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A CASE STUDY ON AID EFFECTIVENESS IN ETHIOPIA

ANALYSIS OF THE HEALTH SECTOR AID ARCHITECTURE

Getnet Alemu

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CONTENTS

TABLES

FIGURES

ABBREVIATIONS AND ACRONYMS

AfDF	African Development Fund
AFI	Aid Fragmentation Index
AMP	Aid Management Platform
APR	Annual Progress Report
CCM	Country Coordinating Mechanisms
CJSC	Central Joint Steering Committee
CPA	Country Programmable Aid
CRDA	Christian Relief and Development Association
DAC	Development Assistance Committee
DBS	Direct Budget Support
GDP	Gross Domestic Product
DFID	Department for International Development, UK
EC	European Commission
EPI	Expanded Programme of Immunization
ETB	Ethiopian Birr (legal currency)
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund Against AIDS, Tuberculosis and Malaria
GHI	Global Health Initiatives
GHP	Global Health Partnerships
GNI	Gross National Income
GoE	Government of Ethiopia
HFL	High Level Government–Donor Forum
HHI	Hirschman-Herfindahl Index
HICES	Household Income Consumption and Expenditure Survey
HPN	Health, Population, and Nutrition
HSDP	Health Sector Development Program
HSPF	Health Sector Pooled Fund
ICC	Interagency Coordinating Committee
IDA	International Development Association
IHP	International Health Partnership
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
JCCC	Joint Core Coordinating Committee
JICA	Japan International Cooperation Agency
MDG	Millennium Development Goals
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
NGO	Non-Governmental Organization
NHA	National Health Account
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PBS	Protection of Basic Services
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PRSP	Poverty Reduction Strategy Paper
SDPRP	Sustainable Development and Poverty Reduction Program
SIDA	Swedish International Development Agency
SWAps	Sector Wide Approaches
TI	Theil's Index
UN	United Nations
UNCDF	United Nations Capital Development Fund
UNDP	United Nation Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	The World Bank
WHO	World Health Organization

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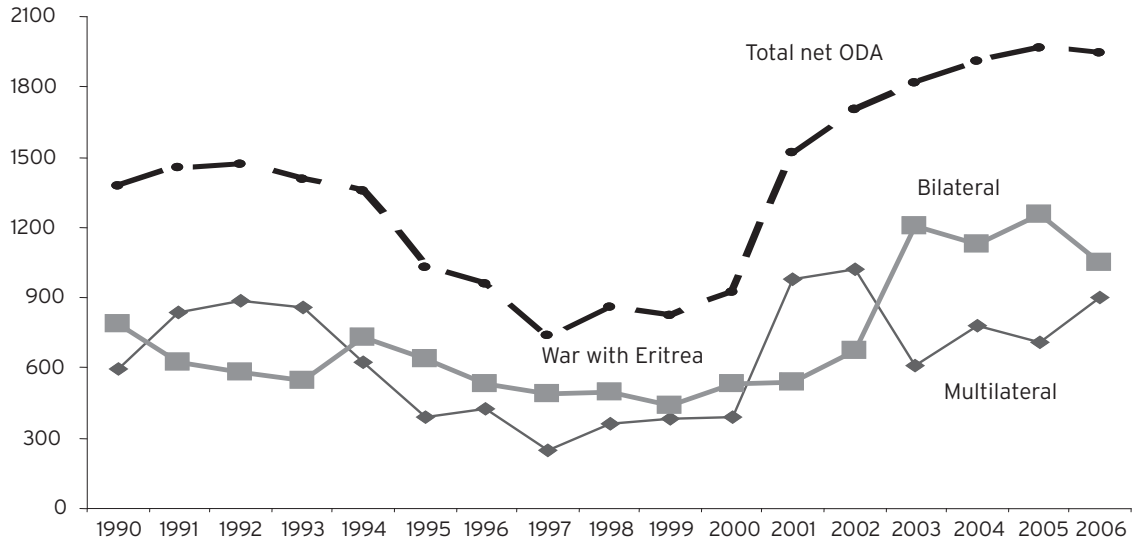
INTRODUCTION

Trends in total inflows of Official Development Assistance (ODA)

Foreign aid has played a major role in Ethiopia's development effort since the end of World War II. It has been instrumental in bridging the country's savings-investment and foreign exchange gaps.[1] Its importance as a source of financing for the development of capacity building (human capital, administrative capacity, institutional building, and policy reforms) is also unquestionable. Thus, increasing efforts were made to mobilize foreign aid in the last two regimes. Following the change in political regime in 1991 and the adoption of the structural adjustment program in 1992/93 in particular, the country has enjoyed a significant amount of aid. A large and growing inflow of concessionary loans and grants has occurred since 2001, following the issuance of the first poverty reduction strategy paper (known as the Sustainable Development Poverty Reduction Program) from 14 multilateral sources—mainly IDA, EC, the Global Fund, and the African Development Fund[2] and more than 30 bilateral sources—mainly the USA, UK, Italy, Canada, Germany, Ireland, Japan, Netherlands, Norway, and Sweden.[3]

Ethiopia has been one of the major recipients of international aid in recent times. According to OECD-DAC statistics, net ODA to Ethiopia amounted to US$1.94 billion in 2006, making it the 7th largest recipient among 169 aid receiving developing countries. In absolute terms, the amount of ODA has risen sharply from an average of $881 million per annum in the second half of the 1990s to over $1574 million per annum for the first half of the 2000s. Over the last seven years (2000-2006), ODA has averaged at $1683 million per year. The average contribution of bilateral donors to ODA over the eight year period was $322.4 million per year accounting for 31 percent of ODA. In the 1990s, some 49 percent of the total net ODA was in the form of multilateral aid. This was slightly reduced to 46 percent for 2000-2006, reflecting the increased importance of non-multilateral sources. Figure 1 presents the recent annual flows of foreign aid to Ethiopia.

Figure 1: Flows of net ODA to Ethiopia[4]



Source: OECD

As shown, the flow of net ODA actually declined from 1992 to 2000 and sharply increased in 2001 with a modest increase onwards. The main driving force for donors to resume their assistance was the issuance of the Sustainable Development Poverty Reduction Program in 2001/02. Of these significant net ODA flows, the contribution of the World Bank's support through the soft windows of IDA was tremendous. In 2001 alone it was 38.7 percent of the total net ODA. Since 1993, the Bank has committed a total of $3.1 billion to Ethiopia. Ethiopia receives about $8.0 per capita from IDA. This makes Ethiopia the largest IDA borrower in Africa and the fifth largest in the world (World Bank, 2005:iii).[5] In addition, the Bank has coordinated a consortium of donors to support the economic reform program.

It is also enlightening to examine the magnitude of ODA in relation to the local economy (Table 1).

As can be seen from Table 1, the share of ODA increased from 1996 to 2002 and is on a declining trend since then. The growth of the economy since 2003 might have been the cause for such decline. In 2006, ODA flows account for about 48 percent of the gross national savings, 40 percent of gross domestic investments, 58.5 percent of overall government expenditure, and 10 percent of the GNI of the country. Although there was an increasing ODA inflow, the savings-investment gap was as high as 20 percent of GDP, leaving a huge gap to be bridged by non-ODA inflows.

ODA in the health sector

We have seen that Ethiopia has been one of the major recipients of international aid in recent times. The health sector is among the few that enjoyed large shares of ODA. A large and growing inflow of aid followed the development of the Health Sector Development Plans (HSDPs) by MoH. Resources were

Table 1: ODA as share of local economy (percent)[6]

	ODA/Gross national income	ODA/Gross national savings	ODA/Gross domestic investment	ODA/Total government expenditure
1996	6.6	44.4	33.3	37.3
1997	5.6	30.1	26.3	30.8
1998	6.7	47.5	30.7	36.3
1999	6.6	38.5	32.6	30.0
2000	7.0	36.8	32.7	27.5
2001	11.6	74.0	48.4	47.5
2002	13.4	81.0	61.1	59.2
2003	12.7	81.5	49.6	63.1
2004	11.9	68.2	51.8	62.7
2005	11.1	62.9	45.8	59.5
2006	10.0	48.2	40.1	58.5

Source: Author's calculations, OECD statistics, and the National Bank of Ethiopia

delivered by ten multilateral sources, more than 22 bilateral sources, and more than 50 international NGOs.[7]

Getting the complete picture on the flow of aid in the health sector is very difficult because of problems associated with the disbursement channel itself. This problem may be understood better by briefly looking into the three disbursement channels practiced in Ethiopia.

It could be said that funds disbursed through "channel 1," MoFED, are immune to data reporting problems: they are invariably captured in the budget. Funds disbursed through "channel 2," via sector bodies, are disbursed outside the mainstream government budget and thus might not be captured. As noted by MoFED (2005), some federal line ministries deal directly with donors and may spend funds without notifying MoFED, let alone reporting to MoFED.

Funds through "channel 3" are those disbursed directly by donors without involving any government agency; they are usually not captured in the budget and, disturbingly, are not reported at all in many cases. In some cases they do report to the regional bureaus or to the sectoral ministry concerned but these parties may not report to MoFED. There seems to be no systematically organized and comprehensive data available on a regular and consistent basis regarding the trends of aid flows to the health sector—either by MoFED or MoH. Data sourced from budget documents/MoFED therefore do not reflect the exact amount of aid used in the health sector. One simple example is that U.S. President's Emergency Plan for AIDS Relief (PEPFAR) data is not available from the budget document; it is disbursed partly through channel 2 and partly through channel 3.

With this limitation (and the lack of an adequate time series on sectoral breakdowns of ODA) Table 2 gives some insight about the share of public health expen-

Table 2: Countrywide public health expenditure and ODA (share in percent)

	Health expenditure/total public expenditure	Health aid/total health expenditure
1993/94	5.0	-
1994/95	5.3	-
1995/96	5.3	-
1996/97	6.0	-
1997/98	6.1	-
1998/99	4.8	-
1999/00	3.2	-
2000/01	6.6	-
2001/02	5.0	-
2002/03	4.7	-
2003/04	4.6	57.3
2004/05	4.9	67.4
2005/06	4.7	62.2
2006/07	6.8	69.7

Source: For public expenditure: NBE Quarterly Bulletin, Third Quarter 2007/08, Vol. 23, No.3 and for health aid: MoFED (External Economic Cooperation Section), various bulletins of external economic cooperation

diture from total public expenditure and the share of aid in the health sector.

As may be observed in Table 2, the share of public health expenditure from total expenditure is very low by any standard. From the data obtained from MoFED (on-budget health aid) the share of aid from total public health expenditure for the last four years is more than 64 percent. Given the problems of volatility, harmonization, and alignment of ODA (discussed below), one can argue that a 64 percent share is a major source of concern for the health sector.[8]

Why focus on health sector

The Ethiopian health sector exhibits many of the general aid problems shared by many African countries. The health sector in Ethiopia continues to attract many aid organizations, even as compared to other sectors. As mentioned above, there are as many as 10 multilaterals, 22 bilaterals, and more than 50 international NGOs providing aid to the health sector, which poses a big challenge for coordination. There are also emerging players in the health sector aid that represent significant changes to the traditional aid architecture. These include the global initiatives that are modeled using a public private partnership arrangement, including but not limited to GFATM, PEPFAR, and the Global Alliance for Vaccine and Immunization (GAVI). The modalities under which these initiatives are operating are significantly different from traditional bilateral and multilateral donors.

It is against a context of aid dependency, aid problems, and changing aid architecture that we choose our focus on the health sector.

Macroeconomic performance and MDG indicators

The Real Sector: During the last 10 years, Ethiopia's economy has nearly doubled at constant prices and tripled at current prices. It is estimated to have had an average annual growth rate of about 6.3 percent, reaching a peak of 13.6 percent growth in 2003/04. The main reason for the wide variation in the GDP growth rates over the ten years has been the volatile performance of the agricultural sector, with high variations in the amount of rainfall affecting output. This, in turn, affected overall growth because of the large share of the agricultural sector in total GDP. The detailed performance of various sectors of the economy is shown in Table 3.

Albeit from a small base, the manufacturing sector has shown steady growth in recent times. Mining, with some fluctuations, has also shown sound growth.

Public Finance: One of the most critical issues for long-term macro-economic stability is public revenue mobilization. The relative share of domestic revenue is not only decreasing but its share of GDP has also averaged 14.6 percent for the last ten years. Revenue collection in Ethiopia is low relative to GDP mainly because direct tax on the dominant agricultural sector is very limited. The existence of a significant tax exemption period to promote investment almost in all sectors also contributed to low tax collection.

Total public spending has increased from 17.3 percent of GDP in 1996/97 to 24.5 percent of GDP in 2006/07, with a record of 27 percent in 2002/03. On the other hand, domestic revenue has increased only by 0.5 percent of GDP for the same period. This differential has increased the public fiscal deficit from 4.3 percent to 11 percent of GDP. The shortfall in domestic revenue to finance public expenditure was bridged by grants from abroad and external borrowing. The overall public deficit, including grants, increased from 1.7 percent to 5.8 percent of GDP for the same period. This shows the increasing dependency of the country's public expenditure programs on donors.

External Sector: The overall balance of payments position improved from a deficit of 8.5 percent of GDP in 1996/97 (ETB 720 million) to a modest surplus of 5.2 percent of GDP (ETB 407 million) in 2001/02. The balance of payments has been much healthier since 2002/03. This is due to improvements in the international price of coffee, Ethiopia's dominant export commodity, and a substantial increase in the quantity of other major export items.

Poverty: According to the Household Income Consumption and Expenditure Survey (HICES, 1995/96, 1999/00, 2004/05), Ethiopia has made a significant improvement in reducing poverty. The proportion of poor people (poverty head count index) in the country has decreased from 45.5 percent in 1995/96 to 38.7 in 2004/05, a 17.6 percent decline in the last ten years (Table 4). The depth and severity of poverty has declined at much faster rate than that of the head count index. Double digit overall economic growth rate since 2004/05 bodes well for future poverty statistics.

Key Millennium Development Indicators: A significant improvement has been recorded in the increasing access to, and quality of, services—particularly in the education, health, and water sectors. Gross primary enrolment has increased tremendously with significant reduction in gender gaps. Infant mortality and under five child mortality have shown tremendous declines. Similarly, life expectancy at birth, immunization coverage, and household access to safe water have registered significant improvements.[9]

Table 3: GDP growth rates for the period 1997/98-2006/07 (in percent at constant price)

Period	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07
Agriculture, Hunting and Forestry	-9.7	3.4	3.1	9.6	-1.9	-10.5	17.0	13.5	10.9	9.4
Mining and Quarrying	2.7	-8.4	11.1	5.2	10.5	4.1	2.0	4.1	7.2	6.0
Manufacturing	0.1	8.2	7.5	3.6	1.3	0.8	6.6	12.8	10.6	10.5
Electricity and Water	3.6	1.6	4.0	3.3	9.7	4.8	6.6	7.9	8.8	13.6
Construction	13.4	5.8	2.8	8.0	16.2	13.6	19.5	7.5	10.5	10.9
Transport and Communications	4.6	-0.8	9.0	13.7	5.6	10.5	9.5	19.2	5.7	7.6
All others	2.5	8.3	10.0	7.0	3.3	3.6	11.2	9.7	11.8	13.5
Over all GDP	-3.5	5.2	6.1	8.3	1.5	-2.2	13.6	11.8	10.9	11.1

Source: Author's calculations and National Bank of Ethiopia

Table 4: Trends in poverty and inequality

Year	National			Urban			Rural		
National poverty line	95/96	99/00	04/05	95/96	99/00	04/05	95/96	99/00	04/05
Headcount	45.5	44.2	38.7	47.5	45.4	39.3	33.2	36.9	35.1
Depth of poverty	12.9	11.9	8.3	13.4	12.2	8.5	9.9	10.1	7.7
Severity of poverty	5.1	4.5	2.7	5.3	4.6	2.7	4.1	3.9	2.6
Gini Coefficient	0.29	0.28	0.30	0.27	0.26	0.26	0.34	0.38	0.44

Source: MoFED 2006 and World Bank 2008

As can be seen from the preceding paragraphs, most macro-economic indicators have shown improvements over the last decade. The magnitude of foreign aid has also risen. The questions that follow, then, are those which ask whether there is room to improve the effectiveness of aid—and generate the maximum impact on growth and poverty reduction.

The effectiveness of aid is currently a hot agenda at the international level and politicians from both developed and developing nations are advocating for reforms in the delivery and management of aid. This has led to international agreement in the form of the Paris Declaration, which aims at improving predictability and fragmentation of aid through better harmonization and alignment, promoting country ownership, managing results, and increasing mutual accountability.

Progress in meeting these targets is mixed. In Ethiopia, there are many donors operating in the country with varied modalities of aid delivery ranging from sector support to project type of aid. In spite of the increase in the magnitude of donor funding, there are questions on the quality of aid, and how much of it is financing the recipients' priorities. The increased

number of donors operating in various sectors brings with it a series of implications on meeting donor reporting requirements which further constrain limited public sector management capacity.

These issues have been a major part of the dialogue between government and development partners particularly since 2005. Various policy and strategy papers address how to better manage aid within Ethiopia. However, studies documenting fragmentation and predictability of aid are few and far between. This paper will attempt to supplement the growing body of literature on aid effectiveness.

Objectives, methodology, and structure of the study

The objective of the study is to:

1. assess trends and experiences in dealing with fragmentation and volatility of aggregate and health sector aid and their impacts in terms of costs and gaps in the delivery of services; and,
2. assess the effectiveness of approaches and innovations that are put in place to smooth and coordinate both aggregate and health sector aid.

This research has two methodological components: quantitative and qualitative. The quantitative component will entail collecting and analyzing data from relevant research reports and databases, such as OECD-DAC statistics. Additional information was gathered from donors and other sources. For the qualitative information, a checklist was used to collect information about alignment and harmonization from multilateral and bilateral donors that are active in the health sector. An extensive review of literature was also carried out to put the argument in context. The whole process of the research is informed and conceptualized by the concept of aid effectiveness.

This paper is organized into seven sections. Following this introductory section, the second section disaggregates overall aid into various sub-components to work out how much actually goes into development programs, referred to as Country Programmable Aid (CPA). The next describes emerging players in health sector aid that significantly affect the health sector aid architecture. Two sections analyze the fragmentation and volatility of aid, describing both overall trends and government responses. A penultimate section investigates various mechanisms and processes that are in place to address the problem of aid coordination. The final section highlights key challenges associated with aid and its delivery in Ethiopia.

COUNTRY PROGRAMMABLE AID (CPA)

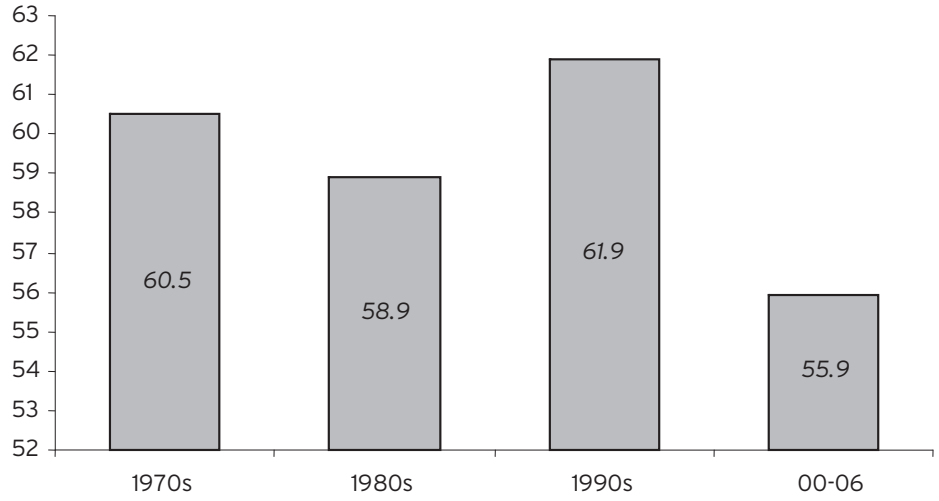
CPA is the part of aid that goes directly into development programs, and thus excludes components such as emergency humanitarian aid, development food aid, debt forgiveness, and technical co-operation. In the Ethiopian context, except for a few years, the share of CPA in total net ODA has always been more than 50 percent (Figure 2). The exceptions are 1971, 1972, 1973, 1981, and 2003. In 1971, non-CPA increased due to technical cooperation and CPA has decreased. What happened in 1972 was that both have decreased but the initial volume for non-CPA was higher than that of CPA. In 2003, CPA decreased significantly and non-CPA more than doubled.[10]

Data about health sector resources are far from accurate and difficult to disaggregate into the various government program priorities. It is even more difficult to disaggregate donors' resources into capital and recurrent expenditures. As can be seen from Table 5, of the total reported donor expenditure of $421.2 million and $538.2 million for 2005/2006 and 2006/2007, only 4 percent and 13 percent, respectively, can be disaggregated into capital and recurrent expenditures by program areas. This inability shows that the information obtained on donor resources—both in terms of forward looking information for budgeting and backward looking information for expenditure tracking—needs to be strengthened. If one also looks at program distribution, more than 72 percent of donor resources financed three diseases: HIV/AIDS, malaria, and tuberculosis (TB). This distribution leaves child and maternal health, as well as health system strengthening, underfinanced. The government's flagship program—the health extension package—received only 1 percent of donor resources in 2005/06 and 2006/07.

If it is difficult to disaggregate donor expenditures into capital and recurrent, it is even more difficult to know the functional distribution of donor resources into primary and curative care. The only evidence that sheds light on this is the National Health Account (NHA) study conducted in 2005. According to this study, donors contributed the lion's share (80 percent) of the total expenditure on prevention and public health services, while the government contributed only 19 percent (MoH 2006). In contrast, the government financed most curative care services (58 percent); with the private sector coming second (39 percent). The private sector financed almost all pharmaceuticals (98 percent). With the emergence and expansion of ARV treatments and new anti-malarial medicines—driven mainly through donor financing over the last three years—donors' shares of financing of curative care and pharmaceuticals are likely to increase from what is estimated in NHA 3.

Donor resource was the major contributor to capital formation (67 percent) followed by government (32 percent). Again, with the increased support from global health initiatives for health systems strengthening over the last three years, the current donors' share might be more than what is stated in this estimation. Government covered most health-related administrative costs, with 83 percent. This again might not have considered the various administrative costs of aid that are incurred in the form of donor expenditure on technical assistance or contractor overheads. These types of costs are always difficult to capture. When one only looks at the donor resources functional classification, the NHA 2005 documented that 52 percent went to prevention and public health, followed by capital formation (27 percent), functions not specified by kind (13 percent), and to diagnosis and health administration (8 percent).

Figure 2: Trends in share of CPA from total net ODA (in percent)



Source: Author's calculation and OECD

Table 5: Donors expenditures by programs and capital versus recurrent (in $)

	2005/2006			2006/2007		
Program	**Recurrent**	**Capital**	**Total**	**Recurrent**	**Capital**	**Total**
Health Extension Package	-	-	3,292,000	28,409	-	4,987,006
EPI	753,148	246,811	32,365,959	152,335	26,944,756	38,639,949
IMNCI	-	-	4,628,526	-	-	5,468,009
Malaria	104,369	246,811	58,375,269	-	20,077,123	149,567,287
HIV/AIDS	787,022	3,511,122	217,483,907	600,000	3,115,077	190,720,059
TB	-	275,072	39,538,813	-	129,682	45,156,804
Reproductive Health	2,561,119	2,569,858	21,847,918	3,090,884	5,773,241	20,456,013
Nutrition	-	246,811	11,721,240	-	444,756	11,243,614
Water, Sanitation & Hygiene	-	-	5,641,349	-	-	3,658,079
Health Systems Strengthening	3,126,376	2,834,246	26,325,063	7,335,021	2,569,049	68,275,822
Total	7,332,034	9,930,730	421,220,042	11,206,650	59,053,683	538,172,642

Source: MoH, 2007.

EMERGING AID PROVIDERS IN THE HEALTH SECTOR

There are emerging players in health sector aid that significantly affect the health sector aid architecture. These include the global initiatives that are modeled using a public private partnership arrangement, including but not limited to GFATM, PEPFAR, and GAVI. The modalities under which these initiatives operate are significantly different from traditional bilateral and multilateral donors.

Recent estimates by the WHO suggest that there are between 75 and 100 Global Health Partnerships (GHPs), sometimes referred to as Global Health Initiatives (GHIs). GHPs are a heterogeneous group, both in mission (advocacy, coordination, financing, etc.) and in design (scale, scope, etc.). However, the vast majority engage communicable diseases; many target the "big three" diseases of HIV/AIDS, TB, and malaria. While there are a large number of GHPs, only a handful have a major impact on health financing—most notably GAVI, GFATM, and PEPFAR. Between 2003 and 2005, GFATM annually committed on average $1.16 billion around the world. Funding from GAVI and GFATM now accounts for 9 percent of development assistance in health.[11]

The significance of these types of funding agencies has grown both in terms of the volume of aid they bring to the health systems and in their organizational impact on health systems. This has generated mixed reactions. On the one hand, there are views stating that these funding mechanisms have brought a number of positive influences including: (i) a global political and technical focus to deliver results for targeted interventions; (ii) the mobilization of significant additional resources to the sector (without which some of the recent gains in health outcomes might not have been achieved), and; (iii) the introduction of a new business model (performance-based funding) to aid delivery both in terms of fund mobilization and providing aid to recipient countries.

On the other hand, there are others that agree with the above findings but question the sustainability of these arrangements over the long term. They argue that GHPs more often than not bypass the mainstream health systems to achieve quick results—sometimes at the cost of other important health sector goals. They establish their own management and reporting structures and create parallel systems, which are likely to collapse when funding from such agencies stops. GHPs also created a number of global institutions and are not adequately represented at country level, which makes alignment and harmonization efforts more complicated. Critics also argue that GHPs create separate financing and delivery modes, leaving very little for flexibility in resource allocation.

Though these conflicting views are expressed, the evidence on the impact of GHPs on country health systems remains scanty. A recent study on 20 countries stated that GHPs pay insufficient attention to health systems, often provide limited technical assistance on how to effectively manage their programs, and impose significant transaction costs to the recipient countries.

The role of NGOs in mobilizing external resources for relief and development has also been a main feature of aid in Ethiopia. In the health sector, NGOs are estimated to provide around 10 percent of all services. In addition, many local and international NGOs support service delivery and management strengthening through government facilities and management structures. However, it is difficult to obtain information on their activities or on the magnitude of their contribution.

There is debate between the government and NGOs about the efficiency, effectiveness, and transparency of NGO-managed services as compared to public services. Some anecdotal evidence shows that the management cost of service delivery is much higher than government services. One study documented that while 60 percent of resources managed by government are spent on service delivery, the analogous proportion of NGOs is much less: about 35 percent.[12] Though NGOs are thought to reach underserved and unreached areas, data available from the government coordinating body in 2003 suggest that NGOs were more concentrated in urban areas and in relatively better-off regions[13]. The same NGO study found a documented existence of problems of poor transparency and accountability, high administrative costs, gaps in capacity, and weak inter-NGO networking. While these anecdotes might not be conclusive facts (and require further scrutiny) they are able to question the validity of the belief that NGOs are more efficient and more effective deliverers of health services in Ethiopia.

The government is drafting a new NGO law, on which both NGOs and donors alike raised concerns regarding its objectives and ability to create a more democratic space in the country. The law delineates activities that national and international NGOs are allowed to be involved in, and thus stands to affect the financing of NGOs. According to the draft law, only national NGOs will be allowed to be involved in advocacy on human rights and good governance, and 90 percent of their finances should be generated within the country. National NGOs with more than 10 percent of their financing coming outside the country will only be allowed to engage in service delivery. NGOs and donors are arguing to change these clauses, but the outcome of the dialogue is yet to be known.

At this juncture, it is necessary to comment on the role of emerging bilateral donors like China and NGOs. China's role in the Ethiopian aid architecture in general, and the health sector in particular, is a recent phenomenon and remains marginal as compared to other bilateral donors. This is particularly apparent as China is not even a member of the Health, Population, and Nutrition (HPN) donor group. Its role might be visible in the next few years in the area of infrastructure development.

In what follows, we explore the magnitude and share of aid from these new sources, investigate their alignment to the government priorities and systems, and analyze their effect on health systems in Ethiopia.

Magnitude of resources for the health sector

In the Ethiopian context, the Global Fund and GAVI account for about 55 percent of all donor resources. Their resources are estimated to account for about 95 percent of the resources going through "channel 2" (the MoH account, see above). This figure does not include PEPFAR, one of the major financiers of health. According to HSDP III midterm review, the attempt to obtain PEPFAR's contribution has not been successful. Table 6 reflects the contribution of these donors for health sector financing.

As can be seen from Table 6, GHPs contributions track nicely with the recent improvements in child mortality, malaria morbidity and mortality, and care for HIV/AIDS, suggesting the importance of GHPs in achieving health outcomes.

Table 6: Role of GHP in financing health in Ethiopia

Source of Funds	2005-06	2006-2007
Global Fund	226,077,626	291,042,978
GAVI	-	23,733,388
PEPFAR	Not known	Not known
Sub total	226,077,626	314,776,366
Total Estimated known public resources	539,103,994	717,276,094
Total estimated external aid and loan	421,220,042	571,121,871
percent of GHP from all known resources	42 percent	44 percent
percent of GHP from external aid	54 percent	55 percent

Source: MoH, 2007

Table 7: Grants portfolio of the Global Fund (approved), updated on August 2, 2006

Component	Round	Grant Number	Grant Agreement Signed	Grant Start Date	Total Funds Requested (US$)	Approved Funding by Phase (US$)		Total Funds Disbursed to Date (US$)
						1	2	
HIV/AIDS	2	ETH-202-03-H-00	Oct 9, 2003	Jan 1, 2004	139,385,088	55,383,811	00.0**	55,383,811
HIV/AIDS	4	ETH-405-GD4-H	Feb 11, 2005	Mar 1, 2005	401,905,883	41,895, 884	00.0	49,931,469
Component Total		-	-	-	542,909,710	97,279,695 (18.0%)	95,415,280 (98.1%)	
TB	1	ETH-102-G01-T-00	Mar 18, 2003	Aug 1, 2003	26,980,649	10,962,600	16,018,049	10,962,600
Component Total		-	-	-	26,980,649	26,980,649 (100%)	10,962,600 (40.6%)	
Malaria	2	ETH-202-G02-M-00	Aug 1, 2003	Oct 1, 2003	73,875,211	37,915,011	35,960,200	70,599,857
Malaria	5	ETH-506-G05-M	May 1, 2006	July 1, 2006	140,687,413	59,113,829	00.0	37,389.954
Component Total		-	-	-	214,562,624	132,989,040 (62.0%)	107,989,811 (81.2%)	
Total All Components		-	-	-	782,834,244	257,249,384 (33.0%)	214,367,91 (83.3%)	

**Disbursed from the GF headquarters to PRs in Ethiopia*
***The requested balance of US $84,011,277 has been approved but not yet signed and disbursed.*
Source: PHRPlus, 2006, the system wide effect of Global Fund in Ethiopia: Final Study report: P71.

Table 8: PEPFAR's contribution in 2006

	Field programs funding by account						Central programs funding by account	Field and Central Total Allocation
	Notified as of May 2006			Current notification August 2006			Current notification August 2006	
Implementing agency	GAP	GHAI	Subtotal	GHAI	GAP	Subtotal	GHAI	
DOD	-	822,000	822,000	-	-	822,000	-	822,000
DOL	-	-	-	-	-	-	-	-
HHS	5,800,000	40,264,000	46,064,000	2,850,000	-	48,914,000	1,026,440	49,940,440
Peace Corps	-	-	-	-	-	-	-	-
State	-	819,000	819,000	-	-	819,000	-	819,000
USAID	-	59,895,000	59,895,000	4,850,000	-	64,745,000	6,631,307	71,376,307
TOTAL Approved	5,800,000	101,800,000	107,600,000	7,700,000	-	115,300,000	7,657,747	122,957,747

Source: PEPFAR, 2006

Alignment with government systems and priorities and their effect on the health system

The Global Fund and GAVI are not only the major financiers of the health sector in Ethiopia, but they are also at advanced levels of alignment with the government system. GAVI is already in the MDG Performance Fund, a pooled fund using government systems.

The operations of GHPs in Ethiopia, especially the Global Fund and GAVI, have significantly improved over the last three years. In this regard Hailom Aklilu and Kate (2006:XVI) state that:

> [The Global Fund's] planning appears now to be in better alignment with Ethiopia's policy of decentralization and power devolution. The regions are actively participating in the preparation of national plans based on their priorities. Review workshops are conducted for consultation in the preparation of national GF-related plans. Moreover, current GF planning is an integral part of Ethiopia's overall third five-year national health plan, HSDP III. Donors report that GF efforts are unfolding in a democratic, transparent, and accountable manner.

Overall, the Global Fund and GAVI are funding government priorities that are aligned to the five year sector strategic plans. On the other hand, the alignment of PEPFAR's financing to health sector strategies is questionable as there is no evidence or mechanism to ascertain this. Its resources are not reflected in the health sector resource mapping exercise and are not part of the integrated Wereda-based planning that tries to bring all actors' activities and resources together at all levels of the Ethiopian health system.

The Global Fund is like most other donors in the health sector in that it follows its own resource channeling approach to support health activities. The result can be a complicated implementation process as well as systems issues in terms of human resources, resource use, measurement, evaluation and reporting, financial management, and requirements for the submission of statements of expenditure and overall accountability. Therefore, harmonization of donor funds is now a priority for the Ethiopian government. The MoH has put a lot of effort to harmonize programs operating in the health sector. One of the most significant early efforts is the signature a memorandum of understanding between the GFATM and PEPFAR to coordinate activities and resources relative to HIV and AIDS. Outcomes from the memorandum still need to be reviewed.

Unlike in other countries, GHPs have started playing a very significant role in financing an accelerated expansion of health infrastructure. MoH in Ethiopia is now using the resources of the GHPs (GAVI and GFATM) as a catalytic fund to increase resource allocation to health at lower tiers of government through signing performance contracts with regional health bureaus. While there is debate about whether the Global Fund should consider diagonal financing of health systems, such a structure is already happening in Ethiopia.[14] The funds are managed through the MoH and government systems, thereby reducing transaction costs. In addition to disease-specific programs, they have also started financing other health systems like human resource development and health management information systems.

FRAGMENTATION OF AID

Fragmentation of total ODA

Ethiopia is one of the countries where donor fragmentation is an issue. The number of donors operating in Ethiopia is large. Excluding international NGOs, there were more than 30 bilateral and 14 multilateral donors operating in the country in 2006. Aid fragmentation can be manifested in different forms: the number of donors, the financial size of each donor, and the number of donor-funded activities.

Most bilateral donors have a small share from the aid market. In 2006, some 54 percent of ODA came from more than 30 bilateral donors, and 12 bilateral donors accounted for only 0.87 percent of total ODA. Countering this fragmentation, the USA accounted for 30.1 percent of total ODA. Furthermore, most donors support more than one project through different disbursement channels, resulting in a proliferation of aid projects.[15]

The main feature of aid fragmentation in Ethiopia is an increasing numbers of donors each with a small share of the total aid envelop yet numerous aid projects. This setup is believed to overburden the Ethiopian government and compromise the effectiveness of aid.[16]

There are three possible methods of computing aid fragmentation.[17] The first one is using data extracted from the OECD, which provides a breakdown of annual disbursements by various bilateral and multilateral donor agencies, treating each funding country or multilateral institution as a single donor. The second method is by treating agencies or departments (within a single donor) as separate donors. The difference between the two methods, however, is small as the correlation coefficient between the two indexes is about 92 percent. The third method computes aid fragmentation based on investment projects and other activities financed by bilateral and multilateral donors. According to Knack and Rahman (2004:14), "A count of projects sponsored by each donor can be made. From these counts, a fragmentation index is computed from donors' shares of projects."[18]

The third method is believed to be more appropriate than the first two as an aid fragmentation index, "based on the number of projects may reflect actual problems associated with lack of donor coordination better than fragmentation indexes based on aid volumes, for which budget support provided by many donors could produce a high value" (Knack and Rahman, 2004:14). The problem with the third method is that one cannot generate annual data as most projects have a lifespan of more than a year. Furthermore, data on projects including start and end dates is very difficult to obtain. In line with this, Knack and Rahman (2004:15) observed that, "about 60 percent of the activities included in AiDA lack project start and end dates." It should be noted also that the results obtained using the first two methods and the third method are quite different as the correlation coefficient between the two is about 45 percent.[19]

In this paper we adopt the first method because of data availability. Based on this method, aid fragmentation is conceptualized as a large number of donors each with a small share of the total aid provided to a given recipient country. Based on this definition, aid fragmentation can be obtained simply as the difference between one and a Hirschman-Herfindahl Donor Concentration Index (HHI).[20]

HHI is calculated by summing the squared shares of each donor in total ODA provided to a given recipient:

$HHI = \Sigma SD^2$

where SD stands for the share of each donor in total ODA. [21]

By subtracting the HHI from 1 and multiplying by 100 we can easily form an aid fragmentation index (AFI):

AFI = 1 – HHI

Since the value of the HHI ranges between 0 and 1, the value of donor fragmentation index is also ranges between 0 and 1. While an AFI close to 0 indicates smaller fragmentation, values close to 1 indicate greater fragmentation.[22] The higher the index, the greater is the degree of donor fragmentation indicating large number of donors and possibly proliferation of aid projects.[23] Based on this, we calculated fragmentation on yearly basis since 1970 (Figure 3).

The increasing trend suggests a small increase in the number of donors. The AFI, averaged over 1970s, was 86.2 percent. This has increased to 90 percent for the 1980s and further increased to 91.4 percent in the 1990s. For the period 2000-2006 it was only 86.4 percent. The overall trend shows that Ethiopia is among the aid recipient countries that have suffered most from aid fragmentation. Using the same method, Knack and Rahman (2004:14) find that aid fragmentation indicies among major aid recipients, averaged over 1982–2000, range from 28.4 for Gabon to 91.6 for Tanzania. For the same period, the AFI for Ethiopia was 90.8.

Aid fragmentation in the health sector

As we discussed earlier, aid fragmentation in the health sector can also be manifested in different forms: the number of donors, donor size, and the number of donor-funded projects/activities. In 2006, there were 14 bilateral donors, which accounted for 46.8 percent of the total net ODA to the health sector.[24] The remainder was sourced from two multilateral donors: UNICEF and GFATM.[25]

Most bilateral donors have a small share of the aid market. For instance, out of the 14 bilaterals, Canada and the UK alone account for 49.2 percent of total bilateral aid in 2006. Furthermore, most donors support more than one project through different disbursement channels, resulting in a proliferation of aid projects. Tables 9 and 10 show donors' shares of total aid in the sector and aid proliferation in the health sector.

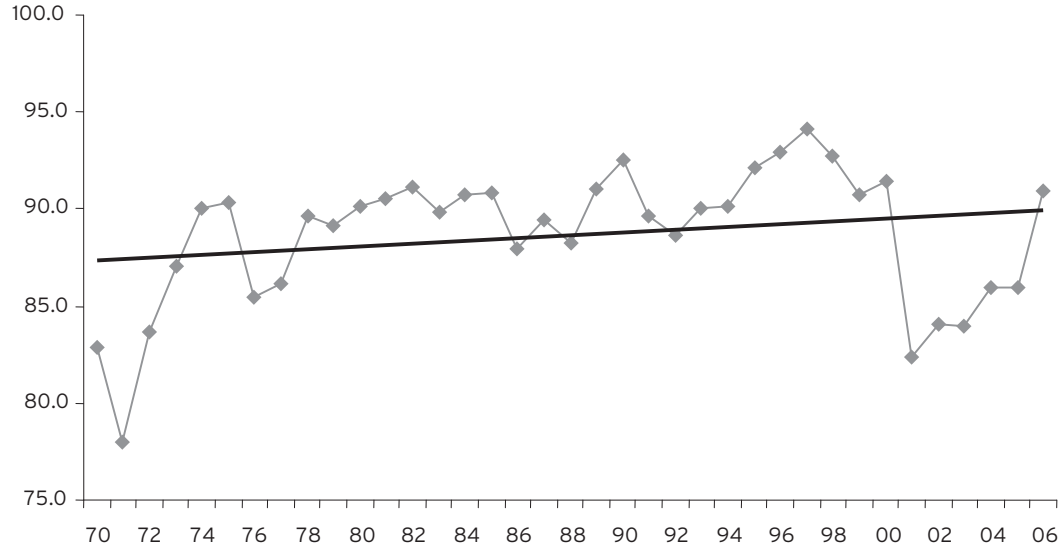
As can be seen from Table 9, the only donors whose share of total aid to the sector exceeds ten percent are the Global Fund, UNICEF, and USAID. PEPFAR is also expected to be in this group, though actual figures are not available.

Though Ethiopia has a sector-wide program (HSDP III), there is no un-earmarked sector support and all aid in the sector is earmarked to a specific disease or the system strengthening area, giving very little room for the country to be flexible or allocate resources to underfunded areas. As a result some of the core MDG targeted interventions (e.g. child and maternal health) remain underfunded.

The number of projects by each donor ranges from 1 to 13 (Table 10). Most donors increase their number of projects with out significant increases in the volume of aid.

For a clear picture we have calculated the AFI for the health sector (Table 11). We employed the same procedure (AFI = 1=HHI).

Figure 3: Total ODA fragmentatin trends



Source: Author's calculations and OECD

Table 9: Shares of donors in the health sector financing (in percent)

Source of Fund	2005/2006	2006/2007
AfDB	0.21	1.00
Austrian development	0.13	0.08
Carter foundation	NA	NA
DFID	1.27	1.11
EC	0.88	3.46
Global Fund	53.67	50.96
GAVI	0.00	4.16
Irish Aid	1.74	0.96
Italian Cooperation	2.06	1.23
JICA	1.27	0.32
Protection of Basic Services component 2	0.00	5.77
PEPFAR	NA	NA
Netherlands	1.93	0.26
SIDA	NA	NA
UNFPA	0.71	0.62
UNICEF	11.65	8.81
USAID	24.48	19.51
World Bank	0.00	1.75
Total	100.0	100.0

Source: MoH (2007)

Table 10: Donor mapping by their projects

	Number of projects		
Donors	2005/06	2006/07	2007/08
Canada	1	1	2
Japan	3	4	5
UK	3	5	5
Norway	1	1	1
Sweden	4	4	4
Austria	6	8	8
Netherlands	9	7	3
Spain	4	7	8
ADB	1	1	1
EC	5	9	8
UNDP		5	9
Clinton Foundation		5	13
Total number of projects	37	57	67
Average number of projects per annum	3.7	4.8	5.6

Source: Author's survey, June 2008

Table 11: Social sector Aid Fragmentation Index (in percent)

Year	Education	Health	Population Programs	Water & Sanitation	Government and Civil Society
1997	74.0	49.7	0.0	68.6	44.9
1998	77.2	67.8	9.4	76.1	76.7
1999	83.7	61.6	38.6	53.9	74.7
2000	73.4	48.5	37.0	65.7	77.5
2001	67.9	76.4	68.3	68.6	87.1
2002	83.1	82.6	78.7	84.6	89.3
2003	87.2	83.9	79.3	89.7	89.5
2004	86.3	85.6	64.8	85.4	86.9
2005	87.0	81.1	75.7	84.9	86.4
2006	74.3	71.2	68.1	82.8	87.7
Average	79.4	70.8	52.0	76.0	80.1

Source: Author's calculations and OECD

Table 12: Health sector fragmentation index (TI)

Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
TI	1.43	0.71	0.78	1.09	0.76	0.81	0.77	0.58	0.92	0.99

Since 2000, the AFI for the health sector has exhibited an increasing trend with modest declines in 2005 and 2006. The overall trend shows that the health sector has been suffering most from aid fragmentation. We also calculated Theil's Index (TI) for the health sector. This second measure is used to decompose the overall fragmentation into within- and across-sector fragmentation (Table 12).

The fragmentation of aid is a constraint to the fiscal space in two ways: (i) most of the aid is provided off-budget to finance NGOs and technical assistants that provide little fungible resources to government; (ii) the proliferation of projects imposes major efficiency costs (i.e., substantial waste of resources resulting from management duplication, weak coordination and the establishment of parallel planning and management structures).[26]

AID PREDICTABILITY AND VOLATILITY

Why does aid predictability and volatility matter? For developing countries like Ethiopia, aid is an important source of public spending. The government has a target for aid revenue, and it incorporates the expected revenue into its fiscal planning. Ethiopia has a plan to mobilize more than 30 percent of its revenue from foreign financing. This means that aid is taken into account when revenue decisions and expenditure allocations are made. Thus, volatile and unpredictable aid undermines the development effort. If the recipient government is not certain about the volume and the time of aid inflows, it is in a very difficult position to plan and implement development expenditures in line with its development priorities. Thus, one can say volatile and unpredictable aid can cause ineffective and distorted uses of resources, and can compromise growth and development.

The government acknowledged the existence of serious challenges to predictability and information on aid flows, pointing out in its annual progress report on Plan for Accelerated and Sustained Development to End Poverty (PASDEP), "aid flow is frequently much less predictable both in terms of timing as well as amount of disbursement. Aid to Ethiopia has been leveling off and new commitments of several bilateral donors have been falling, though some like UK-DFID has increased their support" (MoFED, 2007:51). This problem, however, may be solved once the new database technology adopted by MoFED based on the Development Gateway is fully operational. The system allows donors and recipient government institutions to access and enter data related to signed commitments, planned and actual disbursements, and expenditures—project by project, and on a regular basis (for details, see below).

Aid predictability is all about when and what amount of aid commitments are disbursed. OECD (2005), for instance, defines aid as predictable if "partner countries can be confident about the amount and timing of aid disbursements." If predictability is about the amount and timing of disbursement, one can measure it by taking a number of specific programs over a specific period and comparing the difference between commitments and disbursements with the mean. The higher the gap between aid commitments and actual disbursements, the lower is the predictability of aid.

There is some evidence that suggests aid predictability is poor in Ethiopia. Getnet (2006: Table 2.5), for instance, finds that for the period 2000/01-2004/05 the disbursement ratio of Ethiopia's IDA credit portfolio was, on average, only 25.4 percent. Three-fourths of the commitment was not disbursed as planned. One of the major reasons for this very low disbursement rate was the lack of donor harmonization.

Despite the World Bank's and Ethiopia's insistence to work with a similar modality, donors tend to rely on different instruments of assessment. Instead of planning and working in a harmony—a system which would be more fruitful—most donors tend to prefer to build separate frameworks for identifying areas of intervention in the country. Even worse, some donors often use different systems for disbursements, approval, procurement, monitoring, evaluation, financial management, and reporting. This implies that projects and programs, which are supported by multiple donors, are likely to face overlapping procedures—bringing about difficulties for implementing agencies in the implementation process with subsequent low and slow disbursements.

Due to the paucity of data, we cannot use the gap between commitments and disbursements as a measure

of predictability. Instead, we define aid predictability as the aid recipient government's ability to forecast budget aid disbursements based on the information available at the time of budget formulation. As a result, we shall discuss aid predictability in relation with donor harmonization and alignment of donors with the recipient government in terms of the planning calendar, budgeting process, provision of budget information, and financial management and procedures.

The major principle of predictability is that donors should communicate as much as possible the likely size of the budget envelope they will provide in the budgeting calendar, and to ensure that their financial resources will be transferred to the country on a predictable schedule. It also calls to program aid over a multi-year framework, aligned with partners' financial horizon. Donors should fully disclose expected flows (all aid, without exception, should be captured on the partner budget, even where not channeled through its treasury) and any triggers for their reduction or suspension. They should adapt conditions to make aid more predictable, and commit to disburse funds on schedule, once conditions are met. Partners should build up effective, accountable management systems for raising and using public resources. They also need to reinforce tax systems, improve fiscal planning, and link it firmly to development results.[27]

Most of the donors in Ethiopia have committed certain amounts of resources between 2005/06 and 2009/2010 in support of the third Health Sector Development Program (Table 13). There are significant donors like PEPFAR whose resources are not reflected. Some have provided complete resources (including those that they channel through NGOs), while others provide partial funding information (even missing some resources that go to the government).

Though most donors provide a three- to five-year resources framework, these frameworks are often only indicative and cannot be used for planning. Most donors can only provide two years of resources and most often it is only first year that is useful for planning and priority setting. Most donors indicated that they usually have about 25-30 percent more resources at the end of the year than what they planned for at the beginning.[28]

The Ethiopian budgeting calendar often complicates the ability of donors to align to the country budgeting calendar and process. It is stated that it might take three donor calendar years to fit into two Ethiopian fiscal years.[29]

In one survey, donors were asked to provide their commitments and disbursements for 2005/06, 2006/07, and 2007/08. Almost all donors responded that they have disbursed all of what they are committed for. It is therefore impossible to show gaps between commitment and disbursement, as reliable figures are not available at the country level.

Ethiopia is one of the few countries that have initiated very early on an in-country harmonization and alignment process for better aid predictability—both at the sector and country levels.

At the sectoral level, Ethiopia has utilized a sector wide approach (SWAp) for health sector planning and implementation since 1997. While donors were part of the overall design and implementation process (refer to sections on coordination), the SWAp has not been effectively exploited (by the government or donors) to improve aid predictability and harmonize funding arrangements. By definition, "sector wide" requires following country-defined plans and strategies, using one expenditure framework, one coordination mechanism, and government or harmonized systems for planning,

Table 13: Ethiopian health sector donors and their planning horizon

Name of Donor	Provision of resource envelope (2005/06 to 2009/10)	Earmarking
African Dev't Bank	3 years	Yes
Austrian development	5 years	Yes
Carter Foundation	No information	Yes
DFID	4 years (does not include 2009/10)	Yes
EC	5 years	Yes
GAVI	4 years (the last years)	Yes
Global Fund	5 years	Yes
Irish Aid	5 years	Yes
Italian cooperation	4 years (last year not included)	Yes
JICA	3 years (last three years only)	Yes
PBS (component 2)	4 years (last four years)	Yes
PEPFAR	No information	Yes
Netherlands	5 years	Yes
SIDA	No information	Yes
UNFPA	5 years	Yes
UNICEF	5 years	Yes
USAID	5 years	Yes
World Bank	4 years (does not include last year)	Yes
WHO	No information	Yes

Source: MoH (2007)

financial management, measurement and evaluation, and technical assistance. While a development program (the HSDP III-strategy document) exists, other parts of SWAp are not yet fully in place. For instance, resource mapping exercises have not been successful in building a common expenditure framework. There is no un-earmarked sector support so far; all donors provide projectized support and try to finance activities rather than the agreed overall strategy. Most of the donors are using their program/project approach to finance the health sector.

At the country level, since the launching of the Sustainable Development and Poverty Reduction Program (Ethiopia's PRSP), there was a shift toward budget support until 2005. This movement has significantly improved the government's ability to flexibly allocate resources among the various sectors, including health based on its priorities and strategies. This ability was reinforced by a renewed effort after the signing of the Paris Declaration for improving aid effectiveness. In this regard, a national harmonization action plan was developed in 2005 for implementation. The harmonization action plan states that the country will benefit from external aid if donors could:

1. take necessary steps to effect realignment of their country assistance strategies in terms of content and timing with government strategies;
2. harmonize their institutional assessment, the rules they apply to disbursement and procurement; and use audit procedures relying increasingly on the government systems and procedures; and,
3. provide capacity building support as necessary and help meet donor expectations and international standards.

The action plan states clearly that it will be implemented in a phased manner.[30]

The action plan clearly stipulated action points that the government should undertake to strengthen systems and procedures on the one hand and what donors should do to align and harmonize on the other. As a result of these developments, the coordination and effectiveness of aid have been improving (see the figures on the Paris Declaration Indicators in the subsequent sections). With this overall improvement in coordination, however, there is retrogression in some aspects of provision of effective development aid: working through the government system.

Unfortunately political concerns following the 2005 elections did not help to get the above action plan fully implemented. Harmonization and alignment in the country in general, and in the health sector in particular, is moving slowly. Most donors that were providing Direct Budget Support (DBS) before the 2005 general elections have resorted back to earmarked project support. While DBS has increased predictable and flexible funding at the country level, mechanisms have not been put in place to ensure that more resources are allocated to health once it goes into the government coffers. In project type support (particularly PBS block grants, see below) there has been efforts to increase resources to local district governments, which, in turn, has enabled increased resource allocation to the poverty reduction focused sectors.

In the absence of sector support funds, results have been achieved in getting like-minded donors to establish pooled funds. In-country health sector coordination mechanisms have enabled eight development partners to harmonize among themselves through the establishment of two pooled funds: the Health Sector Pooled Fund (HSPF) and the PBS.[31] These funds are administered outside government systems by UNICEF and the World Bank, respectively, and have not contributed to strengthening government systems in any way.

With the exception of the Bank (that has pooled its resources to the Bank-managed PBS), and UNICEF (that managed health-sector pooled funds) most multilateral organizations continue to use their own systems. UN agencies in particular harmonize neither among themselves nor with the government—again, with the exception of UNICEF. In this regard, donors were asked to fill a questionnaire in order to obtain information on the contribution of development partners in the area of alignment and harmonization. Table 14 summarizes the results.

Table 14 shows the number of donors that use of their own, Ethiopian, or a pooled system (or a combination of these three). Seven out of eight donors that provided information responded that they provide budget information to the government; five use the Ethiopian budgeting calendar and four use the Ethiopian budgeting process. Donors have yet to align their critical budgeting financial management and procurement processes with the national government, raising significant transaction costs for Ethiopia. Because of more aligning and harmonizing policies adopted at headquarters (HQs), two development partners were able to abandon their systems and procedures in favor of either the pooled or government systems. These development partners were encouraged by their HQs to do so. In line with this, the government, in its annual progress report on PASDEP, stated that the country is facing a serious challenge with regard to harmonization and alignment among development partners. It states that the "lack of harmonization and alignment of policies, procedures and programs among various donors' agencies is still a problem in making aid delivery effective. On the other hand there is no mechanism for the country to hold donors accountable.

Table 14: Donor alignment and harmonization in the health sector

Alignment issues	Own Donor system	Ethiopian government system	Pooled system
Planning calendar	3	5	1
Planning process	3	4	2
Budget information	2	7	1
Budgeting process	4	2	1
PFM	4	1	3
Procurement	4	1	3
Audit	4	4	3
Reporting and review	5	5	3

Source: MoH 2008

This needs to be replaced by effective development partnership based on mutual accountability." (MoFED, 2007:51).

There is currently a discussion toward establishing a third pooled fund that will use government systems and will be managed by the government. While most development partners agree on this concept and its rationale, they have not joined (with the exception of GAVI), either because of political reasons (associated with the election of 2005) or because of concerns with the capacity of the government systems to meet donor requirements. Weaknesses observed in the government system (public financial management, procurement, budgeting formulation, and execution of reporting and reviews) to respond in an effective and timely manner are often raised as constraints for moving forward in the alignment and harmonization agenda.

Indeed, Ethiopian government systems require strengthening. Capacity development is a process and cannot be built over night; it also requires investment in skills, processes, procedures, and the enabling environment. It is a documented fact that the management cost of providing aid outside the government system is huge (e.g., the establishment of many parallel systems which is difficult to manage; erosion of government capacity through poaching staff and weakening the already weak government capacity; the time spent to prepare and submit vertical plans and reports by the government to this programs; the time spent by the management of FMOH and RHBs officials to address the issues) and not sustainable. Nevertheless, donors are often not willing to invest on strengthening government systems. Some are reported as demanding more from the Ethiopian government than what they can do themselves.

What really seems to be the main challenge for further alignment, harmonization, and predictability in Ethiopia (and for that matter, any recipient country) is the willingness and political commitment of donor headquarters. Most donors talk positively about the agenda but are not able to walk the talk. One such effort to provide political push for alignment has been the International Health Partnership (IHP) road map. Participants of the IHP first wave countries expected to get more commitment from global signatories of the compact at the Lusaka Meeting in February 2008. What they got instead from the donor HQs was advice to develop more documents and plans that are not significantly different from what already exist. While the main objectives of alignment and harmonization

are to reduce transaction costs, there is an ironic feeling that costs are increasing (from increased meetings) while donor behavior on the ground is only changing a little.

Given the significant dependency on aid, aid flow stability is important for ensuring proper planning and development. In most aid literature, it is claimed that the volatility of aid is increasing recently (see Kharas, 2007). Kharas finds that aid is, "much more volatile than national income" and that, "volatility has risen since 1990, compared to the two preceding decades" (Kharas, 2007:21). Ruth (2005) finds the same result for sub-Saharan African countries. It is shown that aid is more volatile (30 percent from a trended average) than GDP (<10 percent from a trended average). Aid is also twice as volatile as tax revenues (see Ruth, 2005: Figure 1-4).

The same story is true in Ethiopia. Both net ODA and CPA are volatile and volatility has risen in 1990s. The volatility of CPA is higher than the volatility of total ODA. An interesting observation from Table 15 is that the volatility of CPA and the share of CPA in net ODA move in the same direction implying that CPA is more volatile than non-CPA. This is understandable as a significant part of non-CPA has a characteristic of timely and fast disbursing nature. Aid volatility is calculated as the deviation of observed flows from the expected, constant dollar trend of net ODA. Table 15 presents the volatility of total aid and CPA.

As may be observed Table 16, unlike the percentage deviation from the trend, the volatility from the detrended aid series has declined since 1990s.

The volatile and unpredictable nature of aid flows is costly. The cost is reflected in the deviations from actual plans. The Ethiopian government has a target for aid revenue, and this expected revenue is incorporated into its budget. The actual disbursement of aid revenue has always been less than from the level of what was budgeted, except in the 1998/99 fiscal year. The details are presented in Figure 4.

As may be observed, the gap between what is budgeted and the actual disbursement is increasing with no clear pattern. For the period 1996/97-2005/06, on the average, about 77.3 percent of the target for aid revenue was disbursed, ranging between 58.0 percent in 2005/06 and 117.0 percent in 1998/99. The huge gap in 2005/06 was as a result of the aftermath of the May 2005 election. Most multilateral and bilateral donors expressed their concern on the political developments and on how the government handled the situation, sending a clear message that "business as usual will not be possible." Notably the European Union's reaction to the crisis has been critical. Thus, following the May 2005 election, aid disbursement had two characteristics: (i) delayed disbursement despite all technical conditionalities were fulfilled and (ii) most donors suspended their budget support.

As a result, fiscal policy in 2005/06 was marked by a rapid adjustment to this significant shock. The Ethiopian government was forced to adjust its revenue and expenditure plan. The expenditure was adjusted by scaling down activities, abandoning planned projects, and discontinuing existing projects. The expenditure cut was made in those high-import content investment programs, such as public utilities. On the revenue side, the government attempted to finance most pro-poor expenditure plans by increasing domestic financing. Domestic financing of the fiscal deficit in 2005/06 fiscal year had to increase to 4.2 percent of the GDP as opposed to 3.6 percent that was budgeted. A draw down of international reserves, higher fuel prices to consumers through upward adjustment of retail fuel prices, and increased electricity prices through tariff adjustment were all used to raise domestic revenue.

Table 15: Volatility in net ODA and CPA (percent deviation from the trend)

	Total ODA	CPA	Health	Share of CPA from total ODA (percent)
1970s	25.9	46.6		60.5
1980s	27.1	31.8		58.9
1990s	37.9	42.4		61.9
2000-06	16.7	23.0	96.3	55.9
1970-2006	27.7	37.0		

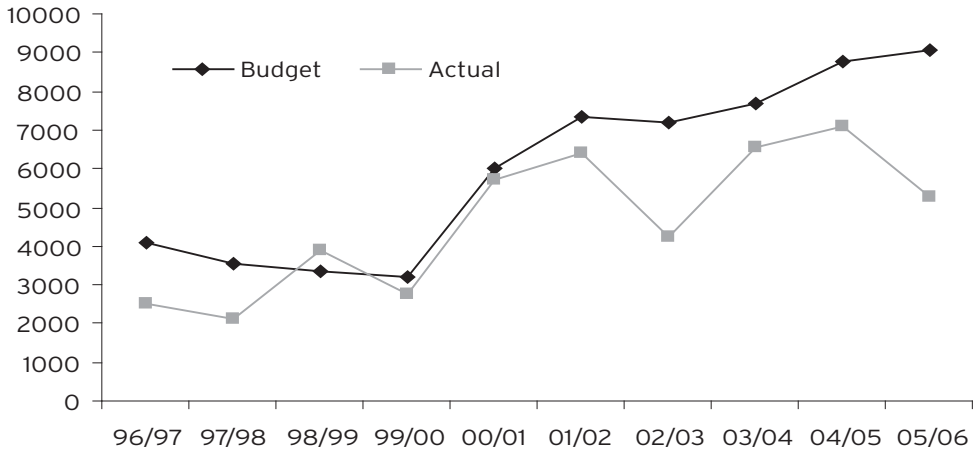
Volatility of aid was also estimated from de-trended aid series using the Hodrick-Prescott filter (HP).
Source: Author's calculations

Table 16: Trends in volatility of net ODA, de-trended series

	1970-79	1980-89	1990-99	1997-2006
Option I: shorter				
RMSE	59.2	246.2	93.8	119.4
Mean	345.3	985.5	1147.0	1420.4
Volatility = RMSE/Mean	0.17	0.25	0.08	0.08
Option II: longer				
Mean square error	3503.4	3503.4	3503.4	3503.4
RMSE	59.2	59.2	59.2	59.2
Volatility = RMSE/Mean sq. error	0.17	0.17	0.17	0.17

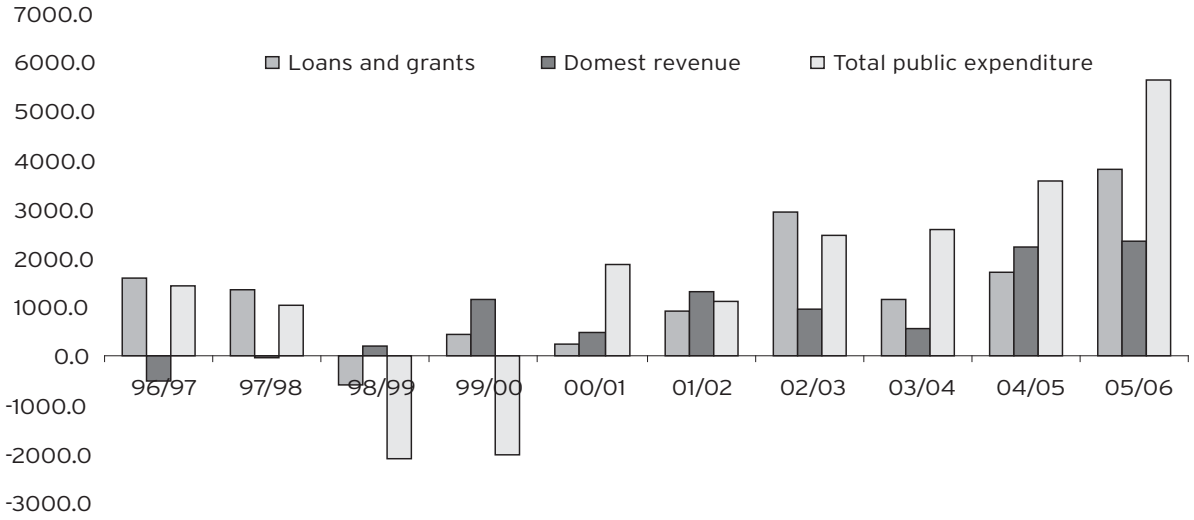
Source: Author's calculations

Figure 4: Aid as budgeted by the government and actual disbursements (in millions of Ethiopian Birr)[32]



Source: MoFED, various budget documents

Figure 5: Government responses to cope with aid volatility (budget, actual in millions of ETB at current price)



Source: Author's calculations and various budget documents

Figure 5 reveals the government response to cope with aid volatility and unpredictability.

As may be observed from Figure 5, except for 1998/99 and 1999/00, the government response to cope with volatility and unpredictability of aid was by downsizing its expenditure plan, largely the capital nature of its expenditure. Government responses seem to show that aid is pro-cyclical with respect to public expenditure. The correlation coefficient between the two is 81.9 percent. The fluctuation of aid did not exhibit a clear pattern in relation with government domestic revenue. This is also supported by a weak correlation coefficient of 48.7 percent.

As indicated above, scaling down of activities is one of the costs of the volatility of aid. It is reflected by adjusting government expenditure which boils down to differing priorities between donors and the government. In addition to this, there are a number of concrete anecdotes about the costs of aid volatility reflected by the discontinued aid-supported government activities both before and after the 2005 election. The Afar Livestock Recovery Program Phase III and the Seed Security Project Phase II, supported by the Norway Government and implemented by FAO, were discontinued simply because two Norwegians were expelled from Ethiopia due to security reasons.

The United Nations Capital Development Fund (UNCDF) projects—Woreda Development Fund ($4 million), Adiarkay Sustainable Development Project ($8 million), and the Shehedi-Shinfa-Gelego road project ($2.5 million)—were reduced from $14.5 million to about $2 million once the projects were under implementation. Projects like the Integrated Biodiversity Management in and around Yangudi Rasa National Park were discontinued two years after signing the agreement simply because of policy changes by the French government.

AID COORDINATION

Instruments of coordination

The government of Ethiopia has used the earlier Sustainable Development and Poverty Reduction Program (SDPRP) and now the PASDEP as its development strategy. PASDEP has a five year horizon and its development has been led and owned by the government. Though the extent to which the process of its development has been broad based and participatory is debatable—its ownership and government-commitment is not questionable at all. Based on the development strategy, the health sector has also developed a health sector development program to guide the health sector spending decisions. Both PASDEP and HSDP III aim their targets and resource requirements at meeting the MDG goals and are based on an MDG Needs Assessment Study.

There are a number of structures and systems that are put in place for aid coordination. As described below, some are working better than others. (See previous section on predictability for information on the instruments of financing—sector wide approaches, direct budget support, and pooled funding.) This section will only focus on the structures of the new database technology based on the Development Gateway to record and coordinate all aid, dialogue, monitoring, and mutual accountabilities.

Cognizant of the problem of recording and coordinating the aid inflows, MoFED has adopted a new database technology based on the Development Gateway known as the Aid Management Platform (AMP). The database technology enables MoFED to record aid inflows (commitments, disbursements, and expenditures) by type of aid (loan, grant, and in-kind), sector, component, and location (federal, region, or woreda) on a regular basis. Basic project information is also recorded. Physical and financial reports are to be generated from the AMP on a quarterly and annual basis.

Introduction of the AMP has two phases. The first phase is to fully operationalize within MoFED. The AMP is under implementation within MoFED since 2007/08 and all relevant departments are progressively being familiarized with the system. Once this phase is completed, the second phase is to rollout the AMP to federal and regional aid recipients, public institutions, and donors. In the second phase, the first target is line ministries. Line ministries will be allowed to have access to the database and also obliged to report expenditure data in the system. Once this is operational the major four regions will have access to the data base and they are also obliged to fill expenditure data.[33] Donors are last in the second phase to have access to the database. Donors will be also required to fill disbursement data regularly. It is hoped that by 2009/10 the AMP will be fully operational in the country.[34]

Despite the current confinement of the AMP within the MoFED, benefits are already starting to be reaped. Bulletins of external economic cooperation are being made based on data obtained from the AMP. Officials from Tanzania, Zanzibar, Burkina Faso, and Malawi have visited to learn about the system.

Structures and mechanisms for dialogue

There are established structures at county and sectoral levels that help the coordination of aid. An enhanced mechanism for government-donor dialogue has been put in place since 2004 to assist "each party to hold the other transparently accountable" and for better dialogue on program implementation and policies. A high level government-donor forum (HLF) led

by the State Minister of MoFED and co-chaired by the Development Assistance Group is expected to meet on quarterly basis to meet the three main HLF agendas (program implementation, harmonization, and policy discussions). In addition to the HLF, subsidiary groups (health, education and food security) sector coordinating institutions (see below for health) have been recognized and should link to the HLF.[35]

The health sector is one of the few sectors in the country with development program in place for more than a decade. The Central Joint Steering Committee (CJSC), consisting of donors and the government, is the highest policy decision making body with the responsibility of overseeing, coordinating, and facilitating the implementation of the health sector development programs (HSDP I to HSDP III). Membership of the CJSC is from MoH, other government ministries, and donor representatives. The Christian Relief and Development Association (CRDA), an umbrella organization for NGOs, also sits as a member of the CJSC though its capacity to negotiate with government and donors on behalf of its members. Still, its ability to effectively coordinate its members is questionable.

There are also parallel coordinating structures for HIV/AIDS and the Global Fund, like Country Coordinating Mechanisms (CCM) and Interagency Coordinating Committees (ICCs). Most of the membership of these two types of coordinating structures is similar and yet it has not been possible to bring these coordinating structures together to allow meaningful implementation of the one plan, one budget and one monitoring processes. The transaction cost of involvement is very high, though it is reported that GAVI and GFATM are willing to reconsider joining a strengthened in-country coordinating structure.[36] Currently, it seems there are two plans, two budgets, and two monitoring systems: one for health and one for HIV/AIDS.

The CJSC is expected to meet every quarter but has not been as functional as it should be for many reasons: (i) it has not met on a quarterly basis; (ii) the members of the committee were not able to attend these meetings as they are ministers and in some cases ambassadors. When members are not available, they are represented by health program officers who make the CJSC more or less similar with the Joint Core Coordinating Committee (JCCC, described below). As a result, the interest to convince the CJSC seems very low.

The next level coordinating body is the MoH-HPN Donor Joint Consultative Forum. NGOs are represented by CRDA in this forum, too. The forum is more of a broader consultative forum, which promotes dialogue and regular exchange of information, enhances the spirit of partnership, and builds confidence among the stakeholders to facilitate the implementation and monitoring of the HSDP program.

The JCCC is both a coordination and executive organ, as well as the technical arm of the CJSC. It follows up the implementation of CJSC and MoH-HPN joint consultative meeting decisions; it assists the HSDP secretariat (Planning and Programming Department of the MoH) in undertaking review and other necessary activities to manage the implementation of the HSDP. CRDA is also expected to be part of this committee but it does not usually attend.

There is a health sector harmonization manual, which describes the process by which harmonization is going to be undertaken in the health sector. Furthermore, a Code of Conduct between some 14 donors and the government of Ethiopia has been signed. [37] The USA has not signed the Code of Conduct. (See previous sections relating to the gains, challenges, and constraints in the various thematic issues.) It is important to note

that the gains that have been achieved so far have been far below what is agreed both in the country and at international levels. Progress did not meet the high expectations that the Paris Declaration process hoped for. There was a general impression that the rhetoric was well ahead of action. Donor coordination and collaboration in general is not about producing policies, studies, and guidelines but to change behavior and to improve development results in the health sector. It is therefore necessary to explore the main issues that undermine the alignment and harmonization agenda and what should be done to try and encourage stakeholders of aid to "walk the talk." These issues can be placed in three groups.

First, the country's political situation affected progress and trust between donors and the government. The government finds itself in difficult position after the 2005 election to take leadership and enforce alignment and harmonization commitments. Donors feel that the country has not fully met its commitment of good governance as is stated in the Paris Declaration. Hence it was difficult to have one plan, one budget, and one monitoring framework. Because of governance concerns, some donors resorted from general budget support to earmarked project type funding through the establishment of PBS. The weak country systems (financial management, procurement, budgeting, and auditing) provided adequate reason for donors to continue strengthening parallel systems. There have been very weak enforcement mechanisms for donors that perpetuate non-aligning behaviors. There are instances where some donors opt out from the sectors with strong leadership and opt in to weaker sectors.

Second, the alignment and harmonization agenda takes the transaction cost of aid from the government to donor offices within countries. Donor staff must prepare and work toward one plan, one budget, and one monitoring framework. The various sector leads in the donor community, more often than not, must translate the sector's priorities and reports to their agency's own planning, budgeting, and reporting formats. This takes time and energy. Most donors have no incentive mechanism designed to encourage these officers to exert more energy and time toward harmonization.

Third, the commitments, willingness, and the ability of most donor headquarters to change their behaviors (policies, processes, and procedures) are at best questionable and at worst non-existent. This is compounded by the fact that donor agencies need to be accountable to their tax payers. It still remains a challenge to balance "accountability at home" and mutual accountability with the recipient country.

Monitoring and evaluation frameworks and their success/failure in achieving the objectives

Countrywide framework

Government wide, the performance of the Ethiopia is being reviewed through the Annual Progress Reports (APRs) of PASDEP, which has now been prepared for the third time after the Joint Declaration on Harmonization, Alignment, and Aid Effectiveness of 2006. The report analyzes the performance of the economy based on administrative reports generated for sector and macroeconomic performance, and is supported by various survey-based data including but not limited to: household income, consumption and expenditure, welfare monitoring surveys, and the participatory poverty assessment.

Though all sector performance indicators have been reviewed and included in the APR, the 12 indicators

and 22 targets of aid effectiveness to be reached by December 2010 have not been reviewed as part of the APR. [38] The section on the aid management remains too general without reflecting progress or lack of it. Unless mechanisms are put in place to follow up and hold both government and donors "transparently accountable" for the commitments made as part of the APR, the declaration will not be realized.

Health sector framework

Ethiopia is one of the countries that routinely carries out these sector reviews. So far two final evaluations, three midterm reviews and nine annual health sector reviews have been carried since the initiation of the sector wide approach. International and national consultants have been selected and deployed for these reviews. The review teams usually are composed of various disciplines. Most of the recommendations, particularly in the recent times, have been followed up and implemented. The main achievements of these reviews have been their ability to show, through an independent team, the status of the commitments and their ability to tease out the main challenges/possible solutions. The reviews have enabled stakeholders to re-negotiate targets and strategies for improvement. On the other hand, reviews are carried out by independent teams and have so far not involved, in a systematic way, implementers in the evaluation process. Consequently some of the recommendations are not followed up or may not be owned/shared by implementers.

What follows from the above is that that there is a need to refocus the objective of the external review on verification and providing external quality check. This could assist in getting issues taken up and recommendations implemented. The findings of the annual reports and midterm and final reviews and other topical issues have been presented and actions and recommendations are made during annual review meetings, which have been carried out without any interruption for the last nine years. Regional health bureaus have started to take on organizational and leading roles since last year. These are expected to improve with the results framework to be adopted as part of IHP compact.

Reviews mainly focus on all issues of recipient government accountability to results. The Paris Declaration clearly states mutual accountability as one of the five principles. However, in practice, there is only one-sided accountability (government to donors) and not vice-versa. There is no mechanism put in place to ensure that donors are also accountable for predictability of aid, aligning, and harmonization to the government systems and priorities. That is the main reason for lack of progress in the area of alignment and harmonization in Ethiopia.

Results from survey of monitoring Paris Declaration

Ethiopia took part in both the 2006 and 2008 Paris surveys monitoring donors' efforts to coordinate. The survey report (OECD 2008b) from these two surveys assesses progress made with regard to Paris Declaration in terms of country-owned policy processes and systems, alignment of aid with country systems, aid harmonization, and accountability. Responses to the 2006 and 2008 surveys in Ethiopia are summarized in Table 17.

As may be observed from Table 17, the aid coordination effort seems to be moving slowly. The reflection of aid flows in the country's national budget suggests that aid flows are aligned with national priorities. The alignment initiative was weakened following the events surrounding the 2005 election. The govern-

Table 17: Indicators measured through the surveys

Indicators	2005	2006	2007	2008	Implications
Existence of operational development strategies (ownership)	C		B		Positive
Reliability of PFM system (ownership)	3.5		4.0		Positive
Comprehensiveness and realism of government budget system (aid flows are aligned on national priorities)[39]	74 percent		62 percent		Negative
Coordination of TA with country programs	27 percent		67 percent		Positive
Use of country system					
Financial management[40]	45 percent		47 percent		Positive
Procurement	43 percent		41 percent		Negative
Number of PIUs parallel to country structure	103		56		Positive
Aid disbursements on schedule and recorded by government (Aid is more predictable)	96 percent		73 percent		Negative
Program-based aid (Use of common arrangements or procedures - harmonization)	53 percent		66 percent		Positive
Donor missions coordinated (Joint missions)	27 percent		29 percent[41]		Positive
Joint country analytic work	50.0 percent		52 percent		Positive
Results-oriented framework	C		C		

Source: OECD, 2008b Appendix A

ment has, however, made significant improvements in aligning technical assistance with its National Capacity Building Strategy. There is also a modest progress in harmonization. Sixty-six percent of the total aid is program based, which is an increase of 13 percent relative to what was in 2005.

KEY CHALLENGES

Aid is not effectively coordinated. It is fragmented and unpredictable. There are several donors that have several projects but only a small share of the aid market. Despite Ethiopia's early initiation of an in-country harmonization and alignment process, both at the sector and country levels, achievements have not been comprehensive . The health sector SWAp, for instance, has not been effectively exploited by either the government or donors to improve aid predictability or harmonize funding arrangements. Progress is often made in areas where significant transaction costs cannot be reduced. Most multilateral organizations continue to use their own systems rather than aligning and harmonizing. UN agencies, in particular, harmonize neither among themselves nor with the government, with exception of UNICEF. What really seems to be the main challenge for further alignment and harmonization in the health sector is the willingness and political commitment of donors and their headquarters. Most of donors do talk positively about the agenda but are not able to walk the talk. Without political commitment at donor headquarters or incentive mechanisms to change the attitude and behavior of donor staff, recipient counties are likely to be frustrated by the lack of meaningful progress.

The other challenge is related to meeting the ideals and principles that underpin the Paris Declaration. A lot more should be done to strengthen good governance, the rule of law, and fiduciary systems to an acceptable standard. These are real challenges, as they require huge investment in a country with severe financial and capacity constraints. These investments require commitment well before visible results. The IHP initiative in the health sector that aims to ensure that aid is more predictable and aligned to government priorities and systems can reduce a number of transaction costs—but only if systems are strengthened and become acceptable to donors.

The coordination structures both at the country and sectors levels exist, but their full functionality remains a challenge. Most coordination structures need to work as per their terms of references. In the health sector, the coordination structures require consolidation and reduction of parallel mechanisms. These coordination structures should practice the concept of mutual accountability (including naming and shaming) rather than government-to-donor accountability to influence donor behavior on aid effectiveness in general, and on alignment and harmonization in particular. The concept of division of labor among donors through the introduction of lead and silent donors, delegated partnership, or specialization in a few sectors has yet to be practiced in Ethiopia.

The composition of the existing consultative and coordination mechanisms at all levels do provide room for all stakeholders to voice their concerns and issues. However, in terms of power and decision making, one can say that it is dominated by the government and donors. The involvement of the private and NGO sectors is weak. This is justifiably so for reasons related to their limited roles (comparatively) in service delivery and management, and their weak organizational strength. But it is a challenge for the private sector and NGOs to align their interests and strengthen their negotiating ability with the government and donors.

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ENDNOTES

1. For an account of the special interest of the role of aid in Ethiopia see Getnet 2002 and 2006.
2. Other multilateral sources include: GEF, Nordic Development Fund, IFAD, UNDP, UNFPA, UNHCR, UNICEF, UNAIDS, UNTA, and WFP.
3. Other bilateral sources include: Australia, Austria, Belgium, Denmark, Finland, France, Greece, Luxemburg, New Zealand, Portugal, Spain, Switzerland, Czech Republic, Hungary, Korea, Poland, Slovak Republic, Thailand, Turkey, and Arab countries. All data used in this study were extracted from OECD.Stat on April 28, 2008, unless and otherwise indicated. Data represent donors active since 2000.
4. Values are in 2006 constant price, US$ millions. Of the total net ODA Ethiopia received in 2006, IDA (17 percent) and USA (16 percent) forms the single most important source from multilateral and bilateral group.
5. It should be noted, however, that, considering the total aid inflows, Ethiopia receives a significantly lower level of development aid than most other low-income countries. Excluding humanitarian relief, aid inflows have averaged between $7.5 and $9.0 per capita over the past decade, rising to about $12 per capita in the recent past against $23.0 for sub-Saharan Africa and $21 for all least developed countries. (See World Bank, 2003:7; World Bank, 2004:28; MoFED, 2005:18.)
6. National accounts are deflated by GDP deflator (2006/07 price) and converted into US$ by using the average exchange rate.
7. Data sources are OECD.Stat and Resource Mapping Study for Education, Health, and HIV/AIDS, MoH forthcoming.
8. It should be noted, however, that the data on aid in the health sector is disbursement and not actual expenditure.
9. For details see World Bank 2008: Figure 3.
10. Humanitarian aid has increased more than four times.
11. WHO (2007:3).
12. FMOH, Second National Health Account 2003, draft and not published
13. FMOH, HCF Secretariat. 2003. "NGO Involvement in the Ethiopian Health Sector: facts, challenges, and suggestions for collaborative environment." Addis Ababa
14. Gorik Ooms and et al (2007).
15. There are three disbursement channels practiced in Ethiopia. Channel 1 refers to those funds coming through the central treasury; Ministry of Finance and Economic Development. Funds disbursed through channel 2 directly go to line ministries and/or lower level of public agencies. Funds disbursed through channel 3 are directly goes to implementers completely bypassing the mainstream budget process.
16. See Radelet (2006), Knack and Rahman (2004) and Roodman (2006).
17. See Knack and Rahman (2004:14-15).
18. The Development Gateway's AiDA (Accessible Information on Development Activities) database is used to construct this kind of aid fragmentation index. This source contains records provided by the DAC and other sources on investment projects and other activities financed by various donor agencies.
19. See Knack and Rahman (2004:14).
20. The Hirschman-Herfindahl Index is more commonly used as a measure of the degree of concentration—in terms of the number and size of firms—in a given industry. In this case, the parameter s would be interpreted as the market share of each individual firm. The lower (higher) is the index, the more (less) competitive is the industry. A value of 1 for the index indicates a single monopolistic firm. (International Development Association Resource Mobilization (FRM) February 2007, Aid

Architecture: An overview of the main trends in official development assistance flows.)

21. See Knack and Rahman (2004:13-14).
22. If there is no any dominant donor and all have somehow equal share, the fragmentation index will take higher values.
23. If there is no any dominant donor and all have somehow equal share, the fragmentation index will take higher values.
24. Canada alone accounts for 33.6 percent and UK 15.6 percent.
25. The data extracted from OECD.statistics on April 28, 2008 at 22:13 has serious problems. On the one hand the total net ODA of all sectors is only $1216.5 million while the total Net ODA by aid types (CPA and non-CPA) is $1946.8 million for 2006. The net ODA for health sectors for 2006, for instance, did not include some bilateral and multilateral donors like Italy, AfDB, EC, UNFPA, and UNICEF to mention a few.
26. OECD/DAC (2005:22).
27. OECD/DAC, High Level Forum, Joint Progress toward Enhanced Aid effectiveness, Harmonization, Alignment Results: Report on Progress Challenges and opportunities, 2005, p 22.
28. Catriona (2007:55)
29. The Ethiopian budget year runs from July to June and the calendar year runs from September to August while most donor calendars follow January to December. Two Ethiopian calendar years therefore fall into three donor calendar years. Donors therefore have to grapple with scheduling their funding to fit to Ethiopian fiscal year. This has therefore complicated the alignment agenda.
30. See GoE (2005)
31. PBS has two components: component one consisting of block grants to Regional states and Districts and component two of health sector commodities.
32. Aid includes grants and loans from the government budget document.
33. These are Amhara, Oromia, Southern Nations Nationalities and Peoples, and Tigray regional state.
34. Based on the interview with Mr. Admasu Nebebe, UN team leader, Multilateral Department, MoFED.
35. GoE (2003), Mechanisms for Enhanced Government-Donor Dialogue in Ethiopia.
36. See Waddingtton (2008).
37. Donors that have signed the COC for the sector include ADB, DFID, GAVI, Irish Aid, Italian Cooperation, Royal Netherlands's Embassy, SIDA, UNAIDS, UNFPA, UNICEF, WHO, and World Bank.
38. GoE and DAG (2006) Draft Joint Declaration on Harmonization, Alignment and Aid Effectiveness.
39. The percent is computed as a ratio of government budget estimates of aid flows to aid disbursed by donors.
40. This includes budget execution, financial management, and auditing.
41. Total donor missions in the same year were 222.

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