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USAID Health Financing Improvement Program

USAID Health Financing Improvement Program Quarterly Performance Report – Year 2, Quarter 1 (October 1, 2019 - December 31, 2019)

January 2020

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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 T.H. Chan School of Public Health.

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Cover Photo: A community-based health insurance member accesses health services at Kibet Primary Hospital in Silti woreda, SNNP region. Photo credit: Ayenew Haileselassie, Abt Associates.

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Acronyms

AOR	Agreement Officer's Representative
BOFED	Bureau of Finance and Economic Development
CBHI	Community-Based Health Insurance
CHAI	Clinton Health Access Initiative
EHIA	Ethiopian Health Insurance Agency
ENAO	Ethiopian National Accreditation Office
FGB	Facility Governing Board
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GOE	Government of Ethiopia
HCF	Health Care Financing
HF	Health Facility
HSTP	Health Sector Transformation Plan
IR	Intermediate Result
IST	In-service Training Centers
MEL	Monitoring, Evaluation, and Learning
MOH	Ministry of Health
MOU	Memorandum of Understanding
N/A	Not Applicable
PHC	Primary Health Care
Q1, Q2, Q3, Q4	Quarter 1, Quarter 2, Quarter 3, Quarter 4
RHB	Regional Health Bureau
SHI	Social Health Insurance
SNNP	Southern Nations, Nationalities, and Peoples' (Region)
SR	Sub-Result
STTA	Short-Term Technical Assistance
TWG	Technical Working Group
USAID	United States Agency for International Development
WOFED	Woreda Finance and Economic Development Office
WorHO	Woreda Health Office
Y1, Y2	Year 1, Year 2

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 is doing this by consolidating the achievements of past reforms and broadening to new strategies to further improve access, equity, utilization, and quality service provision. The Program consortium, led by Abt Associates, includes core partners Breakthrough International Consultancy, Dimagi, Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard T.H. Chan School of Public Health. The Program works in close collaboration with the GOE to achieve four program objectives/intermediate results (IRs):

1. Increase domestic resource mobilization 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 HCF 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 out of total health expenditure 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 performance report describes the progress and key accomplishments, lessons learned, and challenges experienced during Year 2 (Y2) Quarter 1 (Q1), of implementation, October 1, 2019, through December 31, 2019.

The following section describes key achievements and major activities undertaken by the Program, followed by a success story and summary of Monitoring, Evaluation and Learning (MEL)-specific achievements. Program management and operations are discussed in Section 3, followed by challenges (Section 4) and lessons learned (Section 5). The quarterly expenditure and accrual report is included as Section 6. A list of deliverables produced this quarter is included in Annex A. International short-term technical assistance (STTA) visits that supported implementation are detailed in Annex B. Finally, accomplishments by key performance indicator and target are reflected in Annex C.

2. Key Activities and Achievements

This section provides a snapshot of the USAID Health Financing Improvement Program's key activities and achievements in Y2Q1. The Program's main focus was accomplishing activities related to the further institutionalization and transition of first generation HCF reforms (i.e., revenue retention and use, facility governance boards (FGBs), outsourcing of non-clinical services, exempted health services, fee waiver system, user fee setting and revision, and private wing) in the Program's target reform-advanced agrarian regions (Amhara, Harari, Oromia, Southern Nations, Nationalities and Peoples (SNNP), and Tigray) and city administrations (Addis Ababa and Dire Dawa). The key Program activities included: supporting the GOE to revise HCF implementation manuals, prepare training materials, put in place institutional structures, and define roles and responsibilities.

Highlighted achievements from this quarter include:

- Finalized the prototype HCF implementation manual.
- Developed the Ministry of Health's (MOH) "Roadmap for Institutionalizing First Generation Health Care Financing Reforms in Five Agrarian Regional States and Two City Administrations" to facilitate transition of these interventions to local health bureaus and governements in planning, financing, implementing, and managing the reform activities starting next year.
- Provided continued technical assistance to support the development of the Ethiopian Health Insurance Agency's (EHIA) draft five-year Health Insurance Strategic Plan. As a main input to the plan, the Program conducted an assessment of the previous five-year strategic plan implementation (2015/16-2019/20).
- Completed the fiscal space analysis as part of an effort to identify potential alternative ways to increase domestic resources for health.
- Assisted in the development of terms of reference to guide the development of a directive to engage private pharmacies in making essential medicines available for community-based health insurance (CBHI) beneficiaries.
- Supported EHIA to develop a concept note and a memorandum of understanding (MOU) that will be used to facilitate CBHI beneficiary access to tertiary-level health care.
- Provided support to organize and facilitate 30 review meetings to enhance CBHI community mobilizations. Evidence from supportive supervision was presented during the meetings.
- Supported training to 1,423 individuals from FGBs, HFs, woreda health offices (WorHOs), and woreda bureaus of finance and economic development offices (BOFEDs).
- Supported the MOH and other select government agencies in building capacity and experise in use of the World Health Organization's OneHealth Tool for costing and financial analysis of the essential health services package and the next 5-year health sector national plan (HSTP II: Health Sector Transformation Plan).

The sections below details this quarter's key achievements and activities by IR and sub-result (SR).

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 revenue retention and utilization by HFs.

Finalized the prototype HCF implementation manual

The Program team finished revising the prototype HCF implementation manual, which it had started in Y1Q3. The manual is a high priority as it will serve as the foundation for institutionalizing and transitioning first generation HCF reform activities by the end of Y2. Regional health bureaus (RHBs) will adapt the prototype to their own contexts and customize the training materials and in-service training centers (ISTs) will use the training materials to train governing board members, HF management teams, and HF finance teams. Tasks included:

- Updating and refining operational guides based on years of experience across all regions and city administrations.
- The technical working group (TWG) critically reviewed the draft manual during a thematic meeting held in Debre Birhan September 30–October 5, 2019. The Transform: Primary Health Care Project staff participated in collaboratively enriching the draft.
- Conducted a consultative workshop in collaboration with the MOH Partnership and Cooperation Directorate (November 20–22, 2019) that included 60 (52 male and 8 female) participants from MOH, RHBs, HFs, communities, and EHIA. Engaging RHBs at this stage was a strategy to facilitate seamless regional adaptation of the prototype, in addition to obtaining their input to enrich the manual. After incorporating comments from the consultative meeting, the manual was finalized and submitted to the MOH.

Revitalization of the implementing partners' forum

The Program advocated alongside the Amhara RHB's new Resource Mobilization and Partnership Directorate to RHB leadership to revitalize the implementing partners' forum, which had been inactive for three years, and provided assistance in revising the terms of reference for the forum. The objective of the forum is to align implementing partners' plans with the RHB's plan, to avoid duplication of effort. The Program team also provided technical support to the RHB on how to distribute the block budget allocated to the RHB for different departments and institutions reporting to the bureau.

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

The fiscal space analysis entitled "Exploring Options for Increasing Fiscal Space for Health in Ethiopia: Evidence Review and Options Analysis" was nearly completed and is expected to be finalized in Q2. The study protocol for the political economy analysis was completed, and data collection was started.

SR 1.4: Sustainability financing plan for the exempted service package developed.

Conducted plan alignment with Federal HAPCO

A joint consultative meeting was held between the Program's senior staff and Federal HIV/AIDS Prevention and Control Office (FHAPCO) officials to align the Program's PEPFAR-funded COP 2019 activities on HIV sustainable financing. The meeting helped to create common understanding on joint implementation and coordination of our activities with FHAPCO.

In addition, the Program:

- Provided technical assistance to address review comments in the finalization of FHAPCO's HIV Domestic Resource Mobilization and Sustainability Strategy 2020–2025.
- Assisted FHAPCO in planning an upcoming consultative workshop on the strategy to be held with the Women, Children, Youth, and Social Standing Committee of the House of Peoples Representatives.

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

During Q1, RHBs and city administrations launched CBHI community mobilization activities, with technical support from the Program through review meetings and supportive supervision. The data associated with CBHI are not yet available for the current fiscal year, in which the reporting quarter is included, as the enrollment period has not ended.

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 EHIA to develop a directive for engaging private pharmacies in CBHI

The Program provided technical assistance to EHIA in developing a directive for engaging the services of private pharmacies for the CBHI program/beneficiaries. EHIA will finalize and submit this directive for MOH approval. It is anticipated that private pharmacy participation in CBHI will improve the quality of services provided to CBHI beneficiaries, which in turn will help achieve the financial protection goals of the CBHI program and contribute to increases in CBHI enrollment. According to the current practice, whenever pharmacies in public facilities are out-of-stock of prescribed drugs, CBHI beneficiaries have to purchase drugs from private pharmacies by paying out of pocket. Although there are practices by CBHI schemes to reimburse these out-of-pocket payments to the beneficiaries, there are instances where the money is not being reimbursed.

Supported EHIA to develop a concept note and MOU to engage tertiary hospitals in CBHI

The Program also assisted EHIA in developing a concept note and later an MOU that will be used by EHIA and regions to facilitate CBHI beneficiary access to tertiary care. The administrative complexities of arranging contractual agreements between CBHI schemes and tertiary care hospitals had seriously challenged the capacity of CBHI schemes to ensure continuity of care to their beneficiaries. To mitigate this challenge, a concept note that explained and recommended possible contractual arrangements was developed. Later, a MOU was developed based on the recommendations. Using the MOU, EHIA will enter into contractual agreements with tertiary hospitals on behalf of the CBHI schemes, giving CBHI beneficiaries from across Ethiopia full access to services without being charged any out-of-pocket

payments. To reimburse the tertiary-level HFs for services rendered to CBHI beneficiaries, EHIA is allowed to deduct the amount schemes are entitled to receive from the federal government in the form of general subsidy funds.

Assisted the SNNP RHB to make CBHI schemes cost centers

The Program team in SNNP held high-level meetings with BOFED and RHB officials to encourage the creation of a cost center for CBHI schemes' use, which BOFED ultimately did.

Supported training to scheme, HF staff, and auditors on CBHI

The Program supported CBHI training to scheme staff, HF staff, and BOFED auditors. A total of 1,321 individuals (894 male and 427 female) were trained. Of the 1,870 annual target, 71% was achieved. Table 1 shows the trainings arranged by the Program in collaboration with RHBs and EHIA.

Table 1: Number of individuals trained in CBHI and CBHI financial audit in Y2Q1

Region	Scheme staff trained in CBHI	HF staff trained in CBHI	Auditors trained on CBHI financial audit
Addis Ababa	410	0	0
Amhara	0	0	106
Oromia	408	348	0
SNNP	26	0	0
Tigray	23	0	0
Total	**867**	**348**	**106**

Supported SNNP RHB to revise the CBHI directive

The Program regional team also facilitated CBHI consultative meetings to revise the regional CBHI directive. The revised directive fills the gaps in the previous version and addresses newly emerging challenges in the implementation of the CBHI program. Among others, the directive incorporated standardizing minimum contribution amount across the region, and fixed a specific calendar for community mobilization activities. The directive was shared with zonal and woreda offices for implementation.

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

Supported training to all Addis Ababa CBHI executive staff at woreda level

In collaboration with the Addis Ababa Health Bureau and EHIA's Addis Ababa branch office, the Program supported training on CBHI to all woreda-level Addis Ababa CBHI executives (October 31–November 2, 2019). The participants were drawn from all 120 woredas of the 10 sub-city schemes in Addis Ababa. A total of 178 participants (56 male and 122 female) attended the training in three sessions.

A one-day training in CBHI was arranged for staff from Addis Ababa sub-city CBHI schemes on November 8, 2019. The participants included the scheme coordinator and three team leaders from each of the 10 schemes. Technical staff from Addis Ababa Health Bureau's CBHI directorate and EHIA's Addis Ababa branch office also participated in the training. Forty-eight participants (27 male and 21 female) attended.

The Program also supported EHIA through its seconded staff in arranging training for the Addis Ababa City and sub-city CBHI board members on the topics of health financing, health insurance, CBHI current achievements, lessons learned, challenges, and way forward. The purpose of this training was to sensitize the board members on the need to focus on CBHI community mobilization activities during the annual

CBHI community mobilization period, in October and November. The training was held in Addis Ababa on October 26, 2019, and a total of 42 (26 male and 16 female) participants attended. Out of the total participants, 34 (19 male and 15 female) were sub-city board members and the remaining 8 were city administration board members.

Supported supportive supervision conducted by the Addis Ababa Health Bureau

The Program provided technical support to supportive supervision visits the Addis Ababa Health Bureau made in collaboration with EHIA's Addis Ababa branch office on September 23–October 7, 2019. The main focus of the visits were to assess the status of CBHI community mobilization in the city administration. Visit were conducted at all 10 sub-city schemes and in 64 of the 120 woredas (40 old and 80 new). Following the supportive supervision, feedback was provided to woreda officials on the status of CBHI enrollment and the challenges observed during community mobilization. This helped the woreda officials to take appropriate action to increase enrollment.

The following results have been achieved in relation to CBHI implementation in Addis Ababa:

- A total of 187,876 members enrolled (new and renewal); of these, 30.4% are indigent households whose contributions are paid by the city administration.
- The overall enrollment rate in the schemes has reached 88%, while the renewal rate is 66%.
- More than 57 million birr (US$ 1.78 million[1]) have been mobilized from paying members.
- All of the health centers in the new CBHI woredas have signed contractual agreements with the schemes.

CBHI registration and renewal in Addis Ababa takes place in October and November every year. However, due to a late start of registration in newly implementing woredas, the period was extended through December 2019. Hence, the final numbers are expected to be greater than those above.

SR 2.3: Safety-net provisions strengthened/expanded to include the poor/indigents in CBHI program.

CBHI community mobilization was ongoing during Q1. The full report related to this SR will be included in the next quarterly report.

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

SR 3.1: Management structures, roles, and capacities streamlined for pooling (insurance) programs to ensure better interface between them, and a functional split between health providers and purchasers.

In Y1, an assessment was conducted to identify gaps and document lessons on implementation of the existing medical audit manual. Led by EHIA, the Program started revising the manual in collaboration with the MOH and Clinton Health Access Initiative (CHAI). Medical auditing practices in Ghana, Egypt, India, and Kenya, and the Joint Learning Network guidelines were reviewed to consider how those experiences and standards could be adapted for Ethiopia. The TWG decided to limit the manual to two

[1] Exchange rate ($1=32 ETB) used to convert Ethiopian Birr to U.S. Dollars.

sections, one for clinical audits and the other for claim audits. Issues related to prepayment claim verification, post payment claim verification, and institutional arrangement responsibilities were incorporated into the claim audit section. Next quarter, the Program will work to finish drafting the medical audit manual and proceed to prepare audit tools, standard operating procedures, and monitoring and evaluation frameworks.

SR 3.2: Tools and skills institutionalized for periodic revision of user-fee schedules.

Supported MOH to cost and analyze components of the HSTP II using the OneHealth tool

Our Program, through Avenir Health, prepared and delivered a training (November 18–23, 2019) on use of the OneHealth Tool for costing health plans to about 65 participants including MOH and cooperating partner trainees. MOH trainees included staff from the Policy, Planning, Monitoring and Evaluation Directorate which supported different expert groups such as EHIA, the Ethiopia Public Health Institute, the Food and Drug Administration, the MOH Partnership and Cooperation Directorate and Public Health Infrastructure Directorate, and the Armauer Hansen Research Institute. The participants list is included in Annex D. Following this training, assistance was provided to attendees in gathering data and doing preliminary data entry for costing the HSTP II. Zero draft total cost and impact results were compiled by the Avenir and Ministry team and presented to the management team on November 23. The relevant technical experts continued to gather and enter data through December 20 and the Avenir team continued to support the MOH in compiling the master file and troubleshooting results through December, including in-person meetings and Skype calls to discuss issues.

SR 3.3. Health facility accreditation requirements improved and made mandatory for all public and private providers under the SHI and CBHI programs.

Aimed at identifying and documenting the scope of accreditation practices in Ethiopia, preparatory work to conduct an assessment of accreditation practices in Ethiopia was started. A desk review on quality policy, quality infrastructure, quality health care status, challenges, and opportunities in Ethiopia was completed. To frame the assessment, peer-reviewed articles and gray literature from the MOH, Ministry of Innovation and Technology, and World Bank country reports were collected and analyzed. In addition, discussions were held with the Director General and other staff of the Ethiopian National Accreditation Office (ENAO), and visits were made to the International Clinical Laboratories which is the only Joint Commission International-accredited medical laboratory in the country. From the discussions and desk reviews, the team identified the following major challenges: there is no national accreditation policy for health in Ethiopia, accreditation activities are fragmented, and developing an accreditation system for the health sector is currently a low priority. The Program will continue collaborating with EHIA in having dialogue with the MOH, professional associations, and ENAO.

Participated in TWG established to work on national hospital star labeling

The Program worked as part of the National Hospital Star Labeling TWG formed by the MOH's Clinical Service Directorate. Star labeling is the practice of using a star symbol to reflect the performance rating of health care facilities against a set of quality standards. The Program staff attended a meeting held in November 2019 organized to develop the terms of reference for the TWG and conducted a desk review of international experiences with star labelling/quality ranking systems. Based on this review, the TWG decided to use the Tanzanian experience as a springboard for developing Ethiopia's system as it was found to be most relevant to the Ethiopian context.

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.

In Amhara, the Program followed up with the RHB to fill positions as per the approved structure. Currently, all positions except one are filled with the required staff at the regional level.

Produced a roadmap to facilitate institutionalization of first generation reforms

The Program worked with the MOH to develop a roadmap for institutionalizing first generation HCF reforms in five regional states (Amhara, Harari, Oromia, SNNP, and Tigray) and two city administrations (Addis Ababa and Dire Dawa). The roadmap defines the processes, structures, and support required at federal and regional levels to facilitate the institutionalization of first generation HCF reforms so that they function through and use GOE systems and funding. It also defines the roles and processes that need to be put in place between the MOH and RHBs and between regions and ISTs, and describes the support that the Program will provide during the transition process.

Supported training on HCF to woreda health and finance offices, HF staff, and FGB members in collaboration with government counterparts

Trainings were arranged to woreda health and finance office staff, HF staff, and FGB members on various HCF implementation topics (Table 2). Of the annual target of 941, 11% (102) individuals were trained in HCF reform implementation and financial management during Q1. These trainings were conducted in collaboration with the government counterparts.

Table 2: Number of individuals trained in HCF and financial management in Y2Q1

Region	HCF training to WorHO and WOFED staff			HCF financial management training to HF finance team			HCF training to HF management team and FGB members		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Afar	0	0	0	0	0	0	21	1	22
Gambella	19	2	21	18	3	21	0	0	0
Somali	0	0	0	7	5	12	0	0	0
Tigray	0	0	0	9	17	26	0	0	0
Total	**19**	**2**	**21**	**34**	**25**	**59**	**21**	**1**	**22**

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

The Program incorporated institutionalization arrangements for FGB implementation in the final prototype HCF implementation manual.

SR 4.3: Transition/Institutionalization arrangements completed for operating private wings within public hospitals to support improved staff retention and revenue generation.

This activity is on hold. The MOH has instructed the Program not to include private wing and user fee revision in the prototype HCF implementation manual.

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 zonal- and regional-level review meetings

As shown in Table 3, the Program conducted 30 review meetings (27 zonal and 3 regional level).

Table 3: Number of zonal and regional review meetings conducted in Y2 Q1

Region	Zonal	Regional	Total
Afar	9	1	10
Amhara	5	0	5
Benishangul-Gumuz	11	1	12
Tigray	2	1	3
Total	**27**	**3**	**30**

Study of CBHI in urban settings

This study originally started in Y1Q3; however, the scope has been evolving and, based on a request from EHIA, it has changed from a focus solely on Addis Ababa to one on Addis Ababa, Amhara, and SNNP regions. The methodology and sampling frame as well as the overall budget were revised. The inception report was discussed with EHIA and overall agreement on the tools and methodology was reached. The study will be completed in May 2020.

Data collection for the readiness assessment of ISTs

As part of institutionalizing HCF reforms, the Program planned to work with the ISTs to prepare them for the hand-over of capacity-building activities. Accordingly, the Program initiated a readiness assessment of ISTs, aimed at generating evidence on the human resource, infrastructure, structural arrangements, availability of training materials, and experiences in providing in-service training. During Q1, the team collected data via key informant interviews at 38 ISTs and their associated RHBs using a data collection instrument prepared specially for that level. Analysis and synthesis of the data will be completed in Q2.

Supported development of EHIA's five-year Health Insurance Strategic Plan

EHIA's five-year Health Insurance Strategic Plan is being developed as part of the HSTP II and Growth and Transformation Plan III development process. To inform this process, a review of the performance of EHIA's 2015/16-2019/20 strategic plan that the Program began in Y1 was completed and a draft report submitted to EHIA. The Program also presented review findings to EHIA and partners at a workshop held in November 2019. Based on comments from workshop participants and other pertinent stakeholders, the draft was revised and submitted to EHIA. The report was also presented to a wider group of more than 100 participants, which included representatives from EHIA branches and partners. EHIA endorsed the final report, which now is serving as input to the preparation of EHIA next strategic plan (2020/21-2024/25).

The Program also facilitated organizing two consultative meetings that reviewed drafts of the new strategic plan. The first meeting, held on November 11–15, 2019, focused on reviewing and enriching

the SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, stakeholder analysis, strategic issues, values, mission, vision, customer value preposition, strategic themes, and strategic objectives. Participants included EHIA management and technical staff, and staff from partners working closely with EHIA such as our Program, CHAI, and the Transform: Primary Health Care Project. A total of 34 (28 male and 6 female) participants attended this meeting.

The second consultative meeting (December 10–12, 2019) was held to glean the broader reactions to the draft from additional delegates from the MOH, institutions and agencies under the MOH, RHBs, selected zonal and woreda health offices, CBHI schemes, and universities, as well as delegates from UNICEF, the World Health Organization and World Bank, and USAID. Branch managers of EHIA and regional directors of our Program also attended the meeting for a total of 132 attendees (117 male and 15 female).

In addition, members of the Program's team are providing technical assistance to address and incorporate comments on the document from various consultative meetings.

Conducted Program supportive supervision

As depicted in Table 4, the Program team carried out supportive supervision at 53 CBHI schemes (32 rural and 21 urban) and 39 HFs.

Table 4: Number of schemes and HFs covered by supportive supervision in Y2Q1

Region	CBHI schemes			Health facilities		
	Rural	Urban	Total	HCs	Hopsitals	Total
Afar	0	0	0	2	1	3
Addis Ababa	0	10	0	0	0	0
Dire Dawa	0	1	1	2	0	2
Harari	1	2	3	2	1	3
Oromia	24	5	29	26	2	28
SNNP	7	3	10	0	0	0
Somali	0	0	0	2	1	3
Total	**32**	**21**	**53**	**34**	**5**	**39**

2.1 Success Story

New Directorate for HCF Reform: An Institutionalization Step in Amhara Health Bureau

An important focus in the second year of the USAID Health Financing Improvement Program is institutionalizing first generation HCF reforms, i.e., facility governance, retained revenue and utilization, standardization of the fee waiver system, outsourcing of non-clinical services, and revision of user fees and exempted services reforms. The Program is expected to transition any remaining project support for these reforms to RHBs, which will be able to assume full responsibility for their implementation, using their own human resources and regional training capabilities.

This year, the Amhara Health Bureau has taken a major step in the direction of institutionalization by establishing a new directorate for that purpose: the Resource Mobilization, Administration and Partnership Directorate. This directorate, already staffed and operational, will be responsible for first generation HCF reforms as well as CBHI, although the Program will continue to support the latter.

The new directorate's dedicated structure and staffing at the regional, zonal, woreda, and health center levels will lead, coordinate, and oversee implementation of HCF reforms to enhance resource mobilization and utilization. HFs have been retaining and using their internal revenue (collected via fees they charge for the services they deliver) since mid-2000, and the region is rapidly expanding CBHI.

The Program supported the Amhara Health Bureau and Regional Civil Service Commission to conduct a series of consultative meetings that led to the approval of the structure for the new directorate and to recruit staff. These meetings took place over a three-month period, during which the Program, the Bureau, and the Commission discussed the rationale for establishing the directorate and how to establish it; the resulting proposal then received approval from the regional health and finance bureaus.

2.2 MEL Accomplishments

Configuration of DHIS2 started this quarter. The configuration will help the Program to collect, store, analyze, and visualize data using the DHIS2 platform. As part of these efforts, the MEL team contracted a local DHIS2 consultant, and worked with her to define datasets and data elements, and to refine requirements for the configuration. The team has also worked to submit research studies to the Abt and local institutional review boards for ethical review and approval.

3. Program Management and Operations

3.1 Program Performance Review

The broader Program management team (including the senior management team and regional directors) conducted its quarterly meeting to review Y1 performance and agree on next steps for acceleration of priority initiatives such as institutionalization and transition of the first generation HCF reforms.

3.2 Recruitment and Onboarding Staff

The project filled 45 technical and 35 administrative and support positions in the central (Addis Ababa) and regional project offices. By the end of Q1, 80 staff members were on board, and 15 remaining technical and support staff are expected to be recruited and hired in Q2.

3.3 Operationalizing Central and Regional Offices

The Program's IT Manager travelled to Dire Dawa, Bahir Dar (in Amhara), and Mekelle (in Tigray) regional offices and installed server racks, mounted racks to maintain network cables that interconnect the various devices, and facilitated VPN configuration. He also checked the completed installation for proper functionality. Now the regional offices are fully functional in terms of network cabling and configuration.

3.4 Procurements

4. Challenges

The following challenges were experienced this quarter. Where possible, actions were taken to try to address the difficulty or resolve bottlenecks.

External challenges

- Starting the study on urban CBHI in Ethiopia has been delayed [redacted] The Program held discussions with EHIA to determine the study focus, ways to minimize the budget implications of the expanded study, and the time it will take to finalize the study.
- A decision made by the Addis Ababa City Administration Health Bureau to scale up CBHI in all of its woredas before sufficient preparation took place has caused challenges in identifying the correct eligible target population during mobilization activities. The Program continues to advise EHIA and the Addis Ababa City Administration Health Bureau on the potential negative effect this can have on sustainability of the CBHI program. To minimize further challenges, the Program supported training to scheme and section staff by revising the training contents to accommodate existing staff from all woredas and sub-cities. The Program shared the costs of training with the Bureau.
- The high attrition rate of trained CBHI scheme staff following the recent changes in the job evaluation and grading system (e.g., in Addis Ababa City Administration) puts pressure on the Program to support training for newly hired staff on an ongoing basis to address the capacity gap. In addition, the Program faces challenges in getting information related to implementation of CBHI as CBHI data management is affected in the interim gap between when staff leave and new staff start. The Program is using its supportive supervision mechanisim to capacitate some of the newly recruited staff.
- The GOE is not performing institutionalization-related activities at the expected speed. The Program is using various platforms to urge the MOH and the directorates under it to expedite the activities.

5. Lessons Learned

The following lesson was learned this quarter:

- The MOH instructed the Program not to include the private wing and user-fee revision HCF reform components in the revised prototype HCF implementation manual. This indicates that these components may not mature sufficiently for institutionalization in the near future. Having learned this, the Program will focus on transitioning first generation reforms as a package, and the institutionalization of private wing and user fee revision will be subject to MOH decision.

6. Quarterly Expenditure and Accrual Report

Budget and Expenditures

Period: October1, 2019 – December 31, 2019

Total Program Ceiling: [redacted]

Obligation: [redacted]

Expenditures to date by line item

Line Item	Total Budget	Total Accumulated Expenses as of Sept 30, 2019	Y2 Q1 (Oct - Dec 2019)			Total Expenditures to Date	Remaining Funds
			Actuals	Accruals	Actuals + Accruals		
Labor - Rockville Staff	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Labor - Site Office Staff	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Fringe Benefits	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Overhead	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Consultants	[redacted]		[redacted]		[redacted]	[redacted]	[redacted]
Travel	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Other Direct Costs	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Grants	[redacted]		[redacted]		[redacted]	[redacted]	[redacted]
Subawards	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Other Indirect Costs	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Total Obligated Funds: $ [redacted]

Total Expensed Funds: $ [redacted]

% Obligated Funds Expensed: [redacted]

Total Obligated Funds Remaining: $ [redacted]

7. Planned Activities for Next Quarter

- Complete the assessment report on the implementation of CBHI in urban settings.
- Complete the political economy study.
- Complete the CBHI zonal pooling study.
- Develop comprehensive HCF reform implementation training-of-trainers modules for use by universities/ISTs.
- Complete report on IST readiness assessment.
- Facilitate prototype HCF implementation manual approval and adaptation by RHBs.
- Support zonal-level bi-annual review meetings for CBHI.
- Start the development of a domestic resource mobilization road map to accompany the revised HCF Strategy.
- Provide technical assistance on the revision of the operational framework/tool for priority public health programs, including HIV/AIDS.
- Support/participate in integrated supportive supervision organized by the MOH and RHBs.
- Start assessment of the trends in budget allocation for priority public health programs including HIV/AIDS.
- Finalize medical audit manual.
- Support RHBs to adapt the prototype organizational structure for the institutionalization of the HCF reform implementation.
- Complete configuration of DHIS2 for the Program.

Annex A: Cumulative List of Deliverables

The cumulative list of deliverables completed through Y2Q1 is provided in the below table. The list also indicates the status of posting deliverables to USAID's Development Experience Clearinghouse (DEC).

Deliverable Title	Author	Program year and quarter completed	Posted to DEC (Y/N)	Comments
Program				
USAID Health Financing Improvement Program Annual Performance Report: Year 1 (October 2018 – September 2019)	USAID Health Financing Improvement Program	Y2Q1	N	Redacted version pending Agreement Officer's Representative (AOR) review and approval for DEC submission.
Quarterly Newsletter of the USAID Health Financing Improvement Program Vol 1. No 2 • September 2019	USAID Health Financing Improvement Program	Y2Q1	N	Posting to DEC TBD pending AOR guidance.
IR 1				
Revised Health Care Financing Implementation Manual	MOH	Y2Q1	N	Produced by the Program for the MOH. GOE documents may not need to be posted to DEC, pending AOR confirmation.
IR 4				
Roadmap for Institutionalizing First Generation Health Care Financing Reforms in Five Agrarian Regional States and Two City Administrations	MOH	Y2Q1	N	Produced by the Program for the MOH. GOE documents may not need to be posted to DEC, pending AOR confirmation.

Annex B: International STTA

International STTA visits that took place during Y2Q1 are provided in the table below.

Name	Arrival	Departure	Scope of Work
[redacted], Portfolio Manager, Abt Associates	Oct 9, 2019	Oct 25, 2019	Provided technical assistance for designing capacity-building activities as part of transitioning HCF reform activities through selected ISTs. Provided training to Program staff on instructional design and development of modules, Outlined framework to help package the trainings envisioned to be transitioned through ISTs.
[redacted], Technical Advisor, Abt Associates	Oct 23, 2019	Nov 6, 2019	Provided technical assistance for the development of USAID Health Financing Improvement Program First Generation Health Care Financing Reforms Transition Action Plan for Year 2, reviewed the First Generation HCF Reforms Institutionalization Roadmap and discussed its refinement and finalization with the senior management and technical team, and reviewed HCF implementation manual and other technical documents.
[redacted], M&E Specialist, Abt Associates	Dec 11, 2019	Dec 18, 2019	Provided technical assistance in the review of the current MEL system and program design with the purpose of enhancing Program learning, participated in the kick-off meeting to launch DHIS2 configuration, reviewed the learning agendas in alignment with the journey to self-reliance principles, identified existing data/evidence for learning based on the learning agenda, and participated in the interview of shortlisted applicants for the MEL officer position
[redacted], Director Global Security, Abt Associates	Oct 15, 2019	Oct 24, 2019	Met with senior team, U.S. Government Regional Security Officer and other Organization Security Focal to review country-specific policies and procedures, conducted physical review of office premises, developed safety and security training for staff and shared with members of senior management team, and advised Program team on essential safety and security precautions related to threats from civil unrest or violence.

Annex C: Indicator Reporting

USAID Health Financing Improvement Program Indicators Table – Y2 Q1 Update

Indicators		Disaggregates	Frequency	Baseline	Targets		Actuals	
					Y1 Target	Y2 Target	Y 1 Actual	Y2 Q1 Actuals
Strategic Objective: Improved institutional capacity and health financing functions and systems in Ethiopia								
1	Health service utilization rate	Region, insured/uninsured	Annually (Starting from Y2)	0.67	N/A	0.73		
2	Share of out-of-pocket expenditure to total health expenditure	Public health facility/Private health facility	At baseline, Year 3 and Year 5	33%	N/A	N/A	30.6%	
3	Number of individuals who received in-service trainings	Region, training type, participant type and gender, urban/rural	Quarterly	0	3,414	2,236	2,002	1,423
IR 1—Increased domestic resource mobilization for enhanced provision of quality PHC services								
1.1	Percent of domestically mobilized resources for the health sector	N/A	Year 1, Year 3, Year 5	64%	64%	N/A	64.8%	
1.2	Percent of donor contribution to the health sector	N/A	Year 1, Year 3, Year 5	36%	36%	N/A	35.2%	
SR 1.1— Availability of operational funds increased at PHC facilities through revenue retention and utilization								
1.1.1	Percent of public health facilities using retained revenue for facility and service improvement	Region, facility type (health center, hospital)	Annually	91%	91%	91%	93%	
1.1.2	Percent of health facility budgets made up by retained revenue	Region, facility type (health center, hospital)	Annually	30%	31%	32%	30.2%	
1.1.3	Percent of health facility retained revenue being used for drugs, medical equipment, and facility renovation	Region, facility type (health center, hospital)	Annually	75%	76%	77%	77%	

Indicators		Disaggregates	Frequency	Baseline	Targets		Actuals	
					Y1 Target	Y2 Target	Y 1 Actual	Y2 Q1 Actuals
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	Annually	40% (113/280)	40%	40%	36%	
1.2.2	Percent cost reduced/saved from interventions on efficiency improvement (of the outsourced services)	Region	Baseline, Year 2 and end-line	TBD	N/A	TBD	TBD	
1.2.3	Number of private enterprises engaged in outsourcing services	Region, type of services	Annually, starting Year 2	113	130	143	216	
1.2.4	Number of job opportunities created as a result of outsourcing non-clinical services	Gender, region, type of services	Annually, starting Year 2	1,695	1,950	2,145	1,384	
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	Year 1, Year 3, end-line	6.65%	7%	N/A	9%	
1.3.2	Availability of a fiscal space and international best practice analysis report on innovative domestic financing	N/A	Year 2	0	-	Yes	-	
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	Year 2	0	-	-	-	

Indicators		Disaggregates	Frequency	Baseline	Targets		Actuals	
					Y1 Target	Y2 Target	Y 1 Actual	Y2 Q1 Actuals
IR 2—Streamlined risk-pooling mechanisms for wider access to PHC services with reduced financial barriers								
2.1	Percent of population enrolled in health insurance programs	Region, scheme type	Annually	20%	25%	32%	24.8%	
2.2	Re-enrollment rate in CBHI schemes (renewal)	Region, urban/rural	Annually	75%	75%	76%	74%	
2.3	Share of expenditure from prepayment (insurance) funds in total health expenditure	NA	Annually	TBD	N/A	N/A	0.54%	
SR 2.1 and 2.2— CBHI rolled out, institutionalized, and consolidated in the rural districts of the 4 agrarian regions and urban setting								
2.1.1	Percent of schemes bankrupted	Region, urban/rural	Annually		13.8	TBD	13.8	
2.1.2	Number of new functional CBHI schemes established with program support in urban and rural woredas	Region, urban/rural	Annually	357 (321 rural, 36 urban)	174	54	149	
2.1.3	Percent of CBHI schemes audited per year (financial) in rural and urban woredas	Region, urban/rural	Annually	43% (36% rural 50% urban)	60%	75%	41%	
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	Region, urban/rural	Annually	18%	22%	40%	23%	
2.3.2	Number of woreda governments that allocated/transferred full budget to cover targeted poor households under CBHI schemes	Region, rural/urban	Annually	357	531	585		
2.3.3	Number of CBHI woredas that are harmonized with safety-net targeting criteria	Region, rural/urban	Annually	0	TBD	TBD		

Indicators		Disaggregates	Frequency	Baseline	Targets		Actuals	
					Y1 Target	Y2 Target	Y 1 Actual	Y2 Q1 Actuals
2.3.4	Percent of female headed indigent households among the total indigent households enrolled in CBHI schemes	Region	Annual starting Year 2	TBD	30%	N/A	30%	
2.3.5	Percent of CBHI board with at least one woman board member	Region	Annual starting Year 2	TBD	N/A	N/A		
SR 2.4— SHI program launched and implemented								
2.4.1	Existence of functional SHI technical working group	N/A	Quarterly	No	Yes	N/A	Yes	Yes
2.4.2	Availability of phased implementation plan for initiation and scale up of SHI	N/A	Year 2	No	-	Yes		
IR 3—Improved arrangements for strategic purchasing of health services from public and private providers								
3.1	Percent of health facility claims audited	Region	Annually	79%	100%	100%	80%	
SR 3.1— Comprehensive organizational structure for health insurance designed and implemented								
3.1.1	Percent of schemes staffed as per the organizational structure	Region	Annually	86%	100%	100%	86%	
SR 3.2— Tools to facilitate periodic revision of user-fee schedules implemented								
3.2.1	Availability of user-friendly health service costing tool and operational manual	N/A	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	Year 3	0	-	Yes		
SR 3.4— Quality assurance standards developed and piloted								
3.4.1	Availability of quality assurance standards developed and piloted	N/A	Year 2	No	-	Yes		

Indicators		Disaggregates	Frequency	Baseline	Targets		Actuals	
					Y1 Target	Y2 Target	Y 1 Actual	Y2 Q1 Actuals
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)	Annually	90%	90%	90%	93%	
4.2	Percent of woreda health offices generated HCF related evidence	Region	Year 2, 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 with functioning resource mobilization structure	Region	Annually	1	1	4	1	
4.1.2	Availability of self-assessment tools	N/A	Year 2	0		Yes		
SR 4.2— Health facilities are managed by functional governing boards with community representations								
4.2.1	Percent of health facilities with 2 or more women board members participating in the health facility board meeting	Facility type (health center, hospital),	Annually	35.80%	36%	49%	35.8	
4.2.2	Percent of health facilities with community participation in board meetings	Facility type (health center, hospital)	Annually	85.00%	85%	95%	85%	
SR 4.3— Institutional arrangements and standard operating procedures for private wings improved								
4.3.1	Number of public hospitals with private wings established	Federal, region, hospital type	Annually	63	37	38	49	
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	Year 2, Year 3	0		4		

Indicators		Disaggregates	Frequency	Baseline	Targets		Actuals	
					Y1 Target	Y2 Target	Y 1 Actual	Y2 Q1 Actuals
4.4.2	Number of operations research/studies/surveys conducted and results/reports disseminated/published	Type of study	Annually	-	2	2	1	
4.4.3	Number of reports, success stories, and newsletters developed and disseminated	Type of document	Quarterly	-	8	12	7	3
4.4.4	Number of review meetings and policy dialogues organized	Federal, regional, zonal	Quarterly	-	47	136	61	30
4.4.5	Number of health facilities visited through supportive supervision visits	Federal, regions, facility type	Quarterly	-	274	196	147	39
4.4.6	Number of CBHI schemes visited through supportive supervision visits	Federal, regional	Quarterly		215	213	189	53

Annex D: OneHealth Tool Training Participant List

Training Workshop on Strategic Planning and Costing Using the OneHealth Tool

November 18-23, 2019

Participant List by Training Group

Group 1: MCH and Nutrition Costing Team 1. Dr Mulat Adefris (Maternal) 2. Dr. Yared Tadesse (Child Health) 3. Mulat Nigus (EPI) 4. Dr. Belaynesh Yifru (Nutrition) 5. Genet Dress (FP) 6. Aster Teshome (AYH) 7. Sr. Zebideru Zewdie (PMTCT) 8. Dr Muluken Yohannes (MDU) 9. Dr Lisanu Tadesse (MDU) 10. Zenebe Akale (Maternal) 11. Tamrat (PPMED) 12. Mebrahtom Belay (PPMED)	**Group 2: Primary Health Care, Hygiene and Environmental Health Costing Team** 1. Kasahun Sime 2. Sorsa Faltamo 3. Abriham Misganaw 4. Dr. Tamiru Wonde (MDU) 5. Yitna (PPMED)
Group 3: Disease Prevention and Control Costing Team (HIV, TB, Malaria, NCD, Mental Health, NTD) 1. Dr Zerihun Hika (HIV) 2. Afendi Ousman (NCD) 3. Dr Dereje Aseffa (Mental Health) 4. Kadu Meribo (NTD) 5. Demelash Assefa (TB) 6. Gezahagn Tesfaye (Malaria) 7. Dr Awoke Misganaw (GBD) 8. Dr Sentayehu (MDU) 9. Selam (PPMED) 10. Almaz (PPMED)	**Group 4: Medical Services (Quality, Clinical, Emergency Medical Services), and Blood Bank Costing Team** 1. Dr Fitsum Kibret 2. Naod Wendrad 3. Sr. Fatuma Ebrahim 4. Dr. Daniel Gebremichael (MDU) 5. Shegaw Mulu (PPMED) 6. Yaregal Bante (Blood Bank)
Group 5: Human Resources Costing Team 1. Mohamed Husien (MoH) 2. Solomon W/Amanuel (MoH) 3. Ketema (PPMED)	**Group 6: Research, Information Costing Team** 1. Netsanet Animut (PPMED) 2. Eskedar Ameneshewa (AHRI) 3. Eyerus (PPMED) 4. Gezahegn Feyisa (HITD) 5. Gadisa Lamecha (PPMED) 6. Dr. Kedir (PPMED)
Group 7: Supply Costing Team 1. Tsegaye Mebrahtu (EPSA) 2. Sofiyan Abdulber (PLMSD) 3. Yordanos Gidey (PPMED)	**Group 8: Public Health Infrastructure Costing Team** 1. Samuel Kebede (PHID) 2. Wubishet Temesgen (PPMED)

Group 9: EPHI: Public Health Emergency; Traditional Medicine Costing Team 1. Ato Gonfa Ayana 2. Dr. Assefa Deressa 3. Dr. Asfaw Debella 4. Muluken (EPHI Plan) 5. Dr. Feyisa Regassa (EPHI) 6. Dr. Wakgari Deressa (PPMED)	**Group 10: Regulatory, (FDA, Health service regulation, License) Costing Team** 1. Abiyot Aschenaki (FDA) 2. Lesanework Alemu (FDA) 3. Assegid Bekele (Health Inspectorate) 4. Eden Workineh (License)
Group 11: Health Care Financing, including Fiscal Space Analysis Costing Team 1. Mesfin Kebede (PCD) 2. Nishali Patel (PCD) 3. Ataklti Abrha (EHIA) 4. Ermias (PCD) 5. Tseganeh (WB) 6. Tesfaye (PCD)	**Group 12: Equity Costing Team** 1. Dr Wakgari Deressa (PPMED) 2. Hintsa (HSSD)