USAID
FROM THE AMERICAN PEOPLE

USAID Health Financing Improvement Program

USAID Health Financing Improvement Program Quarterly Performance Report – Year 1, Quarter 3 (April 1, 2019 - June 30, 2019)

July 2019

This report is made possible by the support of the American People through the United States Agency for International Development (USAID).

The USAID Health Financing Improvement Program
The USAID Health Financing Improvement Program supports the Ethiopian government in its efforts to further strengthen and institutionalize health care financing reforms and initiatives to provide accessible, high quality, primary health care services for all Ethiopian citizens with reduced financial barriers. Led by Abt Associates, the program is implemented in collaboration with core partners Breakthrough International Consultancy, Dimagi, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard School of Public Health.

July 2019

Cooperative Agreement No. 72066319CA00001

Submitted to: Dr. Subrata Routh, Agreement Officer's Representative
USAID Health Financing Improvement Program
USAID/Ethiopia Health Office

Recommended Citation: USAID Health Financing Improvement Program. July 2019. *USAID Health Financing Improvement Program Quarterly Performance Report – Year 1, Quarter 3 (April 1, 2019 – June 30, 2019).* Rockville, MD: USAID Health Financing Improvement Program, Abt Associates.

Cover Photo: CBHI member [redacted] has her blood pressure checked at a health center in Jida woreda. Jida recently enrolled the highest percentage of CBHI eligible households in the Oromia region. See success story included on page 14. Photo credit: Ayenew Haileselassie, Abt Associates.

Abt Associates
6130 Executive Boulevard, Rockville, Maryland 20852
T: 301.347.5000
www.abtassociates.com

USAID Health Financing Improvement Program Quarterly Performance Report – Year 1, Quarter 3 (April 1, 2019 – June 30, 2019)

Contents

List of Tables and Figures

Acronyms

AOR	Agreement Officer's Representative
BIC	Breakthrough International Consultancy
BOFEC	Bureau of Finance and Economic Cooperation
CBHI	Community-Based Health Insurance
CHAI	Clinton Health Access Initiative
CSD	Clinical Service Directorate
DRM	Domestic Resource Mobilization
DQA	Data Quality Assurance (DQA)
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
FGB	Facility Governing Board
FMC	Facility Management Committee
GOE	Government of Ethiopia
HC	Health Center
HCF	Health Care Financing
HF	Health Facility
IHI	Institute for Healthcare Improvement
IR	Intermediate Result
ISS	Integrated Supportive Supervision
MEL	Monitoring, Evaluation, and Learning
MOFEC	Ministry of Finance and Economic Cooperation
MOH	Ministry of Health
PCD	Partnership and Cooperation Directorate
PFM	Public Financial Management
PHC	Primary Health Care
Q1, Q2, Q3	Quarter 1, Quarter 2, Quarter 3
R4D	Results for Development
RHB	Regional Health Bureau
RRU	Revenue Retention and Utilization
SHI	Social Health Insurance

SNNP	Southern Nations, Nationalities, and Peoples' (Region)
SR	Sub-Result
SS	Supportive Supervision
STTA	Short-Term Technical Assistance
TWG	Technical Working Group
USAID	United States Agency for International Development
Y1, Y2	Year 1, Year 2
ZHD	Zonal Health Department

1. Introduction

The five-year USAID Health Financing Improvement Program is aimed at supporting the government of Ethiopia (GOE) to further strengthen and institutionalize health care financing (HCF) functions and systems to support universal health coverage of quality primary health care (PHC) services for Ethiopian citizens with reduced financial barriers. The Program builds on previous investments in HCF reform by USAID and the GOE. The consortium implementing the Program is led by Abt Associates, and includes core partners Breakthrough International Consultancy (BIC), Dimagi, Institute for Healthcare Improvement (IHI), and Results for Development (R4D), and resource partner Harvard T.H. Chan School of Public Health. Abt and its consortium partners work in close collaboration with the GOE to achieve four program objectives/intermediate results (IRs):

1. Increase domestic resource mobilization (DRM) for enhanced provision of quality PHC services;
2. Streamline pooling of risk-sharing/insurance mechanisms for wider access to PHC services with reduced financial barriers;
3. Facilitate strategic purchasing of health services from public and private health providers; and
4. Improve governance, management, and evidence-generation for health financing reforms and health facilities (HFs).

By the end of the Program in 2023, Ethiopia's health sector is expected to have more resources available for PHC services. The share of domestic financing of health care services will increase from 2014's 64% to 70%. More people, including the poorest, will have insurance coverage. The GOE will employ evidence-based practices that engage the full spectrum of health sector partners. The Program team will work on purposefully and systematically building local capacity to institutionalize and transition Program responsibilities to federal, regional, and sub-regional health authorities and institutions for sustainable and continuous implementation.

This Year 1, Quarter 3 (Y1Q3) performance report covers the period April 1– June 31, 2019. During the quarter, the Program accomplished several activities and also started Y2 implementation planning.

2. Summary of activities and key results

[redacted] To accommodate the new funding level, the Program instituted a strategy to curtail expenditures, which included reprioritizing and delaying activities, and a hiring freeze. This quarterly report reflects activities conducted within the lower budget ceiling which impacted the pace and intensity of implementation.

Several noteworthy activities took place in Q3. The Program provided technical assistance (TA) to finalize the CBHI legal framework which was submitted it to the Ministry of Health (MOH). TA was also provided in preparing several key documents that are essential for the Ethiopian Health Insurance Agency's use and support the institutionalization and transitioning of first generation reforms, including:

- A roadmap with milestones and activities to be performed in order to launch Social Health Insurance (SHI) by its anticipated start date in July 2021.
- An explanatory document for decision-makers on key SHI legal framework issues.
- An estimate of the amount of general and indigent subsidy needed for the GOE to finance the expansion of CBHI schemes across Ethiopia. EHIA plans to share this information with top government officials when the CBHI proclamation is being discussed.

A number of training activities were undertaken in new rural woredas and in urban settings to build and further strengthen local capacity to implement HCF reforms (Box 1). Program supportive supervision (SS) was provided for 146 schemes and 107 HFs, and the Program provided TA during integrated supportive supervision (ISS) led by the MOH/EHIA that covered 39 schemes and 20 HFs. The Program also participated in the annual HCF thematic meeting organized by the MOH and the annual review and planning meetings organized by EHIA. During these meetings the team shared supervision findings and provided technical recommendations on ways to address HCF reform implementation challenges.

Box 1: Training conducted in Y1Q3

- 44 CBHI scheme staff trained on CBHI in new CBHI rural woredas
- 34 HF staff trained on CBHI in new CBHI rural woredas
- 55 HF staff trained on CBHI in urban settings
- 25 CBHI scheme staff trained on CBHI in urban settings
- 1,129 HF managers and facility governing board/facility management committee (FGB/FMC) members trained in governance and management in newly joined regions

The following section describes the work undertaken towards planned activities for Y1Q3, organized by IR and sub-result (SR). A cumulative list of deliverables is included in Annex A. International short-term technical assistance (STTA) visits that supported implementation are detailed in Annex B. Lastly, accomplishments by target are reflected in Annex D.

IR 1: Increase Domestic Resource Mobilization for Enhanced Provision of Quality PHC Services

SR 1.1 Availability of operational funds increased at all levels of PHC service provision, including transition/institutionalization arrangements completed for rollout and sustained continuation of RRU by health facilities.

The Program supported the leadership of the MOH's Partnership and Cooperation Directorate (PCD) to establish a technical working group (TWG) to develop the prototype HCF structure and revise the HCF implementation manual with members from the MOH, Oromia Regional Health Bureau (RHB), Addis Ababa City Administration (AACA) Health Bureau, Transform: Primary Health Care Project, and the USAID Health Financing Improvement Program. The manual includes chapters covering first generation reforms, including retained revenue and utilization (RRU).

The TWG began work to revise the MOH's HCF manual, including reviewing legal frameworks, identifying issues, and developing an annotated outline. As part of the revision, all relevant existing HCF legal documents were identified and limitations of the proclamations, regulations, and other pertinent documents were reviewed. The need to revise the manual had been identified during an earlier HCF thematic meeting. It was one of several challenges related to first generation reform implementation that were raised.

Examples of RRU reform institutionalization efforts and achievements from the Program's regional work over the quarter are highlighted in Table 1.

Table 1. Major accomplishments of RRU institutionalization efforts, by region

Region	Achievements
Amhara	Having held discussion with the Bureau of Finance and Economic Cooperation (BOFEC) on the budget formulation for HFs, the RHB spearheaded the finalization and submission of 850 health centers' (HCs') and 79 hospitals' RRU plans in Q3. The Program provided key support in facilitating the collection, aggregation, and analysis of the revenue and expenditure budgets. Program support has built the capacity of the RHB in budget formulation, demonstrating progress toward self-reliance.
Benishangul-Gumuz	The Program provided TA to the RHB, which resulted in the submission of 6 hospitals' and 59 HCs' RRU plan for appropriation by BOFEC. As in Amhara, Program support has built the capacity of the RHB in budget formulation, demonstrating progress toward self-reliance.
Tigray	As part of the institutionalization process, the Program team advocated to the RHB to staff the RHB with needed personnel to support HCF implementation. This resulted in the assignment of an HCF expert in the RHB, which has helped in the preparation of primary and general hospitals' budgets for approval by the regional council. The assignment of the HCF expert demonstrates RHB commitment to assume responsibility for HCF reform activities. The Program also worked with the RHB to obtain BOFEC's approval to make primary hospitals independent cost centers with their own budget line item. As cost centers, primary hospitals will now be able to request budget from Treasury as independent entities. The need for the cost center was supported by evidence generated through SS conducted under the Program. The RHB was able to use this evidence to support their request, and BOFEC was able to use the same evidence to make a decision that ultimately resulted in approving the RHBs request.

SR 1.3: Explored and implemented strategies on additional domestic resource mobilization for PHC, including public budget and innovative financing sources.

Started the fiscal space and political economy analysis

The general objective of the fiscal space and political economy analysis is to assess how the dynamics of existing institutions, actors, agents, and contextual realities may impact DRM for health. Use of the analysis results will strengthen the Program's advocacy efforts, by providing a better understanding of the role political economy factors play in processes and decisions around the creation and use of fiscal space for health. The Program prepared three key inputs for the analysis during Q3: (1) Study concept note; (2) Key informant interview guide for data collection; and (2) Desk review of existing literature related to the health financing landscape and DRM, organized in matrix format by four thematic areas – i.e., government and public funds, DRM, efficiency, and external grants.

IR 2: Streamlined Risk-Pooling Mechanisms for Wider Access to PHC Services with Reduced Financial Barriers

SR 2.1: Implemented strategies on further consolidation of the CBHI schemes and institutionalization of the CBHI implementation systems in the rural districts of the four agrarian regions.

Supported finalization of the CBHI legal framework

The Program provided TA to further refine and finalize the CBHI legal framework (proclamation and regulation). The final drafts were submitted to the MOH. Next steps include public consultations on the drafts.

Two important consultative meetings to refine the CBHI legal framework took place. The first meeting was held on March 30–31, 2019 in Bishoftu town with the MOH Executive Committee. Main contents of the proclamation and regulation were presented by the management of EHIA and feedback was received from the participants. Executive Committee membership comprises top management from the MOH and institutions and agencies accountable to the MOH. A total of 16 persons (12 male and 4 female), including one of the State Ministers of Health, attended the meeting. The Program provided TA by making presentations on two topics, "Health insurance concept and development in Ethiopia" and "CBHI development in Ethiopia." The second significant meeting was held on April 3–6, 2019 in Bishoftu town with the management of EHIA and other partners to incorporate comments and suggestions forwarded by the Executive Committee. The contents of the draft proclamation and regulation were reviewed thoroughly to ensure that all comments and suggestions from previous meetings were incorporated. Nine persons (8 male and 1 female) attended the meeting.

Summary of CBHI status in the four agrarian regions (Amhara, Oromia, SNNP, and Tigray)

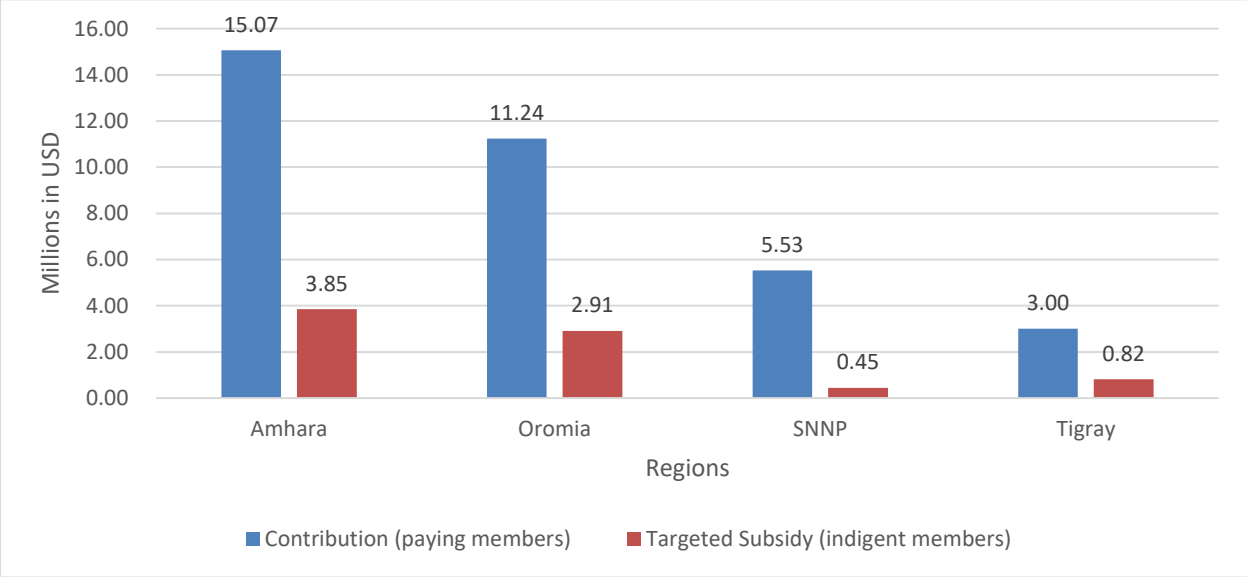
According to the latest data received from RHBs of the four agrarian regions, 77% (627; 558 rural and 69 urban) woredas and town administrations are implementing CBHI; 443 of the schemes (400 rural and 43 urban) are providing services to members based on the schemes' benefit packages (Table 2). The total number of enrolled members reached 5,122,243. As the number of schemes providing services increases, the number of households with financial risk protection is being improved.

Table 2: Coverage of CBHI implementation in the four agrarian regions as of end of Y1Q3

Region	Number of woredas		Number of CBHI implementing woredas EFY 2011 (2019)		Number of functional schemes EFY 2011 (2019)	
	Rural	Urban	Rural	Urban	Rural	Urban
Amhara	142	43	141	41	120	27
Oromia	291	45	242	5	176	4
SNNP	186	55	141	21	76	11
Tigray	34	18	34	2	28	1
All	**653**	**161**	**558**	**69**	**400**	**43**

CBHI paying members account for 78% of the total registered households, and indigents account for 22% (1,132,344 households). TA provided by the Program to follow-up on the transfer of targeted subsidy by regional and woreda administrations to CBHI schemes helps ensure equity and builds local administrator commitment. The total amount of money mobilized from contributions and subsidies amounted to $42.88 million in the four regions (Figure 1).

Figure 1. Total resources mobilized from CBHI membership contributions and GOE targeted subsidy for indigent members in the four agrarian regions, EFY 2011 (2019)



Note: Mid-April 2019 exchange rate (28.5) is used to convert Ethiopian Birr to USD

Provided training to scheme staff

Tigray: The Program, in collaboration with EHIA, provided TA to train 37 (29 male, 8 female) scheme staff and health providers from Raya Alamata woreda on June 12, 2019. Training participants included: the woreda health office (WorHO) head, HC directors, finance officers, pharmacy experts, scheme staff, and EHIA staff members. Following discussions made during the training, CBHI scheme and HFs reached a consensus to sign a CBHI contractual agreement that will allow CBHI members to obtain health

services at the HFs using their member benefits. Participants that attended the training agreed to share their learning with the remaining HF staff.

Amhara: The Program provided training to 66 (43 male, 23 female) CBHI executive staff from 28 districts and town administrations. In addition, it provided training to 55 (43 male and 12 female) providers from eight HFs and five district health offices. The training covered purchaser-provider relations, contract administration, claim submission and reimbursement, clinical auditing, and overall health care service purchasing process.

Supported zonal-level review meetings

Oromia: The Program provided support to conduct a RM on the previous nine months of implementation, with a focus on the Wachale woreda, a center of excellence woreda. The RM was organized by the North Shoa Zone Health Department in collaboration with EHIA Finfinnee branch and the Program. The participants came from kebele and woreda cabinets, zone administrations, RHBs, and the Finfinnee branch of EHIA; WorHO heads and CBHI coordinators also attended. The meeting mainly focused on reviewing the performance of the COE scheme and the readiness of HFs to provide adequate quality services for CBHI members. During the meeting, participants learned from Wachale woreda how to create community awareness on CBHI, collect and deposit contributions, and manage CBHI data. The RHB also expressed its commitment to fill the gaps related to drugs, equipment, and human resource shortages.

Harmonized CBHI plan at regional, zonal, and district levels

Tigray and Amhara: The Program collaborated with the Transform: Primary Health Care project to harmonize CBHI plans with key implementing partners including RHBs and EHIA. The alignment exercise allowed the projects to plan for collaboration, determine levels of responsibilities, map available resources, avoid potential duplications, and align timeframes.

Supported the design and establishment of higher-level pooling

Amhara: The Program conducted an orientation session on the regional directive for pool formation and the preparatory work needed to establish a zonal-level CBHI pool. A total of 13 (10 male, 3 female) zonal board members in Awi zone attended the orientation. The Program also collaborated with the Amhara RHB to organize a CBHI zonal pool General Assembly and annual performance RM that was held on June 15, 2019 and attended by 43 participants. Major issues raised during the meeting included: inequitable utilization of the pool fund by member schemes, lengthy out-of-pocket reimbursement process, and financial constraints making the pool unable to cover its fourth quarter payment. The General Assembly requested further analysis be done to determine a reasonable share of annual income that zonal pools need from the lower-level schemes (currently set at 25%).

Strengthened financial management and auditing of CBHI schemes

Amhara: To improve the financial management of schemes, the Program together with government counterparts advocated for periodic financial auditing of CBHI schemes through discussions made with the woreda finance and economic cooperation office (WoFEC). This year, all but four schemes in the region were audited by WoFEC).

SR 2.2: Supported the rollout and consolidation of CBHI schemes in the urban settings within the seven implementation regions (the four agrarian regions, Harari, and Addis Ababa and Dire Dawa City Administrations).

Conducted integrated supportive supervision and supportive supervision at CBHI schemes and health facilities in selected urban areas implementing CBHI

Addis Ababa: The Program in collaboration with Addis Abba Health Bureau and the EHIA Addis Ababa branch office conducted ISS at the 10 CBHI schemes of Addis Ababa (June 5–13, 2019). The CBHI schemes were established at the sub-city level, and will pool resources from members' contributions and government subsidies, and make contractual agreements with HFs. The woredas (or CBHI sections) are responsible for members' registration and collection of contributions from members.

Amhara: The Program team together with the RHB and EHIA branch offices conducted SS at seven urban schemes to understand the challenges involved in implementing CBHI in urban settings and to assess possible mechanisms for making the schemes financially sustainable. The findings of the SS revealed low enrollment rates, absence of differential contribution practices, poor data management, questions of eligible population size, and weak community awareness. This suggests the need to conduct an assessment of CBHI implementation in urban settings to help redesign the implementation parameters.

Advocated for increased targeted subsidy at the regional level

Amhara: The Program advocated for the on-time release of regional and woreda targeted subsidies to CBHI schemes. Although the regional subsidy was disbursed to each scheme in the second quarter of the Ethiopian fiscal year (EFY), it was behind schedule. Similarly, in a few woredas, the woreda's share was not disbursed to schemes on time. To alleviate delays in disbursement, the Program advocated to the authorities through review, SS, and other regional meetings, as well as by telephone follow-up, to disburse the targeted subsidy on time. Currently, all woreda subsidies have been released to schemes, and the regional subsidy has been disbursed to 159 schemes.

Harari: The Program in collaboration with the EHIA provided a one-day orientation on CBHI to all cabinet members of the Harari regional government. During the orientation, the Program facilitated a discussion led by the regional president on how CBHI could be implemented at Harari region. The discussion motivated government officials at all levels to prioritize CBHI, undertake CBHI mobilization campaigns, and set a timetable for finalizing CBHI mobilization.

SR 2.4: Worked with EHIA and MOH in supporting implementation of the SHI program

Supported the revision of the legal framework for SHI

The Program supported the EHIA in implementing tasks required to launch SHI, including the following:

- Developed an explanatory document for decision-makers on key issues that were raised during previous platforms organized to create awareness on the about SHI legal frameworks (proclamation and regulation).
- Developed a roadmap detailing the important milestones and activities with a timeframe that need to be performed for the successful launching of SHI. The roadmap anticipates SHI launching in July 2021.

- Provided orientation for nine newly appointed EHIA board members (6 male, 3 female) on health insurance concepts and health financing landscapes, which highlighted potential financing sources for health.

Supported updating of the SHI financial sustainability study

The Program finalized an updated SHI financial sustainability study based on new data collected on basic variables including population projections for 10 years, a formal sector employment growth rate, wage growth rate, health service unit costs of HCs, primary hospitals, secondary hospitals, and tertiary hospitals for outpatient and inpatient department services, unit cost growth projection, health service provision proportion between private and public facilities, and cost sharing proportion dynamics between employers and employees. The financial sustainability projection was made for three population coverage scenarios:

- Scenario 1: SHI scheme covers the public service and pensioners for the entire projection period.
- Scenario 2: SHI scheme covers public service, pensioners, and government development enterprise employees immediately and the private sector in the third year.
- Scenario 3: SHI scheme covers all eligible formal sector employees from the start.

With the above population coverage scenarios as a base, and considering alternative contribution rates of 8%, 6%, and 5%, further projections were made to see the effect of including and excluding exempted health services in the package and shifting all (100%) bypassing fees to the beneficiaries versus partial (50%) transfer and updating also made important assumptions, projected utilization following introduction of insurance.

The results of the simulation are the following:

- In scenarios with 6% contribution, the fund first shows a deficit in the seventh year.
- In scenarios with 5% contribution, the fund first shows a deficit is the fifth year.
- In scenarios with 8% contribution, the fund shows a surplus throughout the projection period.
- When exempted health services are included in the benefit package, the SHI system faces a deficit immediately.

The findings of the report were reviewed and validated by EHIA management, senior health financing consultants, and partners working in health financing. The study is now finalized pending the narrative report and the PPT presentation of the study findings is shared with the EHIA for next actions.

IR 3: Improved Arrangements for Strategic Purchasing of Health Services from Public and Private Providers

SR 3.4. Health facility accreditation becomes mandatory in CBHI and SHI programs

Participated in the revision of Essential Health Service Package

A team with members (25 male and 8 female) from the MOH, universities, agencies, and other entities met in Addis Ababa on April 16-17, 2019 to start revising the Essential Health Service Package (EHSP) first introduced in EFY 1998 (2005). This revision will cover promotive, preventive, curative, and rehabilitative interventions including but not limited to communicable diseases, maternal health, child health, non-communicable diseases and injuries, surgery, and neglected tropical diseases. It also will

consider other system-wide interventions such as health education and communications, laws, and regulations. The Program, through Avenir Health, provided TA in scoring the exhaustive list of interventions.

Avenir Health supported the development of the EHSP by providing assistance with decisions about how to estimate cost effectiveness for different services, parameterization of the projection, file, and reviews of preliminary results. This was an ongoing process, with weekly check-in calls between the Ethiopia team, WHO, and Avenir to ensure prompt support in case of questions or problems. The decision about what services to include will be driven by cost effectiveness, equity, and budget impact, and other considerations.

Avenir also mapped the EPHS intervention list to those in the OneHealth Tool/Spectrum. This allowed the team to identify which services could have cost-effectiveness ratios estimated directly in the software for Ethiopia, and which would need to be estimated based on publicly available literature. Guidance was also provided to the team on configuring the costing file and by sharing cost-collection templates to support them in estimating budget impact of different services.

Additional work was conducted to adapt the default Generalized Cost Effectiveness Analysis software for Ethiopia by incorporating calibrated HIV Goals models into the projection, and testing cervical cancer results against expected outcomes.

IR 4: Strengthened Governance, Management, and Evidence Generation for Health Financing Reforms and Health Facilities

SR 4.1: Institutional structures and roles defined and capacities strengthened for spearheading and managing the health reforms at all levels of the health system.

Amhara: The Program provided TA to adapt the draft HCF organizational structure proposed by the MOH which mirrors the national-level PCD at the RHB level. It also supported the creation of corresponding case teams at zonal, woreda, and HF levels. It provided TA to finalize the proposed structure and facilitate its endorsement by RHB management. The proposed structure was then sent to the Regional Human Resource and Civil Service Bureau where it awaits final approval.

Harari: The Program advocated to the Harari RHB to establish its regional HCF unit. As a result, the RHB established a case team comprising three HCF technical experts and a coordinator within the Medical Service Directorate.

SR 4.2: Transition/Institutionalization arrangements completed for rollout and sustained continuation of FGBs for HFs with community representatives.

Supported MOH in training hospital governing board members

Several FGB/FMC trainings were held in Q3:

- The Program provided FGB training to 1,129 FGB/FMC members in newly joined regions.
- In Amhara**,** the Program participated as a facilitators during FGB training organized by the MOH's Clinical Service Directorate provided for 614 (580M, 34F) FGB members from 78 hospitals.

- In collaboration with the PCD and EngenderHealth, the Program provided a two-day training in Addis Ababa on HCF reform implementation for 26 FGB/FMC members (18 male and 6 female) from HFs located in Afar, Somali, and Benishangul-Gumuz.
- The Program organized FGB/FMC training in Somali region for 36 (27 male and 9 female) participants from five HCs.
- In AACA, the Program provided FGB/FMC training for 34 (19 female and 15 male) FGB members.

SR 4.4: Generation of evidence and documentation and dissemination of lessons learned improved for policy refinement and decision-making on the health financing reforms and health facility management.

Supported/participated in ISS organized by EHIA

EHIA organized ISS in the four agrarian regions (May 12-22). The ISS team was composed of members from EHIA, RHBs, zonal health departments (ZHDs), CHAI, the Transform: Primary Health Care project, and eight Program technical staff. The ISS covered 18 zones, 24 woredas, and 50 kebeles. In each woreda, one primary hospital, one HC, and two kebeles were visited, in addition to the CBHI scheme. The Program will prioritize issues identified during supervision (Box 3) as learning agendas for upcoming SS, ISS, RMs, advocacy activities and other platforms. Best practices will also be shared with HFs to replicate as appropriate.

Box 3: Strengths and gaps identified during the ISS:

Strengths

- CBHI enrollment rate varies from woreda to woreda and from kebele to kebele. Woredas with an enrollment rate as low as 20% were observed in Oromia. However, some kebeles in Amhara, SNNP, and Tigray have reached universal enrollment.
- Regions like Tigray and SNNP have approved a structure and recruited staff at the kebele level to follow-up CBHI activities.
- Schemes entered contracts with pharmacies outside of HFs, particularly with Red Cross and community pharmacies, as a practice to improve access to drugs for CBHI beneficiaries when public HFs are out of stock (AA, Tigray and Oromia).

Gaps

- ID distribution is still a problem in most CBHI woredas. On average, 18% of CBHI members have not received CBHI ID cards.
- No and/or partial allocation of targeted subsidy by some woreda administrations in SNNP and Oromia.
- High attrition of trained manpower, mainly finance staff.
- Frequent referral of beneficiaries to private pharmacies, particularly by hospitals.
- Upward revision of fee schedule by HFs with the intention of tapping more resources from CBHI. Although revision may be required to meet costs of service delivery, they must be standardized across HFs and approved by appropriate authorities.
- Further develop monitoring and evaluation mechanisms for HCF reforms.

Supported federal-level health insurance annual review meetings

EHIA organized its annual review meeting and planning session (June 17-21). Stakeholders from government institutions such as the MOH, Ethiopian Pharmaceuticals Supply Agency, and RHBs, and from implementing partners and international organizations working on HCF participated. The Program provided TA in preparing EHIA's annual performance report and technical inputs to EHIA departments and branches in refining EHIA's draft annual work plan.

Supported zonal and regional level review meetings

The Program provided TA that supported 18 RMs (14 zonal and 4 regional) in the four agrarian regions (Table 3). See Annex C for a summary of RM dates, participants, and type of TA provided by the Program.

Table 3: Number of zonal and regional review meetings conducted in Y1Q3

Region	Number of review meetings conducted		
	Zonal	Regional	Total
Amhara	3	1	4
Oromia	3	0	3
SNNP	8	2	10
Tigray	0	1	1
Total	14	4	18

Supported HCF thematic meeting organized by the MOH

The PCD organized a two-day thematic meeting on HCF reform implementation in Bishoftu (May 10-11, 2019). During the meeting, a total of 65 participants (52 male and 13 female) from RHBs and the MOH discussed the preceding nine months of HCF reform implementation performance reports and the challenges encountered. Except Gambella and Harari, all regions had representatives at the meeting. Major issues raised during the meeting revolved around:

- Absence of HCF structure at the regional levels.
- The need to revise the existing legal framework to respond to recurrent challenges.
- Lack of evidence on the performance of private wing and outsourcing of non-clinical service HCF reform implementation.
- Lack of capacity to periodically revise and inconsistencies in user fee schedules.
- Limited auditing coverage of HFs.
- Poor data management and reporting systems.

As a way forward, the MOH committed to spearheading the: (1) Development of a prototype HCF organizational structure for regions; (2) Revision of the legal framework; development of standardized HCF data tracking and reporting formats; and the (3) Development of a user fee revision tool. The Program facilitated the meeting, technically reviewed regional reports, and forwarded recommendations on how to address the issues identified.

Supported Program supportive supervision

The Program covered 146 schemes (25 urban, 121 rural) and 107 (87 HCs, 20 hospitals) with SS. CBHI SS was conducted in the four agrarian regions (Tigray, Amhara, Oromia and SNNP) and HF SS was conducted in all regions and city administrations (Table 4). During supervision, on-the-job TA was provided to schemes and HF staff, and Program baseline and annual data was collected.

Table 4: Number of schemes and HFs covered by supportive supervision in Y1Q3

Region	Number of schemes and HFs covered by supportive supervision					
	CBHI schemes			Health facilities		
	Rural	Urban	Total	HCs	Hopsitals	Total
Tigray	3	0	3	5	1	6
Afar			0	3	1	4
Amhara	12	4	16	13	3	16
Oromia	85	5	90	38	6	44
Somali					1	1
Benishangul-Gumuz				1	1	2
SNNP	21	2	23	8	3	11
Gambella		1	1	11	1	12
Harari		2	2	2		2
Dire Dawa		1	1	3	1	4
Addis Ababa		10	10	3	2	5
Total	**121**	**25**	**146**	**87**	**20**	**107**

2.1 Success story

Jida Woreda: Committed to CBHI, Making it Thrive

Jida woreda in North Shewa Zone of Oromia region has 14 kebeles. It's unique in North Shewa in that it was able to launch CBHI services the same year it was selected to introduce it. [redacted], head of the WorHO and secretary of the local CBHI board, says that woreda authorities immediately set to work by allocating finances from the woreda's available budget. The woreda administrator held a meeting with heads of the various offices, including health and finance, and they made a series of decisions, formed a board, and initiated mobilization. They obtained CBHI identification cards from the zone and sent a locally-hired crew of photographers to the villages to take a group photo of household members for each household. In the first year of CBHI implementation, the woreda reached 72% enrollment. By comparison, other woredas in Oromia selected for CBHI achieved less than 40%.

Jida woreda CBHI members started accessing health care through their membership starting in July 2018. Now in its second year, renewal and new enrollment have reached up to 85%. The woreda currently has the highest percentage of enrolled households in Oromia, with almost 12,000 of its total 13,777 eligible household enrolled.

The USAID HSFR/HFG project, implemented by Abt Associates, played a key role in the woreda's success. The project helped with encoding and entering application form data on a computer, and developed data bases for members, contributions, and service utilization. Support continues under the USAID Health Financing Improvement Program with technical assistance for review meetings and supportive supervision at the regional and zonal levels. Feedback and findings from these interventions are used in guiding CBHI practices in woredas across the region.

See cover photo and inside cover caption.

3. Program management and operations

3.1 Program performance review, theory of change, and Year 2 implementation planning

The Program carried out its performance review (covering Y1 Q1-Q3) and Y2 implementation planning meeting. The three-day meeting, held June 24-26, included central, regional, and Abt home office teams. During the meeting, the team reviewed Program performance, and conducted an exercise to review and revise the Program's theory of change. It also developed its strategic approach for implementing Y2 activities and prioritized activities by IR and region. The AOR attended the final day of the meeting and highlighted USAID Ethiopia priorities and expectations that served as important inputs for plan refinement and finalization in subsequent days.

3.2 MEL accomplishments

[redacted] DHIS2 configuration which is planned to begin in Q4. The configuration will help the Program to collect program monitoring data digitally and use the DHIS2 platform. The team also prepared a field guide for the Program's annual and baseline data collection process. Data from schemes and HFs was collected by regional teams, cleaned, and made ready for analysis by the MEL team. Based on the Program's performance review and implementation planning meeting, the team worked on updating the theory of change and reviewed key performance indicators that will be reflected in the revised MEL plan. The draft Data Quality Assurance (DQA) plan was also prepared.

3.3 Recruitment and onboarding staff

[redacted]

At the end of Q3, 66 staff members were on board and eight remaining positions were planned to be filled in Q4.

3.4 Operationalizing central and regional offices

The Afar, Dire Dawa, Harari, and Somali Regional Office became fully operational in Q3, making all of the Program's regional and satellite offices operational during the quarter. The initial set up of servers in 2 offices (Center and Tigray) were completed. In Q4, the server will be set up in the Afar, Dire Dawa, Harari and Somali Regional Office, the Amhara and Benishangul-Gumuz Regional Office, and the SNNP and Gambella Regional Office.

4. Challenges

The following challenges were experienced this quarter:

- [redacted]
- Ratification of the revised HCF Strategy by the Council of Ministers has been delayed. The Program attended a meeting at which officials of the Prime Minister's Office were briefed on the strategy and agreed to expedite its endorsement.
- PCD has delayed the HCF partner mapping exercise, which in turn has delayed the Program's work to review and identify potential gaps in the existing analysis. In the interim, the Program has made plan alignments and conducted resource mapping with MOH, and the Program's seconded staff have been following up with other HCF implementation partners for resource mapping.

5. Lessons learned

The following lesson was learned during the quarter:

- Incentives such as recognizing "champions of the week," and awarding certificates and mobile cards, have led to increased CBHI enrollment. Lesson learned from implementation experience in Oromia.

6. Quarterly expenditure and accrual report

[redacted]

[redacted]

[redacted]

Line Item	Total Budget	Total Previous Expenditures Q1 -Q 2 (Oct 2018-Mar 2019)	Q3(Apr - Jun 2019)			Total Expenditures to Date	Remaining Funds
			Q3 Actuals (Apr - Jun 2019)	June 2019 Accruals	Q3 Actuals + Accruals		
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							

[redacted]

7. Planned activities for next quarter

- Complete the assessment report on the implementation of CBHI in AACA pilot woredas.
- Complete first draft HCF implementation manual.
- Finalize transition strategy for first generation HCF reforms.
- Participate in public consultation forums on the CBHI legal framework to be held in regions.
- Conduct regional consultative meetings to revise the legal framework and implementation manuals for RRU, outsourcing, and FGB/FMC.
- Provide CBHI training for scheme and HF staff in newly joined woredas.
- Conduct SS at CBHI schemes and HFs in selected woredas implementing CBHI.
- Conduct training for WOFED auditors on CBHI financial auditing.
- Support zonal level biannual review meetings for CBHI.
- Conduct periodic SS and participate in ISS organized by EHIA.
- Finalize the Program's DQA plan.
- Finalize the Program's gender analysis and strategy and submit to AOR.
- Finalize the Program's communications plan and submit to AOR.
- Finalize the Program's revised MEL Plan and submit to AOR.

Annex A: Cumulative list of deliverables

The cumulative list of deliverables completed through Y1Q3 is provided in the below table. The list also indicates the status of posting deliverables to USAID's Development Experience Clearinghouse (DEC).

Title	Author	Program year and quarter completed	Posted to DEC (Y/N)	Comments
USAID Health Financing Improvement Program Year 1 Implementation Plan (October 25, 2018 - September 30, 2019)	USAID Health Financing Improvement Program	Y1Q1	N	Initial version. Per the cooperative agreement, implementation plans should not be posted to the DEC.
USAID Health Financing Improvement Program Year 1 Implementation Plan (October 25, 2018 - September 30, 2019) (Revised/Final)	USAID Health Financing Improvement Program	Y1Q2	N	Final version addressing AOR review. Submitted within 10 days of receipt of comments. Approved by AOR. Per the cooperative agreement, implementation plans should not be posted to the DEC.
USAID Health Financing Improvement Program Year 1 Monitoring, Evaluation, and Learning (MEL) Plan (October 25, 2018 - September 30, 2019)	USAID Health Financing Improvement Program	Y1Q1	N	Initial version. Per the cooperative agreement, MEL plans should not be posted to the DEC.
USAID Health Financing Improvement Program Monitoring, Evaluation, and Learning (MEL) Plan (Revised/Final)	USAID Health Financing Improvement Program	Y1Q2	N	Final version addressing AOR review. Submitted within 15 days of receipt of comments. Approved by AOR. Per the cooperative agreement, MEL plans should not be posted to the DEC.
USAID Health Financing Improvement Program Quarterly Performance Report – Year 1, Quarter 1 (October 25, 2018 – December 31, 2018)	USAID Health Financing Improvement Program	Y1Q2	N	Per the cooperative agreement, this report has not been submitted to the DEC pending AOR approval to do so and guidance on information to omit.
USAID Health Financing Improvement Program Quarterly Performance Report – Year 1, Quarter 2 (January 1, 2019 – March 31, 2019).	USAID Health Financing Improvement Program	Y1Q3	N	Per the cooperative agreement, this report has not been submitted to the DEC pending AOR approval to do so and guidance on information to omit.

Annex B: International STTA

International STTA visits that took place during Y1Q3 are provided in the table below.

Name	Arrival	Departure	Scope of Work
[redacted]	June 17, 2019	July 3, 2019	Provided managerial and oversight support; Met with the senior management team on technical and administrative matters; Participated in theory of change exercise and provided guidance and TA for implementation planning; Led a strategy session for Year 2 planning. Trip/LOE costs shared proportionately with work conducted for PHSP and Transform: Primary Health Care projects and corporate business.
[redacted]	June 19,2019	July 5, 2019	Participated and provided TA for theory of change exercise and implementation planning. Facilitated the performance review and planning meeting sessions. Trip/LOE costs shared proportionately with work conducted for Transform: Primary Health Care project, and corporate and personal business.
[redacted]	June 22,2019	July 10, 2019	Participated in theory of change exercise and implementation planning; Provided assistance in drafting the implementation plan; Contributed to strategy sessions and incorporation of strategy into the implementation plan; Provided technical review and input to the communications plan; Facilitated advancement of the gender analysis and strategy. Trip/LOE costs shared proportionately with work conducted for Transform: Primary Health Care project and corporate business.
[redacted]	June 22, 2019	July 3, 2019	Reviewed key performance indicators; co-facilitated the theory of change exercise; revise the theory of change; contributed to DQA plan development; participated in implementation planning sessions.
[redacted]	June 22, 2019	July 2, 2019	Participated in theory of change and implementation planning; worked with the Finance and Administration team in preparing for the implementation plan budget and on recruitment and other operations and finance issues.

Annex C: Summary of zonal and regional level review meetings, participants, and Program and counterpart roles, by region

Region	Zonal review meetings	Regional review meetings	Role of the USAID Health Financing Improvement Program, MOH, and EHIA
Tigray	Three zonal RMs held in South East (May 25), Eastern (June 1), and Southern (June 9) zones, respectively. 166 (121 male and 45 female) participants included zonal heads, zonal vice heads, zonal social affairs, woreda CBHI board members, EHIA management, and Program.	One RM on CBHI, HCF, and other health performance activities held in Mekelle town (May 14-16) 348 (290 male and 58 female) participants included HF directors and CEOs, WorHO heads, RHB senior staff, and zonal social affairs.	• Program facilitated discussions and provided feedback from SS at two RMs; • Program covered costs for one RM and EHIA covered costs for two. • Regional RM was organized by the RHB.
Amhara	Five zonal RMs held in Oromo Nationality (April 4), South Gondar (April 16), Wag Himira Nationality (April 23), North Shoa (May 5), and South Wollo (April) zones. 600 (515 male and 85 female) participants included chief administrators, health administrators, health department and office heads, MOFEC office heads, and woreda and zone CBHI board members.		Program assisted as technical lead facilitating all RMs.
Oromia	Six Zonal Health Offices (ZHOs) North Shoa (April 3-4), East Harerge (April 4-5), Buno Bedele (May 7), Oromia Special Zone Surrounding Finfinne (May 7-8), and South-West Shoa (May 20) and two Town Health Offices (Sebeta and Shashemene) were supported to organize review meetings on CBHI. 665 (551 male and 114 female) participants including zonal and woreda administrators, political party leaders, MOFEC office heads, Women's Affairs Offices, health offices, CBHI coordinators, HF directors; and representatives from EHIA branch offices.	RHB organized one RM in collaboration with the Program and the Transform: Primary Health Care project in Adama (June 13-14). 104 participants (88 male and 16 female) included RHB and ZHO staff, CBHI coordinators, EHIA branch managers, and members' affairs team leaders.	• Program provided TA for two RMs by aligning action plans with the relevant stakeholders, allocating budget on cost sharing basis, and facilitating the RMs. • Program provided TA to organize and conduct the CBHI annual RM. • Program collaborated with the Transform: Primary Health Care project by jointly facilitating and co-funding the RMs.
SNNP		Regional bi-annual RM held in Hossana town (April 9-10). 1,054 participants. Participants presented best practices, lessons from HCF reform implementation and HF management.	• Program provided TA to RHB in identifying major discussion agendas for RM and provided technical input at meeting.

Annex D: Indicator reporting

USAID Health Financing Improvement Program Indicators Table – Q1-Q3 Update

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
	Strategic Objective: Improved institutional capacity and health financing functions and systems in Ethiopia											
1	Health service utilization rate	Federal /Region, insured/uninsured, Gender	CBHI scheme records, Health facility	Year 2 and end-line	0.67	N/A						0.80
2	Share of out-of-pocket expenditure to total health expenditure	N/A	National Health Accounts reports	Year 3 and end-line	33%	N/A						25%
	IR 1—Increased domestic resource mobilization for enhanced provision of quality PHC services											
1.1	Percent of domestically-mobilized resources for health sector	N/A	National Health Accounts reports	Year 1, Year 3, Year 5	64%	64%						70%
1.2	Percent of donor contribution to the health sector	N/A	National Health Accounts reports	Year 1, Year 3, Year 5	36%	36%						30%
	SR 1.1— Availability of operational funds increased at PHC facilities through RRU											
1.1.1	Percent of public health facilities using retained revenue for facility and service improvement	Region, facility type (health center, hospital)	HMIS, RHB reports	Annually	91%	91%						93%
1.1.2	Percent of health facility budgets made up by retained revenue	Region, facility type (health center, hospital)	HMIS, supportive supervision visits	Annually	30%	31						35%

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
1.1.3	Percent of health facility retained revenue being used for drugs, medical equipment and facility renovation	Region, facility type (health center, hospital)	HMIS, supportive supervision visits	Annually	75%	76%						80%
	SR 1.2— Strategies on efficiency improvement and rational resource use implemented											
1.2.1	Percent of public hospitals outsourcing cost inefficient non-clinical/ancillary services	Region/ type of services outsourced	RHB records	Annually	40% (113/280)	40%						40%[1]
1.2.2	Percent cost reduced/saved from interventions on efficiency-improvement (of the outsourced services)	Region	RHB, supportive supervision	Baseline, Year 2 and end-line	TBD	N/A						TBD
1.2.3	Number of health administrators and managers trained in efficiency improvement and rational resource use(outsourcing) in newly-joined region	Region, gender	Program records (training report)	Quarterly	0		0	0				75
	SR 1.3— Options on domestic resource mobilization (innovative + government budget) implemented											
1.3.1	Percent share of government spending on health out of general government expenditure	N/A	National Health Accounts reports	Year 1, Year 3, and end-line	6.65%	7%						10%
1.3.2	Availability of a fiscal space and international best practice analysis report on innovative domestic	N/A	Program records (Study report)	Year 2	0	-						Yes

[1] Target revised from 90% to 40% because the number of hospitals expected to increase substantially in small rural towns where service providers for non-clinical services are not expected to be available.

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
	financing											
	SR 1.4— Sustainability financing plan for the exempted service package developed											
1.4.1	Availability of phased plan for sustainable financing of the Exempted Services Package from domestic sources	N/A	Program records (Sustainable financing plan)	Year 2	0	-	-					Yes
	IR 2—Streamlined risk-pooling mechanisms for wider access to PHC services with reduced financial barriers											
2.1	Proportion of population enrolled in health insurance programs	Federal/Region, scheme type	RHB/EHIA	Annually	20%	25%						50%
2.2	Re-enrollment rate in CBHI schemes (renewal)	Federal /Region, urban/rural	RHB/EHIA	Annually	75%	75%						80%
	SR 2.1— CBHI institutionalized and consolidated in the rural districts of the 4 agrarian regions											
2.1.1	Number of CBHI scheme staff trained on CBHI in new CBHI rural woredas	Federal/Region, gender	Program records (training records)	Quarterly	0	288	0	0	44			1440
2.1.2	Number of health facility staff trained on CBHI in new CBHI rural woredas	Federal/Region, gender Program records (training records)	Program records (training records)	Quarterly	0	960	0	287	34			2640
2.1.3	Expenditure-income ratio for CBHI schemes in rural woredas	Federal//Region	Supportive supervision report, RHB records	Annually	0.84	0.95						0.95

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
2.1.4	Number of new functional CBHI schemes established with program support in rural woredas	Federal, Region	RHB/EHIA	Annually	321	149						265
2.1.5	Percent of CBHI schemes audited per year (financial) in rural woredas	Federal, Region	RHB/EHIA	Annually	36%	50%						100%
	SR 2.2— CBHI rolled out and consolidated in the urban settings of the 4 agrarian regions, Harari, Addis Ababa and Dire Dawa											
2.2.1	Expenditure-income ratio for CBHI schemes in urban setting	Federal, Region	Supportive supervision report	Annually	TBD	TBD						TBD
2.2.2	Number of new functional CBHI schemes established with program support in urban setting	Federal, Region	RHB/EHIA	Annually	36	25						125
2.2.3	Percent of CBHI schemes audited per year (financial) in urban setting	Federal, Region	RHB/EHIA	Annually	50%	70%						100%
2.2.4	Number of scheme staff trained on CBHI in urban setting	Federal/Region, gender	Program records	Quarterly	0	273	0	20	25			573
2.2.5	Number of health facility staff trained on CBHI in urban setting	Federal/Region, gender	Program records	Quarterly		702	0	0	55			1902
	SR 2.3— Coverage of poor households in CBHI schemes (and fee-waiver in non-CBHI woredas) increased											
2.3.1	Percent of poor households enrolled in CBHI schemes on contribution-exemption basis	Federal , Region, urban/rural	RHB/EHIA	Annually	18%	22%						84%
2.3.2	Number of woreda governments that allocated/transferred full budget to cover targeted poor households under CBHI schemes	Federal, Region, rural/urban	RHB/EHIA	Annually	357	531						747

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
2.3.3	Number of CBHI woredas that are harmonized with safety net targeting criteria	Federal, Region, rural/urban	RHB, Ministry of Agriculture, MOLSA	Annually	0	TBD						TBD
	SR 2.4— Worked with EHIA and MOH in supporting implementation of the SHI program.											
2.4.1	Existence of functional SHI TWG	N/A	Program records, MOH, EHIA	Quarterly	No	Yes	0	0				Yes
2.4.2	Number of EHIA staff trained on management and initiation of SHI	Gender	Program records	Quarterly	0	50	0	0				500
2.4.3	Availability of phased implementation plan for initiation and scale up of SHI	N/A	Program records	Year 2	No	-						Yes
	IR 3—Improved arrangements for strategic purchasing of health services from public and private providers											
3.1	Percent of scheme staff who applied the skill/knowledge acquired from CBHI training.	Federal, Regional, Gender	Program/ Sample survey	Year 2, Year 4	0	-						75%
3.2	Percent of health facility claims audited	Health center, Hospital, Federal, Regional	Program/ Supportive supervision	Annually	TBD	TBD						TBD
	SR 3.1— Comprehensive organizational structure for health insurance designed and implemented											
3.1.1	Availability of comprehensive framework that facilitates streamlined management	N/A	Program records	Year 2	No	-						Yes
3.1.2	Number of Auditors trained on CBHI financial audit.	Federal, Regional, Gender	Program records	Quarterly	0	720	0	0				1400
3.1.3	Percent of schemes staffed as per	Federal, Regional	Program/Su	Quarterly	TBD	TBD	0	0				TBD

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
	the organizational structure		pportive supervision visits									
	SR 3.2— Tools to facilitate periodic revision of user-fee schedules implemented											
3.2.1	Number of participants trained to use the costing tool for user-fee revision	Federal, Regional, Gender	Program records	Quarterly in Year 2	0	-						130
3.2.2	Availability of user friendly health service costing tool and operational manual	N/A	Program records	Year 2	No	-						Yes
	SR 3.3— New provider payment approaches that facilitate private sector involvement explored and piloted											
3.3.1	New payment mechanisms piloted	N/A	Program records	Year 2	0	-						Yes
	SR 3.4— Health facility accreditation becomes mandatory in CHBI and SHI programs											
3.4.1	Availability of accreditation guideline /manual /procedure	N/A	Program records, EHIA	Year 2	No	-						Yes
3.4.2	Number of health facilities accredited as per standards	Federal, Region, facility type (health center, hospital), ownership type (public, private)	Program records, EHIA	Annually (from Year 3)	0	-						TBD
	IR4—Strengthened governance, management, and evidence-generation for health financing reforms and health facilities											
4.1	Percent of public health facilities managed by functional governing boards	Region, facility type (health center, hospital)	MOH, RHB	Annually	90%	90%						90%

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
4.2	Percent of Facility Governance Board (FGB) members who applied the skill/knowledge acquired from FGB training	Federal, Region, facility type (health center, hospital), gender	Program records/Sample survey	Year 2 and Year 4	0							75%
4.3	Percent of woreda health offices with evidence of data use for decision making	Region	Sample survey	Year 2 and Year 4	TBD							TBD
	SR 4.1— Institutionalization of structures/arrangements for coordination and management of health financing reforms strengthened and expanded											
4.1.1	Number of RHBs/zonal health departments with functioning resource mobilization structure.	Region, zone	RHB/ZHD		1	6						101
4.1.2	Availability of self-assessment tools	N/A	Program records	Year 2	0							yes
4.1.3	Number of master trainers trained	Federal, Regional, entity (EHIA, RHB, universities, IST sites), gender	Program records	Quarterly	0	91	0	0	0			492
	SR 4.2— Health facilities are managed by functional governing boards with community representations											
4.2.1	Number of health facility managers and FGB members trained in governance and management in newly joined regions	Federal, Region, facility type (health center, hospital), gender	Program records	Quarterly	0	330	0	199	1129			2040
4.2.2	Percent of health facilities with women board members participating in bored meeting	Federal, Region, facility type (health center, hospital), Number of women	Program/ Supportive supervision	Annually (starting from Year 2)	TBD	TBD						TBD

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
4.2.3	Percent of health facilities with community participation in board meetings	Federal, Region, facility type (health center, hospital)	Program records/, supportive supervisor	Annually (starting from Year 2)	TBD	TBD						TBD
	SR 4.3— Institutional arrangements and standard operating procedures for private wings improved											
4.3.1	Average Physician/specialized/technical medical staff retention rate	Federal, Region, hospital type	Program records/sample survey	Baseline, Year 2, Year 4	TBD	-						TBD
4.3.2	Number of public hospitals with private wings established	Federal, Region, hospital type	MOH, RHB	Annually	63	37						250
4.3.3	Number of hospital staff f trained on operationalization of private wings in newly-joined regions	Federal, Region, hospital type	Program records	Quarterly (Y2-5)	0	-	0	0				120
	SR 4.4— System, process and practice institutionalized for evidence generation and data use											
4.4.1	Number of policies, legal frameworks and guidelines revised to improve health financing reforms	Document type	Program records	Annually	0							6
4.4.2	Number of National Health Accounts surveys/reports and secondary analyses supported	N/A	Program records	When complete	-	-						2
4.4.3	Number of operations research/studies/surveys conducted and results/reports disseminated/published	Type of study	Program records	Annually	-	2						10
4.4.4	Number of reports, success	Type of document	Program	Quarterly	-	8	0	0	2			52

Indicators		Disaggregates	Data Source	Frequency	Baseline	Target	Achievement					LOP
						Y1	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y1 Annual	
	stories, and newsletters developed and disseminated		records									
4.4.5	Number of review meetings and policy dialogues organized	Federal, regional, zonal	Program records	Quarterly	-	47	0	14	18			591
4.4.6	Number of health facilities visited through supportive supervision visits	Federal, Regions, facility type	Program records	Quarterly	-	274	0	9	107			1060
4.4.7	Number of CBHI schemes visited through supportive supervision visits	Federal, regional	Program records	Quarterly		215	0	12	146			1067