USAID
FROM THE AMERICAN PEOPLE

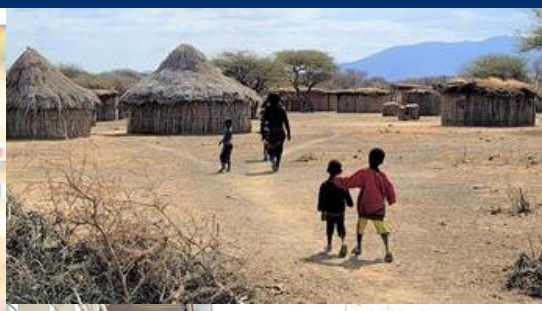
USAID Health Financing Improvement Program

ANNUAL PERFORMANCE REPORT

YEAR 3

(OCTOBER 1, 2020 - SEPTEMBER 30, 2021)





October 2021

This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the USAID Health Financing Improvement Program and do not necessarily reflect the views of USAID or the United States Government.

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, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard T.H. Chan School of Public Health.

October 2021

USAID Cooperative Agreement No: 72066319CA00001

Submitted to: Dr. Helina Worku, Alternate Agreement Officer's Representative
USAID Health Financing Improvement Program
USAID/Ethiopia Health Office

Recommended Citation: USAID Health Financing Improvement Program. October 2021. *USAID Health Financing Improvement Program Annual Performance Report Year 3 (October 1, 2020 – September 30, 2021).* Rockville, MD: USAID Health Financing Improvement Program, Abt Associates.

Cover Photos: Credit: Ayenew Haileselassie, Abt Associates.

Abt Associates
6130 Executive Boulevard | Rockville, Maryland 20853
T: 301.347.5000 | F: 301 652.3916 | www.abtassociates.com

CONTENTS

LIST OF TABLES AND FIGURES

ACRONYMS

AACA	Addis Ababa City Administration
BOFEC	Bureau of Finance and Economic Cooperation
BOFED	Bureau of Finance and Economic Development
CBHI	Community-Based Health Insurance
CHAI	Clinton Health Access Initiative
COVID-19	Coronavirus Disease 2019
CPD	Continuing Professional Development Center
DDCA	Dire Dawa City Administration
DEC	Development Experience Clearinghouse
DRM	Domestic Resource Mobilization
DRMS	Domestic Resource Mobilization and Sustainability (Strategy 2020-2025)
DRS	Developing Regional States
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
EPSA	Ethiopian Pharmaceuticals Supply Agency
FGB	Facility Governing Board
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMC	Facility Management Committee
GOE	Government of Ethiopia
HCF	Health Care Financing
HAPCO	HIV/AIDS Prevention and Control Office
IR	Intermediate Result
MEL	Monitoring, Evaluation, and Learning
MOF	Ministry of Finance
MOH	Ministry of Health
N/A	Not Applicable
PCD	Partnership and Cooperation Directorate
PHC	Primary Health Care
Q1, Q2, Q3, Q4	Quarter 1, Quarter 2, Quarter 3, Quarter 4
RHB	Regional Health Bureau
RRU	Revenue Retention and Utilization
SHI	Social Health Insurance

SNNP	Southern Nations, Nationalities, and Peoples' (Region)
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
WOFEC	Woreda Finance and Economic Cooperation (Office)
WorHO	Woreda Health Office
Y1, Y2, Y3, Y4	Year 1, Year 2, Year 3, Year 4
ZHD	Zonal Health Department

EXECUTIVE SUMMARY

This annual performance report describes the progress and key accomplishments, lessons learned, and challenges experienced by the USAID Health Financing Improvement Program during Year 3 of Program implementation (October 1, 2020, through September 30, 2021). Key accomplishments for the year include:

- Completed putting in place nearly all system elements needed to finalize the institutionalization and transition of first-generation health care financing (HCF) reforms. The remaining steps are delayed primarily by prolonged counterpart processes to endorse the HCF implementation manual and to plan and engage continuing professional development centers to provide training.
- Supported the Ethiopian Health Insurance Agency in advancing the community-based health insurance (CBHI) proclamation endorsement process, including orienting members of the Social Standing Committee of the House of Peoples' Representatives on the contents of the proclamation.
- Conducted studies to generate evidence on HCF and CBHI reforms. The studies completed include: the assessment of the East Gojjam CBHI zonal pool, political economy analysis of domestic resource mobilization for health, and two rapid assessments of CBHI implementation experience in pastoralist settings (one in Oromia and one in SNNP).
- Supported health bureaus in establishing HCF technical working groups that will coordinate, technically support, and monitor HCF activities in their regions, and serve as a clearinghouse that will disseminate HCF learning.
- Arranged training for 3,630 individuals on CBHI topics (2,924) and first-generation HCF reform training and facilitation skills (706).

The Program was not able to carry out many field-based activities in Tigray due to unsafe and insecure conditions in the region caused by a conflict between the Tigray People's Liberation Front and the federal government, which started in the first quarter and continued throughout the year. The Tigray conflict also affected some Program activities in the neighboring regions of Afar and Amhara.

In light of the continuing COVID-19 pandemic and increasing cases in Ethiopia, the Program instituted safety precautions that were in compliance with Ethiopian government regulations and Abt policies to mitigate the spread of the disease.

1. INTRODUCTION

The USAID Health Financing Improvement Program supports the government of Ethiopia (GOE) in further strengthening and institutionalizing health care financing (HCF) functions and systems that support universal health coverage of quality primary health care (PHC) services for Ethiopian citizens with reduced financial barriers. The five-year (2018–2023), $39.6 million activity works throughout the country at the national, regional, woreda, and health facility levels.

The Program works in close collaboration with the GOE to achieve four program objectives/ intermediate results (IRs):

- IR 1: Increased domestic resource mobilization (DRM) for enhanced provision of quality PHC services.
- IR 2: Streamlined pooling of risk-sharing/insurance mechanisms for wider access to PHC services with reduced financial barriers.
- IR 3: Facilitated strategic purchasing of health services from public and private health providers.
- IR 4: Improved governance, management, and evidence generation for HCF reforms and health facilities.

In Year 3 (Y3), the Program focused on:

- Completing institutionalization of first-generation HCF reforms in the agrarian regions regions, the two major city administrations and Harari.
- Consolidating and institutionalizing the implementation systems for community-based health insurance (CBHI).
- Expanding HCF reforms, including CBHI, in Developing Regional States (DRS).
- Introducing new initiatives to further solidify the ongoing HCF reforms.
- Strengthening evidence generation and performance review of HCF reforms' implementation.

This annual performance report begins by describing key Program activities and accomplishments for Y3, by IR, followed by a success story, and monitoring, evaluation, and learning (MEL) achievements. It also discusses management and operations activities, challenges, and lessons learned during the year and Y4 prospects. The report concludes with the annual expenditure and accrual report. A cumulative list of Y3 deliverables is included in Annex A, and performance by indicator is in Annex B.

When referring to regions, the following groups are used, where relevant:

- Agrarian regions: Amhara, Oromia, Sidama, Southern Nations, Nationalities, and Peoples' (SNNP) region, and Tigray.
- City administrations and Harari region: Addis Ababa City Administration (AACA), Dire Dawa City Administration (DDCA), and Harari region. Though Harari is administratively a region, it has predominantly urban characteristics and, therefore, is grouped with AACA and DDCA.
- DRS: Afar, Benishangul-Gumuz, Gambella, and Somali. DRS are primarily populated by pastoral and highly-mobile communities where the rollout of reforms is relatively new.

A conflict in Tigray between the Tigray People's Liberation Front and the federal government began in the first quarter of Y3 (November 2020) and persisted throughout the year. Instability, insecurity, and infrastructure disruption was ongoing in Y3 and the majority of planned field-based activities in Tigray

could not be carried out. Data related to first-generation HCF reforms and CBHI in Tigray are also unavailable this year, so Tigray data in this report are limited to what was most recently available or not reported. The Tigray conflict also affected neighboring regions Amhara and Afar, which affected some Program activities. Sporadic security concerns in other regions such as Benishangul-Gumuz and Oromia also led to some activity delays.

2. KEY ACTIVITIES AND ACHIEVEMENTS

IR 1: INCREASED DOMESTIC RESOURCE MOBILIZATION FOR ENHANCED PROVISION OF QUALITY PHC SERVICES

The Program worked with local counterparts to institutionalize and complete transition of first-generation HCF reforms in reform-advanced regions and city administrations. The activities and accomplishments related to this work are described under IR 4. With respect to overall national-level implementation of first-generation HCF reforms, including the most recently available data for Tigray (September 2020), the following results were attained by the end of Y3:

- Of the 4,095 functional health facilities in the country, 3,841 (94%) were implementing the retained revenue and utilization (RRU) reform during Y3. This exceeds the Program's 91% target. In total, 578 new health facilities became functional during the year and 348 health facilities started implementing RRU.
- 134 hospitals (40% of all functional hospitals) had outsourced at least one non-clinical service. No new hospitals started outsourcing in Y3. One hospital that was implementing the reform in Y2 stopped doing so.
- 45 hospitals (13.5% of all functional hospitals) had established a private wing. This is two hospitals fewer than in Y2.
- Nearly all (4,087) health facilities have established a facility governing board or management committee (FGB/FMC); of these, 3,704 (91%) are functional.[1]

The Program's target of 90% of health facilities implementing RRU and having a functional FGB/FMC has been consistently achieved or exceeded over the life of the project, including in this year. The percentages of facilities implementing the private wing and outsourcing reforms are below the 90% target. Counterparts have no interest in advancing the private wing HCF reform.

Table 1 summarizes the number of health facilities implementing first-generation reforms in the agrarian regions, DRS, city administrations, and Harari in Y3. The implementation of RRU in the agrarian regions and city administrations remains high. In the DRS, work is being done to further expand RRU implementation. Of all DRS, CBHI performance in the Somali region is the lowest. This is because the regional government, including the regional health bureaus (RHBs), are not giving sufficient attention to implementing HCF reform activities. In Y3, the Program organized a high-level health financing workshop in the region, with the objective of helping members of regional cabinets in Somali region to understand the implementation status of HCF reforms and how to address major roadblocks that contribute to the slow pace of implementation in the Somali region.

[1] Although the Program's cooperative agreement reflects the FGB/FMC first-generation HCF reform under IR 4, it is presented here as part of the overall discussion about first-generation reforms.

Table 1: Number of health facilities implementing RRU, hospitals outsourcing non-clinical services, hospitals with private wings, and health facilities with functional FGB/FMCs, Y3

Regional group	Region	# Functional HFs		# HFs implementing RRU		# Hospitals established private wing	# Hospitals outsourcing non-clinical services	# HFs with functional FGB/FMCs	
		HCs	Hospitals	HCs	Hospitals	Hospitals	Hospitals	HCs	Hospitals
Agrarian	Amhara	862	83	862	83	2	45	862	83
	Oromia	1,410	95	1,410	95	24	54	1,264	95
	Sidama	135	21	135	21	0	3	135	21
	SNNP	593	59	588	59	0	12	588	59
	Tigray*	245	38	226	38	13	2	245	38
	Subtotal	3,245	296	3,221	296	39	116	3,094	296
DRS	Afar	94	7	67	7	0	4	46	7
	BG	62	6	62	6	2	2	62	6
	Gambella	27	5	27	5	0	1	27	5
	Somali	208	12	9	10	0	4	24	12
	Subtotal	391	30	165	28	2	11	159	30
City Administrations and Harari	AACA	101	6	99	6	3	5	99	
	DDCA	15	2	15	2	1	1	15	2
	Harari	8	1	8	1	0	1	8	1
	Subtotal	124	9	122	9	4	7	122	3
Total		**3,760**	**335**	**3,508**	**333**	**45**	**134**	**3,375**	**329**

Note: HF=health facility; HC=health center; BG=Benishangul-Gumuz

* Data for Tigray is as of September 2020

Initiated an assessment on the contribution of RRU to quality improvement at health facilities: The main objective of the RRU HCF reform is to increase the resource base that health facilities can draw on to make service delivery quality improvements. To generate evidence on the contribution of RRU to the quality of health services, the Program initiated an assessment of selected health centers located in Amhara, Oromia, SNNP, and AACA. The study protocol and data collection tools were developed, and the tools were pilot tested in the field. The data collection and the overall study will be completed in Y4.

S***upported FHAPCO in organizing advocacy forums on increased DRM for HIV/AIDS:*** The Federal HIV/AIDS Prevention and Control Office (FHAPCO), which coordinates the country's HIV response, developed a draft HIV/AIDS Domestic Resource Mobilization and Sustainability (DRMS) Strategy 2020-2025. The strategy aims to scale up, standardize, and align resource mobilization initiatives with the continued needs of the HIV program. It is currently being reviewed by stakeholders to facilitate its endorsement by the Council of Ministers. The Program supported FHAPCO in organizing a two-day consensus-building workshop with officials from the Ministry of Finance (MOF) and senior-level FHAPCO personnel. The purpose of the meeting was to create understanding of the rationale for the strategy among MOF staff and was used as a platform to get inputs to further refine the draft strategy.

Supported FHAPCO in developing national-level legal frameworks to guide implementation of the HIV/AIDS DRMS Strategy 2020-2025: The DRMS Strategy, developed by a technical working group (TWG) established by FHAPCO and of which the Program is a member, is awaiting endorsement by the Ministry of Health (MOH) and the Council of Ministers. The Program provided technical support to FHAPCO in revising its proclamation and developing a regulation and directive that can enable the effective implementation of the major initiatives included in the draft Strategy. The Program provided technical assistance to FHAPCO's legal consultant on the areas of the strategy that should be included in the proclamation.

Supported AACA HAPCO in various activities related to HIV/AIDS DRMS Strategy: The Program provided technical assistance to AACA HIV/AIDS Prevention and Control Office (HAPCO) to undertake the following activities:

- *Supported AACA HAPCO in establishing a TWG to adapt and support implementation of the HIV/AIDS DRM Sustainability Strategy:* The Program provided technical assistance to the AACA HAPCO in establishing a TWG responsible for adapting the HIV/AIDS DRMS Strategy for use in the city administration. The program developed terms of reference (TOR) to guide the establishment of the TWG, including defining member composition, roles and responsibilities, and working modalities. The TOR was endorsed by the AACA HAPCO after series of consultation with stakeholders. The TWG is made up of personnel from the Bureau of Finance, Bureau of Labour and Social Affairs, Bureau of Women and Children Affairs, Addis Ababa Network of PLHIV Association, AACA Health Bureau, AACA HAPCO, and the Program.
- *Supported an assessment of AACA's implementation of four HIV/AIDS DRMS Strategy initiatives:* The Program supported the AACA HAPCO in conducting an assessment of its implementation of the first four DRMS Strategy initiatives (i.e., government budget allocation and execution for HIV, implementation and management of AIDS fund, funds mainstreamed for HIV within priority sectors, and community coalitions). The assessment report was shared with the AACA HAPCO TWG. Based on recommendations of the assessment, the TWG and AACA HAPCO agreed to have regular joint-review forums with different sector bureaus to discuss performance and challenges, and develop an action plan to coordinate resource mobilization and allocation. AACA also pledged to pool 50% of the HIV/AIDS mainstreaming budget from all sector offices and transfer it to the AACA HAPCO account to use in strengthening AACA's HIV mainstreaming activities based on the assessment recommendations. The source of this budget is the 1% HIV mainstreaming budget of the different sectors.
- *Supported AACA HAPCO in developing a sustainable financing plan for HIV/AIDS in Addis Ababa:* The Program supported the AACA HAPCO in developing a phased plan for sustainably financing the HIV/AIDS program from domestic sources. The plan includes the magnitude of resources that can be mobilized from various domestic financing sources and how donor funding will be replaced gradually with domestic financing. As part of this effort, the Program organized a three-day planning workshop in collaboration with the AACA HAPCO to review and finalize the plan.

Conducted an analysis of the political economy of DRM for health: The objective of the political economy analysis was to understand the political economy context, the constraining and enabling factors, and the interests of actors and stakeholders related to DRM for health. The results of the analysis can strengthen the MOH's advocacy to decision-makers including their finance and revenue counterparts, legislators, and other stakeholders, 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. This analysis builds on the fiscal space analysis that was conducted by the Program in Y2, which helped to identify potential alternative ways to increase domestic resources for health.

Provided technical assistance related to corporate social responsibility: The Program provided technical assistance to SNNP and Sidama regions in developing region-specific guidelines for documenting their experiences in mobilizing resources through corporate social responsibility.

IR 2: STREAMLINED RISK-POOLING MECHANISMS FOR WIDER ACCESS TO PHC SERVICES WITH REDUCED FINANCIAL BARRIERS

In Y3, the Program planned to support local counterparts in rolling out CBHI nationwide, streamlining the viability and management of CBHI pools, and solidifying standardization of targeting for safety-net programs and for CBHI schemes related to the provision of support and financial protection for the poor/indigent. Throughout the year, the Program provided technical assistance and training, and support for thematic meetings, and performance reviews. This assistance contributed to the further expansion of CBHI and resolved some of the operational challenges of CBHI implementation by the regions. Program support per region is detailed in the reporting by regional group below.

At the end of Y3, 907 (637 rural and 270 urban) woredas in regions across the country were implementing a CBHI scheme, exceeding the Program's annual target of 825. Of the 907 woredas, 720 (582 rural and 138 urban) schemes are fully operational and providing benefit coverage, and therefore financial protection, for their members/beneficiaries (Table 2). These figures and all data presented under IR 2 do not reflect data from Tigray. Refer to the region-specific activities for a summary of what the Program was able to accomplish in Tigray.

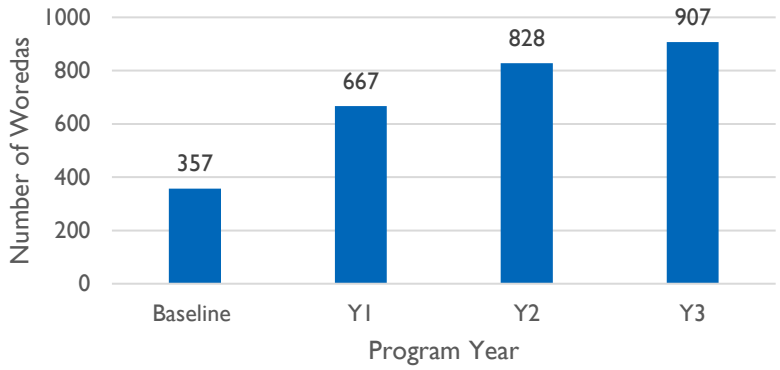
Table 2: Number of woredas implementing CBHI in Ethiopia, Y3

Regional group	Region	# Woredas			# CBHI-implementing woredas EFY 2013 (2020/21)			# Functional schemes EFY 2013 (2020/21)		
		Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Agrarian	Amhara	143	41	184	143	41	184	141	38	179
	Oromia	290	46	336	290	46	336	282	42	324
	Sidama	30	14	44	30	14	44	17	14	31
	SNNP	152	42	194	151	41	192	133	32	165
	Tigray	34	18	52						
	Subtotal	649	161	810	614	142	756	573	126	699
DRS	Afar	35	5	40	5	0	5	2	0	2
	Benishangul-Gumuz	20	3	23	9	0	9	3	0	3
	Gambella	13	1	14	3	0	3	3	0	3
	Somali	93	6	99	3	1	4	1	0	1
	Subtotal	161	15	176	20	1	21	9	0	9
City Administrations and Harari	AACA*	0	120	120	0	120	120	0	10	10
	DDCA**	0	1	1	0	1	1	0	1	1
	Harari***	3	6	9	3	6	9	0	1	1
	Subtotal	3	127	130	3	127	130	0	12	12
	Total	**813**	**303**	**1,116**	**637**	**270**	**907**	**582**	**138**	**720**

*In Addis Ababa, all 120 woredas (also called sections) now are covered by 10 CBHI schemes established at the sub-city level. An 11th sub-city was recently added to Addis Ababa. The residents of this new sub-city can join one of the 10 schemes.
**The CBHI scheme is established at the city administration level in Dire Dawa. There are CBHI sections at the kebele level.

Figure 1 depicts the trend in CBHI woreda coverage for the past three years starting from the baseline. Y3 does not include data from Tigray; even without Tigray, there has been an increase from Y2.

Figure 1: Trend in numbers of woredas implementing CBHI, Y1–Y3



At the end of Y3, a total of 8.98 million households covering 41.6 million beneficiaries throughout the country were enrolled in CBHI (Table 3). This accounts for 40.4%[2] of the total population and exceeds the Program's 38% target. Of these, 1.73 million households covering 7.95 million beneficiaries were classified as poor/indigent, representing 19.1% of the total enrolled population and 32.8% of the total population below the poverty line.[3]

Table 3 shows CBHI enrollment rates by region. The rates show increases in almost all regions compared to the previous year. Along with the increase in woreda coverage, the number of people covered by the CBHI program has also increased as shown in Figure 2 for select regions.

Table 3: Number of CBHI households and beneficiaries enrolled in CBHI program, Y3

Regional group	Region	# Total CBHI-eligible HHs in EFY 2013 (2020/21)	# Total HHs enrolled EFY 2013 (2020/21)			# Total CBHI beneficiaries EFY 2013 (2020/21)	Enrollment rate (% of eligible HHs)
			Paying	Non-paying	Total		
Agrarian	Amhara	4,020,936	2,159,867	518,962	2,678,829	11,518,965	66.6
	Oromia	7,073,072	3,607,178	799,481	4,406,659	21,151,963	62.3
	Sidama	519,098	125,506	78,218	203,724	998,248	39.2
	SNNP	2,550,746	1,109,358	223,134	1,332,492	6,529,211	52.2
	Tigray						
	Subtotal	14,163,852	7,001,909	1,619,795	8,621,704	40,198,386	60.9
DRS	Afar	62,909	15,267	4,426	19,693	112,250	31.3
	Gambella	25,064	10,900	2,275	13,175	60,605	52.6
	BG	101,887	27,239	7,233	34,472	155,124	33.8
	Somali	75,393	17,613	3,562	21,175	139,755	28.1
	Subtotal	265,253	71,019	17,496	88,515	467,734	33.4

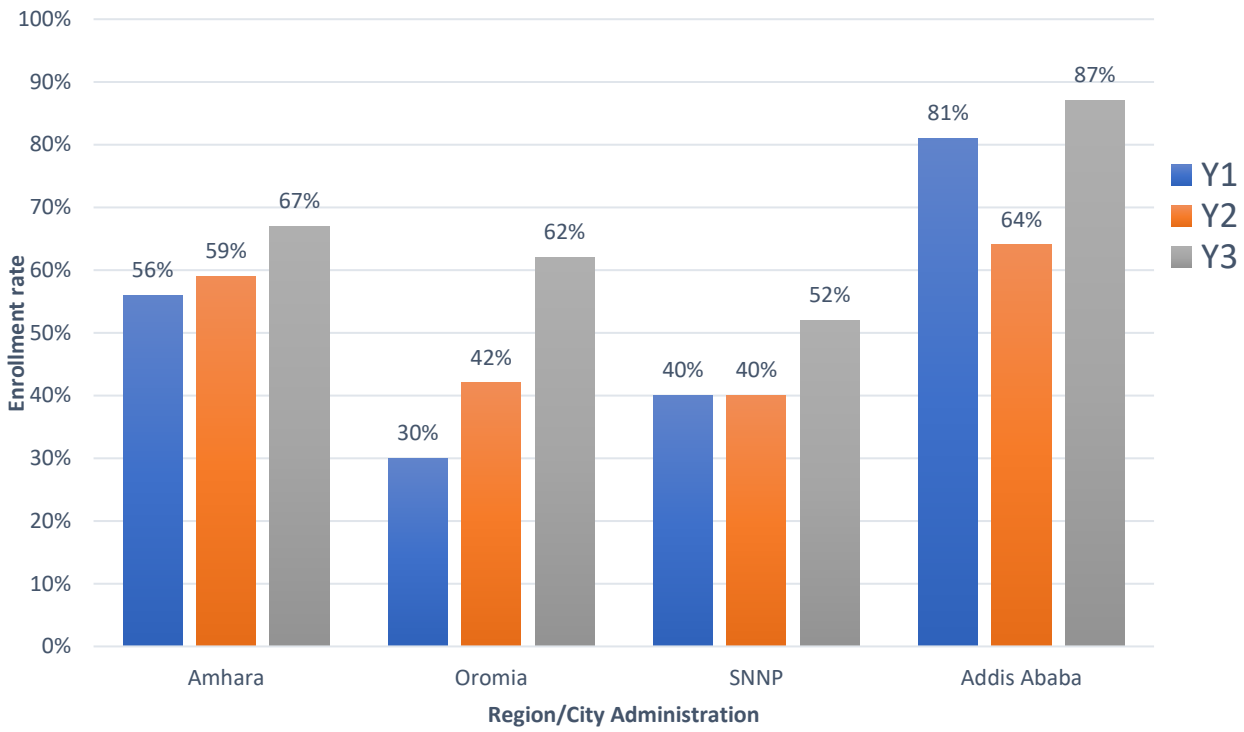
[2] According to the Central Statistics Agency census report (2007), the projected Ethiopian population is estimated to be 104,606,000 people in 2021.
[3] According to the Central Statistics Agency census report (2007), 23.5% of the Ethiopian population, or 24,204,530 people, are estimated to live below the poverty line.

Regional group	Region	# Total CBHI-eligible HHs in EFY 2013 (2020/21)	# Total HHs enrolled EFY 2013 (2020/21)			# Total CBHI beneficiaries EFY 2013 (2020/21)	Enrollment rate (% of eligible HHs)
			Paying	Non-paying	Total		
City Administrations and Harari	Addis Ababa	258,744	152,877	72,757	225,634	760,396	87.2
	DDCA	72,802	12,206	9,208	21,414	96,363	29.4
	Harari	49,047	19,053	7,353	26,406	102,983	53.8
	Subtotal	380,593	184,136	89,318	273,454	959,742	71.8
Total		**14,809,698**	**7,257,064**	**1,726,609**	**8,983,673**	**41,625,863**	**60.7**

HH=household; BG=Benishangul-Gumuz

Overall, the CBHI enrollment rate has shown incremental increases in the agrarian regions and AACA (regions and city administrations with complete data for three years). Figure 2 shows the enrollment rates in these areas for the past three years.

Figure 2: Trends in CBHI enrollment rates in the agrarian regions and AACA, Y1–Y3



As shown in Table 4, the total amount of money mobilized in EFY 2013 (2020/21) from paying-member contributions and from regional and local governments in the form of targeted subsidy for indigents was $61.16 million (84.6% from contributions and 15.4% from targeted subsidy). In addition, $6,115,842 in the form of general subsidy from the federal government was transferred to CBHI schemes, making the overall resource mobilized for the year $67,274,259. The Y3 Program target was to reach $58.5 million. This indicates that the achievement is 115% of the target (exceeding the target by $8.7 million). The CBHI program is an additional source of domestic revenue for the health sector and health providers in these regions.

Table 4: Resources mobilized from CBHI program, EFY 2013 (2020/21)

Regional Group	Region	Contribution (paying members) (Birr)	Targeted subsidy (Birr)	Total resources (Birr)	Total Resources (US$)*
Agrarian	Amhara	777,396,648	145,669,499	923,066,147	23,577,679
	Oromia	877,159,366	143,535,832	1,020,695,198	26,071,397
	SNNP	256,373,276	27,342,194	283,715,470	7,246,883
	Sidama	23,205,578	9,931,201	33,136,779	846,406
	Tigray				
	Subtotal	1,934,134,868	326,478,726	2,260,613,594	57,742,365
DRS	Afar	3,097,449	1,411,640	4,509,089	115,175
	BG	7,755,348	864,321	8,619,669	220,170
	Gambella	2,755,348	494,190	3,249,538	83,002
	Somali	4,599,964	1,370,250	5,970,214	152,496
	Subtotal	18,208,109	4,140,401	22,348,510	570,843
City Administrations and Harari	AACA	62,125,030	29,100,880	91,225,910	2,330,164
	DDCA	5,544,098	3,800,000	9,344,098	238,674
	Harari	6,462,055	4,357,860	10,819,915	276,371
	Subtotal	74,131,183	37,258,740	111,389,923	2,845,209
Total		**2,026,474,161**	**367,877,867**	**2,394,352,027**	**61,158,417**

*Annual average exchange rate used is 1 US$=39.15 Birr

Provided training on CBHI implementation: The Program arranged training for 2,924 scheme staff, health facility staff, and auditors working in four agrarian regions, four DRS, and two city administrations on CBHI concepts and principles, legal frameworks, financial management and auditing, and the medical audit (Table 5). In addition, the Program arranged a three-day master training of trainers (TOT) session on the medical auditing manual for staff of Ethiopian Health Insurance Agency's (EHIA's) Provider Affairs and Quality Assurance Directorate, the MOH Quality and Clinical Service Directorate, the Clinton Health Access Initiative (CHAI), and the Program, and a TOT training for 93 individuals selected from RHBs and other institutions. Overall, the Program exceeded Y3 targets in most regions by leveraging resources to train greater numbers of individuals. Costs for most of the trainings were shared with regional and city administration health bureaus and EHIA. Program staff arranged the trainings and served as trainers.

Table 5: Total number of trainees who attended CBHI trainings, Y3

Regional group	Region	Y3 target	Y3 accomplishment		
			Men	Women	Total
Agrarian	Amhara	245	633	205	838
	Oromia	661	725	274	999
	Sidama	42	52	28	80
	SNNP	320	418	164	582
	Tigray	190			
	Subtotal	1,458	1,828	671	2,499
DRS	Afar	101	18	2	20
	Benishangul-Gumuz	45	224	123	347
	Gambella	53	17	4	21
	Somali	166	16	5	21
	Subtotal	365	275	134	409
	AACA	30	0	0	0

Regional group	Region	Y3 target	Y3 accomplishment		
			Men	Women	Total
City Administrations and Harari	DDCA	10	7	9	16
	Harari	10	0	0	0
	Subtotal	50	7	9	16
Central		93	0	0	0
Total		**1,966**	**2,110**	**814**	**2,924**

Developed a TOR for the TWG that will prepare comprehensive CBHI training materials: The Program anticipates transitioning of CBHI training activities to government continuing professional development centers (CPDs). To support this, the Program handed over the existing CBHI training materials, which are being revisited and updated for use by the CPDs in the future. The Program assisted the MOH in preparing a TOR that guided the establishment and operationalization of a TWG that will develop the materials. The TWG members include experts from the Program, EHIA, and CHAI. The TWG is expected to take into account the latest CBHI legal frameworks, including the draft CBHI proclamation, regulation, and prototype directives, when updating the materials, and standardize the methodology and contents.

Developed a concept note on CBHI fund distribution across CBHI pool tiers: The draft CBHI proclamation allows for the gradual integration of CBHI schemes from the existing, fragmented woreda-level pools to more sustainable, larger, and broader zonal-, regional- and national-level pools. As per the current provision in the draft proclamation, two levels of higher-level pooling will be established: federal and regional. It also allows for the regional-level pool to be sub-divided into zonal- and woreda-level pools, depending on the context of the region. The Program produced and shared a concept note with EHIA that shows the percentage amount of pooled funds that will go to the different CBHI pool tiers (woreda, zonal, regional, and federal) based on variables that include the unit cost of services, utilization rate, and size of population utilizing the services. The concept note proposes the following:

- 64% of CBHI revenue would need to go to the primary-level tier (woreda-level pool) that finances CBHI beneficiary services at the health center and primary hospital level;
- 25% would go to the secondary-level tier (regional/zonal pool) that finances services at secondary hospitals and provides reinsurance to woreda pools; and
- The remaining 11% would go to the tertiary-level tier (federal pool) that finances services at tertiary hospitals and provides reinsurance to regional/sub-regional pools.

Provided technical assistance to EHIA in producing draft directive for CBHI zonal-level pool: The purpose of zonal-level pools is to cross-subsidize woreda-level CBHI schemes (pools) and relieve them of financial deficits. In addition, it helps hospitals to reduce the administrative burdens that arise when entering contracts. The draft directive will undergo a series of technical reviews and consultations before the MOH endorses it. The Program provided technical inputs in the preparation of the directive.

Provided technical assistance to facilitate the process of CBHI proclamation endorsement by the Council of Ministers and the House of Peoples' Representatives: The Program supported EHIA in undertaking activities to help move the CBHI proclamation endorsement process forward. As part of this effort, the Program helped EHIA in arranging an orientation session for members of the Social Standing Committee of the House of Peoples' Representatives on the importance of the CBHI program and the contents of the proclamation to facilitate their decision-making. The Program also supported a field visit by the Women, Youth, Children and Social Standing Committee under the House of Peoples' Representatives to a CBHI scheme in Oromia to help raise awareness among the members.

The proclamation was accepted by the Social Standing Committee and cleared to go to the Council of Ministers. Once reviewed and approved by the Council of Ministers, the draft will be subjected to a public hearing before its final endorsement by the House of Peoples' Representatives as a law.

Conducted a study on East Gojjam CBHI zonal pooling implementation experience: The Program completed an assessment of the implementation experience of East Gojjam zonal pool in Amhara region. The objective of the study was to generate evidence that can inform CBHI implementation regulation and higher-level CBHI pools. The Program arranged a review session with EHIA to obtain feedback on the study report. The final report addressing EHIA's comments was made ready for dissemination to relevant institutions.

Conducted rapid assessments of CBHI implementation experiences in pastoralist settings to support adaptation of CBHI design parameters: CBHI schemes are being extended to pastoralist areas as part of the ongoing scale-up of CBHI country wide. This is being done using the current CBHI design parameters and implementation approaches, which are based on the agrarian context. However, pastoral settings differ from sedentary agrarian settings in many ways, including: their socio-economic features and other determinants of health; frequent mobility of pastoralist households in search of grazing lands and water for their herds; scattered settlements across wide geographic areas; and poorer infrastructure and less adequate basic health services than in agrarian regions. Because of these differences, CBHI design elements and implementation approaches require some adaptation for use in pastoral settings.

Two assessments, one in SNNP region and one in Oromia, were conducted in select pastoralist woredas to review and understand the successes, failures, and implementation challenges of CBHI in pastoral settings. They also recommend changes to CBHI design and implementation approaches that could improve CBHI implementation in similar settings. The assessments will inform the adaptation of the CBHI implementation directive that is being developed by EHIA. The woredas selected were Gnangatom, Mali, and Bena-Tsemay in South Omo Zone of SNNP, and Dubluk and Dire in Borena Zone of Oromia. Reports (one for each region) were prepared and reviewed by EHIA.

Supported an assessment of CBHI beneficiary perceptions and awareness of and satisfaction with the CBHI program: No comprehensive data are available on CBHI beneficiary perceptions and awareness of and satisfaction with the CBHI program. Hence, EHIA started undertaking a study to assess these issues. The Program provided technical support to EHIA in preparing the study protocol and arranged a meeting with EHIA to validate the objectives and geographic scope of the study. The study was intended to be completed in Y4.

Supported EHIA in producing technical document for the 10th anniversary of CBHI implementation: The 10th anniversary of CBHI implementation in Ethiopia is set to be celebrated in 2021/22. EHIA has planned events around this benchmark aimed at increasing in CBHI uptake. The Program is a member of the TWG established by EHIA to produce technical documents that will be disseminated at various platforms as part of celebrating the anniversary. To this end, the Program prepared a technical document that covered the evolution of CBHI in the country.

Supported EHIA in printing the final five-year Health Insurance Strategic Plan: In Y2, the Program supported EHIA in preparing its five-year health insurance strategic plan for 2020/21–2024/25. In Y3, the Program supported EHIA in printing 1,000 copies for distribution to CBHI schemes and other stakeholders.

Supported EHIA with preparatory activities to launch SHI: The Program provided technical assistance to EHIA in developing a Social Health Insurance (SHI) launch action plan with activities and milestones. It also assisted EHIA in revising the SHI implementation directive, which included arranging consultative meetings with EHIA directorates to review the contents of the draft directive.

IR 2 ACCOMPLISHMENTS BY REGIONAL GROUP

Agrarian Regions

During Y3, 756 woredas (614 rural and 142 urban) in the agrarian regions excluding Tigray were at different stages of establishing CBHI schemes. In these woredas, 92.5% of the CBHI schemes (699 total; 573 rural and 126 urban) were functional and providing financial protection coverage for their beneficiaries seeking health care services in contracted health facilities. The Program's regional teams supported RHBs and local counterparts in conducting community mobilization activities, compiling CBHI data, providing training for 2,499 (1,828 men and 671 women) personnel of new CBHI schemes, organizing review meetings, and conducting supportive supervision of CBHI schemes. Refer to Tables 2, 3, 4, and 5 for additional details.

Amhara

At the end of Y3, a total of 2,678,829 households were enrolled in CBHI out of 4,020,936 eligible households. Nineteen percent of the enrolled households were categorized as poor/indigent covered by the targeted subsidy of regional and woreda governments. The overall enrollment rate was 67%. Key activities accomplished over the year include:

- Provided technical support to the Amhara RHB in revising, printing, and distributing 4,000 copies of the CBHI directive.
- Provided technical support in collecting data from 13 zones to get feedback from zonal authorities on a new CBHI premium contribution rate proposed by the RHB. The new rate has been in use since it was approved by the regional CBHI board earlier this year.
- Provided CBHI training for 787 scheme staff, CBHI coordinators, health facility staff, woreda finance and economic cooperation (WOFEC) auditors, zonal attorneys and EHIA accountants. In addition, provided a five-day training for 51 CBHI scheme medical auditors and EHIA staff on medical auditing.
- Advocated and followed up with the RHB to help ensure that the regional share of the CBHI targeted subsidy budget was transferred to CBHI schemes' bank accounts.
- Provided technical support in revising the CBHI zonal pool directive based on experience from piloting and findings of the East Gojjam zonal pool study.

Oromia

At the end of Y3, a total of 4,406,659 households were enrolled in CBHI out of 7,073,072 eligible households. Eighteen percent of the enrolled households were categorized as poor/indigent. The overall enrollment rate was 62.3%. Key activities accomplished over the year include:

- Provided technical assistance as a member of TWG in adapting the prototype CBHI zonal pool directive for use in Oromia region.
- In collaboration with the Oromia RHB and EHIA branch office, arranged CBHI training for 852 CBHI scheme staff, WOFEC auditors, and health facility staff in newly joined woredas/towns.
- Arranged a five-day training on medical auditing 147 (106 men and 41 women) for CBHI scheme and EHIA branch office staff.
- Organized a CBHI annual conference on January 4, 2021, in Adama town, to review CBHI performance and implementation challenges for Y2 and acknowledge best performers. The Program's Oromia Regional Office was awarded a trophy and a certificate recognizing its support of CBHI implementation in the region.

Sidama

At the end of Y3, a total of 203,724 households were enrolled in CBHI out of 519,098 eligible households. About 34% of the enrolled households were categorized as poor/indigents. The overall enrollment rate was 39.2%. Key activities accomplished over the year include:

- Provided technical assistance to the RHB in adapting a CBHI fund pooling management guideline for use in the region. The guideline outlines the steps for establishing a mechanism to collect funds from the RHB and woredas to back up and help ensure financial sustainability of schemes.
- Provided training for 61 CBHI scheme staff on CBHI concepts and implementation process, CBHI financial and data management, and the revised CBHI directive.
- Arranged training on CBHI financial auditing for 19 auditors from the Woreda Finance and Economic Development office to strengthen financial management at the woreda level.
- As a TWG member, contributed to the development of guidelines for linking CBHI with the Productive Safety Net Program and directive for CBHI regional pooling.
- Provided technical support in revising the regional CBHI directive.
- Supported the RHB in conducting an experience sharing workshop aimed at providing a platform for discussion and sharing good CBHI and first-generation HCF reform implementation practices. A total of 101 participants from the RHB, EHIA, woreda health offices (WorHOs), and CBHI schemes attended the workshop.

SNNP

At the end of Y3, a total of 1,332,492 households were enrolled in CBHI out of 2,550,746 eligible households. About 16% of the enrolled households were categorized as poor/indigents. The overall enrollment rate was 52.2%. Key activities accomplished over the year include:

- Provided CBHI training for 532 scheme staff (including staff from pastoralist and sedentary/agricultural woredas), health facility staff, and Bureau of Finance auditors.
- Provided a five-day training on CBHI medical audit manual for 51 professionals drawn from CBHI schemes, WorHOs, and zonal health departments (ZHDs).
- Provided technical support to EHIA branch office and ZHDs in conducting a medical audit at six hospitals. The main objective of the audit was to validate the claims of health facilities.
- Supported the RHB in adapting the national prototype guideline issued by EHIA to harmonize indigent targeting criteria and tools in CBHI with that of the Productive Safety Net Program.

Tigray

All woredas in Tigray were implementing CBHI and 34 had functional schemes before conflict started in the region. The Program conducted a rapid assessment of the status of the CBHI schemes in collaboration with the Tigray EHIA branch office before the Tigray People's Liberation Front took over most towns in the region in June. The findings showed that schemes were not active during the mobilization period this year. Activities conducted in Tigray during the year include:

- Provided support for a regional-level meeting organized by the RHB during the period of the transitional government of Tigray (November 2020–June 2021) to assess damage to physical infrastructure, understand the health service delivery situation across the region, discuss how to return health staff to the workplace, and restore HCF and CBHI activities. Meeting attendants were zone and woreda administration heads, WorHO heads, and delegates of the RHB, EHIA, Ethiopian

Pharmaceuticals Supply Agency (EPSA), UNICEF, World Health Organization (WHO), USAID Transform: Primary Health Care project, Save the Children, and the Program.

- Supported organization of zonal-level review meetings to discuss how to make CBHI functional. The meetings were carried out in five zones in May and June 2021. Staff safety and redeployment and major constraints to restarting scheme operation were part of the discussion.
- Supported the RHB and EHIA branch office in redesigning CBHI to align with new woreda restructuring. The activity is ongoing. A seven-person technical team was established to do the redesign; its members are from the RHB, EHIA, CHAI, and the Program.

City Administrations and Harari Region

At the end of Y3, all woredas in AACA, DDCA, and Harari were implementing CBHI, which is set up differently than in regions, taking into considering city administrative structures. Refer to Tables 2, 3, 4, and 5 for additional details.

AACA

CBHI was being implemented in all 120 woredas of AACA, with 10 CBHI schemes established at the sub-city level starting from Y2. As of end of Y3, the schemes enrolled 225,634 households (87.2% of eligible households); of these, 72,757 (32.2%) were categorized as indigent. Key activities accomplished over the year include:

- The AACA CBHI office established a TWG composed of members from the AACA CBHI office, EHIA, Addis Ababa Bureau of Attorney, and the Program, to revise the AACA CBHI Regulation to adapt CBHI design features to support implementation in the city. Issues proposed in the revision included design features such as: raising the annual contribution, requiring members who have dropped out to pay accumulated contribution fees, and legislating that beneficiaries who by-pass the referral system to pay out of pocket for the higher-level services, and that composition of CBHI boards is to be established at the city and sub-city levels.
- Arranged orientations for CBHI executive staff on CBHI implementation issues for existing urban CBHI schemes. A total of 382 participants attended the orientations, which were organized with costs shared by the AACA Health Bureau, EHIA Addis Ababa branch office, and the Program.
- As a member of a TWG, the Program supported AACA in undertaking an assessment of medicine abuse affecting CBHI schemes. Study findings revealed a high incidence of fraudulent activity related to drugs issued from Kenema Pharmacies (community pharmacies). The TWG proposed that health facilities need to have the required supply of medicines on hand to avoid prescription referrals. The long-term recommendation was to use automation to help deter fraud by linking Kenema Pharmacies with health facilities through an electronic system. Concerted efforts of the health bureau, health facilities, and EPSA are required to address this issues.

DDCA

DDCA has one CBHI scheme that is established at the city administration level. It was launched in 2020. At the end of Y3, a total of 21,414 households (29.4% of eligble households) were enrolled in CBHI; of these, 43% were categorized as indigent. The DDCA health bureau plans to formally establish schemes at the section/kebele level in the future. Key activities accomplished over the year include:

- Provided technical assistance to the DDCA health bureau to organize a consultative meeting with key actors including the Mayor's Office, Bureau of Finance and Economic Development (BOFED), EHIA, Public Service Bureau, Disaster Risk Management Coordination Office, and Bureau of Labor and Social Affairs to discuss CBHI performance in the city administration. The Program gave a presentation on the basic concepts of CBHI and its implementation process and status in Ethiopia.

- Advocated to BOFED to allocate the targeted subsidy for households categorized as indigent.
- Provided technical assistance to DDCA in developing its CBHI mobilization action plan.
- Conducted a two-day training on basics of CBHI for 16 (7 men and 9 women) individuals drawn from CBHI sections, CBHI schemes, kebeles, and the health bureau.
- Provided technical assistance to the DDCA health bureau in developing draft guidelines to link indigent household targeting conducted for the CBHI program and Productive Safety Net Program.

Harari

Harari has one functional regional-level scheme that covers all nine woredas of the region. At the end of Y3, 26,406 households (53.8% of eligible households) were enrolled in CBHI; of these, 27.8% were categorized as indigent. Key activities accomplished over the year include:

- Provided support in conducting a general assembly meeting for the CBHI scheme in Harari. Consensus was reached to increase coverage of indigents from 10% to 12%, increase the CBHI enrollment rate from 32% to 65%, and roll out CBHI in the remaining four woredas of the region.
- Organized a consultative meeting with the RHB and WorHO officials and staff to review CBHI mobilization progress in the region. At the meeting, participants discussed CBHI performance, implementation challenges, and ways to scale up best practices.

Developing Regional States

In Y3, the Program increased its CBHI implementation technical assistance to the DRS. The following sections provide insight on the overall status of CBHI and accomplishments of the Program in the DRS. Refer to Tables 2, 3, 4 and 5 for additional details.

Afar

In Afar region, CBHI is being piloted in five woredas: Asayita, Afambo, Yallo, Berhale, and Chifra. Of these, Asayita and Afambo launched CBHI schemes and are providing health service coverage to beneficiaries. At the end of Y3, a total of 19,693 (31.3% of the eligible households) households were enrolled; of these, 22.5% were categorized as indigent. Yallo, Berhale, and Chifra have been affected by the security problem in the Northern part of the country and were not able to provide health service coverage. Key activities accomplished over the year include:

- In collaboration with the RHB and EHIA branch office, organized a regional-level CBHI workshop to sensitize regional-, zonal-, and woreda-level officials on CBHI community mobilization and kick-off in four woredas.
- Arranged CBHI training for 20 participants drawn from the RHB, Asayita WorHO, CBHI scheme, Asayita Primary Hospital, Dubti Referral Hospital, and the EHIA branch office.
- Provided technical guidance on budget allocation, mobilization campaigns, and other activities to four woredas (Chifra, Berhale, Afambo, and Megale) to start CBHI.
- Supported the organization of CBHI scheme launch events in Afambo and Yallo woredas.
- Conducted facility readiness assessments at three health centers of Yallo in collaboration with the RHB and EHIA branch office.

Benishangul-Gumuz

At the end of Y3, nine woredas in Benishangul-Gumuz region were implementing CBHI. Of these, three had functional schemes. The schemes had enrolled 34,472 households (33.8% of eligible households), of which 21% were categorized as indigent. The region was working to launch CBHI in the remaining six woredas. Key activities accomplished over the year include:

- Provided technical support in revising the regional CBHI implementation directive and adapting the CBHI implementation guideline. The documents were being further refined by the regional TWG and will be endorsed by the RHB once finalized.
- Provided CBHI training for 347 (224 men and 123 women) participants including CBHI scheme staff, health professionals, health extension workers, and woreda and kebele officials.

Gambella

Gambella region launched CBHI in three woredas and enrolled 13,175 (52.6% of eligible households) households this year; 17.3% of the enrolled households were categorized as indigent. Key activities accomplished over the year include:

- Provided CBHI training for 21 (17 men and 4 women) CBHI scheme staff drawn from three woredas.
- Provided technical support to the RHB in conducting a high-level consultative meeting to review CBHI performance and implementation status. The regional president, vice president, speaker of the regional council, regional cabinet members, RHB head, EHIA deputy director, and zonal administrators attended the meeting. The officals passed important decisions that helped improve performance and launch CBHI in the region.

Somali

At the end of Y3, four woredas in Somali region (Awbare, Ararso, Erer, and Gode City) were implementing CBHI. Of these, Awbare had a functional scheme providing coverage for beneficiaries by contracting with five health centers. At the end of Y3, 21,175 (28.1% of eligible households) households were enrolled in CBHI in the region; of these, 16.8% were categorized as indigents. The RHB plans to launch health service coverage for CBHI beneficiaries in the remaining three woredas in the region. CBHI implementation in Somali requires greater attention from the MOH, EHIA, and the regional government to strengthen implementation in the region. Key activities accomplished over the year include:

- Provided CBHI training for 21 (16 men and 5 women) participants from the RHB, EHIA branch office, and Gode City, Awbare, Ararso, and Erer woredas. The objective of the training was to enhance the capacity of scheme staff in CBHI data management and expedite the launch of CBHI in the region.
- Organized a high-level health financing workshop in Somali region aimed at helping regional cabinet members understand the implementation status of first-generation HCF reforms and CBHI in the region and address major roadblocks that have slowed implementation. The event brought together 28 higher government officials and other stakeholders including the State Minister for Health, the head of Regional President's office, and heads of different sector bureaus. The Program gave a presentation on the progress, status, and challenges of HCF reform in the region.
- Conducted facility readiness assessments in four health centers in Erer woreda. The assessments evaluated the capacity of health facilities to provide health services for CBHI beneficiaries.

IR 3: IMPROVED ARRANGEMENTS FOR STRATEGIC PURCHASING OF HEALTH SERVICES FROM PUBLIC AND PRIVATE PROVIDERS

Supported EHIA in preparation of CBHI medical audit manual and arranged training: In Y3**,** a TWG composed of EHIA, the MOH, CHAI, and the Program finalized the medical audit manual. As part of the process, the team pilot tested the medical and claims audit manual at selected CBHI schemes and health facilities in three agrarian regions (Amhara, Oromia, and Sidama) and in AACA. Following this, the Program provided three rounds of six-day trainings for master-trainer TOT participants from 17 EHIA branch offices, 7 RHBs, and 4 Program regional offices, in collaboration with EHIA (reflected in Table 5). The training content included facilitation skills, the objectives and principles of medical auditing, claim auditing, clinical auditing, and the institutional arrangements that support auditing. A total of 94 participants (79 men and 15 women) attended the training. The basic training will be cascaded to 3,300 participants.

Provided technical assistance in the medical audit activities of EHIA and the MOH: The Program provided technical assistance in integrating medical audit-related indicators into the electronic recording system being piloted by EHIA in collaboration with CHAI in Sululta woreda. Program staff assisted the EHIA team in refining the link between the electronic community health information system and the CBHI membership dataset. Furthermore, the Program provided technical advice to EHIA in designing its new Claim Management Directorate structure and job descriptions. In addition, the Program provided technical support to EHIA by checking data completeness and the analysis of compressive audit findings based on audits done in seven hospitals in AACA. These hospitals provide health services for CBHI scheme members that are referred to them.

Developed a costing tool for user fee revision and arranged TOT training on the tool: To provide RHBs and health facilities with a technically sound cost estimation tool for health care services, the Program developed a costing tool for user fee revision. The tool helps health facilities conduct periodic user fee revision based on the cost of services. The tool was field-tested to ensure it conforms to the data capturing system in health facilities and is user friendly. The Program also provided TOT training to 12 Program staff who are expected to cascade the training in Y4.

Started conducting mapping of strategic purchasing for health: EHIA established a TWG to conduct mapping of strategic health purchasing of health services from providers and to prepare an implementation roadmap. The Program is supporting EHIA in this endeavor as a member of the TWG. So far, a concept note and TOR that guide the TWG and the process are prepared and they will be endorsed after consultation with EHIA management. Members of the TWG include the MOH, EHIA, EPSA, Ethiopian Food and Drug Authority, WHO, World Bank, CHAI, and the Program.

Supported MOH in developing a roadmap for health facility accreditation: The Program is a member of and technical resource to the TWG established and led by the MOH's Health Service Quality Directorate to develop the 'Health Facility Accreditation Roadmap for Ethiopia.' The Program presented the accreditation scoping review findings from Y2 to the TWG as a background working document to facilitate discussion at a consultative meeting on the roadmap organized by the MOH. The Program's technical assistance in the development of the roadmap was a step forward in helping set the standards for a health facility accreditation program that will benefit CBHI beneficiaries as major users of health services. The roadmap stipulated that the accreditation activity will be implemented in two phases— the piloting phase (2021- 2025) and the scale-up phase (2026-2030). The team also drafted a policy brief on the role of accreditation from the health insurance perspective.

Provided technical assistance to the MOH and EHIA on activities related to health facility accreditation and quality improvement:

- Provided technical assistance to the MOH as a member of a TWG led by the MOH's Health and

Health Related and Regulatory Directorate, which was established to identify and label (rank) health facilities based on their compliance with MOH service quality standards and identify the type of support health facilities need to help them meet the minimum standards. The Program supported the TWG in its efforts to customize and refine the tools and standards being used.

- Participated in consultative meetings organized by the MOH to review, analyze, and synthesize the findings of the pilot hospital starring program. "Starring" is the process of labelling health facilities by measuring their performance against the quality standards set at each tier of the health system: primary, secondary, and tertiary. The main purpose of hospital starring is to ensure efficient utilization of resources (including human, financial, infrastructure, and equipment), to identify gaps and design a quality improvement plan, and to increase accountability in service delivery by enhancing the engagement of political leadership.
- Participated in developing the TOR and initial documents that supported the establishment of a high-level national forum that was established this year. The Quality Forum oversees quality issues impacting the health insurance system. Its members are the State Minister of Health, EHIA Director General, Parliamentarians, and EHIA board members.

IR 4: STRENGTHENED GOVERNANCE, MANAGEMENT, AND EVIDENCE GENERATION FOR HEALTH FINANCING REFORMS AND HEALTH FACILITIES

The Program's support this year focused on putting in place the systems elements to institutionalize first-generation HCF reform activities in the reform-advanced regions and city administrations that apply to IR 4 and IR 1. The Program also generated evidence through assessments, review meetings, and supervisory visits, and supported the organization and facilitation of 87 (2 national, 23 regional, and 62 zonal) review meetings and covered 232 (168 rural and 64 urban) CBHI schemes and 293 health facilities (235 health centers and 58 hospitals) with supervisory visits.

Completed nearly all steps for institutionalizing and transitioning first-generation HCF reforms in the agrarian regions of Amhara, Oromia, Tigray, and SNNP, and in the city administrations and Harari region:

- *Developed comprehensive first-generation HCF reforms training materials to be used by CPDs in carrying out first-generation HCF reform training:* The Program provided technical support to the MOH in developing a comprehensive set of first-generation HCF training materials applying instructional design methods. The materials, which include participant and facilitator guides for FMC members, FGB members, and health facility finance staff, were endorsed by the MOH and received final approval of the CPD case team of the Human Resources for Health Directorate.
- *Supported Oromia and SNNP regions and AACA and DDCA in conducting a TOT session on first-generation HCF reforms:* The Program provided technical support to the Oromia, SNNP, AACA, and DDCA health bureaus in providing TOT training on HCF reform and facilitation skills using the training materials developed with Program assistance. The four-day training was attended by 86 participants drawn from the pool of experts established by DDCA, AACA, Harari, Oromia, and SNNP regions (Table 6). Two of the four training days were allotted to the HCF reforms and the remaining two days were for the facilitation skills training.

Table 6: Number of individuals who received TOT on first-generation HCF reforms and facilitation skills, Y3

Regional group	Region	Y3 target	Y3 achievement		
			Men	Women	Total
Agrarian	Oromia	22	22	0	22
	SNNP	21	24	5	29
	Subtotal	43	46	5	51
City Administrations and Harari	DDCA	19	14	5	19
	AACA	16	14	2	16
	Subtotal	19	28	7	35
Total		**78**	**74**	**12**	**86**

- *Provided TOT on facilitation skills for HCF master trainers*: The Program arranged a six-day TOT training on facilitation skills for 23 Program team members and RHB staff selected to be first-generation HCF reform master trainers. The RHB participants were drawn from Amhara, Harari, Oromia, and SNNP regions and DDCA. Four senior instructional designers and trainers from the MOH provided the training using the MOH's standard facilitation skills training module, which is built on key principles and applications of adult learning.
- *Supported continued set-up of dedicated HCF organizational structures in regions that enable the health sector to spearhead, oversee, manage, and monitor HCF reform implementation:* Permanent HCF organizational set-ups (e.g., health care directorates and units/case teams) with specific scope and functions defined is created within the regional/city/zonal and woreda health bureaus to work on HCF matters.

Execution of the remaining steps has been held up due to delays in counterpart approvals and training scheduling, and the cessation of activities in Tigray.

The status of all implementation steps to achieve the institutionalization and transition benchmark are presented in Table 7, by system element. Tigray information is based on the last known status (as of November 2020).

Table 7: Status of implementation steps to complete benchmark transition tasks and remaining tasks by systems element

Systems element	Description	Steps completed	Steps to be completed
Institutional structure	HCF institutional structure at regional, zonal, woreda, and PHC levels specified for each reform-advanced region (i.e., Amhara, Oromia, SNNP, Tigray, AACA, DDCA, Harari)	All steps completed ✔ Developed the prototype HCF organizational structure that is the model for regional structures ✔ Developed the HCF organizational structure for all/relevant levels for each reform-advanced region	
Roles and responsibilities	Explicit roles and responsibilities of these institutional structures determined	All steps completed ✔ Prepared job descriptions for each position in each HCF organizational structure of each reform-advanced region ✔ Defined the roles and duties of regional-level, zonal-level, and woreda-level organizational structures for each reform-advanced region	
Operational procedures	Implementation and monitoring guidelines/manuals related to first-generation HCF reforms revised/updated (i.e., prototype HCF implementation manual)	All steps completed ✔ Developed the prototype HCF implementation manual	
	Prototype HCF implementation manual adapted for use in each reform-advanced region	All steps completed ✔ Adapted the HCF implementation manual for each reform-advanced region	
	Printing and dissemination of HCF implementation manual arranged in each reform-advanced region	Most steps completed ✔ Printed and distributed the HCF implementation manual in Amhara, Oromia, SNNP, DDCA, and Harari	✔ AACA and Tigray manuals cannot be printed until government authorities endorse them. Program is working to facilitate endorsement in AACA. Tigray is to be determined.
Capacity development	Effective training and capacity-building arrangements to conduct first-generation HCF reform trainings designed for each reform-advanced region	Most steps completed ✔ Developed transition plan used by MOH and regions in preparing for transition ✔ Identified and selected CPDs that meet requirements to be first-generation HCF training providers ✔ Adapted prototype memorandum of understanding that is being used by regions to contract CPDs in providing first-generation HCF training ✔ Developed first-generation HCF reform training materials which received MOH approval ✔ Individuals (master trainers) received facilitation skills training in preparation for providing HCF TOT ✔ Supported Oromia, SNNP, AACA, and DDCA in conducting TOT sessions on first-generation HCF reforms	✔ CPD staff and others engaged in first-generation HCF reform training to complete rollout (except in Tigray, which will be reevaluated when implementation in the region is possible).
Initial supervisory visits	The Program provides supportive supervision to monitor development of localized rollouts, and provide limited technical assistance and reinforcement, as needed	All steps completed ✔ Conducted initial supervisory visits for each reform-advanced region conducted ✔ Developed standardized checklists for use by MOH and health bureaus in conducting first-generation HCF reform supervisory visits in each reform-advanced region	

In addition to the systems elements, the Program carried out additional activities that support the institutionalization process:

- ***Supported RHBs in establishing regional-level HCF TWGs:*** The Program provided technical assistance to Amhara, Oromia, SNNP, Harari, and DDCA in customizing the protype HCF TWG TOR to their local context. Each TWG will coordinate HCF activities, provide HCF technical support, monitor HCF activities, and disseminate HCF learning in the respective region. TWG composition varies by region but members are generally RHBs and other relevant sector bureaus, EHIA branch offices, research institutions, implementing partners, and other regional-level stakeholders.
- ***Provided grants to RHBs to support institutionalization and rollout of first-generation HCF training activities provided by CPDs:*** The Program, with approval from USAID, provided grants to five of the seven reform-advanced regions/city administrations – Oromia, SNNP, AACA, DDCA, and Harari – to fund first-generation HCF reform rollout training.[4] The objective of the grants is to bridge the temporary health bureau budget gaps for providing the training during the first year of transition. After the grant award period, the regions and city administrations are expected to fund all first-generation HCF reform trainings on their own.

  The grants were structured to disburse funding based on receipt and Program approval of health bureau deliverable submissions. Deliverables included training work plans, training reports, a sustainability plan, and a cost share report. The Program provided support in grant management and execution to the health bureaus. The health bureaus were delayed by about a quarter in their deliverable submissions based on the due dates included in the award agreements. By the end of Y3, all five of the grantee health bureaus had submitted their first deliverable (their one-year first-generation HCF reform training plan) and two of the five (Harari and Dire Dawa) had also submitted their more specific work plan for their first batch of trainees. The bureaus did make good progress in planning for the grant award year but, unfortunately, due to the pace of completing the deliverables, the actual rollout training using grant funds did not take place in Y3.

  The Program also developed a memorandum of undersanding that the health bureaus can use and adapt to contract CPD HCF reform training services.

Oriented media and public relations officers on ways to support CBHI community mobilization: The Program supported EHIA in organizing a two-day orientation session for media and public relation officers. The objective of the orientation was to enhance participants' awareness of the CBHI program and the support they can provide during community mobilization periods. A total of 63 participants that included communications and public relations directors from the Regional President Offices and RHBs; regional media managers; and representatives of mass media agencies including the Ethiopian Broadcasting Corporation, Ethiopian News Agency, Fana Broadcasting, and Walta Media and Communication attended the orientation. The orientation will enable the participants to contribute their support for CBHI community mobilization activities across the country.

Supported EHIA's national-level review meetings: EHIA organized three review meetings in Y3. During the first and second meetings, the following issues were discussed: the performance and challenges experienced with CBHI implementation in the review period, the Monitoring and Evaluation Manual for the Ethiopian Health Insurance Program developed with Program technical support, results of the CBHI threshold contribution amount study conducted by the Program in Y2, cascading EHIA's CBHI core plan to EHIA branches and RHBs, and the capacity of the CBHI scheme structure. In the third meeting, EHIA conducted its eight-month performance review; other presentations and discussions

[4] USAID did not approve of a grant for the Amhara region. The grant approved for Tigray was put on hold because it was not possible to implement training or associated activities in the region.

were on a CBHI impact study and a CBHI scheme financial capacity study conducted by other partners, medical audit manual, and SHI preparatory activities action plan. At this meeting, Program staff made presentations on the medical audit manual, responded to questions related to SHI, and facilitated technical discussions.

Conducted a rapid assessment of the performance of CBHI schemes in Amhara, Oromia, and SNNP: The Program conducted a rapid assessment of the performance of CBHI schemes in Amhara, Oromia, and SNNP to generate evidence on how performance has trended over the past three years in terms of enrollment, re-enrollment, and new uptake in the face of challenges such as environmental, health, and security shocks. Assessment results showed that CBHI performance over three years has been on an increasing trend and no negative impact was observed in CBHI scheme performance due to the COVID-19 pandemic (a health shock) or the locust invasion (an environmental shock). However, it was found that the security shock brought a slight decrease in the average performance of schemes. The assessment further found that the local authorities took effective field-level mitigation measures to counter the potential impact of these shocks particularly in relation to COVID-19 and the locust invasion. The report also documented lessons learned that will be useful for further consolidating the CBHI program. The findings of the rapid assessment were shared with the USAID Health Office.

Provided technical support to the MOH in undertaking the eighth round of Ethiopia's health accounts: In response to the MOH request to support the 8th round of health accounts, the program provided technical support for the exercise. As part of the TWG working on the health accounts, the Program supported the cleaning and validation of the health expenditure data collected from various institutions, including government, donors, NGOs, employers, and insurance companies. It also provided support in reviewing and readying the household health service utilization and health expenditure data by extracting the data from the household survey conducted by EHIA. The Program also provided technical assistance in mapping the health expenditure data gathered from these sources. The exercise will be completed in Y4.

Supported a national-level HCF thematic review meeting: The MOH/Partnership and Cooperation Directorate (PCD) arranged a thematic meeting on HCF during a virtual meeting on June 16, 2021. Health bureau representatives from Amhara, Oromia, Sidama, Tigray, Harari, Afar, and Benishangul-Gumuz regions, AACA, and DDCA attended the half-day meeting. During the meeting, RHBs and the MOH/PCD made presentations on HCF reform implementation, progress on institutionalization, challenges encountered, and the way forward. Regional and city administration health bureaus reflected the overall support they need from the MOH to enhance the institutionalization process and improve reform implementation. At the end of the meeting, the director of the PCD gave directions and concluding remarks to further enhance institutionalization and transitioning of reform activities. The Program worked with the health bureaus to organize data and presentations for the meeting.

Supported regional- and zonal-level review meetings: The Program provided technical support to RHBs and ZHDs in conducting 62 zonal and 23 regional review meetings (79 in the four agrarian regions, 2 in the DRS, and 4 in the city administration and Harari) (Table 8). The meetings were important platforms for discussing the performance of CBHI and HCF reform implementation. The Program exceeded targets for Y3 by 11.5%.

Table 8: Number of review meetings supported by the Program, Y3

Regional group	Region	Y3 target	Y3 accomplishment		
			Zonal	Regional	Total
Agrarian	Amhara	26	26	2	28
	Oromia	28	22	8	30
	Sidama	2	1	4	5
	SNNP	14	13	3	16
	Tigray	3	0	0	0
	Subtotal	73	62	17	79
DRS	Afar	0	0	1	1
	Gambella	0	0	1	1
	Subtotal	0	0	2	2
City Administrations and Harari	AACA	1	0	1	1
	DDCA	1	0	1	1
	Harari	1	0	2	2
	Subtotal	3	0	4	4
National level		2	0	0	2
Total		**78**	**62**	**23**	**87**

Conducted supervisory visits at health facilities: The Program conducted supervisory visits at 293 health facilities (235 health centers and 58 hospitals), which is a 74% achievement of the Y3 target. Details are included in Table 9.

Table 9: Number of health facilities covered by the Program during supervisory visits, Y3

Regional group	Region	Y3 target	Y3 accomplishment		
			Health centers	Hospitals	Total
Agrarian	Amhara	60	66	30	96
	Oromia	60	40	8	48
	Sidama	16	20	7	27
	SNNP	60	46	2	48
	Tigray	20	0	0	0
	Subtotal	216	172	47	219
DRS	Afar	32	0	0	0
	Gambella	15	12	3	15
	Benishangul-Gumuz	15	11	1	12
	Somali	60	2	0	2
	Subtotal	122	25	4	29
City Administrations and Harari	AACA	32	26	3	29
	DDCA	17	7	2	9
	Harari	9	5	2	7
	Subtotal	58	38	7	45
Total		**396**	**235**	**58**	**293**

Conducted Program supervisory visits to CBHI schemes: The Program covered 165 schemes (119 rural and 46 urban) with supervisory visits during year (Table 10), which is a 100% achievement of the Y3 target.

Table 10: Number of Program supervisory visits to CBHI schemes, Y3

Regional group	Region	Y3 target	Y3 accomplishment		
			Rural schemes	Urban schemes	Total
Agrarian	Amhara	60	34	6	40
	Oromia	82	62	23	85
	Sidama	11	25	6	31
	SNNP	40	32	5	37
	Tigray	8	0	0	0
	Subtotal	201	153	40	193
DRS	Afar	3	8	0	8
	Gambella	0	3	0	3
	Benishangul-Gumuz	11	0	0	0
	Somali	4	4	0	4
	Subtotal	18	15	0	15
City Administrations and Harari	AACA	10	0	20	20
	DDCA	1	0	2	2
	Harari	1	0	2	2
	Subtotal	12	0	24	24
Total		**231**	**168**	**64**	**232**

IR 4 ACCOMPLISHMENTS BY REGIONAL GROUP

Agrarian Regions

In agrarian regions, the focus has been on concluding the institutionalization of first-generation HCF reform components. During Y3, the Program worked on organizing review meetings, conducting supervisory visits, and facilitating the provision of HCF TOTs. It also provided technical assistance in establishing HCF TWGs. Following are its accomplishments by region in relation to HCF institutionalization and evidence generation activities.

Amhara

- Provided technical assistance in customizing the national-level prototype TOR to establish HCF TWG for the region.
- Provided technical support to the RHB in drafting job positions for the Resource Mobilization, Administration, and Partnership Directorate at the RHB and ZHD levels.
- Facilitated organization of 26 zonal and 2 regional review meetings in collaboration with EHIA and the RHB. In addition, provided technical assistance for the organization of three provider and scheme review meetings, and two zonal pool general assembly meetings (East Gojjam and Awi zones).
- Conducted routine supervisory visits on HCF considering institutionalization of first-generation HCF reform implementations using the program's standard checklist in 66 health centers and 30 hospitals.
- Conducted routine supervisory visits to 10 schemes using the Program's standard checklist.
- Supported the RHB in conducting a workshop to align the annual plan for EFY 2014 (2021/22) among the RHB, EHIA, HFIP, and other government counterparts and implementing partners.

- Supported the Amhara RHB in distributing the revised HCF directive and implementation manual to stakeholders.

Oromia

- Supported the RHB in establishing HCF positions and a regional HCF TWG. The region has endorsed HCF positions within the existing CBHI structure at the zonal and woreda levels.
- Arranged HCF reform and facilitation skills TOT training for 41 persons in two sessions. Trainees were mobilized from different organizations including the CPD, Oromia Bureau of Finance and Economic Cooperation (BOFEC) /zone office, and RHB/zone health offices.
- Supported the conduct of 22 zonal/ town administration and two regional-level CBHI/HCF review meetings in collaboration with the RHB and EHIA branch offices.
- In collaboration with the Oromia RHB, zonal health offices, and EHIA branch offices, conducted supportive supervisions in 48 (37 rural and 11 urban) schemes.
- Conducted routine supportive supervision on HCF in light of institutionalization of first-generation HCF reforms using the program's standard checklist in 77 health centers and 8 hospitals.
- Provided technical assistance as a TWG member in adapting the national-level HCF strategy for use in the region.
- Supported the RHB in conducting a workshop to align the annual plan for EFY 2014 (2021/22) among the RHB, EHIA, HFIP, and other government counterparts and implementing partners.
- Provided technical assistance to the RHB in adapting three HCF training modules to the regional context. The Program also supported the RHB in selecting 300 participants for the planned HCF rollout training.

Sidama

- Conducted program supervisory visits in 31 CBHI schemes (25 rural and 6 urban).
- Conducted program supportive supervision on HCF considering institutionalization of first-generation HCF reform implementations in 20 health centers and 7 hospitals.
- Provided technical support to the RHB in conducting four regional-level and one zonal/town review meetings and a CBHI sensitization workshop.
- Provided technical assistance to the RHB in tailoring the national prototype TOR to establish a HCF TWG for the region.
- Provided technical support in adapting the prototype HCF training materials to the regional context.
- Provided technical support to the RHB in conducting a regional review meeting aimed at reviewing CBHI and HCF performance and challenges in the region.
- Provided technical support to EHIA branch office in conducting a medical audit at six hospitals.

SNNP

- In collaboration with the RHB and EHIA, supported the conduct of 13 zonal and 3 regional CBHI/HCF review meetings on a cost-sharing basis.
- Provided technical assistance to the RHB in preparing the Health Service Delivery and Management regulation and directive, which have been endorsed by the regional cabinet and the RHB, respectively.

- Conducted HCF supportive supervisions at 46 health centers and 2 hospitals using program's standard checklist with a view to institutionalize HCF reform activities in the health facilities.
- Conducted CBHI supportive supervisions at 37 (32 rural and 5 urban schemes) focusing on community mobilization, enrollment, financial management, and health service utilization.
- Supported the RHB in providing financial management training for 74 health facility and woreda finance officers.
- Provided technical support to the RHB in adapting the prototype TOR to establish a HCF TWG at the regional level.
- Provided technical assistance to the RHB to ensure fulfillment of the resource mobilization positions at regional and zonal/special woreda levels.
- Provided technical assistance in adapting HCF facilitators' and participants' modules for three type of training modules (FGB, FMC, and health facility finance staff).
- Provided technical support in conducting consultative meetings on documenting corporate social responsibility.
- Provided technical support in adapting the prototype CBHI zonal pool directive to the regional context and provided technical support in organizing consultative meetings on the draft directive.
- Provided training on HCF and CBHI for 44 newly recruited resource mobilization staff drawn from the RHB, ZHDs, and WoHOs.

City Administrations and Harari Region

AACA

- The Program in collaboration with the AACA Health Bureau and EHIA Addis Ababa branch office conducted supervisory visits at 10 CBHI schemes in Addis Ababa using a checklist prepared by the Program.
- Supported the AAHB's Partnership and Cooperation Directorate in establishing a database on HCF reform and monitoring resource mobilization for health.
- In collaboration with the health bureau and sub-city health office, conducted HCF supervisory visits in 23 health centers in the 10 sub-cities and in 3 hospitals.
- Provided technical support to the RHB in the HCF regulation revision process, including addressing feedback from the AACA Justice Bureau on the draft regulation.
- Assessed the status of first-generation HCF reform institutionalization in 8 sub-city health offices and 12 health centers in AACA. Findings revealed the health bureau must do a lot of work to operationalize the HCF organizational structure.
- Provided technical assistance to the AACA in organizing a city-level review meeting. The role of the Program in the meeting included presenting the findings of the assessment on the six-month performance of CBHI in AACA.
- Continuously advocated for the assignment of staff to the HCF positions created at the AACA Health Bureau level. As a result of the frequent discussions and engagement with the deputy head of the health bureau, a PCD director has been assigned.

DDCA

- Worked with the newly recruited DRM experts for HCF activities to fully transition and sustain HCF activities in the city administration.
- Supported establishment of the HCF TWG within the DDCA Health Bureau, comprising members from 10 institutions including the Program.
- Supported the health bureau in selecting staff from the health bureau, BOFED, and CPD center, who received the first-generation HCF reform TOT training.
- Facilitated the endorsement of DDCA's HCF directive and supported the health bureau in printing 80 copies of HCF manuals and directives.
- Conducted supportive supervisions at nine health facilities (seven health centers and two hospitals) in DDCA to provide technical assistance and monitor the post-transition implementation of the reform.
- Participated and facilitated technical discussion in a review meeting organized by the DDCA Health Bureau. During the meeting, participants reviewed the DDCA's performance in CBHI and HCF.
- In collaboration with the Dire Dawa Health Bureau and Harari RHB, organized a plan alignment meeting among the RHB, EHIA branch offices, CBHI schemes, CBHI sections, and kebeles.

Harari

- Provided technical support to the RHB in conducing the region's annual review meeting. During the meeting, the Program team facilitated technical discussions on HCF and CBHI performance in the region.
- Provided support to the RHB in organizing annual review meeting conducted with the objective of reviewing implementation performance and challenges of the health sector in the region in EFY 2013 (2020/21). The program team facilitated technical discussions on CBHI and HCF.
- Conducted HCF supportive supervisions at seven health facilities (five health centers and two hospitals).
- Conducted supervisory visits at three woredas during which the Program provided onsite technical support including on CBHI mobilization.
- Assisted the RHB to identify staff who will receive first-generation HCF TOT training from the RHB, BOFEC, and CPD center.
- Provided technical support in establishing a health financing TWG for the Harari RHB. The TWG comprises 10 members from regional sector bureaus, the health science college, and the Program.

Developing Regional States

In DRS, the Program worked to strengthen implementation of HCF reform activities taking place and expand them to new woredas. The following activities were accomplished to strengthen structural arrangements and evidence generation activities during Y3.

Afar

- Provided technical assistance to the RHB in adapting the prototype hospital governing board directive to the region's context. The program supported conducting a consultative meeting with stakeholders to enrich the document. The directive was approved by the RHB and distributed to all hospitals in the region.

- Provided HCF training in collaboration with the RHB and BOFED for 119 staff from FGBs and health facility staff.
- Conducted HCF supervisory visits at 12 health centers and 3 hospitals.
- Conducted supervisory visits at six CBHI woredas to support mobilization activities. As part of the visit, the supervisory team assessed the readiness of selected health facilities in the woredas.
- Provided technical support to the RHB in compiling health facility RRU plans of 39 HCs and 7 hospitals for 2013 EFY to be sent to BOFED for appropriation.
- Participated in plan alignment meeting among the RHB, EHIA, and the Program. The RHB highlighted its plan and commitment to expand CBHI to five additional woredas in 2014 EFY.

Benishangul-Gumuz

- Supported the RHB in revising the HCF directive and implementation manual for use in the region. The directive and manual are drafted separately for health centers and hospitals, considering the experience of Amhara region.
- Conducted HCF reform implementation and institutionalization supervisory visits at 11 health centers and one hospital in Asosa zone.
- Provided technical assistance to the Benishangul-Gumuz RHB in creating a new organizational structure on DRM at the regional, zonal, and woreda levels. The structure was approved by the regional civil service commission.
- Provided technical support in a plan alignment workshop organized by the EHIA branch in collaboration with the RHB.

Somali

- Conducted HCF supervisory visits at two health centers with a focus on progress and challenges encountered in implementing HCF reforms.
- Conducted supervisory visits at four CBHI woredas to help strengthen CBHI community mobilization and enrollment activities. During the visit, the team provided onsite technical support on determining eligible households for CBHI and preparing identification cards.
- Participated in a review meeting organized by the Somali RHB to evaluate the progress of HCF reforms in the region and provide strategic guidance.
- Advocated for recruitment of key finance personnel at health facilities. As a result, 42 finance officers and 42 cashiers were deployed at 42 health facilities located in 18 woredas.
- Conducted a facility readiness assessment in four health centers.
- Provided training on health facility governance for 91 FGB members from 32 health centers.

Gambella

- Provided training for 26 health facility staff on basic concepts of HCF reform implementation and public financial management at health facilities.
- Conducted supervisory visit in the three (Lare, Gog, and Godere) CBHI woredas.
- Participated in plan alignment meeting organized by the RHB and EHIA Gambella branch office.
- Participated in a one-day consultative meeting organized by the RHB in collaboration with BOFED with the objective of discussing the appropriation and approval of health facility's retained revenue.

3. COLLABORATION

The table below details Program activities conducted in collaboration with implementing partners and projects during Y3.

Table 11: Program Collaboration with USAID, development partners, and projects

IR	USAID, Development Partner, or Project	Area of Collaboration
IR 1	Transform: Primary Health Care Project	• Arranging training for health facility staff in HCF and financial management in the agrarian regions
IR 2	Transform: Primary Health Care Project	• Arranging CBHI training for scheme and health facility staff in the agrarian regions • CBHI community mobilizations for and performance reviews at zonal, regional, and national levels
	Clinton Health Access Initiative	• Finalizing the CBHI legal framework • Developing 10-year health insurance strategic plan
IR 3	Clinton Health Access Initiative	• Developing a comprehensive medical audit manual for CBHI
IR 4	Transform: Primary Health Care Project	• Supervisory visits in the agrarian regions

4. SUCCESS STORY

Program Assists Transfer of Health Care Financing Reform Training to Government Counterparts

Beshir Mohamed, head of the new Partnership and Cooperation Directorate in the Addis Ababa City Administration (AACA) Health Bureau, is the face of first-generation health care financing (HCF) reform institutionalization in Addis Ababa. The USAID Health Financing Improvement Program (the Program) worked with the bureau to facilitate the creation of the new directorate which is responsible for HCF reform activities in the city administration. The directorate is further institutionalizing the reforms by building its capacity to conduct HCF reform training without the involvement of implementing partners, including the Program. To date, first-generation HCF reform training has been heavily dependent on support from implementing partners.

Beshir Mohamed presents during the training of trainers session. Photo credit: Ayenew Haileselassie

To support transferring the training role from the Program to local counterparts, the Program supported training of trainers (TOT) sessions for participants from the Addis Ababa City Administration, Dire Dawa City Administration, Harari, Oromia, and SNNP regions to develop a pool of local trainers who will train health facility personnel, managers, and board members on first-generation HCF reform implementation.

Beshir was one of the 14 participants from Addis Ababa in the TOT session co-organized by the Bureau and the Program, which took place in Bishoftu, Oromia, on July 28 – 31, 2021. Participants at the training represented different directorates of the health bureau, the finance bureau, sub-city health offices, and Yekatit 12 Medical College Hospital. Two days of the training session covered the chapters included in the first-generation HCF reform training material produced by the Ethiopian Ministry of Health with technical support from the Program. Facilitation skills training was also provided on the remaining two days, using training material fully developed by the Ministry.

Participants and trainers. Photo credit: Ayenew Haileselassie

The trainees will use the HCF reform knowledge and facilitation skills they gained to cascade the HCF reform training through continuing professional development centers to health facility governing board members, management committee members, and key finance staff selected from health centers and hospitals in the city administration.

"I am a participant of the TOT, so I will be one of the trainers. From here on the health bureau will start to take over the trainings from the Program," Beshir said.

5. MONITORING, EVALUATION, AND LEARNING ACCOMPLISHMENTS

The MEL accomplishments in Y3 include:

- Updated the MEL plan as part of the yearly revision of the plan.
- Completed retrospective data entry into the DHIS2 system configured for the Program. The system underwent testing for systems functionality related to data entry, analytics, and dashboard production prior to the entry. Refresher training on the Program's DHIS2 was provided for the Program's regional staff and currently the system is being used by the Program.
- Worked with the technical team to review and modify the HCF supportive supervision checklist so that it can also be used to monitor post-transition activities and guide the provision of light-touch first-generation HCF-related support to health facilities.
- Ensured research being conducted under the Program met quality and ethical requirements and was processed through institutional review boards.
- Coordinated the preparation of weekly highlights of the Program every Monday and ensured their on-time submission to USAID.
- Initiated and worked on conducting mid-term internal review to assess the program's two-and-a-half year performance, intended to inform future Program course correction. During the year, the Program conducted desk reviews, and interviews with the MOH, EHIA, RHBs, and USAID as part of the data collection for the review. The report will be finalized in Y4.
- Supported the development of the 10-year health insurance strategic plan. The Program provided assistance by serving as the secretary of the TWG working on the plan.
- Provided technical assistance in the orientation of EHIA and RHB staff on the Monitoring and Evaluation Manual for use in the health insurance system that was developed with Program technical inputs.

6. COMMUNICATIONS AND KNOWLEDGE MANAGEMENT ACCOMPLISHMENTS

Communications and knowledge management accomplishments in Y3 include:

- Produced content for three USAID Ethiopia social media posts which garnered more than 4,000 likes.
- Conducted interviews, took photos, and produced success stories as part of the quarterly report submissions. Three quarterly newsletters were produced. The fourth newsletter was put on hold pending clarification of USAID Ethiopia shifts in strategy that occurred in the fourth quarter of Y3.

7. PROGRAM MANAGEMENT AND OPERATIONS

7.1 PROGRAM MANAGEMENT

COVID-19 impact on operations and implementation: Due to the COVID-19 pandemic, the Program continued employing a mix of remote/virtual and in-person implementation, applying safety measures included in the project's detailed COVID-19 mitigation plan. The plan aligns with Abt policies and GOE regulations. During Y3, Program staff who normally work out of the central office in Addis Ababa, including the co-located Oromia regional office team, primarily teleworked from home with some team members working in the physical office space on a rotating basis. All regional and satellite offices were open with caps on the number of staff in the office at the same time. Other mitigation measures in offices included physical distancing, use of hand sanitizer and masks, and regular cleaning and disinfecting. Program activities were prioritized to take place remotely, when possible. Travel continued to be cautious within Ethiopia and no international short-term technical assistance was planned or conducted. During the year, most of the Program staff were able to receive both first and second doses of a COVID-19 vaccine.

Executed an office move:

Security issues and impact on implementation:

7.2 HUMAN RESOURCES

[redacted]

7.3 PROCUREMENT

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

7.4 GRANT MANAGEMENT

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

8. CHALLENGES

[redacted]

9. LESSONS LEARNED

The following lessons were learned in Y3:

- Holding regular CBHI monthly review sessions with EHIA and relevant GOE counterparts has proven to be a useful way to address joint implementation issues, improve responsiveness from government counterparts, and keep activities on track. Conducting similar meetings for other Program workstreams could be beneficial and the Program plans to do so.
- Training facilitators reported that four days is not enough time to present the two modules (HCF reform implementation and facilitation skills) of the HCF TOT training. They found it difficult to apply the training methodologies suggested in the document within the allotted time. This could be related to time management by the facilitators or there may be a need to pilot test the training materials to set an optimal training time before finalizing the materials.
- A rapid assessment conducted by the Program this year showed that security issues impacted CBHI performance in some areas of the country. Different government counterparts were also undertaking situational assessments to understand how health facilities and schemes in areas affected by ongoing conflict and insecurity were impacted, including related to health service provision and physical condition. The Program learned that there is a need to coordinate the provision of technical assistance to the various counterparts in conducting situational assessments, especially those related to CBHI. Doing so will allow resources to be leveraged. Accordingly, coordination activities have been included in next year's implementation plan.

10. PROSPECTS FOR YEAR 4 PERFORMANCE

Following guidance from USAID Ethiopia, the Program will pivot its activities in Y4 to target implementation at the local (woreda, CBHI scheme, health facility, and community) level to directly benefit Ethiopian citizens. Activities such as policy and legal framework development, consultative meetings, and capacity building for counterparts at the regional and national levels will not be conducted as in prior years. Specifically, the Program will focus on:

- CBHI in rural woredas and urban centers; and
- First-generation HCF reforms at health facilities in DRS.

Technical assistance will be provided in implementing CBHI in the rural woredas of agrarian regions, in urban areas, and in DRS, to improve access to health services and the financial risk protection of citizens as measured by levels of household out-of-pocket payment for health. In DRS, the Program will assist woredas and health facilities to strengthen and expand implementation of first-generation HCF reforms at the health facility level. To a lesser extent, the Program will conduct work that if discontinued could disrupt activities started in collaboration with counterparts. The Program will also accelerate activities to sustain gains in previous investments to complete the transition of first-generation HCF reform activities from the Program to local counterparts in reform-advanced regions and city administrations.

Due to the ongoing conflict and associated security challenges in northern Ethiopia, health service delivery and first-generation HCF reform and CBHI implementation have been disrupted in Tigray and parts of Afar and Amhara. In Y4, if feasible, the Program will conduct assessments in these areas to determine the extent to which CBHI schemes and health facilities have been affected by the conflict. Based on assessment findings, the Program will arrange meetings with key stakeholders to build consensus and support the development of action plans to restart reform implementation and resume health service provision.

11. SUMMARY OF FUNDS EXPENDED BY SOURCE

[redacted]

Funding Source	Amount
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

ANNEX A: CUMULATIVE LIST OF DELIVERABLES

The cumulative list of deliverables completed in Y3 is provided in the below table. The status of deliverables posted to USAID's Development Experience Clearinghouse (DEC) is also indicated.

Deliverable Title	Author	Program year and quarter completed	Posted to DEC (Yes/No)	Comments
Program				
USAID Health Financing Improvement Program Annual Performance Report: Year 2 (October 2019 - September 2020)	USAID Health Financing Improvement Program	Y3Q1	Yes	
USAID Health Financing Improvement Program Quarterly Performance Report Year 3, Quarter 1 (October 1, 2020 - December 30, 2020)	USAID Health Financing Improvement Program	Y3Q2	Yes	
USAID Health Financing Improvement Program Quarterly Performance Report: Year 3, Quarter 2 (January 1, 2021 - March 31, 2021)	USAID Health Financing Improvement Program	Y3Q3	Yes	
USAID Health Financing Improvement Program Quarterly Performance Report: Year 3, Quarter 3 (April 1, 2021 - June 30, 2021)	USAID Health Financing Improvement Program	Y3Q3	Yes	
Quarterly Newsletter of the USAID Health Financing Improvement Program Vol. 1, No. 5 September 2020	USAID Health Financing Improvement Program	Y3Q1	Yes	
Quarterly Newsletter of the USAID Health Financing Improvement Program Year 3, No. 1 January 2021	USAID Health Financing Improvement Program	Y3Q2	Yes	
Quarterly Newsletter of the USAID Health Financing Improvement Program Year 3, No. 2 April 2021	USAID Health Financing Improvement Program	Y3Q3	Yes	
IR 1: Increased DRM for enhanced provision of quality PHC services				
Phased Plan for Domestic Resource Mobilization and Sustainability for HIV/AIDS in Amhara Region	Amhara National Regional State Health Bureau	Y3Q2	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
Phased Domestic Resource Mobilization and Sustainable Financing Plan for HIV/AIDS in Oromia Region	Oromia Regional Health Bureau	Y3Q2	No	Produced by Program for GOE. GOE documents not to be posted to DEC.

Deliverable Title	Author	Program year and quarter completed	Posted to DEC (Yes/No)	Comments
The Political Economy of Domestic Resource Mobilization in Ethiopia: Analysis to Support Domestic Resource Mobilization for Health	USAID Health Financing Improvement Program	Y3Q4	Yes	
IR 2: Streamlined risk-pooling mechanisms for wider access to PHC services with reduced financial barriers				
Performance Review of East Gojjam Zonal Community-Based Health Insurance Pool	USAID Health Financing Improvement Program	Y3Q4	Yes	
Assessment of Urban CBHI Schemes in Amhara and SNNP Regions	USAID Health Financing Improvement Program	Y3Q4	Yes	To be uploaded
Assessment of Urban CBHI Schemes in Addis Ababa	USAID Health Financing Improvement Program	Y3Q4	Yes	To be uploaded
Evolution of Community-Based Health Insurance in Ethiopia: A Focus on Agenda Setting, Policy Formulation, and Policy Adoption	Ethiopian Health Insurance Agency	Y3Q4	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
IR 3: Improved arrangements for strategic purchasing of health services from public and private providers				
Medical Audit Manual	Ethiopian Health Insurance Agency	Y3Q3	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
IR 4: Strengthened governance, management, and evidence generation for health financing reforms and health facilities				
Health Care Financing Reforms Training Course for Health Facility Governing Board Members – Participant's Guide	Ministry of Health	Y3Q3	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
Health Care Financing Reforms Training Course for Health Facility Governing Board Members – Facilitator's Guide	Ministry of Health	Y3Q3	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
Health Care Financing Reforms Training Course for Health Facility Finance Staff – Participant's Guide	Ministry of Health	Y3Q3	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
Health Care Financing Reforms Training Course for Health Facility Finance Staff – Facilitator's Guide	Ministry of Health	Y3Q3	No	Produced by Program for GOE. GOE documents not to be posted to DEC.
Health Care Financing Reforms Training Course for Health Facility Management Committee Members – Participant's Guide	Ministry of Health	Y3Q3	No	Produced by the Program for GOE. GOE documents not to be posted to DEC.

Deliverable Title	Author	Program year and quarter completed	Posted to DEC (Yes/No)	Comments
Health Care Financing Reforms Training Course for Health Facility Management Committee Members – Facilitator's Guide	Ministry of Health	Y3Q3	No	Produced by Program for GOE. GOE documents not to be posted to DEC.

ANNEX B: INDICATOR REPORTING

USAID Health Financing Improvement Program Indicators Table – Year 3

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
	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	0.7	0.9	0.73	1.02	0.75	1.09	Data obtained from MOH Health and Health-Related Indicator Annual Report for 2013 EFY. Health service utilization rate (outpatient attendance per capita) for public includes visits made for exempted health services.
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	30.6 %	N/A	N/A	28%	N/A	To be reported after MOH releases 8th round health accounts report.
3	Number of health managers, health providers, other government officials, and community representatives received trainings HCF reform interventions including the CBHI program	Region, training type, participant type and gender, urban/rural	Quarterly	0	3,414	2,002	2,236	4124	1,966	3,630	Target exceeded. Increased EHIA and RHB requests for technical assistance to arrange additional CBHI trainings for newly established schemes and medical auditing training in agrarian regions contributed to the over achievement. Most trainings provided on a cost-sharing basis.
4	Health service utilization rate (CBHI beneficiaries)	Region	Annually (Starting from Y2)	1.1	N/A	N/A	1.1	0.71	1.4	0.68	Target not achieved. Achievement reflects utilization data from 610 of the 720 total woredas because 110 woredas did not report utilization data. Lack of complete utilization data contributed to underachievement. Failure of some woredas to distribute identification cards to CBHI members also contributed. The card enables CBHI members to access health services using insurance coverage. Health service utilization rate for CBHI beneficiaries is expected to increase when complete data is obtained from remaining 110 functional schemes and when all members obtain identification cards.
	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%	64.8%	64.8%	N/A	N/A	66%	N/A	To be reported after MOH releases 8th round health accounts report.

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
1.2	Percent of donor contribution to the health sector	N/A	Year 1, Year 3, Year 5	36%	36%	35.2%	N/A	N/A	34%	N/A	To be reported after MOH releases 8th round health accounts report.
	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										
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%	93%	91%	94%	91%	94%	Target achieved. Number of health facilities implementing RRU is increasing every year.
1.1.2	Percent of health facility budgets made up by retained revenue	Region, facility type (health center, hospital)	Annually	30%	31%	30.2%	32%	30.8%	33%	23%	Target not achieved. Significant increase of government recurrent budget allocated to health facilities to fulfill vacant posts and cover duty allowance partly contributed to lower share of retained revenue from total facility budget.
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%	77.7%	78%	77.9%	Target achieved. Determination is based on data collected from 63 sampled health facilities.
1.1.4	Amount of budget appropriated from RRU	Region, facility type (health center, hospital)	Annually		3.13 Billion ETB	3.1 Billion ETB	3.4 Billion ETB	4.3 Billion ETB	3.7 Billion ETB	5.5 Billion ETB	Target exceeded. Partly because health facilities could plan for increased internal revenue due to rapid expansion of CBHI which became main source of internal revenue. Additionally, the number of health facilities implementing RRU is increasing every year.
	SR 1.2— Strategies on efficiency improvement and rational resource use implemented, including transition/institutionalization arrangements completed for rollout and sustained continuation outsourcing by public hospitals										
1.2.1	Percent of public hospitals outsourcing cost-inefficient non-clinical/ancillary services	Region, type of services outsourced	Annually	90% (113/280)	90%	36%	90%	41%	90%	40%	Achievement far below target (134/333). Contributors to achievement: Absence of competitive vendors/service providers for non-clinical services in remote areas; numbers of hospitals increasing substantially; and limited internal capacity of most of these hospitals to prepare technically-feasible and all-binding contracts. Program learned that given the rapid expansion of primary hospitals in rural areas and associated challenges mentioned above, achieving the minimum target (90%) indicated in the Cooperative Agreement is unattainable.
1.2.2	Number of private enterprises engaged in outsourcing services	Region, type of services	Annually, starting Year 2	113	130	216	143	263	157	267	Target exceeded. Most public hospitals contracted out more than two non-clinical services to different enterprises.

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
	SR 1.3— Explored and implemented strategies on additional domestic resource mobilization for PHC, including public budget and innovative financing sources										
1.3.1	Percent share of government spending on health out of general government expenditure	MOF, MOH annual reports	Year 1, Year 3, end-line	6.6%	7%	9%	8%	N/A	8.6%	N/A	To be reported after MOF releases its audited expenditure review which is the source of data for this indicator.
1.3.2	Percent share of government allocation to health in the national budget	Sources of funding (Government allocation/treasury source, RRU)	Annually	11.5%	12.2%	12.2%	12.7%	10.2%	12.8%	13.2%	Target achieved. Data obtained from MOH Health and Health-Related Indicators Annual Report 2013 EFY.
	SR 1.4— Sustainability financing plan developed for the exempted services package										
1.4.1	Proportion of domestic source out of the total spending for exempted health services	Region	Y4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	A survey planned for Y4 will be the source of data for this indicator.
	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%	24.8%	32%	31.9%	38%	40.4%	Target exceeded. Rapid expansion of the CBHI program in both rural and urban areas contributed to the achievement.
2.2	Re-enrollment rate in CBHI schemes (renewal)	Region, urban/rural	Annually	75%	75%	74%	76%	76%	77%	78.7	Target achieved. Community mobilization activities conducted to increase CBHI coverage contributed to the achievement.
2.3	Share of expenditure from prepayment (insurance) funds in total health expenditure	N/A	Y1, Y3 and Y5		0.54%	0.54%	N/A	N/A	0.80%	N/A	To be reported after MOH releases 8th round health accounts report.
2.4	CBHI enrollment rate from the total eligible households	Region, urban/rural/pastoral	Annually			N/A	40%	44.1%	50%	60.7%	Target exceeded. Community mobilization activities conducted to increase CBHI coverage contributed to achievement.
2.5	CBHI enrollment rate from the eligible households of functional woredas	Region, urban/rural/pastoral	Annually			N/A		N/A	55%	61.4	Target exceeded. Increase in number of functional schemes from 601(in Y2) to 699 (in Y3) in Amhara, Oromia, and SNNP regions contributed to achievement.
2.6	Total amount of money mobilized from CBHI membership contributions and government subsidies	By source (contribution, targeted subside, general subsidy)	Annually	1.04 Billion ETB	1.42 Billion ETB	1.19 Billion ETB	1.85 Billion ETB	1.86 Billion ETB	2.29 Billion ETB	2.4 Billion ETB	Exceeded target. Attributed to increase in CBHI population coverage/enrollment.

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
	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	Number of woredas covered by CBHI program	Region, urban/rural Functional/under establishment	Annually	351	531	667	770	828	825	907	Target exceeded. Contributors to the achievement: Expansion of CBHI program in DRS; spilt of some CBHI woredas into two or three new woredas in Oromia, Sidama, and SNNP that contributed to increased number of new functional schemes; and expansion of CBHI to all 120 woredas in AACA (from 40 in Y1) that contributed to increased number of CBHI-implementing woredas.
2.1.2	Percent of CBHI schemes audited per year (financial) in rural and urban woredas	Region, urban/rural	Annually	43% (36% rural 50% urban)	60%	41%	75%	68.6%	83%	84%	Target achieved (539/642). Data obtained from EHIA 2013 EFY annual report.
	SR 2.3— Safety-net provisions strengthened and expanded to include increased coverage of poor/indigent households in CBHI and fee-waiver in non-CBHI woredas										
2.3.1	Percent of poor households enrolled in CBHI schemes on contribution-exemption basis	Region, urban/rural	Annually	18%	22%	23%	40%	29.4%	50%	33.5%	Target not achieved. Failure/inability of some woreda administrations to cover required targeted subsidies for indigents because COVID-19, locust invasion, and security problems caused resource shifts, partly contributed to the low achievement.
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	530	585	721	825	843	Target achieved. 64 woredas (13 Oromia; 24 Sidama; 4 Amhara, 23 SNPP) did not allocate/transfer the budget.
2.3.3	Number of CBHI woredas that are harmonized with safety-net targeting criteria	Region, rural/urban	Annually	0	N/A	N/A	N/A	N/A	TBD	120	All woredas in Addis Ababa City Administration harmonized indigent selection criteria with safety-net targeting criteria. Progress in agrarian regions to be reported in Y4.
2.3.4	Percent of female headed indigent households among the total indigent households enrolled in CBHI schemes	Region	Annual starting Year 2	N/A	N/A	30%	30%	46.4%	31%	46.1%	Target exceeded. Advocacy work conducted by the Program using various platforms like review and community mobilization meetings contributed to the achievement. Reporting based on data collected from 49 randomly selected schemes in the agrarian regions.
2.3.5	Percent of CBHI board with at least one woman board member	Region	Annual starting Year 2	N/A	N/A	N/A	100%	100%	100%	100%	Target achieved. Reporting based on data collected from 49 randomly selected schemes in agrarian regions.

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
2.3.6	Percent of poor population covered by CBHI from total poor population below poverty line in the country	Region, urban/rural	Annually	18%	22%	24.9%	40%	28.9%	60%	32.8%	Target not achieved. Failure/inability of some woreda administrations to cover required targeted subsidies for indigents because COVID-19, locust invasion, and security problems caused resource shifts, partly contributed to the low achievement.
	SR 2.4— Worked with EHIA and MOH in supporting implementation of SHI program										
2.4.1	Number of technical consultation meetings conducted as part of preparation for SHI launch	N/A	Annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No targets set as GOE delayed launch of SHI and it is projected to start in 2023 (final program year). Targets have been deleted from Program's Y4 MEL plan.
	IR 3—Improved arrangements for strategic purchasing of health services from public and private providers										
3.1	Percent of health facility claims verified	Region	Annually	79%	100%	80%	100%	86.9%	100%	82.7%	Target not achieved. Some woredas failed to verify all claims submitted by contracted health facilities due to staff turnover. Reporting based on data collected from 49 randomly selected schemes.
3.2	Percent of hospitals audited by pool of medical auditors	Clinical/claim	Annually	0	0	N/A	0	N/A	10%	N/A	EHIA has not started the activity.
	SR 3.1— Management structures, roles, and capacities streamlined for health insurance programs to ensure better interface between them and functional split between health facility providers and purchasers										
3.1.1	Percent of schemes staffed as per the organizational structure	Region	Annually	86%	100%	86%	100%	83%	100%	76%	Target not achieved. CBHI executive staff turnover observed in some woredas may have contributed to underachievement. Reporting based on data collected from 49 randomly selected schemes.
	SR 3.2—Tools and skills institutionalized for periodic revision of user-fee schedules										
3.2.1	Number of regions implemented tool to facilitate periodic revision of user fee schedules	N/A	Annually	N/A	N/A	N/A	N/A	N/A	2	N/A	Tool developed and piloted in Y3. Tool to be implemented in Y4 after training provided to users.
	SR 3.3— New provider payment approaches explored and piloted, particularly within urban insurance programs that also facilitate better participation of private health sector providers										
	SR 3.4— Health facility accreditation requirement made mandatory for all providers under SHI and CBHI programs										

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
3.4.1	Proportion of health facilities assessed for fulfillment of minimum quality standards	N/A	Annually (starting from Y3)	N/A	N/A	N/A	N/A	N/A	10%	N/A	EHIA did not undertake this activity in Y3.
	IR 4—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%	93%	90%	91%	90%	90%	Target achieved.
	SR 4.1— Institutional structures and roles defined and capacities strengthened for spearheading and managing health financing reforms at all levels of the health system										
4.1.1	Number of RHBs with functioning resource mobilization structure	Region	Annually	1	1	1	4	4	11	6	Target not achieved. Priority was given to reform-advanced regions/agrarian and city administrations.
	SR 4.2— Transition/institutionalization arrangements completed for rollout and sustained continuation of facility governing boards with community representatives										
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	35.8%	36%	35.8%	49%	37%	62%	44.4%	Target not achieved. Although regions started implementing revised manual that stipulates FGBs should have at least two women members in Y3, and there is an increase in women board members compared to Y2, the Y3 target was not met. Underperformance may be attributable to fact that some woredas have already-established boards that serve for two to three years; therefore, government bodies that assign/nominate board members might be waiting for existing boards to finish their term before applying manual. Reporting based on data collected from 63 sampled health facilities.
4.2.2	Percent of health facilities with community participation in board meetings	Facility type (health center, hospital)	Annually	85%	85%	85%	95%	81.3%	100%	100%	Target achieved. Reporting based on data collected from 63 sampled health facilities.
	SR 4.3— Transition/institutionalization arrangements completed for operating private wings in public hospitals to support improved staff retention and revenue generation										
4.3.1	Total number of public hospitals with private wings established	Federal, Region, hospital type	Annually	63	49	49	49	49	49	45	Target not achieved. Program learned regions have no interest in establishing private wings for various reasons and interest is likely to decline further as public hospitals in Amhara have closed private rooms.
	SR 4. 4— Generation of evidence and documentation and dissemination of lessons learned improved for policy refinement and decision-making on HCF reforms and health facility management										

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Remarks
					Target	Actual	Target	Actual	Target	Actual	
4.4.1	Number of policies, strategies, legal frameworks, and guidelines revised to improve health financing reforms	Document type	Annually	0	0	N/A	5	2	2	2	Target achieved. CBHI proclamation and implementation regulation.
4.4.2	Number of operations research/studies/surveys conducted, and results/reports disseminated/published	Type of study	Annually	-	2	1	2	4	2	5	Target achieved. Y3 studies: Political Economy of DRM in Ethiopia, Review of East Gojjam Zonal CBHI Pool, Assessment of Urban CBHI Schemes in Amhara and SNNP Regions, Assessment of Urban CBHI Schemes in Addis Ababa, Evolution of Community-Based Health Insurance in Ethiopia: A Focus on Agenda Setting, Policy Formulation, and Policy Adoption.
4.4.3	Number of reports, success stories, and newsletters developed and disseminated	Type of document	Quarterly	-	8	7	12	12	12	10	Target not achieved. Newsletter with success stories not produced for Y3 Q4.
4.4.4	Number of review meetings and policy dialogues organized in support of the health care financing reform interventions (to secure needed policy changes, decision-making and proper implementation at the federal, regional, and zonal/woreda levels)	Federal, regional, zonal	Quarterly	-	47	61	136	84	78	87	Target exceeded (112%). Due to high number of requests from RHBs (including DRS) for technical support to organize regional and zonal level CBHI review meetings (62 zonal, 23 regional, and 2 national).
4.4.5	Number of health facilities visited through the Supportive Supervision visits to monitor and strengthen the implementation and impact of the health care financing reform at all levels (national and sub-national)	Federal, regions, facility type	Quarterly	-	274	147	196	169	396	293	Target not achieved (74%). 235 health centers and 58 hospitals were visited. Team was unable to conduct targeted number of visits as institutionalization of first-generation reform activities were prioritized. No visits were made in Q1 which partly contributed to the low performance.
4.4.6	Number of CBHI schemes visited through the Supportive Supervision visits to monitor and strengthen the coverage and implementation of the CBHI schemes at woredas	Federal, regional	Quarterly	-	215	189	213	204	231	232	Target achieved (168 rural, 64 urban schemes).