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## EVALUATION

# Ethiopia Health Sector Financing Reform Midterm Project Evaluation

December 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by George Purvis (Team Leader), Abebe Alebachew, and Wendwossen Feleke, through the Global Health Technical Assistance Project.



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**DISCLAIMER**

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## ACRONYMS

BOFED	Bureau of Finance and Economic Development
CBHI	Community-based health insurance
CEO	Chief executive officer
ETB	Ethiopian monetary unit, the birr
FGB	Facility governance board
FMOH	Federal Ministry of Health
FWS	Fee waiver system
GHI	Global Health Initiative
GH Tech	Global Health Technical Assistance Project
HCF	Health care financing
HIA	Health insurance agency
HSDMA	Health Service Delivery Management and Administration
HSDP	Health sector development plan
HSFR	Health sector financing reform
HSFRP	Health Sector Financing Reform Project
MOFED	Ministry of Finance and Economic Development
NHA	National Health Accounts
QM	Quality management
PSI	Population Services International
PFSA	Pharmaceutical Fund and Supply Agency
P4P	Pay for Performance
RHB	Regional health bureau
RSC	Regional steering committee
SHI	Social Health Insurance
SNNPR	Southern Nation, Nationalities, and Peoples Region
TA	Technical assistance
TOT	Training for trainers
USAID	U.S. Agency for International Development
WHO	World Health Organization



## EXECUTIVE SUMMARY

This report is the midterm evaluation of the Health Sector Financing Reform Project (HSFRP) in Ethiopia, which is a five-year, \$15 million U.S. Agency for International Development (USAID) financed bilateral contract to Abt Associates, Inc., to support government at the federal, regional, and woreda levels, as well as to work closely with health facilities to improve financing of health care. The project began August 1, 2008 and is scheduled to end July 31, 2013. The purposes of the midterm evaluation were to: (1) assess the performance of the project in meeting its four main goals, results, and targets; (2) identify areas of success and challenges in the implementation; (3) develop next steps and any modifications for the remainder of the project; and (4) identify opportunities for the future of the health sector financing reform efforts and develop specific recommendations for USAID and Ethiopia for the next five years. The results of the evaluation will be used to inform USAID's and Ethiopia's immediate and future program planning and implementation.

The evaluation methodology and framework relied on a number of proven approaches for project evaluation, including document and literature review, development of key informant questionnaires, interviews with implementing partners, focus group discussions, site visits to the three consolidating regions (Amaha, Oromia, and SNNP) and two expanding regions (Dire-Dawa and Harari), and development of three regional reports outlining the findings and challenges in each region as well as for the project as a whole. The evaluation team consisted of three external evaluators and three internal USAID personnel (two USAID/Ethiopia personnel and one USAID/Washington person). These included international and national economists, health systems specialists, a practicing physician, and a logistics expert.

This report presents the findings, challenges, and recommendations for each component of the project. The major finding is that the project has had outstanding results and performance in all major components, and no major midterm corrections are required. The depth of ownership, commitment, and passion that are apparent in this project is apparent at all levels. The program's institutionalization; coordination; communication with national, regional, and local counterparts; and degree of integration with other Ethiopian reforms have been unusually high. As highlighted by counterparts and stakeholders, this project has "revolutionized" the decentralization of health finance at the local level.

The biggest overall success has been the increased availability of drugs, pharmaceuticals, and medical supplies. New medical equipment and facility renovations are also notable accomplishments. These were due mainly to the ability of health facilities to retain revenues at the facility level and use them to purchase drugs, pharmaceuticals, and medical supplies, as well as physical building improvements. Another big success has been the implementation of governance boards at the hospitals and management committees at the health centers. This change has allowed more autonomy and decentralization and led to greater local input and control of resources. While there are some regional variations, the overall findings and challenges are the same in the regions visited.

The project has been highly successful overall. Success was defined as the effective implementation of project plans and methods, and achievement of the targets set. While some components have enjoyed greater success than others, the performance of all components has been high relative to the targets of the project. The greatest accomplishments have been in four major components: (1) development of a legal framework, (2) revenue retention and utilization, (3) facility governance, and (4) development of community-based health insurance (CBHI) schemes. The result of each of these components is clearly outlined in the respective section of this report. The components that have been more difficult to implement or have just started to

impact policy and strategy are: (1) revision and updating of user fees, (2) implementation of fee waivers and exempted services, (3) development of a private wing and outsourcing of non-clinical services, and (4) social health insurance (SHI) development. While these four components have been effective interventions and have been implemented in most health facilities, they have been slower to develop and have experienced more obstacles to implementation. In many cases, the difficulty in implementation was outside the scope of the contractor and was due to national and regional Ethiopian governmental issues. The last component (SHI development) remains at the regulation and strategy level and has yet to be put into action. The performance of the contractor and the project management at all levels has been outstanding. This judgment is based on the team's experiences with many other health financial reform projects in other countries, as well as a review of the results of project planning and control activities.

Each section of this report clearly outlines the various challenges in each component. At present, one of the larger challenges is continued funding of the project for the remaining project period; this issue is reviewed in a separate memo to USAID. However, funding alone will not solve many of the project problems. There is a need for a strong Ethiopian Government presence and commitment to SHI/CBHI, and there are large cultural, health system readiness, and financial barriers to overcome. Health insurance is a new concept in Ethiopia, and it will take a long time for attitudes and behavior to change. The immediate funding issue is due to the rising number of new health facilities and new personnel coming into full operation within the consolidating regions, as well as countrywide. The project's demand for continuing technical assistance (TA) is significantly greater than the resources available. As the project management is well aware of the resource problem, they have recommended that some existing health facilities be "graduated" from the project, thus allowing these limited resources to be used in newer facilities. Project management has developed "criteria" for this graduation exercise and is in the process of refining and testing implementation of these criteria. The evaluation team agrees that graduation of the well-developed health facilities is necessary for the next few years of the project and recommends moving forward immediately with this process of shifting some of the resources to the newer emerging health facilities. This report discusses this graduation process in greater depth.

One issue of importance that was discussed in almost every interview with health facility managers and implementing partners was the lack of a "performance-based" reward system for personnel. The evaluation team was informed that efforts to design and implement some system that motivates and provides incentives for staff, increases the quality of care, improves productivity, and retains critical staff have a long history in Ethiopia. With the initiation of the CBHI schemes and the health development army, it is likely that the workload of health professionals will increase significantly. Unless some performance incentive system is permitted, this increase in workload may have an adverse effect on the attitude of staff and the quality of care. If some incentive system cannot be implemented (due to civil service-wide implications), the Federal Ministry of Health (FMOH) and the regions affected could consider revising the negative list on the utilization of the retained revenue to allow, upon approval of their health facility board, a capped percentage of this fund to be used to compensate for the longer hours. The region could also draw up guidelines on how this can be implemented.

In summary, the reform initiatives are owned and managed by and through the various government management systems and have revolutionized not only the health financing system in the country, but also local ownership and stakeholder involvement in the management of health facilities. Most of the reform program outputs have been realized and a significant number of outcomes and impact targets are likely to be achieved by the end of the program period. With this in mind, outlined below are suggestions for the Government of Ethiopia to consider in future reform efforts, recommendations for USAID, and recommendations for the project:

## **SUGGESTIONS FOR THE GOVERNMENT OF ETHIOPIA:**

1. Develop a consolidated health finance strategy that sets out the vision and future structure for health care financing (HCF) in the country for the next 10 plus years. This strategy needs to cover all aspects of health financing that the current strategy implementation does not fully capture. These include improving efficiency in the allocation and use of health resources and coverage of high-impact interventions; improving alignment, effectiveness, and efficiency of external assistance; and strengthening the institutional environment for sustainable financing of the health sector. The current health financing strategy, issued in 1998, needs to be thoroughly revised in view of the current status of HCF reform in Ethiopia and in order to document best practices and lessons learned. The new strategy should include a critical assessment of HCF reform strengths and weaknesses to inform the development of a new vision, goals, objectives, and a work plan for the next 10 years.
2. Develop a scaling-up strategy for CBHI that outlines steps with different scenarios for coverage, subsidy rates, and TA required for implementation. The plan should also lay out the responsibilities and implications for government at all levels, with buy-in from policymakers, ideally before proceeding beyond the current pilot phase. It should clearly outline what development partners, including USAID, could do to support the scaling-up process.
3. Initiate a program to strengthen development and implementation of the health insurance agency (HIA). International experience has shown that HIAs are resource-intensive—especially in the early development stages, take longer to implement than envisioned, and are difficult to manage effectively due to their complexity.
4. Improve facility readiness—particularly of newly established health centers—to provide quality care by improving water and electricity services, as well as availability of drugs, pharmaceuticals, medical supplies, and equipment. This may require a multi-sector response by the Ethiopian water and power authorities and development partners.
5. Review the negative list of “uses of retained funds” and utilize some of these funds for a performance-based reward program for health sector personnel. The demand for health services is likely to increase as a result of the CBHI and SHI implementation. Quality of care, productivity, staff retention, and staff attitude and behavior could be significantly improved if a specific percentage of the retained revenues was earmarked for a performance-based reward system for health workers.
6. Establish a technical working group for HCF reforms with major stakeholders and implementing partners to more effectively communicate results, discuss costs and benefits, outline challenges, and plan jointly for development and implementation of future reforms in the health sector. The need for this group was highlighted by all implementing partners during the evaluation interview process. This was further emphasized during the dissemination workshop.
7. As Ethiopia moves into the SHI and HIA activities, there will be a need to develop accreditation methods and practices for both the public and private sectors. The evaluation team recommends that the Government of Ethiopia consider the development of an accreditation system and form a study group to explore the various options for implementation. The capacity of the Food, Medicine, and Health Care Administration and Control Authority—the authority that regulates health service provision in Ethiopia—needs to be strengthened to carry out this task.
8. Future evaluation of the impact and performance of health sector financing reform activities should examine how to measure the improvement in the quality of care. Assessing the impact of the quality of care is one of the weaknesses of the current project. The evaluation team recommends the use of hospital/health center reform management initiative quality

indicators for annual performance review. Access and equity impacts should be evaluated by carrying out benefit incidence analysis before and at the end of the follow-on program. The National Health Accounts (NHA) analysis could also track the progress in increasing per capita resource availability for health sector. It may be useful to consider carrying out regular public expenditure reviews to understand the effectiveness and efficiency of resource allocation of all sources, including retained fees.

## **RECOMMENDATIONS FOR USAID:**

1. USAID should develop additional TA to strengthen development and implementation of the SHI agency, as international experience has shown that this process is significantly more complex and difficult than originally envisioned. This TA could begin with a study group to review the preliminary research on SHI development and implementation strategies, followed by visits to other countries that have recently gone through this process—taking along key decision makers to see firsthand the complexity of the systems required—and finally the development of a detailed work plan for the proposed activities. While it is necessary to provide additional TA to the newly established SHI agency through the existing implementing partners during the project’s life time, USAID may consider separating SHI from the other components of the reform and establishing a project of its own in the medium term. The future project can be implemented by the exiting contractor or could also be provided through another implementing partner.
2. USAID should assist Ethiopia with the design of a comprehensive health finance strategy that sets out a clear vision for the structure of HCF in the country. This should be included as part of a larger vision of the entire health system in Ethiopia, both public and private. This should be done within the existing project lifetime.
3. USAID should ensure that the HSFRP has the necessary resources to fulfill its mandate with regard to coverage of health facilities in the various regions as new facilities come into operation.
4. USAID should work with the Government of Ethiopia to mobilize the financing of the CBHI scaling-up process and to coordinate on SHI development and implementation.
5. USAID should work with the Government of Ethiopia to develop a study group to review the costs and benefits of a performance-based reward program for health sector personnel that utilizes some percentage of retained revenues to provide incentives, increase productivity, and retain and motivate staff in the health facilities.

## **RECOMMENDATIONS FOR THE HSFRP:**

1. The HSFRP should “graduate” well-functioning health facilities from project support. A concept note has been developed by the project with criteria for graduation, but further work on these criteria is needed. These criteria should to be agreed to by government, and graduation of facilities should start as soon as possible. This will allow a shifting of resources to implementation of the key reforms in the new and less effective health facilities.
2. The HSFRP should expand implementation to a larger number of new health centers, and the project should develop a strategy for accelerating this process. The project should also consider alternative, less intensive strategies to spread the limited resources further. This is critical, as it is not be possible to initiate both CBHI and SHI in facilities that have not started retention of fees. the right time period to cover these other facilities is the next two years. This will possibly require strengthening the regional teams with more finance and human resources staff.

3. In collaboration with USAID, the HSFRP should revise the target and outcome indicators to better measure project outcomes and impact on both equity and quality. Some of the project-targeted outputs (e.g., 80% of woreda coverage by fee waivers) are beyond the scope of the project and may not be realized. This is mainly because the number of woredas and health facilities have increased significantly since the planning phase. Consequently, it is necessary to revise the targets. The other intended outcome is improved quality of care through HSFR intervention. However, the evaluation team was unable to find any documentation by the project of the direct impact of HSFR on quality of care. The project staff should focus on documenting the extent to which retained revenues improve quality, in terms of clearly defined quality indicators. One option is to utilize some of the 36 indicators being promoted through the government's new quality improvement efforts. These indicators should include measurement of changes in patient/staff satisfaction, retention, and waiting time for services.
4. The HSFRP should begin to document the known "unknowns" (the impediments and design flaws that might exist now or in the future) of the CBHI schemes.: The results of the piloting need to be well analyzed and explored to answer some of the difficult issues, including: (1) the number of members required for the scheme to be sustainable, (2) the fiscal feasibility of funding for indigents by the regional and woreda governments and the 25% subsidy by the FMOH, (3) the functionality of the institutional setup and its scalability, (4) indigent selection criteria, and (5) linkages between CBHI and SHI and the scheme provider agreements.
5. The HSFRP should develop a scaling-up strategy for CBHI to assist the follow-on program. This strategy should spell out what it takes to scale up the CBHI with different scenarios in terms of coverage, options for different subsidy rates, and required TA. The plan should lay out the responsibilities and implications for government at all levels and gain buy-in from policymakers before proceeding beyond the current pilot phase. This strategy should clearly outline what development partners, including USAID, should do to support the scaling-up process.
6. The HSFRP should provide additional technical support in the area of the private wing development and outsourcing of non-clinical services. There is a need for TA in these two areas, ideally from consultants who have had experience in other countries. The HSFRP staff would also benefit from experience sharing and site visits to other countries with HCF projects.



## I. INTRODUCTION

This report is the midterm evaluation of the Health Sector Financing Reform Project (HSFRP) in Ethiopia, a five-year, \$15 million USAID-financed bilateral contract to Abt Associates, Inc. to support government at the federal, regional, and woreda levels, as well as to work closely with health facilities to improve financing of health care. The midterm project evaluation was conducted from September 18 to October 13, 2011.

The purposes of the midterm evaluation are:

- To assess the performance of the project in meeting its four main goals,<sup>1</sup> results, and targets and identify areas of success and challenges in the implementation;
- To develop next steps and any modifications for the remainder of the project; and
- To identify opportunities for the future of the health sector financing reform efforts and develop specific recommendations for USAID and the Government of Ethiopia for the next five years.

Specific evaluation questions for each of the three objectives are listed in the evaluation scope of work in Annex A. The results of this evaluation will be used to inform USAID's and the Government of Ethiopia's immediate and future program planning and implementation.

This midterm evaluation report is organized as follows: background of the reforms; methodology; findings (both general and specific findings for each project component); discussion of related issues, including the Global Health Initiative (GHI); and recommendations, which are broken out into three major areas.

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<sup>1</sup> The four goals of the project are: (1) enhanced quality and equity of essential health services in public health centers and hospitals; (2) expansion of HSFR policy frameworks, legal, and operational guidelines; (3) improved access to health insurance mechanisms; and (4) systematic program learning to inform policy and program investment.



## **II. BACKGROUND OF HEALTH SECTOR FINANCING REFORM**

Prior to the reform, financing rules required that all revenues collected by health facilities be transferred to the Regional Finance Bureau/Ministry of Finance (RFB/MOF). This meant that health facilities, Regional Health Bureaus (RHBs), and the Federal Ministry of Health (FMOH) received no direct benefit from any of the fees collected. Consequently, the reform agenda of reducing leakage through better targeting, increasing the supply of drugs through revolving drug schemes, and revising user fees has had little direct impact on public sector provider behavior. Even efforts made in some of the regions to retain some revenues—for example, the retention of proceeds from revolving drug funds—were in contradiction to the financial law of 1997, which required all revenues to be remitted to the Bureau of Finance and Economic Development (BOFED) and the Ministry of Finance and Economic Development (MOFED). Additionally, health centers and hospitals suffered from shortages of essential drugs and supplies. It was frustrating to health providers to have no recourse to discretionary resources to improve quality of care, nor incentives to introduce innovative management practices. There was no formal fee waiver policy and no reimbursement of cost-of-fee waivers. Consequently, waiver grantors had little incentive to control leakage. Although out-of-pocket spending was high (53% of total health spending in the first NHA), there was no effort to promote a risk-sharing mechanism. All of these deficiencies necessitated the introduction of new HCF reforms.

In June 1998, after noting these challenges, the Council of Ministers of the Government of the Federal Democratic Republic of Ethiopia approved the Ministry of Health's proposed Health Care and Financing Reform Strategy, which established a new policy on HCF. The goals were: (1) identify and obtain resources, (2) increase efficiency in the use of available resources, (3) promote sustainability, and (4) improve the quality and coverage of health services. The following guiding principles also inform the strategy: services will be offered on the basis of cost-sharing between the receiver of services (patient) and provider of services (government), and user fees will be retained and used by the health facilities to improve the quality and quantity of services. In addition, any fee waivers shall be granted to reduce financial barriers for the poor, and exemptions shall be given to encourage consumption of particular kinds of preventive or public health services. The cost of fee waivers shall be covered by an appropriate third party. This reform implementation was supported through the USAID-funded Essential Services for Health in Ethiopia 1 and 2 for more than 12 years, and more recently through the HSEFR project.

The reform package also ensures that people pay for health services according to their ability, protecting the “poorest of the poor” from the financial barriers to seeking health care services. The reforms provide hospitals and health centers with greater responsibility, authority, and accountability in managing service delivery. Finally, the reforms create opportunities for hospitals and health centers to develop a private wing for those who can pay more and to outsource non-clinical services to the private sector in order to improve quality and reduce cost. The reforms support the regional health bureaus, woreda health offices, and various health facilities by allowing the local retention and utilization of revenues, the establishment of facility management boards, developing and revising fee schedules, providing exempt services to protect the poorest of the poor, and establishing CBHI schemes for the informal sectors. All of these reforms are meant to bring about increased levels of ownership and to assist the local government in taking leadership on health care quality improvements in their communities.



### **III. METHODOLOGY AND EVALUATION FRAMEWORK**

The evaluation methodology and framework were based on a number of proven approaches for project evaluation. Broadly speaking, operational evaluations address three types of questions:<sup>2</sup>

- **Descriptive questions:** The evaluation seeks to determine what is taking place and describes processes, conditions, and organizational relationships.
- **Normative questions:** The evaluation compares what is taking place to what should be taking place; it assesses activities and whether or not targets are accomplished. Normative questions can apply to inputs, activities, and outputs.
- **Cause-and-effect questions:** The evaluation examines outcomes and tries to assess what difference the intervention makes in outcomes. This third method is outside the scope of this midterm evaluation, is not applicable here, and is listed here only as part of the key reference below.

The evaluation team started with the results framework outlined in the request for proposal (RFP) and developed evaluation methods to assess how the project was meeting these results as outlined in the scope of work. The document reviews helped the team to understand the progress the project has made in meeting its targets. The key informant interviews helped to answer the normative question about the various stakeholders' assessments of the project's performance, its successes and challenges, and what should be done in the short and long term. Finally, the field visits to the facilities helped the evaluation team to understand the effect the reforms have had on access to and quality of care. Each of these evaluation methods are discussed briefly below.

#### **DOCUMENT AND LITERATURE REVIEW**

Documents collected and reviewed included all relevant Government of Ethiopia, USAID/Ethiopia, and HFSRP documents; background documents on prior health financial reform projects; the original RFP; various annual and quarterly project reports and work plans; Government of Ethiopia demographic and health surveys; Government of Ethiopia health sector reform-related documents, as well its five-year Health Sector Development Program (HSDP) IV documents and background reports; NHA studies and reports; evaluation studies and reports; various health finance laws, regulations, and guidelines; other related information on health reform and health activities in Ethiopia; and USAID evaluation principles and guidelines. Most of the relevant documents were collected and given to the team by USAID/Ethiopia and by Abt Associates, Inc.; a list of all the relevant documents are included as an appendix to this final report. The evaluation team reviewed over 100 documents.

The evaluation team reviewed documents relevant to the project in order to gain knowledge and understanding of the Ethiopian health reforms and project targets. This information allowed the evaluators to assess what has been done or not done within the project, to determine what program and project gaps exist, and to document the various successes and challenges. This review set the stage for the evaluators to begin to identify the existing challenges, best practices, and opportunities for future scaling-up for the remaining period of the project; more importantly, it allowed them to identify the longer-term challenges for the Government of Ethiopia in health sector financing, with possible USAID TA.

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<sup>2</sup> See Imas, Linda G. M. and Ray C. Rist, *The Road to Results: Designing and Conducting Effective Development Evaluations* (Washington, DC: The World Bank, 2009).

## **KEY INFORMANT INTERVIEWS**

The team developed detailed interview questionnaires covering the specific evaluation issues and concerns for all levels of the health system. These questionnaires included specific questions for the federal, regional, and woreda-level health providers; health facilities; development partners; and various other implementing partners. The detailed interview questionnaires were used as discussion guidelines and allowed the evaluators to obtain similar types of qualitative information at the various levels of the project implementation. Using these flexible key informant questionnaires, extensive interviews were carried out with key counterparts and stakeholders at all levels of the health system. The detailed questionnaires, developed by the evaluation team and reviewed by USAID, are available from the USAID/Ethiopia office in Addis Ababa but were too lengthy to attach to this report. Prior to, during, and after the field visits, meetings and interviews with key Ethiopian government officials in the FMOH and at the regional and woreda levels were conducted. The counterpart interviews were utilized to obtain various types of information, opinions, attitudes, and practices concerning the strengths and weaknesses of project implementation components. The interviews also helped to identify possible lessons learned and best practices within the project. A list of the organizations, individuals, and groups interviewed is included as an appendix to this report. Over 100 interviews and focus group discussions were undertaken by the evaluation team.

## **SITE VISITS AND LIMITATION OF THE EVALUATION DESIGN**

The sites were not selected on a random sample basis but rather purposefully chosen to reflect all project activities and programs. Sites were chosen to include:

- The three consolidated regions (Amhara, Oromia, and SNNP) related to goal 1,
- The expansion regions of Harari and Dire Dawa related to goal 2,
- Woredas and facilities where most of the reform interventions are being implemented, and
- The existence of CBHI pilots related to goal 3.

The midterm evaluation team conducted a field trip and site visits to key regions, woredas, and health facilities. The sites selected also consider woredas and facilities where most of the reform activities are being implemented. These site visits and meetings with key stakeholders were utilized to get firsthand information and to verify the evidence that was provided by the project with regard to project performance. A list of the sites visited and the persons interviewed are included as an annex to this report. Wherever possible, focus group interviews were conducted with CBHI beneficiaries and health facility board members. The focus group discussions followed a structured discussion process developed by the evaluators to capture perspectives of beneficiaries and governing boards, as well as to identify gaps and challenges for both the short and long term.

During the interviews and site visits, the evaluation team wrote up the findings and recommendations. These were shared with USAID and the project contractor in the form of debriefing; implementing partners also reviewed them. This review allowed for questions and feedback and provided a forum for discussion of the longer-term vision of the financing of Ethiopia's health system.

There were some limitations to the design of the evaluation. The time spent with the emerging regions was limited, as was the time spent interviewing counterparts and CBHI beneficiaries. Every attempt was made to review all available data and information at the various levels of the health system to ensure the data matched the various findings. The evaluation team feels strongly that the generalized as well as the specific findings are valid and accurate for the project being evaluated, considering the time, effort, and resources expended, as well as the efforts made to verify all the collected data with a wide array of secondary information.



## IV. FINDINGS

This section presents the findings of the midterm evaluation of the HSFRP. The subsection “General Findings” provides an overview of the project’s success in meeting the project goals. The three main objectives of the evaluation are also listed and general explanations given of how the project has met the various project goals. Detailed progress—including challenges faced—on stated objectives is presented in depth for each component in “Findings by Project Component.”

### RESPONSES TO EVALUATION QUESTIONS

As outlined in the scope of work:

“The evaluators are required to address the three main objectives and general questions as listed below for reference and highlighted *in italics*.

- I. *Assess the performance of the project in meeting its 4 main goals, results and targets and identify areas of success and challenges in the implementation.*
  - a. *How effectively have Abt Associates and subcontractors managed and monitored the implementation of various activities?*
  - b. *To what extent has each of the goals and targets been met? What are the main reasons/factors for exceeding or not meeting expected results?*
  - c. *What key products or tools have been developed by the project? How well has the partner communicated project successes and disseminated lessons learned?*
  - d. *What process does the partner use for identifying and resolving problems and challenges to project implementation?”*

#### **How effectively have Abt Associates and subcontractors managed and monitored the implementation of various activities?**

The effectiveness of the contractor and subcontractors in managing and monitoring the implementation of the various activities has been high. The effectiveness was clearly apparent in our discussions with regional leadership (see comment from regional leaders). This effectiveness was also apparent during our review of the various project documents and in discussions with project staff and key counterparts and stakeholders. The involvement of the local counterparts in the various planning and control processes is exceptionally high. Our site visits to local health centers and hospitals were opportunities for the facility heads to present to us their plans and achievements. In every case, the reports were available, accurate, timely, and effective.

The successes of the health sector financing reforms have been significant over the life of the HSFRP. Project management at the national and regional levels has done an outstanding job of working with various stakeholders of the health system. The regional counterparts (not only in the health sector but also in the woreda administration and finance offices) along with project staff have an exceptionally high degree of ownership of, commitment to, and passion for these reforms. The contractor for the project management of the HSFRP—Abt Associates, Inc.—has facilitated this process very well. The project has ensured that the reform plans (projects and activities) are included in the counterparts’ annual plans for effective implementation.

The effectiveness of the project management might best be expressed by an interview with the SNNP regional heads:

The relationship between the RHB and the project is outstanding. For the RHB, the HSFR project is the most important project in the region. The two reform activities, the HCF and the CBHI programs, are so important that the Bureau

has a focal person assigned to work closely with the project management, and to follow up the activities that need decision-making on our part. The project activities have been incorporated into the activities into the BPR system in order to improve effectiveness of that program. The project personnel consider themselves a part of the Bureau staff. Capacity building and supportive supervision has been most effective and the project management has been excellent, committed, and supportive in all areas, with the project staff having a real passion for their work. The project's short run and long run support has been outstanding, and without the project we could not have achieved what we did these last few years.<sup>3</sup>

This is also the opinion of the regional leadership in the Amhara and Oromia regions.

The project management has done excellent work in providing the needed TA in all areas of the reform, including the scaling-up and developing of policy instruments and legal documents needed for the HCF. These include legal frameworks—including proclamations, regulations, and directives—in the various regions; advocacy and consultations with key stakeholders; and operational manuals for accounting, HCF implementation, and guidelines. The project management in the various pilot regions is working extremely well. It has been able to influence the regional governments to discuss and promulgate health financing laws. The level of community mobilization undertaken in CBHI woredas demonstrates the commitment and passion of the staff to work under difficult circumstances. Officials in all three regions have expressed a great deal of appreciation for the technical and management assistance from the project. Key management issues, as highlighted by counterparts, are having professional managers at the health facility level, developing and carrying out management training programs on an ongoing basis for managers at all levels, and sharing regional experiences both within the region and nationally.

Project management is usually defined as “getting the work done through others,” and the management process and functions are: planning, organizing, staffing, directing, and controlling. In reviewing these five functions within the HSFRP, the midterm evaluators have reviewed over 100 reports, studies, consultancies, and various project documents that demonstrate professional project management of the necessary research and documentation to carry out the project's various TA requirements. A review of the project management activities has shown that the planning and control systems are excellent and sufficient time is put into the planning process to ensure things go according to plan. The project activities in the three regions were organized effectively, and the staffing and personnel systems are well developed. The mixture of on-the-job training and supportive oversight has proven to be an excellent combination of two effective teaching methods. The significant capacity building throughout the project was highlighted by all counterparts and stakeholders. Visits to the national project office and the three regional offices have revealed well-organized offices, excellent staff, and effective planning and control systems for project activities.

One step in the reform process assisted by the project is the development of guidelines that are either directly implemented or adopted by regions before implementation. The key technical tools/deliverables are reflected in the table below.

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<sup>3</sup> Taken from interviews with SNNPR Health Bureau Head, Ato Kare Chawicha, and the Curative and Rehabilitative Core Process Owner, Ato Habitamu Beyene.

**Table 1: Key Products and Tools for Development**

HCF Core Areas	Key Products/Tools
General health care financing	HCF reform manual
	Establishing private wing in public health facilities: operational manual
	Utilization of retained revenue for quality improvement: guide for health facilities
	Outsourcing of non-clinical services in health facilities: operational manual
Community-based health insurance scheme	CBHI directive: prototype. Amharic and English
	Bylaws of CBHI, prototype
	Financial and administrative management system manual for CBHI scheme
	Piloting CBCHI-technical background
	CBHI pilot M&E plan
Social health insurance scheme	SHI regulation
	SHI proclamation
	SHI background documents
	Health insurance agency structure
	Financial sustainability study for SHI in Ethiopia
	Provider payment mechanism: literature review
Program learning	Assessment of the implementation of fee waiver system: Amhara, Oromia; SNNP regional reports: three documents
	Assessment of user fee revision: Amhara, Oromia, SNNP Regional reports: three documents
	NHA 4
	NHA 4 PLWA health service utilization and expenditure survey
	NHA 4 Household health service utilization and expenditure survey

## CHALLENGES

While the project management has done excellent work, there are many challenges both within and outside the project that need to be addressed. First, although the project is highly cost effective, due to its national scope it is faced with serious resource limitation in light of its five-year mandate. Given that the number of new health facilities have increased from 670 during the project conceptualization phase to 2,700 currently, the number of woredas increased from 600 to 817 during the same period, and there is increasing demand by the government to cover more of these facilities at the regional level and revise the HCF strategy at the federal level, the remaining project resources are inadequate to cover these needs.

A previously highlighted, the project should graduate well-functioning health facilities from project support. A concept note has been developed by the project with criteria for graduation, but further work on these criteria is needed. These criteria should to be agreed to by government, and graduation of facilities should start as soon as possible. This will allow a shifting of resources to implementation of the key reforms in the new and less effective health facilities. The project should provide additional technical support in the area of the PW development and

outsourcing of non-clinical services. There is a need for additional TA in these two areas, ideally from consultants who have had experience with these concepts in other countries. The project staff would also benefit from experience sharing and site visits to HCF projects in other countries.

An increase in resources is necessary and should be in place before the planned scaling-up of CBHI and SHI. The regional personnel are implementing the reform programs, especially CBHI, through a learning by doing process. Given the scale and innovation required in these CBHI schemes, it is important that the project take advantage of experiences from other countries, possibly through fact-finding visits.

One of the major observations from counterparts in government, at both the regional and national levels, is that the skill mix within the team is inadequate (this was not verified by the evaluation team). Most of the members of the team are economists, and there are few public health professional to provide TA on issues of quality management. This is important, as this skill is required for the implementation of the SHI program, which will include skills in “accreditation of all health facilities.” Another regional concern is insufficient staff to undertake adequate and timely supervision and training given the geographic coverage. During the evaluation team visits, both the counterparts and staff highlighted the fact that they are “thin on the ground.” Finally, the project has not communicated effectively its successes and challenges to in-country development partners. Many of the partners do not have sufficient knowledge of what is going on in this reform; this was highlighted in interviews with the implementing partners.

**To what extent has each of the goals and targets been met? What are the main reasons/factors for exceeding or not meeting expected results?**

The goals and targets set by the project and the current status are listed in the following table. The overall performance has been high, as noted below.

**Table 2: Overall Performance with Targets**

HSFR Outputs	Target	Current Status
Legal framework, directives, and guidelines prepared	all regions	In place, except in Afar
Health financing management units established	all regions	
Percentage of health centers with functioning primary health care management committee	100	78
Percentage of hospitals with functioning management board	100	81
Percentage of health centers retaining fees	100	78
Percentage of hospitals retaining fees	100	81
Percentage of woredas covered with waiver system	80	72

Number of individuals trained in CBHI management at the woreda level	TBD	903
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Number of CBHI schemes supported	TBD	13
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Source: Various project documents and reports

The main reason why progress in some areas has surpassed what might be expected at midterm is that the planning, coordination, and communication between the project and various national, regional, and woreda government units were unusually high. The reasons why some targets have not been met are due mainly to the difficulties in getting the regional leadership and regional health decision-making process to move effectively in the same timeframes as the project plans and processes.

***What key products or tools have been developed by the project? How well has the partner communicated project successes and disseminated lessons learned? What process does the partner use for identifying and resolving problems and challenges to project implementation?***

The project has developed a number of products and tools, which are clearly outlined in Table 5 (Section VI). These tools have been used in the field to guide implementation of the various components of the program as demonstrated during the evaluation field visits.

The project has been able to utilize research and strong quarterly “supportive supervision” to identify best practices and challenges and take corrective actions when necessary. The project’s close working relations with federal, regional, and zonal government, as well as health facilities, have enabled it to use the findings of the supportive supervision to influence actions by the government. The project has conducted research to inform and adjust its programming. The project has successfully developed NHA 4 and its sub-accounts and shared its findings with all stakeholders. The project teams have also managed to do an operational review of the waiver and user fee studies in the consolidated regions and have communicated the findings to the regional decision makers. However, the project needs to do additional work on reviewing the reform’s impact on the overall goal of the project (equity and quality of care), as this remains one of the gaps of the program learning component. Furthermore, together with FMOH and USAID, the project should make a more systematic effort to communicate its successes and challenges to other development and implementing partners, who could be mobilized to fill the gap in the financial implication of the CBHI and SHI schemes in the medium term.

2. *Develop next steps and any modifications for the remainder of the project.*
  - a. *How can local ownership of reform efforts at every level be strengthened?*
  - b. *Are there additional indicators that should be identified and tracked that will assist in measuring the short and longterm project outcomes? Changes to the current targets? Additional operational research studies?*
  - c. *How can USAID and the implementing partners improve their management, collaboration, and communication with each other and the Government of Ethiopia on this project?*
  - d. *What specific changes to the strategy, approach, or timeline should be made for the remainder of the project to maximize impact and sustainability?*

There is already strong local ownership of the reform program by the government at all levels. The existing communication and coordination levels should simply be continued. What is required is to guide this sense of commitment and ownership to focus on strategic issues. The evaluation team recommends the development of a comprehensive health financing strategy,

whose main pillar should focus on strengthening institutional capacity for health finance reform at all levels, including the institutionalization of pre-service training in the HCF. The project has been strong in closely following up the outputs of the project, but less so in developing outcome indicators. The evaluation team recommends that the project develop an annual process of tracking progress in quality of care using the quality indicators presently being used for hospital and health center reforms. The project should also to carry out additional research on access and equity impacts by conducting benefit incidence analysis, before and at the end of any follow-on program. It may also be useful to consider carrying out regular public expenditure reviews to understand the effectiveness and efficiency of resource allocation of all sources, including retained fees and government allocation to the health sector.

The project has had excellent communication with government and USAID; this should continue during the remaining period of the project. In order to improve overall management, communication, and coordination with the Government of Ethiopia, USAID—along with the other implementing partners—should consider establishing a technical working group in HCF. The project is working well in many of the operational components of the program. However, the project needs to explore mechanisms for strengthening its support to the newly established SHI agency, as this may require more effort and investment than it gets presently. Implementing CBHI pilots and SHI activities using existing project staff may carry the risk of undermining one at the benefit of the other. No major changes in strategy, approach, or timeline are required other than those recommendations for the Government of Ethiopia, USAID, and the HFSRP that are included in the recommendations section of this report (Section IX).

3. *Identify opportunities and specific recommendations for future USAID investments in the Government of Ethiopia's health sector financing reform efforts for the next five years.*
  - a. *What areas should USAID focus on over the next five years that will provide the maximum benefit to the Government of Ethiopia's reform efforts, align with the Global Health Initiative strategy, and not duplicate other donors' work? What current activities/efforts should be scaled up or decreased? New pilot studies?*
  - b. *What is an appropriate level of USAID investment in each of the Government of Ethiopia's health sector financing reform areas?*
  - c. *How should USAID evaluate the impact and performance of future health sector financing reform activities?*
  - d. *How can USAID facilitate collaboration and communication with the GOE and other partners on health sector financing reform activities and progress?*

The support to HFSRP is well aligned with government HSDP IV targets and strategies as well as USAID's specific GHI Ethiopia strategy. Furthermore, there is little risk in duplicating the efforts of other development partners, as Ethiopia's health finance reform is largely implemented through this existing project support. USAID therefore needs to continue its support if the gains made so far are to be scaled up and sustained. Consequently, the following items need further attention:

- The project needs to work on strategies to reduce its support to first generation reforms through a considered strategy of “graduation” of health facilities in the consolidating regions. The project needs to strengthen its performance on these reforms to reach out to the new health facilities in the consolidating regions as well as in the expansion regions.
- Document the lessons learned in CBHI pilots and develop a scaling-up strategy as soon as possible to inform the follow-on program. Scaling up the CBHI initiative should form one of the core elements of any follow-on program.
- Enhance documentation and lesson learned on the impact of the reform program on the reform goals within the remaining period of the project.

- More focus should be given to strengthening the newly formed HIA in the short term and within this project life. Consideration should be given to a separate project in any follow-on program.

One of the deliverables of this assignment was to provide a rough estimate of the level of funding required to implement the HSFRP in Ethiopia for the next five years. Given that the second generation or demand-side interventions (CBHI and SHI) are in their infancy, it is still unclear what resources are needed to scale up CBHI, or what financial, technical, and material support the SHI requires. Consequently, it is difficult to estimate the appropriate level of USAID investment. The midterm evaluation team suggests the design of the CBHI and SHI scaling-up and implementation strategy include a clear estimation of the technical and financial requirement for the next five years. We recommend that these strategies be developed with the Government of Ethiopia before the concept note for follow-on program is drafted. The intensity of community-level activities for CBHI is significant. These activities include: (1) training community CBHI initiators, (2) consulting with the community at the kebele level, (3) training woreda cabinets, (4) conducting general assemblies to ratify the bylaws in each woreda, (5) conducting the follow up required to ensure accreditation activities for both public and private providers, and (6) the difficult task of establishing and furnishing the head and branch offices of the HIA (developing manuals, guidelines, methods, procedures, and systems, etc.). Any possible follow-on project resource requirements most likely would be larger than the existing project.

In addition to financing the project, USAID should also play a significant role in using its policy leverage to influence both Ethiopia and its development partners to ensure the continued implementation of the reforms. This includes engaging with government about the need for development of a long-term vision for health sector financing and revision of the HCF strategy. As outlined in the recommendations section, USAID and other implementing partners should work with Ethiopia to develop a technical working group on health financing strategy and development. USAID should also motivate the Government of Ethiopia to consider introducing performance-based financing using retained revenues, continue to focus on the development and implementation of a program for providing power and water services in the newly built health centers, and continue dialogue with the Government of Ethiopia—especially the PFSA—to ensure that there is improved availability of drugs and medical supplies in the health system. Scaling up CBHI and SHI will require increased funding both from Ethiopia and the development partners. USAID can play a catalytic role through its continued advocacy for the governmental spending to be “additional.” USAID can also strengthen linkages with its other current health systems strengthening projects and assist in mobilizing donors to address the budget implication of the scaling-up of this project.

## **GENERAL FINDINGS**

The major finding is that the project has had outstanding results and performance in all major components, and no major midterm corrections are required. The evaluators have reviewed a number of health finance projects in many countries<sup>4</sup> and have never seen a project with the depth of ownership, commitment, passion, and performance as is apparent in this project. The project’s institutionalization; coordination; communication with the national, regional, and local counterparts; and degree of integration with other Ethiopian reforms is unusually high. As highlighted by counterparts and stakeholders, this project has “revolutionized” the decentralization of health finance at the local level.

The biggest overall success has been the increased availability of drugs, pharmaceuticals, and medical supplies. New medical equipment and facility renovations are also notable

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<sup>4</sup> The senior consultant and team leader has reviewed or worked on HCF projects in 20 countries.

accomplishments. These were due mainly to the ability of health facilities to retain revenues at the facility level and use them to purchase drugs, pharmaceuticals, and medical supplies, as well as physical building improvements. The other big success has been the implementation of governance facility boards at the hospitals and management committees at the health centers. This change has allowed more autonomy and decentralization and led to greater local input and control of resources. While there are some regional variations, the overall findings and challenges are the same in the regions visited.

The overall success of the project has been high.<sup>5</sup> While some components have enjoyed greater success than others, the performance of all components has been good. The biggest successes have been in four major components: (1) development of a legal framework, (2) revenue retention and utilization, (3) facility governance, and (4) development of CBHI schemes. The results of each of these components are clearly outlined in the respective sections of this report.

The components that have been more difficult to implement are: (1) revision and updating of user fees, (2) implementation of fee waivers and exempted services, (3) development of a private wing and outsourcing of non-clinical services, and (4) SHI development. While these last four components have been effective interventions and have been implemented in most health facilities, they have been slower to develop and have experienced more obstacles to implementation. In many cases, the difficulty in implementation was outside the control of the contractor and was due to national and regional Ethiopian governmental issues. In the case of SHI and CBHI activities, these were second generation reforms and are only in the beginning stages. SHI is rated moderately successful because it had not been launched as per the plan in October 2011. The SHI component was possibly too ambitious and was slow in getting started. Overall, the performance of the contractor and project management, at all levels, has been outstanding. This judgment is based on the team's experiences with many other health financial reform projects.

The four goals of the project are:

1. Enhanced quality and equity of essential health services and public health centers and hospitals
2. Expansion of HSFR policy frameworks and legal and operational guidelines
3. Improved access to health insurance mechanisms
4. Systematic program learning to inform policy and program investment

The performance on each of these goals is discussed in detail under "Findings of Project Components" and also in Table I, which presents outputs with targets. A brief summary is provided as follows:

## **GOAL I: ENHANCED QUALITY AND EQUITY FOR ESSENTIAL HEALTH SERVICES IN PUBLIC HOSPITALS AND HEALTH CENTERS**

The project components falling under this goal are: (1) revenue retention and utilization, (2) fee waiver system and exempted services, (3) fee setting and fee revision, (4) facility governance

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<sup>5</sup> Success was defined broadly as the effective implementation of project plans and methods, and the achievement of each reform component against its planned targets and in light of its contribution to the overall reform objectives. Certain other desirable criteria were taken into account, including integration into the existing government systems, acceptability to major stakeholders, and consistency with the policy and strategy of the government.

boards, (5) private wings, and (6) outsourcing of non-clinical services. A brief review of the performance follows:

1. Revenue retention and utilization activities have been the most successful component, with 90 (88%) hospitals and 2,151 (79%) health centers retaining revenue, and 87 (96%) hospitals and 1,738 (81%) health centers using retained revenue for health service quality improvement as of September 30, 2011. This has led to the ability of health facilities to renovate existing facilities and to purchase drugs, pharmaceuticals, and medical supplies, all of which help improve the quality of essential health services.
2. The fee waiver system and exempted services component has targeted indigents, with over 2.2 million waiver beneficiaries selected and certified in eight regions (Amhara, Oromia, SNNPR, Addis Ababa, Tigray, Dire Dawa, Harari, and Benishangul Gumuz) and preparatory works in progress in Gambella, Afar, and Somali. The budget allocation for waiver beneficiaries by woredas as of September 30, 2011, were ETB<sup>6</sup> 25.6 million (ETB 41,006 per woreda on average). This program has allowed large improvements in the access to care and the equity of essential health services. Although the list of exempted services are posted at health facility levels and many of the services are provided free, there is concern that no one is covering the cost of delivery services (especially for supplies) at facility levels. This is one of the barriers to increasing skilled deliveries.
3. Fee setting and revision of fees has been effective to a lesser extent; it is working in some facilities and not others. However, as of September 30, 2011, a total of 1993 accounting and financial personnel had been trained. In addition, financial management capacities had been improved, manuals developed and adopted, key finance staff in place, and ongoing training provided.
4. Facility governance boards have been the other most effective component and have allowed improved decision-making at the local level, leading to better utilization of scarce resources. As of September 30, 2011, health facility governance was strengthened with 90 hospitals and 2,079 health centers having established governing boards. These boards have also led to improvements in equity and quality of health care services.
5. The process of establishing private wings in a total of 18 public hospitals (as of September 30, 2011) has been improved by developing “implementation” manuals that have been utilized to establish new services and orientation program for staff. This has led to greater equity, requiring those who can pay more to utilize more private facilities and staff.
6. The outsourcing of non-clinical services has reduced cost and improved quality by allowing hospitals to focus more directly on patient services and the quality of care, and allowing other emerging micro-industries to manage the non-clinical services like dietary services and housekeeping.

The component sections of this report present more detailed discussions of achievements, challenges, and recommendations.

## **GOAL 2: EXPANSION OF HSNR POLICY FRAMEWORKS, LEGAL, AND OPERATIONAL GUIDELINES**

The project has had excellent performance in scaling up and developing policy instruments and legal documents needed for HCF. These include HCF legal frameworks endorsed in Addis Ababa, Dire Dawa, Tigray, Benishangul-Gumuz, Harari, Gambella, and Somali. The only region that has yet to endorse the legal framework is Afar. All expansion regions, except Afar and Somali, are implementing some, if not all, of the reforms. HCF guidelines were developed and

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<sup>6</sup> At the time of the evaluation, 1 birr = approximately \$0.06 (1 USD = 17 birr).

customized. The project produced HCF guidelines and operational manuals for Benishangul-Gumuz, Gambella, Harari, Dire Dawa, Tigray, and Addis Ababa. A more detailed discussion of achievements, challenges, and recommendations is found in the component sections of this report, Section IV, number 1.

### **GOAL 3: IMPROVED ACCESS TO HEALTH INSURANCE SCHEMES**

The project has made excellent progress with the CBHI development and begun the process of improved access to health insurance mechanisms. At the national level, capacity was strengthened, CBHI pilots designed, a feasibility study conducted in four pilot regions, training manual developed, a prototype directive and bylaw developed, and CBHI communication strategy and tools developed. At the regional level, capacity was strengthened, CBHI regional steering committee (RSC) established, woreda-based Health Insurance Steering Committee and Kebele Health Insurance Initiative Committees established, CBHI policy workshops conducted, CBHI training for trainers (TOT) provided (with 6,226 people trained [woreda and kebele cabinets, and WHISC and kebele health insurance initiative committee members]), and the CBHI prototype directive adapted in three pilot regions: Amhara, Oromia, and SNNPR. At the woreda level, CBHI bylaws were adopted in each pilot woreda, CBHI communication strategy and tools were implemented in each pilot region, sensitization and awareness creation activities took place at the community level, a general assembly for establishing pilot CBHI schemes was established in 13 woredas, ID cards (200,000) and financial forms were distributed, 37,195 paying household members were enrolled as of September 30, 2011, and ETB 2.64 million was collected, with indigents (17,285 households) identified and enrolled. Monitoring and evaluation was strengthened, with a CBHI monitoring and evaluation framework put in place. Four control woredas were selected with routine monitoring data collection and encoding forms developed.

The development of SHI programs and implementation plans has been slow. This is due to a number of factors, possibly including an overly ambitious agenda. However, there has been some excellent progress, including endorsement of a legal framework, establishment of an agency, endorsement of SHI Proclamation # 690/2010, provision of TOT for 724 representatives of formal sector employees, development and enrichment of SHI implementation by a series of stakeholder consultations, completion of a study on SHI financial sustainability, establishment of an HIA, development and endorsement of Council of Ministers Regulation # 191/2010, definition of the agency structure and functions, and initial development of provider payment mechanism.

A more detailed discussion of achievements, challenges, and recommendations is found in the component sections of this report, item IV, number 10.

### **GOAL 4: SYSTEMATIC PROGRAM LEARNING TO INFORM POLICY AND PROGRAM INVESTMENTS**

Systematic program learning aims to improve decision-making through action-oriented research and the dissemination of the findings. The project has carried out various studies to this end. The major undertaking of the project in this regard was the publication of the fourth NHA. The account, with its six sub-accounts, was estimated to be the largest to date compared with other countries. It involved institutional surveys, household surveys on the general public, and surveys of people living with HIV/AIDS. The NHA exercise has provided the necessary evidence on per capita spending, the overall health financing in the country, and who the financiers and financing agents are. NHA results were disseminated and widely known by many development partners. The per-capita sector and sub-accounts spending estimates were used for the costing and financing of the HSDP IV, the country's sector development program. At the regional level, two

studies—on user fee revisions and and fee waivers—were carried out in the three consolidating regions of Amhara, Oromia, and SNNP. These studies documented the processes, best practices, and challenges of implementing these two reforms. Their findings were shared with the regional stakeholders. Oromia is also carrying out additional fee waiver assessments to complement the earlier study. There is evidence that the findings of these studies have impacted on the regional year IV workplans.

Given that there are many unknowns in HCF in Ethiopia, the studies carried out to improve decision-making seem to be limited. While the project aims at improving access and quality of care, this program has not come out with a systematic mechanism to track progress. Neither did it complete studies on the impact of health financing reform on access and quality of care. In this regard, the project may consider establishing a mechanism to collect and analyze the 40 quality indicators of the hospital reform/health center initiatives (which capture patient perceptions and clinical outcomes) and see the impact of retained fees on their improvement. Hospitals are collecting this information on monthly basis and are reporting to the Medical Service Directorate. The second challenge, which is not unique to Ethiopia, is lack of institutionalization of the NHA process. The government should increasingly take leadership and ownership of this exercise. The project needs to work with government and other stakeholders to institutionalize HCF in pre-service training programs.

The project could enhance its efforts to communicate successes and achievements, as some developmental partners are not fully aware of what has been implemented. This was evidenced by the interest of workshop participants during the dissemination workshop. Ensuring other partners are involved during the design and policy debate is critical, in view of the fact that some of the reform components (CBHI and SHI) may require donor assistance to augment the government's resources. Ideally, these needs should be addressed in the remaining period of the present project. The development and implementation of an effective communication strategy may be necessary. The project also needs to consider organizing “experience sharing” visits and learning opportunities in other countries for the regional staff.

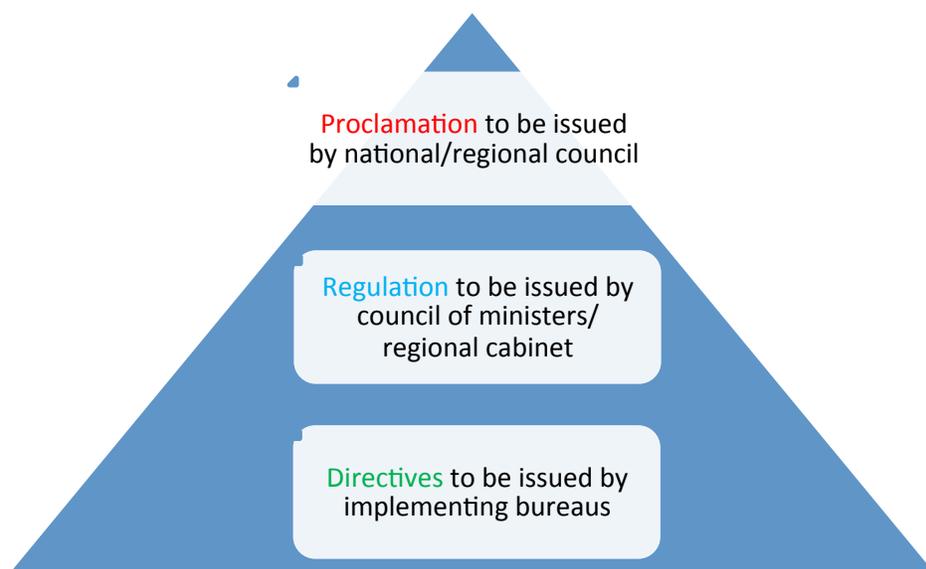
## FINDINGS BY PROJECT COMPONENT

This section includes a discussion of each of the project components and outlines specific findings, challenges, and recommendations.

### I. LEGAL FRAMEWORK

The financing regulations before HCF did not allow fee retention and utilization at the facility level. Facilities were managed entirely through civil service rules and regulations, with limited involvement of communities and major stakeholders. Fees were not revised for more than 50 years. Implementing reforms required the development and endorsement of the legal framework, which provides rules and regulations on how facilities should be governed and how the reforms should be implemented. Regions cannot implement the reforms without the legal framework. Developing and endorsing a legal framework is a complex process, as it has both technical and political dimensions as well as different levels of details, which need to be in place before implementation of HSFR starts in any region. The different legal frameworks required and their respective approving authority is shown in Figure 1.

**Figure 1: Dimensions of Legal Framework in Health Financing in Ethiopia**



This component of the HSFRP is a critical element because it establishes the legal and institutional framework that allows other components of the reform programs to operate. The legal framework for implementing the first generation<sup>7</sup> reforms was already in place in the preceding program in the consolidating regions of Amhara, Oromia, and SNNP. During the project period, regulations and guidelines in these regions were revised. Since Ethiopia has gone through a devolution process, the legal frameworks must be ratified both at the federal and regional levels.

The main achievements at the federal level were the ratification of Social Health Insurance Proclamation 690/2010, which established the scheme, by the Ethiopian parliament and the

<sup>7</sup> First generation reforms comprise all components of the health sector reform with the exception of community-based health insurance and social health insurance schemes, which are second-generation reforms.

endorsement of Regulation 191/2010 by the council of ministers that established the HIA. The federal level developed and shared the prototype CBHI directive and bylaws with the regions. The three consolidated regions of Amhara, Oromia, and SNNPR—where pilots for the CBHI schemes are being implemented—were adapted and approved through a CBHI prototype directive. Furthermore, all pilot woredas have endorsed the CBHI bylaws at the scheme level.

Goal 2 of the project aims to expand the health finance reform program to all regions within its project life. This requires the legislation of relevant proclamations, regulations, and directives in eight regions, excluding the three consolidating regions. Currently, all regions except Afar have endorsed the health finance reform proclamation. This shows that the project achieved 91% of the target set for it for the entire project life. The success of the reform program in the consolidating regions has motivated the implementation in the expansion regions.

### **Challenges**

There are three major challenges related to the legal framework. First, due of the lack of any legal framework, the federal referral and university hospitals have not been able to retain their fees, while the lower level facilities are implementing revenue retention. This has possibly negatively affected the quality of care in these hospitals, as less revenue is available. The development and implementation of this legal framework requires a proactive engagement of the FMOH with the Ministry of Education (MOE) and MOFED. Second, the legal regulation framework for Afar needs to be in place for the project to achieve universal coverage of regions. Finally, there is divergence between the legal framework and its implementation in the area of user fee revision, fee-waivers, and exemptions, as documented by the various studies and the evaluation team's assessment. Some of these discrepancies may be reduced if a periodic review of the legal framework is conducted to identify gaps and clarify ambiguity. Some key informants have requested revising the positive and negative list on the utilization of retained revenue and user fee revision procedures. The project should facilitate the review and revision of the regional HCF proclamation to adapt its directives in light of emerging issues. The remaining phase of the program is also critical for getting in place the regulation and directives for regional CBHI scaling-up. As a principal technical arm of the health finance reform of government, the project should enhance its efforts to meet the HSDP IV's target of insurance coverage for 50% of Ethiopia's population by 2014/15.

## **2. REVENUE RETENTION AND UTILIZATION**

This component of the reforms aims to increase the amount of discretionary resources available at the facility level to improve the quality of care. Once the legal framework was in place, the project facilitated implementation by building the capacity of health facilities and their governance boards to retain and use these funds. The HSFRP developed and implemented a financial management manual and trained 1,993 key staff at the facility level. The project also provides on-site action-oriented TA through its supportive oversight. It provided supervisory visits to 165, 404, and 519 health facilities in its first, second, and third year operations, respectively. This is the most advanced component of the reform program and is widely implemented (see table below). Overall, 88% of hospitals and 79% of health centers are implementing the health finance reform throughout the country. The performance is continuously changing due to the increasing number of hospitals and health centers. However, there is no health facility implementing health financing reform in the two pastoral regions of Somali and Afar. As described above, Afar has yet to put in place the legal framework while the Somali region's recent legal framework still needs to be implemented.

**Table 3: Facilities Implementing Health Financing Reforms by Region**

N/S	Administrative region/city	Number of health facilities		Number of facilities implementing the reform		Percent of facilities implementing the reform	
		Hospitals	HCs	Hospitals	HCs	Hospitals	HCs
1	SNNPR	16	578	16	546	100%	94%
2	Amhara	16	745	16	358	100%	48%
3	Oromia	35	1053	35	1053	100%	100%
4	Tigray	12	211	12	118	100%	56%
5	B/ Gumuz	2	29	2	21	100%	72%
6	Harari	2	8	2	8	100%	100%
7	Dire Dawa	1	15	1	15	100%	100%
8	Gambella	1	18	1	1	100%	6%
9	Addis Ababa	5	31	5	31	100%	100%
10	Afar	4	40	0	0	0%	0%
11	Somali	8	62	0	0	0%	0%
Total		102	2,790	90	2,151	88%	77%

Source: Project data. Amhara's number of health centers adjusted.

The amount of retained revenue varies from facility to facility. Health centers, on the average, retained about ETB 200,000 and utilized about ETB 140,000 per year. In all health facilities, the proposal for using the retained funds comes from the facility management body, while the decision is made by the governance structure. The use of the funds varies depending on the health facility's priorities, but the first priority always goes to ensuring availability of drugs and medical but varies by facilities). Other uses for the retained fees include additions to the existing health facility (e.g., maternal wings, waiting rooms, etc.) and auxiliary services like meeting halls and cafeterias, fixed assets and equipment (anesthetics, imaging machines, and generators), manpower gaps and staff training. One best practice in allocating resources on improving quality of care is seen in Debre-Berhan hospital (see Box 1 on next page). By and large, facilities adhere to the guidelines for retained revenue utilization, and the midterm evaluation team has not found facility financing activities in the negative list.

### Box 1: Investment of retained fees to improve quality of care in Debre-Berhan hospital

Furthermore, the few audits carried out by the woreda finance offices have not found any major issues with collection and utilization of retained revenues. The health facilities visited have reported that in addition to improving the quality of care in the facilities, retained revenues have reduced the bureaucratic procedures of procuring funding through the normal government channels. Retained fees were expected to be “additive” to government allocation, the woreda allocation to the health sector has not declined over time, and the concern of budget offset is therefore not observed, at least not in absolute terms or in share from the total woreda spending. However, budgetary allocations for drugs are declining, resulting from operational budget shortages at the woreda level and limited “fiscal space” for all the sectors in the woreda. Health remains one of the sectors that receives a higher percentage of woredas’ operational budget allocations.

#### Challenges

The major challenges for this component are: (1) implementing it in the federal and university hospitals; (2) covering capacity-building requirements for expanding the reform to primary hospitals (planned at 700 facilities) and expanding health centers (not covered but estimated to be at the existing 600 and another 700 whose construction is currently being completed); and (3) strengthening the link between retained resource allocation and the quality of care initiative indicators, in order to impact clinical outcomes and client perception of quality.<sup>8</sup> Although revenue retention is recorded at the health facility level, there are no reporting mechanisms through the existing government system. On the other hand, the retained revenue at hospitals levels is recorded and reported through the government system. This should be replicated at the health center level.

Another area that needs to be explored further is how to extend the health finance reform beyond the health centers. As it stands now, the health posts are providing preventive health services and are not expected to charge fees. Their supplies are being procured centrally (through different support and financing modalities) and delivered in kits through health centers. The Government of Ethiopia and the HSRP should look into ways to use a certain percentage of the health center’s retained fee to strengthen the quality of care at its satellite health posts.

### 3. FACILITY GOVERNANCE

The third component of the HSRP is the establishment and operations of the facility governance boards (FGB), which have been effectively implemented throughout the country. The governance boards and management committees were implemented to allow devolution of

<sup>8</sup> There are 124 hospital management reform indicators, 36 of which are related to quality. The survey indicators include waiting time, patients undergoing triage within five minutes, and patient and staff satisfaction surveys. There are some financing indicators as well. The rest are clinical outcome indicators and are reported to FMOH on monthly basis.

the responsibility and authority from the regional level to local levels. These FGBs were designed to reduce the administrative complexity, enhance effectiveness and efficiency of management, increase accountability for public funds, create a sense of ownership by management, increase the role of the local community, respond better to local needs, and improve resource mobilization by allowing local decision-making.

As of July 2011, there were 90 hospitals and 2,097 health centers with established governance structures. The governance component of the reforms has been one of the project's major successes and has had outstanding results. The FGB's are implemented in two governance formats. The hospitals have formal management boards, usually with seven to eight members. The mayor or other senior official serves as the chairperson of the board, and have various other community officials are members. The health centers have health management committees, usually with five to seven members.

Major activities for both the boards and management committees include: approving the strategic plan for the facility; reviewing and approving the budget and action plan; reviewing quarterly and annual performance results, including revenue retention and utilization reports; following up on the financial performance of the facility; control and oversight of the technical and administrative systems performance; approving revisions to user fees; and ensuring community participation in the entire process. Board and committee meetings are normally held once a quarter, but this varies by region and facility, with some meeting more frequently and some less frequently or not at all. Normally, formal minutes of the meetings are taken and reviewed.

The effectiveness of these boards is best expressed in an interview with the SNNP regional heads:

The FGBs have allowed a real devolution of power to the health facilities based on having a board oversee all activities and programs of the facility. The governance bodies in many facilities, particularly in hospitals, are well functioning but the health centers less well functioning. A series of trainings both for Hospital Governance Board members and Woreda Health Management Committee members were provided by the project, and were most helpful in establishing the boards and getting the process started. The frequency of meetings is important and many facilities do not meet frequently, and some not at all. The health center's governance process is highly dependent on the skills and behavior of the health center's head, while the hospitals have a better balance of leadership and participation by all members.<sup>9</sup>

Most importantly, the establishment of formal governance structures is evidence that the communities are increasingly taking ownership of health facilities. In addition, the FGB members become advocates for increased resources during cabinet and public meetings. There are indications that such efforts have helped increase allocations to health services. Another important aspect of the FGBs is that they bring complaints about service delivery to the management of the health center and hospital community. Trained CEOs currently lead hospitals, while health officers direct health centers. Though the level of success varies from facility to facility, the hospitals visited have acknowledged significant benefits of professional management. The education and training by the HSFRP has been a key ingredient in the success of the establishment and operations of these FGBs. Over 1,000 FGB members have been trained nationally.

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<sup>9</sup> Taken from interviews with the SNNPR Health Bureau Head, Ato Kare Chawicha, and the Curative and Rehabilitative Core Process Owner, Ato Habitamu Beyene.

## Challenges

One of the major challenges to the facility governing body process is the high turnover of the board members, due to a variety of reasons but often because of the local political situation. Limited capacity of some members of governing boards and, in some cases, the involvement of members in various government and political activities have constrained their effectiveness. About double the currently provided training is needed, especially with all the new health centers coming into full functioning and the turnover of existing board members.

The setting up of these boards and management committees and the initial governance training are the most important ingredients for success. The follow-up training is less important, given the high member turnover. Another challenge for the project is securing the additional resources for expanding the governance coverage over the new hospitals and health facilities. With the demands on the project to provide assistance to even more facilities, and with even more training needed for new health centers, the project should consider “graduating” many of the health centers and hospitals from the project activities. This graduation concept is discussed more fully in a later section of this report.

## 4. USER FEES SETTING AND REVISION OF FEES

User fees at public health facilities had not been systematically revised for over 50 years prior to the introduction of the reforms. As a result, user fees were very nominal and could not reflect the cost of health services and provide appropriate market responses. In recognition of this problem, provisions for setting and revising user fees were included in the Health Service Delivery Management and Administration (HSDMA) proclamations, regulations, and directives issued by the regions. The HSDMA proclamations, regulations, and directives state that: (1) initial fee setting and subsequent revisions should be based on cost-sharing principles covering variable cost and the ability and willingness to pay by the public at large, and (2) revisions of user fees have to be justified through a study conducted on the improvements in quality, availability of health services, and the ability and willingness to pay.

The contents of the HSDMA legal frameworks are almost the same in most provisions. However, the body authorizing the revisions varies among regions. While in SNNPR the facility governing bodies are approving the revisions, in Oromiya and Amhara the mandate of approving revisions is reserved for the regional cabinets. The legal frameworks suggests a region-wide comprehensive fee revision every five years. Thus far, no region-wide comprehensive revision has been made in Oromiya or for health centers in Amhara.

All of the health facilities visited reported that they regularly revise the prices of drugs and medical supplies whenever new drugs and medical supplies are purchased. In most cases, a 25% mark-up is added to the purchase price to cover the cost of loading, unloading, transport, and other related costs. However, fee revision for health service charges within the three visited regions has been mixed, with some health facilities revising fees and some not doing so.

Out of the health facilities visited by the team, Felege Hiwot and Debre Berhan hospitals in Amhara, Deder Hospital and Chefe Donsa Health Center in Oromiya, and Dil Chora Hospital in Dire-Dawa have revised their fees. The fee revisions in all facilities in Oromiya and in Debre Berhan Hospital were approved by facility governing boards. The discrepancy between policy provisions and actual practice in fee revision is also confirmed by the findings of the fee revision

assessment conducted in the regions.<sup>10</sup> Getting approval to revise fees is difficult and time consuming, as stated in the user fee assessment.

Despite the fee revisions in some facilities, the user fees seem affordable for the majority of patients. The findings from patient exit interviews in the fee revision assessment study<sup>11</sup> revealed that the majority (82% at health centers and 66% at hospitals in Oromiya, 82% at health centers and 66% at hospitals in SNNP, and 73% at health centers and 72% at hospitals in Amhara) reported that the fees were affordable. According to the same study, the user fees for consultation at health centers range from ETB 1–5, and at hospital from ETB 3–10. While the difference in service charges among health facilities is narrowing after the revisions, the lack of uniformity is still a problem.

User fees need to be established depending on the level of the service provider and amount of service provided. Higher fees are charged for secondary and tertiary levels. This is necessary to rationalize and encourage utilization of health service at the appropriate level. In addition, health facilities are allowed to charge a bypass fee for self-referrals. However, the bypassing fee (e.g., ETB 25 charged in Amhara) has not adequately signaled patients to use lower level facilities.

### **Challenges**

The major challenges for this component include: (1) lack of region-wide uniform revision of user fees, resulting in different fees charged for the same services by facilities at the same level; (2) fee revisions effected without proper approval processes; (3) fees not revised in some facilities for so long that they are unable to accurately reflect costs of services or provide market signals; and (4) lack of balance between local discretion and regional control in the regional laws and regulations.

The evaluation team recommends that regions: (1) conduct a region-wide comprehensive fee revision every three to five years to cope with general price increases and set a reference for local adjustments; (2) review the health facilities that have revised their fees, have fulfilled the preconditions in terms of improving quality and availability of service delivery, have made proper assessment of beneficiary willingness and ability to pay, if there, and have taken appropriate follow up actions; and (3) review the legal provisions for the revision of user fees and the actual practice in terms of regional variation, applicability to local contexts, and effectiveness.

## **5. FEE WAIVER SYSTEM**

The fee waiver system (FWS) is a mechanism established to protect the “poorest of the poor” against financial barriers created by user fees. In the FWS, eligible beneficiaries are screened and identified through community participation. The selected beneficiaries are given a certificate entitling them to free health care services. Before the reforms, identification of beneficiaries was not systematic, targeting was seriously flawed, the body issuing the certificate was not linked with the cost of the services, and the health facilities had to cover the cost. The woreda administrations are now budgeting to cover the cost, entering agreements with health facilities, and reimbursing health facilities for services rendered to the fee waiver beneficiaries. This is based on the principle that no service is “free” and is intended to link the body issuing the fee waiver certificate with the payment.

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<sup>10</sup> According to the study, 100% of hospitals and health centers visited in SNNPR have revised their fees. In Amhara, 75% of health centers and 66.7% of hospitals have revised their fees. In Oromiya, 93% of health centers and 71% of hospitals have done so. In Amhara and Oromiya, hospitals and health centers have been revising their user fees with the approval of their governing bodies, while the mandate for approval of user fees revision is that of the regional cabinet.

<sup>11</sup> HSRFP, “Assessment of User Fees Revision in Health Facilities in Ethiopia,” SNNPR report, April 2011; Amhara and Oromiya report, May 2011.

The necessary provisions for the implementation of the fee waiver component have been included in the Health Service Delivery and Administration legal frameworks (proclamation, regulations, and directives) issued by the regions. As reported by the fee waiver assessment findings in SNNPR, the legal framework documents are not adequately distributed to the woredas. While the status varies among regions, implementation of FWS has started in all the regions except Afar, Somali, and Gambella. The number of indigents identified among the visited regions varies significantly (1.3 million in Amhara, 160,409 in Oromiya, and 13,919 in SNNPR). In SNNPR, only 27 out of 157 woredas have started implementing the waiver system. The major reason for the greater achievement in Amhara is stronger government commitment to enhancing equity and the use of a fixed payment per treatment<sup>12</sup> mode of payment that ensured predictability.

## Challenges

HSFRP has conducted an assessment of implementation of the FWS in Amhara, Oromiya, and SNNPR (May 2011).<sup>13</sup> The findings of the assessment are consistent with the team's findings, and information from the assessment is utilized to justify some of the observations in the visited woredas. The following are the major challenges for this component:

1. **Targeting:** The indigent selection process is based on the guidelines prepared by the HSFRP and targeting the right beneficiary remains an issue. However, it is reported that some woredas in Oromiya, Amhara, Diredawa, and SNNPR determine the number of fee waiver beneficiaries coming from each kebeles using a quota system regardless of the socioeconomic variations among the kebeles. The lack of objective selection criteria remains the major constraint to ensuring equity in the system.
2. **Budget allocation:** Most of the woredas visited have reported that the woreda administration has allocated funds for the fee waiver system from its own limited resource base. However, the amount allocated varies significantly among regions and among woredas within regions.<sup>14</sup> Except in Amhara, where a capitation system is established for reimbursement, woredas do not have specific formula or standard for determining the FWS budget. Allocation is not based on proper analysis of the number of beneficiaries and the cost of health service but rather on the financial status and level of commitment of the woredas.
3. **Resource shortage:** There is a general consensus that the budgetary amount allocated is inadequate to cover all deserving beneficiaries.<sup>15</sup> Unless a strategy is sought for mobilizing additional resources to fund the fee waiver system, access to care will remain a dream for most of the "poorest of the poor" in the country.
4. **Budget utilization:** Furthermore, the budget and utilization data gathered from the woreda/town administrations revealed that some woredas have fully consumed their budgets and failed to reimburse the claims submitted by health facilities, while other woredas did not exhaust their budgets. More woredas in SNNPR and Oromiya fully or over-utilized their budgets than woredas in Amhara. The low budget utilization could be

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<sup>12</sup> Woredas are expected to pay ETB 15 for outpatient and ETB 30 for inpatient services at the health center level, which is ETB 30 and 200, respectively, at hospital level.

<sup>13</sup> HSFRP, "Assessment of the Implementation of Fee Waiver System in Ethiopia," Regional Reports for Amhara, Oromiya, and SNNPR (May, 2011).

<sup>14</sup> In SNNPR, the budget allocated for fee waiver in EFY 2003 varies from ETB 5000 in Sodo to ETB 135,000 in Hawasa. In Oromiya, it varies from ETB 5,000 in Senana to ETB 60,000 in Haromaya. In Amhara, it varies from ETB 1,676 in Meket to ETB 50,000 in Gondar Zuria.

<sup>15</sup> According to the fee waiver assessment in the three regions of the woreda administrators interviewed, 80% of them in SNNPR and Oromiya and 70% in Amhara stated that budget shortage is a serious problem for the FWS.

either due to under-utilization of the service by the beneficiaries, delay in request for payment or reimbursement, a problem of access to the health facilities, or delay in starting the service.

5. **Reimbursement:** Reimbursement for health facilities is based on fee-for-service, except in Amhara. No problems were reported in reimbursement of claims for health centers, though in some regions the hospitals have not been reimbursed by the regional health bureau as per the regulations. It is difficult to enforce other regulations when the main architect of the law violates the law; this needs to be rectified.

The major recommendations for this component include: (1) improve targeting and selection of the right beneficiaries through capacity building (TA and frequent training) and improving the targeting criteria to be more applicable; (2) establish cost data base to ensure that budget allocation is based on number of beneficiaries and average cost of health service; (3) develop communication and resource mobilization strategy to expand options for new sources of funds; and (4) improve budget utilization and reimbursement to ensure health facilities are paid on time for services rendered. In addition, the findings of the recent fee waiver assessment study should be examined for regional variations in the legal provisions, best practices, and constraints. This could be facilitated through organizing forums to share experience among regions.

## 6. EXEMPTED SERVICES

This component of the reforms has had good success, but there are still a number of challenges. All health facilities are posting a list of exempted services in their waiting areas. The list of exempted services are almost the same across regions and include family planning, delivery, pre- and postnatal care, TB, leprosy, EPI, VCT, ART, and PMTCT services and programs. Most of these services are being financed through third-party payers such as family planning by the U.S. Government; HIV/AIDS by PEPFAR, Global Fund, and others; malaria and TB by the U.S. Government, PSI, and Global Fund for AIDS, TB, and Malaria. However, there is no major financier for deliveries and safe motherhood at the health facility level. Because of the lack of third-party payer for deliveries and safe motherhood, there is reported divergence between policy and practice, especially when it comes to deliveries. According to a study conducted by Luwei Pearson et al., 17% of health centers and 77% of hospitals charged mothers for normal deliveries, and 58% of health centers charged an average of \$0.70 for gloves, syringes, and needles.<sup>16</sup> The data for this study may have been gathered some time ago, as there are indications that efforts have been made to address the issue over the last two years. This is evidenced by the fact that: in the absence of third-party payers, health centers in some regions have started financing as much as ETB 30,000 per year to cover the costs of supplies for deliveries. All health centers in Amhara have recorded the amount of retained fees paid for deliveries; according to the user fee revision study conducted in the three regions, some health centers that previously charged fees for deliveries have abolished them altogether.<sup>17</sup> Some woredas in Oromiya and SNNPR have also allocated resources from their retained revenues to finance exempted services. There have also been suggestions that retained revenues be utilized to finance deliveries due to the very low level of institutional delivery and the ambition of the Government of Ethiopia to achieve their Millennium Development Goals.

### Challenges

According to the 2011 Ethiopian Demographic Health Survey (DHS), the percentage of deliveries by skilled providers was low—51% in urban areas and only 4% in rural areas. There

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<sup>16</sup> Luwei Pearson, et al., “User Fees and Maternity Services in Ethiopia,” *International Journal of Gynecology and Obstetrics*, 2011.

<sup>17</sup> Abt Associates, Inc., “Assessment of User Fee Revision in Public Facilities: Amhara, Oromia, and SNNPR Regional Reports,” 2011.

should be some solution to ensure continuous provision of exempted services free of charge, especially for deliveries and safe motherhood. In the project's remaining two years, HSFRP could undertake: a study of sample facilities in the regions to assess availability of drugs and medical supplies for exempted services, in order to provide evidence on the magnitude and severity of the problem and variation among regions; explore the possibility of using retained fees for financing exempted services, particularly delivery; explore the inclusion of hospital-level delivery in the list of exempted services in the regions where it is excluded; and explore mechanisms for mobilizing external resources to fund cost of the supplies for deliveries and safe motherhood.

## **7. PRIVATE WINGS**

This component of the reform is the establishment of a private wing at both hospitals and health centers for providing services to those who can afford to pay more for those services. The private wing is meant to improve the quality and timeliness of services—especially on weekends—to help reduce the turnover of skilled manpower through additional compensation, and to motivate staff members to provide more and better service for an additional fee to those who can afford to pay. The quality of services—including timeliness, access to private or semi-private accommodations, availability of specialists, quality and quantity of nursing staff, and waiting time for elective surgery—is a key issue in the development of private wing services.

The results of private wings vary greatly by region. Oromia has had good success; Amhara has been slower to develop; and SNNPR has yet to begin, but has completed feasibility studies and has visited two pioneer hospitals in the Oromia region on a fact-finding mission. The experience of the private wing also varies from region to region. In Amhara, hospitals provide both inpatient and outpatient services; in Oromia, it is only outpatient services. Again, in Oromia the private wing is also implemented in few health centers. SNNPR is considering both inpatient and outpatient services.

A quote from the FMOH director of medical services directorate, during an interview and discussion of the private wing concept, might be representative of the experience thus far: “The implementation of the private wing concept is difficult, complex, with many abuses, and needs constant monitoring, but it is working and helping to retain key staff, especially physician specialists with small additional income to the staff working in the private wing.” He further stated that “18 hospitals nationwide and all but one federal hospital have implemented private wings.”<sup>18</sup>

### **Challenges**

The income tax issue has slowed the development of the private wing. This was highlighted in each interview with counterparts. Income that exceeds the normal staff salary is taxable. This means the incentive to provide services in the private wing is lessened if the staff member has to report the extra income and pay taxes. There is a need to discuss the tax issues with the BOFED and arrange a mutually acceptable mechanism. In general, the decision to implement is up to the board of each facility, but this varies by region. The tax issue needs to be resolved with the regional tax bureau, or there may need to be a national policy. A related issue is the need for some system to reward staff based on performance. This is discussed in a later section of this report.

The private wing component is still in the early phases of implementation, and the experience thus far has been mixed. There is limited experience with private wing services, and it will take time to develop and implement effective programs in this area. Some of this is due to the

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<sup>18</sup> Taken from interview with Dr. Abraham Endeshaw Mengistu, Director of Medical Services Directorate, FMOH/Ethiopia.

different perceptions of the various regions on the effect the private wing will have on the normal health facility services. The evaluation team recommends that an in-depth study on the various methods presently utilized in the various regions as well as in the FMOH facilities be conducted, and the costs/benefits and best methods of operating private wings be presented for all regions to consider. Some national guidelines may also need to be established to allow some consistency across the country; this should also be highlighted in the study.

## 8. OUTSOURCING OF NON-CLINICAL SERVICES

Outsourcing of non-clinical services is a relatively new concept in Ethiopia. At present, there is a shortage of competent qualified suppliers of non-clinical services in the marketplace, especially outside of Addis Ababa. Outsourcing can ease the health facility's overall administrative burden, as the hospital management can focus more on its core business of improving quality of care and service to patients. The outsourcing process has also empowered nurses, since nurses are the ones to approve payments to the suppliers (of laundry, housekeeping/cleaning, dietary, and other outsourced services). Outsourcing of various non-clinical services is working effectively and is bringing new ideas and more efficient management to the health facilities, as well as allowing new micro-enterprises to grow and prosper.

The results with outsourcing vary greatly by region. But all three regions (Amhara, Oromia, and SNNP) have had initial successes. Hospitals can both improve quality and decrease cost if outsourcing is done properly. Experiences differ from region to region, but dietary/food services are generally the most popular outsourced service, as local alternative suppliers are available. Table 3 presents an example of the services and benefits from Amhara.

**Table 4: Outsourcing of Non-clinical Services in Amhara**

	Name of hospital	Town /city	Types of services provided	Outsourcing date	Reported benefits of outsourcing
1	Debre Berhan	D/Berhan	Laundry, food, and security	2010	Cost reduction, improved efficiency and quality
2	Metema	Metema	Food/all items	2010	Cost reduction, improved managing the service
3	Debark	Debark	Food/all items	2010	Cost reduction, improved managing the service
4	D/Tabore	D/ Tabore	Food/all items	2010	Cost reduction, reduced administrative complexity
5	Shegaw Mota	Mota	Food/all items	2010	Cost reduction, reduced administrative complexity
6	Dessie	Dessie	Enjera	2010	
7	Woldiya	Woldiya	Food/all items	2010	Cost reduction, reduced administrative complexity
8	Yemekdela Jegnoch	Lalibela	Food/all items	2010	Cost reduction, reduced administrative complexity
9	Felegehiwot	Bahir Dar	Enjera and firewood	2010	Cost reduction (15,000 per month), reduced administrative complexity

Source: Regional project office.

## **Challenges**

One major challenge to outsourcing non-clinical services highlighted during the site visits is finding alternative employment opportunities for employees of outsourced departments and services. This is often a very difficult task in a small community. This should be emphasized as a cost of implementing outsourcing, and new facilities considering these changes should be aware of this issue before implementation. Another challenge is the lack of competent bidders for outsourced activities, mostly due to a limited market of capable and qualified vendors.

Outsourcing is a relatively new concept, and health facilities will require some time to learn the best methods; however, early experience has shown that this concept is being implemented successfully and can both improve quality and reduce cost. The new micro-enterprises are developing and will increase to meet this need over time.

## **9. GRADUATION AND FIRST GENERATION REFORMS**

The project has had two generations of reform, with the first group of components as outlined above. The second generation of reform basically involves the health insurance activities of CBHI and SHI. The first generation reform components have been implemented for more than five years in the consolidated regions. These reforms have been highly successful. It is now time to consider “graduation” of the well-functioning health facilities. This is necessary for two reasons: First, it is important to reduce the dependence of the region administrations and their health facilities on the project for ongoing support. Second, the number of new health facilities coming online has greatly increased the demands on the project for support to these new health facilities. Consequently, the project has developed a concept note on the graduation of health facilities with initial criteria for graduation.

There are approximately 600 health centers waiting to introduce these reforms and another 700 health centers under construction. The evaluation team concurs with the project’s proposal to move toward graduation. The reforms that have been most effective in improving the quality of care are the revenue retention/utilization and the FGB implementation. Now the best strategy is to graduate well-functioning facilities in these two components and move on to the new facilities most in need. The evaluation team suggests that the criteria used for graduation could be different for health centers and hospitals. The team also suggests that the project revisit the criteria and consider a combination of the following attributes:

- A functioning and effective governance structure
- An ability to retain a minimum level of resources (e.g., not less than ETB 300,000 per year at health centers and ETB 3 million at the hospital level)
- An availability of adequate support staff (more than 80%) to manage the collection and financial management activities
- Having been supported for a longer time (e.g., not less than two years)

An alternative approach might be for hospitals to graduate from user fee retention and utilization and FGB training support, but continue to be supported on outsourcing and private wing development. Regardless of the criteria chosen for graduation, the process should include the government at federal, regional, and local levels.

## **10. HEALTH INSURANCE**

Access to quality and affordable health service for all citizens is one major policy objective of the Government of Ethiopia. To this end, and in addition to the current supply-side reforms, the government has developed a health insurance strategy as a complementary policy to improve financial access and reach universal coverage. Accordingly, the government aims to increase the

population covered through health insurance to 50% by 2014/15. The main goals of health insurance are to: (1) improve access to care by reducing out-of-pocket spending; (2) remove and/or reduce substantial financial burdens on households during illness; (3) improve quality of care by increasing resources for health facilities, enhancing accountability, and mobilizing additional resources for the health sector through collection of contributions/premiums. The planned health insurance initiatives are CBHI, which is voluntary and designed for the informal sector, and the SHI scheme, which is a mandatory health insurance program that will be introduced for categories of formal sector employees.

### **Social Health Insurance**

The parliament of the Federal Democratic Republic of Ethiopia ratified the SHI proclamation on August 19, 2010 (No 690/210). Subsequently, the Council of Ministers issued regulation on December 2, 2010 (No. 191/2010), which endorsed the establishment of the HIA. According to the proclamation, SHI membership is mandatory; employees and employers shall make equal percentage contributions based on the employee's salary. However, the proportion is to be determined by the SHI implementation regulation to be issued by the Council.

In collaboration with federal and regional government offices, the HSFRP has organized subsequent SHI TOT for participants from federal and regional levels. A total of 724 individuals have received the TOT and have facilitated consultations on the SHI proclamation and draft regulations. According to our interviews, more than 50,000 formal sector employees have been consulted on the SHI and useful feedback obtained. The SHI implementation regulation has been drafted and revised as per comments obtained through consultations of stakeholders. However, it is not yet in place. It has to be finalized by FMOH and submitted to the Council of the Ministers for approval. The SHI agency has been established and its first general director appointed. The structure of the agency and other necessary systems, such as provider payment mechanisms, are presently being studied.

### **Challenges and the Way Forward**

1. **Institutional setup:** While the government has planned to launch SHI in August 2011, it seems unlikely that the HIA will be ready to begin to operate at that date. A director general has been appointed and it is reported that the HIA will have 24 branches in the country with an estimated manpower requirement of over 1287 of which 30% are support staff. This implies that the task ahead in hiring; training; deploying manpower; establishing and furnishing the head and branch offices; and developing manuals, guidelines, and systems will be a daunting task which could be the focus of the HSFRP not only within the remaining project period.
2. **Sequencing:** The government's intention is to start the SHI in both government and private organizations at the same time. Human resource capabilities and systems and tools for promotion, coordination, management, and implementation of SHI are yet to be put in place. Until adequate capacity is established, government may consider adopting a learning-by-doing approach, by starting with the inclusion of civil servants followed by public enterprise, private enterprises, and the police. This would give more time and opportunity to learn the "unknowns," build implementation and management capacity, and fine-tune the design parameters (contribution, copayments, benefit packages, etc.).
3. **Result indicator:** As stated in the RFP, the key outcome target for the HSFRP is 20% (minimum) of the Ethiopian population be covered by health insurance. Given the status of both SHI and CBHI at the moment, it is unlikely that insurance coverage will reach 20% of the population in any reasonable time frame. Consequently, we suggest revision of the target.

4. **Budget implication:** The government will cover the administrative cost of the HIA and contribute as an employer its fair share of the premium. The total budget requirement is very high, unless other sources of financing are explored.

Our recommendations include: (1) exploring the possibility of sequencing SHI coverage; (2) providing adequate financial, technical, and material support for the HIA to ensure timely operationalization; and (3) developing effective communication and resource mobilization strategies to promote SHI.

### **Community-based Health Insurance**

The CBHI scheme is intended to serve the population engaged in the informal sector in Ethiopia, which represents 89% of the total population (Census 2007). CBHI will initially be implemented on a pilot basis and will later be scaled up by incorporating lessons learned.

Accordingly, various preparatory activities have been performed, including a feasibility study, the design of the pilot scheme, consultation with major stakeholders, sensitization and awareness campaigns, establishment of CBHI structures, development of financial and administrative manuals, and training of major actors before and during the establishment of the CBHI schemes.

Thirteen pilot woredas were selected from the regions of Amhara, Oromiya, SNNP, and Tigray. The woredas were selected on criteria developed jointly by FMOH and HSRP. The major criteria include: (1) readiness of health facilities in the woredas in terms of drug availability, human resources, physical accessibility, and implementation of HCF reforms and (2) representation of both resource-poor as well as better-off woredas, which is reflected by the selection of one food-insecure woreda in each region. The CBHI scheme has been established in all pilot regions, and service to the members started in 2011 (SNNPR in April, Oromiya in July, Amhara in June.) Thus far, 37,766 paying households are enrolled, with ETB 3.5 million collected (see Table 4). Every CBHI member in each pilot woreda is expected to pay an ETB 5 registration fee (a onetime payment) and annual contribution of ETB 180. However, member contribution varies among regions, ranging from ETB 132 in Tigray to ETB 34.4 in SNNPR. The factors causing these variations among regions are the size of paying membership and indigents as well as the total amount and per member contribution to date (as shown in the table). This needs to be examined carefully to identify problems and take appropriate actions as well as to properly document lessons for the scale-up design.

Regions and woredas have started allocating resources for subsidizing indigents. So far, 17,285 indigents have been identified in Amhara and Oromiya. The project facilitated the transfer of ETB 650,000 (part of the general subsidy) from the FMOH through their respective RHBs to each of the 13 pilot woredas (ETB 50,000 per woreda). This fund will be used to equip the woreda executive bodies with office equipment and furniture. The introduction of CBHI has also injected an element of empowerment to its members, who started demanding their rights at the facility levels as claim holders. This was observed in all regions and is encouraging.

FMOH and the HSRP have conducted a joint facility assessment in 64 health centers located in the pilot woredas. The joint team assessed the status of health centers in terms of availability and gaps in human resources, drugs and other medical supplies, diagnostic equipment, water supply, electric supply, etc. The team costed the amount of resources required to fill the identified gaps. Upon presentation of the findings, the regions have promptly acted on the issue. Oromiya allocated ETB 200,000 to each pilot woreda; Amhara allocated a total of ETB 2.5 million to the three pilot woredas.

**Table 5: Number of CBHI Households Registered and Paying by Region**

No.	Pilot region	No of pilot woreda	Registered & paying members	Premium collected	Number of indigents registered	Contributions paid per member
1	Tigray	3	1,023	35,036	na	132.00
2	Amhara	3	19402	2,285,705	13,875	117.81
3	SNNPR	3	12,339	430,897	na	34.92
4	Oromiya	4	5,002	644,284	3,422	128.81
	Total	13	37,766	3,495,922	17,297	92.57

Source: HSFRR third year progress report and regional visit reports.

There has been significant progress in registering members, but progress varies from region to region. In Amhara, the three pilot woredas have managed to cover 27% of their total population. The high performing pilot woreda, Tehuledere, reached coverage of 50% within six months. mainly due to the higher commitment of the woreda administration. The poverty level, limited awareness of the community, harvest failure, and timing of premium collection are factors reported by regions and woredas for the slow coverage.

As the CBHI implementation is strengthened, the patient load at each health facility will significantly increase. This could generate burnout and lack of interest among health professionals unless there is mechanism to compensate for the additional workload. The scheme signs agreements only when health centers are ready. As a result, many new health centers are not considered service providers. However, there is strong pressure from members living in these areas to use these facilities not accepted by the scheme. Facility readiness is an issue, as the quality of service at some health centers is poor and the administrative burden of enrolling members and collecting premiums is high. To assess health center readiness and identify areas for improvement, the FMOH and the HSFRR conducted a joint facility assessment in 64 health centers located in the pilot woredas. The assessment revealed that there are gaps in human resources, problems with the availability of drugs and medical equipment, and some centers with no available water supply or power services.

### Challenges and the Way Forward

1. **Government commitment at all levels:** While the CBHI scheme is institutionalized in the woreda administration, except in Amhara, it is not considered one of the core focus areas like the health extension program. Unless CBHI tasks are made one of the core tasks upon which woreda and kebele officials will be evaluated, the current enthusiasm may soon fade out.
2. **Facility readiness:** The quality of service is poor at some CBHI health facilities. The joint FMOH and the HSFRR assessment of health centers in the pilot woredas has revealed that there are gaps in human resource, problems with the availability of drugs and medical equipment, and some centers with no available water supply or power services. While the team appreciates the prompt actions taken by the FMOH and the regions to improve the situation, the actions have not adequately solved the problems. The woreda visits revealed that the cost of water and electricity within health facilities is beyond the woredas' financial capacity. The availability of drugs and medical supplies from the Pharmaceutical Fund and Supply Agency (PFSA) is irregular and has become one of the major obstacles to improving the quality of care. The investment has to extend to the newly built health facilities that are geographically closer to the beneficiaries but not considered CBHI providers.

3. **Scheme design:** Piloting activities are expected to identify, develop, test, and refine the CBHI options that are appropriate and viable to the Ethiopian context; currently, all pilot woredas are adopting uniform scheme designs in terms of membership, premium, copayment, and structure. This uniform approach will not allow for testing various options that may be more appropriate than the current option. The HSFRP has to find means of testing other design options or at least properly document issues, problems, constraints, and challenges associated with different options of the basic design parameters.
4. **Piloting CBHI in the urban informal sector:** The selected pilot woredas are predominantly rural, and the informal sector in the big urban centers seems excluded from the pilot. Hence, the HSFRP should consider piloting in the city administration of locales like Addis Ababa, Harari, or Dire Dawa to document issues, problems, constraints, and challenges to be considered in the design and implementation of CBHI in the urban informal sector.
5. **Copayments:** The CBHI is designed to cover the full cost of member's medical bills; there are no copayments. While the absence of copayments may improve utilization of health services by reducing the cost of visiting a health facility, it may also trigger abuses of health service by beneficiaries (moral hazard). Hence, the impact of no copayment on the efficient utilization of health service and on the financial sustainability of the scheme has to be examined carefully. There are early signals of moral hazard in Amhara where 15,000 CBHI patients from the three pilot woredas have visited health facilities in three months.
6. **Sensitization and promotion:** Health insurance is not a familiar concept for most of the community members. Hence, individuals and households under resource-constrained environments may not see the rationale behind putting money aside for future use and leaving some basic needs unsatisfied. Thus, the proportion of households willing to join the CBHI scheme is highly contingent upon the community's level of awareness and understanding of CBHI. In the remaining project period, the HSFRP should conduct aggressive marketing and all-inclusive awareness creation and sensitization on the benefits and importance of health insurance schemes.
7. **Resource mobilization:** Because of their small scale, their voluntary nature, and their low premiums, CBHI schemes face severe limitations in terms of financial sustainability and managerial capacity. In addition, the number of indigents whose premiums have to be covered by a third party is very high. The level of subsidy expected from the regional and local government is very large compared to the small budget and other competing priorities. Hence, support from development partners and government at all levels is very important, particularly since the amount of resources required for the scale-up is very large and beyond the capacity of the government. Accordingly, in the remaining project period, the HSFRP has to focus on developing appropriate communication and resource mobilization strategies to obtain buy-in from development partners. Although resource mobilization is beyond the scope of the project and should primarily be the responsibility of government and USAID, it is critical to note the issue since the visible progress made in this regard could easily be lost or remain stagnant.
8. **Capacity building:** In the remaining project period, training and technical support must continue to be strengthened. Refresher courses and training on the major elements of the reform should be offered for all stakeholders, including regional authorities, board members, health facility staffs, and the community.

The recommendations of the evaluation team are to: (1) review the piloting exercise to learn the unknowns for scaling up (minimum membership, benefit package versus premium, mode of reimbursement, funding for indigents, and potential moral hazard), (2) increase investment and follow-up to improve the quality of health service and ensure that health facilities have access to improved water supply and continuous power supply, (3) expand the piloting to include the

urban setting, and (4) conduct aggressive marketing and all-inclusive awareness creation and sensitization on the benefits and importance of health insurance. Increased resources are necessary and should be in place before the planned scaling-up of CBHI and SHI takes place. Regional personnel are implementing the reform programs, especially CBHI, and generally lack significant experience in the area of health insurance. Given the scale and innovation required in these CBHI schemes, it is important that the project take advantage of experiences in other countries, possibly through fact-finding visits to other successful countries. There is also a need to expand the TA skill mix to ensure that the team has the skills to support the government agency responsible for quality assurance and SHI accreditation.

In summary, the HSFSP has made significant progress both in terms of SHI and CBHI. However, as a health insurance initiative is new to the country, the learning-by-doing approach has to be adopted until experience is gained and adequate information obtained. Efforts should be made to create capable human resources, systems, and tools for the promotion, coordination, management, and implementation of these new insurance schemes.

## V. HSNR'S ALIGNMENT WITH ETHIOPIA'S GHI STRATEGY

The U.S. Government has approved a GHI/Ethiopia Strategy that will contribute to realizing the ambitious Ethiopian goals and the overall GHI goals of reducing maternal and child mortality by 2015. Under GHI, the U.S. Government will therefore prioritize reduction of maternal, neonatal, and child mortality and apply key GHI principles, including “smart” integration and coordination, a woman- and girl-centered approach, health systems strengthening, a strong focus on monitoring and evaluation, and a robust country-led approach to find more efficient and effective ways of delivering evidence-based assistance.<sup>19</sup> This vision and the goals are planned to be delivered through the effective implementation of three interdependent pillars: (1) improved access to health care services, (2) increased demand for health services, and (3) improved health systems. The HCF is categorized under the health systems pillar.

GHI has seven guiding principles: (1) implement a woman- and girl-centered approach; (2) increase impact through strategic coordination and integration; (3) strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement; (4) encourage country ownership and invest in country-led plans; (5) build sustainability through health systems strengthening; (6) improve metrics, monitoring, and evaluation; and (7) promote research and innovation. It is important to look how HSNR contributes to this framework and implements its programs according to GHI principles.

The HSNR contributes directly and indirectly to all the three result areas. It increases access to care through its impact on quality of care, expansion of facilities, and procurement of equipment for providing services. This is documented in the health facilities visited. The fee waiver and the CBHI and SHI components target the removal of financial barriers to care at the point of use. The improved demand for care by fee waivers and CBHI members in the pilot woredas under the project contributed to increasing demand for health services. The health finance reform supports the development of effective and sustainable government-owned health financing system at all levels. The project is also implementing its own programs according to most of the GHI principles. The strengths and the areas for further enhancement are presented in the table below.

**Table 6: Alignment of HSNR Project Implementation to GHI Principles**

GHI principles	Strengths	Areas for enhancement
Implement a woman- and girl-centered approach.	There is progress in establishing and piloting pro-poor financing schemes (fee waivers and CBHI) to enhance equity, including for women-headed households.	Women’s role in governance structure is not that pronounced.
Increase impact through strategic coordination and integration.	HSNR is working with Clinton Health Access International on some reform initiatives (e.g., on strengthening facility governance structures). It has impact on recruiting additional human resources to health facilities on a contract basis. It has also contributed to access and quality of care through expansion of additional services within facilities and procurement of equipment, drugs, and medical supplies from retained revenue.	It could use some of the hospital reform quality indicators not only to document and report progress on the reform’s impact on quality but develop a tool that uses them as a guide for resource allocation at facility level.

<sup>19</sup> USAID/Ethiopia GHI Team, Ethiopia Global Health Initiative Strategy, Final Approved.

<b>GHI principles</b>	<b>Strengths</b>	<b>Areas for enhancement</b>
Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement.	The project scope is limited to providing TA to implement the reform within the country.	Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement.
Encourage country ownership and invest in country-led plans	There is very high ownership of the program by federal, regional, and woreda governments. The drivers of the reform are government counterparts, and supports government's own plans in these reforms.	No further recommendation
Build sustainability through health systems strengthening.	It strengthens government systems for sustainability.	The investment to get the system working is high. Government is not investing resources to strengthen capacity. It is necessary to develop strategic direction on how government will take over the full responsibility in the long term.
Improve metrics, monitoring ,and evaluation.	Strong supportive oversight is being carried out at all levels of the project. The findings are being used to take actions by the project and their government counterparts.	The project should exploit the potential of the emerging focus on quality in hospitals and HCs and work out mechanisms to link investment of retained fee with quality. The HMIS has also not captured some of the HSFR indicators.
Promote research and innovation.	Have program learning component that assisted government to project the cost and financing of the health sector development program; research also helped to refine implementation strategies.	There is a need to scale up evidence generation, specifically on the goals of the program (quality and equity). There is a need to have a standardized data collections mechanism in regions to track progress in outputs and outcomes.

## **VI. OTHER HEALTH SYSTEMS STRENGTHENING ISSUES**

In conducting the regional site visits, the evaluation team became aware of a number of issues that were not included in the scope of work of this midterm evaluation but have wider implications for future health systems strengthening efforts in Ethiopia. These issues include: (1) the need for: some type of performance-based payment system for staff in the various health facilities; (2) the need for improved quality management techniques, especially with regard to SHI accreditation activities; and (3) the role of the private sector under the new health financing reforms.

During most of the site visits, the heads of the facilities mentioned the lack of a formal mechanism to reward staff for excellent or outstanding performance on the job. The present policy states that retained revenues cannot be utilized for performance bonuses or for improved salary arrangements for staff (list of negatives for retained revenue utilization). However, it was apparent from discussions with a number of facility heads (both hospitals and health centers) that they had already developed their own programs, although these are formally “outside of existing regulations.” This presents a dilemma for facility management trying to improve performance of the health system and follow regulations at the same time.

### **PERFORMANCE-BASED PAYMENT**

Over the last 10 years, Pay for Performance (P4P) systems<sup>20</sup> have been developed in many countries and utilized in many health financing projects. These incentive payment systems have made significant changes in the method of payment of staff (doctors, nurses, and others). The existing literature on the subject is extensive, and the various sources are footnoted below.<sup>21</sup> The evaluation team was made aware that there is a long history in Ethiopia concerning this topic, and there have been recommendations under previous projects.<sup>22</sup> While the literature is quite extensive on this topic, and there have been many pilot demonstrations and successes, the literature is short on rigorously documented evidence.

However, it is generally recognized internationally, in both the profit and non-profit sectors, that performance-based payment systems have a positive role in improving productivity, output, quality improvement, retention of staff, and general attitudes of staff. Considering that the effective implementation of CHBI and SHI activities will most likely increase the workload at the various health facilities, it is recommended that the Government of Ethiopia take another look at P4P programs and assess the costs and benefits of these programs in the light of existing and future health financing reforms. The team also recommends that the Government of Ethiopia develop a study group to review performance-based reward programs for health sector personnel that utilize some percentage of retained revenues to provide incentives, increase productivity, and to retain and motivate staff.

### **QUALITY MANAGEMENT AND ACCREDITATION**

The existing quality improvement methods and techniques (quality assurance, quality improvement, continuous quality improvement, etc.) have more recently been classified under

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<sup>20</sup> See signature article by Alan Maynard, “Pay for Performance (P4P): International Experience and a Cautionary Proposal for Estonia,” Health Insurance Fund, WHO Europe, 2008.

<sup>21</sup> See USAID Health System 20/20 website ([www.hs2020.org](http://www.hs2020.org)) and the World Bank RBF Trust Fund website ([www.rbfhealth.org/rbhealth/](http://www.rbfhealth.org/rbhealth/)).

<sup>22</sup> This was taken from discussions with headquarters staff of the contractor, Abt Associates, Inc.

the title of quality management (QM). With the development and implementation of the SHI program and the HIA, there is a need to improve QM methods and programs in Ethiopia. Internationally, “accreditation” programs are an outgrowth of the health insurance industry and its concern that health facilities are providing “continuous quality improvements” over time to their health insurance clients/patients. Normally under international SHI programs, only health facilities that are accredited are permitted to receive payment from the HIA. Accreditation<sup>23</sup> is a higher-order QM activity (usually meaning more standards, more continuing education, more measurement activities, establishing a culture of quality improvement, as a program of implementing a continuous quality improvement process in each health facility). “Licensing” is a lower order QM activity (few standards and less measurement) and is usually concerned only with patient safety issues. Normally, the accreditation process is carried out by an independent body while licensing is usually done by the state or a governmental agency.<sup>24</sup> This distinction is not well recognized, and many health care practitioners confuse licensing and accreditation programs.

As Ethiopia moves into the SHI and HIA activities, there will be a need to develop these accreditation methods and practices for both the public and private sectors. It is recommended that the Government of Ethiopia consider developing an accreditation system and forming a study group to explore the various options for implementation.

## **THE PRIVATE SECTOR**

During the evaluation team’s site visits and interviews with implementing partners, many of the various issues of the private health sector were discussed briefly. It is clear that in the pilot regions the relationship between the public and private sector is a good one, and in the case of hospitals there is often coordination of programs and services and sometimes even sharing of staff. However, it is also clear that there is competition between the two sectors on both quality and price. While there is much discussion on these issues within the health community (both public and private), as well as among the international donor community, it is sufficient to state that there is a need for the Government of Ethiopia GOE to formally outline the role of the private sector, especially in the light of the SHI and HIA implementation and the scaling-up of CBHI. If there is to be a level playing field for both sectors, there will be strong and active involvement of the private sector in SHI programs, including accreditation. While the SHI has plans for the private sector involvement, its input needs to come early in the development stages and not as a second thought. Ideally, this would be done as part of a new health financing strategy and overall health plan for the entire country. As there are USAID projects in the private health sector in Ethiopia, there are no specific recommendations from the evaluation team in this area, except as outlined under implementation of SHI activities.

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<sup>23</sup> See Charles Shaw et al., “Toolkit for Accreditation Programmes: Some issues in the design of external assessment and improvement systems,” International Society for Quality in Health Care (ISQua) for the World Bank, 2003.

<sup>24</sup> See George Purvis et al., “International Health Care Accreditation Models and Country Experiences: Report on Options for the Republic of South Africa” (Washington, DC: USAID, February 2010).

## VII. RECOMMENDATIONS

In summary, the reform initiatives are owned and managed by and through the various government management systems and have revolutionized not only the health financing system in the country but also local ownership and stakeholders' involvement in the management of health facilities. Most of the reform program outputs have been realized, and a significant number of outcomes and impact targets are likely to be achieved by the end of the program period. With this in mind, outlined below are suggestions for the Government of Ethiopia (GOE), recommendations for USAID, and recommendations for the project.

### SUGGESTIONS FOR THE GOVERNMENT OF ETHIOPIA:

1. Develop a consolidated health finance strategy that sets out the vision and future structure for HCF in the country for the next 10 plus years. This strategy needs to cover all aspects of health financing that the current strategy implementation does not fully capture. These include improving efficiency in the allocation and use of health resources and coverage of high impact interventions; improving alignment, effectiveness, and efficiency of external assistance; and strengthening the institutional environment for sustainable financing of the health sector. The current health financing strategy, issued in 1998 needs to be thoroughly revised in view of the current status of HCF reform in Ethiopia to document best practices and lessons learned. The new strategy should include a critical assessment of its strength and weaknesses to inform the development of a new vision, goals, objectives, and a work plan for the next 10 years.
2. Develop a scaling-up strategy for CBHI that outlines steps with different scenarios for coverage, subsidy rates, and TA required for implementation. The plan should also lay out the responsibilities and implications for government at all levels, with buy-in from policymakers, ideally before proceeding beyond the current pilot phase. It should clearly outline what development partners, including USAID, could do to support the scaling-up process.
3. Initiate a program to strengthen development and implementation of the HIA. International experience has shown that HIAs are resource-intensive, especially in the early development stages; take longer to implement than envisioned; and are difficult to manage effectively due to their complexity.
4. Improve facility readiness—particularly of newly established health centers—to provide quality care by improving water and electricity services, as well as improving availability of drugs, pharmaceuticals, medical supplies, and other equipment. This may require a multi-sector response by the Ethiopian water and power authorities and development partners.
5. Review the negative list of “uses of retained funds” and utilize some of these funds for a performance-based reward program for health sector personnel. The demand for health services is likely to increase as a result of the CBHI and SHI implementation. Quality of care, productivity, staff retention, and staff attitude and behavior could be significantly improved if a specific percentage of the retained revenues was earmarked for a performance-based reward system for health workers.
6. Establish a technical working group for HCF reforms with major stakeholders and implementing partners to more effectively communicate results, discuss costs and benefits, outline challenges, and plan jointly for development and implementation of future reforms in the health sector. The need for this group was highlighted by all implementing partners during the evaluation interview process. This was further emphasized during the dissemination workshop.

7. As Ethiopia moves into the SHI and HIA activities, there will be a need to develop accreditation methods and practices for both the public and private sectors. The evaluation team recommends that the Government of Ethiopia consider the development of an accreditation system and form a study group to explore the various options for implementation. The capacity of Food, Medicine, and Health Care Administration and Control Authority, the authority that regulates health service provision in Ethiopia, needs to be strengthened to carry out this task.
8. The future evaluation of the impact and performance of future health sector financing reform activities should examine how to measure the improvement in the quality of care. Assessing the impact of the quality of care is one of the weaknesses of the current project. The evaluation team recommends the use of hospital/health center reform management initiative quality indicators for annual performance review. Access and equity impacts should be evaluated by carrying out benefit incidence analysis before and at the end of the follow-on program. The NHA analysis could also track the progress in increasing per capita resource availability for health sector. It may be useful to consider carrying out regular public expenditure reviews to understand the effectiveness and efficiency of resource allocation of all sources, including retained fees.

### **RECOMMENDATIONS FOR USAID:**

1. USAID should develop additional TA to strengthen development and implementation of the SHI agency, as international experience has shown that this process is significantly more complex and difficult than originally envisioned. This TA could begin with a study group to review the preliminary research on SHI development and implementation strategies, followed by visits to other countries that have recently gone through this process—taking along key decision-makers to see first-hand the complexity of the systems required—and finally the development of a detailed work plan for the proposed activities. While it is necessary to provide additional TA to the newly established SHI agency through the existing implementing partners during the project’s life time, USAID may consider separating SHI from the other components of the reform and establishing a project of its own in the medium term. The future project can be implemented by the exiting contractor or could also be provided through another implementing partner.
2. USAID should assist the Government of Ethiopia with the design of a comprehensive health finance strategy that sets out a clear vision for the structure of the HCF in the country. This should be included as part of a larger vision of the entire health system in Ethiopia, both public and private. This should be done within the existing project lifetime.
3. USAID should ensure that the HSFRP has the necessary resources to fulfill its mandate with regard to coverage of health facilities in the various regions as new facilities come into operation.
4. USAID should work with the Government of Ethiopia to mobilize the financing of the CBHI scaling-up process and to coordinate SHI development and implementation.
5. USAID should work with the Government of Ethiopia to develop a study group to review the costs and benefits of a performance based reward program for health sector personnel that utilizes some percentage of retained revenues to provide incentives, increase productivity, and retain and motivate staff in the health facilities.

### **RECOMMENDATIONS FOR THE HSFRP:**

1. The HSFRP should “graduate” well-functioning health facilities from project support. A concept note has been developed by the project with “criteria” for graduation, but further work on these criteria is needed. These criteria should to be agreed to by government, and

graduation of facilities should start as soon as possible. This will allow a shifting of resources to implementation of the key reforms in the new and less effective health facilities.

2. The HSFRP should expand implementation to a larger number of new health centers, and the project should develop a strategy for accelerating this process. The project should also consider alternative, less intensive strategies to spread the limited resources further. This is critical, as it is not possible to initiate both CBHI and SHI in facilities that have not started retention of fees. The right time period to cover these other facilities is the next two years. This will possibly require strengthening the regional teams with more finance and human resources staff.
3. In collaboration with USAID, the HSFRP should revise the target and outcome indicators to better measure project outcomes and impact on both equity and quality. Some of the project's targeted outputs (e.g., 80% of woreda coverage by fee waivers) are beyond the scope of the project and may not be realized. This is mainly because the number of woredas and health facilities has increased significantly since the planning phase. Consequently, it is necessary to revise the targets. The other intended outcome is improved quality of care through HSFR intervention. However, the evaluation team was unable to find any documentation by the project of the direct impact of HSFR on quality of care. The project staff should focus on documenting the extent to which retained revenues improve quality, in terms of clearly defined quality indicators. One option is to utilize some of the 36 indicators being promoted through the government's new quality improvement efforts. These indicators should include measurement of changes in patient/staff satisfaction, retention, and waiting time for services.
4. The HSFRP should begin to document the known "unknowns" (the impediments and design flaws that might exist now or in the future) of the CBHI schemes.: The results of the piloting need to be well analyzed and explored to answer some of the difficult issues, including: (1) the number of members required for the scheme to be sustainable, (2) the fiscal feasibility of funding for indigents by the regional and woreda governments and the 25% subsidy by the FMOH, (3) the functionality of the institutional set-up and its scalability, (4) indigent selection criteria, and (5) linkages between CBHI and SHI and the scheme provider agreements.
5. The HSFRP should develop a scaling-up strategy for CBHI to assist the follow-on program. This strategy should spell out what it takes to scale up the CBHI with different scenarios in terms of coverage, options for different subsidy rates, and required TA. The plan should lay out the responsibilities and implications for government at all levels with buy-in from policymakers before proceeding beyond the current pilot phase. This strategy should clearly outline what development partners, including USAID, should do to support the scaling-up process.
6. The HSFRP should provide additional technical support in the area of the private wing development and outsourcing of non-clinical services. There is a need for TA in these two areas, ideally from consultants who have had experience in other countries. The HSFRP staff would also benefit from experience sharing and site visits to other countries with HCF projects.



## **ANNEX A. SCOPE OF WORK**

### **Global Health Technical Assistance Project**

#### **GH Tech**

**Contract No. GHS-I-00-05-00005-00**

### **SCOPE OF WORK**

**(Revised: 08-26-11)**

## **I. TITLE: USAID/ETHIOPIA: HEALTH SECTOR FINANCING REFORM MIDTERM PROJECT EVALUATION**

Contract: Global Health Technical Assistance Project (GH Tech)

### **PERFORMANCE PERIOD**

Evaluation preparations should begin in late August 2011 depending on the availability of the selected consultants. In-country field work scheduled to begin on/about September 19. Final revised draft report should be available by mid-November.

### **FUNDING SOURCE**

Mission Funded

### **OBJECTIVES AND PURPOSE OF THE ASSIGNMENT**

The Health Sector Financing Reform (HSFR) Project in Ethiopia is a 5-year, \$15 million USAID-financed bilateral contract to Abt Associates to support government at the Federal, Regional and Woreda levels as well as health facilities to improve financing of health care. The project began 1 August 1, 2008 and is scheduled to end 31 July 2013.

The purpose of the midterm evaluation will be to:

- Assess the performance of the project in meeting its four main goals, results, and targets, and identify areas of success and challenges in the implementation.
- Develop next steps and any modifications for the remainder of the project.
- Identify opportunities for the future of the health sector financing reform efforts and develop specific recommendations for USAID and the Government of Ethiopia for the next five years.

Results will be used to inform USAID's and the Government of Ethiopia's immediate and future program planning and implementation.

### **BACKGROUND**

The Ethiopian health system is characterized by extreme underfinancing, low protection mechanisms for the poor, and a lack of risk pooling and cost sharing mechanisms, all of which result in unacceptable poor quality of health services. To address the growing need for health services and ensure sustainable health financing, the Ethiopian Ministry of Health has embarked on health sector financing reform efforts beginning in 1998. These reforms are one of the major components of the Ethiopian Health Sector Development Program. They promote alternative options for financing, allocating, organizing, and managing health resources and services, emphasizing cost sharing and an expanded role for the private sector and health insurance.

USAID has worked with the FMOH in the development and implementation of ongoing health sector financing reform activities. These activities have resulted in major changes in health financing policy that are currently being implemented, particularly in the three regions (SNNPR, Oromia, and Amhara). Regions differ in their progress with reforms; for those regions that are at the implementation phase, USAID provides support through its HSFR Project to strengthen implementation capacity while expanding financing reform to new regions.

Reforms are building a health financing system that accommodates diverse financing and decentralized management mechanisms. The Reform Proclamation encourages local retention and utilization of user fees by collecting facilities (hospitals and health centers) for use at those facilities to improve quality of health services. The retention of user fees by the collecting facilities will result in a net increase in resources available to these health care facilities as the user fees are additive to the budget they receive from existing federal and regional block grants. Decisions for use of retained funds are made by local governance entities.

The reform package also:

- Ensures that people pay for health services according to their ability and protects the poorest from financial barriers to health care services;
- Provides greater authority and accountability to hospitals and health centers to manage service delivery through establishment of management boards;
- Creates opportunities for hospital private wings and the ability to outsource non-clinical services, such as laundry or cleaning services, to the private sector for efficiency gains, etc.

The HSFR Project supports the regional health bureaus, woreda health offices, and facilities in:

- The local retention and utilization of resources,
- The establishment and functioning of health center/hospital management boards/bodies,
- The establishment and functioning of protection mechanisms for the poor,
- The promotion of outsourcing of non-clinical services,
- The promotion of private wings in public health facilities, and
- Development of the regional level policy and legal instruments guiding implementation of the reforms.

The HSFR Project also supports the FMOH in:

- Establishing social health insurance,
- Piloting and evaluation of community-based health insurance,
- Scaling up community-based health insurance,
- Establishing a health insurance institution,
- Creating legal instruments for health insurance, and
- Generating evidence in health financing.

## **SCOPE OF WORK**

The evaluators are required to address the three main objectives and general questions. (Specific evaluation questions related to each of the four main goals will be developed at a later date with stakeholders prior to start of assessment)

- 1. Assess the performance of the project in meeting its four main goals, results, and targets, and identify areas of success and challenges in the implementation.**
  - a. How effectively have Abt Associates and subcontractors managed and monitored the implementation of various activities?
  - b. To what extent has each of the goals and targets been met? What are the main reasons/factors for exceeding or not meeting expected results?
  - c. What key products or tools have been developed by the project? How well has the partner communicated project successes and disseminated lessons learned?
  - d. What process does the partner use for identifying and resolving problems and challenges to project implementation?
  
- 2. Develop next steps and any modifications for the remainder of the project.**
  - a. How can local ownership of reform efforts at every level be strengthened?
  - b. Are there additional indicators that should be identified and tracked that will assist in measuring the short and long-term project outcomes? Changes to the current targets? Additional operational research studies?
  - c. How can USAID and the Implementing Partners improve their management, collaboration and communication with each other and the Government of Ethiopia on this project?
  - d. What specific changes to the strategy, approach, or timeline should be made for the remainder of the project to maximize impact and sustainability?
  
- 3. Identify opportunities and specific recommendations for future USAID investments in the Government of Ethiopia's health sector financing reform efforts for the next five years.**
  - a. What areas should USAID focus on over the next five years that will provide the maximum benefit to the Government of Ethiopia's reform efforts, align with the Global Health Initiative strategy, and not duplicate other donors' work? What current activities/efforts should be scaled up or decreased? New pilot studies?
  - b. What is an appropriate level of USAID investment in each of the Government of Ethiopia's health sector financing reform areas?
  - c. How should USAID evaluate the impact and performance of future health sector financing reform activities?
  - d. How can USAID facilitate collaboration and communication with the Government of Ethiopia and other partners on health sector financing reform activities and progress?

## **METHODOLOGY**

### **Team Planning Meeting (TPM):**

The assignment work will commence with a two-day team planning meeting (TPM). This meeting will allow the team to meet with the USAID/Ethiopia staff to be briefed on the assignment. It will also allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will: clarify team members' roles and responsibilities; review and develop final survey questions; review and finalize the assignment timeline and share with USAID; develop data collection methods, instruments, tools, guidelines, and analysis; review and clarify any logistical and administrative procedures for the assignment; establish a team

atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion; develop a preliminary draft outline of the team's report; and assign responsibilities for the final report.

Document and literature review: Including but not limited to the Task Order Proposal, Annual and Quarterly project reports, Government of Ethiopia Health Sector Reform background reports, evaluation studies and reports from the partner and from other countries with similar projects/reform efforts.

Interviews and focus groups: Key informants at Government of Ethiopia; partner organizations (Addis and field offices); regional, woreda, and community leaders; community insurance organizations or the emerging social insurance organizations/stakeholders.

Surveys and site visits: Convenience sample of health facilities, health center management bodies, hospital boards, and community members.

Stakeholder meeting(s): Participatory review of findings and discussion of recommendations for future of health sector reform efforts.

USAID/Ethiopia will provide a detailed contact list of key informants, focus group participants, and list of health facilities to the consultants during the document review period, so that appointments, interviews, and site visits can be set up for the team's arrival in-country. USAID/Ethiopia will also provide a draft schedule for field visits including duration of stay at various sites to inform the team's time in-country.

## **TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT**

### **Team Composition:**

The five-person evaluation team should be comprised of two international (expatriate) consultants and three local consultants in addition to USAID advisors. Team lead and technical expert will be external and identified by GH Tech. Local consultants will be identified by USAID/Ethiopia and hired by GH Tech. A local logistics consultant will coordinate and oversee the evaluation preparations and implementation such as making hotel reservations; scheduling stakeholder meetings, key informant interviews, and focus group discussions; and organizing field visits. The evaluation team leader will be responsible for team coordination and performance and for ensuring the timeliness and quality of deliverables. USAID may propose internal staff members from USAID/Washington or other Missions to accompany the team during site visits or participate in key parts of the evaluation (specific event participation to be determined in conjunction with the team leader), and they are expected to provide written inputs to the draft report prior to their departure from country prior to completion of the full in-country work period.

### **Team Qualifications:**

Team lead/health economist with a minimum of eight years of experience in health sector financing reform efforts in Ethiopia or other African countries and who has led at least two similar evaluation studies. [Hired through GH Tech]

Health policy specialist with a minimum of five years of knowledge of and experience in evaluating social and community-based health insurance models in developing countries. [Hired through GH Tech]

Local health economist with a minimum of five years of experience in Ethiopia health sector reform issues, fluent in Amharic and English. [Hired through GH Tech]

Local health economist with minimum of five years of experience in Ethiopia, fluent in Amharic and English, and skills in survey development, data collection, and analysis using culturally appropriate methods. [Hired through GH Tech]

Local logistics coordinator will have experience managing complex evaluations within the development sector, such as coordinating business travel, field visits, and meetings. [Hired through GH Tech]

Additional participants from Abt and sub-partners, Government of Ethiopia officials, and USAID will be included, as needed, in meetings and field work. USAID staff and representatives from implementing partners will be responsible for arranging their own travel, logistics, and other arrangements, as well as financial responsibility for their participation.

An illustrative table of level of effort (LOE)—dates may be modified based on availability of consultants, key stakeholders, and time for field work.

<b>Activity</b>	<b>Team Member(s)</b>	<b>Total Team Days</b>	<b>Period of Performance (illustrative depending on start date)</b>
Mission sends background documents to GH Tech and Team Members	USAID/ET		Early Sept
Review of Documents and begin drafting evaluation protocol and survey instruments; logistics coordinator prepares for survey	All	4	Early Sept
Team planning conference call with USAID and modify protocol and tools according to discussion	All	3	Early Sept
Travel to country	International consultants	2	Sept 15-16
In-briefing with USAID, team planning meetings and interviews with key stakeholders in Addis; finalize workplan, protocol, and survey tools; organize logistics for field work	All	8	Sept 19-26
Fieldwork (including travel days)	Technical consultants	12	Sept 28-Oct 9
Preliminary data analysis and synthesis; drafting report and presentation materials with additional follow up mtgs as needed in Addis	Technical consultants	6	Oct 10 -15
Stakeholders presentation on preliminary findings	Technical consultants	1	Oct 17
Debriefing of Mission staff—draft report submitted	Technical consultants	1	Oct 18
Team departs country	International consultants	1	Oct 18-19
Mission sends technical feedback/comments on draft to team leader			Nov 1
Draft revised by team leader and GH Tech submits final report to Mission	Technical consultants	6	Nov 15

Activity	Team Member(s)	Total Team Days	Period of Performance (illustrative depending on start date)
Missions approves report			Nov 22
Total LOE = External Consultants (2)		44	
Total LOE = Local Consultants (2)		40	
Total LOE = Local Logistics Consultant (1)		25	

Travel over weekends may be required during site visits. Note that September 27 is an Ethiopian holiday (Meskal) and October 10 is a U.S. federal holiday (Columbus Day). The U.S. Embassy is closed on both of those days.

A six-day work week is approved while in-country.

## LOGISTICS

GH Tech will be responsible for all international travel and consultant logistics. USAID/Ethiopia will be responsible for liaising with the local logistics consultant to arrange local travel and meetings in collaboration with Abt.

## DELIVERABLES AND PRODUCTS

Based on the above stated purpose, objectives, and key tasks, the consultant team will submit the following deliverables:

Evaluation framework including revised evaluation questions, detailed approach/methodology to be used including the documents to review, key informants to interview, sampling frame, survey protocols and instruments, and plans for analysis and dissemination of findings. The team leader will submit the evaluation framework to USAID/Ethiopia and GH Tech after the in-country team planning meeting. USAID/Ethiopia will then review the proposed workplan/methodology and submit comments to the team leader. The evaluation team will revise the workplan/methodology and send the final version to USAID/Ethiopia and GH Tech. The evaluation framework must be finalized and approved prior to the initiation of the interviews and site visits.

Interim briefings including status reports. The team leader will provide bi-weekly status reports on workplan implementation to USAID/Ethiopia and GH Tech. The evaluation team will also conduct at least two interim briefings with the Mission while in-country to review the progress and methodology of the evaluation.

Presentation slides (in MS PowerPoint) used during stakeholder meeting and debriefing to HAPN staff on the preliminary findings and recommendations that addresses each of the three objectives and associated questions. The PowerPoint presentations will be shared with GH Tech prior to the USAID and stakeholder debriefings.

Draft report in English no longer than 30 pages with an executive summary, introduction, methodology, findings, and recommendations that address each of the three objectives and subsequent questions with bibliography and annexes. The team leader will submit the first draft report to USAID/Ethiopia and GH Tech at the end of the evaluation team's visit. The Mission will provide consolidated, written comments to the evaluation team and GH Tech within 10 working days of receiving the draft report.

Final report will address the Mission's comments. The team leader will submit the final unedited report to USAID/Ethiopia and GH Tech within 10 working days after the team receives consolidated comments from USAID/Ethiopia. GH Tech will provide the edited and formatted final document approximately 30 days after USAID/E provides final approval of the content. Procurement sensitive information will be removed from the final report and incorporated into an internal USAID Memo. The remaining report will then be released as a public document on the USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) and the GH Tech project web site ([www.ghtechproject.com](http://www.ghtechproject.com)).

## **RELATIONSHIPS AND RESPONSIBILITIES**

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

Recruit and hire the evaluation team.

Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

USAID/Ethiopia will provide overall technical leadership and direction for the evaluation team throughout the assignment and will undertake the following specific roles and responsibilities:

### **Before In-country Work**

Respond to any queries about the SOW and/or the assignment at large.

Consultant conflict of interest: To avoid conflicts of interest or the appearance of a conflict of interest, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential conflict of interest with the project contractors or NGOs evaluated/assessed and information regarding their affiliates.

Documents: Identify and prioritize background materials for the consultants and provide them, preferably in electronic form.

Local consultants: Assist with identification of potential local consultants and provide contact information.

Site visit preparations: Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.

Lodgings and travel: Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics (i.e., visa letters of invitation etc.).

### **During In-country Work**

Mission point of contact: Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team's work.

Meeting space: Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available or other known office/hotel meeting space).

Meeting arrangements: While the logistics assistant typically will arrange meetings, support logistics assistant in coordinating meetings with stakeholders.

Other meetings: If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.

Facilitate contact with implementing partners: Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

### **After In-country Work**

Timely reviews: Provide timely review of draft/final reports and approval of the deliverables.

### **MISSION CONTACT PERSON**

Kristin Saarlus  
Evaluation Coordinator, HAPN  
Eshete Yilma  
Deputy Health Team Leader and project COTR

### **COST ESTIMATE**

TBD

### **REFERENCES (PROJECT DOCUMENTS—WILL BE SENT TO TEAM ONCE SELECTED)**

Task Order—Project Description

Annual reports and most recent quarterly reports from Abt

Operational studies from Abt

M&E plan and achievement toward targets

Government of Ethiopia relevant documents and reports

## **ANNEX B. INTERVIEWS AND PERSONS CONTACTED**

### **MEETINGS AND INTERVIEWS WITH USAID/ETHIOPIA**

Jason D. Fraser, Deputy Mission Director

Eshete Yilma, Deputy Health TL and HSFR COTR

Meri Sinnitt, Chief, Health, AIDS, Population and Nutrition Office

Jeanne Rideout, Health Team Leader, Health AIDS Population Nutrition Office

Faris Hussein (MD), Private Sector Advisor (evaluation team member)

Kris Saarlas, M&E Coordinator, HAPN (evaluation team member)

Ishrat Z. Husain, Senior Health Advisor, USAID/W, AFR/SD/HT (evaluation team member)

### **MEETINGS AND INTERVIEWS WITH FEDERAL MINISTRY OF HEALTH/ETHIOPIA**

Adraham Endeshaw Mengistu (MD), Director, Medical Services Directorate

Roman Tesfay, Director General Policy, Planning and Finance, General Directorate

Abdujeld Reshad, Director, Resource Mobilization Directorate

Nared Mola, new Director General of Social Health Insurance

### **MEETINGS AND INTERVIEWS WITH ETHIOPIA COUNTERPARTS**

Dr. Gebre Selasse, Health Section, World Bank

Dr. Luwei Pierson, Chief Health Section, UNICEF

Dr. Sophonias, Country Director, WHO

### **MEETINGS AND INTERVIEWS WITH ABT ASSOCIATES, ETHIOPIA**

Leulseged Ageze, Chief of Party, Project Director

Workie Mitiku, Deputy Chief of Party for Programs & Senior Health Insurance Advisor

Yenehun Tawye, Monitoring and Evaluation Advisor

Nina Negash, CBHI Communication

Habtamu Tadesse, Research and Knowledge Management Advisor

Getacjen Worku, Regional Director

D Nariye Hegash, Finance Administrative Director

Emuye Nurlign, Head Driver

Tiliku Yeshanew, Regional Director, SNNP Region

Ashenafi Wagisso, Health Insurance Specialist, SNNP Region

### **SOUTHERN NATION, NATIONALITIES, AND PEOPLES REGION**

#### **Hawassa Regional Offices**

Ato Kare Chawicha, Regional Health Bureau Head

Ato Habitamu Beyene, Division Director, Curative and Rehabilitative Core Process Owner

Ato Kifle W/Mariam, Public Finance CPO/BOFED

### **Yirgalem Town**

Ato Wondwosen Bolka, Yirgalem Town Administrator/Mayor

Ato Habite Senbato, Yirgalem Town Health Unit Head

Ato Wozere, Yirgalem Town Administrator and Finance and Economic Director

S/r Abebech Yakob, Yirgalem Health Center Head

Beneficiaries/Members of the CBHI:

Aschalew Mengisso, Head of the CHBI Scheme

Angele Boke Kebele, Secretary and Member of CHBI Scheme

Teklu Kabisse Kebele, Political Leader and Member of CHBI Scheme

Meskerem Tilahum, Member of the CHBI Scheme

Lakew Kelkem, Member of the CHBI Scheme

Ato Admassu Arsicha Nanebo, Yirgalem Hospital CEO

S/r Misagana Kilrugael, Woreda Yirgalem Coordinator CBHI Scheme

### **Wolita Sodo Woreda**

Ato Yoseph Dolebo, Bedessa Health Center Head

Ato Zergene, Damot Woyde Woreda Administrator

Ato Amare Abebe, Damot Woyde Woreda, HO Head

Ato Samuel, Damot Woyde, CBHI Scheme Head

Ato Zerihuer Ermeko, Community Facilitator, CBHI Scheme, Damot Woyde

Ato Akal Grumba Mega, Accountant, CBHI Scheme, Damot Woyde

Ato Zekapiad Zewde Loveto, Clinical Nurse, CBHI Scheme, Damot Woyde

Ms Shitave Korkisa, IT Specialist, CBHI Scheme, Damot Woyde

Ato Bilbo Bedessa, Members/Beneficiaries of CBHI, Damot Woyde

Ato Tora Sedebo, Members/Beneficiaries of CBHI, Damot Woyde

Ato Marcho Ejajo, Members/Beneficiaries of CBHI, Damot Woyde

Ato Birhaau Bibiso, Members/Beneficiaries of CBHI, Damot Woyde

Ato Ahiera Bulgeda , Members/Beneficiaries of CBHI, Damot Woyde

Ato Alena Asha, Members/Beneficiaries of CBHI, Damot Woyde

Ato Alen Gutra, Members/Beneficiaries of CBHI, Damot Woyde

Ato Getu Gamo, Sodo Hospital General Manager and CEO

Ato Dana Debusca, Procurement Manager, Sodo Hospital

Ato Alemaehu Seta, Financial Manager, Sodo Hospital

Ato Million Nadew, Sodo Health Center Head

### **Halaba Woreda**

Ato Usni Husien, Arsho Health Center Head

## **Abt Associates Inc., SNNP Regional Project Office**

Ato Tiliku Yeshanew, Regional Director, SNNP Region

Ato Ashenafi Wagisso, Health Insurance Specialist, SNNP Region

## **AMHARA REGION**

### **Regional Abt Office**

Genet Anteneh, Regional Director

Abay Akalu, Health Insurance Specialist

Dessalegn Regessa, HCF Specialist

Zelalem Gahsaw, HCF Specialist

Abul-Aziz Mohammad, Junior HCF Specialist

Emebet Mohammad, Admin Program Assistant

### **Regional Health Bureau**

Bogal Dememe, Curative and Rehabilitative Process Owner

Bayeh Atinaf, HCF Officer

### **Fogera Woreda**

Gebbru Belay, Head Woreda Health Office

Challachew Kassie, Head WOFED and Deputy Head of CBHI Board

Lulie Hyamanot, Delegated Head of the Woreda health center

Getasew Abebaw, CBHI Office Coordinator

Tarekegn, HSRF Woreda Coordinator

Engidaw Mola, CBHI Officer

Wuletaw Altseb, CBHI Medical Coordinator

### **Felege Hiowt Hopsital**

Andarege Atinafu, Chief Executive Officer

Dr Muluneh, Medical Director

### **South Achefer**

Shambel Sete, Head Woreda health office

Getachew Tadesse, CBHI Coordinator

Be-ewketu Mekuria, Accountant

### **Tarmaber Woreda**

Assefa Taye, Head Woreda health office

Zemene Mitiku, Delegated Head of Debrsina Health Center

Mersha Tsgaye, Head WOFED

Dr Fesseha, Medical Director

## **OROMIA REGIONAL**

### **Oromia Regional Bureaus**

Ato Elema Daba, Deputy Head, Oromiya BoFED

Ato Shallot, Head, Oromiya Region Health Bureau

Dr. Jemal, Deputy Head, Oromiya Region Health Bureau

### **Harari Region**

Ato Afendi Basha , Deputy Head, Harari Regional Health Bureau

Ato Abdulahi Idris, Board Chairperson, Jegole Hospital

Ato Haji Ali Mohammed, Board Member and Community Representative

Ato Tofik Mohhamed, Board Member, Jegole Hospital

Ato Gedion Medi, Finance Officer, Jegole Hospital

Ato Fetih Mehadi, CEO, Jegole Hospital

W/rt Selamawit Shetaye, Focal person, HCF, Regional Health Bureau

### **Diredawa City Administration**

W/ro Meskerem Asseffa, CEO, Dil Chora Hospital Diredawa

Ato Yeshe Belay, Board Member, Representatives of Nurses

### **Deder Woreda**

Ato Daginew Hailu, Deputy Administrator, Deder Woreda

Ato Desalign Teffera, Head, Deder Woreda Health Office

Ato Teshome Shume, Head, Deder Woreda Finance Office

Ato Abdu Ali, CBHI Coordinator, Deder Woreda CBHI

W/ro Elisabet Teshagir, Community Mobilization Officer, Deder Woreda CBHI

Ato Mohammed Tahir Mayor, Board Chairperson, Deder Town

Ato Abdi Oumere, CEO, Deder Hospital

Dr. Habtamu Beyene, Medical Director, Deder Hospital

Ato Tofik Abdi, Health Officer, Board Member

W/ro Kemya Adem, Board Member, Representatives of Nurses

### **Bishoftu Hospital**

Ato Asnake Wakjira, CEO, Bishoftu Hospital

### **Mojo Health Center**

Ato Hajji Rabo, Manager, Mojo Health Center

Ato Abdo Mohhamed, Board Member Representatives of Nurses, Mojo Health Center

### **Gimbichu Woreda**

Ato Taddese, Administrator, Gimbichu Woreda

Ato Abebe Mamo, Head, Gimbichu Woreda Health Office

Ato Umer Kasim, CBHI Coordinator, Gimbichu Woreda

## **ANNEX C. DOCUMENTS REVIEWED**

“Brief Note on the Design of Community-Based Health Insurance (CBHI) Technical Brief #1.”

Concept note to Graduate Health facilities in three regions: Amhara, Oromia, and SNNP Region. Health Sector Financing Reform Project. October 2010.

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“A Directive to Provide Legal Backing for Piloting and Promotion of Community-Based Health Insurance.” Federal Ministry of Health. Addis Ababa, January 2011.

“Establishing Private Wings in Public Health Facilities: Operational Manual.” Health Sector Financing Reform Project. Addis Ababa, October 2009.

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Numerous Newsletters and Press Clippings during the life of the HSFRP

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“Outsourcing of Non-Clinical Services in Health Facilities, Operations Manual.” Health Sector Financing Reform Project, October 2009.

Pearson, Luwei, Meena Gandhi, et al. “User fees and maternity services in Ethiopia.” *International Journal of Gynecology and Obstetrics*, December 2011.

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