USAID Health Financing Improvement Program

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July 2022

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USAID Health Financing Improvement Program

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

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Cover Photo: CBHI members present prescriptions at the pharmacy in Awbare Health Center, Somali Region.

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

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ACRONYMS

AACA	Addis Ababa City Administration
CBHI	Community-Based Health Insurance
DDCA	Dire Dawa City Administration
DEC	Development Experience Clearinghouse
DRS	Developing Regional States
EFY	Ethiopian Fiscal Year
EHIS	Ethiopian Health Insurance Service
FGB	Facility Governing Board
FMC	Facility Management Committee
HCF	Health Care Financing
HPR	House of Peoples' Representatives
IR	Intermediate Result
MEL	Monitoring, Evaluation, and Learning
MOH	Ministry of Health
N/A	Not Applicable
PHC	Primary Health Care
Q1, Q2, Q3, Q4	Quarter 1, Quarter 2, Quarter 3, Quarter 4
RHB	Regional Health Bureau
RRU	Revenue Retention and Utilization
SNNP	Southern Nations, Nationalities, and Peoples' (Region)
SWEP	South West Ethiopian Peoples' (Region)
TA	Technical Assistance
TWG	Technical Working Group
USAID	United States Agency for International Development
WorHO	Woreda Health Office
Y1, Y2, Y3, Y4	Year 1, Year 2, Year 3, Year 4
ZHD	Zonal Health Department

EXECUTIVE SUMMARY

This quarterly performance report describes the progress, key accomplishments, and challenges of the USAID Health Financing Improvement Program (Program) during Year 4, Quarter 3 of Program implementation (April 1, 2022, through June 30, 2022). Key accomplishments for the quarter include:

- Provided technical assistance to the Ethiopian Health Insurance Service in drafting the community-based health insurance (CBHI) regulation based on a provision in the CBHI proclamation, which was also developed with technical assistance from the Program and enacted into law by the House of Peoples' Representatives this quarter.
- Conducted a rapid assessment of the extent and impact of the war in northern Ethiopia on CBHI schemes in Amhara and Afar regions, including physical damage and routine functions.
- Conducted routine supportive supervision visits and on-site coaching at 32 CBHI schemes (25 rural and 7 urban) in Amhara, Oromia, and SNNP.
- Trained 178 individuals on CBHI basics, medical audit, and facility governance.

The Program was not able to conduct field-based activities in Tigray and parts of Afar, Amhara, Benishangul-Gumuz, and Oromia regions due to security problems.

1. INTRODUCTION

The five-year (2018-2023) USAID Health Financing Improvement Program (Program) works to improve health care financing (HCF) in Ethiopia to support universal health coverage of quality primary health care (PHC) services for Ethiopian citizens with reduced financial barriers. Its activities support improvements in access to and equity, utilization, and quality of health care services.

The Program works to achieve four Program objectives/ intermediate results (IRs):

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

In Year 4 (Y4), following the new guidance from USAID Ethiopia, the Program pivoted its activities to target implementation at the local (woreda, community-based health insurance (CBHI) scheme, health facility, and community) level to directly benefit Ethiopian citizens. Specifically, the Program currently focuses on:

- CBHI in rural woredas and urban centers.
- First-generation HCF reforms at health facilities and expanding CBHI in the Developing Regional States (DRS).
- Supporting counterparts with planning and, if feasible, implementing activities to restart reform implementation and resume health service provision in conflict-affected areas in northern Ethiopia.

The Program also works to accelerate activities to sustain gains in previous investments to complete the transition of first-generation HCF reform activities from the Program to local counterparts in reform-advanced regions and city administrations.

This performance report begins by describing key Program activities and achievements for Y4, Quarter 3 (Q3) by IR, followed by a success story, and monitoring, evaluation, and learning (MEL) and communications accomplishments. It then discusses management and operations issues, and challenges and lessons learned. The report concludes with the quarterly expenditure and accrual report and a summary of activities planned for next quarter.

When referring to local-level activities, the following regional groups are used, where relevant:

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

Due to the conflict between the federal military and forces linked to the Tigray People's Liberation Front and the destruction and insecurity resulting from it, health service delivery and first-generation HCF reform and CBHI implementation were disrupted in Tigray and parts of Afar and Amhara this

quarter. As a result, field-based activities in Tigray and some areas of Afar and Amhara could not be conducted. Security challenges also occurred in parts of Benishangul-Gumuz and western Oromia this quarter, which disrupted health service provision and Program activities.

Data related to first-generation HCF reforms and CBHI in Tigray are unavailable and therefore not reflected in this report.

2. KEY ACTIVITIES AND ACCOMPLISHMENTS

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

The Program continued collaborating with local counterparts to accelerate transition of first-generation HCF reform activities through light-touch support to health facilities in reform-advanced regions and city administrations (Amhara, Oromia, SNNP, AACA, and DDCA). The activities and accomplishments related to this work are described under IR 4. With respect to overall national-level implementation of first-generation HCF reforms, excluding Tigray due to lack of data, the following results were attained by the end of Y4Q3:

- Of the 3,810 functional health facilities[1] in the country, 3,582 (94%) were implementing the revenue retention and utilization (RRU) reform for facility and service improvement during the quarter, more than the Program's target of 91%.
- 124 hospitals (40% of all functional hospitals) had outsourced at least one non-clinical service prior to Q3. No hospitals initiated outsourcing in this quarter.
- 33 hospitals (10.6% of all functional hospitals) had established a private wing prior to Q3. No hospitals established a private wing in this quarter.
- 3,696 (97% of functional health facilities) had established a facility governing board or management committee (FGB/FMC); of these, 3,345 (88%) are functional.

Table 1 on the following page summarizes the number of health facilities implementing first-generation HCF reforms in the agrarian regions, DRS, city administrations, and Harari as of the end of Y4Q3. There is no information available on the status of health facilities in Tigray.

[1] The total number of functional health facilities does not include facilities in Tigray. It also does not include 29 health facilities (28 health centers and 1 hospital) in Afar and 17 health centers in Benishangul-Gumuz that are affected by the conflict. These facilities are not functioning and therefore not implementing RRU.

Table 1: Number of health facilities implementing RRU, hospitals outsourcing non-clinical services, hospitals with private wings, and health facilities with functional FGB/FMCs, Y4Q3

Regional group	Region	# Functional HFs		# HFs implementing RRU		# Hospitals established private wing	# Hospitals outsourcing non-clinical services	# HFs with functional FGB/FMCs	
		HCs	Hospitals	HCs	Hospitals	Hospitals	Hospitals	HCs	Hospitals
Agrarian	Amhara	866	86	866	86	3	43	866	86
	Oromia	1,426	105	1,426	105	24	50	1,290	105
	Sidama	135	21	135	21	-	3	135	21
	SNNP*	593	59	588	59	-	12	588	59
	Tigray								
	Subtotal	**3,020**	**271**	**3,015**	**271**	**27**	**108**	**2,879**	**271**
DRS	Afar	65	6	35	6	-	2	35	6
	BG	49	6	49	6	2	2	49	6
	Gambella	27	5	27	5	-	1	27	5
	Somali	211	16	20	16	-	4	28	12
	Subtotal	**352**	**33**	**131**	**33**	**2**	**9**	**139**	**29**
City Admins and Harari	AACA	101	6	99	6	3	5	-	-
	DDCA	15	2	15	2	1	1	15	2
	Harari	9	1	9	1	-	1	9	1
	Subtotal	**125**	**9**	**123**	**9**	**4**	**7**	**24**	**3**
	Total	**3,497**	**313**	**3,269**	**313**	**33**	**124**	**3,042**	**303**

Note: HFs=health facilities; HCs=health centers

*SNNP includes the SWEP Region

Finalized assessment on the contribution of RRU to quality improvement at health facilities: In Y4Q2, the Program completed secondary data collection for the assessment of the contribution of RRU to quality improvement at health facilities from selected health facilities in AACA, Amhara, SNNP, and Oromia. In Q3, the Program collected qualitative data from key informants and focus discussion group members in the study areas. The data were transcribed and translated and primary summary report, which will be part of the main report, was produced. In addition, a descriptive and trend analysis was conducted using the quantitative data collected from the health facilities, and preliminary tables and figures were produced. The final assessment report will be completed in Q4.

Provided technical assistance (TA) in drafting the directive for exempted health services: The Program has been providing TA to the MOH in developing a protype directive that supports regions in providing standardized exempted health services since Y4Q1. It has also provided TA to the MOH in putting mechanisms in place to ensure the sustainable financing of these services. In Q3, the Program provided TA to the MOH in facilitating discussions about the draft prototype directive between its senior management and staff of various MOH directorates. Following the discussion, the Program team helped to incorporate discussion comments. The Program, as a technical working group (TWG) member, also participated in defining the minimum standard list of exempted health services and

developing reporting template for the services to be used by health facilities in reporting to regional health bureaus (RHBs).

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

In Y4Q3, the Program provided training on CBHI to scheme and health facility staff. It also continued assisting local counterparts in community mobilization campaigns, registration and renewal of members, contribution collection, and financial and data management in areas where local counterparts had delayed CBHI enrollment for various reasons, including security. The Program's support in each region is detailed in the sub-section "IR 2 Accomplishments by Regional Group" that begins on page 9.

As part of the initiative to gradually expand financial protection for communities in DRS and in pastoral areas in agrarian regions, the Program continued providing TA for CBHI implementation and scale-up at the local levels in these regions.

At the end of Q3, 927 (647 rural and 280 urban) woredas across Ethiopia were implementing CBHI. Of these, 772 (613 rural and 159 urban) schemes were fully operational and providing benefit coverage for their members/beneficiaries (Table 2).

Table 2: Number of woredas implementing CBHI in Ethiopia, Y4Q3

Regional group	Region	# Woredas			# CBHI-implementing woredas EFY 2014 (2021/22)			# Functional schemes EFY 2014 (2021/22)		
		Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Agrarian	Amhara	143	41	184	143	41	184	139	41	180
	Oromia	290	46	336	290	46	336	287	45	332
	Sidama	30	14	44	30	14	44	27	14	41
	SNNP*	157	51	208	157	51	208	151	46	197
	Tigray	34	18	52						
	Subtotal	**654**	**170**	**824**	**620**	**152**	**772**	**604**	**146**	**750**
DRS	Afar	35	5	40	5	0	5	2	0	2
	Benishangul-Gumuz	20	3	23	9	0	9	3	0	3
	Gambella	12	2	14	7	0	7	3	0	3
	Somali	93	6	99	3	1	4	1	0	1
	Subtotal	**160**	**16**	**176**	**24**	**1**	**25**	**9**	**0**	**9**
City Administrations and Harari	AACA	0	120	120	0	120	120	0	11	11
	DDCA		1	1		1	1	0	1	1
	Harari	3	6	9	3	6	9	0	1	1
	Subtotal	**3**	**127**	**130**	**3**	**127**	**130**	**0**	**13**	**13**
	Total	**817**	**313**	**1130**	**647**	**280**	**927**	**613**	**159**	**772**

* SNNP includes the SWEP Region

At the end of Y4Q3, 9.68 million households covering 44.9 million beneficiaries—43% of the country's total population—were enrolled in CBHI. Of these, 1.78 million households covering 8.26 million beneficiaries were classified as poor/indigent, 18.4% of the total enrolled population.

Table 3 shows CBHI enrollment rates by region at the end of Q3.

Table 3: Number of CBHI households and beneficiaries enrolled in CBHI program, Y4Q3

Regional group	Region	# Total CBHI-eligible HHs in EFY 2014 (2021/22)	# Total HHs enrolled EFY 2014 (2021/22)			# Total CBHI beneficiaries EFY 2014 (2021/22)	# HHs renewed membership	Enrollment rate (% of eligible HHs)
			Paying	Non-paying	Total			
Agrarian	Amhara*	4,072,842	2,670,602	507,176	3,177,778	13,664,445	2,255,532	78.0
	Oromia	6,087,598	3,345,920	788,078	4,133,998	19,843,190	3,039,498	67.9
	Sidama	634,028	275,581	78,728	354,309	1,736,114	92941	55.9
	SNNP	2,989,682	1,324,361	297,952	1,622,313	7,949,334	994870	54.3
	Tigray							
	Subtotal	**13,784,150**	**7,616,464**	**1,671,934**	**9,288,398**	**43,193,084**	**6,382,841**	**67.4**
DRS	Afar	64,284	16,260	4,426	20,686	117,910		32.2
	Gambella	55,195	2,589	116	2,705	12,443	167	4.9
	Benishangul-Gumuz	106,274	30,361	7,232	37,593	169,169	12,024	35.4
	Somali	77,190	18,238	5,756	23,994	158,360		31.1
	Subtotal	**302,943**	**67,448**	**17,530**	**84,978**	**457,882**	**12,191**	**28.1**
City Administrations and Harari	AACA	290,770	156,217	73,221	229,438	940,696	179,605	78.9
	DDCA	75,684	23,123	9,208	32,331	145,490		42.7
	Harari	46,561	39,005	7,478	46,483	181,284		99.8
	Subtotal	**413,015**	**218,345**	**89,907**	**308,252**	**1,267,469**	**179,605**	**74.6**
	Total	**14,500,108**	**7,902,257**	**1,779,371**	**9,681,628**	**44,918,435**	**6,574,637**	**66.8**

Note: HHs=households

* *The data for Amhara includes households in 68 CBHI-implementing woredas (rural and urban) affected by the conflict.*

Conducted training on CBHI basics for scheme and health facility staff: The Program planned to provide training for 110 trainees on CBHI basics. During this quarter, it provided training for 132 staff from CBHI schemes and health facilities (Table 4).

Table 4: Number of trainees trained on CBHI basics, Y4Q3

Regional group	Region	Y4Q3 target	Men	Women	Total
DRS	Afar	60	25	3	28
Agrarian	Amhara	50	87	17	104
	Total	**110**	**112**	**20**	**132**

Provided TA for enhancing cross subsidization among CBHI schemes: The Program, as a TWG member, revised the draft CBHI proclamation based on feedback received from the House of Peoples' Representatives (HPR) Health, Social, Tourism and Sport Affairs Standing Committee and from the community through public consultations. In Q3, the proclamation was presented to the HPR for review and endorsement. The HPR reviewed and enacted the proclamation as the national CBHI proclamation. The Program also provided TA to the Ethiopian Health Information Service (EHIS) in explaining the provisions of the proclamation to the HPR's Social Standing Committee. It also provided TA in drafting the CBHI regulation, which is based on the provisions in the newly endorsed proclamation.

As a TWG member, the Program also participated in developing the draft organizational structure proposed for implementing CBHI functions at the federal, regional, zonal, and woreda levels, as per the new CBHI proclamation.

IR 2 ACCOMPLISHMENTS BY REGIONAL GROUP

Agrarian Regions

At the end of Q3, 772 woredas (620 rural and 152 urban) in the agrarian regions excluding Tigray were at different stages of establishing CBHI schemes. Most of the woredas (750, 97%; 604 rural and 146 urban) have functional CBHI schemes providing financial protection for their beneficiaries when they seek health services at contracted health facilities. The Program's regional teams supported woreda health offices (WorHOs), CBHI schemes, and other local counterparts in conducting community mobilization activities, member registration, contribution collection, and financial and data management. The performance on CBHI implementation in each agrarian region is described below along with Program activities accomplished in Q3. Refer to Tables 2, 3, and 4 above for additional details.

Amhara

At the end of Q3, 78% of eligible households in Amhara (3,177,778 out of 4,072,842) were enrolled in CBHI. Sixteen percent of the enrolled households were categorized as poor/indigent, and their membership fee was covered by the targeted subsidy of the regional and woreda governments.

The ability of households to pay for CBHI membership in conflict-affected areas of Amhara Region was low this quarter. The region and woreda administrations mobilized resources in addition to the targeted subsidy for selected severely affected indigent households, so that they could continue their membership.

Activities accomplished by the Program during the quarter include:

- Provided technical support to EHIS branch offices in their effort to provide training for CBHI schemes and health facilities on CBHI data management, reporting, and complaint handling.
- Provided a two-day training on the updated CBHI directives for 104 (87 men and 17 women) participants that included CBHI scheme executive staff, the zonal Domestic Resource Mobilization Administration and Partnership case team, and heads of zonal finance offices and zonal health departments (ZHDs).
- Provided TA in conducting quarterly CBHI TWG meetings. The agenda of the meeting was to discuss and forward recommendations for addressing the financial deficit faced by the East Gojjam zonal pool.
- Provided TA in conducting the Awi zonal pool board of director's meeting. During the meeting, the board members reviewed the annual performance and challenges associated with the zonal-level pool. The board recommended the RHB provide financial, technical, and material support to the

zonal pool in order to lessen the chance that the pool will face a financial deficit by next year. The Program team also provided support to the zonal pool in compiling data to check the pool's financial status.

Oromia

At the end of Q3, 68% of eligible households in Oromia (4,133,998 out of 6,087,598) were enrolled in CBHI. Nineteen percent of the enrolled households were categorized as poor/indigent. Activities accomplished by the Program during the quarter include:

- Provided TA to the RHB and EHIS in preparing a zonal pooling by-law for the establishment of zonal pool in Borena Zone.
- Supported the RHB in collecting and compiling data on indigent households from all rural and urban schemes to ensure fair allocation of regional target subsidy to schemes. The RHB has transferred the required subsidy to woreda administrations. The Program team is closely following up to make sure that the allocated subsidy is deposited in full in the schemes' bank account.

Sidama

At the end of Y4Q3, 56% of eligible households in Sidama (354,309 out of 634,028) were enrolled in CBHI. About 22% of the enrolled households were categorized as poor/indigent. Activities accomplished by the Program during the quarter include:

- Advocated for CBHI schemes' auditing activity to be integrated into the annual plan of each woreda finance and economic development office in the region. Accordingly, by the end of Q3, six CBHI schemes were audited, and the audit report is being shared with the schemes, WorHOs, and woreda administrations to help them to take corrective measures based on the findings.
- Provided TA to EHIS in conducting training on CBHI monitoring and evaluation and complaint handing for staff from CBHI schemes, health facilities, and WorHOs. The Program team served as a facilitator in the training, organized by EHIS.
- Provided TA to the Hawassa City Health Department in providing training for health facility staff on HCF reform implementation.

SNNP (including SWEP)

At the end of Y4Q3, 54% of eligible households in SNNP (1,622,313 out of 2,989,682) were enrolled in CBHI. About 18% of the enrolled households were categorized as poor/indigent. Activities accomplished by the Program during the quarter include:

- Advocated that woreda finance and economic development offices include CBHI auditing in their annual plan. As a result, 43 CBHI schemes were audited, and the audit report is being shared with the relevant stakeholders so they take corrective measures based on the audit findings.
- Provided technical support to SWEP's RHB by providing a five-day training on medical auditing for participants drawn from CBHI schemes and WorHOs. The objective of the training was to enhance the knowledge and skill of the staff on medical auditing and to strengthen medical auditing practices in CBHI schemes of the region.
- Provided TA to the RHB in preparing a directive for higher-level pooling and provided on-site TA in financial management procedures for Halaba zonal pool staff.
- The Program participated in a thematic review meeting organized by EHIS and provided inputs on the financial transaction management of CBHI schemes and health facilities engaged in piloting of the capitation payment mechanism.

City Administrations and Harari Region

At the end of Y4Q3, all woredas in AACA, DDCA, and Harari were implementing CBHI. Their performance on CBHI implementation is described below, along with Program activities accomplished in Q3. Refer to Tables 2, 3, and 4 above for additional details.

AACA

At the end of Y4Q3, CBHI was being implemented in all 120 woredas of AACA. The schemes have 229,438 members (79% of eligible households); of these, 73,221 (32%) are categorized as poor/indigent. Activities accomplished by the Program during the quarter include:

- The Program team provided TA to the Addis Ababa Health Bureau by providing a two-day training for CBHI scheme and health bureau staff on CBHI financial management.

DDCA

DDCA has one CBHI scheme, established at the city administration level. At the end of Y4Q3, the scheme had 32,331 members (43% of eligible households). Of these, 28% are categorized as poor/indigent. The DDCA Health Bureau plans to formally establish schemes at the section/kebele level in the future. The city administration also revised the contribution rate for rural schemes from 240 to 375 birr and for urban from 500 to 665 birr. The new rate helps to ensure financial sustainability of the scheme given the escalating cost of health services.

Harari

Harari has a single regional-level CBHI scheme that is functional and covers all nine of the region's woredas. At the end of Y4Q3, the scheme enrolled 46,483 members, nearly all eligible households (99.8%). Of these, 16% are categorized as poor/indigent. The region now applies a revised contribution fee of 370 birr in rural and 570 birr in urban settings, an increase from 240 and 500 birr for rural and urban schemes, respectively. These increases are in response to the escalating cost of health services in the region.

Developing Regional States

The Program continued to provide TA to DRS in CBHI implementation. The following sections describe the overall status of CBHI and Program accomplishments in the DRS. Refer to Tables 2, 3, and 4 above for additional details.

Afar

At the end of Y4Q3, five out of 40 woredas in Afar—Asayita, Afambo, Berhale, Chifra, and Yallo—continued to pilot CBHI. The schemes in Asayita and Afambo are functional, providing benefit coverage for beneficiaries. A total of 32% eligible households (20,686 out of 64,284) were enrolled in CBHI. About 21% of these enrolled households were categorized as poor/indigent. Activities accomplished by the Program during the quarter include:

- The Program provided a two-day training on CBHI basics for 28 (25 men and 5 women) CBHI scheme and health facility staff drawn from four woredas (Asayita, Afambo, Chifra, and Yallo).

Benishangul-Gumuz

At the end of Y4Q3, nine out of 23 woredas in Benishangul-Gumuz were implementing CBHI, and three of the schemes were functional. The schemes enrolled 37,593 households (35% of eligible households), of which 19% are categorized as indigent. The region continued working to launch CBHI in its remaining six woredas. The Program was not able to provide technical support in most of the region due to security problems. In the safe areas, the Program provided TA in the enrollment and renewal of CBHI members and provision of training. Activities accomplished by the Program during the quarter include:

- Provided TA to EHIS Assosa branch in providing training on CBHI data management, reporting, and complaint handling for professionals drawn from RHB, ZHDs, WorHOs, CBHI schemes, and health facility.
- Provided TA in conducting a general assembly meeting aimed at establishing CBHI scheme for Mengie woreda. The general assembly elected CBHI board members and decided the scheme would start health service provision on August 15, 2022, after completing the remaining preparatory activities.
- Continued providing TA in adapting CBHI design parameters into the regional context. Accordingly, the contribution rate was increased from 180 to 350 birr per household.

Gambella

At the end of Y4Q3, CBHI was being implemented in seven rural woredas out of 14 woredas in the region. Three of these woredas (Lare, Godere, and Gog) have functional CBHI schemes that provide health service coverage for beneficiaries. The remaining four woredas just began implementing CBHI in Q2. A total of 2,705 households (5% of eligible households) enrolled in CBHI. Of these, 4% are categorized as poor/indigent.

Somali

Only one woreda—Awbare—out of 99 woredas in Somali had a functional CBHI scheme at the end of Y4Q3. The scheme has 23,994 members (31% of eligible households); of these, 24% are classified as poor/indigent. The region is implementing CBHI in three additional woredas: Ararso, Erer, and Gode city. However, these schemes are not yet providing health service coverage for CBHI beneficiaries due to delays in completing preparatory activities.

IR 3: IMPROVED ARRANGEMENTS FOR STRATEGIC PURCHASING OF HEALTH SERVICES

Provided TA in conducting a strategic purchasing in health scoping review: In Q3, as a member of the TWG for strategic purchasing, the Program actively participated in preparing the draft scoping review report on strategic purchasing. The report was produced using secondary and primary data collected through the qualitative and quantitative approaches. The TWG presented the report to EHIS's senior management team and shared it with the Strategic Purchasing Africa Resource Center and Results for Development for technical review. Currently, comments from the technical review are being incorporated to finalize the report.

Participated in a TWG to finalize the draft accreditation road map to improve the quality of services provided for CBHI beneficiaries: In Q2, the TWG submitted the final accreditation road map to the Ministry of Health's (MOH's) Health Management Committee for approval. In Q3, as a TWG member, the Program supported the MOH's preparation of a PowerPoint presentation on the contents of the road map. The PPT was presented during the annual National Healthcare Quality and Safety Summit, which was attended by participants from the MOH, EHIS, and RHBs. The Program also helped collect inputs and feedback from the participants during the panel discussion and provided technical support in incorporating them to enrich the accreditation road map. The MOH plans to organize a consultation workshop to finalize and operationalize the road map.

Participated as a core team member of the TWG established to develop a senior management team hospital audit tool: In Q2, the Program team participated in the TWG established by the MOH Clinical Service Directorate and developed a draft outline after identifying areas of auditing to be included in the tool. In Q3, the team produced the draft Senior Management Team Audit Tool and submitted it to the Directorate for review.

Participated in developing hospital clinical audit manual: The Program, as a TWG member, participated in the development of a clinical audit manual for hospitals. The manual is being piloted in selected hospitals. The TWG will refine the manual based on the feedback obtained from the pilot.

Provided TA to EHIS in preparing terms of reference and a proposal to assess the nationwide landscape of medical auditing: The Program provided TA to the EHIS Claims Directorate in developing terms of reference to assess the nationwide landscape of medical auditing specific to claim practices. It also provided TA to EHIS to participate in the National Healthcare Quality and Safety Summit of 2014 (2022) held on June 2-3, 2022. The Program also provided TA in developing a proposal to establish a center of excellence for claim auditing and submitted the draft to the EHIS Claims Directorate director for review and next action.

Provided TA to organize CBHI-health facility forums for quality: The Program provided TA to EHIS branch offices in Amhara in organizing CBHI-health facility forums in six zones and one city administration to discuss health service quality and related issues.

Provided training on medical auditing: In Q3, the Program provided a five-day training on medical auditing for 12 (11 men and 1 woman) health professionals from the RHB and hospitals in Oromia (Table 5). It also provided TA to EHIS branch offices in Amhara, Oromia, and SNNP regions on medical audit training for health professionals from WorHOs and health facilities.

Table 5: Number of health care workers trained on medical auditing, Y4Q3

Regional group	Region	Y4Q3 target	Men	Women	Total
Agrarian	Oromia	12	11	1	12
	Total	**12**	**11**	**1**	**12**

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

Facilitated transitioning of first-generation HCF reforms in Sidama and Addis Ababa: Adaptation and translation of HCF reform training materials is one of the transition activities in Sidama and ACCA. In Q3, the Program provided the two regions' health bureaus TA in adapting the reforms to their local context and translating the HCF training materials into local languages.

Provided HCF training for health facility staff and FGB/FMC members in DRS: In Q3, the Program planned to train 40 FGB members to build their capacity and improve how the board functions. The Program provided a two-day training for 34 health FGB members, achieving 85% of what was planned.

Table 6: Number health facility staff and HFB members trained on HCF, Y4 Q3

Region	Y4 Q3 target	Men	Women	Total
Afar	40	29	5	34
Total	**40**	**29**	**5**	**34**

Conducted routine supportive supervision visits to CBHI schemes to provide on-site coaching: The Program planned to make supervisory visits to 57 CBHI schemes in Q3. During the quarter, the Program team visited and provided on-site coaching to 32 schemes (25 rural and 7 urban) (Table 8). The achievement is 56% of the plan; the shortfall is attributed to the Program's budget constraint.

Table 7: Number of Program supervisory visits to CBHI schemes, Y4Q3

Regional group	Region	Y4Q3 target	# Schemes visited		
			Rural	Urban	Total
Agrarian	Amhara	32	11	3	14
	Oromia	16	12	1	13
	SNNP	9	2	3	5
	Total	**57**	**25**	**7**	**32**

Participated in writing the 8th round health accounts main and statistical reports and briefs: As a core health accounts TWG member, in this quarter, the Program participated in organizing the Ethiopia's National Health Accounts 8th National Dissemination Workshop, which was conducted on April 12, 2022. The Program played critical role in the preparation of materials including PowerPoint slide decks for the national dissemination workshop and in serving as a panelist at the policy dialogue session of the workshop. The Program also provided TA in drafting a policy brief on Child Health based on the output tables generated as part of the National Health Accounts report.

Participated as a core team member of the TWG established to revise the Ethiopian Health Services Transformation Guidelines: The Program team participated in the TWG established by the MOH to revise the Ethiopian Hospital Services Transformation Guidelines that have been implemented since 2016. The objective was to develop hospital service guidance that contains new initiatives, responds to new needs and developments, and further enhances the hospitals' service delivery and governance system.

Finalized rapid assessment of the impact of the war in northern Ethiopia on CBHI schemes: In Q3, the Program conducted a rapid assessment on the extent and impact of the war in northern Ethiopia on the organizational capacity of CBHI schemes in Amhara and Afar regions. The assessment aimed at measuring the extent of the damage the war has inflicted on the regions' CBHI schemes and their ability to resume their routine functions. It covered all the woredas affected by the war except for some that were not liberated or where there were threats of attacks/clashes. Accordingly, a total of 57 (55 in Amhara and 2 in Afar) woreda CBHI schemes and 4 CBHI zonal offices were assessed.

The findings of the rapid assessment show that the war severely damaged the two regions' CBHI schemes, which suffered heavy losses to their physical property and other assets, in particular their databases and records. The findings show policy/decision makers, donors, and other stakeholders where the schemes need support and collaboration to fully revitalize their CBHI functions. The findings also will be useful for planning by the CBHI schemes to address gaps and normalize operations. The final report was shared with relevant stakeholders including the Amhara and Afar EHIS offices and RHBs, and USAID.

IR 4 ACCOMPLISHMENTS BY REGIONAL GROUP

Agrarian Regions

Amhara

- Provided technical support to the RHB in collecting and organizing RRU data from 962 health facilities (876 health centers and 86 hospitals) for the region's EFY 2015 plan. The RRU budget will be appropriated by the regional council.
- Provided TA to the RHB in organizing a regional-level CBHI performance review meeting.
- In collaboration with the RHB, organized a partners meeting to discuss their responsibility in supporting the health system in the war-affected areas of the region.

- Conducted routine supportive supervision visits to 14 CBHI schemes to provide on-site coaching.

Oromia

- In collaboration with the local EHIS office and Borena ZHD, the Program team in Oromia provided technical support to the ZHD in conducting a general assembly meeting aimed at establishing a zonal pool. During the meeting, members of the general assembly endorsed the zonal pool by-law, elected the CBHI board members, and announced the official establishment of the zonal pool.
- Conducted routine supervisory visits to 13 CBHI schemes selected from three (Arsi, Guji, and Jimma) zones. During the visit, the team provided on-site TA on CBHI membership and financial data management.
- The Program's regional office provided TA to the RHB in organizing an annual regional meeting to review CBHI performance and follow up remaining activities for the year. Meeting participants discussed the CBHI monitoring and evaluation system and mechanisms for handling complaints. A total of 56 participants from the RHB, ZHD, CBHI schemes, EHIS, and the Program attended the meeting. The RHB awarded the Program a certificate of recognition for its outstanding contribution to HCF in the region.

BFO

Oromia Health Bureau

Certificate of Recognition

This certificate of recognition is awarded to Health Financing Improvement Program – Oromia for the outstanding and remarkable contribution made in providing financial and technical support to the implementation of Community Based Health Insurance in Oromiya region. Therefore, the Bureau would like to recognize your organization for its commitment, dedication and tireless support made to our region.

June 28, 2022

Mengistu Bekele (MD, MPH)
Head, Oromia Health Bureau

Sidama

- Provided TA to the RHB in adapting and translating HCF training materials. Once approved, the modules will be used to provide HCF training for health facility staff.
- Participated in a national CBHI review meeting organized by EHIS aimed at reviewing the performance and challenges of CBHI implementation during the Ethiopian fiscal year.
- The Program team participated in integrated supportive supervision visits to selected health facilities in Hawassa City Administration. The visit was organized by the RHB in collaboration with the MOH.

SNNP

- Provided TA in organizing a CBHI scheme and health facility forum for Kafa Zone. Twenty-nine participants from CBHI schemes, health centers, and hospitals attended the forum. They discussed health service quality based on gaps identified by the medical audit and recommended actions to be taken by responsible bodies to remedy the gaps.
- The Program in collaboration with the RHB and ZHDs conducted supervisory visits to five CBHI schemes (three urban and two rural) in Gurage and Hadya zones. During the visits, the team provided on-site TA on CBHI data and financial management based on gaps identified.
- Participated in integrated supportive supervision on HCF implementation in eight health facilities in Wolayita and Gamo zones. The visit was organized by the RHB.

City Administrations and Harari Region

AACA

- Provided TA to the AACA Health Bureau in adapting the participant and facilitator guides of the HCF training manual and translating them into Amharic. Once completed and approved, the manual will be used in training for FGB/FMC members and finance staff.

- Provided TA to the Addis Ababa EHIS branch in organizing an inter-woreda reviewing meeting for CBHI woredas in Addis Ababa. The agenda of the review meeting included how to resolve challenges to member registration and renewal; the contribution collection method with a focus on bank transactions; and data management and reporting.
- In collaboration with AACA Health Bureau and EHIS, conducted a supervisory visit to CBHI schemes.

DDCA

- Provided TA to the DDCA Health Bureau in organizing the first round of the health financing TWG meeting comprising members from the health bureau, the Bureau of Finance and Economic Development, General Auditor, Public Service, EHIS, CBHI scheme, and the Program. The major issue discussed during the meeting was under-financing of the health sector. The team stressed the need to increase the share of the budget that goes to the health sector, enhance health facility autonomy, and strengthen health facility and scheme auditing practices.
- Provided TA in translating HCF training modules into local languages of the city administration and submitted the translated modules to the DDCA Health Bureau for approval. Once approved, the modules will be used to provide HCF training for health facility staff.

Harari

- Provided TA in translating HCF training modules into local languages of the region and submitted the translated modules to the RHB for approval. Once approved, the modules will be used to provide HCF training for health facility staff.

Developing Regional States

Afar

- Provided TA to the RHB in collecting and compiling the 2015 EFY RRU plan from 41 health facilities (37 health centers and 4 hospitals). The RRU plan was submitted to the Bureau of Finance and Economic Development for final appropriation by the regional council.

Gambella

- Participated in a partners' forum organized by the RHB. During the meeting, a discussion was held on the performance of the health system and roles and responsibilities of partners.
- Provided TA to the RHB in organizing a meeting to discuss the performance of and challenges to CBHI implementation in Anuwak and Nuer zones. Consensus was reached on the need to increase enrollment in the CBHI woredas.
- Participated in woreda-based planning organized by the RHB with the aim of preparing the region's 2015 EFY plan for the health sector.

Benishangul-Gumuz

- In collaboration with the RHB and MOH, conducted an HCF supervisory visit to Assosa general hospital and Assosa health center. The visit focused on review of HCF reform implementation.
- Provided technical support to the RHB in collecting and organizing RRU data from 70 health facilities (63 health centers and 7 hospitals) in the region for EFY 2015 planning.

3. SUCCESS STORY

CBHI is a Divine Gift for Borena Pastoralists

Borena Zone in Oromia Region launched community-based health insurance (CBHI) four years ago, but zone residents initially viewed it skeptically. "We refused to accept community-based health insurance at first, because it was difficult for us to believe that a person could be treated for free with a membership card that cost the price of a goat," said , a traditional community leader. But after much discussion, residents decided to register and see if the claims were true.

"But when we tasted what we had been told, it was sweeter than honey. [Now] we consider CBHI a gift from God, especially when we see the benefits it provides to women and children. By the following year, everyone had renewed their membership," said. In four years, membership coverage in 14 woredas across Borena Zone has reached 91%.

Recently, a severe drought hit, killing thousands of livestock and forcing many men to seek pasture for the remaining animals elsewhere. Over 10,000 households in the zone moved to neighboring areas in search of assistance. "CBHI is saving our women and children," said Elima Arbole, a resident of Dubuluk Woreda, one of the Borena woredas most affected by drought—but also where all 5,812 households are CBHI members. "Without CBHI, a family has to wait for the husband to return, who could be away from home for months, to decide to sell an animal to raise money for health care," she explained. "Thank God, we no longer have that issue."

A CBHI beneficiary shows her CBHI membership ID card. Dillo Megala, Borena Zone. Photo credit: Ayenew Haileselassie, Abt Associates

When CBHI was launched in 2019, members of the Dubuluk scheme made 12,564 visits to health facilities; 8,291 of the visits were by women. By 2021, the number of visits had almost doubled, to 24,128, including 14,991 by women. According to Abdulqadir Ali, head of the woreda administration, high enrollment continued despite the drought. "We were able to deposit 104,000 birr in the bank to cover CBHI membership contributions for indigent members who could not afford to pay. We also developed a way communities that were less affected by the drought could help those severely affected. We intend to mobilize city dwellers and others to do the same in the coming year," said Abdulqadir.

The Borena Zone Health Department has formed a task force in 12 woredas to provide mobile health services to CBHI members displaced by the drought. Borena Zone has also merged the woreda schemes to form one zone-wide pool, and is allowing members to seek care in all health facilities across the zone.

4. MONITORING, EVALUATION, AND LEARNING ACCOMPLISHMENTS

The Program's MEL accomplishments in Y4Q3 include:

- Contributed to the development of the data collection checklist. It also reviewed the report on the rapid assessment aimed at measuring the extent to which the war in the northern part of the country has damaged CBHI schemes in Amhara and Afar, and the schemes' ability to resume their routine functions.
- Coordinated the preparation of weekly highlights and biweekly reports of the Program every Monday and ensured their on-time submission to USAID.
- Prepared a case story on how Collaborating, Learning, and Adapting is applied in CBHI implementation and submitted the case study to the USAID Collaborating, Learning, and Adapting 2022 case competition.

5. COMMUNICATIONS AND KNOWLEDGE MANAGEMENT ACCOMPLISHMENTS

During Y4Q3, the Program conducted the following activities related to communications:

- Produced three newsletter stories

6. PROGRAM MANAGEMENT AND OPERATIONS

6.1 PROGRAM MANAGEMENT

Security issues and their impact on implementation: Since June 2021, the conflict that started in November 2020 in northern Ethiopia escalated and crippled administrative, financial, and social services. CBHI scheme offices and health facilities were looted and destroyed. Information collected by the RHBs in 2021 showed that:

- In Amhara, 23 hospitals, 314 health centers, and 71 CBHI schemes offices were destroyed.
- In Afar, 1 hospital and 17 health centers were destroyed.
- In Tigray, 27 CBHI scheme offices were damaged. No information was provided on the extent of damage to health facilities.

The conflict initially disrupted the functioning of health facilities and therefore the implementation of first-generation HCF reforms, in addition to the provision of health services. Implementation of CBHI activities by local counterparts and the Program, including community mobilization, capacity building, and supportive supervision, were also suspended in these conflict areas during the conflict and in its aftermath.

In Q2 and Q3, despite their operational and infrastructure challenges, most schemes in conflict-affected areas of Amhara and the two affected schemes in Afar resumed implementation of CBHI activities. The Program team provided TA in re-starting mobilization activities of these schemes by collaborating with the RHBs. In Tigray, the CBHI schemes are not functional.

In addition, security issues continue to be a challenge to the implementation of CBHI inter-woreda review meetings and routine supportive supervision visits in areas of Oromia Region: five zones (Kellam Wollega, Horo Guduru, East Wollega, West Wollega, and Guji), six woredas of North Shewa Zone, 11 woredas of West Shewa Zone, and seven woredas of Guji Zone.

6.2 HUMAN RESOURCES

6.3 PROCUREMENT

7. CHALLENGES

The Program experienced the following challenges during Y4Q3. Where possible, it took action to address and overcome the difficulties.

External

- The AACA cabinet members' delay in approving the HCF regulation and the AACA Health Bureau's insufficient attention to establishing and operationalizing the city administration's HCF TWG delayed completion of the institutionalization systems element. The Program team continued its TA and follow-up with the health bureau in order to push forward the approval of the regulation and operationalization of the TWG.

8. LESSONS LEARNED

The following lesson was learned in Y4Q3:

- Commitment by the local administrations and communities has produced good progress in CBHI enrollment in conflict-affected areas despite the challenges that conflict poses to the schemes. This commitment was made possible by the continuous education and sensitization efforts of the Program and other stakeholders in earlier years and especially over the past year. It shows the extent of the trust the community has in the CBHI Program.

9. QUARTERLY EXPENDITURE AND ACCRUAL REPORT

Line Item	Total Budget	Total Accumulated Expenses @ March 31, 2022	Y4 Quarter 3 (April 2022- June 2022)			Total Expenditures to Date	Remaining Funds
			April Actuals	May Actuals	June Actuals		

10. PLANNED ACTIVITIES FOR NEXT QUARTER

- Provide TA to enhance cross subsidization among CBHI schemes.
- Provide TA to EHIS in developing an action plan for strategic purchasing in health.
- Finalize the report on the assessment of the contribution of RRU to quality improvement at health facilities.
- Accelerate transitioning of first-generation HCF reform activities through light-touch support, reinforcing transition at health facilities in reform-advanced areas.
- Provide TA to Sidama and AACA health bureaus to establish HCF TWGs and finalize directives that will help to transition first-generation HCF reform activities.
- Support finalization of adapted HCF legal frameworks in DRS.
- Consolidate HCF reform implementation by participating in regional-level TWGs.

ANNEX A: CUMULATIVE LIST OF DELIVERABLES

The cumulative list of deliverables completed in Y4 through Q3 is provided in the table below. The status of deliverables posted to USAID's Development Experience Clearinghouse (DEC) is also indicated.

Deliverable title	Author	Program year and quarter completed	Posted to DEC (Yes/No)	Comments
Program				
USAID Health Financing Improvement Program Annual Performance Report: Year 3 (October 2020 - September 2021)	USAID Health Financing Improvement Program	Y4Q1	Yes	
USAID Health Financing Improvement Program Year 4 Implementation Plan (October 1, 2021 - September 30, 2022)	USAID Health Financing Improvement Program	Y4Q1	N/A	As per the cooperative agreement, implementation plans should not be posted to the DEC
USAID Health Financing Improvement Program MEL Plan - 2021 Update	USAID Health Financing Improvement Program	Y4Q1	N/A	As per the cooperative agreement, MEL plans should not be posted to the DEC
USAID Health Financing Improvement Quarterly Performance Report: Year 4 Quarter 1 (October 1, 2021 - December 31, 2021)	USAID Health Financing Improvement Program	Y4Q2	No	Pending USAID approval
USAID Health Financing Improvement Program Internal Mid-Term Review (October 2018 - September 2021)	USAID Health Financing Improvement Program	Y4Q2	N/A	Internal review for USAID and project use
USAID Health Financing Improvement Quarterly Performance Report: Year 4 Quarter 2 (January 1, 2021 - March 31, 2021)	USAID Health Financing Improvement Program	Y4Q3	No	
IR 1: Increased resource availability for enhanced provision of quality PHC services				
N/A				
IR 2: Streamlined risk-pooling mechanisms for wider access to PHC services with reduced financial barriers				
Rapid Assessment of Community-Based Health Insurance Implementation in Pastoral Woredas in Oromia and SNNP: Lessons for Adaptation and Scale-up	USAID Health Financing Improvement Program	Y4Q1	Yes	
Rapid Assessment of the Impact of War in Northern Ethiopia on Organizational Capacity of CBHI Schemes in Afar and Amhara Regions	USAID Health Financing Improvement Program	Y4 Q3	No	
IR 3: Improved arrangements for strategic purchasing of health services				
N/A				

Deliverable title	Author	Program year and quarter completed	Posted to DEC (Yes/No)	Comments
IR 4: Strengthened governance, management, and evidence generation for health financing reforms and health facilities				
Produced 3 newsletter articles	USAID Health Financing Improvement Program	Y4Q3	N/A	Posted to Program's online newsletter

ANNEX B: INDICATOR REPORTING

USAID Health Financing Improvement Program Indicators Table – Year 4, Quarter 3

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Year 4	Y4Q1 Actual	Y4Q2 Actual	Y4Q3 Actual	Remarks
					Target	Actual	Target	Actual	Target	Actual	Target				
	Strategic Objective: Improved institutional capacity and health financing functions and systems in Ethiopia														
1	Health service utilization rate	Region, insured/uninsured	Annually (Starting from Y2)	0.67	0.7	0.9	0.73	1.02	0.75	1.09	0.77	N/A	N/A	N/A	
2	Share of out-of-pocket expenditure to total health expenditure	Public health facility/Private health facility	At baseline, Y3, and Y5	33%	N/A	30.6%	N/A	N/A	28%	N/A	N/A	N/A	N/A	N/A	
3	Number of health managers, health providers, other government officials, and community representatives received trainings HCF reform interventions including the CBHI program	Region, training type, participant type and gender, urban/rural	Quarterly	0	3,414	2002	2,236	4124	1,966	3,630	1,074	284	269	178	Q3: 152 M; 26 W
4	Health service utilization rate (CBHI beneficiaries)	Region	Annually (Starting from Y2)	1.1	N/A	N/A	1.1	0.71	1.4	0.68	1.6	N/A	N/A	N/A	
	IR 1 — Increased resource availability for enhanced provision of quality PHC services														
1.1	Percent of domestically mobilized resources for the health sector	N/A	Year 1, Year 3, Year 5	64%	64.8%	64.8%	N/A	N/A	66%	N/A	N/A	N/A	N/A	N/A	
1.2	Percent of donor contribution to the health sector	N/A	Year 1, Year 3, Year 5	36%	36%	35.2%	N/A	N/A	34%	N/A	N/A	N/A	N/A	N/A	
	SR 1.1 — Availability of operational funds increased at all levels of PHC service provision														

Indicator		Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Year 4	Y4Q1 Actual	Y4Q2 Actual	Y4Q3 Actual	Remarks
					Target	Actual	Target	Actual	Target	Actual	Target				
1.1.1	Percent of public health facilities using retained revenue for facility and service improvement	Region, facility type (health center, hospital)	Annually	91%	91%	93%	91%	94%	91%	94%	92%	N/A	N/A	94%	
1.1.2	Percent of health facility budgets made up by retained revenue	Region, facility type (health center, hospital)	Annually	30%	31%	30.20%	32%	30.80%	33%	23%	35%	N/A	N/A	N/A	
1.1.3	Percent of health facility retained revenue being used for drugs, medical equipment, and facility renovation	Region, facility type (health center, hospital)	Annually	75%	76%	77%	77%	77.70%	78%	77.9%	79%	N/A	N/A	N/A	
1.1.4	Amount of budget appropriated from RRU	Region, facility type (health center, hospital)	Annually		3.13 Billion ETB	3.1 Billion ETB	3.4 Billion ETB	4.3 Billion ETB	3.7 Billion ETB	5.5 Billion ETB	4.1 Billion ETB	N/A	N/A	N/A	
	SR 1.2 — Strategies on efficiency improvement and rational resource use implemented														
1.2.1	Percent of public hospitals outsourcing cost-inefficient non-clinical/ancillary services	Region, type of services outsourced	Annually	90% (113/280)	90%	36%	90%	41%	90%	40%	90%	N/A	N/A	N/A	
1.2.2	Number of private enterprises engaged in outsourcing services	Region, type of services	Annually, starting Year 2	113	130	216	143	263	157	267	173	N/A	N/A	N/A	
	SR 1.3 — Explored and implemented strategies on additional resource availability for PHC														
1.3.1	Percent share of government spending on health out of general government expenditure	MOF, MOH annual reports	Year 1, Year 3, end-line	6.60%	7%	9%	8%	N/A	8.60%	N/A	9.4%	N/A	N/A	N/A	
1.3.2	Percent share of government allocation to health in the national budget	Sources of funding (Government allocation/treasury source, RRU)	Annually	11.50%	12.2%	12.2%	12.7%	10.2%	12.8%	13.2%	12.9%	N/A	N/A	N/A	
	SR 1.4 — Sustainability financing plan for the exempted service package developed														
	IR 2 — Streamlined risk-pooling mechanisms for wider access to PHC services with reduced financial barriers														

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Year 4	Y4Q1 Actual	Y4Q2 Actual	Y4Q3 Actual	Remarks
					Target	Actual	Target	Actual	Target	Actual	Target				
2.1	Percent of population enrolled in health insurance programs	Region, scheme type	Annually	20%	25%	24.80%	32%	31.90%	38%	40.40%	45%	N/A	N/A	43%	
2.2	Re-enrollment rate in CBHI schemes (renewal)	Region, urban/rural	Annually	75%	75%	74%	76%	76%	77%	78.7	78%	N/A	N/A	N/A	
2.3	CBHI enrollment rate from the total eligible households	Region, urban/rural/ pastoral	Annually			N/A	40%	44.10%	50%	60.70%	60%	N/A	N/A	66.8%	
2.4	Total amount of money mobilized from CBHI membership contributions and government subsidies	By source (contribution, targeted subside, general subsidy)	Annually	1.04 Billion ETB	1.42 Billion ETB	1.19 Billion ETB	1.85 Billion ETB	1.86 Billion ETB	2.29 Billion ETB	2.4 Billion ETB	2.81 Billion ETB	N/A	N/A	N/A	
	SR 2.1 and 2.2 — CBHI rolled out, institutionalized, and consolidated in the rural districts of the 4 agrarian regions and urban setting														
2.1.1	Number of woredas covered by CBHI program	Region, urban/rural functional/under establishment	Annually	351	531	667	770	828	825	907	858	N/A	N/A	927	647 rural, 280 urban
2.1.2	Percent of CBHI schemes audited per year (financial) in rural and urban woredas	Region, urban/rural	Annually	43% (36% rural 50% urban)	60%	41%	75%	68.60%	83%	84%	100%	N/A	N/A	N/A	
	SR 2.3 — Safety-net provisions strengthened and expanded to include increased coverage of poor households in CBHI and fee-waiver in non-CBHI woredas														
2.3.1	Percent of poor households enrolled in CBHI schemes on contribution-exemption basis	Region, urban/rural	Annually	18%	22%	23%	40%	29.40%	50%	33.50%	75%	N/A	N/A	33.5%	
2.3.2	Number of woreda governments that allocated/transferred full budget to cover targeted poor households under CBHI schemes	Region, rural/urban	Annually	357	531	530	585	721	825	843	858	N/A	N/A	N/A	

	Indicator	Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Year 4	Y4Q1 Actual	Y4Q2 Actual	Y4Q3 Actual	Remarks
					Target	Actual	Target	Actual	Target	Actual	Target				
2.3.3	Number of CBHI woredas that are harmonized with safety-net targeting criteria	Region, rural/urban	Annually	0	N/A	N/A	N/A	N/A	TBD	120	N/A	N/A	N/A	N/A	
2.3.4	Percent of female-headed indigent households among the total indigent households enrolled in CBHI schemes	Region	Annual starting Year 2	N/A	N/A	30%	30%	46.40%	31%	46.10%	32%	N/A	N/A	N/A	
2.3.5	Percent of CBHI board with at least one woman board member	Region	Annual starting Year 2	N/A	N/A	N/A	100%	100%	100%	100%	100%	N/A	N/A	N/A	
	SR 2.4— Worked with EHIS and MOH in supporting implementation of SHI program														
	IR 3 — Improved arrangements for strategic purchasing of health services														
3.1	Percent of health facility claims verified	Region	Annually	79%	100%	80%	100%	86.90%	100%	82.70%	100%	N/A	N/A	N/A	
3.2	Percent of hospitals audited by pool of medical auditors	Clinical/claim	Annually	0	0	N/A	0	N/A	10%	N/A	15%	N/A	N/A	N/A	
	SR 3.1 — Management streamlined at health facilities and CBHI schemes														
3.1.1	Percent of schemes staffed as per the organizational structure	Region	Annually	86%	100%	86%	100%	83%	100%	76%	100%	N/A	N/A	N/A	
	SR 3.2 — Tools and skills institutionalized for periodic revision of user-fee schedules														
3.2.1	Number of regions implemented tool to facilitate periodic revision of user fee schedules	N/A	Annually	N/A	N/A	N/A	N/A	N/A	2	N/A	3	N/A	N/A	N/A	
	SR 3.3 — New provider payment approaches explored, particularly within urban insurance programs that also facilitate better participation of private sector health														
	SR 3.4 — Health facility accreditation requirements made mandatory for all public and private providers under health insurance programs														
3.4.1	Proportion of health facilities assessed for fulfillment of minimum quality standards	N/A	Annually (starting from Y3)	N/A	N/A	N/A	N/A	N/A	10%	N/A	15%	N/A	N/A	N/A	

Indicator		Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Year 4	Y4Q1 Actual	Y4Q2 Actual	Y4Q3 Actual	Remarks
					Target	Actual	Target	Actual	Target	Actual	Target				
	IR4 — Strengthened governance, management, and evidence generation for health financing reforms and health facilities														
4.1	Percent of public health facilities managed by functional governing boards	Region, facility type (health center, hospital)	Annually	90%	90%	93%	90%	91%	90%	90%	90%	N/A	N/A	88%	
	SR 4.1 — Institutional structures and roles defined and capacities strengthened for spearheading and managing health financing reforms strengthened														
4.1.1	Number of RHBs with functioning resource mobilization structure	Region	Annually	1	1	1	4	4	11	6	12	N/A	N/A	N/A	
	SR 4.2 — Health facility governing boards reform rolled out and transitioned/institutionalized														
4.2.1	Percent of health facilities with 2 or more women board members participating in the health facility board meeting	Facility type (health center, hospital),	Annually	35.80%	36%	35.80%	49%	37%	62%	44.40%	75%	N/A	N/A	N/A	
4.2.2	Percent of health facilities with community participation in board meetings	Facility type (health center, hospital)	Annually	85%	85%	85%	95%	81.30%	100%	100%	100%	N/A	N/A	N/A	
	SR 4.3 — Private wings in public hospitals reform rolled out and transitioned/institutionalized														
4.3.1	Total number of public hospitals with private wings established	Federal, region, hospital type	Annually	63	49	49	49	49	49	45	49	N/A	N/A	33	
	SR 4. 4 — Generation of evidence and documentation and dissemination of lessons learned improved for HCF reform policy refinement and decision-making of health facility management														
4.4.1	Number of policies, strategies, legal frameworks, and guidelines revised to improve health financing reforms	Document type	Annually	0	0	N/A	5	2	2	2	3	N/A	N/A	N/A	
4.4.2	Number of operations research/studies/survey s conducted, and	Type of study	Annually	-	2	1	2	4	2	3	2	N/A	N/A	N/A	

Indicator		Disaggregate	Frequency	Baseline	Year 1		Year 2		Year 3		Year 4	Y4Q1 Actual	Y4Q2 Actual	Y4Q3 Actual	Remarks
					Target	Actual	Target	Actual	Target	Actual	Target				
	results/reports disseminated/published														
4.4.3	Number of reports, success stories, and newsletters developed and disseminated	Type of document	Quarterly	-	8	7	12	12	12	10	12	N/A	N/A	N/A	
4.4.4	Number of review meetings and policy dialogues organized in support of the health care financing reform interventions (to secure needed policy changes, decision-making and proper implementation at the federal, regional, and zonal/woreda levels)	Federal, regional, zonal	Quarterly	-	47	61	136	84	78	87	34	5	17	0	
4.4.5	Number of health facilities visited through the Supportive Supervision visits to monitor and strengthen the implementation and impact of the health care financing reform at all levels (national and sub-national)	Federal, regions, facility type	Quarterly	-	274	147	196	169	396	293	62	6	30	0	
4.4.6	Number of CBHI schemes visited through the Supportive Supervision visits to monitor and strengthen the coverage and implementation of the CBHI schemes at woredas	Federal, regional	Quarterly	-	215	189	213	204	231	232	138	33	29	32	25 rural; 7 urban schemes

Note: The narrative report includes status updates for some annual key performance indicators irrespective of the reporting period. The key performance indicators table above reports on annual indicators only at the end of the year.