PFM system that can be used to administer and manage emergency funding mobilised from different sources (government and partners, NGOs/IPs). The IBEX is used only to manage the budget allocated by federal and regional governments.

> *Lack of budget integration* [partner-allocated and government budget] *to a single financial management system has created challenges in monitoring budget utilisation and timely reporting. Partners have their own report requirements and formats, which is not in line with the government reporting. This has resulted in challenges related with reporting burden, and use of different reporting formats to fulfil requirements of different donors.* (RFB, Benishangul-Gumuz)

4.2 Timeliness of allocating the resources

Federal level

The time that is required to mobilise and distribute resources is affected by different factors. These factors include bureaucratic systems, logistical issues, and security issues. The magnitude of crises, including the number of people affected and resource availability, also determines the time it takes to mobilise and distribute resources to respond to emergencies. If a huge number of people are affected, a large number of vehicles will be required to transport the supplies. In this case, the logistic arrangements and transportation of items to the distribution area can take a long time. Another factor that can result in a delay is the absence of timely and complete reporting on the occurrence of the emergency and the number of affected people. Sometimes, woredas or zones fail to report emergencies, or the number of people affected is not reported accurately or in a timely fashion. Exaggerated reporting is also another issue that was mentioned by the respondents: woredas request support for a huge number of beneficiaries, and people who are not eligible are included in the list.

According to the respondents from MoF, the funding/budget approval process for emergency health and nutrition is much swifter given the urgent need to respond to emergencies. MoF gives high priority to budget allocation requests related to emergency responses. Most of the respondents mentioned the existence of a highly flexible internal (government) budget allocation mechanism that ensures the timely availability of resources for emergency responses.

> *The emergency funding request could be processed, and the budget disbursement will be made within 24 or 48 hours. When it comes to emergencies, you do*

> *everything in your power. … The funding process could take one to three days; we monitor the situation and allocate as soon as we can.* (MoF respondent)

On the other hand, some respondents reported the existence of intermittent situations in which the allocation of budget for emergency requests is delayed: for example, when the amount of required funding is more than the available contingency budget, which is the primary source of emergency funding within the GoE. In this case, a supplementary budget (an additional budget request – availed upon approval by the parliament) is needed, which requires a longer time to be approved. Moreover, a few respondents mentioned delays in budget allocation because of the extensive resource mobilisation process, mainly due to strict documentation requirements and the time-consuming approval process in some of the donor organisations (who provide funding to the GoE).

EPSA's Procurement Directorate gives high priority to the procurement of emergency commodities, to ensure the timely availability of products for emergency responses, and the Contract Management Directorate does the same. In the case of an emergency, they stop routine activities and fully dedicate their time to the preparation of contracts for the procurement of emergency commodities. Similarly, insurance agreements and port clearance activities are also expedited during emergency response. In general, EPSA exerts the maximum effort to ensure the timely procurement and distribution of commodities for emergency responses.

EPSA respondents are among the few government key informants that stated that the current mechanisms in place allow for a timely response and the availability of supplies during health and nutrition emergencies.

> *The speed at which we procured and availed COVID-19 commodities was unbelievable! We had active taskforce that involve all relevant stakeholders, including regulatory body, the National Bank, and Customs Authority. The coordination of these stakeholders greatly facilitated the procurement process, transportation, and distribution of COVID-19 commodities. The taskforce members were very helpful in loosening strict requirements and avoiding some of bureaucratic procedures, which could have delayed the procurement.* (EPSA respondent)

According to the donors, it can take from a few days to a couple of months to mobilise and release the funds required for emergency responses. Overall, the time between the onset of an emergency health and nutrition crisis to the allocation and release of funds varies from donor to donor. Some donor respondents reported that their respective organisations have utilised financial options and crisis modifier systems to ensure timely allocation and release of resources to respond to emergencies. The crisis modifier system, the existence of a contingency budget, a bridging financial option, and a 'buffer stock system', enable timely allocation and release of funds to respond to emergencies.

> *Well, it depends on the onset of the crisis, provide funding can take anywhere from 10 days to three weeks. This is due to the fact that donors have different modalities, different conditionality, and different ways of doing business. In some cases, like nutrition, we have what we call bridging finance options. This financial option is intended for prompt response to a nutritional crisis until the fund is secured from donors.* (Donor respondent)

> *Our partners have buffer stock system in which they quickly avail nutrition commodities/supplies and fill gaps, even before they get award* [fund]*. This system allows our partners to have a response capacity to timely respond for emergency needs.*

According to some respondents, the complex procurement process, the administrative burden (signing of agreements), delays from the EPHI side (in terms of request), and the magnitude of the crisis were reported to be among the challenges for timely response to emergencies. The type and source of funds were also reported to determine the time needed to respond to emergencies: for example, the timescale can vastly differ if the funds are released from internal resources or requested from donors.

> *It could take four to five days to release funds for emergency response. If there is money in the in-country office's bank account, funds could be released easily. However, problems related to communication channels and delays from the EPHI side contribute to the extended time to release funds.* (IP respondent)

A donor respondent stated that they can mobilise fairly quickly because they already have emergency resources at the national and regional levels. In addition, they have warehouses that can supply the urgent need for medicines and supplies if required.

> *It may not be enough to be able to adequately respond to the medical emergency, but we are often the first responders when it comes to emergencies. So that's something that we can trigger and deploy, as soon as possible.* (Donor respondent)

However, the administrative process can take four to six weeks. The need to have a formal agreement, which varies across the regions, was also reported to contribute to delays in the provision of emergency services. The relationship between IPs and regional authorities has the potential to determine the timeliness of the response to public health and nutrition emergencies.

According to IPs, if the funds are being mobilised internally from the IP's internal fund, the mobilisation time is very quick. However, if additional funds have to be requested from donors this can increase the timescale by weeks or even months. The funding release itself can involve its own delays. If funding approval is requested after the emergency has already occurred, there can be a lot of delays from the donor's side. This might be because the required criteria were not fulfilled by the requesting organisation.

Another reason for delays highlighted by an IP respondent is the time it takes to hire and deploy emergency personnel. When an IP does not have in place a rapid recruitment process for emergencies, the regular recruitment process can end up delaying the deployment and response. The same IP respondent pointed out that while it is able to mobilise internal funds for a quick response, this is usually a very small amount, and they almost always have to go to donors for additional funding, which prolongs the response time. Also, the time it takes to disburse funds to local IPs presents a challenge and can lead to further delays.

Another IP stated that in cases where the emergency is already expected or predicted, donors will allocate funding ahead of its occurrence. However, in other cases the funding can be received after the emergency has already occurred. This can be as late as one or two months after the emergency.

One IP reported a different experience when it comes to the time of resource allocation. When an emergency occurs, they receive an assessment report and response plan from requesting partners or governments and requests for approval from the concerning clusters. For instance, if there is a need for emergency health response, they request approval from the health cluster and provide the support within 72 hours after approval (the approval process itself can be completed within 24 hours). If they request funds through a proposal, it may take up to six weeks to obtain approval from potential donors. There are different application templates for different donors and the time it takes differs by the donor. We note that the fact that IPs, donors, and the GoE gave mixed responses in terms of timeliness could signal a lack of coordination.

Regional level

The lack of timely resource allocation that ensures the timely provision of emergency response and health services to the beneficiaries (people affected by emergencies) was reported to be a major challenge across all regions and city administrations in the study. The respondents from the regional government sectors and IPs/NGOs widely described delays in getting emergency funding from partners/donors and the federal government.

> *The funding from partners is much delayed. There are situations in which the funding was disbursed after we managed the emergency. For instance, funding aimed at responding to flood may come on October given the fact that the funding should come in July or in August.* (RHB, Afar)

> *We can take the recent locust infestation as an example – during that time, we asked for funding to purchase the chemicals, and the spraying equipment. … We actually got approved for funds after the locust had already moved well outside of the region*. (IP, Amhara)

On the other hand, the emergency funding from the regional government, which is obtained through shifting from other programmes/sectors or from the contingency budget, was mentioned as the quickest resource that is used to implement initial and lifesaving emergency response interventions. The respondents from government sectors in all regions and city administrations mentioned the existence of a quick and simple budget processing (request, approval, and disbursement) mechanism that accounts for the urgency of the emergency funding/response.

> *We* [the RHB] *will mobilise funding from internal sources to quickly act when emergency happens, then we immediately submit the emergency response plan with budget proposal (funding request) to the EPHI (federal).* (RHB/PHEM, Benishangul-Gumuz)

> *The regional funding is quick. The only time it takes is gathering the regional parliament for the final decision and approval. Then the disbursement is also quick. There are also situations in which the regional cabinet, without calling the parliament, approve the funding for urgent emergencies.* (Regional DRMC, Afar)

Similarly, some of the IP/NGO respondents from Afar, Gambella, and Benishangul-Gumuz regions mentioned the existence of internal funding mechanisms and/or reserved budgets labelled as crises modifiers for quicker emergency funding, which ensure the timely provision of lifesaving health services and support. However, these funding mechanisms are

unable to allocate adequate resources for implementation of full-scale emergency response/interventions.

> *We release fund from its internal resources allocated for regular programmes. This budget will be used as a bridging fund to avoid gaps until the main emergency funding is mobilised and secured.* (IP, Afar)

In addition, IP/NGO respondents from Afar, Gambella, and Benishangul-Gumuz regions frequently mentioned how the timeliness of emergency response was aided by the availability of pooled and prepositioned emergency funding through the SWAN consortium. However, the coverage of this funding is limited to only a few operational areas/woredas within these regions.

> *Our organisation is a member SWAN project. In this project, the fund is allocated for each year. Items need for shelter and NFI are readily available at the national level. We also have contingency items at the regional level. Therefore, it is possible to respond within three to four days.* (IP, Gambela)

The lack/absence of an adequate prepositioned/earmarked budget for emergencies was the most frequently cited reason for the existing delays, by all categories of respondents. In addition, failure to mobilise resources prior to the occurrence of an emergency, and the existence of length procedures for funding requests (the time taken to conduct assessments and prepare proposals), approvals, and disbursement, were mentioned as underlying causes for delays in emergency funding and response.

> *If there is a dedicated budget line and contingency budget available, it does not take time. If there is a need for new budget approval, it could take more than six weeks.* (RFB, Somali)

Moreover, all categories of participants from all regions and city administrations mentioned variation in the timescale of resource allocation based on the level of priority given to the type of emergency. There is relatively quick resource mobilisation and budget allocation for emergencies that are perceived to be more important in terms of severity (causing mortality and morbidity) and magnitude.

> *… it could take months to develop a proposal, get donors' approval, and receive funds, which does not allow for the timely provision of support.* (IP, Gambela)

Furthermore, some of the government and IP respondents from SNNPR, Gambella, and Benishangul-Gumuz regions mentioned bureaucratic and lengthy procurement systems, logistics and transportation issues, the inaccessibly of woredas due to poor road infrastructure and security problems, as contributing factors leading to delays in responding to emergencies.

> *We mainly delivery food and non-food item support and the delivery time depends on availability of transportation, accessibility, the distance of the woredas we need to reach. … the timescale is so long that by the time the funds are released, the emergency has already claimed many lives.* (SNNPR DRMC)

Borrowing from the regular budget, to be reimbursed when emergency funding is obtained, credit purchase of supplies, and shifting or reallocating budget from other programmes to

emergency response were the most frequently mentioned coping mechanisms used to overcome challenges associated with delays in receiving funding for emergency response.

4.2.4 Good coordination

Operational definition: All actors involved (government at all levels, donors, IPs) agree in advance what their roles are and there is a clear division of labour and responsibilities; clear workplan and good communication between actors before, during, and after the emergency (recovery) which helps prepare for the next emergency/crisis.

Research questions:

- Do actors involved have a clear understanding of who does what?
- Are good communication strategies in place?
- Is there duplication of efforts?
- How do NDRMC and MoH collaborate and work together at the federal level, and at the sub-national level?
- When and how is MoF involved when a health and nutrition emergency happens? How does the information (the need for more money) reach MoF?
- How does EPHI work with MoH and regional health offices? How do they coordinate? Do they have an agreement? What does the PHEM system look like at sub-national level? Does the regional PHEM team report to EPHI? Does EPHI support the regional PHEM team when an emergency happens? What kind of support do they give? How does EPHI support regions and woredas?
- Do the current emergency financing arrangements and structure (including pooling and mobilisation of resources) promote coordination across the different actors involved in health emergency preparedness, response, and recovery programmes/interventions? (*Adapted from HFPM Q7.2)*

Table 15: Good coordination performance standards

Standard	Definition
Advanced	Actors' roles and responsibilities are clearly defined for the emergency financing system overall. All actors are systematically involved, and communication strategies function very well.
Established	Roles and responsibilities are clearly defined and divided collectively among the actors in emergency health financing, although better coordination is still required. Communication strategies are in place and function relatively well.
Progressing	Some roles and responsibilities are defined and divided across the actors in emergency health financing, but poor coordination remains. Some communication strategies are in place but they remain weak.
Emerging	Roles and responsibilities are not clearly defined among the actors involved in emergency health financing, and there is no clear division of labour and responsibilities (government at all levels, donors, IPs); there is poor coordination among actors, and there are no clear communication strategies.

Federal-level judgement: 'progressing'
Some roles and responsibilities are defined among actors, with NDRMC as the principal coordinator of stakeholders and resource mobilisation for emergency responses. There are established communication strategies, such as taskforces, technical working groups, and humanitarian clusters, between and within the government and development partners. There are contradicting claims: some government institutions claim donors do not coordinate well with the government and among themselves, and, on the other hand, donors claim they coordinate well with the government. This is sign that the existing communication strategies are not very functional and better coordination is required. IPs seem to coordinate and communicate well with both the government and donors.
Regional-level judgement: 'progressing'
There are established communication strategies, such as technical working groups, humanitarian clusters, taskforces, and emergency coordination committees, across the regions. Clear roles and responsibilities across the different actors are less evident from the regional research findings. The existing communication strategies are not very functional due to the lack of commitment to consistently convening and sharing information among actors. Other consequences of weak coordination that were reported were duplication of efforts and resources.

Detailed evidence

5.1 Coordination among the actors

Federal level

According to the GoE, there is a coordination mechanism for both health and nutrition. At the national level there is the ENCU, which is led by NDRMC. UNICEF leads the nutrition cluster, but the coordination is led by NDRMC. Partners involved in the unit have signed a memorandum of understanding with the government and actively work with line ministries and supporting partners. EPHI is responsible for health coordination.

A few respondents from MoF mentioned the establishment of *ad hoc* committees or teams when an emergency occurs. Nevertheless, none of the respondents from MoF mentioned the existence of a permanent coordination platform for emergency funding and response. The emergency response committee for health and nutrition is established and led by MoH and serves as the major coordination mechanism in which relevant stakeholders (governmental organisations and non-governmental/donors) who can contribute to the emergency response are involved. The emergency response committee or team is responsible for the overall coordination of activities, which includes resource mobilisation, planning and budgeting, facilitation of adequate emergency funding/budget allocation, and follow-up of the emergency response interventions. One of the respondents also mentioned NDRMC as being principally responsible for the coordination of stakeholders and resource mobilisation for emergency responses.

Respondents from EPSA stated that EPSA works jointly with many partners, including MoH and EPHI, when it comes to emergency health and nutrition scenarios. MoH and EPHI make requests when public health and nutritional emergencies occur and based on the request, EPSA conducts the procurement of drugs and supplies to be used for the emergency response. EPSA also closely works with various other stakeholders from governmental and non-governmental organisations. MoH, the Food and Drug Association, the Customs Authority, the National Bank, and Ethiopian Airlines are the governmental institutions

considered to be major stakeholders. Various organisations like UNICEF, WHO, and the Global Fund are among the major non-governmental partners.

EPSA uses two types of coordination platforms: a technical working group and a taskforce. The technical working group is established for the coordination of routine procurement activities, and the *ad hoc* taskforce is established for coordination of procurement during emergency responses. Both the taskforce and technical working group platforms involve representatives from donors, MoH, and EPSA directorates (Quantification and Market Shaping, Contract Management, Tender Management, Warehouse and Inventory Management, and Fleet Management Directorate). Additionally, the emergency taskforce can involve other stakeholders, such as the Food and Drug Authority. The technical working group has a regular weekly meeting, which is held every Thursday. In the case of the emergency taskforce, there are more frequent meetings – these can be on a daily basis.

As with the other cluster meetings discussed by other respondents, EPSA's coordination platform mainly aims to facilitate communication among the internal and external stakeholders. During the technical working group or taskforce meetings the members discuss challenges and required actions to address current challenges. These platforms are important in facilitating the procurement process. The Deputy General Director of EPSA or the Chief of Staff is responsible for leading the taskforce. The Chief of Staff is also responsible for follow-up of action points from the taskforce meetings.

The respondents described the importance of the coordination mechanism in facilitating the funding process and ensuring the efficiency of emergency responses.

> *There is an institution* [the ministry that is primarily responsible for emergency response] *that coordinates the emergency response. If not, it will be difficult for MoF to process fragmented requests by different governmental institutions. The existence of stakeholder coordination plays vital role in ensuring efficient and optimal resources for emergency response.* (MoF respondent)

> *Emergencies might not be alleviated by one sector, there should be more collaboration between line ministries. Rather than putting a committee when something happens, there should be rules and regulations on how they communicate.* (MoF respondent)

The respondents were asked about their working relationship with development partners/donors for emergency responses. Some of the MoF respondents highlighted the contribution of development partners/donors in terms of their technical capability or expertise in emergency response activities, and the additional resources/funding they bring for emergency responses. Respondents also mentioned the significant funding contribution of development partners/donors to the health sector through pooled funding mechanisms, mainly the SDG funding.

On the other hand, some of the respondents mentioned that there was **an absence of strong coordination among development partners and government institutions/ministries, and a failure to align their funding or interventions with some of the government priorities**. According to some of the respondents, development partners lack coordination among themselves, resulting in duplication of effort and inefficient resource utilisation. One of the respondents from MoF described the existence of improper and

inefficient resource allocation because of poor coordination between development partners and MoH:

> *Some of the development partners go straight to the region without the coordination of the Ministry of Health in that case the balance and formula* [budget allocation] *is affected. So, every development partner should go to the Ministry of Health and the Ministry of Health should also report back every expenditure to the Ministry of Finance.* (MoF respondent)

From the donor's perspective**,** coordination mechanisms, such as technical working groups and cluster meetings, are reported to be in place among actors involved in emergency responses to ensure that they have a clear understanding of their roles and avoid duplication of efforts. Technical working groups and cluster meetings were repeatedly mentioned as **communication mechanisms** for communication between the different actors involved in emergency responses. The donor's working relationship with the government was expressed as their involvement in different taskforces, the establishment of ENCUs, and the establishment of disaster response teams. All respondents reported regular relationships and coordination with EPHI, MoH, and the different regional health structures.

The ENCU serves as a bridge between the government, NGOs, and donors for emergency nutrition response:

> *As far as I am concerned, we don't directly coordinate with the Government of Ethiopia, but the Emergency Nutrition Coordination Unit* [within MoH] *serves as a middleman between NGOs, the GoE and donors.* (Donor respondent)

According to most of the IP respondents, IPs are a part of the health cluster (headed by WHO) and the nutrition cluster (headed by supported by UNICEF and NDRMC), where emergency response is planned and coordinated. The health and nutrition clusters are the two main emergency humanitarian coordination mechanisms/platforms. Whenever there is an emergency, IPs coordinate through these platforms to avoid effort duplication and maximise effectiveness and efficiency – and to some extent sustainability. Each cluster coordinator will approach humanitarian implementors and discuss and assign where each IP should focus their efforts. Overall, respondents agree that, in general, these platforms and response mechanisms seem to be well-coordinated and well-guided.

IP respondents outlined that they have good coordination and working relationships with the federal as well as regional governments – namely MoH, NDRMC, the Ministry of Women and Children's Affairs, and the Ministry of Water and Mines. They have a very close relationship with MoH due to the fact that they provide it with TA, advisers for different health and nutrition activities, as well as other developmental programme support.

Regional level

Study participants mentioned the importance of coordination platforms for joint planning, resource mobilisation, and efficient implementation of emergency response interventions. In Afar and Benishangul-Gumuz, respondents from both regions underlined the key role of coordination in ensuring efficient use of resources through minimised duplication of effort. Technical working groups reported to be the main communication platform, where multiple actors, across various sectors, meet to update each other on their activities.

> *The taskforce plays great role in avoiding duplication of efforts and resources. Every partner will present progress report for the action points it is responsible for; hence, gaps and challenges will be identified, and another partner might be assigned to fill the gap. The progress update presentation during the coordination meeting serves as a mechanism to identify problems associated with resource utilisation.* (IP, Afar)

In both the Afar and Benishangul-Gumuz regions, the emergency response planning and execution is coordinated through a cluster-based approach. Health and nutrition is one of the eight clusters led by the RHB and the regional Public Health Institute, and key stakeholders such as WHO, UNICEF, World Food Programme, and other NGOs are involved. The cluster approach serves as a coordination mechanism in which the member organisations collaborate on emergency response planning, resource mobilisation, execution of emergency response interventions, and M&E of the emergency response (during and after the emergency).

Coordination is strong in Oromia, with multiple coordination platforms used for effective emergency management. The DRMC has a technical working group that is co-chaired with UN-OCHA. This platform was mentioned by both respondents in Oromia and Gambella. There is also a nutrition cluster led by the DRMC, co-chaired with the World Food Programme and the Emergency Coordination Centre. All coordination platforms have strong linkages. Respondents in Dire Dawa noted that taskforces differ from emergency to emergency.

> *Depending on the emergency we have different taskforces. If it is a flood emergency, then we have a flood taskforce and if it's a nutrition problem we have the nutrition taskforce. When we go out for observation and assessment, we also have the technical team with us.* (DRMC, Dire Dawa)

In the Amhara and SNNPR regions coordination is mainly through the regional government-headed health cluster and emergency operation centre. Coordination during the COVID-19 pandemic was very strong, with three-tiered coordination. There is also the incidence management system which outlines all aspects of response and coordinated medical services in the region. This exists at all levels where incidence is tracked and surveillance is done. At the kebele level, Amhara and SNNPR use this as a means of disseminating information to the community. Similarly, in Afar and Benishangul-Gumuz respondents noted the existence of an emergency coordinating committee/centre that oversees and coordinates any emergency response activity in the region. The regional emergency coordinating committee/centre is led by the regional DRMC commissioner, and representatives from the eight clusters are involved as members.

The RFB in Amhara region participates in working groups and cluster meetings with different sectors. For example, during the response for COVID-19, the RFB was heading the resource mobilisation efforts and headed those working groups and commission meetings. When it comes to resource mobilisation during emergency response, the RFB leads those meetings and coordination.

In the Harari region, there are vertical and horizontal programs. The vertical programs have mechanisms whereby the national government supports regions. The directorate itself communicates directly with EPHI. Financial issues are communicated through the Finance Bureau. The Finance Bureau Communicates directly with the Finance Ministry. Except for

the Covid incident, other health related emergencies are dealt with the region's regular budget. We request EPHI support and if they agree to support us they communicate with the Finance Bureau through an officially signed document.

The emergency operation system for COVID is still active and meets every Thursday morning to present updates on health emergencies in the region. Every Wednesday, every actor (donor, partner, NGO) is also obligated to send in reports to the emergency operation centre on their weekly activities and updates.

5.2 Coordination of resources and funds

Federal level

NDRMC is mainly responsible for the coordination of stakeholders and resource mobilisation from internal and external sources (donors). MoF is responsible for budget allocation, approval, and disbursement, and follow-up expenditures for the emergency response. MoF is the only institution mandated to approve budget shifting or redistribution of resources between sectors and/or regions.

One donor respondent explained that there are procedures to ensure rapid redistribution and coordination of funds among the actors involved in supporting emergency health and nutrition financing. According to the respondent, the United Nations Office for the Coordination of Humanitarian Affairs is responsible for pooling together resources from donors, the government, and others into a single fund to be used for emergency response.

> *The Ethiopia Humanitarian Fund, a country-based pooled fund, is also a multi-donor humanitarian financing instrument established by the Emergency Relief Coordinator and is managed by the UN-OCHA to allow for rapid redistribution and coordination of funds and resources at the country level under the leadership of the Humanitarian Coordinator.* (Donor respondent)

Similarly, IP respondents mentioned that different platforms, such as cluster meetings and NGO forums, are used to identify potential funders, and also partners for applying for potential funds. Furthermore, one IP respondent identified UN-OCHA as the main coordinator, which plays a key role in the allocation and identification of partners for funds – especially for major funding in an emergency context. The Ethiopian Humanitarian Fund, also coordinated by UN-OCHA, was identified as one of the mechanisms in place for the redistribution and coordination of funds and resources among involved actors at various levels.

Regional level

In Amhara, Harari, Oromia, and Sidama, respondents stated that it is not common to rapidly redistribute and coordinate funds. In Oromia they noted that it is common for government funds to get shifted from one programme to another, but not between sectors, and in Sidama there were reported to be instances of materials being redistributed.

> *Yes, for example when there was a malaria outbreak, the Ethiopian Pharmaceutical Agency – well for example with malaria there are many items needed in order to respond to an outbreak, like lifesaving drugs. If there are extra resources like*

> *mosquito nets, then there is the possibility of moving resources form one woreda to another with the written approval of the bureau head.* (RHB, Sidama)

IPs in SNNPR and Amhara reported that they do not co-apply or work in consortiums at the regional level. If there are multiple partners working on a similar issue and they have overlapping interventions, they will approach the regional government to conduct a mapping exercise and assign and allocate activities to different partners, to avoid duplication.

In Addis Ababa, Benishangul-Gumuz, Dire Dawa, Gambella, Somali, and Dire Dawa, there is a system in place to redistribute funds from programmes and sectors. Specifically in Dire Dawa the system is called sub-duty, whereby personnel from all facilities are deployed to affected areas and resources are handled centrally.

> *In case of a shortage of supplies, we commonly redistribute resources between woredas. For example, flooding commonly affects Jore Woreda, and SAM* [severe acute malnutrition] *cases increase as a result. We take supplies needed for the management of SAM cases from the adjacent woredas in case of shortage.* (RHB, Gambella)

> *We use the coordination platform to ensure fair and proper distribution of resources. There is situation in which extra resources are allocated to certain woredas, due to overestimation or considering the worst-case scenario* [the maximum impact that the emergency could cause]*. In this case, the taskforce will discuss with the higher officials to facilitate reallocation by shifting resources from the areas with extra resource to the areas with shortage of resources*. (RHB, Benishangul-Gumuz)

Across most regions the main challenge to coordination that was reported is a lack of commitment and consistency; this includes a lack of regular meetings and delays in providing meeting minutes. Particularly in Amhara region, participants noted a lack of consistency with regard to commitment to meeting: in the beginning of an emergency commitment to attend meetings is higher than towards the end. Similarly, in SNNPR, participants noted that not everyone will convene and share information as consistently as they should. There is a lack of commitment from actors and stakeholders. This contributes to the region's inability to respond to emergencies and public health concerns internally as well.

> *The coordination has been continuous and extensive. For the last 1.5 years, we have met every single week and have dispatched more than 80 situational reports on the conflict-affected communities. Similarly, we have been very consistent on our COVID-19 coordination as well. However, we are currently seeing multitudes of issues come up and when new priorities start presenting themselves, it becomes hard to stay consistent*. (APHI)

Participants in SNNPR reported that one reason for weak coordination is the vastness of the groups who are invited to participate in the groups and cluster: too many people are invited to participate.

Respondents in SNNPR noted a lack of commitment from partners and donors: they do not attend coordination and planning meetings until the last minute, and then they join response efforts.

> *This usually leads to duplication efforts and lot of inefficiencies. There is also sometimes misalignment on where the emergency is and where they choose to implement their activities, which is further evidence of their lack of communication and coordination with the Regional Health Bureau and other regional sectors.* (SNNPR, RHB)

Specifically in the Harari region, respondents noted challenges relating to coordination are the issue of status, inadequate resources, a knowledge/understanding gap on the disaster risk management policy, the absence of an emergency coordination centre in the region, and a lack of infrastructure (like the internet) to make use of modern technologies to facilitate the communication.

> *The issue of status is one factor creating a gap in the coordination activity when we call on all sectors. A body found at the level of a lower organisational structure level cannot call on to heads of sector bureaus. Sector Bureau heads answer to somebody found above them on the organisational structure. Second is the issue of resource. We require logistics and finance to call professionals from sector bureaus for a meeting or to send them out to field data collection task. If we don't get access to resources like logistics, vehicles, or meeting halls when we want them, it is going to affect the coordination activity we do.* (DRMC, Harari)

Respondents in Gambella believe that there is considerable resource duplication in the region. This is due to relatively weak coordination mechanisms, duplication of efforts, and inefficient resource utilisation, which were reported to be common. Resource duplication was also attributed to the lack of a resource pooling mechanism, and CRRF, which requires all partners operating in the refugee camps to also support the host community.

> *Resource duplication is common. Similar capacity-building training could be provided. This duplication is due to the CRRF that all partners operating in refugee camps must be supporting the woredas hosting the refugees. The second reason for the duplication of effort could be direct support provided to the RHB by UNICEF and the EU* [European Union] *to support health and nutrition activities in the region.* (IP, Gambela)

A noted weakness of development partners in Dire Dawa was not having a clear exit strategy. The RFB spoke of a United States Agency for International Development food distribution programme being implemented by Catholic Relief Services: without a clear exit strategy, they withdrew from leading distribution, and the respondent spoke of projects not having clear handover procedures with the government, leaving communities more dependent than they were before.

In Sidama region one challenge with development partners is the fact that the region is still relatively new. As a result it is hard for development partners to understand who and when they are supposed to help. It was noted that specifically WHO and UNICEF work very slowly, and that even if there is an emergency, they only support the areas that they mapped initially. As the region is fairly new, it has not yet been fully mapped.

4.2.5 Accountability and transparency

Operational definition: There is a clear and standardised reporting system that can help track and trace resource allocation and expenditures, and this information is available to the public.

Research questions:

- Is there a specific reporting system for emergency health financing which can help track how the funds are spent at all levels (beyond the standard reporting of health financing)? Is there a written document (standard operating procedure)?
- Is the reporting system transparent and standardised across channels?
- Is information shared appropriately between government departments, international NGOs, and donors?
- Is the emergency health expenditure reporting comprehensive, timely, and publicly available? (*Adapted from HFPM Q6.5)*
- Do reporting and data meet expected quality standards?

Table 16: Accountability and transparency performance standards

Standard	Definition
Advanced	Accountability mechanisms are very functional, and stakeholders are publicly accountable for performance. There is a clear and standardised reporting system that can help track and trace resource allocation and expenditures, and this information is consistently and openly available to the public.
Established	Accountability mechanisms function relatively well. There is a standardised reporting system and resource allocation, and use is regularly tracked, with minor improvements required. Information is publicly available but still needs improvement.
Progressing	Some accountability mechanisms are in place but they remain weak. There is some form of standardised reporting system, but resource allocation and use are not regularly tracked, and information is not consistently available to the public.
Emerging	Accountability is weak. There is no clear and standardised reporting system that can help track and trace resource allocation and use, and this information is not available to the public.

Federal-level judgement: 'progressing'

Some forms of accountability mechanism exist within the government, donors, and IPs. IPs, such as Save the Children, demonstrate some public performance accountability to beneficiaries. Standardised reporting systems seem to exist within the GoE, donors, and IPs, but whether these are very functional, especially within government, is not clear. Regular tracking of resource allocation and use seems consistent in MoF and among donors. This is not clear for other government institutions and IPs. According to some respondents, especially donors, information is available publicly, but the overall information is not public.

Regional-level judgement: 'progressing'

Across nearly all regions, funds received from various sources are tracked and monitored using the government PFM system (IBEX). In Amhara and SNNPR, reports are also collated from woredas, to zones, to the region, and all the way up to their federal counterparts as well, following an emergency response. In Harari, there is a PFM team that controls and monitors budgets. In Somali, there is an emergency bank account and withdrawals are only made with the approval and signature of authorised personnel. Supportive supervision, review meetings, joint monitoring visits, and after-action reviews are some of the accountability mechanisms used to ensure proper budget utilisation across woredas, in Afar, Benishangul-Gumuz, and Gambela. Regional IPs have their independent tracking systems, which are shared with donors and government counterparts. There is limited transparency and accountability to the public, except for Gambela and Somali IPs, which ensure accountability to beneficiaries.

Across regions, reporting on expenditure of emergency funding allocated by the government is integrated with the regular reporting system – commonly through IBEX. There is thus no separate reporting on emergency health financing within the government system. There are separate reporting mechanisms and formats for donors; these tend to be standardised and vary according to donor. In SNNPR, Afar, and Benishangul-Gumuz, the regularity and timelines of reporting need to be improved as emergency reports are delayed due to various logistical issues. Statements of expenditure or expenditure reports are some reporting mechanisms used in Harari, depending on who provides the funds. In Gambela, reports are accessible to the public following formal requests and approvals.

Overall, some accountability mechanisms are in place but they remain weak. There is some form of standardised reporting system, for resource allocation and use, but information is not consistently available to the public

Detailed evidence

6.1 Accountability mechanism

Federal level

According to GoE respondents, financial systems such as the IBEX and IFMIS are used to track funds for emergencies and to ensure accountability in the utilisation of funds. MoF employs various accountability mechanisms in which the funding is monitored or tracked to verify the proper and efficient utilisation of the budget for the intended objective or activity. The M&E and Treasury directorates of the MoF are primarily responsible for conducting budget tracking and performance auditing across the federal and regional organisations.

Respondents also mentioned that the IFMIS is used by the federal and regional institutions to report their budget expenditure/utilisation to MoF on a quarterly basis. In addition to the quarterly reports, the IFMIS is also used to track budget utilisation. Furthermore, MoF conducts joint (with representatives from donors and MoH) on-site monitoring visits to verify/validate the reports. One of the respondents mentioned an evaluation by an independent team for EU funding.

However, EPSA respondents stated that once the supplies are delivered to health facilities, there is no mechanism to track the delivery of the commodities to beneficiaries. There is a facility assessment, which is mostly done by donors to see the availability of required commodities at health facilities. However, the assessments can only provide information about the availability of commodities at health facilities, not whether they reach the beneficiaries who need them or not.

Respondents from donor organisations reported the existence of mechanisms to ensure accountability in the utilisation of funds allocated to respond to emergencies. According to these respondents, there is a clear reporting system that is used to track the expenditure of resources allocated for emergency responses. Regular reporting by the government and IPs, and third-party monitoring systems, are among the mechanisms used to ensure accountability. One donor respondent also mentioned that financial narrative reports are part of grant agreements and are a requirement for grant funds to be released. According to another donor respondent, there is a mechanism to track the funds allocated to health and nutrition emergency programmes and interventions. Expenditures are tracked on a weekly basis and a formal report is generated at the end of the year and made available to the public. The government submits reports on the utilisation of funds provided, which is a prerequisite for the next funds to be released. IPs prepare more disaggregated reports based on a template prepared for the purpose.

> *We produce situation reports that are submitted to donors and the government. These situation reports show how much* [money] *we have received and how much has been spent, what has not been spent, what is in the pipeline, and how we plan on using those unspent funds. At the end of the year, we do a formal report that is available to the public.* (Donor respondent)

> *We have agreements with government and non-governmental partners that we work with, where we set deliverables and indicators. Our monitoring mechanism is based on those agreements with our IPs. As a part of these agreements, IPs are expected to submit technical reports outlining the activities and achievements.* (Donor respondent)

The strength of accountability mechanisms seems to vary across the implementing organisations interviewed. One IP has two accountability mechanisms: one is expenditure reporting to the government, which includes the number of beneficiaries reached; the other is a NHA exercise led by MoH, where the IP communicates the amount of funding received for nutrition and health emergencies, which donor it came from, the types of interventions in a given project, the amount spent, and the beneficiaries reached.

Another IP's accountability system is integrated with their monitoring, evaluation, accountability, and learning (MEAL) system. This includes sharing information with the beneficiaries of the intervention's objectives and the kinds of activities to be carried out. It also communicates the benefits they are going to receive and who is responsible for the implementation. This allows for an accurate beneficiary selection, beneficiary verification, and distribution of supplies. The same IP also has an accountability system at the community level which involves a complaints and feedback mechanism, including complaints committees and registration books for feedback. Initial workshops are often launched with the government and community partners to share information on the definitions and objectives of the project, the operational area, the budget amount, and the

involved partners and their roles and responsibilities. Additionally, this IP also produces periodic reports that are often shared with donors and government structures at various levels. This ensures transparency on-budget utilisation and also on the programme implementation.

Other respondents noted that while they do have M&E systems, they are not very strong, and they are not always able to keep up with them and to monitor and evaluate to the extent that they would like to, due to the ever growing and overlapping emergencies in the country. They reported that they are not always able to keep up with the original M&E plan and to track and monitor everything they set out to track.

Regional level

In most of the regions (i.e. Amhara, SNNPR, Harari, Sidama, Afar, and Benishangul-Gumuz, Gambela, Somali, and Dire Dawa), the respondents mentioned routine financial reporting (quarterly reports) and IBEX as accountability mechanisms through which expenditures are tracked and controlled. The funds received from various sources are tagged and tracked using a PFM system – IBEX. The IBEX financial system is used to track funds for emergencies and to ensure accountability in the utilisation of funds. The existence of the Public Finance Management Team in Harari was mentioned. This team is in charge of controlling and monitoring the budget. The team comprises the departments of budget, purchase, audit, and IT. These departments work together to control and monitor budget effectiveness. In Somali, an emergency bank account was mentioned, from which withdrawals are only made with the approval and signature of authorised personnel.

> *There are two types of auditing, one that is led by BOFED, this is for checks and balances, then there are external auditors – who are general auditors and they report in the IBEX system.* (RFB, Dire Dawa)

Additionally, in Amhara, the RFB takes on the task of compiling and sending woreda and zone financial reports to the MoF at the federal level. Also, in SNNPR, zones compile woreda reports, outlining how and where the supplies were utilised following an emergency response. The regional disaster risk management authority then compiles and sends a report up to the EDRMC and the regional DRMC. Moreover, supportive supervision, review meetings, joint monitoring visits, and after-action reviews were some of the accountability mechanisms reported to exist to ensure proper budget utilisation across woredas, in both Afar and Benishangul-Gumuz.

> *After completing emergency response, we conduct after-action review or post-emergency assessment to appraise effectiveness the emergency response activities/interventions in achieving the desired objectives and outcomes. The budget utilisation and other financial issues are also assessed during the after-action review.* (RHB, Benishangul-Gumuz)

In Amhara and SNNPR, monthly financial and technical reports to donors, indicating where and how the funds are being spent, are required as an accountability mechanism. In Somali, government respondents explained that the RFB has manuals that must be followed to track all types of expenditures, be it emergency or non-emergency activity. A respondent from Benishangul-Gumuz mentioned a financial transparency and accountability mechanism that is used to make the budget and expenditure information available to the public.

> *The region and woredas publicise* [post using billboards] *the amount of money allocated to the health sector with detail. … This information is accessible to the public. The expense reports are also posted for the public, but this is not done consistently. Mostly, the emergency budget expenditure reports are available at regional level, anyone can ask and access the reports from the region. In addition to this, we also publish a comprehensive budget book and distribute* [share] *it to the woredas, and the federal government. Anyone can get the published budget book*. (RFB, Benishangul-Gumuz)

In Gambela, joint spot-checks with donors to check and verify achievements by comparing financial reports with implemented activities were mentioned as an accountability mechanism.

> *Expenditure of a budget allocated by the government is recorded in the IBEX system. We can track the expenditure using this system. Regarding funds we receive from UNICEF, we receive expenditure summary reports from the government sectors and review them. We check if the expenditure is in line with the budget plan. We sometimes jointly conduct spot-checks with UNICEF to check if the expenditure is according to the micro plan.* (RFB, Gambela)

An IP respondent from Amhara region reported that the IP has both horizontal and vertical accountability mechanisms. They try to foster these mechanisms within the communities they support so that the communities will also have a way to voice their inputs and concerns about the interventions being provided. There is also a mechanism for reporting between woredas, zones, and the regional office. These reports are then compiled and sent to the country office and the regional government counterparts. One of these government counterparts is the RFB. The RFB receives reports from the IP throughout the whole intervention process.

> *While funding reporting is consistent and well-established, we need to work on incorporating the community's comments, grievances, and suggestions into our accountability mechanisms.* (IP, Amhara)

Also, an IP from Oromia noted that they have their own tracking system. After funding is received, data are gathered on a quarterly, bi-annual, and annual basis. Reports are shared both with donor organisations and government counterparts. To ensure the quality of reporting, there are standardised checklists that are used to ensure quality standards. This is furthered with review meetings, where checks are made. In Gambela and Somali, IP respondents explained various mechanisms that are in place to ensure accountability to the beneficiaries. These include engagement with community members and structures, and the use of hotline numbers and suggestion boxes to collect feedback. Community members and structures are engaged in the distribution of assistance to the beneficiaries and in setting criteria for the selection of beneficiaries. Hotline and suggestion boxes are used to gather community feedback regarding assistance provided to the beneficiaries. Moreover, IPs assign accountability officers and make information available regarding interventions. The selection process regarding the beneficiaries and objectives of interventions are made transparent to the public. Moreover, spot-checks are conducted to check and verify achievements by comparing financial reports to the activities reported to have been implemented.

> *We have an accountability officer who is responsible to ensure accountability. We use and involve community structures whenever distributing any items including NFIs. We set criteria together with the kebele administration and Women Development Armies. We also use mobile suggestion boxes if there is cash distribution during emergencies. We also create awareness regarding criteria to get benefited from the distributions of items we are going to make. We also have a hotline number, which is posted on our vehicle.* (IP, Gambela)

6.2 Reporting

Federal level

The federal government offices use the IFMIS and IBEX for financial reporting. The regional government offices use a manual expenditure reporting system (called a statement of expenditure). The emergency financial systems were reported to be standardised. The budget department, under MoF, is primarily responsible for the follow-up/tracking of budget utilisation through the quarterly reporting system and internal audit reports. The reporting system is designed to provide information to assess the compliance of organisations in terms of budget expenditure in accordance with their plan.

> *The reporting from the federal level uses programme-based budgeting, in which the report should describe inputs/resources, outputs, and outcomes. On the other hand, at the regional level, line-item budgeting is applied, and the reporting is designed to track only inputs.* (MoF respondent)

One of the respondents explained that there is a separate and independent reporting mechanism for donor funding. For instance, the reporting for EU funding follows the EU development funding procedure and reporting formats, which are more rigorous, complex, and detailed than those of the government reporting system.

According to donors, the government and IPs generate reports for submission. One donor explained that the government uses its own template for reporting and the reports are generally needed to liquidate funds. On the other hand, IP reporting – both financial and activity reporting – is more disaggregated and follows a standardised template. The reports generated indicate how much of the funds allocated were used and what effects they had. A donor respondent also stated that as a part of their agreements with IPs they have to submit technical reports outlining the activities and achievements on a regular basis. Additionally, the same donor conducts spot-checks where they compare financial reports to the activities being conducted on the ground.

While IPs reported using some kind of reporting mechanism to report to their donors, the consistency and details of these reports is not clear. One IP has tracking methods it uses to ensure quality monitoring. This tracking method is employed by the MEAL persons assigned to the programme. Quality benchmarking assessments are also carried out; this is an operating standard that is required in order to implement emergency programmes.

There was scant reference to emergency resource allocations and expenditures being made available to the public. Only a few government respondents and a respondent from one donor reported that expenditures are made accessible to all as per the law on transparency enacted by MoF. According to a respondent from MoH, expenditure reports are posted on

the organisation's website to make this information available to the public, and all those interested can collect the report from EPHI. However, the respondent did not explain how they can be accessed.

> *The report is posted online, there is a web site. Our public relations do that. It also gets posted on screens.* (MoH respondent)

> *An audited report takes from one year to a one and half year time to prepare, and it will be made available for interested parties according to financial law requirements.* (MoH respondent)

In this assessment, respondents were asked about the existence of quality standards and if the emergency financial reports meet the expected standards. Timeliness, completeness, and reliability were mentioned as being the quality standards expected from financial reports/data. However, a respondent from MoH explained that financial reports lack timeliness:

> *There are different parameters that we use to ensure the quality of the data. One of the parameters is timeliness, whether the reports are submitted within the time given or not. The second one is whether all the required information indicated in the reporting template are provided or not. Thirdly, we will see its reliability, whether it will have a similar finding or not, and if it is sent to any entity. We also look into the data's validity. Data quality check is done by the grant management unit.* (MoH respondent)

Regional level

In Amhara, SNNPR, Addis Ababa, and Dire Dawa. public health institutes, RHBs, health centres, and PHEM, respectively, collect financial and technical report from woredas, following the implementation of activities. Woredas send their financial and technical reports to the zone and the zone compiles and sends the reports to the region. In Harari, Sidama, Addis Ababa, Oromia, Afar, Benishangu-Gumuz, Gambela, Somali, and Dire Dawa, the IBEX financial system is used for general financial reporting: there is no separate reporting system for emergency health and nutrition expenditure. In Gambela and Somali, woredas use a manual expenditure reporting system due to the unreliable internet network and power sources to enable the use of IBEX. Additionally, it was highlighted that if funds were provided by MoH, the woredas and zones in SNNPR and Sidama use the 'Settlement of Expenditure' reporting format to send their expenditure reports to the MoH, through their regions. The SNNPR RFB highlighted that each sector is required to submit monthly reports to the RFB as well, and this is done on a monthly and quarterly basis. Though standardised reporting templates were mentioned in Sidama and Gambela, respondents from the Gambela RHB had no detailed information on how expenditure reports are generated, or on the existence of standardised reporting formats. In Oromia, non-standardised reporting formats were reported at the regional and woreda levels.

Respondents in SNNPR and Sidama reported that they each have a dedicated M&E directorate within their bureaus, and those officers conduct the tracking and monitoring of activities during emergency response.

In Afar and in Benishangul-Gumuz, separate reporting mechanisms and formats for donor fundings were reported. The participants, mainly RFBs, expressed their concern regarding the lack of an integrated reporting system for government and donor funding.

IP respondents in Amhara region reported that there is a real-time monitoring mechanism, as well as a well-established M&E structure and reporting format. While rare, real-time monitoring practices are sometimes conducted when an intervention's funding is affected by inflation and is no longer able to achieve the targets it was designed to reach. In these cases, the IP, through real-time monitoring, will identify this issue and make funding amendments to meet the changing resource needs.

> *An example of real-time monitoring was seen recently when we discovered duplication of efforts in one woreda during the conflict-recovery interventions. We found that, due to a lack of coordination, another organisation was already working in the area we had planned to implement in. In this case, we contacted the country office and had to reformulate our plans and funds. Another example of real-time monitoring was when we had to make funding adjustments in the middle of an intervention because of price fluctuations caused by inflation in the country. In this case, we will either reduce the target and try to do the work with the available funding or we will ask for additional funding to adjust for inflation.* (IP, Amhara)

In Gambela and Somali, IPs generate consistent financial expenditure and technical reports for submission to the government and donors. According to the respondents, expenditure reports are made using standardised and donor-specific templates.

Concerning the quality and timeliness of reports, respondents from Gambela RFB explained that the bureau takes different measures to ensure quality reporting, like training the experts and developing manuals to guide experts to generate quality reports. However, in SNNPR Public Health Institute and RHB, respondents suggested that the regularity of reporting needs to be improved. The time it takes for woredas to submit their reports to the zone varies, and can be delayed for various logistical reasons. This in turn leads to the regional public health institute also being delayed when it submits reports to the EPHI and other federal counterparts. A respondent from the Somali RFB acknowledged that expenditure reports fail to meet the expected quality standards. According to the respondent, reports often lack accuracy and are not submitted in a timely fashion. A respondent from Dire Dawa mentioned that reporting does not always meet expected quality standards. High staff turnover is an impediment to the attempted capacity-building activities. The study participants in Afar and in Benishangul-Gumuz described the quality and timeliness of the reports received from woredas and health facilities as poor due to delays and the incompleteness of the financial reports.

> *The major problem is delay. Reports are not timely submitted from woredas to the region. Particularly in areas where there is a security problem, even there are reports that do not come at all, and sometimes they may come two or three months later. In addition, the woreda health office fail to timely compile health facility financial reports and send it to the region*. (RFB, Benishangul-Gumuz)

> *Only some woredas/health facilities send completed reports on the right time. Despite there are tendencies of under- and over-reporting of cases (performance), which of course depends on skill and experience of the reporting person.* (GoE-RHB, Benishangul-Gumuz)

In Addis Ababa, there is Financial Transferability Accountability, which is implemented through the World Bank, to help follow expenditure. Institutions must notify the public of the

amount of funding received and their expenditure. Up-to-date information on Financial Transferability Accountability is not in IBEX, and institutions continually fail to report their recent financial transactions, and therefore manual reporting is needed and incomplete and incorrected data are often presented.

Generally speaking, expenditure reports are not publicly available, though in Gambela and Somali, expenditure reports were said to be accessible to the public upon formal request and approval.

4.2.6 Outcomes achieved (reach, coverage, equity)

Operational definition: The outcomes are achieved in terms of reach/coverage, and who benefits from the resources (equity).

Research questions:

- How many people have the resources been able to reach/be distributed to?
- What are the key outcome indicators used to measure achievement/success?
- Who has benefited and who has not? Have the most vulnerable benefited? (How are the most vulnerable defined?)

Table 17: Outcome Achieved Performance Standards

Standard	Definition
Advanced	The outcomes/impacts are significantly achieved in terms of reach/coverage. Benefits entitlements are explicitly defined for the entire population, with provisions for vulnerable groups, and conditions of access are clearly communicated and understood by the population.
Established	Outcomes/impacts in terms of reach and coverage are relatively achieved. Measures are taken to universalise certain benefits, and significant action is taken to make benefit entitlements and conditions of access explicit for most of the population, but these remain unclear for many.
Progressing	Some outcomes/impacts in terms of reach and coverage are achieved. There is prioritisation for relatively well-off groups, and benefit entitlements and conditions of access are clear for some part of the population but remain uncertain for most; some efforts are made to communicate but these are limited.
Emerging	The outcomes/impacts are not achieved in terms of reach/coverage. There is no prioritisation of vulnerable population groups and benefit entitlements, and conditions of access are implicit and are not clearly defined, and people do not understand them.

Federal-level judgement: 'progressing'
Outcomes are often achieved and reach beneficiaries, especially for donors and IPs which have systems for tracking and measuring outcomes. For the government, there are limitations in tracking and measuring outcomes and it cannot certainly be concluded that funding reaches the most vulnerable and that the desired outcomes are achieved. There is a form of beneficiary prioritisation by the GoE, donors, and IPs, with prioritisation being stronger among the latter two. However, the findings are silent on whether benefits and entitlements and conditions of access are communicated to the masses, and whether beneficiaries are aware of these.
Regional-level judgement: 'progressing'
Indicators exist that can be used to measure or track the achievement of outcomes for emergency health interventions and routine programmes in most regions. However, it cannot be concluded with certainty that funding reaches the most vulnerable and that the desired outcomes are achieved. For IPs, it can be said that outcomes are often achieved, and beneficiaries are often reached, given their systems for tracking and measuring outcomes. There is some form of beneficiary prioritisation across all regions, except Harari, with various criteria for beneficiary entitlement for emergency support. In general, the research findings are silent on whether benefits and entitlements, and conditions of access, are communicated to the masses, and whether beneficiaries are aware of them.

Detailed evidence

7.1 Prioritisation of target groups

Federal level

The respondents mentioned variation in terms of priority groups, depending on the nature of emergency and emergency response interventions. However, in most cases, children under five years old, pregnant and lactating women, people with disabilities, and adolescent girls are considered as target groups for emergency responses, particularly for health and nutrition emergency interventions. Some of the respondents also described variation in the prioritisation of target groups based on geographical location (regions). For instance, a respondent from the IP category stated that Afar and Somali Regions are priority targets for drought emergencies as they are affected by persistent drought.

Only a few GoE respondents mentioned criteria for beneficiaries' entitlement for emergency support. One of the respondents from NDRMC mentioned the use of woreda hotspot classification criteria for the identification of target beneficiaries for nutrition interventions. The respondent also mentioned a target beneficiary identification process that is conducted by a rapid response team (a team of experts representing EPHI, MoH, and NDRMC), in collaboration with community volunteers – mainly the Health Development Army leaders. Another respondent from MoH reported the involvement of community volunteers in identifying beneficiaries for the COVID-19 response.

According to donors, target groups for emergency interventions are reported to be identified through rapid assessments conducted by IPs and based on the national guidelines. These are often children (under five), and pregnant and lactating women, as they are considered the most vulnerable segments of the population and are often targeted for emergency

interventions. In some cases, older children and elderly people are also targeted, especially when there is a risk of famine.

Regional level

Respondents from all regions except Harari region mentioned variation in the identity of priority groups, depending on the nature of the emergency and the emergency response interventions. In most cases, children under five years, pregnant and lactating women, people with disabilities, and adolescent girls are considered as target groups for emergency responses, particularly for health and nutrition emergency interventions. However, a respondent from the Harari RHB reported that they do not have criteria that they use to prioritise target groups for emergency cases, other than being sick.

Almost all respondents from all regions mentioned criteria for beneficiaries' entitlement to emergency support. Respondents from Afar, Benishangul-Gumuz, Somali, and Gambela regions stated that the level of vulnerability, the magnitude of the emergency, family size, household assets/property and household economic status, and HIV status are important criteria that are considered during target prioritisation for emergency interventions. Moreover, respondents from Somali and Gambella regions noted that ethnic minorities, IDPs, the poorest of the poor, prisoners (regardless of other criteria), and elders are considered vulnerable during emergencies.

DRMC respondents from Harari, Sidama, SNNPR, Oromia, and Somali mentioned the use of woreda hotspot classification criteria for the identification of target beneficiaries. Respondents also mentioned that the target beneficiary identification process is conducted with experts through a team of experts from the region and woredas, in collaboration with the community leaders.

In Oromia, the DRMC stated that they have a committee established at the woreda level that oversees screening of beneficiaries, and that there are many inclusion and exclusion criteria. Vulnerable groups are assumed to be 35% of beneficiaries (women and children). Moreover, there are guidelines to maintain gender balance.

The respondents from IPs in Afar and Benishangul-Gumuz mentioned the existence of rigorous screening or a beneficiary identification mechanism.

> *The target beneficiaries are determined based on screening results. For example, malnourished children are targets for food supplementation. Households having a child with severe malnutrition for cash support, considering poverty and food insecurity as underlying cause of severe malnutrition. In addition, female-headed and child-headed households, destitute households that are not able pay community-based health insurance contribution, households with disabled and mentally ill member are eligible for food security and cash support. The prioritisation criteria account for the root causes.* (IP, Benishangul-Gumuz)

> *The prioritisation and selection of beneficiaries pass through multiple verification mechanisms. There are multiple committees established with selected community representatives, who are responsible for identification of eligible beneficiaries based on the criteria. I can say that our verification mechanism is effective in identifying beneficiaries who deserve to get the support.* (IP, Afar)

Respondents from IPs in Amhara and SNNPR mentioned that they identify target beneficiaries by working with the local communities. The M&E units of the IPs work with the kebele managers to identify and list the intended beneficiaries within the community. This ensures that all the intended beneficiaries for the specific intervention are reached.

7.2 Reaching the most vulnerable and the achievement of outcomes

Federal level

One of the respondents from MoH reported that the use of data from the malnutrition case management tracking system is used to undertake trend analysis for the prevalence of malnutrition. The trend analysis results are used to provide information on the effectiveness of the intervention for target beneficiaries. Similarly, another respondent from NDRMC mentioned the availability of data on the effectiveness of emergency response interventions in their database.

Only one donor respondent reflected on how its organisation verifies if the most vulnerable people benefit from the emergency support. According to the respondent, a review of regular field reports and regular monitoring visits are the means of verifying if the beneficiaries have benefited. Other donors more generally spoke about their M&E systems being able to capture this.

Overall, IPs were confident that their target populations are reached and that their desired outcomes are often achieved. For example:

- One IP employs a feedback mechanism with its beneficiaries that allows them to voice their concerns if they feel they have not been reached or have not received the benefits they should.
- During the Tigray conflict, another IP ensured the reach of their target population by requesting partners clearly indicate in their proposals how they plan to target and find vulnerable and hard to reach populations, and that that is taken into consideration when granting funds.
- Another IP said that their organisation ensures that target groups receive the intended services through regular and ongoing monitoring. Additionally, they also conduct cost distribution monitoring exercises, as well as periodic baseline and endline assessments, which show the level of services the beneficiaries have received through a certain project.

However, due to lengthy government bureaucratic procedures, there are sometimes delays in achieving the desired outcomes, especially when implementation processes require government approval. Also, implementation is sometimes delayed due to political or social conflict. For example, during the Oromia youth uprising, it was difficult for an IP to access operational areas and to implement projects due to the blockage of roads etc., which reduced the effectiveness in realising the desired outcomes.

Regional level

Only respondents from Somali, Gambella, and Addis Ababa discussed how they verify if the most vulnerable people benefit from the emergency support. According to these respondents, a review of regular field reports, monitoring visits, spot-checks, discussion with

the community, and a regular M&E system are the means of verifying if the beneficiaries have benefited. A respondent from Gambella RHB explained how an analysis of secondary data of beneficiaries is conducted to determine if the most vulnerable people have been reached.

IP respondents from Gambella and Somali regions explained that they use regular monitoring reports, collection of feedback from the potential beneficiaries, pre-/post-intervention assessments, and spot-checks as the mechanisms used to verify if the most vulnerable people benefited from the emergency support and interventions.

> *There are mechanisms to know who has benefited and who has not. We cross-check through spot-check or we may go house to house to check. We could organise focus group discussions with the community members to explore if there were inclusion and exclusion errors.* (IP, Somali)

7.3 Measurement of outcomes

Federal level

Most of the GoE respondents mentioned the existence of indicators that are used to measure or track the achievement of outcomes for emergency health interventions and routine programmes. The respondents also mentioned the existence of an M&E system to track input, output, and activity/process indicators for M&E of the routine and emergency health programmes. Respondents from MoH mentioned the use of internationally accepted indicators to facilitate comparison with other settings. Similarly, a respondent from NDRMC described an M&E system for tracking nutrition shock indicators (such as percentage of cure rate, percentage of defaulters, percentage of death) to assess the outcomes of emergency nutrition interventions. However, the respondent also mentioned that there is a lack of M&E capacity to produce timely and accurate data/information.

According to a few respondents from MoF, there is a collaborative approach that allows for the involvement of multiple stakeholders for the selection/development of indicators or outcome measures that are used to track achievements. MoF closely works with MoH and the Planning Commission to monitor and verify the utilisation of the allocated budget for the intended objective and in accordance with the plan. Respondents also mentioned the use of outcome measures for budget planning (i.e. to justify budget increases for the next fiscal year), and to meet donor requirements. Nevertheless, one of the respondents mentioned the absence of strong outcome tracking at MoF due to the fragmented system.

From the donors' side, there are both input and output indicators that are used to track achievements. Respondents reported the existence of M&E frameworks to track progress and measure outcomes. Regular implementation reports, and assessments including community surveys and field visits, are used as sources of data for tracking and measuring achievements.

> *Information management officers track all the data and put it into our M&E system. The programme monitoring unit in the office will then compile and track these outcomes. This will then be reported to the donor.* (Donor respondent)

IPs also reported that they utilise their M&E systems to track outcomes and achievements. An IP respondent stated that there are key outcome indicators that are proposed in the

intervention projects' logframe. The indicators in the proposal are then used to determine the effectiveness of a programme. There are different M&E indicators in emergency response programmes. There are dedicated MEAL managers whose sole responsibility is tracking such indicators and producing reports for donors and partners, and for internal consumption. The same outcome indicators are used to produce outcome reports both for donors and for internal use.

Regional level

Most of the respondents in all regions mentioned the existence of indicators that are used to measure or track the achievement of outcomes for emergency health interventions and routine programmes. Respondents also mentioned the existence of M&E systems to track input, output, activity, or process indicators for the M&E of routine and emergency health programmes. Respondents from Afar and Benishangul-Gumuz described the existence of after-action reviews, which are conducted at the end of emergency responses, to measure outcomes achieved and the effectiveness of the response activities.

> *After completing emergency response, we conduct after-action review or post-emergency assessment to appraise effectiveness of the emergency response activities/interventions in achieving the desired objectives and outcomes. The budget utilisation and other financial issues are also assessed during the after-action review.* (GoE, Benishangul-Gumuz)

Respondents from Harari, Dire Dawa, and Sidama reported that there is a lack of M&E capacity to avail timely, consistent, and accurate data/information. On the other hand, the SNNPR RHB highlighted that the bureau has a strong monitoring mechanism and they have been able to gather evidence that indicates if their interventions are successfully reaching their targets and leading to a reduction in harm and loss of life.

A respondent from the Addis Ababa RFB noted that there is no standardised indicator to track the efficiency of public expenditure. At the institutional level there are measurement tools that are used for monitoring and evaluating expenditure. A combination of many assessments is used to assess public expenditure.

IPs in SNNPR, Amhara, Oromia, Gambella, and Somali regions reported that they utilise their M&E systems to track outcomes and achievements. There are dedicated MEAL experts whose sole responsibility is tracking such indicators and producing reports for donors, partners, and internal consumption.

4.2.7 Resource use

Operational definition: The cost of each input translates into the maximum impact achieved.

Research questions:

- Is there an approach for examining the cost per beneficiary of emergency financing for health and nutrition?
- What is the unit cost per beneficiary for a particular type of emergency intervention?
- What are the costs of the key inputs which yield the most impact (for each type of emergency)?

- What is the *per capita* emergency health expenditure for the outcomes achieved?

Table 18: Resource use performance standards

Standard	Definition
Advanced	Invested resources are significantly commensurate with the level of outcome/impact achieved.
Established	Invested resources are relatively commensurate with the level of outcome/impact achieved.
Progressing	Invested resources are fairly commensurate with the level of outcome/impact achieved.
Emerging	Invested resources are not commensurate with the level of outcome/impact achieved.

Federal-level judgement: N/A
Ascertaining whether the cost of each input translates into the maximum desired impact is a challenge due to the lack of mechanisms and limited ability to measure or assess the same. With the available evidence, it is not possible to say whether the resources used are commensurate with the level of outcome achieved or not.
Regional-level judgement: 'emerging'
Overall, there are few or no mechanisms that are used to assess the cost-effectiveness of emergency response interventions. Action reviews, mid-term and end-term evaluations, and regular M&E systems were often cited as mechanisms for assessing effectiveness. However, these do not link outcomes with the resources invested. As a result, unit costs per beneficiary or costs of key inputs for a particular intervention could not be ascertained. As such, a judgement on whether the invested resources are commensurate with the level of outcome or impact achieved cannot be reached.

Detailed evidence

Federal level

According to the GoE, there is a budget for each activity and a financial reporting system that is used to communicate utilisation rates to facilitate necessary adjustments. However, this is not linked to the high end of the results chain, which is about outcomes and impact. The cost-effectiveness or VfM considerations along the results chain, from inputs to outcomes, are not visible in the GoE emergency financing system. Also, none of the respondents from MoF reported the existence of VfM assessments to evaluate whether the invested resources were significantly commensurate with the level of outcomes/impact achieved. Nevertheless, some of the participants reported the use of information generated through various mechanisms (the regular reporting system, yearly and bi-annual performance assessment sessions, field visits, and annual evaluations) to verify the utilisation of resources to achieve the desired objectives. The information obtained through the above mechanisms mostly fails to systematically link outcomes/impacts with the invested resources (time, money, and other inputs). It is difficult to determine the effectiveness and efficiency of interventions.

On the other hand, some donors explained that their organisations conduct assessments and evaluations to examine the cost-effectiveness of emergency financing. Although some

might not be typical cost-effectiveness analyses, there are interaction reviews and after-action reviews in which they reflect on the implemented emergency operations, taking into consideration whether the resources were used as efficiently as they could have been and whether they achieved VfM in terms of the investment made specific to that particular emergency response.

Some implementers have a VfM policy to assess cost-effectiveness. Part of their VfM policy is to carry out a market assessment within operational areas for the primary goods and services provided.

> *We can say that the resources are used efficiently and effectively to achieve the programme's objectives because we have an established accountability system with our donors, beneficiaries, and the government. We have fostered an agreement to effectively and efficiently utilise the allocated budget for intended purposes. And because we have created a system of accountability, interventions involve beneficiaries, government, and donors in planning, implementing, monitoring, and evaluating programmes.* (Save the Children)

Participants from other IPs also mentioned that during the design of their programmes, they include criteria that determine how much funding needs to go directly towards beneficiaries and how much is allowed to cover operational costs.

Regional level

Due to the lack of health economics professionals in this sector, the Amhara regional PHI does not conduct cost-effectiveness analyses. The institute uses indicators like response time, the loss of life, and the status of the outbreak/emergency to measure their effectiveness. An IP in the Amhara regional office attested that cost-effectiveness analysis is not common with emergency programmes. Instead, mid-term and end-term evaluations are usually conducted to assess project effectiveness. Additionally, when proposals and concept notes are prepared for fund application, the regional office writes a section that examines the existing capacity versus the need on the ground. Furthermore, donors conduct evaluations using different sustainability markers. APHI stated that it is hard to pin down the utilisation rate of resources for health emergencies within the region. The funding that comes for health emergencies is very small and limited, so it is not possible to underutilise it.

> *For example, the current conflict has caused tremendous damage in Amhara region. We have assessed and costed the damage and the necessary funding to address it. The resources we have employed in conflict-recovery and the amount that is actually needed is night and day. The amount being invested is a fraction of the need*. (APHI, Amhara)

Similarly, the respondents from the SNNPR regional bureaus and institutes stated that they do not conduct cost-effectiveness assessments. SNNPR DRMC stated that while they do not assess cost-effectiveness, they do conduct post-disaster and post-public health emergency assessments to examine the achieved outcomes. These assessments determine the state of the community after the emergency and assess if they are able to maintain a sustainable livelihood after the interventions. The respondents from the SNNPR PHI and RHB reported that while their institutes and bureaus do not undertake a cost-effectiveness assessment either, they do examine the outcomes achieved.

> *We focus on case management, meaning we treat the population that is affected. Then we focus on surveillance where we work with the Health Extension Workers at the kebele level to track incidence numbers. The way we assess our effectiveness in the intervention is by looking at the incidence numbers after we implement our activities. For example, in cases of a measles outbreak, we will come in and begin a vaccination campaign to immunise the community. And then, after some number of weeks, we will go back to that community and look at the incidence numbers. If we have been effective in our beneficiary targeting, we should see a decline in the measles numbers*. (PHI, SNNPR)

> *We use our M&E mechanisms to track and measure indicators. We also look at the incidence rate after our intervention and make determinations on the effectiveness of our efforts.* (RHB, SNNPR)

Regarding resource utilisation rates, SNNPR DRMC stated that the utilisation rate is hard to determine because, as an organisation, the SNNPR DRMC does not conduct assessments to make judgements on the utilisation rate of its resources. However, since the need is always much higher than the available resources, underutilisation of resources is rare. The respondents from the SNNPR RHB highlighted the challenges in resource utilisation by outlining incidents of mismanagement and planning discrepancies in emergency response programmes. Additionally, timing and gaps in capacity can also lead to underutilisation and ineffective utilisation of resources.

Harari RHB reported that they conduct a post-response cost-effectiveness evaluation. This evaluation is not only limited to emergency responses. Furthermore, they use after-action reviews, which look into the extent of the crisis, how long it lasted, how far the crisis exceeded the base expectations, and how successful the responses were in containing it, to examine the efficiency and effectiveness of the emergency response. A respondent from RFB*(RHB, Harari)* stated that the PFM team monitors if the government-assigned budget is spent on target areas or not. Proper resource utilisation for health in the region was reported by respondents, though overutilisation of resources was reported by the RHB.

> *We do not have enough resources. We use whatever is available to us. We are able to conduct emergency responses by mobilise resources from places other than the government. The budget we receive from the federal government is for the 270,000 people of the region. Somalia and Oromia regions use hospitals in our regions. That also has a great impact on cost-effectiveness. We use the budget allocated to us 100% and plus.* (RHB, Harari)

There is no mechanism to assess the cost-effectiveness of emergency response interventions in Sidama. Only after-action reviews are conducted following program(completion. The regional Public Health Institute reported having effective and efficient budget utilisation rate(s). Post-emergency assessments after the end of the emergency response are conducted, to assess who responded and what the costs were and what the achievements were. The findings are then used for future emergencies, to increase their readiness.

> *To be honest it is hard to talk about the utilisation rate because what we have is not enough to the point that we have to constantly use the contingency budget. We are constantly begging our partners, the regional and federal government for more*

> *resources. The reason we are even going is because we have finished all the resources we have on hand, so utilisation rate is hard to talk about. We have a lot of constraints, at this point what is hard for us is not having enough resources, not the utilisation rate.* (RHB, Sidama)

Based on the interviews in Addis Ababa, there is a mechanism there for assessing the cost-effectiveness of emergency financing for health. However, the city finance bureau stated that 'there is poor follow-up, the measurement of cost-effectiveness of emergency financing is very weak'. It is also difficult to understand how resources have been used to achieve the objectives of programmes, because the finance system is limited. Budgets are allocated to line items and not to programmes, so effectiveness cannot be measured against objectives.

The only mechanism for assessing cost-effectiveness reported in Oromia was through the Oromia DRMC. The cost-effectiveness of NGOs is assessed through the MoF, and NGOs' impacts are assessed by consultants. Regular monitoring within the government, NGOs, and United Nations agencies was cited as a mechanism that is used to understand how resources are being used to achieve objectives to minimise the misuse of funds.

In Afar and Benishangul-Gumuz, the effectiveness, regardless of the cost, is evaluated using key indicators like number of cases treated, number of individuals screened for nutrition, number of deaths averted, etc. Moreover, post-implementation assessments are conducted to determine the number of resources used for the emergency response.

> *There are informal ways of determining cost-effectiveness. For instance, if we see emergency nutrition specifically, example; 100,000 birr is sent for each of two woredas that have similar context for nutrition screening and one screened 80 cases but the other woreda didn't do any, we learn that there is something that went wrong and need investigation.* (RHB, Benishangul-Gumuz)

The IP participants mentioned mid-term and final evaluations being conducted with the aim of assessing the effectiveness of interventions, but that these do not consider the cost component.

> *We conduct evaluations to determine the number of changes we were able to achieve. We also use indicators to monitor progress and to compare changes between the baseline and endline. If we achieve the target, we consider that the project or intervention has meet the desired outcome*. (IP, Afar)

The IPs also mentioned post-distribution monitoring aimed at assessing resource utilisation.

> *We do not conduct systematically designed cost-effectiveness studies; however, we usually do PDM* [post-distribution monitoring] *to assess utilisation of resources we distributed (lifesaving materials and supplies) to woredas and our beneficiaries*. (IP, Afar)

> *They* [M&E officers] *conduct routine PDM to assess effectiveness and appropriateness of the distributed items from the beneficiary perspective. This assessment helps to gather feedback on the quality and appropriateness of the supplies.* (IP, Benishangul-Gumuz)

None of the participants in Gambela reported the existence of an approach used to examine the cost-effectiveness (or VfM) of emergency financing for health and nutrition. The respondents explained that routine M&E and pre-post assessments are used to track the achievements of interventions, which are not typical cost-effectiveness analyses. This indicates that there are no or weak VfM mechanisms for evaluating whether the invested resources were significantly commensurate with the level of outcomes achieved. We asked respondents about the overall utilisation of resources for health emergencies. In general, respondents reported the appropriate utilisation of resources allocated for emergency response-related activities. However, a respondent from the RHB explained differences in budget utilisation between the different government offices. The respondent attributed this difference to the capacity of the offices and financial bureaucracy and procurement processes. A respondent from an IP operating in the region referred to a 'donation certificate' as a means to verify that supplies provided in support of emergency interventions are delivered to the health facilities they are intended for. Routine monitoring reports are also used to verify that resources are being used for the desired outcomes.

Congruent with the findings from Gambela region, none of the respondents in Somali reported the existence of typical cost-effectiveness or VfM mechanisms. The respondents reported the presence of routine M&E systems to track the achievements of emergency interventions, including the number of people who benefited from the interventions, which does not link outcomes with the resources invested. When asked about the overall utilisation of resources, the government respondents reported the proper utilisation of resources allocated for emergency responses.

Respondents in Dire Dawa noted that there is not an approach to examining the cost-effectiveness of emergency financing for health and nutrition. The reported that resources are being utilised effectively in Dire Dawa. The respondents noted that resources are known to be used for their desired outcomes based on follow-up reports and random checks. Further, resources are requested based on their plan, and supervision is carried out, as are post-distribution assessments.

> *We make sure that resources are delivered to the beneficiaries correctly. We do not let anyone purchase these resources that are given to the rural community. We make them aware that the resources are for them and not anybody else. Even the authorities there don't dare take/steal these resources. If we come across such an incident, we would immediately report it to the concerned parties.* (DRMC, Dire Dawa)

5 Concluding remarks

This report has summarised the key findings from an in-depth context analysis, based on findings from KIIs conducted at federal and regional levels, to understand and assess the efficiency and effectiveness of emergency health and nutrition financing in Ethiopia. Specifically, it has examined the sources of emergency financing for health and nutrition, allocation processes, and financial flows, in order to identify the strengths and weaknesses of emergency funding mechanisms, gaps in terms of resources, and bottlenecks in terms of decision-making/reporting processes for emergency financing for health and nutrition.

We created an innovative methodology that embedded VfM analysis within the analysis framework, building on the previous VfM analysis study by MoF and MoH and the performance standards set out in the WHO's HFPM assessment, which is the WHO's standardised qualitative approach to assessing country health financing systems, in terms of both the development and implementation of health financing policy. We focused on eight desirable criteria: (**i) predictability; (ii) adequacy/flexibility; (iii) allocative efficiency; (iv) timeliness; (v) good coordination; (vi) accountability/transparency; (vii) impact (reach/coverage); (viii) resource use/cost-effectiveness.** We used the rubrics approach to make transparent judgements about the performance of the emergency health financing system in Ethiopia. Judgements were made holistically, based on all the evidence presented for each criterion. We reviewed the evidence for each criterion against the relevant standards.

Across the eight desirable criteria, we find that the current emergency financing for health and nutrition in Ethiopia is 'progressing' overall, which means that while some of the fundamental building blocks are there, there is still significant room for improvement. The criterion with the strongest performance is allocative efficiency: there is a well-established evidence-based resource allocation mechanism that is used by the government, donors, and IPs as well as respondents at regional level. The sources of funding are known to all those involved in emergency responses, but there is a lack of a functional budgeting process that allows for an accurate estimate of the required funding for a given emergency event. The contingency budget is generally used to 'fill the gaps' both at federal and regional levels, but since this is not specifically for health and nutrition emergency responses, but the total available contingency budget is small. Given the competing needs in other sectors, it is unclear to what extent and in what proportion the contingency budget is actually allocated to emergency health and nutrition expenditures. Coordination among different actors can be improved (currently this is judged as 'progressing' at both federal and regional levels). To strengthen coordination, every actor needs to further strengthen their capacity to uphold their mandates. It is also important to assign specific responsibilities to specific actors so that there is a strong sense of ownership and responsibility. At regional level, it was raised that one of the challenges with coordination is a lack of ownership and responsibility. This can be seen in all parties and actors, and can often lead to duplication of efforts and inefficiencies.

The use of technology was mentioned by respondents in Addis Ababa, where constant updates are given on the changing needs of an emergency, through the use of a Telegram group. They are able to check this group for updates on the situation on the ground.

A good working relationship and communication with the RHB and DRM also play a key role in facilitating coordination across different actors: some IPs have assigned technical assistants or liaison officers to facilitate smooth communication with the regional government and other sectors.

We also analysed secondary data for trends in regard to the incidence of different types of diseases, based on data availability (i.e. on malaria, nutrition, injuries, and COVID-19), and we analysed financial data on trends for health expenditure between 2016 and 2019 (or EYF 2009–12). We identified variations in the trends for different types of diseases and the number of hospital visits across regions. The purpose of this exercise was to look at the health expenditure trends at federal and regional levels in order to complement the qualitative analysis of the KII results, particularly in terms of allocative efficiency. Overall, it seems that resources are allocated to where the needs are. There are some misalignments between resources and the degree of severity of emergency incidence, but this could be due to other contextual factors which were not captured in this analysis.