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MINISTRY OF HEALTH-ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

TUBERCULOSIS DOMESTIC RESOURCE MOBILIZATION AND SUSTAINABILITY ROADMAP FOR ETHIOPIA

January 2022 · Ethiopia

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January 2022

About HS4TB

The USAID Health Systems for Tuberculosis (HS4TB) project seeks to transform the way country leaders and health system managers understand and work toward TB control and elimination. HS4TB is a five-year USAID contract focusing on health systems priorities that most directly support achievement of TB outcomes, with a focus on health financing and governance in the USAID TB priority countries. The project helps countries increase domestic financing, use key TB resources more efficiently, build in-country technical and managerial competence and leadership, and support policy formation and dissemination. HS4TB is led by Management Sciences for Health (MSH) in partnership with Nathan Associates and Open Development.

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Acronyms

BOFED	Bureau of Finance and Economic Development
CBHI	Community-Based Health Insurance
CCCs	Community Care Coalitions
CDC	US Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CRS	Corporate Social Responsibility
DPCD	Disease Prevention and Control Directorate
DRMS	Domestic Resource Mobilization and Sustainability
DR-TB	Drug Resistance TB
EFY	Ethiopia Fiscal Year
EHIS	Ethiopia Health Insurance Services
EPSA	Ethiopian Pharmaceutical Supply Agency
ERA	Ethiopian Roads Authority
ETB	Ethiopian Birr
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
GGE	General Government Expenditure
GGHE	General Government Health Expenditure
GOE	Government of Ethiopia
HCFS	Health Care Financing Strategy
HIBP	Health Insurance Benefit Package
HIV	Human Immunodeficiency Virus
HPR	House of Peoples' Representatives
HSTP II	Health Sector Transformation Plan II
IBEX	Integrated Budgeting and Expenditure System
IFMIS	Integrated Financial Management Information System
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
MOF/MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
MOR	Ministry of Revenue
NHA	National Health Accounts
NTP	National Tuberculosis Program
OOP	Out of Pocket
PCD	Partnership and Cooperation Directorate
PPD	Policy and Planning Directorate
PPP	Public Private Partnership
RHB	Regional Health Bureau
SDG	Sustainable Development Goals
SHI	Social Health Insurance
TB	Tuberculosis
TBL-NSP	TB and Leprosy National Strategic Plan
THE	Total Health Expenditure
TIFA	TB Implementation Framework Agreement
TWG	Technical working group
UHC	Universal Health Coverage
UN	United Nations
US$	U.S. dollar
USAID	U.S. Agency for International Development
USG	U.S. Government
WHO	World Health Organization
WOFED	Woreda Office of Finance and Economic Development
WorHo	Woreda Health Office

Executive Summary

Ethiopia's Ministry of Health (MOH) is committed to achieving the Global End TB Strategy's objectives of reducing tuberculosis (TB) incidence and mortality by 90 and 95 percent respectively and reducing the percentage of people with TB facing catastrophic costs to 0% by 2035 (compared to 2015 levels). Ethiopia achieved the End TB Strategy 2020 milestones of a 20% reduction in the TB incidence rate and 35% reduction in TB deaths between 2015 and 2020 (WHO Global TB report, 2021). However, Ethiopia continues to have one of the highest burdens of TB and TB/HIV co-infection globally (WHO, 2021). TB is also the fifth overall leading cause of death and the fourth leading cause of death among communicable, maternal, neonatal, and nutritional diseases in Ethiopia (IHME, 2020).

Despite the high burden of TB in Ethiopia, it receives a comparatively small share of health sector resources, accounting for US$ 65 million or 2.1% of total health expenditure in 2016/2017 (MOH, Ethiopia Health Accounts, 2020). According to the latest National Health Account (NHA), TB is majority funded by external sources (44.7%) and households (43.7%); the government contributes only 11.7% of total expenditure on TB. The 5-year TB and Leprosy National Strategic Plan (TBL-NSP), from July 2021 to June 2026, requires an investment of US$ 619 million or an average of US$ 123 million per year to reach its goals. In 2021, the Government of Ethiopia (GOE) contributed an estimated US$ 10.9 million to TB. The plan currently has an estimated US$ 349 million funding gap (66 percent) based on current financing projections.

Due to the lack of a comprehensive electronic financial management system or planning process that considers financing from different funding streams and tracks program-specific expenditures, it is difficult to accurately track TB expenditure through the government system. This makes gathering evidence to support decision-making and budget advocacy for additional government allocation to TB challenging. The lack of cohesive reporting also means that the Ministry of Finance and Economic Development (MOFED) and subnational finance offices may be unaware of the TB financing context and justification or need for additional financing.

TB disproportionately affects vulnerable and poorer populations, and TB-affected households face catastrophic expenditure as a result of TB. A recent study estimated that patients with TB incurred a total cost of US$ 115 per episode, representing 21 percent of the annual household income. In the study, 48 percent of TB affected households faced catastrophic expenditure[1] for TB care (Assebe LF et al., 2020). Social protection mechanisms in Ethiopia—which include free TB services at public facilities, community-based health insurance (including subsidization for indigents) and a fee-waiver scheme for the poor—cover a limited number of TB-related costs. Fifty-four percent of estimated total patient costs are due to indirect costs such as loss of productivity (Assebe LF et al., 2020).

As priorities shift with changing global and domestic landscapes and with stagnating external resources, the MOH recognizes the importance of planning for securing and protecting sustainable funding for the TB response long-term. The GOE has made contributions to the TB program through support of the health workforce and the health facility and laboratory infrastructure, but with unreliable external resources and a high burden on low-income households through out-of-pocket costs, domestic

[1] Catastrophic expenditure for tuberculosis was defined as when the total costs (direct and indirect) related to TB exceeded 20% of pre-TB annual household income, as defined in the WHO End TB Strategy.

resources will be required to fund core elements of the program, including: (1) TB-related commodities and supplies at the federal level, working in close coordination with the HIV program; (2) performance monitoring and other programmatic support areas at the regional level—incentivized through co-financing initiatives and advocacy; (3) protection of households against medical and non-medical out-of-pocket costs through better coordination with social protection programs and community structures; and (4) targeted outreach to key populations through mainstreaming with related sectors and strengthened partnerships with large public and private enterprises, such as mining companies.

The NTP, which is supported and overseen by the Disease Prevention and Control Directorate (DPCD) and the Partnership and Cooperation Directorate (PCD), stewarded the development of this TB domestic resource mobilization and sustainability (DRMS) Roadmap under the umbrella of the Health Care Financing Strategy (HCFS) of Ethiopia 2017-2025. The Roadmap is a strategic and operational plan that outlines objectives and concrete steps towards potential domestic resource mobilization options and opportunities. It offers stakeholders a direction for further developing the evidence base and for engaging organizations, coalitions, and champions to structure subsequent decision-making and support advocacy efforts to spur DRM for TB. This includes leveraging and integrating TB programming into existing and new health financing initiatives. The Roadmap includes an implementation plan, with defined activities, roles and responsibilities, and a timeline to achieving the Roadmap's objectives. The likelihood of these activities being implemented is maximized by aligning them with the approaches being implemented under the HCFS, such as innovative financing mechanisms for health, strengthening and scaling health insurance mechanisms, and improving public financial management.

The overall goal of the Roadmap is for Ethiopia to finance 20% of the cost of the TB program (TBL-NSP) from domestic sources by June 2026. From 2022 to 2026, Ethiopia aims to: 1) Increase the share of the domestic government health budget allocated to TB from 0.9% (estimated US$ 10 million) to 1% (estimated $US 22.8 million) by June 2026; 2) Reduce the share of out-of-pocket (OOP) expenditure of TB patients out of the total tuberculosis expenditure from 43.7% to 31% by 2026; and 3) Establish a baseline for increasing private corporate entity participation in financing TB by strengthening and establishing accountable partnership agreements on TB-related initiatives.

The Roadmap consists of six Strategic Initiatives, three Critical Enablers, and Governance and Implementing Arrangements:

Public Domestic Financing Initiatives

- *SI 1. Increase allocation of general government revenues to health, and specifically TB, at federal and regional levels through evidence-based advocacy, enhanced exempted-service policy and co-financing*

The NTP, Federal Ministry of Health (FMOH), and sub-national health bureaus will strengthen advocacy and negotiation efforts to secure an increase in budget allocations for the TB program from the Ministry of Finance and regional and woreda finance bureaus. Specifically, the NTP will advocate for the financing and procurement of TB drugs, supplies, and equipment to be designated as a Federal responsibility as part of the other exempted services. As the FMOH is revising the list of exempted services and the Ethiopia Health Insurance Services (EHIS) is developing a Health Insurance Benefit Package (HIBP), the NTP and its partners will engage and provide an evidence base to ensure that TB interventions are included in either of these benefit packages. Lastly, the NTP and FMOH will leverage co-financing experiences to catalyze domestic funding for TB at each level of the healthcare system to improve TB services in addition to increased financing for commodities and supplies procurement.

- *SI 2. Explore the potential for eventual integration of TB services into social and community-based health insurance benefits packages in the long term*

Expansion of health insurance coverage is a key component of Ethiopia's HCFS. Integration of TB and other exempted services into the benefit package of the health insurance scheme is essential to ensure long-term sustainability. The NTP will advocate for the inclusion of TB interventions into the HIBP, along with other exempted services, to ensure that services remain accessible to patients but also to benefit from strategic purchasing reforms in the future.

- *SI 3. Explore opportunity to improve TB mainstreaming and multi-sectoral collaboration – particularly related to non-medical OOP costs such as nutritional supplements*

The NTP will continue to further develop and leverage existing relationships with multisectoral ministries and offices, such as the Ministry of Mining and Petroleum, Ministry of Labor and Social Affairs (MoLSA), Ministry of Education, Prison Administration, Police Commission, and the Administration for Refugee and Returnee Affairs, to contribute to reaching priority populations and progress towards TBL-NSP goals through targeted interventions related to their sectors.

Innovative Financing Initiatives

- *SI 4. Explore opportunities to leverage from a forthcoming 'Resilience and Equity Fund' to be financed by proposed excise tax earmark for health to support TB*

As the FMOH navigates the potential earmarking of a proportion of the excise tax revenue for health and the creation of a 'Resilience and Equity Fund' to consolidate health sector funding from innovative sources, the NTP and its partners will support PCD with an evidence base to make the case for the consideration of TB in these broader health sector initiatives. NTP will also support the PCD to develop the resource allocation criteria for the Fund, ensuring it considers TB priorities and key funding gaps as part of its overall prioritization process.

- *SI 5. Explore opportunities for the corporate private sector to contribute sustainably to the TB response*

The NTP will leverage existing relationships with large enterprises, including state-owned corporations, to advocate for the development of workplace wellness programs that support TB, such as screening mining workers. The NTP will also explore the possibility of leveraging the existing HIV DRM strategy that requires HIV programming inclusion in road contracts, by integrating TB into the existing HIV programming in road contracts and/or taking the same approach to the mining industry.

- *SI 6. Examine opportunities for community-level engagement through community care coalitions or similar to help offset non-medical OOP TB-related costs in the long term*

As kebele-level, volunteer-based committees that collect annual community member contributions (financial and in-kind) to support disadvantaged populations, community care coalitions (CCCs) are well-placed to fulfill a role in the community by supporting non-medical TB-related costs that place a high OOP burden on low-income households. The NTP will work in collaboration with MoLSA and other program managers to examine the opportunity for integrating TB-related support into the CCC mandate.

Critical Enablers for Efficiency and Sustainability

- *CE 1. System development to promote transparency and accountability in the collection, allocation, and execution of TB funding by improving resource tracking and monitoring of co-financing practices by different levels of government*

The NTP will support PCD to ensure appropriate inclusion of TB-related allocations and expenditures in the development of a planned new electronic integrated financial management system. PCD, in collaboration with NTP, will be responsible for mapping and tracking the resources committed, allocated, and spent, and the programmatic areas funded.

- *CE 2. Enhance allocative and technical efficiency for TB programming*

TB resources will be allocated to the regions, populations, and interventions of greatest need and cost-effectiveness, as determined in TBL-NSP, to maximize impact. Procurement will be targeted as an area of particular concern for ensuring a cost-efficient response.

- *CE 3. Realize efficiency gains through engagement of the private health sector*

The private health sector plays an important role in TB service delivery and care that will be further strengthened by improving the enabling environment for private sector engagement in TB programming. This will include exploring the creation of performance-based contracting mechanisms with private sector providers, reinforcing government capacity related to private sector engagement, and investing in improved monitoring and reporting among private sector providers.

Governance and Implementing Arrangements

The NTP and PCD, in coordination with other key partners, will sensitize and strengthen capacity at all levels of government and across sectors to implement the Roadmap. NTP and PCD will work together with development partners to improve donor coordination and alignment of external resources with funding needs and TBL-NSP priorities.

Implementation of these six strategic initiatives and three critical enablers, in addition to the governance and implementing arrangements, will be overseen by NTP and PCD and its partners, guided by the implementation plan. Pursuing the initiatives under this Roadmap will represent a critical step in achieving long-term sustainability for Ethiopia's TB response.

Background

Context and Rationale

Ethiopia has made remarkable progress over the last decade to reduce the burden of tuberculosis (TB). All of the major TB indicators—incidence, prevalence, and mortality—have decreased by more than half since 1990. But the gains have been uneven; nearly a third of presumptive TB cases go undetected each year, resulting in continued spread of the disease throughout the country, often among the poorest and most vulnerable communities. While a declining TB incidence will reduce total costs over time, the investment needed in the near term to find and treat undetected cases will be significant. The most recent TB and Leprosy National Strategic Plan (TBL-NSP, July 2021- June 2026) outlines the country's priority strategies for ending the TB epidemic and calls for over US$123 million annually to be invested in TB programming.

One of the complexities of financing TB is that it requires both investments in direct patient care and investments in public health strategies to reach the most at-risk populations and retain these patients in a long treatment regimen that can last up to six to nine months. Even though TB is considered an "exempted" service—provided at no charge to TB patients in public health facilities—patients must pay for medical costs leading up to their TB diagnosis, as well as non-exempted medical and non-medical costs associated with TB care. Nearly 44 percent of TB-related costs are borne by households in Ethiopia (MOH, Tuberculosis program financing, 2020). And while the Government finances the cost of running public health facilities, nearly all of the costs of TB-specific diagnostics and drugs, as well as the outreach strategies to identify new cases and the activities to monitor TB performance, are financed by external partners.

In the context of static or declining external funding, increased programmatic needs, and catastrophic out-of-pocket (OOP) costs, more attention is needed on how Ethiopia can mobilize domestic resources for TB. This will be critically important for building on the gains made to date and making progress towards reducing the burden of disease. Additionally, the economic benefits of ending TB far outweigh the costs, making TB efforts a critical piece of the sustainable development agenda and a worthy investment by both public and private sectors. The High-Level Panel for the UN's SDGs has estimated that an investment of US$ 1 in TB care yields a return of US$ 30 (United Nations Secretary General, 2015). Other studies have put the return as high as US$ 115 for each dollar invested (Goodchild et al, 2011). The global COVID-19 pandemic and its economic implications has further illustrated the critical importance of investing in the systems needed to combat airborne infectious diseases of the present and future.

Purpose of the Roadmap

The purpose of this document is to present a TB Domestic Resource Mobilization and Sustainability (DRMS) Roadmap, under the umbrella of the Health Care Financing Strategy (HCFS), 2021-2030 (see Box. 1), that will guide increased domestic funding from different sources (including the private sector) to sustain TB activities over time. The TB DRMS Roadmap is a practical, operational plan that outlines concrete steps, roles, and responsibilities, and a timeline towards potential domestic resource mobilization options and opportunities. It offers stakeholders a direction for further developing the evidence base and engaging organizations, coalitions, and champions to support advocacy efforts in integration and commitment of TB financing into existing and new health financing initiatives. The likelihood of these activities being implemented is maximized by aligning them with the approaches being

implemented under the HCFS, such as innovative financing mechanisms for health, strengthening and scaling health insurance mechanisms, and improving public financial management.

The TB DRMS Roadmap will be stewarded by the National TB Program (NTP), which is supported and overseen by the Disease Prevention and Control Directorate (DPCD), and the Partnership and Cooperation Directorate (PCD) of the Federal Ministry of Health (FMOH).

Box 1. HCFS Strategic Objectives

The Government has shown political will to advance sustainable financing in the health sector through the Healthcare Financing Strategy 2021-2030 (HCFS). To accelerate Ethiopia's progress toward Universal Health Coverage (UHC), the Government has developed a strategy to increase resource flows into the health sector, improve the efficiency of resource utilization, and ensure sustainability of financing to improve the overall coverage and quality of health services. The HCFS outlines five strategic objectives to guide the transition to more equitable and sustainable financing for health, through gradual substitution of external funding with domestic funding. The HCFS provides the framework for how the TB program can use evidence to advocate for greater and more efficient and sustainable investments in TB within broader health sector resource mobilization efforts.

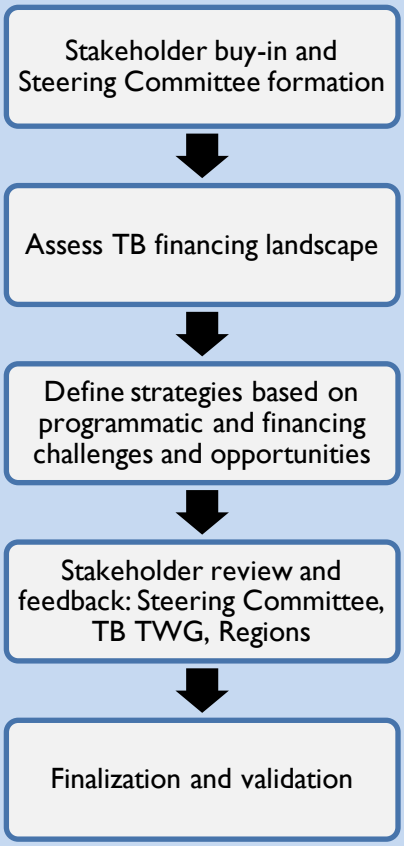
1	• Mobilize adequate resources through traditional and innovative approaches
2	• Reduce Out of Pocket (OOP) spending at the point of use
3	• Enhance equity, efficiency and effectiveness
4	• Strengthen public-private partnership
5	• Capacity development for improved health care financing

Roadmap Development Process

This Roadmap was developed under the guidance and leadership of the Steering Committee and TB Technical Working Group in a consultative and evidence-based process (Box. 2). The Steering Committee is chaired by the DPCD and PCD and includes members from the U.S. Agency for International Development (USAID), World Health Organization (WHO), Clinton Health Access Initiative (CHAI), and other development partners. The TB Technical Working Group (TWG) is hosted by the NTP and includes partners, non-governmental organizations, and private sector partners from the TB community [U.S. Centers for Disease Control and Prevention (CDC), GFATM Country Coordinating Mechanism, Ethiopia Private Health Sector Association, German Leprosy and TB Relief Agency (GLRA-Ethiopia), KNCV Tuberculosis Foundation, Reach Ethiopia, USAID Eliminate TB Project, and WHO)].

Before the development of the Roadmap, a landscape analysis of the TB financing context was conducted from June to October 2021. The landscape assessment reviewed available literature and data to establish the current financing context for TB and to project future funding needs and financial resource gaps. The assessment also examined how TB financing flows through the GOE's financial management systems, including the pathways for external funding, and examined co-financing practices. Desk-based research was supplemented by qualitative key informant interviews with approximately 70 stakeholders at the Federal level and in four regions, to better understand the underlying challenges, funding channel preferences, and opportunities for DRM for TB in Ethiopia with consideration of the political climate. An additional literature review was conducted to examine the experiences of other countries and the issues related to various strategies for funding TB and other essential health programs. A detailed accounting of the approach and methodology can be found in Annex 1.

Box 2. Roadmap Development Process



The Roadmap was developed between October and December 2021 in close consultation with key stakeholders at the national, regional, and woreda levels. Throughout the data collection and roadmap development process, a series of consultative sessions was held with the Steering Committee and TB TWG to define the vision, objectives, strategic pillars, and key action steps for achieving TB DRMS. DRMS mechanisms were evaluated with consideration of the revenue potential, feasibility (technical, legal and economical), acceptability to government (political considerations), and alignment with TB program needs. The draft Roadmap document has been reviewed in consultative meetings with national stakeholders, and the final document includes their inputs.

The Roadmap also includes activities or actionable steps, with timelines and responsibilities for different stakeholders. The FMOH, DPCD/NTP, PCD, and their partners acknowledge that ongoing review and regular updates of this roadmap are required to reflect changes in the political, economic, and programmatic context of strategy implementation.

Situational Analysis

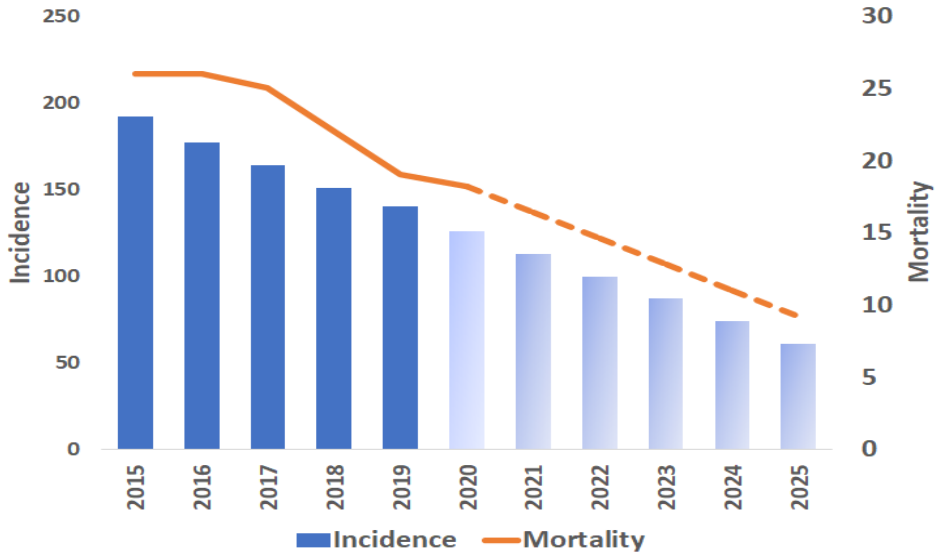
Ethiopia's TB Response

Ethiopia has made remarkable progress in reducing the prevalence and mortality of TB over the last decade by following globally recommended TB policies, largely through the efforts of the Government and its partners. As a result, nearly two million cases of TB have been identified and treated in the last

two decades (MOH, End Term Review TBL-NSP, 2019). All of the major TB indicators—incidence, prevalence and mortality—have decreased by more than half since 1990 (Deribew et al., 2018).

The country has ambitious plans to eliminate TB as a public health problem. To move on this ambition in in 2015, Ethiopia adopted the global END TB Strategy, with the aim of reducing deaths attributed to TB by 95 percent and reducing the number of people who develop TB every year by 90 percent by 2035 (compared to 2015 levels). This translates to less than 10 cases per 100,000 population and zero deaths by 2035. While Ethiopia is on track to meet the END TB targets of reducing TB incidence (i.e., 8 percent annual decline), the country is still a long way from meeting the 2025 milestone of reducing TB-related mortality (i.e., 7 percent annual declines) (Figure 1). Ethiopia is also one of the countries with the highest burden of TB and TB/HIV co-infection globally (WHO, Global TB report, 2021). TB is also the fifth overall leading cause of death and the fourth leading cause of death among communicable, maternal, neonatal, and nutritional diseases in Ethiopia (IHME, 2020).

Figure 1. Progress towards END TB targets (incidence and mortality per 100,000 population) in Ethiopia



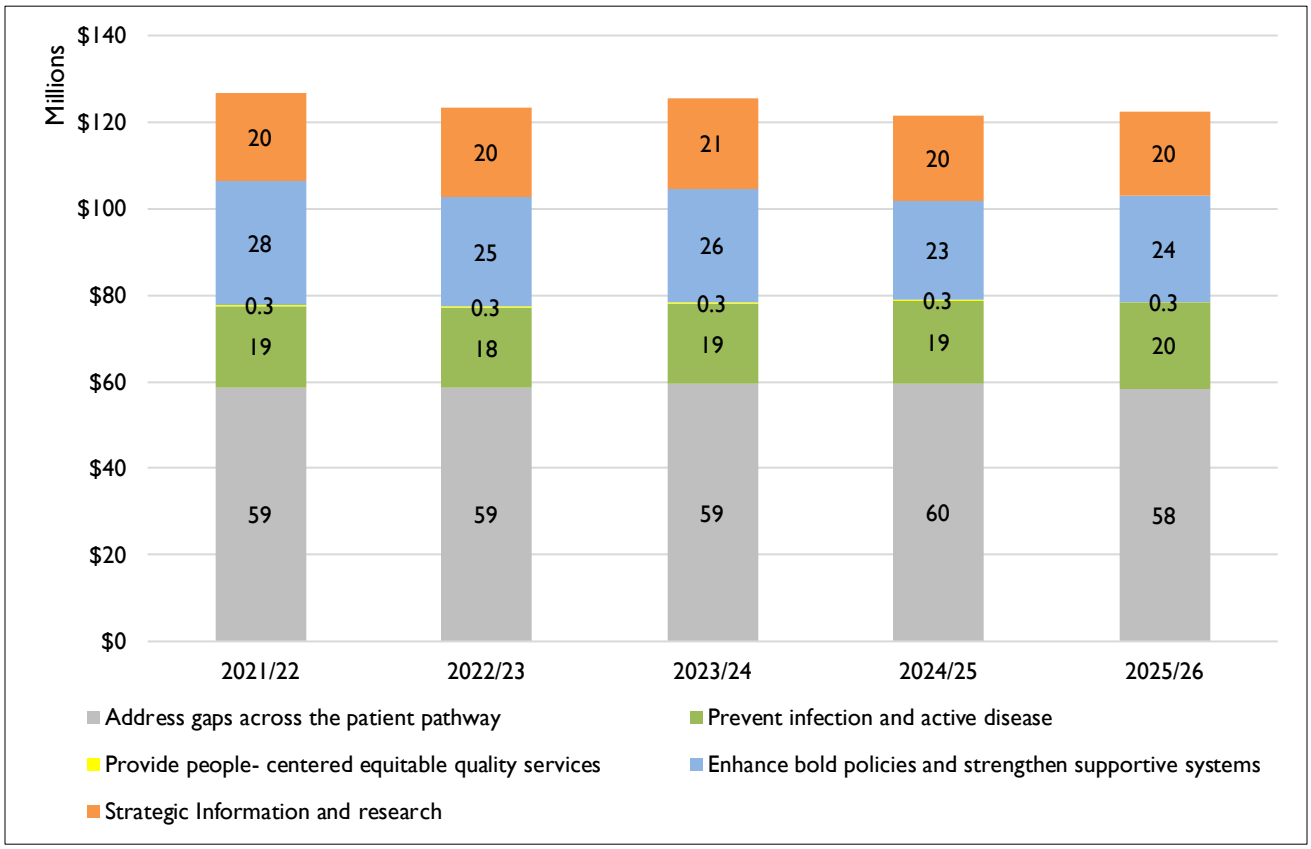
Source: FMOH TB program report 2015-2019 and projection for 2020-25 (DHIS-2)

Ethiopia's Future TB Programming Needs

The most recent TBL-NSP (2021/22 to 2025/26) outlines the country's priority strategies and required budget for meeting the targets defined by the END TB Strategy and ending the TB epidemic—defined as fewer than one hundred incident TB cases annually per one million population. Under the TBL-NSP, the country has developed a plan to reduce TB incidence and mortality by 40 and 70 percent, respectively, during the five-year implementation period. To achieve these goals, the TBL-NSP focuses on achieving the three people-centered targets of reaching at least 90 percent of people with TB, including key and vulnerable populations; placing 90 percent of them on appropriate treatment; and ensuring that at least 90 percent of them successfully complete treatment. A total of 587,000 people with TB and 5,430 with DR-TB are expected to be diagnosed and receive treatment and care during the five-year TBL-NSP period. The total anticipated financial need for implementing the national TBL-NSP strategies and plans

requires an investment of US$ 619,576,000 over five years, with an annual average of US$ 123,915,000 (Figure 2) (MOH, TBL-NSP, 2020). Changes in the political and economic environment since the development of the TBL-NSP, including effects due to the COVID-19 pandemic, call for increased urgency and need to prioritize the health sector and its essential programs, including TB.

Figure 2. TB resource requirements by TBL-NSP strategic objective, 2021/22-2025/26



Source: TBL-NSP; note: The budget follows the Ethiopian fiscal year, and the cost of leprosy is not included. Most of the commodity costs are under the first objective ("Address gaps…").

Priority Programmatic Strategies

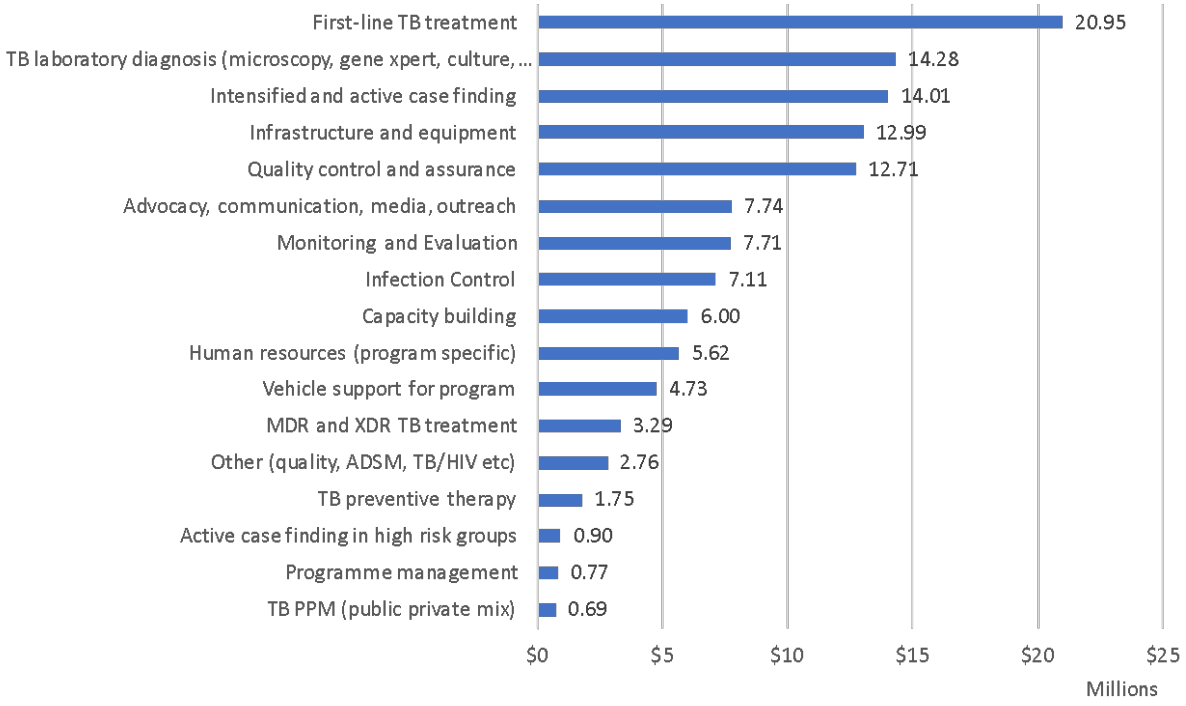
Ethiopia has performed well in treating cases of TB once they are diagnosed. In 2018, the national treatment success rate among all forms of TB was 96 percent. However, the gains that have been made are distributed unequally; only 69 percent of presumptive TB cases were detected in 2018. If undiagnosed and untreated, people can die from TB, become chronically ill, and continue to spread the disease in the community, perpetuating the pandemic.

Some of the challenges for identifying TB cases in Ethiopia are that TB screening is not routinely integrated and reported in all healthcare settings, such as general outpatient and inpatient departments, and diabetic, nutrition, mental, maternal, and child health services. Nationally, close to 20 percent of public health facilities lack any form of TB diagnostic capacity, and only three percent of private facilities are engaged in TB services, even though around 20 percent of TB patients' initial visits are to private

care settings (MOH, TBL-NSP, 2020). Commodities financing is not sufficient to ensure universal access to rapid TB diagnostics, especially for those with presumptive TB, and considerable expansion of TB prevention activities is still needed. Further, COVID-19 has had a profound impact on the national TB program, by interrupting routine services to screen for and treat TB patients and limiting availability of health care providers and rapid diagnostic technologies (MOH, TBL-NSP, 2020).

To address these vulnerabilities, under this phase of the TBL-NSP, the TB program will continue to focus on "addressing gaps in the patient pathway" to care—through systematic screening, universal drug susceptibility testing and imaging techniques, early treatment for all types of TB, contact investigation, and linkage to TB preventive treatment—while doing more to reach high-risk groups through targeted approaches. Interventions to screen, diagnose, and treat TB, and to reach high risk populations, account for half of the projected costs (see Figure 3). More than a quarter of the total TBL-NSP budget is planned to be spent on case finding, laboratory strengthening, capacity building, advocacy, monitoring, and evaluation activities at the regional level.

Figure 3. Annual average TB resource requirements by TBL-NSP programmatic strategies



Source: TBL-NSP; note: The budget follows the Ethiopian fiscal year, and the cost of leprosy is not included.

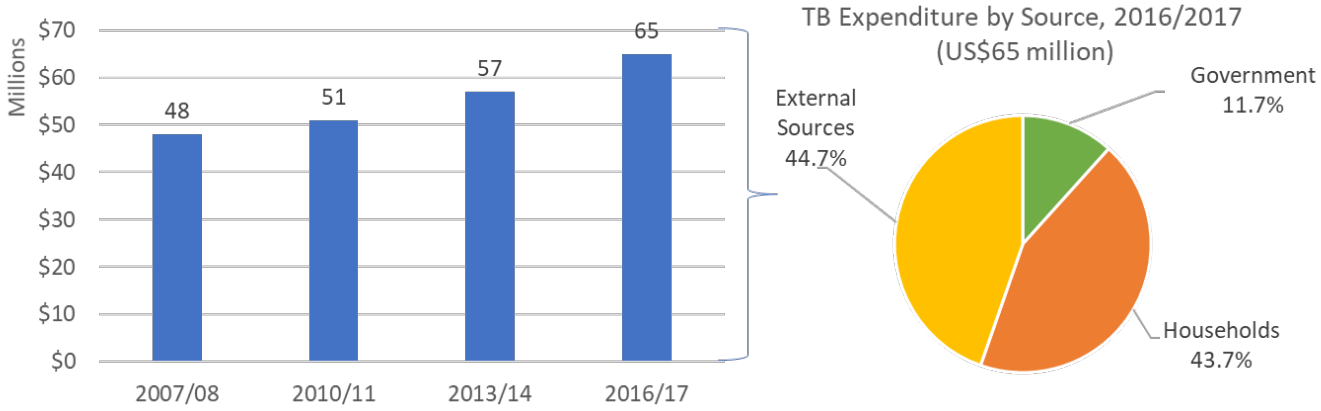
Current TB Financing Landscape

TB Financing Trends

During the last decade, the total TB health expenditures in the country (including government expenditure, external sources, and household contributions) increased at an average rate of 9.5 percent every year (Figure 4). According to the latest National Health Account (MOH, Tuberculosis program financing, 2020), a total of US$ 65 million was spent on TB in 2016/17, though nearly half (43.7 percent) of TB spending was sourced by households. When comparing Ethiopia's level of investment to global

trends, total spending on TB in low-income countries increased by 4.3 percent from 2000 to 2017, with almost a third of the funding coming from household spending (Su et al., 2020).

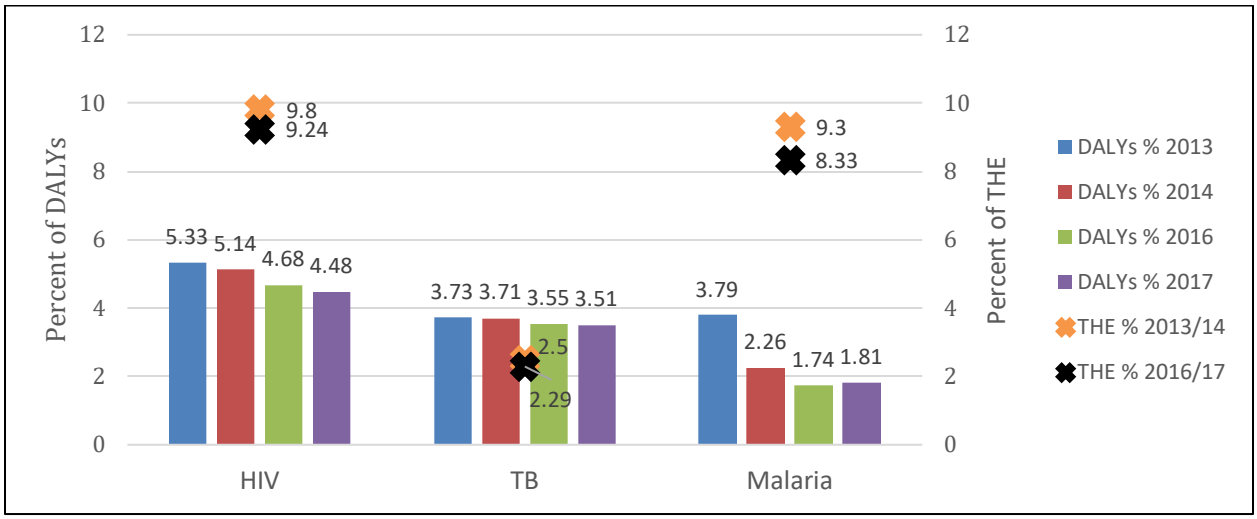
Figure 4. Trend in TB Spending, 2007/08 to 2016/17, and Source of TB Expenditure, 2017



Source: Ministry of Health, TB Program Financing, 2020

Despite the high burden of TB in Ethiopia, TB receives a relatively small share of overall health sector resources, accounting for only 2.1 percent of total health expenditure. Even though disease burden is not the only priority-setting criteria, a recent analysis by the National Data Management Center for Health revealed that while HIV and TB contribute to similar levels of disease burden in Ethiopia (4.5 percent and 3.5 percent of DALYs, respectively), according to NHA data, funding for HIV is four times larger than for TB (9.2 and 2.1 percent of total health expenditure, respectively) (Figure 5). The proportion of health funding for malaria also well exceeds TB funding levels, even though the DALY burden for TB is nearly double that of malaria (National Data Management Center for Health, July 2021).

Figure 5. HIV/AIDS, Malaria and TB DALYs and the Percent of Total Health Expenditure Invested



Source: National Data Management Center for Health, July 2021

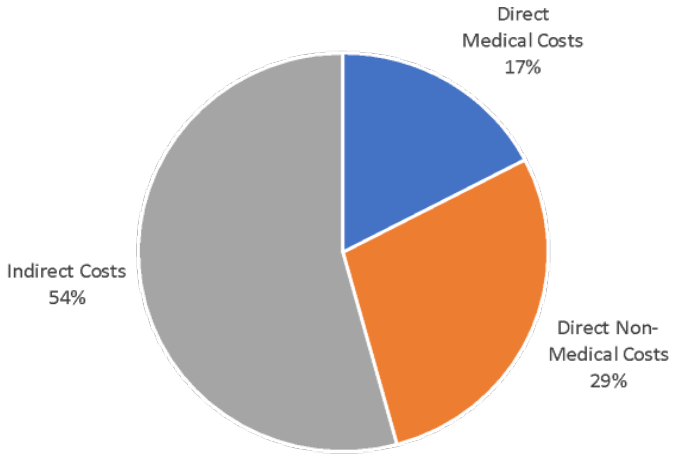
Household Spending on TB

As a result of the under-investment in TB programming in Ethiopia, OOP spending—the least equitable and efficient type of health financing—is nearly a third higher for TB (43.7 percent) than OOP spending for health in general (31 percent) (MOH, Tuberculosis program financing, 2020). In Ethiopia, TB—like HIV and malaria—is an "exempted service" and provided "free" of charge to all citizens, irrespective of income, through the public health sector. However, the exempted service policy is not a panacea. TB patients are responsible for medical costs that are not covered under the exempted services policy, which is limited to TB confirmatory tests and anti-TB drugs. Medical costs that may be borne by TB patients include the cost of basic laboratory tests (other than microscopy and Gene X-pert), hospitalizations, and medicine for management of comorbidities. Such costs impede patient access to high-quality care, which can have a negative influence on health outcomes and household welfare.

A projection derived from data from a recent Ethiopian study showed that the total TB patient cost will come to US$ 135.3 million over the next five years, or US$ 27 million per year. The same study found that patients with TB incurred an average total cost of US$ 115 per episode, representing 21 percent of the annual household income (Assebe LF et al., 2020). It is estimated that more than three-quarters of TB patients' OOP costs go toward non-medical costs such as the cost of transportation to access care, as well as the costs associated with lost productivity and food consumption—as undernutrition and anemia are significant risk factors for TB patients. Direct medical costs for TB patients account for nearly one-fifth of the total patient costs (Figure 6).

Given that TB disproportionately affects vulnerable populations, OOP costs result in major socioeconomic consequences for affected families and communities. One study in low- and middle-income countries estimated that TB patients will spend more than one-third of their annual income on care (Tanimura et al., 2014). To ensure that families are protected against catastrophic health expenditure in line with the END-TB strategy, coordination is needed with health financing as well as social protection mechanisms (such as job protection, paid sick leave, social welfare payments, or other transfers in cash or kind).

Figure 6. Total Estimated TB Patient Costs in Ethiopia

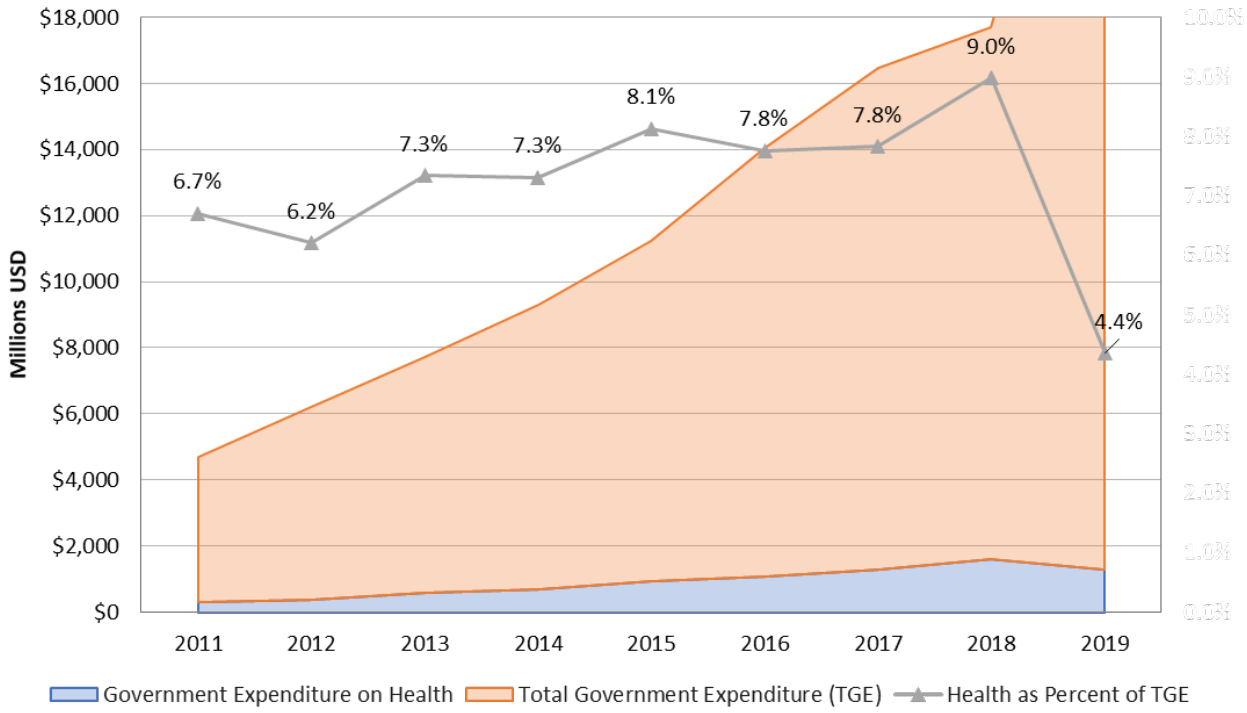


Source: Assebe LF et al., 2020

Government Resources for Health and TB

The amount of government financing available for TB depends on the budgetary prioritization of the health sector first, and then the relative prioritization of TB compared to other health programs. Over the last decade, the share of the general government health expenditure (GGHE) as a percentage of general government expenditure (GGE) reached its highest level in Ethiopian Fiscal Year (EFY) 2010 (9 percent) and on average has fallen between 7 and 8 percent (Figure 7).

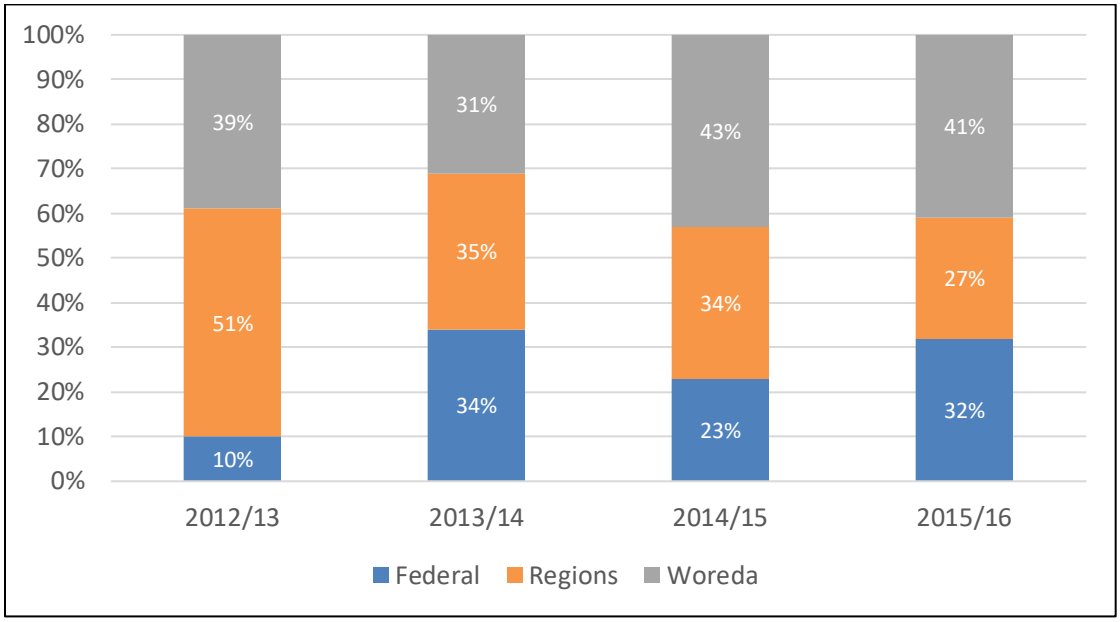
Figure 7. Government Expenditure on Health and Total Government Expenditure (USD millions)



Source: MOF 2012 EFY Proposed Budget; data extracted from IBEX for EFYs 2011 and 2012

When disaggregated by level of government, the federal, regional, and woreda levels spent 6, 14 and 21 percent, respectively, of their recurrent and capital budgets on health in EFY 2012. The majority of government resources and spending on health and TB is at the regional and woreda levels, though a significant portion of this funding goes to fixed, recurrent costs, such as salaries and facility operating expenses (Figure 8).

Figure 8. Distribution of the Health Budget by Level of Ethiopia Healthcare System



Source: MOFEC, 2017; Government expenditure based on treasury expenditures (including general budget support from development partners)

The capital budget is considered a flexible budget—it is not tied to fixed costs such as existing salaries and can therefore be allocated to a priority area. For context, in EFY 2012, 43, 23, and 11 percent of the capital GOE budget was allocated at the federal, regional, and woreda levels, respectively. This means that the amount of budget flexibility at the federal level was nearly twice that of regions and nearly four times that of woredas. While federal and regional governments have a greater percentage of discretionary resources at their disposal that they could in theory be using to invest in health and TB programming, in reality they have placed less priority than regions and woredas on investing in health. Woredas allocated a greater share of their capital budgets to health (21 percent) than the federal and regional levels, as their respective shares of their capital budgets allocated for health were only 1.1 and 10 percent.

Investment in Health by Regions and Woredas

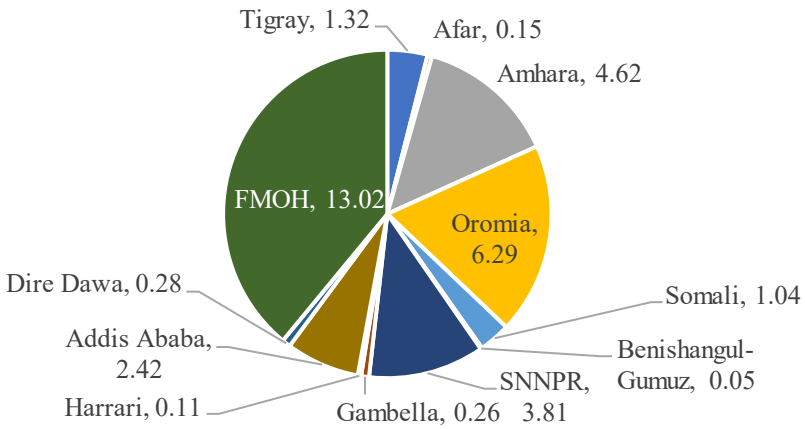
Ethiopia has been implementing fiscal decentralization for more than two decades. The regional states, with the exception of Addis Ababa, only financed about one-fourth of their expenditure from their tax revenue for the year 2015/16—the rest came from revenue assigned from the federal level (Breakthrough International Consultancy, 2017).[2] The federal government uses a federal resource allocation formula to assign block grants to regions; the formula is based on population size, level of development, and ability to mobilize local revenue. Regions use a similar formula to distribute resources to woredas. Government allocation of block grants to regions has increased steadily from ETB 62 billion (28.9 percent of GGE) in 2014/15 to ETB 136.6 billion (39.1 percent) in 2017/18, which approaches the

[2] In addition, the health sector can mobilize and retain user fees collected at public facilities to augment their government allocation, which is a significant source for financing non-salary costs at facility levels. The majority of resources generated by government facilities is primarily at the woreda and regional levels, as the federal function includes only a small number of federal hospitals. Of note, TB, as an exempted service, is not subject to such user fees and thus does not contribute to this funding stream.

target of sending 40 percent of total government expenditures to regions. The distribution of health expenditure by region in 2017/18 is shown in Figure 9. Approximately two-thirds of the regional budget is allocated to woredas.

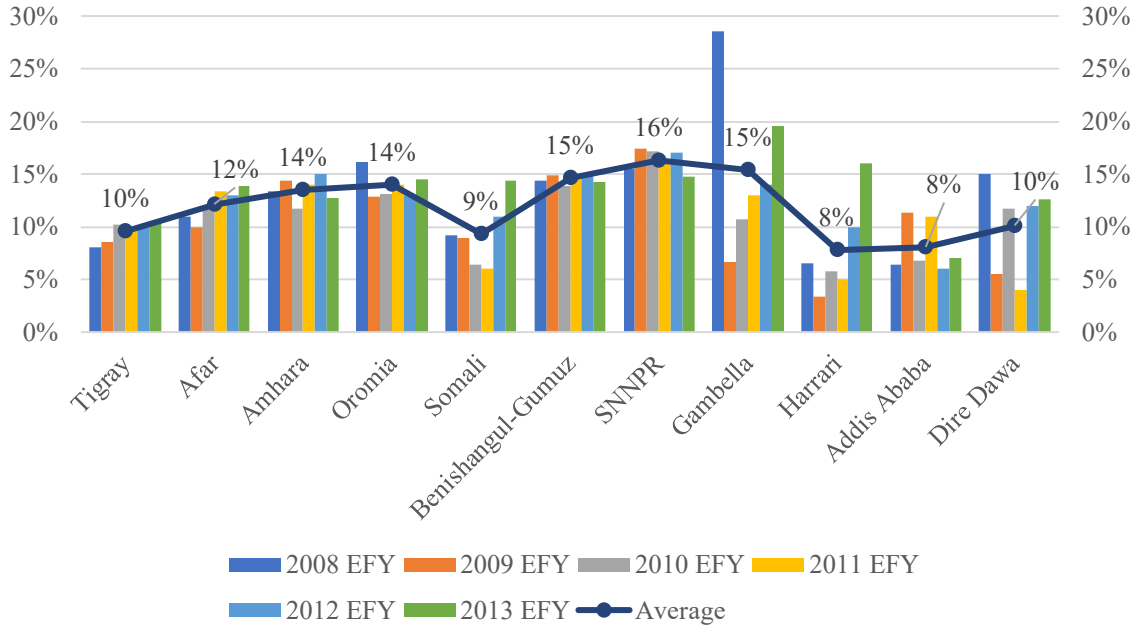
The federal block grants sent to the regions are not earmarked, and regions can allocate resources to any sector based on their priorities. Woredas also have the authority to determine the allocation to the health sector versus other sectors, based on the funds they receive from the regional level. Therefore, in this decentralized context, the regional and woreda governments have an important role to play in resource allocation and mobilization. The share of the total regional government budgets going to health varies from region to region, based on the health sector's ability to advocate for an increased allocation (Figure 10). Evidence-based advocacy, as part of the annual planning and budgeting process at all levels of government—but particularly by Woreda Health Offices (WorHO) and Regional Health Bureaus (RHB)—is important for informing general government budget allocations and co-financing opportunities for TB.

Figure 9. Health expenditure in 2017/18 (ETB Billions)



Source: Ministry of Health, 2021, Sub-national PER

Figure 10. Share of Health Budget from the Total Regional Government Budget



Source: FMOH, 2021, EFY 2013 Annual Performance Report

Government Resources for TB

The amount that the GOE actually spends on TB programming at all levels of the Government, as a proportion of the GGHE, is difficult to calculate. The financial management system (IBEX/IFMIS[3]) used to track budgeting and expenditures at all levels of the government system only tracks general spending categories (e.g., salaries, procurement, per diems) for each of the budget holders (e.g., WorHO, RHB); no program or service-specific categories (e.g., TB, HIV, reproductive health) are used.

To overcome this challenge, the FMOH conducts annual resource-mapping exercises to track and report on the financial commitment for the health sector, including the TB program (Resource Mapping Reports). For example, these estimates have served as the source for the Government's reporting of its co-financing commitments under the GFATM grant. Using audited (when available) IBEX data as well as data from periodic health financing surveys, the FMOH estimated that the GOE had allocated approximately 0.68 percent of its GGHE to TB from 2014 to 2020 (Table 1). The last NHA VII study, which breaks down spending by disease classification, estimated that the Government spent US$ 7.6 million on TB in 2016/2017 which accounted for 0.79 percent of the study's estimated GGHE (US$ 963 million[4]). The NHA also states that funding for TB was spent in the following categories: 4 percent inpatient curative care; 45 percent outpatient curative care; 18 percent preventative care; 2 percent governance, health system, and financing; and 30 percent capital and training. Neither the Resource

[3] The Integrated Budgetary and Expenditure System (IBEX) and the Integrated Financial Management Information System (IFMIS) jointly comprise an electronic public financial management system that was developed by the Ministry of Finance to track treasury resources across all levels of Government. The integrated system has been fully implemented and is being used across all regions. The Finance Bureaus of Regions, and Finance Offices of Zones and Woredas, access IBEX. As long as a health facility has a cost center, its detailed expenditures are found in the IBEX system, enabling IBEX to track expenditure data at the lower administrative levels. IBEX only tracks resources through Channel 1 and does not track resources through Channels 2 and 3 (see further discussion of Channels in the section on External Resources for TB below).
[4] According to NHA, GGHE was ETB23.1 billion in 2016/17; 24 ETB to 1 USD exchange rate is assumed.

Mapping Report nor the NHA contains additional breakdowns of the TB budget, e.g., into categories such as salaries, commodities and activities, or into federal, regional and woreda spending categories.

Table 1. Government Expenditure for TB (USD Million) from 2014-2019

Expenditure	2014	2015	2016	2017	2018	2019	2020*
Total Government Health Expenditure (GGHE) at all levels (Million USD)	750	806	866	1,006	1,081	1,162	1,202
Total Government Tuberculosis (TB) Expenditure (Million USD)	3.2	3.5	3.7	7.6	9.8	10.6	10.9
Percentage of GGHE Expended on TB	0.43%	0.43%	0.43%	0.76%	0.91%	0.91%	0.91%

*Estimated from Budget datasets

Source: FMOH letter to the Global Fund on March 6, 2020.

While the data show an upward trajectory in both the amount of funding going toward TB and its share of GGHE, Government spending on TB in 2018-2020 was slightly under the 15 percent co-financing commitment to the Global Fund (Table 2). Reporting on Global Fund co-financing commitments for 2020 revealed that while the GOE exceeded the 15 percent co-financing target for HIV and malaria by US$ 109.4 and 123.2 million, respectively, the Government fell short of reaching the commitment for TB by 2.3 million. Beginning in 2021, the Government has committed to increase the co-financing commitment to 20 percent of the Global Fund grant (or US$13.1 million) for TB.

Table 2. Government Co-Financing Commitment for TB, HIV and Malaria (USD Million) from 2018-2023

Disease Component	2018	2019	2020	2021	2022	2023
HIV	24.2	25.4	26.7	33.5	34.7	36.0
TB	11.4	12.0	13.2	13.1	13.7	14.9
Malaria	22.6	22.9	23.6	26.4	26.8	27.5

Source: FMOH letter to the Global Fund on August 19, 2020.

To grow the investment in TB, the FMOH successfully requested the first dedicated budget line from Treasury to support TB programming within the 2021/22 health sector budget. While the budget line was for a modest amount (ETB 10 million or ~US$ 200,000, to finance GeneXpert machines), it was an important first step toward advocating for dedicated resources for TB and paving the way for future domestic resource commitments to TB programs. Historically, the government's contribution to TB has been limited to estimating a proportion of salaries and facility operating costs paid by government as part of the exempted services policy.[5] In the Ethiopian context, getting a dedicated budget line is often a major hurdle within the budgetary process; but once it is approved, with appropriate advocacy, it can facilitate greater resource mobilization year over year. In the 2020/2021 budget, the FMOH also

[5] Historically, the proportion of government funding estimated to support TB has been 70 percent human resources and 30 percent facility operating costs, according to the NHA analysis for TB.

attempted to mobilize resources for TB programming by engaging regions in similar TB budget advocacy. Commitment letters were signed by state ministers and sent to RHBs, requesting that all regions mobilize additional resources as part of the Global Fund co-financing commitment. The outcomes of this effort are discussed below. Finally, the FMOH earmarked an additional US$ 2.1 million of the Health SDG Pool Fund for TB programming; while these funds are external resources, they are allocated at the discretion of the FMOH.

Regional Government Contributions to TB

According to interviews with key informants, regions are well-positioned to take up greater responsibility for financing TB performance management activities. Some RHBs have successfully requested dedicated resources for TB from the regional budgets. For example, the Oromia RHB requested ETB 2.5 million (about US$50,000) for TB in EFY2014 that was approved by the regional council and is to be implemented in areas of strengthening monitoring and evaluation of TB and leprosy programs.[6] Yet similar efforts to mobilize additional funding for TB were not successful in Amhara and Dire Dawa. Major challenges cited by regions were the perception that (i) development partners and the national government had provided adequate funding for TB, which is exacerbated by a lack of visibility into the resources allocated through channels 2B and 3 (see section immediately below); and (ii) RHBs lacked compelling evidence to demonstrate why additional resources to support TB should be prioritized within resource-constrained budgets. One approach to catalyze increased domestic resources is through co-financing arrangements made between different levels of the government (usually leveraging external resources) or between the government and its development partners. Amhara, Dire Dawa, and Somali have mobilized additional resources for health under co-financing arrangements (Box 3).

[6] For comparison, over the last three and a half years, Oromia has received approximately US$ 3.4 million from the Global Fund grant, or approximately US$ 1 million annually, to support TB programming.

Box 3. Regional Experiences with Co-Financing in the Health Sector

In Amhara region, the regional- and woreda-level administration co-financed upgrades to the second generation of health posts (25 percent funded by the region, and 75 percent by the woreda). Similarly, the region is upgrading 311 health centers through a co-financing arrangement. The share of the different levels of government for co-financing were the following: 25 percent by woreda, 25 percent by the regional government (including the 15 percent VAT), and 50 percent by the federal government through the SDG Health Fund. While the woredas and regions are funding these upgrades through the government treasury, the federal government is paying its contribution from external resources.

In Dire Dawa city administration, the regional government was initially co-financing UNICEF's WASH program through channel 1B, with 15 percent co-financed by BOFED, and this co-financing level increased to about 60 percent or 2 million ETB annually. Similarly, the city administration was able to sustain some of the activities of the family planning program by allocating ETB 850,000 (50 percent of the cost) when the program phased out. These experiences demonstrate that, despite their fiscal space challenges, regions and lower levels can also mobilize a certain share if all levels of government show commitment and transparency in pushing the resource mobilization agenda forward.

In Somali, 75 percent of the funding for the malaria Insecticide Residual Spray Campaign is provided based on a pre-conditioned regional commitment of 25 percent allocation.

Source: Regional Key Informant Interviews

External Resources for TB

In Ethiopia, TB programming is heavily reliant on external funding (44.7 percent) as mentioned above, and more dependent on development partner resources than the overall health sector (35 percent) (MOH, Tuberculosis program financing, 2020). In 2021, development partners will contribute an estimated US$ 37 million to TB programming, with 85 percent of the resources coming from the Global Fund-supported TB grant and USAID-supported TB projects. At the Government's request, a portion of the SDG Pool Fund also went to support TB, with additional support for the TB program provided by CDC, GLRA-Ethiopia, and the WHO.

Discussion on Use of External Resource Channels

In Ethiopia, development partner resources are managed through three disbursement channels, which have implications for how funds flow through the health sector and for how these funds are planned for, managed, tracked, and reported. Channels 1 and 2 refer to funding channels that utilize government systems, while funds disbursed through Channel 3 go directly to implementing partners and are considered "off-budget".

Channel 1 refers to funds that flow through the central Treasury (MOFED) and down to regional (BOFED), zonal (ZOFED), and woreda (WOFED) counterparts (this is also the fund flow used for all domestic financing). Channel 1A is used for general budget support, such as the development partner-

supported Protecting Basic Services[7] (PBS), as well to provide non-sector specific block grants to regions. Channel 1B is used to finance specific development outcomes and is the MOFED's preferred channel for external resources because it allows for more accountability and transparency in tracking allocations and expenditure at all levels of government. Development partners have been reluctant to use channel 1B as it adds a layer of bureaucracy in the distribution and execution of resources—planning, resource allocation, expenditure management, and follow-up of expenditures must be managed not only by the health structures but also finance structures at all levels. Further, channel 1B offers limited benefits for programs such as TB, as IBEX currently does not disaggregate by program area and therefore still requires manual tracking and reporting.

Funds disbursed through Channel 2 go directly to line ministries, such as the FMOH, and then flow down to their regional counterparts (RHB). Channel 2A funding operates similar to a health basket fund, allowing development partners to provide non-earmarked funds to the FMOH based on agreed work plans, while channel 2B allows development partners to earmark resources. While Channel 2 provides the sector with greater flexibility over how to manage its resources, it lacks oversight and awareness by MOFED and BOFED, which are not consulted in the resource allocation process. Program activities financed through Channel 2 are not included in regions' core plans and are managed outside of IBEX, using a paper-based system that makes coordination, data transparency, and tracking challenging.[8] Channel 2 funds often flow from the RHB to ZOFED and/or WOFED—where they are transferred to pooled accounts—instead of continuing to Zonal Health Offices (ZHO) or Woreda Health Offices (WorHO) (see Figure 11). This is primarily due to the fact that health structures at the decentralized level do not have adequate public financial management capacity to manage these resources on their own, without the involvement of finance structures. Timely identification, utilization, expenditure recording, and reconciliation of the budget for the intended purpose has been identified as a major challenge. While national programs plan and allocate resources as per the agreed priorities, there is limited guidance at the regional level to reprioritize, re-program, and use the resources. As a result, unused resources are often accumulated at lower levels and can result in fund return concerns.[9]

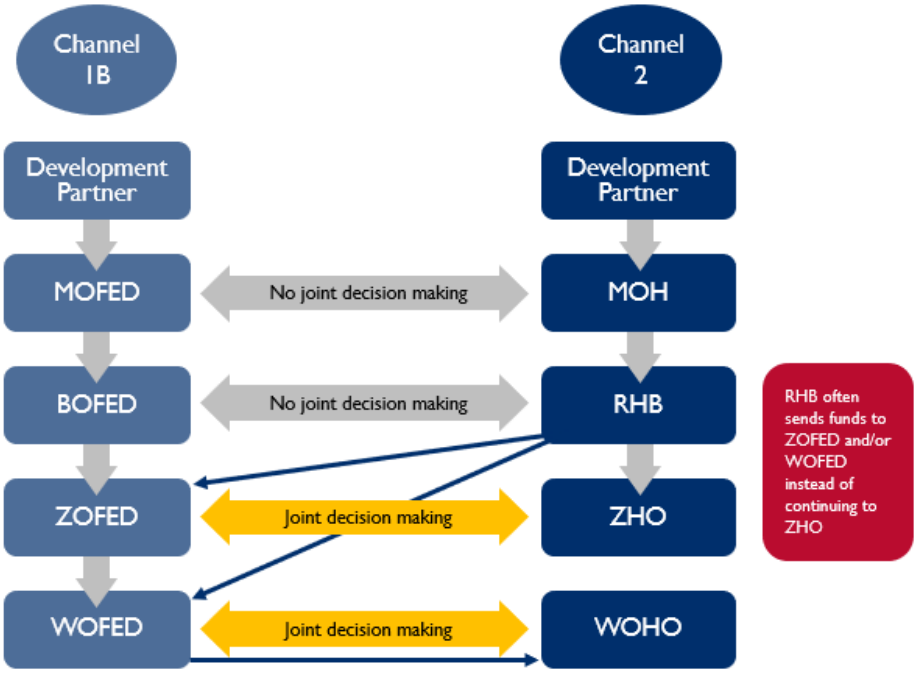
The majority of development partner funds for TB are provided to the government through channel 2B, which allows development partners to transfer earmarked resources through the FMOH to RHBs (as well as Zones and Woredas), which are responsible for managing and reporting on their use as outlined in the development partner agreements. The Resource Mapping Report clearly documented that development partners prefer channel 2B over channel 2A, which is primarily used by the SDG Health Pool Fund. Channel 2A provides greater flexibility for the FMOH, as allocation among different priorities is carried out by the government. As such, mobilization of TB funding from channel 2A requires an additional level of advocacy and engagement at the Regional and Woreda levels to ensure that TB activities are prioritized and funded by this flexible external funding as part of the annual planning and budgeting processes. The share of channel 2A funding for TB has increased over the last two years as TB is being prioritized. Channel 1B is not used to support TB funding and is only modestly used by the wider health sector, primarily by UN agencies (see Figure 12).

[7] The PBS is funded by the Government of Ethiopia and a number of development partners, including the World Bank, the African Development Bank, the UK's Department for International Development (DfID), the European Union (EU), Austria, and Italy. In addition, the social accountability component is being supported by DFID, KfW (Germany), Irish Aid, and the EU. (World Bank, 2014)

[8] To address these challenges, RHBs in Amhara and Oromia, for example, have developed their own financial management systems to track external resources that are overseen by the resource mobilization teams.

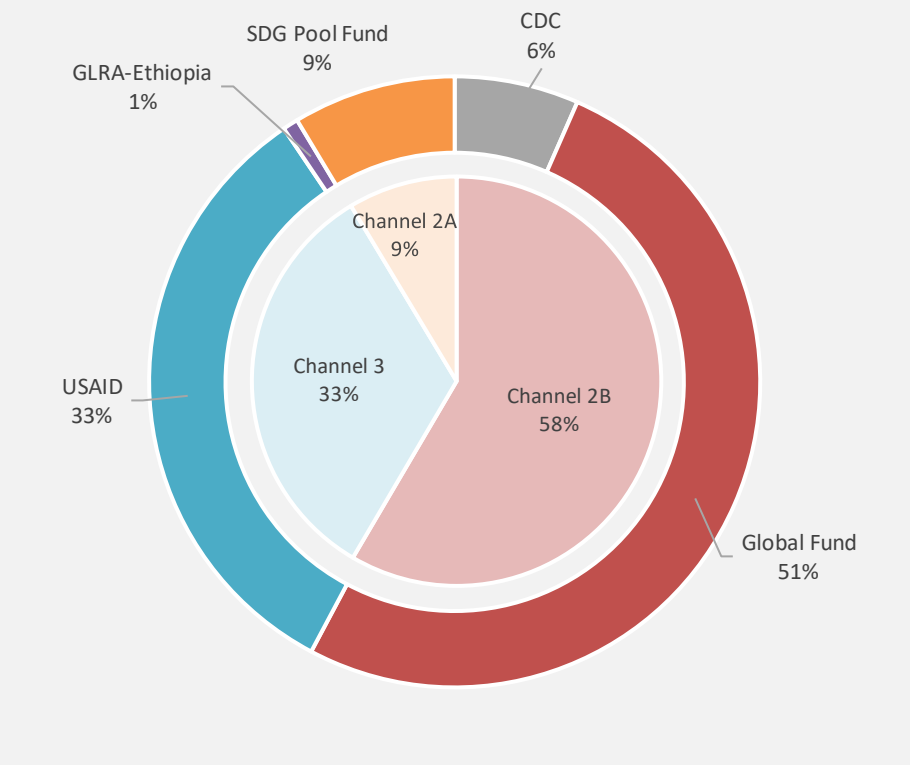
[9] Channel 2b utilization data for TB funding is available for regions. Recent efforts have been made to improve utilization rates, which ranged from 99 to 100 percent for 2020/2021 (Global Fund Cumulative utilizations of June 2021by regions).

Figure 11. Flow of development partner funds for health by funding channels 1B and 2



Source: Key Informant Interviews, Amhara, Dire Dawa, Oromia, and Somali

Figure 12. Estimated development partner financing for TB, by funding channel, 2021



Source: Financial commitment and expenditure report by TB implementing partners for Global TB Report

Allocation/Distribution of TB Resources

The majority of Government and partner spending on TB goes to support access to TB services under the exempted services policy. The Primary Health Care Costing Study of 2016 in Ethiopia, which based itself on actual facility-level expenditures, estimated that more than 86 percent of the TB expenditures (from domestic and external funding sources) at the facility level (including facility-level outreach to communities through the health extension program), were associated with medicines and medical supplies, followed by human resources. Government financing primarily supports recurrent costs—such as human resources and facility operating expenses—that support all of the exempted services, not TB specifically. Woredas and Regions, as part of their expenditure assignment, finance the wages and administrative costs of providing TB care at health facility levels in the public sector at no cost to patients. TB commodities are procured and distributed to facilities based on the Government's forecasting projections and provided to TB patients free of charge. Although the responsibilities for procurement and distribution of commodities for exempted services are not clearly spelled out, financing for TB commodities is heavily dependent upon the Global Fund grant. Over 70 percent of the Global Fund grant for TB goes to supporting commodities, including anti-TB drugs (Figure 13).

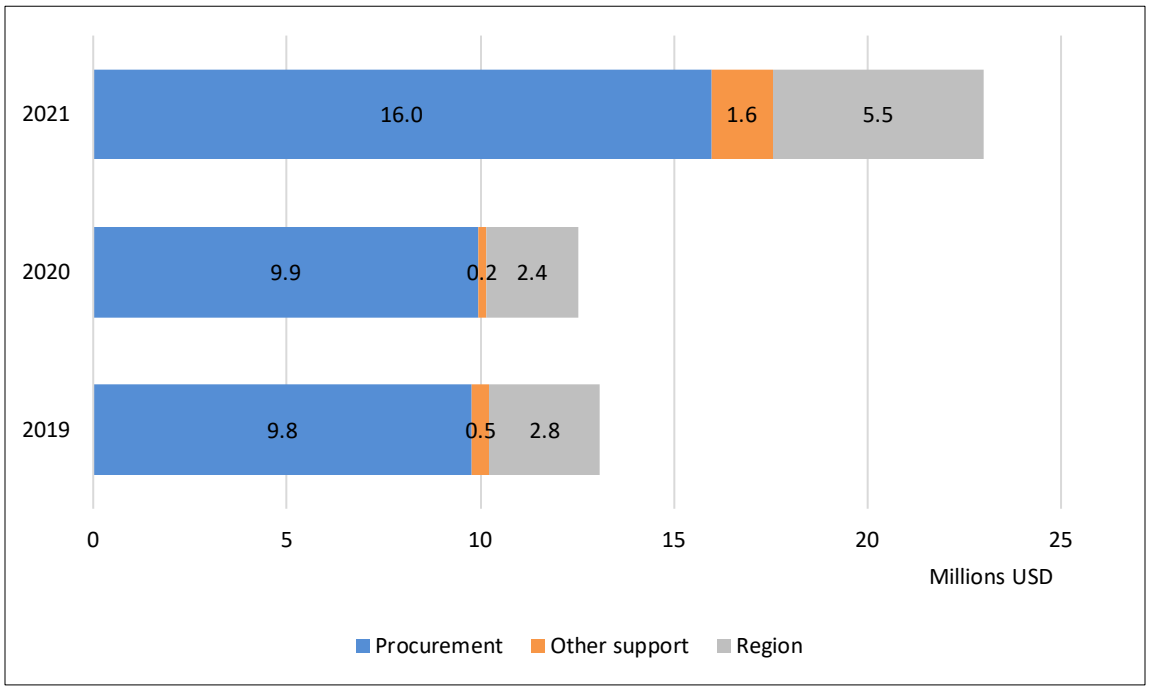
In 2020/2021, regions and zones (where applicable) received approximately US$ 5.5 million through the Global Fund grant for TB (Channel 2B) to support TB program implementation and performance monitoring activities. Within the agreed-upon framework of the Global Fund grant, a memorandum of understanding is developed to transfer the Global Fund grant budget from the FMOH to the RHB Finance Departments annually. The budget mainly supports the MDR-TB program, capacity-building of health care workers, PPM expansion, community TB care, outreach screening for TB key affected populations, laboratory EQA, and monitoring and evaluation activities. The regional program personnel will further conduct budget breakdowns based on different criteria such as TB case load, MDR-TB burden, number of health facilities, number of key affected population sites, and TB/HIV co-infection, to transfer the budget to beneficiaries (Zones, hospitals, etc.).

Due to a shortage of TB program funds, the TB programmatic budget historically has not been transferred to the woreda level, or has only reached a limited number of selected woredas. As a result, unlike for other programs such as malaria, funding has not been provided to reinforce TB as part of lower-level supervision and review meetings, or to amplify community TB care through the health extension worker program or other community outreach activities. USAID, through its TB Implementation Framework Agreement (TIFA) program, has started channeling some of its TB funding through Channel 2B to strengthen woreda-level TB performance monitoring. Whereas the Global Fund resources primarily stop at the regional level, US$ 250,000 of TIFA funds are flowing down to 300 woredas. In addition, regions reported that they also invested in performance monitoring activities by mobilizing resources to support TB-dedicated human resources, such as TB focal persons, and to provide extra duty pay and fuel for supervision activities.

At the national level, the FMOH ultimately is seeking to mobilize US$ 1.67 million in additional funds for TB to support expansion of digital x-ray (US$1.4 million), an innovation TB lab for DST (US$ 0.13 million), and for advocacy, communication, and social mobilization (US$ 0.14 million), all as part of the 20 percent co-financing commitment with the Global Fund grant. As previously discussed, the MOFED approved an ETB 10 million (~US$ 200,000) TB budget request from the FMOH to procure GeneXpert equipment. In addition, the FMOH advocated for a greater share of the SDG Health Pool Fund to support TB programming, to include US$ 2.1 million for procurement of GeneXpert cartridges, Fulcon

tubes, and florescence microscopes; capacity-building on GeneXpert services; strengthening of TB laboratory EQA; and leprosy prevention and control support.

Figure 13. Global Fund Grant, TB Expenditure, 2018/19 – 2021



Source: Global Fund PUDR Report and TB PR Dashboard Data, Master and Expenditure Report

Projected Financial Commitments and Estimated Funding Gap

As previously stated, the total anticipated financial need for implementing the national TBL-NSP strategies and plans requires an investment of US$ 619,576,000 over five years, with an annual average of US$ 123,915,000. This level of investment well exceeds the current level of annual funding by Government (~US$ 10 million) and its development partners (~US$ 37 million). While government funding for TB is projected to increase (as the overall health sector budget grows), resource mobilization efforts for TB at the decentralized level have achieved uneven results. Furthermore, current partner pledges show a decline or steady rate of investment in 2021/22-2025/26.

Government Projections for Overall Health Sector

The Ethiopia Plan and Development Commission, in collaboration with MOFED, has projected GDP for ten years from 2020/21 to 2029/30. Accordingly, as part of the Mid-Term Expenditure Framework (MTEF), government expenditure for 10 years was also projected. However, those projections were completed before the COVID-19 pandemic. In order to adjust the projections for the economic impact of COVID-19, the HSTP-II financing projection employed the Plan and Development Commission COVID-19 economic impact estimates. According to the commission, at moderate case rates, Ethiopia's GDP growth will decline by 2.6 percent due to COVID-19's economic impact.

Building on the modified MTEF projections, the FMOH estimated GGHE as a percentage of GGE, based on the Ethiopian government's commitment towards the health sector and the Abuja Declaration. The forecast considered three options for the proportion of GGHE as a share of GGE—eight (8), 10, and 15 percent (the latter meeting the Abuja Declaration for low- to middle-income countries) in 10 years. For the shorter timeline of the HSTP-II (2020/21-2024/25), 12 percent of general government spending is the highest estimate to be allocated to health by 2024/25. Additional sources of financing—external resources, OOP spending, and insurance—were also used by the FMOH to model its low, medium, and high fiscal space scenarios under HSTP-II (see Table 3).

Table 3. Resource projection assumptions in HSTP II

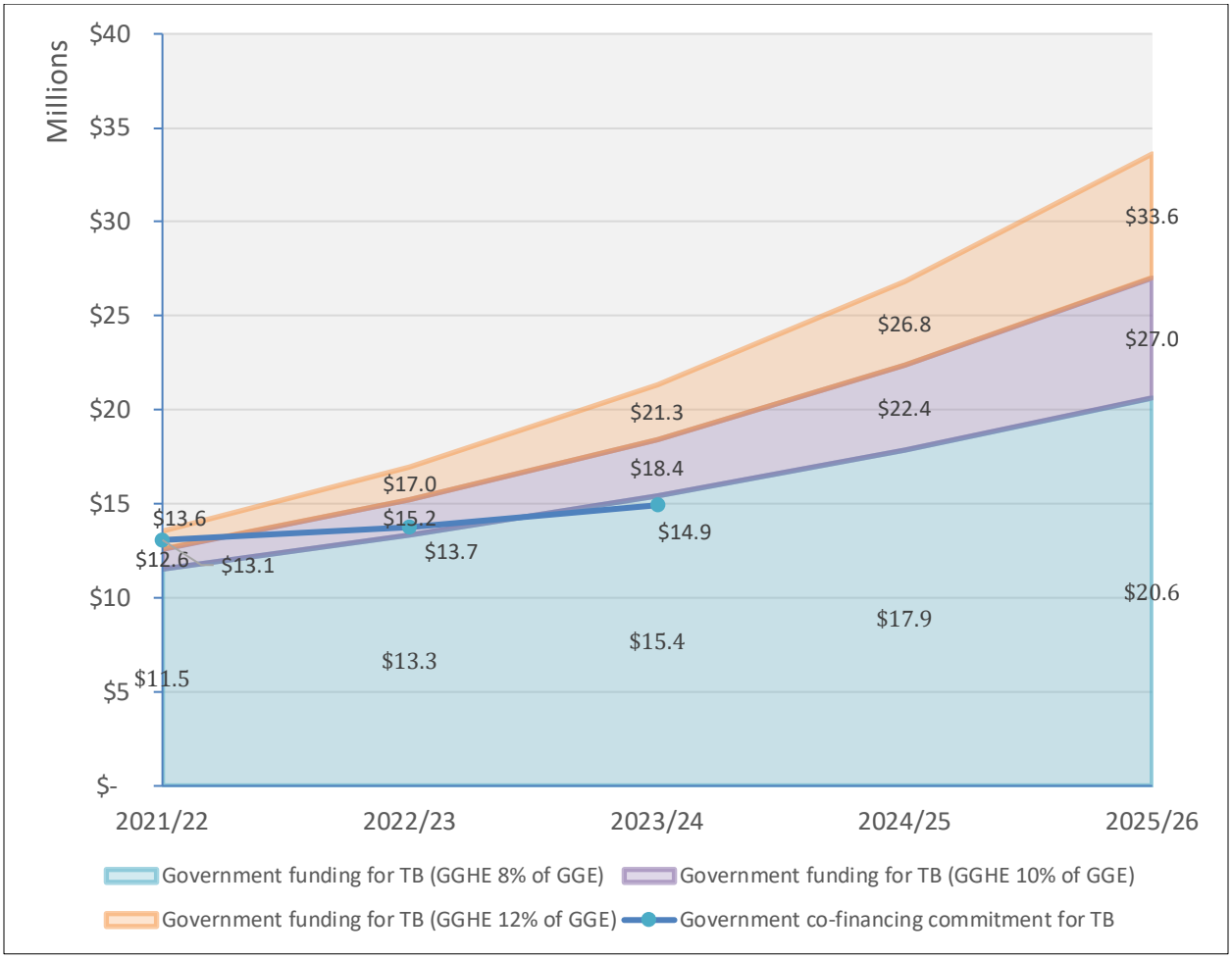
Source finance	Projected assumptions for financial space		
	Base Case	Medium case	High Case
Government	Government allocates 8% of its total expenditure to health (maintaining the current share).	Government increases health expenditure from 8% to 10% of its total expenditure by 2024/25.	Government increases health expenditure from 8% to 12% of its total expenditure by 2024/25.
External resources	External assistance declines from 35% to 20% of THE by 2024/25.	External assistance declines from 35% to 25% of THE by 2024/25.	External assistance keeps the current 35% of THE share. Assumes new donors and also existing ones to increase their allocation to the health sector.
Out of pocket spending	OOP with minimal decline from 31% to 30% of THE by 2020/24.	OOP with moderate decline from 31% to 27% of THE by 2020/24	OOP with significant decline from 31% to 25% of THE by 2020/24.
Insurance	38% of HH and 77% of Woreda enrollment; no SHI.	50% of HH and 77% of Woreda enrollment; SHI starts by 2024 only for civil servants.	80% of HH and 80% of Woreda enrollment; SHI starts by 2023 only for civil servants.

Source: MOH, 2020, HSTP II.

Government Projections for TB Financing

Based on the HSTP-II fiscal space projections outlined above, the projected total financial commitment to TB from the Government for the five-year national TBL-NSP strategy period (2021/22–2025/26) is between US$ 78 and 112 million (Figure 14). These projections are based on the assumption that (i) TB will continue to receive at least 0.91 percent of GGHE (as was the case from 2018-2020), and (ii) that GGHE as a percent of GGE will follow the three scenarios laid out in the HSTP II—base (8 percent), medium (10 percent), and high (12 percent).

Figure 14. TB Funding Projections by Government for the TB Strategic Plan Period, 2021/22-2025/26

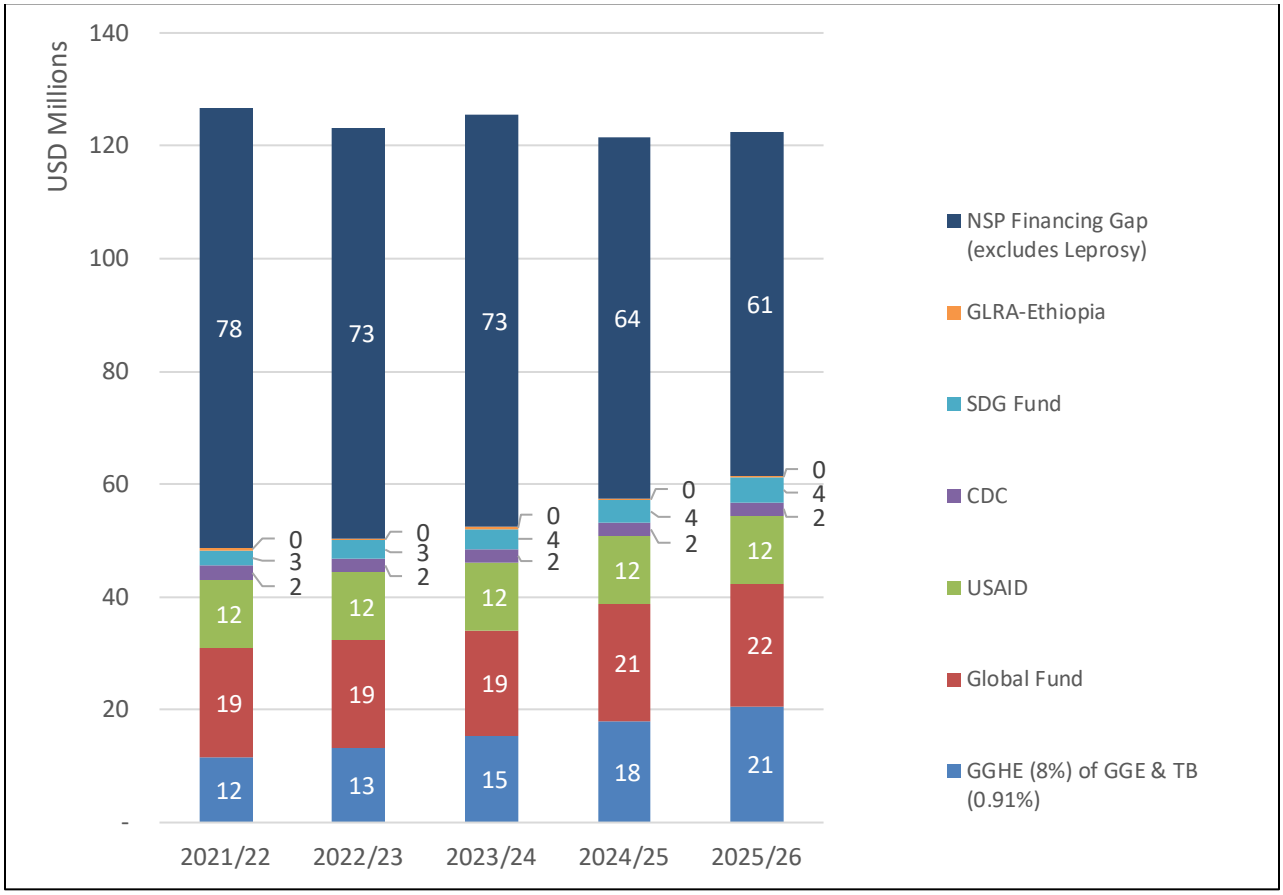


Source: Modeling of GGHE based on HSTP-II projections; year 2025/2026 was not included in the HSTP-II projections and was projected for this exercise using the same rate of growth in the GGHE budget; assumes TB accounts for 0.91% of GGHE.

Overall Projections for TB Financing

Assuming that the GOE and the FMOH achieve the baseline HSTP II scenario (8 percent), and that Global Fund and USAID commitments remain flat, the overall projected financial commitment for TB is US$ 270 million from 2021/22–2025/26, of which external resources contribute about 71 percent of the total projected commitment [mainly from the Global Fund (37 percent) and USAID (22 percent)], while domestic resources account for 29 percent (Figure 15). The total projected commitment indicates that a significant funding gap (56 percent) exists for the implementation of several TBL-NSP strategy objectives, which is higher than the previous strategic plan (2013/14-2020/21) funding gap (53 percent).

Figure 15. Projected Estimated Funding Gap, TB Strategic Plan, 2021/22-2025/26



Sources: Modeling of GGHE (8 percent) based on HSTP-II projections and assuming that TB accounts for 0.91 percent of GGHE; Financial commitment and expenditure report by TB implementing partners for Global TB Report.

The national response to TB in Ethiopia continues to fall considerably short of what is required to implement the levels of service necessary to fully impact the spread of the epidemic, even when the overall health sector budget expands, respectively increasing the allocation to TB. Given the enormity of the financing gap, the NTP will need to articulate a clear investment case for TB programming, identifying priority areas for investment within the TBL-NSP strategy that are underfunded at each level of the health system, and advancing strategies for achieving Government co-financing commitments. Evidence-based advocacy, as part of the annual planning and budgeting process at all levels of government, is needed to inform general government budget allocations and co-financing opportunities for TB. If significant progress is to be made toward achieving the END TB targets and, critically, bringing down catastrophic levels of OOP spending by TB patients, the TB program will need to leverage government resources from beyond the health sector (e.g., social protection) and to engage the private sector. This TB DRMS Roadmap lays out a plan for leveraging existing partnerships and health sector financing initiatives to increase sustainable financing for the TB response.

DRMS Roadmap Objectives

Given the context, it is important for the GOE to take leadership on developing a pathway to sustainably financing TB, while leveraging existing and current health financing initiatives and private sector engagement under the umbrella of the Health Care Financing Strategy (HCFS 2021 - 2030). The goal of the Roadmap is for Ethiopia to finance 20% of the cost of the TB program (TBL-NSP) from domestic sources by June 2026, in line with the TBL-NSP. From January 2022 to June 2026, Ethiopia aims to:

1. Increase the share of the domestic government health budget allocated to TB to complement donor financing in the short term and replace it in the long term, from 0.91 percent or approximately US$ 10 million in 2021 to 1 percent or US$ 22.8 million by June 2026.

Benchmarks in increasing domestic government health budget allocated to TB (Million USD[10])					
2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
10	12.5	15.1	17.7	20.2	22.8

2. Reduce the share of OOP expenditure of TB patients of the total tuberculosis expenditure from 43.7 percent to 31 percent[11] by 2026.[12]

Benchmarks in reducing the share of OOP expenditure			
2016/2017	Government	External	OOP
Amount	$7,605,000	$29,055,000	$28,405,000
Share	11.70%	44.70%	43.70%
2025/26	Government	External	OOP
Amount	$22,782,404	$40,738,000	$28,405,000
Share	25%	44%	31%

3. Establish a baseline for increasing private corporate entity participation in financing TB by strengthening and establishing accountable partnership agreements on TB-related initiatives.

[10] The increase in domestic government funding for TB was calculated based on an HSTP II assumption of 8% of general government expenditure being allocated to health, and a calculated baseline of 0.91 percent being allocated from the health budget to TB. This was projected out to 2026 assuming the same increases in the health budget as in the HSTP II, with the TB budget increasing to 1 percent of the health budget (8 percent of GGE) in 2026.

[11] According to the 2016/17 NHA, out-of-pocket spending accounts for 31 percent of total health expenditure. The OOP expenditure for TB specifically is significantly higher. Reducing the OOP spending on TB from 43.7 percent (based on the 2016/17 NHA) to 31 percent will more closely align it with other health services. Reducing OOP is also a strategic objective in Ethiopia's HCFS.

[12] The OOP goal of 31 percent was calculated assuming a constant level of OOP spending from the most recent NHA (2016/17) estimated at US$ 28.4 million. As the Government grows its domestic investments and the estimated commitments from external partners from Figure 13 remain, the proportion of TB funding from OOP would reduce from 43.7 percent to 31 percent. The proportion of external resources would remain mostly unchanged at 44 percent. The NSP also has an objective to reduce the percentage of families facing catastrophic costs due to TB to ≤ 25 percent, which will be measured through a periodic survey that will complement the measuring of this objective on OOP and can be captured through NHAs.

DRMS Pillars

Aligned with the HCFS and modeled after the structure of the HIV DRMS Strategy, the TB DRMS Roadmap is organized under three components to ensure adequate long-term financing for the TB response and the TBL-NSP:

- **Public domestic financing initiatives** define opportunities to mobilize new domestic resources for TB and integrate TB financing into broader health financing reforms.
- **Innovative financing initiatives** identify potential future strategies to be further explored during the Roadmap period for diversifying and expanding TB funding sources.
- **Critical enablers for stewardship and sustainability, i.e.,** initiatives to identify key areas for building domestic capacity for TB financing and ensuring accountability in domestic resource mobilization efforts.

Table 4 provides a summary of the Strategic Initiatives and Critical Enablers of the Roadmap, and highlights the corresponding strategic initiative in the HCFS with which each align.

Table 4. TB DRMS Roadmap Strategic Initiatives (SI) and Critical Enablers (CE) and corresponding Strategic Initiatives in the HCFS

Area	Strategic Initiative and Critical Enablers	Corresponding Strategic Initiatives in the National Healthcare Financing Strategy
Public domestic financing initiatives	SI 1. Increase allocation of general government revenues to health, and specifically TB, at federal and regional levels through evidence-based advocacy, enhanced exempted-service policy, and co-financing	SI 1.1: Increase government budget allocation for health SI 2.2: Strengthen the mechanism for exempting fee for health services
	SI 2. Explore the potential for eventual integration of TB services into social and community-based health insurance benefits packages in the long term	SI 1.4: Scale-up of pre-payment mechanisms SI 2.3: Strengthen National Health Insurance Systems SI 2.4: Strengthen coverage of health insurance for the poor
	SI 3. Explore opportunity to improve TB mainstreaming and multi-sectoral collaboration—particularly related to non-medical OOP costs such as nutritional supplements	Strategy under SI 1.1: Increase government budget allocation for health: Strengthening the multi-sectoral collaboration and systematic integration of health and its implications in other public sector policies and strategies in order to improve resources for health and efficiency. Strategy under SI 2.4: Strengthen coverage of health insurance for the poor: Advocating for harmonization and engagement of relevant sectors/other ministries in the targeting and selection of the poor, such as Ministry of Agriculture and Rural Development, Ministry of Labor and Social Affairs, Ministry of Women's and Children's Affairs.
Innovative financing initiatives	SI 4. Explore opportunities to leverage from forthcoming 'Resilience and Equity Fund' to be financed by proposed excise tax earmark for health to support TB	SI 1.2: Generate additional finances from innovative financing mechanisms—earmark for health through sin tax, levy, or VAT
	SI 5. Explore opportunities for the corporate private sector to contribute sustainably to the TB response	SI 4.2: Assessing and scaling up the ongoing partnerships with private-for-profit and private-not-for-profit actors

	SI 6. Examine opportunities for community-level engagement through community care coalitions, or similar, to help offset non-medical OOP TB-related costs in the long term	SI 2.4: Strengthen coverage of health insurance for the poor
Critical Enablers for Efficiency and Sustainability	CE 1. System development to promote transparency and accountability in the collection, allocation, and execution of TB funding by improving resource tracking and monitoring of co-financing practices by different levels of government	SI 3.4: Enhance transparent and accountable resource utilization SI 1.3: Mobilize donor support to ensure continued and aligned investment
	CE 2. Enhance allocative and technical efficiency for TB programming	SI 3.1: Continue to invest in high-impact and cost-effective interventions SI 3.3 Improving allocative and operational efficiency
	CE 3. Realize efficiency gains through engagement of the private health sector	SI 4.1: Improving the enabling environment for Public Private Partnership for Health (PPPH), including establishment of simple and transparent partnership modalities

Public domestic financing initiatives

Through revising the Health Financing Strategy and the HIV DRMS Strategy, and setting ambitious targets in the HSTP II for domestic allocation to the health sector, the GOE has shown political will for, and understanding of, the need to invest public resources in sustainably financing the health sector. Financing the Ethiopian TB response with government resources, as outlined in this section, is the most sustainable approach. However, given the limited fiscal space, there is also a need for some exploration and innovation to identify complementary resource mobilization mechanisms (see the following section).

SI 1. Increase financing for TB from general government budget through evidence-based advocacy, enhanced exempted-service policy, and co-financing

The amount of government financing available for TB depends on the budgetary prioritization of the health sector first, and then the relative prioritization of TB compared to other health programs, plus any modification of this TB prioritization based on the availability of complementary external funding for TB. Evidence-based advocacy, as part of the annual planning and budgeting process at all levels of government, is needed to inform general government budget allocations and co-financing opportunities for TB. In addition, the creation of clear guidelines or responsibilities for the financing and reimbursement of exempted services (i.e., fully subsidized by the government and free to the patient at the point of care) will help support sustainable domestic funding for TB in the long term.

Under this initiative, there are three sub-initiatives:

Evidence-based advocacy to prioritize TB investments

To effectively influence decision-makers and garner support for the approval and implementation of the TB DRMS Roadmap and, in particular, the increase in the government budget allocation to TB, it is critical to understand the context and audiences for communication and advocacy efforts. The Roadmap adapts an approach developed by the USAID-funded Health Policy Plus (HP+) project, which focuses on the "Three Ts" for effective advocacy for health budgets and financing: targeting, telling, and timing (Box

4). At both the federal and sub-national levels, advocacy toward MOFED, BOFED, ZoFED, WoFED, and other key stakeholders like parliamentarians for increasing the allocation to TB, will involve:

1. ***Sensitizing*** MOFED, cabinet members, and parliament to domestic and external financing levels, program implications of the financing context (i.e., financing gaps and instability), and impact of reduced financing of TB on health and economic outcomes;
2. ***Demonstrating*** clearly how additional funds will be used to reach programmatic goals and that they will be used effectively, based on tailored historical evidence and clear plans for improved efficiency; and
3. ***Justifying*** these investments based on outcomes—not only on reduced morbidity and mortality, but also on long-term health sector savings and contribution toward cross-sectoral development goals.

Box 4. The Three Ts of Effective Advocacy for Health Financing

Targeting: Ensure that advocacy messages are delivered to key audiences (e.g., parliamentarians, the Ministry of Finance, and regional finance bureau personnel), are tailored based on their initial positions (i.e., supportive or resistant), and use specific arguments and communication methods to which they will be most receptive. This will require making different briefs or presentations and/or arranging different meetings or events to engage the different stakeholders.

Telling: Develop a compelling narrative for budget advocacy tied to key domestic themes such as self-reliance or solidarity, unifying evidence under the themes and explaining why it is important to the country, its development agenda, and its citizens.

Timing: Identify key points in the policy, planning, or budget process/cycle to deliver messages when decision-makers will be most receptive and have the greatest influence on the process. Specific windows of opportunity in the budget process are highlighted in Box 5.

Source: Prabhakaran, Ginivan, and Dutta, 2017

With the health sector, PCD has emphasized the need to prioritize evidence generation to be able to negotiate with the MOFED and relative offices sub-nationally, in order to effectively advocate for an increased allocation to TB from the government budget. PCD plans to increase the frequency of national studies such as public expenditure reviews, continue conducting NHAs every two to three years, enhance annual resource mapping exercises of funding channels 2 and 3, and model returns on investment of the health sector, particularly from an economic standpoint, to help in negotiations.

Action. At the Federal level, DPCD and PCD will enhance their continued advocacy with FMOH decision-makers and MOFED on the importance of the health sector, including TB and other exempted services. In collaboration with DPCD and PCD, the NTP will contribute to the evidence base for TB by: (i) modeling the return on investment of TB, (ii) supporting the resource mapping of TB activities and funding, and (iii) analyzing the financing gap for TB. The NTP needs to continue to use the TIME model (Tuberculosis Impact Model and Estimates) to analyze the epidemiological impact of reaching the TBL-NSP goals. The NTP will also use the resource mapping exercise to identify specific components of the TBL-NSP that require additional funding, and to engage and advocate with relevant stakeholders to address financing gaps. This exercise will involve using any changes to the HSTP-II health sector funding

projections (i.e. updates to the MTEF) to model the government's potential contribution to TB. Components of the TB program will be prioritized for advocacy toward additional government support based on the financial gap (between resources available and project annual costs), potential for high impact and/or important rationale for transitioning that component from donor to domestic funding (i.e., commodities). Data on the impact and return on investment of TB, paired with the financing needs and resource mapping data, will serve as the basis for developing advocacy briefs and messages to key decision-makers. The NTP and PCD, in this process, will also develop a strategy for the regional and woreda levels to help them determine how TB should be prioritized. PCD will use this TB data with impact data from other health programs, such as maternal and child health, family planning, malaria, and HIV/AIDS, to re-examine the resource allocation criteria and propose to the MOFED the appropriate resource allocation given the burden of disease, epidemiological and economic impact of investment, and cost-effectiveness. The NTP will engage TB CSOs and NGOs, particularly through the Consortium of Christian Relief and Development Associations (CCRDA), to build awareness of the financial and programmatic needs of TB and to conduct advocacy.

At the regional level, RHBs and WoHOs will receive direction from the NTP/FMOH on what components of the TB program should be prioritized for regional-level funding from BOFED and WOFED. As part of the capacity development initiatives described later in the Governance and Implementing Arrangements section, the RHBs and WoHOs will receive support on data analysis and use that can be used for advocacy purposes. The data will include results on TB-related indicators at the sub-national level, process toward TB-related goals, funding levels by source, and estimated funding gaps. RHBs also will develop regional advocacy strategies for increasing TB funding allocations at the regional, woreda, and community levels, and will engage existing health sector champions to educate them on the importance of TB and increase visibility of the need for domestic investment in TB. More details on Ethiopia's budget process, and how the NTP and its subnational counterparts will develop an advocacy plan to support the Roadmap as a whole and this strategic objective specifically, can be found in Annex 2.

Clear guidelines for financing TB as an exempted service, including commodities

The country lacks clear guidelines for which level of government should finance TB as an exempted service. Even though commodities are the largest cost driver of TB services, reliance on external support to procure nearly all TB commodities has left the country without a clear mandate for which level(s) of government should be responsible for commodity financing and procurement. Global Fund has requested that the Government institute a budget line and release an allocation for anti-TB drugs (as well as ART) by EFY2023, to build experience in planning for and executing related budgetary allocations working through the Ethiopian Pharmaceutical Supply Agency (EPSA) (Global Fund Letter, 2020). Countries faced with a similar challenge that also have decentralized health systems, such as Kenya and Vietnam, have opted to centralize the financing and procurement functions for HIV and TB commodities. A centralized approach was needed given (i) that despite decentralization, federal levels still tend to have a greater proportion of fiscal space available for health and can account for inequities across regions, (ii) that international commodity procurement benefits from bulk purchasing arrangements, and (iii) that it aligns with the longer-term vision for national or social health insurance schemes. The shift to making financing procurement and distribution of TB commodities a federal responsibility and expenditure assignment was supported by most of the key informant interviews at different levels of the Ethiopian system.

Action. The NTP will advocate for the financing and procurement of TB drugs, supplies, and equipment to be designated as a Federal responsibility. While the country will need to continue to leverage external resources, particularly Global Fund resources, in the foreseeable future, the NTP will work with DPCD and PCD to engage the National HIV/AIDS Program to finance and procure a proportion of anti-TB and ART drugs starting in 2023. Working with the National HIV/AIDS Program, it will be important to establish HIV *and* TB financing ambassadors/champions who will also serve as advocates for increased domestic investment in commodities and strengthened capacity, leveraging the National HIV/AIDS Program's ability to engage with parliamentarian champions to secure the budget line items for commodities.

Since the GoE plans to gradually move away from the current reliance on external funding for procurement of TB commodities and supplies, EPSA will need to increase its capacity to negotiate procurement contracts. The government has procured GeneXpert cartridges, ancillary drugs, and nutrition supplements for MDR-TB patients in the past; however, the government faces significant challenges to accessing foreign currency in order to procure supplies, equipment, and medicines on the international market. The NTP should be aware of these challenges as it assesses the possibilities for continuing the use of existing pooled procurement mechanisms to procure TB commodities. In addition, PCD should conduct a feasibility analysis and examine opportunities to procure some TB-related and other essential health equipment and commodities domestically, with consideration of price and quality. Ethiopia is unlikely to receive lower unit prices domestically than it can in the international market, but supply chain challenges (particularly given Ethiopia's landlocked status) and foreign currency shortages suggest potential long-term benefits to domestic production and procurement (Fagan et al, 2019).

NTP will also track initiatives that are and will be taking place at a higher level of government, and will ultimately support the government's allocation to essential health services, including TB. At the Minister of Health's direction, the essential health package will be reprioritized and the list of exempted services will be re-reviewed and re-costed. This offers the NTP an opportunity to influence which TB-related services are included in the package as exempted services. Given the limited TB-related services that are considered exempt, there is an opportunity to advocate for additional services to be integrated—especially those that incur the highest OOP costs, including additional tests beyond standard diagnostics and medicines (e.g., use of x-ray for screening). PCD is also working to develop a directive on exempted services to provide a uniform guideline for the reimbursement of exempted services, and to set clear responsibilities at each level of the healthcare system. This will help ensure that hospitals and health centers are adequately reimbursed for exempted services, providing sufficient resources so that they are able and incentivized to offer high quality services. While hospitals and health centers do not currently submit TB-specific requests for reimbursement under the current exempted service policy[13]—TB commodities are provided to facilities in-kind—this will be an important reform for TB in the future, if facilities are able to request reimbursement for the use of general equipment, such as x-rays, as part of cost-sharing mechanisms.

[13] All services, including commodities, for exempted services like TB are free of charge to the patient. TB commodities are financed by development partners and provided for free to health facilities. Human resource and indirect costs incurred to provide TB as an exempted services are covered by the government through its existing human resources at health facilities and regular recurrent budget allocated to each health facility (Alebachew et al., 2018).

Leverage co-financing experiences to catalyze domestic resource mobilization at each level of the healthcare system

One approach to catalyze increased government resources for TB is through co-financing arrangements made between different levels of the government or between the government and its development partners. As previously discussed, Amhara, Dire Dawa, and Somali regions have mobilized additional resources for health under co-financing arrangements, leveraging both domestic and external resources.

The co-financing arrangements are developed by the FMOH and negotiated at the FMOH-RHBs Joint Steering Committee (JSC) meeting. Competition between the regions comes into play as some regions may start co-financing a particular program earlier and other regions may want to do the same. The co-financing often comes with additional resources so there is an incentive for the regions to buy into the agreement—regions may be ineligible for certain funding if they don't accept the co-financing terms. Co-financing arrangements are arranged in a way that does not place undue administrative burden on the public financial management system—focusing on larger investments and initiatives. Co-financing between different levels of government is a mechanism that has been used globally to promote domestic resource mobilization for TB programming. For example, India uses co-financing arrangements between the national and state levels as the main domestic financing mechanism for TB. To achieve the Government's 20 percent co-financing commitment under the Global Fund grant, the FMOH could negotiate co-financing agreements with individual regions.

Action: To incentivize RHBs and woredas to invest in TB, the NTP will explore opportunities to proactively incorporate explicit co-financing arrangements when allocating domestic and external resources (such as Global Fund TB grant and USAID TIFA grants) at the decentralized level. There is currently no policy or legal framework that guides or enforces co-financing arrangements; rather, any agreements are negotiated during the JSC meeting between the FMOH and RHBs. As regions receive domestic funding support from the federal level in the form of block grants, there currently is not a way for the federal government to earmark funding within the block grants for a specific purpose. Regions, however, have the authority to prioritize TB when allocating block grant funding from the federal level. The co-financing arrangement could be made without the funding being earmarked for that purpose in the block grant, or the federal level could use external funds—from, for example, the SDG fund—to earmark funding for a co-financing arrangement with a region. Global Fund-related co-financing arrangements are negotiated at the national level with the FMOH and MOFED, and direction on co-financing at the sub-national level related to external funding agreements would need to come from MOFED and the FMOH. Therefore, the FMOH and MOFED—with PCD, NTP, the National Malaria Program, and the National HIV/AIDS Program—should examine the current policy framework and draft a policy framework that guides the development, implementation, and monitoring of co-financing mechanisms and better facilitate an accountable pathway for domestic funding to be used for co-financing arrangements as well. The policy framework will likely be relevant to other health areas too, and therefore a wide range of stakeholders will need to be involved in the process of outlining co-financing requirements and setting goals and milestones for the coming years.

Specific areas that could benefit from co-financing arrangements with regions could include:

- *Training and supportive supervision and review meetings:* Currently, the majority of performance monitoring is supported by the federal level (through external funds), where the NTP either provides training directly or transfers budget to the regional level so regions can pay for their own training and conduct standalone or integrated supportive supervision and review meetings.

- *Outreach for contact investigation and TB prevention treatment (TPT):* NTP is working to better engage regions to support active case finding, and particularly to engage health extension workers to support these efforts.
- *Data surveillance, monitoring, use, and research:* Data consolidation, analysis, and research is primarily a federal-level function; however, the NTP will advocate that the regional level take on additional responsibility for surveillance, monitoring, and contribution to nationally-led research.

Box 5. Advocacy Entry Points in the Budget Process

There are **three major opportunities** for advocacy during the budget process:

February—development of annual workplans: The core plan provides a framework for health sector spending at all levels of government. Engagement with the planning department at this stage can help to shape priorities and motivate specific funding requests.

April—budget hearings: financial institutions at each level of government convene budget hearings during which all sector offices, including the FMOH, RHBs, and WorHOs, present and justify their budget proposal. This is a critical opportunity for the health institution at each level to make its case to the financial institution for additional spending on health and priority programs, using arguments on the economic and population-based impact.

May—before legislative bodies review the budget: the executive and legislative bodies at each level of government review and formally approve the annual budget. This review is particularly important at the regional and woreda levels, where locally-elected councils play a more active role in approving the budget. It is necessary to sensitize and inform these decision-makers of the needs, as well as the impact—particularly the economic impact—of the health sector, before they have an opportunity to review the budget.

Source: Fagan et al., 2019

SI 2. Explore the potential for eventual integration of TB services into social and community-based health insurance benefits packages

Improving financial protection for health by expanding access and uptake of prepayment schemes is a key objective of Ethiopia's proposed HCFS. The HCFS establishes the goal of achieving combined coverage—under social health insurance (SHI), community-based health insurance (CBHI), and private health insurance—of 40 percent by 2025. In addition, the EHIS has initiated the process to redesign the HIBP to explicitly define service coverage under CBHI and eventually SHI, as well as guide communication to beneficiaries and hold service providers accountable. The revised service package is expected to complement the coverage under the exempted services.

CBHI reimburses facilities for services based on user fee schedules that are defined as services to be financed with cost-sharing arrangements. When the user fees were established for non-exempted services, they were only intended to cover the full commodity costs and subsidized fees for other costs associated with outpatient and inpatient services at contracted public facilities (but not the human resource and overhead costs). In public facilities, the government budget pays for human resources, equipment, infrastructure, and other associated costs at the relevant administrative level.

In addition to these limitations of CBHI, TB and other priority health services are designated as exempted from user fees, and thus they are likewise excluded from reimbursement through CBHI. Therefore, although insurance is often identified as a main strategy for mobilizing additional resources for health broadly, Ethiopia's current CBHI (and SHI, if implemented in a similar manner) will not contribute to sustainably financing TB or other exempted health services in the immediate future. In addition, while the coverage of CBHI is currently around 50 percent, CBHI is not financially capable of taking on additional services in its benefit package until it is further implemented and scaled. CBHI targets mostly rural and informal sector workers and families. The premium being paid by the informal sector employees is too low to include TB costs and the other exempted services. Adding TB would require redefinition of the benefit package and revision of premiums, which is not feasible at the moment. About 85 percent of CBHI members are paying members, while the remaining 15 percent are subsidized by the government, as indigents. With over 70 percent of the population working in the informal sector and 24 percent of people living below the poverty line, the government will not be capable of subsidizing a large segment of the population, or of greatly increasing the benefit package via such subsidization. In addition, the CBHI schemes are not all solvent and self-sustaining, suggesting the need to closely monitor the benefit package and the cost of utilization before considering adding additional services (Fagan and Dutta, 2019; Feleke, 2015; World Bank, 2020). There is currently no timeline for the implementation of an SHI scheme, which will focus on the formal sector, including civil servants.

Action. In the short term, the NTP will gather the evidence needed to advocate for TB integration into Ethiopia's health insurance schemes and identify any challenges to doing so. In the long term, it will be important to integrate TB and other exempted services into the benefit package to offer an opportunity for cross-subsidization. The NTP will work with the Ethiopia Health Insurance Services (EHIS), with support from the Steering Committee and TB TWG, to estimate the long-term costs to CBHI and SHI of integration of TB services based on different TB benefits packages and reimbursement rates, considering service utilization rates, enrollment trends, and beneficiary population characteristics. The NTP will engage stakeholders to discuss the results and define a package of services. Lastly, EHIS will lead efforts to revise proclamations/policies to allow for these changes when appropriate.

SI 3. Explore opportunity to improve TB mainstreaming and multi-sectoral collaboration – particularly related to non-medical OOP costs

The NTP has established several agreements with Ministries beyond the health sector to support TB programming, such as the Ministry of Mining and Petroleum and the Prison Administration. Under these arrangements, the NTP provides resources to screen high-risk populations; such as mine workers, prisoners, and refugees; and to connect those in need with treatment through either public sector clinics or by providing in-kind anti-TB drugs to health facilities run by other government ministries. While these are important collaborations for detecting TB cases, the arrangements are primarily financed by the NTP, with other ministries providing in-kind resources. The NTP's Multi-sectoral Accountability Framework for the TB response lays out collaborations and partnerships across ministries and entities to comprehensively support the TB response.

TB mainstreaming is when funding is allocated to TB from non-health sector budgets, such as education and social welfare. In Ethiopia, mainstreaming is encouraged across sectors and has been a strategy[14] for mobilizing resources for HIV; however, the level of financing for TB by non-health sectors is unknown. Mainstreaming is an important opportunity to support non-medical costs that TB patients pay OOP, such as transport and nutritional supplements, which could be offset through social protection programs supported by the Government. The health sector-led fee-waiver program, where the woreda health office pays for the health services for the poor, only covers approximately 7 percent of the population. It is estimated that 24 percent of the population lives below the poverty line, and therefore, coverage of this scheme is insufficient; but the woredas have limited fiscal capacity to take on additional costs. Enhancing the coverage of the very poor through allocated resources from the proposed Resilience and Equity Fund (described later), as well as from other social protection programs led by the MoLSA, should be leveraged further to support TB patients who are living below the poverty line.

Action. The NTP will identify priority ministries and offices to advocate for mainstreaming TB funds. Table 5 presents a draft of priority ministries and components of the TB program that these ministries could finance. The NTP and DPCD will discuss overlapping priority sectors with the National HIV/AIDS Program (e.g., Ministry of Education, Ministry of Labor and Social Affairs) and offer support for the revision and refinement of mainstreaming guidelines that incorporate TB components for specific sectors. NTP will create associated guidelines if needed, with FMOH approval. In addition, the NTP will create an advocacy strategy for engaging each priority sector, with concrete opportunities for the sector to contribute to the TB program—in line with NSP priorities.

Table 5. Proposed list of mainstreaming sectors

Ministry or Office	Current collaboration with NTP	Proposed future support
Ministry of Mining and Petroleum (MoMP)	• NTP screens workers and community members in mining areas • MOMP is part of the TWG and participates in annual review meeting	MoMP to provide financial support for screening and referral of TB-positive individuals.
Ministry of Labor and Social Affairs (MoLSA)	• NTP collaborates with MoLSA on leprosy programming as MoLSA provides social security benefits for the disabled • MoLSA oversees the Productive Safety Net Program (PSNP)[15] to reach the poorest, but the program lacks strategic engagement to identify and support the poorest, including TB patients	MoLSA could proactively target TB-affected households to determine eligibility for—and, if appropriate, enroll in—social safety net programs like PSNP and other income-generating activities.

[14] The Baseline Assessment for HIV domestic resource mobilization and sustainability found that the success of mainstreaming has been extremely limited, primarily due to a lack of (1) a legal basis for enforcing mainstreaming; (2) clear guidelines for how mainstreamed funds should be spent, tracked, and reported; and (3) capacity to deploy mainstreamed funds in an effective manner that aligns with national initiatives and priorities. Addressing these weaknesses is a main component of the HIV DRMS Strategy that can be leveraged by the NTP. Source: http://www.healthpolicyplus.com/pubs.cfm?get=17399

[15] The Productive Safety Net Program, or PSPN was launched in 2005, aiming to reduce food insecurity vulnerability by providing economic opportunities and building resilience to crises, through cash transfers, public works, and nutritional feeding programs. PSNP provides payments to able-bodied members of the community for participation in labor-intensive public works. It provides direct payment support (for six months of the year) to labor-poor, elderly, or otherwise incapacitated households. This support assists households to smooth their consumption, avoid asset depletion, and plan with greater certainty. Source: https://europa.eu/capacity4dev/project_psnp_ethiopia

Ministry of Education	• NTP works with MOE to screen and educate students on TB so they can also educate their families	MOE to provide financial support to screen and educate students
Prison Administration	• TB screening is conducted every 6 months in prisons • NTP works with Administration to conduct case-finding • In prisons with a clinic and healthcare worker, they provide diagnosis and treatment services directly • In cases where there isn't a clinic, the RHB serves as a liaison to TB services	Prisons without their own clinics can fund TB screening programs and then refer patients to the RHB.
Police Commission	• TB screening is conducted every six months at the police commission	Police commission funds their own screening and referral.
Administration for Refugee and Returnee Affairs	• Part of the TWG • Administration works closely with regional government to offer refugees TB screening and treatment	Administration to fund TB-related services.

Innovative financing initiatives

The magnitude of the resource needs for TB are such that public sector contribution alone will not suffice. The NTP will also need to explore strategic opportunities to leverage more innovative financing initiatives, including investments from the private sector at the federal and decentralized levels, in ways that minimize the transaction costs and lead to sustainable, reliable, and coordinated financing. The NTP will explore several different potential avenues for financing TB, leveraging existing mechanisms for other health programs and emerging health financing reforms.

One of the limiting factors to exploring engagement with private corporations and organizations to finance the health sector is the lack of a clear framework within the MOH. While the sector has Public-Private Partnerships in Health (PPPH) Implementation Guidelines that were further elaborated upon by the Public Private Partnership (PPP) Guidelines (developed by the MOF), these documents are primarily focused on how the public sector can engage the private sector to build infrastructure, deliver services, and innovate. The sector needs to review the role of the private sector and develop a sector-specific approach that specifically targets mobilization of domestic financing from the private sector to include contributions from individuals, corporations, and communities; and to outline how those resources would be allocated and prioritized within the sector. PCD has the intention of developing a private sector engagement strategy in the future.

SI 4. Explore opportunities to leverage a forthcoming 'Resilience and Equity Fund' to be financed by proposed excise tax earmark for health to support TB

Earmarking is the practice of establishing through law the allocation of a certain value of funds, or a certain percentage of a specific revenue stream (e.g. a tax), for a specific purpose or institution. Unlike other allocations, earmarks cannot be adjusted as part of the annual budgeting process – rather, they can only be changed by an amendment to the law. Therefore, earmarked funds are seen as protected, and as a more consistent and reliable source of financing than allocation through budget line items. When earmarks are established on a specific revenue stream—either for the full value or a percentage of those revenues—it also serves to tie that allocation more closely to revenue and/or economic growth. Although some of these taxes can be regressive—for example, low-income citizens may end up spending a higher share of their income paying a levy than those with high income—they can generate revenue for priority development programs.

When considering the use of earmarks for health, policymakers may consider whether to earmark an existing revenue stream (a tax) or to create a new tax for the specific purpose of funding a particular program. For example, Ethiopia currently imposes excise taxes on (i.e. a tax on the sale of) alcohol, tobacco products, and sugary drinks (+50 percent on alcohol, 40 percent on sugary drinks, 20 percent on tobacco[16]), though these have no specific earmark to health. In February 2020, the GOE approved a new excise tax (Proclamation No. 1186/2020) that expands the list of taxed products and offers the opportunity to reintroduce discussions on potential earmarks for health and its priority programs, like TB. Under the HCFS, the PCD projected revenue that could be generated for the health sector if an earmark was approved for health.

The FMOH has recently decided to work towards establishing a 'Resilience and Equity Fund' to consolidate domestic innovative financing sources (excise tax earmark, private sector contributions, etc.) that will be efficiently allocated to fill gaps in funding for priority health areas, including TB. However, in order for the Fund to be effective at mobilizing domestic resources, it would need to be backed by a sustainable domestic funding source, such as the earmark mentioned above—which is the intention, if approved. The FMOH needs to actively engage MOFED, the Ministry of Revenue (MOR), the Council of Ministers, Parliament, and the Prime Minister's office, to secure a share of the new taxes for health and gain approval for the establishment of the Fund.

The Oromia RHB has developed a draft regional Health Care Financing Strategy to establish its own Health Equity and Emergency Fund. The Fund would ensure that sufficient resources are available to finance health emergencies and initiatives targeted to health equity, which would include TB. Implementation of health equity initiatives would be led by the RHB in collaboration with relevant sectors. The sources of funding are outlined to be (i) shifting the revenue raised via HIV/AIDS mainstreaming to the Health Equity and Emergency Fund, and increasing its share from two to four percent of the recurrent budget allocated to government sector offices; (ii) organizing proactive and regular fund-raising events; and (iii) initiating development of a legal framework for contributions to the Health Equity and Emergency Fund from public servants, private sector employees, and NGO workers.[17] Once this pooled fund is established, the priority programs under the guidance of the fund's management committee will need to establish resource allocation criteria based on the evidence of impact, underfinancing, and foreign dependence.

[16] There also exists the potential for establishing and earmarking a tax on khat.
[17] Oromia RHB, Draft Regional Health Financing Strategy, May 2021.

Action. Advocacy is needed to secure an earmark for health. PCD is collecting data on the economic impact of investing in health (and of high-impact interventions such as TB), the impact of investing in health on non-health sectors, and the overall return on investment. PCD will use Spectrum and the DemDiv models to estimate impacts. The NTP can use the evidence generated to support general budget advocacy in Strategic Initiative 1 to support PCD in making the business case for health and for TB. PCD will also model options for potential revenue for health, based on a percentage earmark of the excise tax, elasticity of demand, and projected growth, and how it could cover health sector financing gaps. PCD will use this evidence base to advocate to the MOFED for a share of the excise tax revenue for health. The process for legally establishing the earmark will occur under the leadership of the MOFED and outside the purview of the NTP, making it more important to engage PCD and the Minister's Office to see how the NTP can contribute to the evidence base for advocacy and keep engaged and up-to-date on any progress.

Simultaneously with advocacy for a proposed earmark for health, PCD is currently developing a document that details how the 'Resilience and Equity Fund' will be managed, what its mandate will be, and what priorities it will fund. After this technical document is developed and approved, it will be converted into a legal framework. The NTP will support PCD to develop the resource allocation criteria for the 'Resilience and Equity Fund' that considers the cost of TB, its financing gaps, the burden of TB on patients—particularly OOP costs—and the TB cost categories that would be best covered by such a fixed funding stream. The resource allocation decisions for the Fund will be made at a higher level of the FMOH and/or MOFED—depending on where the Fund is housed—and therefore, it is important for the NTP to engage early and often to ensure that TB remains a priority and that a proportion of the revenue will support TB.

The 'Resilience and Equity Fund' would add another much-needed funding stream to a complex public financial management system that is already challenging to monitor. Special attention would need to be paid to how the fund is governed, ensuring alignment and integration with the other funding channels and government planning and budgeting processes to minimize delayed and/or ineffective use of the funds, due to administrative burdens or overlapping mandates.

SI 5. Explore opportunities for the corporate private sector to contribute sustainably to the TB response

Ethiopian culture includes a high degree of social responsibility and solidarity; however, corporate social responsibility (CSR) practice in Ethiopia remains nascent (Kesto, 2017) and is not considered a sustainable financing source. However, given that TB is often concentrated in specific workplace populations, there is an opportunity to partner with specific large enterprises to target their employees, their families, and the surrounding community through corporate wellness programs that focus on how investments in TB can reduce productivity losses and provide a positive ROI. Mining corporations, large farms, and industrial settings with numerous employees, especially those in high-risk areas for TB, should consider addressing TB prevention and control at work as part of their workplace responsibilities (i.e., fighting TB at work). Crowded and/or particulate-filled working conditions in these settings may lead to the spread of TB among employees and the surrounding community. As a result, with both financial and in-kind support to workplace health programs and to local public health facilities, these firms may ensure that their personnel are routinely screened for TB and referred for treatment. For example, in South

Africa, mining companies like Gold Fields educate their workforce and provide counseling during medical reviews and regular screening (Gold Fields, 2021).

The NTP already partners with state-owned or -subsidized corporations, such as the Sugar Corporation—one of the Government's mega projects—to support TB programming. While the Sugar Corporation's clinics conduct TB screening and treat patients at their own clinics, the NTP provides in-kind commodities and up-to-date guidelines and training to healthcare workers on TB. With strategic engagement, the FMOH may be able to negotiate with the Sugar Corporation to provide additional in-kind support to TB.

Another opportunity to consider is how TB could benefit from the innovative way the Government mobilizes resources and reaches HIV target populations through infrastructure projects. By law, every road contract issued by the Ethiopia Road Authority includes a costed HIV program component. The contractor must budget HIV-related activities such as HIV prevention, care, and support interventions targeting staff, workers, and the host community. Most often the HIV activities are implemented by specialized, private sub-contractors. The HIV budget is approximately ETB 500,000 per year/project, equating to a countrywide total of US$ 2–5 million/year. Although this is an established example of external mainstreaming, there remain challenges with monitoring implementation, documenting impact, and coordinating with the national HIV program (HIV DRMS Baseline Report).

Action. The NTP will map large national and global enterprises operating in Ethiopia in targeted industries (e.g., agriculture, mining, sugar, construction) and identify selected industrial operators that have strong workplace health or social services for their employees to target for engagement. The NTP will engage the Ethiopian Public Enterprising Holding and Administration Agency, the entity that oversees large public enterprises, to advocate and discuss opportunities for addressing TB in the workplace. The NTP will conduct advocacy with several targeted enterprises individually to design and develop a workplace-focused TB program based on global best practices.[18] Advocacy with these enterprises will focus on the enterprises' ability to reach individuals and families at high risk for TB, prevent loss in productivity, and benefit from a high ROI of workplace wellness programs. In collaboration with PCD, the NTP will establish a public-private platform and forum for sharing the business case for TB, advocate for investment by national and global corporations in worker health and empowerment, share best practices, report on successes and challenges, and develop joint activities—to specifically target these partnerships beyond those of the TB TWG meetings. The NTP will also leverage its partnerships with CSOs and NGOs—such as Voluntary Health Service, Organic Health, and Consortium of Christian Relief and Development Associations—to support social and behavior change (SBC) messaging through the workplace and in associated communities, in collaboration with private enterprises. Lastly, the NTP with PCD will create a reporting process with national and global enterprises and NGO partners to record and report on TB-related cases and treatment success, as well as document financial contributions to TB that can be integrated in the NTP annual report.

Building on the HIV DRMS Strategy, there is an opportunity for the TB program to leverage investment in the road contracts approach. The NTP and DPCD will consult with the National HIV/AIDS Program on opportunities to include TB components—such as education, screening, and connection to care—to

[18] There are several resources, including Working together with businesses: Guidance on TB care and control in workplaces, and WHO and the International Labour Organization's Guidelines for Workplace TB Control Activities.

HIV programmatic aspects. As appropriate, the NTP or DPCD will join discussions between the National HIV/AIDS Program and the Ethiopian Road Authority to refine the mandate for contractors to address current challenges, improve efficiency, and integrate TB components—particularly given the increase in TB/HIV co-infection in recent years (Stop TB website, 2021).

Under a similar strategy, the NTP and DPCP will engage FMOH leadership and the Ministry of Mines and Petroleum to discuss the opportunity to incorporate TB programming components into Mining contracts. Miners have been identified as a high-risk population for TB, are often not reached by traditional program outreach, and often require additional investment from external partners, which is not consistent. NTP will collate recent evidence to document the higher incidence of TB among miners, and therefore their status as a key target population, as well as the efficacy of programming directed at miners in Ethiopia and other countries. Box 6 is an example of an initiative to specifically address TB incidence among miners in Oromia that could be at least partly financed by adding a required TB component to mining contracts. If incorporating TB programming into mining contracts is not politically feasible, the NTP will leverage its existing relationships with mining companies to explore direct agreements for the mining companies to directly finance TB-related activities like screening.

Approach to private sector engagement

Private sector engagement includes activities that raise awareness of TB activities and initiatives, that request active participation; and that gather direct feedback. The objective for communicating with each targeted actor is listed in Table 6 below.

Below are communication channels and approaches that stakeholders will use to engage the private sector in the DRM initiatives:

1) Advocating for integration of workplace wellness programs
    - Gather data, information, and messaging on the benefits of workplace wellness programs targeted at TB. The World Economic Forum[19] presents six reasons that employers should tackle TB: 1. To reduce the risk of a TB outbreak spreading in a workplace; 2. To strengthen a company's workplace health offering with relatively simple steps that can be integrated with other health programming; 3. To reduce absenteeism and time-off due to ill health, and increase productivity through reduced presenteeism; 4. To build and leverage structures that will protect against the spread of other lethal respiratory pathogens, like SARS-CoV-2; 5. To strengthen brand and profile with an increasingly health-aware public; and 6. Together, these can add up to a meaningful return on investment.
    - Use recent data from work in sugar/mining/construction/etc. sector on TB incidence to make and share print or digital factsheets and advocacy materials that make the case for the importance of investing in TB. Messaging will be targeted to the benefits for the specific sector.
    - Meet with high-level officials at the enterprise to discuss benefits of TB prevention/treatment to employees and employer.
    - Organize quarterly meetings with officials responsible for workplace wellness and/or CSR program—offer technical support based on best practices and document program impact.

[19] https://www.weforum.org/projects/ending-workplace-tuberculosis

2) Advocating and sensitizing private-sector corporations to integrating TB into corporate contracts
   - Present evidence of what level of funding is needed, what it is needed for, and how additional resources would be spent
   - Negotiate financing commitment
   - Share HIV/AIDS experience integrating programming into road contracts, operational mechanism, requirements, and benefits to employer, employees, and community
   - Invite mining companies to dialogue with MOFED and high-level government decision-makers on proposed legal and policy framework for TB integration into contracting mechanism

Table 6. Objectives for GOE engagement with different private sector actors

Private sector entity	Objective
Large corporate industries—agriculture, construction, mining, etc.	• Inform about importance and impact of TB • Engage in workplace wellness to support TB
MEGA Sugar Corporation	• Leverage current relationship, in which NTP offers guidelines and training to sugar corporation clinic workers to obtain additional in-kind commitment to TB through strengthened workplace wellness activities, such as regular screening
Mining companies	• Leverage current relationship to either 1) sensitize mining companies on the prospect of integrating TB into each mining contract and/or 2) obtain additional in-kind commitment to TB through strengthened workplace wellness activities, such as regular screening
Road construction companies	• Leverage HIV/AIDS program relationship and experience to sensitize road construction companies on the prospect of integrating TB into each road contract, and/or integrating TB activities into existing HIV work under such contracts
Industrial parks	• Negotiate TB workplace wellness intervention and financial commitment to TB prevention with Industrial Parks Development Corporation of Ethiopia (IPDC)

Box 6. Targeted TB case finding in Oromia mining sector

A project, funded by USAID and implemented by MSH, recruited volunteers and development army members to provide health education for the workers at the mining shafts in Oromia. They screened the workers for TB, provided health education, referred presumptive cases to a nearby health center for TB evaluation, and served as treatment supporters for those who started on TB medication. In addition, the team carried out contact investigation for individuals who had come into close contact with the presumptive cases. Over a nine-month period, 22,000 mining workers were reached and 11,842 were screened for TB. The incidence of TB was found to be 1,756 per 100,000 screened mining workers—seven times above the WHO threshold for a health emergency—reinforcing the need for continued targeting of this population.

Source: MSH, 2017

SI 6. Examine opportunities for community-level engagement through community care coalitions or similar to help offset non-medical OOP TB-related costs

Community care coalitions (CCCs) are kebele-level, volunteer-based committees that collect annual community member contributions (financial and in-kind). Collections are used to support disadvantaged population groups, especially people living with disabilities, the elderly, people living with HIV, and orphans. The HIV DRMS Strategy proposes working with the Ministry of Labor and Social Affairs (MOLSA); the Ministry of Women, Children, and Youth Affairs; and partners; to build capacity of and scale up CCCs to implement a package of HIV prevention interventions. The National Growth and Transformation Plan also supports significant scale-up of CCCs. The TB program has an opportunity to leverage CCCs to help cover the high OOP indirect costs of TB (e.g., transport, nutritional supplements, etc.). Recognizing that TB affects the poorest and most disadvantaged households, many key informants advocated for the approach of leveraging CCCs for TB. As noted in the Baseline Assessment of HIV Domestic Resource Mobilization and Sustainability, with active community members, CCCs have shown the potential to mobilize significant resources—half of which have historically been in-kind—making nutritional support and psycho-social support a strong option for TB-related support through CCCs. However, as volunteer-based community structures, capacity varies and turnover in leadership can be high, which makes it challenging to collect funds efficiently and use them transparently.

Action. To leverage this opportunity, the NTP and DPCD will identify a small, targeted package of TB services appropriate for implementation by the CCCs. They will collaborate with the National HIV/AIDS Program in their engagement with the MOLSA to examine the opportunity to integrate support for non-medical TB costs into the legal framework and guidelines for the CCCs as they are developed to strengthen CCC governance and effective funding use. The NTP will also provide MOLSA and partners with technical support to integrate TB and track TB-related resources.

Critical Enablers for Efficiency and Sustainability

Many aspects beyond resource mobilization require investment to support the TB program and its advocates to effectively steward, manage, implement, and monitor the TB DRMS Roadmap; and to advocate for increased investment in TB. The critical enablers below touch on health systems components that require attention to support DRM.

CE 1. Promote transparency and accountability in the collection, allocation, and execution of TB funding by improving resource tracking and monitoring through system development, especially to support the co-financing practices by different levels of government

TB stakeholders require timely and accurate financial data on TB resources to inform decision-makers and advocate for greater resources for TB. In 2021, more than half of the funding for TB was donor funds managed through channel 2—a system that relies on mostly paper-based financial reporting, making it challenging to accurately and efficiently track available resources, disbursements, and expenditures. Nearly one-quarter of TB funds (those mobilized by the government) were managed

through channel 1 using a financial management system (IBEX) that is not currently configured to support program-based budgeting. Off-budget resources from development partners (channel 3)—which are difficult to predict and track—account for 27 percent of TB funding, and data from the private sector remains extremely limited. The FMOH supports a NHA study, including TB expenditure, every 2-3 years, but the data is not timely enough to use for annual or monthly decision-making. PCD conducts retroactive resource-mapping of channels 2 and 3 on a yearly basis, which contributes to the FMOH reporting on co-financing for TB and other programs; but this exercise does not address the fragmentation and lack of transparency in annual planning and budgeting processes at all levels of government to effectively plan for, manage, and report on TB financing.

The FMOH is about to initiate a process to determine options for moving away from a paper-based system to track and monitor allocations and expenditures for channel 2 resources. PCD is currently examining the NHA approach and resource mobilization tools to identify indicators and a structure that would best support expenditure reporting. The preference would be to identify an existing electronic system that could be modified to serve as the financial accounting and tracking system for channel 2. The NTP will work with PCD to ensure appropriate inclusion of TB-related allocations and expenditures, including requirements to track and report on co-financing commitments for TB at different levels of government. The NTP also will highlight the need to consider how the system will coordinate with and track TB resources programmed through core regional and woreda plans and budgets, as well as TB resources that come from outside the health sector to include mainstreaming and private sector contributions.

Once the system has been identified, PCD, in collaboration with NTP, will be responsible for mapping and tracking the resources committed, allocated, and spent; and the programmatic areas funded. The data will allow the NTP, FMOH, and RHBs to determine if and how the resources are being used in line with the NSP; and to increase efficiency of use. The NTP will use the data to examine TB funding and expenditure by category in the database, compared to what was planned in the annual plan and NSP priorities. This can then be used to inform budget allocation and prioritization for the next year, as well as to help inform the next NSP. These data will also allow the NTP, FMOH, and RHBs to improve coordination among partners and make informed decisions for planning and advocacy.

Beyond a dedicated, unified financial accounting and expenditure record system, the NTP will also advocate for more investment in human resources, infrastructure, and ICTs at the zonal and woreda levels in support of a holistic approach to strengthening the public financial management system. This will include strengthening regional and woreda-level utilization, liquidation, and audit teams, continuing to focus on improving budget disbursement, utilization, and liquidation performance indicators, and providing clearer guidance on re-programming guidelines for unutilized funds to improve efficiency.

CE 2. Enhance allocative and technical efficiency for TB programming

Resources are finite and need to be used efficiently to maximize impact. Efficiency gains can be achieved through improved targeting of key and priority populations, as well as through alignment with high-impact NSP interventions and with the needs of the regions and woredas.

To promote allocative efficiency—honing where resources are targeted and which interventions are funded—resources will be mobilized and allocated based on TBL-NSP priorities. RHBs and WorHOs

will be supported to help determine an appropriate evidence-based allocation to TB, given the burden in each locale.

In addition, as the GOE increases its contribution to the procurement of TB commodities, supplies, and equipment, EPSA, in coordination with the NTP, will conduct a market analysis of TB commodities to examine options for pooled bulk procurement and negotiate the lowest prices across the domestic and international markets. The data will be discussed and shared with the FMOH and MOFED to identify long-term procurement options. However, tight management of the exchange rate and foreign exchange controls reinforces the country's dependence on external financing for commodity procurements and stifles the ability of the private sector to access international markets. The ability of the government to use domestic revenues to meet its full procurement needs, particularly for medicines and supplies not currently produced domestically (including those for HIV, TB, and malaria), will be contingent upon national monetary policy (Fagan et al., 2019). Moreover, the 2017 Global Fund auditing report highlights multiple inefficiencies in procurement, warehousing, and distribution arrangements, as well as inventory management and quality assurance. Broader health system support beyond the NTP is addressing these challenges.

To promote technical efficiency—maximizing results of interventions—the NTP and TB TWG will continue to advocate for TB service delivery to occur at lower levels of care and for improved quality of care. Misdiagnosis and missed diagnosis of TB can be costly to the health sector in terms of continued transmission, retesting, and/or inappropriate use of drugs. The false positive test rate for TB in Ethiopia is low at 2.4 percent, and not a strong concern. The TB treatment success rate is 96 percent and also not an efficiency concern. The NTP and TB TWG will look to explore opportunities to better engage health extension workers to improve community engagement and retention. The NTP will also invest in training NTP, RHB, and strategic sector staff on results-based planning, high-impact interventions, TLP-NSP priorities, and resource tracking, to improve allocative efficiency and effective use of resources. In addition, the NTP will collaborate with other health programs to integrate performance monitoring teams across the disease programs.

CE 3. Realize efficiency gains through engagement of the private health sector

Private providers account for approximately 20 percent of facility visits nationally and 35 percent among the growing urban population. Current engagement of private providers in the provision of TB services is growing in the identification of presumptive TB and referral and/or diagnosis and referral and/or diagnosis and treatment. There are more than 12,000 private and public/private mix (PPM) health facilities in Ethiopia. In 2020/2021, the national TB report showed that nearly 980 private health facilities are engaged in TB care and prevention and contributed 17 percent of national TB notifications. However, the private sector represents 5% of the diagnosis and treatment rates, and therefore still a small percentage of the overall TB response. As an exempted service, TB service delivery in the private sector has not always been prioritized. However, it offers an opportunity to reduce the burden on public facilities, both financially and in overcrowding of infrastructure and demand on health workers' time.

Private providers currently offer TB services as part of their social responsibility, and there is limited incentive to provide TB services. The government does not contract with private facilities and offer reimbursement for services. Instead, the district government signs a memorandum of understanding (MOU) agreement with the facilities that the government will provide commodities free-of-charge to the

private facility to offer to their patients for free and support supervision and monitoring and evaluation. The government also has agreements with civil society organizations or non-governmental organizations, like REACH TB, which supports case finding in urban areas to reach priority and/or hard to reach populations. The MOU contains articles with requirements that facilities must adhere to, such as sending providers for training and following national standards. The MOU can be canceled at any time, but it requires a 3–6-month lead time to allow for patients to be referred and commodities to be transferred to a nearby facility. TB commodities must be given to patients for free, but private facilities can charge a consultation fee, the cost of which they agree to with the district government. These operational guidelines and directives are detailed in the NTP's PPM guidelines for TB.

While the MOU agreements allow for TB commodities and services to be available, it relies on the facilities' own motivation and interest in providing the service and does not provide incentives. Establishing formal performance-based contracting mechanisms with private providers would create a stronger partnership between the public and private sectors and would incentivize quality TB service offerings. It would also support the government's goal of expanding and scaling health insurance schemes by establishing contracting mechanisms that could be used in the future under CBHI, with the future integration of TB-related services into the benefit package. Providing low-income clients with the opportunity to seek services in the private sector would require two components—first, a system to determine a client's ability to pay, i.e., through the fee waiver or CBHI indigent identification systems—and second, a way to reimburse private providers for services provided to those identified as low-income clients through a contracting mechanism.

To do so, the NTP and PCD teams will examine the willingness and ability of people with TB to pay for key services, including diagnostic testing and treatment, and the willingness of private providers to either provide these services for fees that such patients will accept, or to join contracting schemes. As an exempted service, the legal framework needs to be further strengthened to allow for the provision of TB services in the private sector, and to facilitate private facilities to purchase or receive either partially- or fully-subsidized TB commodities. If the costs of TB commodities in private facilities are covered by the public sector, then the service fee that private providers would have to charge (to cover the basic consultation only) could be far more manageable for private clients with TB symptoms. The NTP will examine these issues in collaboration with the National HIV/AIDS Program, which is currently exploring this avenue for HIV.

The NTP will conduct a feasibility assessment to determine the extent to which contracting of private clinical providers or private entities such as NGOs would be a cost-effective solution, particularly for reaching high-risk populations and achieving TB programmatic goals. The assessment will include extensive mapping to understand the needs and possibilities for service provision through contracting, with consideration of the quality of services; government and private sector capacity for implementing contracting arrangements; political economy; and the policy, legal, and regulatory environment. If the findings are promising, a needs assessment will be conducted to determine the cost of establishing and implementing contracting arrangements, and the resources available to support it. In the beginning, it would likely require upfront external investment, but in the long term it would serve as a government-led and financed initiative for efficient and high-impact use of resources.

While the strategic documents for engagement with the private health sector exist, implementation of the documents is weak. Action is needed to raise engagement of the private health sector as a priority and integrate the facilities into the health care system to facilitate improved data collection, reporting,

and quality assurance. Due to under-reporting by private facilities into the health information system, limited data is available to support higher-level advocacy for the importance of the private sector in TB service delivery and outreach. The NTP will work with the PPD to identify under-reporting facilities and target them for supportive supervision. The NTP has limited capacity to manage private sector-related initiatives, with only one focal point at the federal level. The NTP will advocate for additional human resources to support these initiatives at the federal and regional level, in line with the MOH's PPP framework. In addition, to help strengthen the capacity of the NTP, health officers, and MOH directorates, the PCD will develop operational guidelines for the PPP framework to guide implementation.

Governance and Implementing Arrangements

Together, the NTP (under the leadership of DPCD) and PCD will steward the implementation of the roadmap with stakeholders. For this to be a success, PCD will need to invest in opportunities for the NTP to strengthen its capacity, particularly in health financing, so that it can provide technical input needed to inform the development and implementation of each strategic objective. Implementation of the roadmap will require strong advocacy and coordination with RHBs, ministries outside the health sector, and the private sector. The PCD and DPCD will support the NTP to coordinate with these entities and develop advocacy messaging to engage with new and external stakeholders.

The NTP, TB TWG, and Steering Committee will also be responsible for sensitizing their organizations and offices about the DRMS Roadmap and introducing the Roadmap to other ministry offices and RHBs. The NTP will lead workshops with priority offices and sectors for mainstreaming and collaboration to talk about their roles and potential contributions. The NTP will also assign a focal point for each of the sector offices to streamline communication and technical assistance support related to mainstreaming or private sector engagement. The NTP will offer the same support to the RHBs, and will help them integrate relevant activities into their annual plan and monitor implementation.

In terms of governance structures, the NTP will continue to chair the TB TWG and participate as a key partner on the Steering Committee. The TORs for each of the groups will be re-reviewed to include responsibilities for the oversight of the DRMS Roadmap. In addition, the NTP will assign a representative to serve on the Health Financing TWG. As the TB DRMS Roadmap falls under the umbrella of the broader health financing strategy, it is important for the NTP to be informed of health financing reform updates, and to have the opportunity to participate in the broader conversation and give the TB program a voice to ensure sufficient integration into broader health system efforts.

Lastly, NTP, PCD, and DPCD will work together with development partners to improve donor coordination and alignment of external resources with funding needs and TBL-NSP priorities. The revitalization of one plan, one budget, and one report; as well as having a functional Joint Consultative Forum (JCF)—a forum for dialogue and consultations on the overall policy direction, reform, and institutional issues of the health sector between the Government, development partners, and other stakeholders, that plays a leading role in mobilizing resources to fund the sector in a sustainable manner—and Joint Core Coordinating Committees (JCCC)—a committee that serves as the technical arm of the JCF—has been raised as part of HSTP medium-term review. Donor coordination and funding alignment is a broader initiative that the FMOH is working on.

Roles and Responsibilities of Key Actors

The NTP will be responsible for overall leadership, coordination, implementation, and monitoring and evaluation of the DRMS Roadmap. The TB TWG and Steering Committee will continue to lead and oversee implementation of the DRMS Roadmap, particularly collection, allocation, and use of resources. The TB TWG will oversee the alignment of the DRMS Roadmap with the NSP and will lead prioritization of how resources are allocated. The Steering Committee will ensure alignment of the DRMS Roadmap with broader health sector financing initiatives, assign responsibilities, and monitor progress on action steps.

Roles and responsibilities of key stakeholders will be as follows:

NTP

- Lead, coordinate, monitor, and evaluate implementation of the TB DRMS Roadmap
- Support tracking of TB financing commitments and allocations from different Roadmap DRM mechanisms
- Advocate for action on, and communicate the content of, the TB DRMS Roadmap to all stakeholders at all levels
- Sensitize NTP counterpart staff to TB DRMS Roadmap at regional, zonal, and woreda levels
- Provide leadership and direction on efficient allocation of domestic resources through alignment with the NTSP
- Lead the execution of studies/assessments required to establish an evidence base for advocacy
- Chair the TB TWG
- Include progress on the TB DRMS Roadmap in quarterly progress reports

Ministry of Health – DPCD

- Oversee and provide support to the implementation of the TB DRMS Roadmap
- Request, negotiate, and secure budget funds from the government treasury at the federal level
- Support tracking, collection, allocation, and use of domestic resources
- Chair the Steering Committee

Ministry of Health – PCD

- Oversee and support implementation of the TB DRMS Roadmap, in coordination with DPCD and NTP
- Support tracking, collection, allocation, and use of domestic resources
- Provide technical support on technical assessments/studies
- Support the development of regular TB funding landscapes to identify and close TB program funding gaps
- Use the TB DRMS Roadmap to integrate TB into ongoing health financing reforms and initiatives
- Serve on the Steering Committee
- Build capacity for effective implementation of the DRMS Roadmap at all levels

Ministry of Health – Leadership

- Offer political support and guidance on necessary steps to integrate TB into the broader health financing agenda

TB Technical Working Group

- Provide technical support and guidance for the implementation of the TB DRMS Roadmap, particularly in ensuring alignment between DRMS initiatives and TB programmatic needs

Steering Committee

- Provide leadership in the oversight and decision-making for the implementation of the TB DRMS Roadmap

Ministry of Finance and regional offices

- Collaborate with MOH to identify opportunities for DRM for TB, with consideration of the legal framework needed
- Support tracking, collection, allocation, and use of domestic resources
- Support requests and negotiation of TB-related budgets from the government treasury
- Join and participate in Steering Committee meetings

RHBs

- Lead, coordinate, and monitor and evaluate implementation of TB-related domestic resource mobilization at the regional level
- Advocate for and communicate the TB DRMS Roadmap at regional and woreda levels
- Track collection, allocation, and use of TB domestic resources, and report to NTP and PCD
- Build capacity for effective implementation of the TB DRMS Roadmap at regional and woreda levels
- Provide technical support to regional- and woreda-level stakeholders
- Request, negotiate, and secure TB-related budget funds from the government treasury at regional and woreda levels
- Produce quarterly reports on performance of TB DRMS initiatives at regional and woreda levels

Development partners and donors

- Participate in, and provide strategic guidance through, the TB TWG and Steering Committee
- Provide technical and financial support for implementation of the TB DRMS Roadmap

Private health sector

- Partner with the government to provide access to effective and affordable TB control and prevention services

Implementation Roadmap

The activities and interventions below are actionable steps that are necessary to engage stakeholders, generate data needed for evidence-based decision-making and advocacy, and make progress towards each of the Strategic Initiatives. The implementation timeframe is January 2022 to June 2026, represented as fiscal years 2021/22 to 2025/26 in the tables below.

SI 1. Increase allocation of general government budget to health, and specifically TB, at federal and regional levels

#	Activity	Outputs	Implementation Year					Responsibility [20]	Collaborators
			21	22	23	24	25		
1.1	Evidence-based Advocacy: Federal level								
1.1.1	Develop annual costed action plans for TB and conduct annual TB commodity quantification as part of the existing planning process	Action plan developed	X	X	X	X	X	NTP, PCD, Policy and Planning Directorate (PPD)	FMOH, TB TWG, Steering Committee
1.1.2	Conduct resource mapping and projections exercise for TB and determine financing gap	Resource mapping projections and financing gap exercise completed	X	X	X	X	X	NTP, PCD	FMOH, Steering Committee, RHBs
1.1.3	Determine TB funding priorities for federal and regional level	TB funding priorities identified		X	X	X	X	NTP, PCD	FMOH, TB TWG, Steering Committee, RHBs
1.1.4	Model the health and economic impact and ROI of TB	Impact of TB modeled	X					NTP, PCD	FMOH, TB TWG, Steering Committee

[20] As this document was being finalized, the PCD became part of the Strategic Affairs Lead Executive Office (SALEO). The actions assigned to the PCD in the current document will generally be taken on by SALEO.

#	Activity	Outputs	Implementation Year					Responsibility [20]	Collaborators
			21	22	23	24	25		
1.1.5	Develop a clearly articulated, multi-year budget ask (i.e., how much should be allocated for TB and how much should the amount increase by annually)	Analysis developed and shared with FMOH	X					NTP, PCD	FMOH, TB TWG, Steering Committee
1.1.6	Develop an advocacy brief for MOFED/BOFEDs that identifies the TB funding gap and the potential impact if under-funded	Brief shared with MOFED/BOFED	X					NTP, PCD/RMD	TB TWG, Steering Committee
1.1.7	Use existing budget process mapping to identify key moments for engagement and necessary approvals	Map and description of budget process completed and disseminated to key stakeholders	X					NTP	TB TWG, Steering Committee
1.1.8	Develop an advocacy plan in collaboration with CSOs to ensure implementation of DRM mechanisms identified	Advocacy plan developed	X					NTP, Consortium of Christian Relief and Development Associations (CCRDA)	TB TWG, Steering Committee
1.1.9	Implement and monitor progress of the advocacy plan	Quarterly progress reports completed		X	X	X	X	NTP	TB TWG, Steering Committee, NGOs
1.1.10	Identify parliamentarians to serve as champions for increased health budget allocation to priority public health programs (including TB), and coach them on key data and talking points	Number of coaching sessions for parliamentarians		X				DPCD	PCD, PPD

#	Activity	Outputs	Implementation Year					Responsibility [20]	Collaborators
			21	22	23	24	25		
1.2	Evidence-based Advocacy: Sub-national level								
1.2.1	Develop annual costed action plans, including resource mapping data from the FMOH (regional and woreda level)	Action plan developed	X	X	X	X	X	RHBs, woreda health offices	NTP, TWGs at regional/woreda level
1.2.2	Develop regional advocacy plans for increasing TB funding allocations at the regional, woreda, and community level	Number of regions with TB financing advocacy plans	X					RHBs, woreda health offices	NTP, TWGs at regional/woreda level
1.2.3	Establish appropriate policies, regulations, and/or guidelines for allocation to TB at the local level	Policies, regulations or guidelines developed and disseminated		X	X	X		RHBs, woreda health offices	NTP, BOFED, WOFED
1.2.4	Identify regional/woreda level representatives to serve as champions for increased health budget allocation to priority public health programs (including TB) and coach them on key data and talking points	Number of coaching sessions for representatives		X				RHBs, woreda health offices	NGOs
1.3	Secure budget								
1.3.1	Conduct a consultation workshop with the MOH; MOF; HPR Women, Youth and Social Affairs Standing Committee; the Prime Minister's Office; the Council of Ministers; and regional governments	Consensus on the responsibility of the government to increase budget allocation for the TB program		X	X	X	X	NTP	MOH, Steering Committee

#	Activity	Outputs	Implementation Year					Responsibility [20]	Collaborators
			21	22	23	24	25		
1.3.2	Request, negotiate, and secure budget funds from the government treasury at federal, regional, and woreda levels	Budget allocated for the TB program	X	X	X	X	X	NTP, MOH, RHBs, woreda health offices	U.S. Government (USG) partners, Global Fund, World Bank, NGOs
1.3.3	Conduct a biannual review and report on budget allocation and use at federal, regional, and woreda levels	Biannual domestic budget allocation report produced and distributed		X	X	X	X	NTP, MOH, RHBs,	Steering Committee
1.3.4	Conduct an annual audit of budget allocation and use at federal and regional levels	Annual audit report		X	X	X	X	NTP, MOH, RHBs, MOFED	Steering Committee, Auditor General
1.4	Clear guidelines for financing TB as an exempted service								
1.4.1	Review TB-related services that are exempted and non-exempt, and compare relative impact and cost to NTP and patient	Proposed list of TB-related exempted services developed		X				NTP, TB TWG	PCD
1.4.2	Develop advocacy brief to propose list of TB-related exempted services	Advocacy brief developed		X				NTP, TB TWG	CSOs
1.4.3	Participate in stakeholder meetings to review exempted services list	Revised exempted services list approved			X			NTP, PCD	FMOH, MOFED
1.4.4	Revise the expenditure assignments for procurement of commodities for exempted services (shares between the federal	Expenditure assignments revised		X				PCD and MOFED	

#	Activity	Outputs	Implementation Year					Responsibility [20]	Collaborators
			21	22	23	24	25		
	government and regional government), including TB								
1.4.5	Advocate and track that these commodities are included as part of program budgeting by the MOFED, to ensure its regular allocation	Exempted service commodities budgeted			X	X	X	PCD and MOFED	
1.5	Leverage co-financing experiences to catalyze DRM								
1.5.1	Assess the legal and policy environment to institutionalize co-financing mechanisms	Legal and policy assessment conducted	X					PCD, PPD	Legal/policy consultant
1.5.2	Draft policy framework that guides development, implementation, and monitoring of co-financing mechanism	Policy framework for co-financing developed		X				PCD	FMOH
1.5.3	Present draft to FMOH and MOFED leadership	Draft shared		X				PCD	FMOH
1.5.4	Revise draft and resubmit for approval	Draft revised			X			PCD	FMOH
1.5.5	Submission to and approval by Council of Ministers	Draft submitted for approval			X			PCD	Council of Ministers
1.5.6	Develop annual co-financing goals for each region for TB	Co-financing goals developed				X		PCD, NTP	

SI 2. Explore the potential for eventual integration of TB services into social and community-based health insurance benefits packages

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
2.1	Estimate the long-term costs to CBHI and SHI of integration of TB services; based on a range of possible TB benefits packages (e.g., testing, treatment, lab work) and reimbursement rates; and considering service utilization rates, enrollment trends, and beneficiary population characteristics	Integration feasibility analysis completed		X				Ethiopia Health Insurance Services (EHIS), FMOH, USG partners	Steering Committee
2.2	Conduct stakeholder dialogue based on results of the feasibility of developing consensus around and strategy for TB integration into CBHI and/or SHI	Consensus developed on need for TB insurance integration			X			EHIS, FMOH – DPCD, NTP	Steering Committee and USG partners
2.3	Define a TB benefits package and reimbursement rates for SHI and/or CBHI based on results of the feasibility analysis	Benefits package and reimbursement rates defined				X		NTP/FMOH, EHIS	Clinton Health Access Initiative, Health Financing Improvement Program, TB TWG
2.4	Make revisions to exempted services proclamations and policies to allow facilities to charge insurance schemes for TB services provided to enrolled clients	Legal framework established					X	EHIS	MOH, National HIV/AIDS Program

SI 3. Improve management and targeting of funds mainstreamed for TB within priority sectors

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
3.1	Identify priority sectors for mainstreaming funds for TB (Ministry of Mining and Petroleum [MoMP], Ministry of Labor and Social Affairs [MoLSA], Ministry of Education, Prison Administration, Police Commission, Administration for Refugee and Returnee Affairs)	Priority mainstreaming sectors for TB identified	X					NTP, PCD	TB TWG, Steering Committee
3.2	Discuss overlapping sectors with National HIV/AIDS Program	Meeting with National HIV/AIDS Program		X				NTP, PCD, DPCD	National HIV/AIDS Program
3.3	NTP to offer technical support in the development of a proclamation and the revision of mainstreaming guidelines for strategic sectors; develop a supportive legal framework to mandate and standardize the practice across sectors; and assign an account code and expenditure title for TB mainstreaming	Mainstreaming proclamation approved, guidelines revised, legal framework developed, and account code and expenditure title created		X	X			NTP, MOF, Attorney General	Steering Committee, MOR
3.4	Create an advocacy plan for engaging each priority sector with concrete opportunities for the sector to contribute to TB	Advocacy plan developed			X			NTP	TB TWG, Steering Committee
3.5	Conduct advocacy and consensus-building meetings with strategic sectors at federal and regional levels	Consensus created on roles and responsibilities of strategic sectors			X	X	X	NTP	Steering Committee

SI 4. Explore opportunities to leverage the forthcoming 'Resilience and Equity Fund' to be financed by proposed excise tax earmark for health to support TB

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
4.1	Earmark								
4.1.1	Collect data on the economic impact, impact on non-health sectors, and ROI of investing in the health sector and high-impact interventions, including TB—use Spectrum and DemDiv to conduct modeling exercises	ROI for health, including TB, clearly defined	X					PCD	NTP, TB TWG, Steering Committee
4.1.2	Model options for potential revenue for health based on a percentage earmark of the excise tax, elasticity of demand, and projected growth, and how it could cover health sector financing gaps	DRM proposals and projections developed and submitted to Minister	X					PCD	NTP, Development partner TA
4.1.3	Advocate to key decision-makers for a health earmark using above generated evidence base	Meetings with MOFED, Ethiopia Revenue and Customs Authority (ERCA), MOR, Parliament, and other key stakeholders conducted	X					NTP and PCD	TB TWG and Steering Committee
4.1.4	Develop legal/tax reforms necessary to establish earmark	Legal documents developed and adopted		X				MOFED, FMOH	DPCD, PCD, PPD

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
4.1.5	Identify parliamentary or other relevant champions for proposed earmarks, and coach them on key data and talking points	Number of parliamentarians coached and number of coaching sessions		X				DPCD	PCD, PPD
4.1.6	Approve earmark for health	Earmark for health approved			X			Council of Ministers, Prime Minister	PCD
4.2	Resilience and Equity Fund								
4.2.1	Develop technical document that outlines how the 'Resilience and Equity Fund' will be managed, what its mandate will be, and what priorities it will fund	Technical document developed	X					PCD	
4.2.2	NTP to use the resource mapping, gap analysis, and impact data (SI 1.1 and 1.2) to develop advocacy messaging for the integration of TB in the priorities of the 'Resilience and Equity Fund'—particularly what cost categories would benefit from additional funding; and to share messages with PCD and Minister of Health	Advocacy messages developed and shared with PCD and Minister's office	X					NTP	PCD, TB TWG and Steering Committee
4.2.3	Support the development of resource allocation criteria that considers the cost of TB, its financing gaps, the burden of TB on patients (OOP costs), and the TB cost categories that would benefit from the Fund	Resource allocation criteria developed						NTP with PCD	

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			Y1	Y2	Y3	Y4	Y5		
4.2.4	Organize advocacy meetings with and solicit feedback from FMOH, MOFED, and MOR on proposed Fund structure	Advocacy meetings conducted		X				DPCD and PCD	FMOH, MOFED, MOR
4.2.5	Establish legal framework for Fund	Legal framework developed			X			PCD and legal department	
4.2.6	Approve Fund	Fund approved			X			Minister of Health, Council of Ministers, Prime Minister	
4.2.7	Monitor, track, and report on Fund allocation to TB program	TB allocations tracked and reported				X		NTP and PCD	TB TWG and Steering Committee

SI 5. Explore opportunities for the corporate private sector to contribute sustainably to the TB response

#	Activity	Outputs	Implementation year					Responsibility[20]	Collaborators
			21	22	23	24	25		
5.1	Workplace Wellness programs								
5.1.1	Map large enterprises in targeted industries (e.g., agriculture, mining, sugar construction) and identify a selection with strong workplace health or social services to target for engagement	Enterprises mapped	X					PCD	NTP, FMOH
5.1.2	Develop guidelines for workplace-focused TB program, based on global best practices such as WHO and ILO's guidelines for workplace TB control activities	Guidelines developed		X				NTP	PCD, TB technical working group, Steering Committee
5.1.3	Conduct advocacy with several enterprises to design and develop a workplace-focused TB program, highlighting the ROI of workplace wellness programs, especially among high-risk TB populations	Advocacy sessions occurred			X			NTP, DPCD, PCD	Civil society organizations
5.1.4	Establish a public-private platform and forum for sharing the business case for TB, best practices, and results from workplace wellness programs	Platform established			X			NTP	Private enterprises, PCD
5.1.5	Hold semi-annual meetings of platform	Meetings held				X	X	NTP and PCD	Private enterprises
5.1.6	Engage CSOs and NGOs to support SBC messaging through the workplace and in associated communities, in collaboration with the private enterprise	CSOs and NGOs engaged in workplace wellness programs					X	NTP	Voluntary Health Service, Organic Health, Consortium of Christian Relief and Development

#	Activity	Outputs	Implementation year					Responsibility[20]	Collaborators
			21	22	23	24	25		
									Associations, Private enterprises, REACH Ethiopia
5.1.7	Establish a reporting process to record and report on TB-related cases and treatment success, as well as financial contributions	Reporting template and process established				X		NTP, PPD	PCD
5.2	Infrastructure contracts								
5.2.1	Consult with National HIV/AIDS Program on opportunities to combine forces to advocate to Ethiopian Roads Authority (ERA) for the inclusion of both HIV and TB components in ERA contracts	Meeting with National HIV/AIDS Program	X					DPCD and NTP	National HIV/AIDS Program, HIV DRMS Task Force, Steering Committee
5.2.2	Join discussion between National HIV/AIDS Program and ERA to refine mandate for contractors	Infrastructure mainstreaming mandate refined	X					DPCD and NTP	National HIV/AIDS Program, ERA, MOFED
5.2.3	Develop guidance for contractors on targeted TB interventions that would be most effective in road construction context, including options for collaborating with NTP and CSOs	Guidance document developed		X				NTP	TB TWG
5.2.4	Determine reporting structure for contractors to report to ERA and NTP on activities conducted, people reached, cases identified and successfully treated or	Reporting structure established						PPD, PCD	FMOH, NTP

#	Activity	Outputs	Implementation year					Responsibility[20]	Collaborators
			21	22	23	24	25		
	referred, as well as expenditure on TB-related activities								
5.3	Mining sector contracts or other agreement								
5.3.1	Collect previous and recent evidence to support TB incidence among miner population, and domestic and regional experiences for targeting them	Evidence-base collected for miners and TB	X					NTP	TB TWG, development/ implementing partners, PCD
5.3.2	Hold meetings with FMOH, MOFED, MOR, and Ministry of Mining and Petroleum about the possibility of integrating TB programming into mining contracts	Number of advocacy meetings conducted		X				DPCD, NTP, PCD	Steering Committee, FMOH leadership
5.3.3	Option 1. Support establishment of legal framework to support TB program integration into mining contracts	Legal framework established			X			PCD	NTP
5.3.4	Sensitize mining companies to policy change	Mining companies sensitized			X	X		NTP, PCD	FMOH
5.3.5	Develop guidance for contractors on targeted TB interventions that would be most effective in mining context, including options for collaborating with NTP and CSOs	Guidance document developed			X			NTP	TB TWG
5.3.6	Determine reporting structure for mining companies to report to MoMP and NTP on activities conducted, people reached,	Reporting structure established				X		PPD, PCD	FMOH, NTP

#	Activity	Outputs	Implementation year					Responsibility[20]	Collaborators
			21	22	23	24	25		
	and cases identified and successfully treated or referred, as well as expenditure on TB-related activities								
5.3.7	Option 2. If integrating TB programming into contracts is not politically feasible, directly target mining companies with existing relationship with NTP to advocate for an annual agreement to support TB activities in contracts	Agreement negotiated			X			NTP, DPCD	PCD

SI 6. Examine opportunities for community-level engagement through community care coalitions or similar, to help offset non-medical OOP TB-related costs in the long term

#	Activity	Outputs	Implementation Year					Responsibility	Collaborators
			21	22	23	24	25		
6.1	Identify a package of TB-related care and services to be supported by CCC financing, and update CCC guidelines	Expansion of CCC guidelines to include allocations to TB-related care and services	X					NTP, MOLSA, Ministry of Women, Children and Youth Affairs (MOWCYA)	FMOH, USAID/FHI 360, community leaders
6.2	Support other institutions to advocate for a legal framework to formally integrate CCCs into the government system and set standards for leadership, oversight, governance, and financial management and reporting	Legal framework developed	X					MOLSA, NTP, Attorney General, MOWCYA	USAID/FHI 360, National HIV/AIDS Program

#	Activity	Outputs	Implementation Year					Responsibility	Collaborators
			21	22	23	24	25		
6.3	Develop reporting guidelines for CCCs to report financial and programmatic support for TB-related care and services	Reporting guidelines developed for effective monitoring, evaluation, and resource tracking	X					NTP	USAID/FHI 360, MOLSA, Bureaus of Women, Children, and Youth Affairs (BWCYAs)
6.4	Increase the capacity of existing CCCs to effectively implement TB-related interventions and mobilize, allocate, and track resources allocated to TB	CCCs have capacity to manage resources and support TB-related activities	X	X	X	X	X	RHB, BOLSAs, BWCYAs	USAID/FHI 360, community leaders
6.5	Provide technical assistance in the scale-up of CCCs in TB priority woredas	Number of CCCs supporting TB-related interventions increased		X	X	X	X	BOLSAs, RHBs, BWCYAs	United Nations, USG partners
6.6	Participate in annual performance reviews of CCCs at national and regional levels	Share lessons learned from performance review	X	X	X	X	X	FMOH, NTP, MOLSA, RHB, BOLSA, BWCYAs	TB DRMS TWG, United Nations, USG partners

CE 1. Promote transparency and accountability in the collection, allocation, and execution of TB funding by improving resource tracking and monitoring through system development, especially co-financing practices by different levels of government

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
1.1	Review resource mapping, NHA, and other tools used to track expenditures to determine what indicators and structure are most conducive to effectively tracking health sector channel 2 resources	Assessment of budgeting/ expenditure tracking needs conducted	X					PCD	PPD
1.2	Develop a new PFM system, or integrate budget and expenditure tracking into an existing electronic system for health sector channel 2 resources—system should align with other FMOH and GOE PFM systems	Electronic PFM system developed/ integrated	X	X				FMOH finance and administration, PPD, MOFED	Steering Committee, RHBs, PCD
1.3	Ensure inclusion of TB-related expenditure and resource tracking needs, including co-financing	TB PFM needs taken into account	X	X				NTP	PCD, FMOH finance and administration
1.4	Support the development of new PFM and financial reporting guidelines, including those relevant for TB	Electronic PFM system guidelines developed			X			FMOH finance and administration, MOFED, PCD	NTP, PPD
1.5	Train administrators on new system, including NTP program	Responsible parties trained				X	X	FMOH finance and administration, PPD	NTP, PCD
1.6	Explore the options for, and establish a mechanism to, pool different health sector co-financing contributions together where they can still be audited separately	Examples gathered from domestic and international experiences Mechanism developed		X	X	X		FMOH finance and administration, MOFED	PCD, PPD
1.7	Track TB resources committed, allocated, and spent on a monthly basis	TB resources regularly tracked				X	X	NTP and PCD	

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
1.8	Upload all published performance and financial reports on existing or new website or public portal	Information platform online and publicly accessible	X					FMOH	FHAPCO, MOLSA, MOMP, and mainstreaming ministries
1.9	Establish and update an online TB financing dashboard; in coordination with the Aid Management Platform, update government data quarterly and donor data annually/semi-annually	TB allocation and expenditure by source updated on an annual basis			X			PCD, NTP	Development partners, RHBs
1.10	Ensure that health management information systems are interoperable with the integrated financial management system to connect financial performance and health impacts	Online management platforms merged/synced		X	X			FMOH	MOFED
1.11	Advocate for, and ensure inclusion of, TB-related expenditure and resource tracking needs, including co-financing in line with budget process	Advocacy conducted with PCD, PPD, Minister's Office, and TB champions			X	X	X	NTP	PCD

CE 2. Enhance allocative and technical efficiency for TB programming

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
2.1	Conduct an efficiency study to identify areas of inefficiency and potential efficiency gains in TB service delivery and procurement,	Efficiency study completed and action plan developed	X	X				NTP	TB implementing partners, civil society, development partners

#	Activity	Outputs	Implementation Year					Responsibility[20]	Collaborators
			21	22	23	24	25		
	and identify key actions to improve efficiencies								
2.2	Conduct a market analysis of TB commodities on the domestic and international market	Market analysis conducted	X					EPSA	NTP, PCD
2.3	Present data to FMOH and MOFED, discuss long-term procurement options, and develop action plan	Market data shared; action plan for long-term procurement options developed		X				EPSA, NTP	FMOH, MOFED
2.4	Train NTP, RHB, and strategic sector staff on results-based planning, high-impact interventions, TLP-NSP priorities, and resource tracking to improve allocative efficiency and effective use of resources	Key stakeholders trained in high-impact practices	X	X				PCD	NTP, TB TWG, Steering Committee, RHBs
2.5	Integrate monitoring of the TB DRMS Roadmap in federal and regional TB program joint supportive supervision and annual review meetings	Performance of TB DRMS Roadmap initiatives tracked; challenges identified and addressed		X	X	X	X	NTP, PPD, PCD, RHBs	TB TWG
2.6	Explore opportunities to better engage health extension workers to improve community engagement and patient retention	Lessons learned and adopted in annual plans on how to leverage health extension workers to improve TB outcomes	X	X				NTP	TB TWG, PPD, development/ implementing partners
2.7	Gather data on, and report to health sector stakeholders about, the effect of healthcare worker turnover on TB outcomes; and contribute to broader conversation on improving health worker retention	Evidence base established and policy discussion facilitated on health worker retention		X	X	X		NTP, FMOH HR	TB TWG, FMOH leadership, PPD

CE 3. Realize efficiency gains through engagement of the private sector

#	Activity	Outputs	Implementation Year					Responsibility	Collaborators
			21	22	23	24	25		
3.1	Examine willingness and ability of the community and people living with TB to pay for key services; including testing and diagnostics, treatment, and laboratory work; and identify determinants of private sector facility use	Evidence generated to guide decisions	X					PCD	NTP/FMOH, private sector providers and associations
3.2	Conduct a feasibility assessment to determine feasibility and opportunities to use contracting to reach high-risk TB populations and undertake other TB tasks within the MOH's public-private partnership framework	Feasibility assessment conducted	X					PCD, NTP, MOLSA	FMOH, Steering Committee
3.3	Conduct a needs assessment to determine cost of establishing and implementing contracting arrangements, and resources available to support it	Needs assessment conducted		X				PCD, NTP, MOLSA	FMOH, Steering Committee
3.4	Develop/adjust and approve contracting mechanisms (tendering process and accountability requirements) for the procurement of both private health facility- and civil society organization (CSO)-provided services	Contracting mechanism developed and approved			X			FMOH, MOLSA	MOLSA, CSOs, development/ implementing partners
3.5	Building on the Implementation Guide for Tuberculosis Prevention and Control	Operational guidelines updated				X		NTP	FMOH, TB TWG

#	Activity	Outputs	Implementation Year					Responsibility	Collaborators
			21	22	23	24	25		
	Program Through Public-Private Mix Approach in Ethiopia, develop and add guidelines for charging for services, fee limits, reporting, and supervision.								
3.6	Develop human resource capacity of purchasing agency(ies) for monitoring and evaluation of contracting arrangements	Staff trained				X	X	FMOH, MOLSA	CSOs, facilities
3.7	Building on the PPP framework, develop an operational guide to help stakeholders identify action steps for implementation	Implementation guide developed				X		PCD	FMOH, Steering Committee
3.8	Develop capacity of the government to undertake private sector engagement initiatives, including hiring additional personnel	Capacity developed and additional staff hired							
3.9	Build private clinic/CSOs' capacity in monitoring and evaluation and reporting	Partners trained				X	X	FMOH, MOLSA	MOLSA, private clinics, CSOs, development/ implementing partners

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Annex 1. Methodology

The methodology to support the development of the TB DRMS Roadmap was developed in collaboration with the FMOH through the Steering Committee and the TB Technical Working Group (TWG). A detailed Inception Report that outlined the proposed objectives, approach, methodology, team composition, and timeline was endorsed by the Steering Committee. The Inception Report was shared with the Ethiopian Public Health Institute (EPHI) for their input and feedback on the objectives, methods, and questionnaires. In consultation with EPHI, the Steering Committee confirmed that the assessment was not a study and therefore was not subject to ethics review and approval.

Stated Objectives

The USAID-funded Health Systems for Tuberculosis (HS4TB) focuses on health systems finance and governance priorities and strengthens the performance of these systems in relation to TB programming. The HS4TB project applies systems thinking to transform the way we see and understand health systems for TB. At USAID's request, HS4TB has been engaged to offer its support to the FMOH/NTP to conduct three tasks/activities:

1. Develop a TB domestic resource mobilization and sustainability Roadmap, under the umbrella of the Health Financing Strategy, that will guide increased domestic funding from different sources to sustain TB activities over time;

2. Analyze efficiencies in the flow and management of funds earmarked for TB performance management activities through GOE systems (channels 1 and 2);

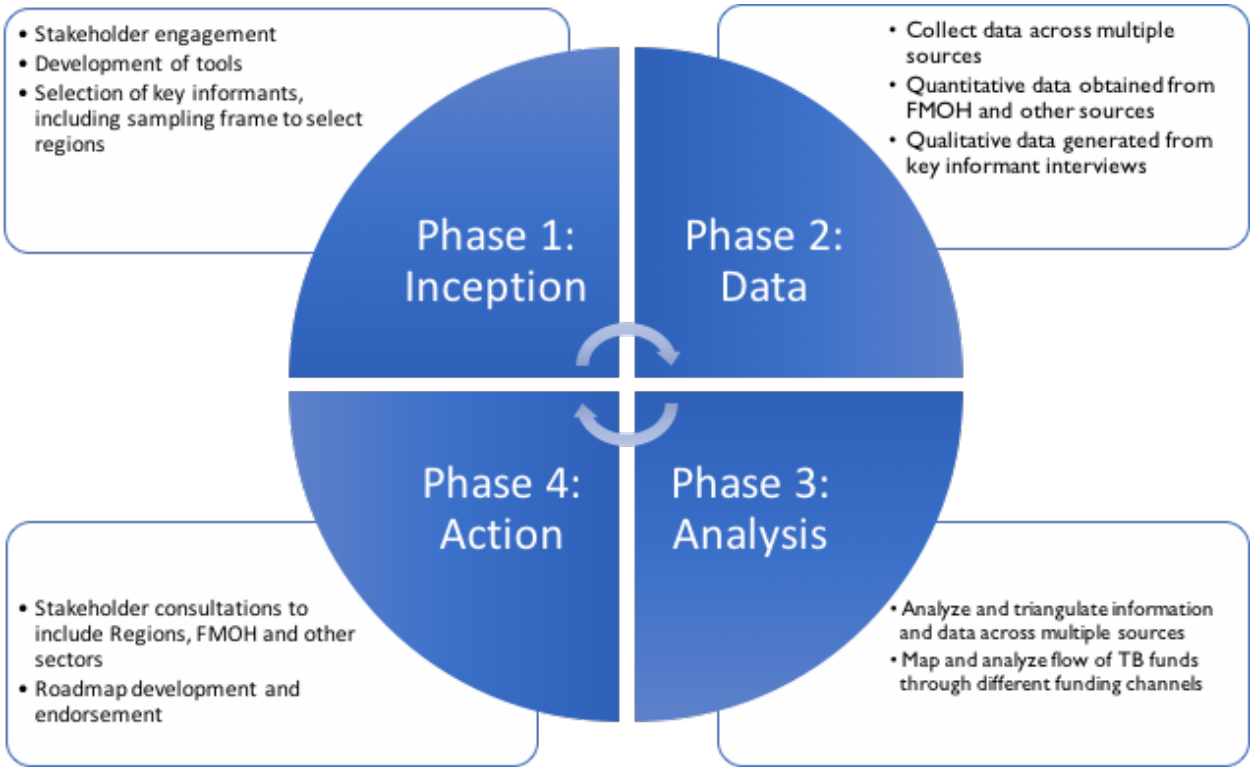
3. Identify opportunities to strengthen and track the mobilization of domestic resources by local administrations to support co-financing (in-kind and financial) of TB activities, to include identifying opportunities to strengthen the role and contribution of private and civil society organizations.

The major deliverable from this work will be to develop a roadmap for mobilizing and sustaining resources for TB programming in Ethiopia. This TB Resource Mobilization and Sustainability (TB DRMS) Roadmap is envisioned to guide the materialization of the overall National Health Financing Strategy tailored to TB financing perspectives. Additional analyses of Government funding channels and realization of the country's co-financing commitments for funds earmarked for TB programming will also inform the practical operationalization aspects of the TB DRMS Roadmap.

Overall approach

To conduct the three tasks outlined above, the team undertook a four-step approach to data collection, analysis, and drafting and revising the deliverables, as shown in Figure A1.1. Throughout each of these steps, government leadership and ownership of the process was critical for guiding the technical inputs from the HS4TB team. The work benefited from broad consultation within the FMOH and its partners, as well as engagement of select regions and woredas.

Figure A1.1. Summary of the methodology for developing the Roadmap



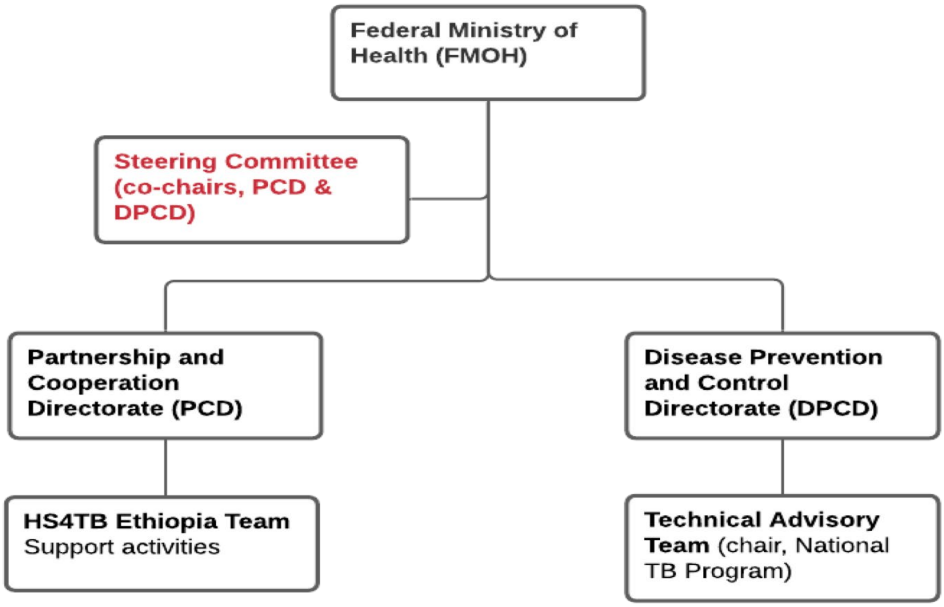
Government Ownership and Leadership

While HS4TB was responsible for producing analyses and presenting viable options for decision-making, government leadership and ownership of the process was the most critical component of the Roadmap development. The Concept Note was approved by the top management of the FMOH, and the assessment was led and coordinated by the Partnership and Cooperation Directorate (PCD)—the directorate within the FMOH that leads partnerships with all development partners and the implementation of the health care financing strategy, including fund flows and domestic resource mobilization—and the Disease Prevention and Control Directorate (DPCD)—the directorate that oversees the National TB and Leprosy Program (NTP). The PCD and DPCD established and co-chaired a Steering Committee, drawing upon different directorates and partners, to guide the development of the methodology and analytical review, facilitate access to data collection and key informants, and oversee the development of the Roadmap. HS4TB also worked closely with the NTP, as the primary beneficiary of HS4TB support. At the technical level, a Technical Advisory Team was formed by the NTP to ensure that experts in TB from Government and development partners shared their collective knowledge.

In order to support the FMOH and Steering Committee, HS4TB fielded a team that produced the analyses and presented viable options—supported by evidence—for decision-making. The team was composed of a team leader, a global health financing expert, an in-country coordinator with health financing expertise, a TB expert with a background in financing and costing, and a TB specialist/strategic advisor. The team's work was guided by the Steering Committee, as discussed above. To ensure that the activity was being implemented as agreed to by all parties, the HS4TB Activity Management Team

met on a biweekly basis to provide oversight, coordination, and implementation monitoring and management support.

Figure A1.2 Relationships between key stakeholders in the development of the Roadmap



Regional and Woreda Consultations

A primary source of information for this study is secondary information collected at the federal level to reflect data across all regions. However, the team also sought out perspectives from a subset of Regions and Woredas to include as key informants. Based on the constraints of the assessment budget and timeline, it was determined that the team would visit four regions and would ensure that each team consisted of a health financing and TB expert.

The final selection of Regions was determined in consultation with the Steering Committee and the Regions themselves. The sampling method for the selection of Regions was purposeful to learn from best practices and gaps in the flow of funds, to include the capacity to mobilize, utilize, and report funds on a timely basis. The team considered both TB treatment coverage rates and the utilization rate of Global Fund grant funds transferred from FMOH through Channel 2b. The choice of Regions also took into consideration the three different Ethiopia contexts—agrarian, urban, and pastoralist—and included visits to two agrarian (one stronger and one weaker), one pastoralist, and one urban region.

Table A1.1 Regional Selection

Region	Geographic Type			TB treatment coverage (2019/20)	GF Resource Utilization Rate (2018-20)	GF Resource Utilization Rate Update (2020-21)
	Urban	Agrarian	Pastoral			
Addis Ababa	x			127%	90%	100%
Afar			x	90%	89%	100%
Amhara		x		59%	84%	99.7%
Benishangul-Gumuz			x	45%	85%	100%
Dire Dawa	x			152%	93%	100%
Gambela			x	150%	94%	100%
Harari	x			120%	91%	100%
Oromia		x		73%	87%	99.8%
Somali			x	61%	100%	100%
Tigray		x		81%	90%	52.4%*
Sidama		x		99%		100%
SNNPR		x		60%	78%	99.2%
National				71%	86%	95.4%

** This does not reflect the exact utilization figure in Tigray region; due to the current situation, the statement of expenditure was not submitted.*

Source: Annual DHIS2 TB treatment coverage (2019/2020); Global Fund Grants Management Unit reported on utilization rates for 2018-2020

Analysis Plan

The team utilized a mix of qualitative and quantitative methods to collect, analyze, and triangulate information and data across multiple sources. The team used three approaches to analyze data. First, the team explored and undertook different aspects of quantitative analysis (trends, percentages, shares, unit costs, etc.) using the secondary data obtained from FMOH and other sources. Second, the team carried out a rolling analysis of the qualitative data generated from federal, regional, woreda, and development partner interviews. Third, the team developed a process map of the different funding channels to illustrate key differences and findings from the qualitative and quantitative analyses. At the end of each day of fieldwork, the team members met to review the field notes and develop an ongoing tally sheet to log key findings. The team discussed new findings and trends that may have emerged during the day and placed them into a findings, conclusions, and recommendations matrix that was developed on an ongoing basis during the fieldwork. Finally, the team conducted a joint analysis to systematically identify preliminary findings, conclusions, and recommendations for all of the key activities.

Comprehensive desk review

To facilitate qualitative analyses, the team used a structured desk review on a broad range of policy, strategy, and planning documents; and on performance related to the NTP and other relevant programs and their linkages to the broader national health sector funding and financing landscape. To support its quantitative analyses, the team used available data to assess the efficiency and effectiveness of resource disbursement and utilization, as well as to estimate the costs of undertaking TB M&E and to assess the share of flexible financing at different levels of government to support co-financing (see Roadmap references for documents reviewed).

Semi-structured interviews with key stakeholders

In addition to reviewing secondary sources, the team conducted key informant interviews (KIIs) with Government, development partners, civil society, NGOs, and the private sector, using tailored semi-structured interview guides. In addition to conducting nearly 20 KIIs at the federal level, the team interviewed more than 50 key informants from regions and woredas across Amhara, Dire Dawa, Oromia, and Somali. The goal of the KIIs was to provide clarity to data and processes found in the secondary literature, such as the fund flows, and to provide qualitative inputs to better understand the political will and feasibility for domestic resource mobilization and tracking for TB programming.

The KIIs at the regional and woreda levels provided inputs into mapping the flow of funds to support TB performance management programming, capturing the perceptions of the strengths and challenges of different financing channels, documenting the capacity of sub-national administrations to introduce and manage co-financing, and analyzing the potential sources and mechanisms for sustaining TB management. These KIIs also provided information on the MOF, BOFED, and WOFEDs' preferred channel of funding to use to budget for their share of co-financing.

Figure A1.3. Key Informant Interviews Conducted

Federal Level

Sector	Actors
Government / Public Sector	•Federal Ministry of Health •DPCD and PCD •Ethiopia Health Insurance Authority • National HIV/AIDS Program •TBC: Federal Ministry of Finance
Development Partners	•Global Fund and CCM •World Health Organization •USAID
NGOs, Civil Society, and Private Sector	•GLRA •KNCV •Private Sector Association •REACH •USAID Eliminate TB

Sub-national Level

Region	Regional Bureaus	Woreda Offices	Total
Amhara	9	5	14
Dire Dawa	10	N/A	10
Oromia	12	6	18
Somali	5	4	9
Total	36	15	51

Annex 2. Ethiopia's Budget Process and Developing an Advocacy Plan

Ethiopia's Budget Process

Summary of the budget process below is an excerpt from: Fagan, Thomas; Elise Lang and Bryant Lee. 2019. Achieving Sustainable Health Financing in Ethiopia: Prospects and Advocacy Opportunities for Domestic Resource Mobilization. Global Fund and Palladium: Washington D.C.

Budget Preparation The budget preparation process is part of the government's strategic and annual planning processes conducted in anticipation of the upcoming fiscal year, which spans from July 1 to June 30. At the federal level, MOFEC first prepares or updates the Macro-Economic and Fiscal Framework, which forecasts government revenue and expenditure for the coming three years on a rolling basis. Based on this, MOFED prepares or updates its three-year Medium Term Expenditure Framework and establishes a budget ceiling for each line ministry and region. These budget ceilings are communicated to all government offices through a budget call letter in February. Budget ceilings are similarly cascaded to agencies at their respective regional, zonal, or woreda level by the relevant finance institution (e.g., BOFED, WOFED) (FMOH, 2007).

Within FMOH, the resource mobilization team in the Partnership and Cooperation Directorate conducts a resource mapping exercise to determine how much funding will be available from different sources and for which programs during the coming fiscal year. This resource mapping exercise typically occurs in February and includes input from all financing sources, both domestic and external, although key informants have suggested the focus is predominantly on external sources. Around the same time, the FMOH Policy and Planning Directorate conducts a review of last year's financial performance (e.g., budget absorption) to inform needs in the coming fiscal year. These two inputs inform the development of a draft core plan—an annual work plan and accompanying budget. This core plan is discussed and agreed upon by the FMOH-RHB Joint Steering Committee and then shared with the RHBs, zonal health bureaus (ZHBs), and WorHOs to support the development of their annual core plans.

The core plan and budget focuses on the HSTP priorities and considers the MOFED communicated ceilings, but it is possible to request additional support. The same process happens at the regional and woreda levels. Each RHB and WorHO conducts a resource mapping exercise and develops an annual plan, in line with their strategic plans. The RHBs and ZHBs develop a draft core plan that is shared with the WorHOs. The WorHOs use the regional plan to inform the development of their plans, which are reviewed by the Woreda Cabinet before being submitted to the regional or zonal level. The RHB, ZHBs, and WorHOs conduct a series of meetings to revise the regional core plan based on the needs in the zones and woredas. The ZHBs participate in these regional consultation meetings and play a coordination and facilitation role between the regions and the woreda level but otherwise are not active in the budget development process. The final regional core plan is shared with the FMOH, which revises their core plan based on lower-level health system inputs. Each level then uses these annual core plans to develop detailed annual plans, which include activities from all domestic and external stakeholders. The FMOH, RHBs, and WorHOs extract the activities to finance by the government and submit this

information in a program-based budget to the respective finance institution at the federal, regional, and woreda levels.

Budget Approval During the next phase, the FMOH, RHBs, and WorHOs participate in budget hearings with their respective finance institutions, occurring in April. These hearings involve a budget defense, in which each program presents and justifies their proposed activities and level of resources needed to fund them. In their budget review, finance institutions weigh heavily on past budget execution and evidence of impact. Based on this review process and considering current national priorities, programs at each level (federal, regional, and woreda) revise their proposed budgets.

The reviewed and revised budget for all sectors is then consolidated by the respective finance institution. At the regional level, BOFED develops a budget with allocations to regional sector offices (including RHBs), zonal offices, and woredas. The allocation to sector offices is based on the previous year's expenditure and new recurrent activities or capital projects. Approximately two-thirds of the regional budget is allocated to the woredas. These allocations are based on the regional transfer formula, which itself is based on the population size of the region; the resources needed to provide each region with equal access to health, education, clean water, agricultural development, and accessible roads; and the local revenue-generation potential (MOFED, 2009). The transfer formula is approved by the Regional Cabinet and Council and is subject to change each year.

Once the recommended budgets are compiled, the respective finance institution presents the budget to each level of government's relevant executive and legislative body. At the federal level, the budget (including regional block grants) is first sent to the Council of Ministers (chaired by the Prime Minister) for approval. The budget is then sent to the Federal Parliament for approval. At the regional level, BOFED submits the budget to the regional cabinet (consisting of an administrator and the heads of the sector bureaus) for endorsement before it is passed to the Regional Council (consisting of elected representatives from woredas and urban administrations) for approval. If the council rejects the budget proposal, the budget is returned to BOFED for revision. After council approval, WOFEDs are notified of their approved budget allocations. WOFEDs then submit their budgets, within the approved budget ceiling, to the Woreda Cabinet, which reviews the budget proposal and makes the necessary adjustments. The Woreda Cabinet submits the agreed-upon budget to the Woreda Council, which approves the final allocation.

The majority of the regional and woreda funding comes from the federal budget subsidy; therefore, their budget processes are highly influenced by the timeframe and budget ceiling amount provided by the MOFEC to regions.

Budget Execution and Disbursement As soon as the budgets are officially approved, the respective finance institution informs the FMOH, RHBs, and WorHOs of their final budget to execute during the fiscal year. Each health institution then may revise and adjust allocations across programs or activities as needed within a month. Regions develop financial action plans, indicating monthly disbursement requirements, and submit them to MOFED to guide the budget execution process.

Based on the action plans, budgets are disbursed by MOFED to BOFED and to the different central-level ministries on a monthly basis. Similarly, BOFED disburses funds to the regional sector bureaus, woredas, and urban administrations on a monthly basis. Monthly reports on expenditure are sent by FMOH, BOFED, and WorHOs to their respective finance and development institutions. If there is a delay in approving the new budget, the budget law allows MOFED and BOFED to disburse the same recurrent budget as the previous financial year, as well as funds for previously-approved capital projects, until a

new budget is approved. WOFED makes monthly payments based on requests from the sector offices. Each woreda may manage its disbursement differently. For example, salaries can be provided at the kebele (subdistrict) level, at a central kebele, or at the WOFED office.

Sources:

- Federal Ministry of Health (FMOH). 2007. The Health Sector Development Plan Harmonization Manual. Addis Ababa: FMOH.
- Ministry of Finance and Economic Development (MOFED). 2009. Layperson's Guide to the Public Budget Process at the Regional Level: A Prototype for Regions. Addis Ababa: MOFED.

Developing an Advocacy Plan

Given Ethiopia's decentralized system, multi-level advocacy is needed. Following the Three T's, the NTP and its regional and woreda counterparts will develop advocacy plans to respond to the following:

> 1) Audience: To whom do we advocate? (Targeting) Who are the audiences for advocacy (i.e., actors in the budget development and approval process) and what is their role, level of influence, and current level of understanding and stance on the TB DRMS Roadmap (e.g., supportive, not supportive)?
>
> 2) Key themes and messages: What information and arguments do we communicate to them? (Telling) What are the key messages that need to be conveyed to these actors to persuade them to support the TB DRMS Roadmap and its strategic objectives?
>
> 3) Communication channels: When and how do we communicate these messages? (Timing) What channels of communication are most effective for reaching each audience (e.g., in-person or virtual meetings, mass media), and at what times?
>
> 4) Scheduling advocacy efforts: When should advocacy occur? (Timing) When is the best time to conduct advocacy, given institutional schedules and decision-making processes and cycles (e.g., budget, payroll, tax), and how should advocacy efforts be sequenced to ensure that audiences are receptive?

The NTP will develop advocacy objectives aligned with each strategic objective in the Roadmap and include an objective for the endorsement of the Roadmap itself. For example, one advocacy objective will be: Secure commitment from the MOFED on the increased allocation to TB from the general government budget. For each objective, the NTP, with support from the TB TWG and Steering Committee, will examine the audience, key themes and messages, and communications and scheduling of advocacy efforts needed to achieve each advocacy objective. The regions and woredas will develop their own plans, building from the national level approach and messaging.

1) Audience:

A stakeholder analysis will be conducted. Below is an illustrative example of what that can look like:

Stakeholder	Stakeholder's role	Stakeholder's priorities	Stakeholder's position on TB DRMS Roadmap/strategic objectives
Federal Parliament (Social Standing Committee)	• Issues proclamations • Oversees the implementation of sector's major plans • Approves federal government budget	• Reducing out-of-pocket costs • Efficiency	Position on TB DRMS Roadmap unknown Generally supportive of DRM efforts

2) Key themes and messages:

To ensure a common understanding of the TB financing context, common messages should be shared with each stakeholder. However, other messages will be more specific and tailored to the individual stakeholder. The NTP will develop messages that can be pulled from to insert into presentations, briefings, and other materials for the specific stakeholder, as appropriate.

Illustrative themes may include:

- TB as a public health priority and its impact on other health services such as HIV
- TB as a development priority and its impact on non-health sectors, such as employment and the economy
- TB's return on investment
- Declining development partner funding for TB
- Financing gap for the TB response at the federal, regional, and woreda levels, and the impact of not addressing those gaps
- TB as a leader in fostering private sector engagement

3) Communication channels:

The advocacy plan will identify which communication channels are most appropriate for each type of stakeholder. Communication channels may include:

- Standing meetings
- One-on-one advocacy meetings
- Advocacy forums
- Joint meetings with other stakeholders/directions/sectors
- Print communications such as handouts, briefs, and fliers
- Digital and social media—such as website postings, blogs, Facebook, and Twitter
- Television or radio spots

4) Scheduling advocacy efforts:

For each advocacy objective, the NTP will consider planning, budgeting, and other relevant processes and cycles; and will identify key opportunities for advocacy throughout the year to schedule the timing of each communication with each stakeholder.