Health Systems for Tuberculosis (HS4TB)

Assessment of Ethiopia's Health Sector Co-Financing Framework

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About HS4TB

The US Agency for International Development (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 Open Development.

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CONTENTS

ACRONYMS

ACG	Advocacy Core Groups
BMGF	Bill and Melinda Gates Foundation
CSO	Civil Society Organizations
DFID	Department for International Development
DRMS	Domestic Resource Mobilization and Sustainability
EFY	Ethiopian Fiscal Year
EPSS	Ethiopian Pharmaceutical Supply Service
ETB	Ethiopian birr
FHS	Family Health Strategy
MOH-E	Ministry of Health-Ethiopia
FP	Family Planning
GOE	Government of Ethiopia
GTP	Growth and Transformation Plan
HCF	Health Care Financing
HS4TB	Health Systems for TB
HSTP	Health Sector Transformation Plan
IBEX	Integrated Budget and Expenditure System
IDA	International Development Association's
IFMIS	Integrated Financial Management Information System
IRS	Indoor Residual Spray
JSC	Joint Steering Committee
KOICA	Korean International Cooperation Agency
M&E	Monitoring and Evaluation
MOF	Ministry of Finance

MOU	Memorandum of Understanding
NHA	National Health Authority
NSP	National Strategic Plan
NTP	National Tuberculosis and Leprosy Program
OECD	Organization for Economic Co-operation and Development
PBB	Program-Based Budgeting
PDU	Program Delivery Unit
PHCU	Primary Health Care Unit
PF	Pooled Fund
PFM	Public Financial Management
PHC	Primary Health Care
PM-JAY	Pradhan Mantri Jan Arogya Yojana
RHB	Regional Health Bureau
RTPM	Resource Tracking and Partnership Management Tool
SAEO	Strategic Affairs Executive Office
SD	Seqota Declaration
SDG	Sustainable Development Goals
SHA	State Health Agencies
SNNPR	Southern Nations, Nationalities, and People's Region
STBF	Susan Thompson Buffett Foundation
SUS	Sistema Único de Saúde (Unified Health System)
TB	Tuberculosis
TCI	The Challenge Initiative
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
UNISE	Unified Nutrition Information System
UHC	Universal Health Coverage
USD	United States Dollar
WHO	World Health Organization

EXECUTIVE SUMMARY

The Ministry of Health-Ethiopia (MOH-E) has emphasized the importance of increasing domestic funding for the health sector through a coordinated effort to mobilize resources at all levels of government [Ethiopian Health Care Financing (HCF) Strategy, 2022-2031]. The HCF Strategy calls for the use of co-financing arrangements as a crucial approach in bridging the health care financing gap. Mechanisms to effectively coordinate co-financing commitments between different levels of government will be essential if the Government of Ethiopia (GoE) is to successfully implement the revised Exempted Health Services Policy.

Co-financing occurs when two or more entities from within the government (or in partnership with a development partner) agree to jointly finance a program or intervention. Co-financing arrangements present opportunities to increase domestic funds for public health priorities, and they can be particularly effective in a decentralized context, where regional governments have the mandate to allocate funds towards health.

This *Assessment of Ethiopia's Health Sector Co-Financing Framework* identifies opportunities and barriers within the legal and policy environment for implementing and institutionalizing co-financing mechanisms to broadly support the health financing reform agenda. There are instances of co-financing in the health sector in Ethiopia, but these experiences have not been sufficiently documented and reviewed for the benefit of other health and social sector programs. This assessment considers the lessons from past and present co-financing arrangements within the health sector in Ethiopia and globally, the existence of associated policy guidance, and the state of key systems needed to realize co-financing arrangements.

The assessment found that, while co-financing arrangements between the national and regional levels of government are permissible, Ethiopia lacks an implementation framework or guidelines for intra-governmental co-financing negotiation and enforcement. The report recommends developing a *Co-financing Implementation Guide* for negotiation and enforcement of such mechanisms within the health sector and provides recommendations for how the country can develop co-financing arrangements moving forward that benefit from:

- Strong political commitment and sustained stakeholder engagement;
- Clearly defined roles and responsibilities;
- Established frameworks for monitoring and accountability;
- Ability to track commitments through the financial management systems; and
- Opportunities for capacity strengthening.

While this analysis is intended to benefit the entire health sector, it is being championed by the National Tuberculosis and Leprosy Program (NTP) and Strategic Affairs Executive Office (SAEO), with support from the USAID Health Systems for TB (HS4TB) Project. In 2022, Ethiopia developed a TB Domestic Resource Mobilization and Sustainability (DRMS) Roadmap[1] that recommended that co-financing commitments for TB between the federal and regional levels be developed to foster more locally driven

[1] Tuberculosis Domestic Resource Mobilization and Sustainability Roadmap for Ethiopia, January, 2022 (https://pdf.usaid.gov/pdf_docs/PA00ZW7S.pdf)

investments in public health interventions for TB at the subnational level. This assessment is meant to guide the development of any co-financing arrangements between the national and regional governments to support TB programming.

Furthermore, this assessment will guide the GoE as it plans to implement the forthcoming Exempted Health Services Policy, which will likely require co-financing between the Ministry of Finance (MOF) (treasury), regional bureaus, and development partners. In addition, this assessment has the potential to provide valuable insights to the government on how to increase regional contributions to meet the co-financing commitments made with the Global Fund and recently announced Support Wide Scale Interventions to Find TB (SWIF TB).[2]

[2] USAID Secures $18 Million in New Funding to Accelerate Efforts to End TB, March 14, 2024. Available at https://www.usaid.gov/news-information/press-releases/mar-14-2024-usaid-secures-18-million-new-funding-accelerate-efforts-end-tuberculosis

INTRODUCTION TO CO-FINANCING ARRANGEMENTS

According to the Organization for Economic Co-operation and Development (OECD),[3] effective public investment across levels of government requires coordination, strengthened capacities and a sound framework so that more and better public investment can occur at all levels of the government (and particularly by subnational governments). While policy makers recognize the advantages of coordinated intragovernmental investments, "transaction costs, competitive pressures, resource constraints, differing priorities and fears that the distribution of costs or benefits from co-operation will be one-sided," are all impediments to bringing governments together.[4]

A co-financing arrangement is one approach that governments can use to overcome these impediments and achieve better coordinated and more effective programming with public funds across all levels of government. Other approaches include but are not limited to contracts between levels of government, formal consultation processes, national agencies or representatives working with subnational areas, joint investment strategies, and the use of incentives and conditionalities when assigning public funds–all of which have governance and accountability elements that could be incorporated into co-financing arrangements. [5]

In the context of the global public health sector, a co-financing arrangement exists when two or more entities (from within the government or between government and development partners) agree to jointly plan and finance a health program or intervention. These arrangements are designed to increase the resources available for a particular public health aim and encourage coordination among those providing financing (i.e., each financing entity supports a discrete component within the program or intervention).

When designed with development partners, co-financing arrangements can promote sustainability by 'crowding in' domestic financing and allowing governments to fund their priorities, with external resources then being used to fill financing gaps.[6] While development partners frequently employ co-financing policies to incentivize countries to mobilize more domestic resources for health, the use of co-financing arrangements *within* governments is less well known, but it too can crowd in domestic resources for health – in this case from the level of government that has previously been less inclined to finance a particular health area or initiative. Co-financing arrangements have also been used to advance 'whole-of-government' or 'health-in-all' approaches by coordinating financial investments beyond the health sector to achieve public health objectives.[7]

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[3] OECD (2019), Effective multi-level public investment, OECD principles in action, https://www.oecd.org/effective-public-investment-toolkit/Full_report_Effective_Public_Investment.pdf

[4] Ibid

[5] Ibid

[6] Ayan Jha, Robert John Kolesar, Sophia Comas, Jay Gribble, Jorge Ugaz, Eduardo Gonzalez-Pier, Getting ready for reduced donor dependency: the co-financing of family planning commodities, *Health Policy and Planning*, Volume 39, Issue 1, January 2024, Pages 87–93, https://doi.org/10.1093/heapol/czad106

McGuire, F., Vijayasingham, L., Vassall, A. et al. Financing intersectoral action for health: a systematic review of co-financing models. *Global Health* 15, 86 (2019). https://doi.org/10.1186/s12992-019-0513-7

[7] McGuire, F., Vijayasingham, L., Vassall, A. et al. Financing intersectoral action for health: a systematic review of co-financing models. *Global Health* 15, 86 (2019). https://doi.org/10.1186/s12992-019-0513-7

The potential benefits of co-financing arrangements are not solely focused on generating more resources for public health priorities. According to the OECD, the "low level of capacities to design and implement the right investment mix, particularly at the subnational level, is probably one of the most important bottlenecks for effective public investment," even among high-income countries.[8] By bringing together national and subnational governments, co-financing arrangements can also ensure that investments in a public health program are more effective by benefiting from both the expertise and evidence from national programs as well as an appreciation of the local context and needs. In summary:

> *"Intergovernmental earmarked grants and co-financing (matching) arrangements are appropriate when projects generate positive spillovers, when economies of scale are needed, when risk sharing or temporary co-operation is sought, when it is necessary to align priorities across levels of government and when capacities of sub-national governments need to be bolstered. Co-financing can also increase the commitment of different stakeholders to the success of a project as well as encourage resource pooling across sub-national governments."*[9]

ASSESSMENT OBJECTIVE

The Ethiopian Health Care Financing (HCF) Strategy (2022-2031) recognizes the potential benefits of co-financing arrangements and calls for the Government of Ethiopia (GOE) to increase its contribution to the health sector at *all* levels of the government. According to the HCF Strategy, this will be accomplished by generating and using evidence to inform financial decision-making during budgeting processes at the federal, regional, and woreda levels, and by demonstrating how additional resources, through co-financing commitments, will be well coordinated within government and complementary to resources provided by development partners.

Box 1: Oromia Regional Health Bureau contribution to TB financing

Regional Health Bureaus (RHBs) have the potential to take on greater responsibility for financing TB performance management activities. Some RHBs have already requested dedicated resources for TB from regional budgets successfully. For instance, the Oromia RHB has asked in successive financial years for Ethiopian birr (ETB) 2.5 million ($48,076 United States Dollar [USD]*), ETB 1.5 million ($28,846 USD), and ETB 5 million ($92,593 USD) for TB. The first two were approved by the regional council – the second one despite an overall reduced national government allocation to the Oromia Region for that year – and the third has yet to be approved. The funds will be used to strengthen the monitoring and evaluation of TB and leprosy programs in the area.

* The 2015 and 2016 EFY exchange rates from the Commercial Bank of Ethiopia were used.

The GOE already has intra-governmental co-financing arrangements that coordinate financial contributions at both federal and subnational levels toward the achievement of priority health goals, though these experiences have not been comprehensively documented for the benefit of other health programs. Further, the lack of an implementation guide for intra-governmental co-financing negotiation and enforcement is a current challenge, even as Ethiopia's HCF Strategy calls for the use of co-financing arrangements as a crucial approach in bridging the health care financing gap. Effective implementation of co-financing commitments between different levels of government will be essential for the implementation of the forthcoming

[8] OECD (2019), Effective multi-level public investment, OECD principles in action, https://www.oecd.org/effective-public-investment-toolkit/Full_report_Effective_Public_Investment.pdf
[9] Ibid.

Exempted Health Services Policy, which calls for coordinated financing from the central and regional levels to support the Exempted Health Services list, a set of interventions that should be provided to patients free of charge at the point of care. The MOH-E and the MOF are negotiating how to finance the Exempted Health Services list through a mix of program-based budgeting (PBB) through federal funds (treasury) in coordination with regional co-financing commitments.

The objective of this report, an *Assessment of Ethiopia's Health Sector Co-financing Framework,* is to identify opportunities and barriers within the legal and policy environment for implementing and institutionalizing co-financing mechanisms to broadly support the health financing reform agenda. This assessment considers the lessons from past and present co-financing arrangements within the health sector (both in Ethiopia and globally), the existence of associated policy guidance, and the state of key systems needed to realize co-financing arrangements.

While the current analysis will benefit the entire health sector, it has been developed with guidance from the Ministry of Health's Strategic Affairs Executive Office (SAEO) and the National Tuberculosis Program (NTP) and is intended primarily for their use. From 2021-2023, the GOE struggled to meet its domestic co-financing commitment to the Global Fund for its tuberculosis (TB) grant. As a result, Ethiopia's TB DRMS Roadmap[10] recommended that co-financing commitments for TB between the federal and regional levels be developed to foster more locally driven investments in public health interventions for TB at the subnational level. Box 1[11] provides an example of the type of regional financing for TB that the NTP would like to incentivize through the expansion of co-financing arrangements.

METHODOLOGY

The HS4TB project first reviewed global best practices and lessons in co-financing arrangements in the health sector. Specifically, we analyzed the global experiences of co-financing arrangements led by and with development partners, such as the Global Fund and GAVI. We also examined co-financing cases within governments, with a focus on low- and middle-income countries that operate through a federal system similar to Ethiopia. The aim of the global review was to better interpret the Ethiopia experience and inform our analysis with a global perspective on co-financing in the health sector.

Within the Ethiopian context, the HS4TB project, with the guidance of NTP and SAEO, conducted a comprehensive review of national health policy, strategy, and financing documents to identify any guidance on co-financing agreements between the national and regional levels in Ethiopia. Currently, no established policy or legal framework exists that provides guidance or enforces co-financing arrangements between the national and regional levels. At the same time, no policy or legal barriers to establishing co-financing arrangements were identified through the document review and key informant interviews. The national policy and strategy documents reviewed highlighted the need for increasing

[10] Tuberculosis Domestic Resource Mobilization and Sustainability Roadmap for Ethiopia, January, 2022 (https://pdf.usaid.gov/pdf_docs/PA00ZW7S.pdf)
[11] The 2015 Ethiopian fiscal year runs from July 8, 2022, to July 7, 2023. The exchange rate for 2015 and 2016 EFY used from the Commercial Bank of Ethiopia.

domestic financing, including through better engagement and coordination of national and subnational entities (see Annex 1).

To gain a comprehensive understanding of existing co-financing arrangements in Ethiopia, a review of past and current co-financing mechanisms within the health sector was conducted. This included a document review of existing co-financing arrangements, followed by interviews with key informants. This assessment identified four cases of co-financing arrangements in the health sector (see Box 2) that were included in the analysis. These co-financing arrangements include: the Seqota Declaration initiative for eliminating under-two stunting; the Malaria Indoor Residual Spray (IRS) Initiative to reduce malaria cases by eliminating malaria larvae; the Health Infrastructure project for building and improving health facilities; and the Family Planning Compact agreement to improve Family Planning (FP) commodity funding gap. These arrangements typically involve subnational entities receiving a predetermined allocation of federal funds (including treasury and/or donor funds) for a specific purpose, contingent upon their own contributions towards a shared goal.

One challenge is that co-financing arrangements between the national and subnational levels in Ethiopia are not well documented. We carefully examined roadmaps, guidelines, directives, allocation letters, and office memos for co-financing arrangements established between the national and subnational levels and extracted information on co-financing commitments, arrangements, and procedures from these documents.

We then conducted interviews with health financing experts in the SAEO and key informants involved in the aforementioned co-financing initiatives. These interviews provided valuable insights into the practical implementation of co-financing arrangements, challenges faced, and potential areas for improvement. The stakeholders' perspectives contributed to a more holistic understanding of co-financing practices in Ethiopia. See Annex 2 for the list of key informants interviewed and Annex 3 for the interview template used.

Box 2: Ethiopia's co-financing arrangements reviewed

1. ***Seqota Declaration—Nutrition Program:*** Co-financing arrangement established between the national government (MOF and MOH-E) and the regional and woreda bureaus to end under-two stunting in Ethiopia by 2030. National funds are exclusively domestic while sub-national funds include both domestic and Channel 3 funds (funds that are flowing directly to regional and woreda finance bureaus from donors or development partners).
2. ***Indoor Residual Spray (IRS) Initiative—Malaria Program:*** An initiative which supports malaria IRS chemical procurement and indoor spraying to reduce malaria infection in high burden areas. Funding for the initiative is from national and regional domestic sources.
3. ***Health Infrastructure—Primary Health Facilities:*** Co-financing arrangement between the national government (MOH-E) and RHBs for the construction and maintenance of primary health care units in woredas and kebeles within each region.
4. ***Family Planning Compact Agreement***: A three-year agreement between the MOF, MOH-E, and a coalition of partners to address FP commodity availability and procurement challenges.

GLOBAL EXPERIENCE WITH CO-FINANCING ARRANGEMENTS

To better interpret the Ethiopia experience and to inform the analysis, this assessment reviewed the global best practices and lessons in co-financing arrangements, particularly in the health sector. The following section discusses the global experience with co-financing in the health sector with multilateral development partners, namely the Global Fund and Gavi, in collaboration with low- and middle-income countries. Additionally, examples of co-financing within the governments are also presented though a lack of resources that analyze co-financing experiences globally was a limiting factor for this assessment. One compelling case study from Nigeria, The Challenge Initiative, is discussed in detail. This example is particularly relevant for Ethiopia and the NTP as it involves the collaboration of both development partners and governments to develop a co-financing framework that specifically mobilized domestic resources for a particular health objective.

Global Experience with Health Sector Co-Financing with Multilateral Partners

Much of the attention on health sector co-financing, particularly in low and middle-income countries, has been focused on the use of co-financing arrangements between multilateral development partners and countries to increase domestic resources towards a specific health investment area. The use of co-financing arrangements has been prominent among the major global health initiatives, including the Global Fund[12], Gavi[13], and the World Bank[14].

The Sustainability, Transition and Co-financing (STC) Policy outlines The Global Fund's co-financing policy, which was introduced in the 2017-2019 funding cycle. The policy emphasizes strengthening sustainability, encouraging domestic financing through co-financing, and helping countries to prepare for the transition from Global Fund funding.[15] The Global Fund co-financing model is adapted to the specific country's economic context; two core co-financing requirements apply to all countries regardless of their income status: (1) progressive government expenditure on health and (2) progressive absorption of key program costs.[16] Taken together, these two prerequisites are expected to reduce dependency on external resources by national disease programs and promote long-term sustainability. The Global Fund STC policy primer provides detailed information on the structure, progress, and challenges of the co-financing arrangements.[17] Of interest is that the second pre-requisite is reinforced through a co-financing incentive (of at least 15% of the Global Fund grant) that is frozen until the country commits to and meets its co-financing target.

[12] The Global Fund Sustainability, Transition and Co-financing Policy, https://archive.theglobalfund.org/media/4221/archive_bm35-04-sustainabilitytransitionandcofinancing_policy_en.pdf
[13] Gavi Co-Financing Policy, https://www.gavi.org/programmes-impact/programmatic-policies/co-financing-policy
[14] World Bank Direct Co-Financing, https://www.worldbank.org/en/programs/trust-funds-and-programs/co-financing
[15] The Global Fund's Role and Approach to Domestic Financing for Health (DFH), OIG Advisory, 21 July 2022. https://www.theglobalfund.org/media/12155/oig_gf-oig-22-011_report_en.pdf
[16] The Global Fund Guidance Note Sustainability, Transition, and Co-Financing, December 12, 2022, https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf
[17] The Global Fund's Co-financing Policy: A primer, https://aidspan.org/?action=catelog_singlepost&id=13448

While the intention of the co-financing model is to incentivize greater prioritization of government healthcare spending to strengthen and sustain national responses, challenges have been observed in tailoring the STC policy. Some of the challenges are: a) consistently translating STC policy into country-level requirements remains challenging, weakening impact; b) insufficient emphasis on 'more health for money' lowers the overall effectiveness of this mechanism; c) reporting inconsistencies in country-level co-financing investments weakens implementation of this lever; and d) the absence of a well-defined approach and clearly defined responsibilities for compliance assessment with co-financing commitments undermines the effectiveness of this mechanism.[18,19]

Gavi also uses a co-financing policy[20] to support countries in transitioning from receiving Gavi funding for vaccines to self-financing their immunization programs. As countries' incomes exceed a set threshold, Gavi's support phases out, requiring governments to assume responsibility for financing vaccines. This method aims to ensure a smooth transition to domestic financing while maintaining vaccination coverage.[21] The co-financing obligation for individual countries is determined by their transition phase and vaccination approach as per the Eligibility and Transition Policy.[22] During the first phase of self-financing, the domestic government provides a fixed amount of US$ 0.20 for each dose of any vaccine supported by Gavi that is used in routine immunization programs. During the second preparatory transition phase, the government's share of the contribution increases by 15 percent each year. In this phase, the co-financing requirement is calculated as a percentage of the vaccine price, leading to varying absolute amounts. When a country's average GNI per capita over three consecutive years surpasses the eligibility threshold, it enters an accelerated transition phase. This phase requires the country to co-finance at a minimum of 35 percent, and the funding increases from the previous phase level to the full cost over eight years.[23] The GAVI co-financing model has allowed Gavi to focus on addressing gaps identified through transition assessments, such as weak procurement processes or lack of community demand. However, the model's simplicity may have downsides, as it may not fully address the challenges faced by countries transitioning from Gavi funding to self-financing, such as the financial burden related to increased vaccine prices, and the need for technical assistance and capacity-strengthening support.[24]

A recent study assessed the political economy of financing traditional vaccines and vitamin A supplements in six African countries that were receiving GAVI support, and identified a number of challenges that are hindering countries from meeting co-financing requirements for essential health commodities. These challenges include political instability, bureaucratic complexities, competing priorities, leadership turnover, health sector inefficiencies, and budget execution challenges. In addition, the lack of a long-term financing strategy, economic difficulties, corruption, mistrust, and limited

[18] The Global Fund's Role and Approach to Domestic Financing for Health (DFH), OIG Advisory, 21 July 2022. https://www.theglobalfund.org/media/12155/oig_gf-oig-22-011_report_en.pdf
[19] Update on co-financing, GFO Issue 441, 2023-11-17, https://aidspan.org/update-on-co-financing/
[20] GAVI Alliance Co-financing Policy. https://www.gavi.org/sites/default/files/programmes-impact/Gavi-Co-financing-Policy.pdf
[21] Kallenberg, J., Mok, W., Newman, R., Nguyen, A., Ryckman, T., Saxenian, H. and Wilson, P., 2016. Gavi's transition policy: moving from development assistance to domestic financing of immunization programs. Health Affairs, 35(2), pp.250-258
[22] GAVI Alliance Eligibility and Transition Policy. https://www.gavi.org/sites/default/files/programmes-impact/gavi-eligibility-and-transition-policy.pdf
[23] GAVI Alliance Co-financing Policy. https://www.gavi.org/sites/default/files/programmes-impact/Gavi-Co-financing-Policy.pdf
[24] Kallenberg, J., Mok, W., Newman, R., Nguyen, A., Ryckman, T., Saxenian, H. and Wilson, P., 2016. Gavi's transition policy: moving from development assistance to domestic financing of immunization programs. Health Affairs, 35(2), pp.250-258

understanding of health impacts were also noted as significant barriers. However, the study also highlights several facilitators that can help increase government financing for health commodities in low- and middle-income countries. These include establishing a legal basis for government commitment, economic improvements that may increase government revenues, better coordination among partners, enhanced visibility of health commodity financing, and advocacy from civil society and media. The study emphasizes the role of citizen voice and leadership in influencing government decisions on health commodity financing. It also underscores the importance of strong leadership and political will in prioritizing funding for critical health interventions.[25]

Global Experience with Health Sector Co-Financing within Governments

Co-financing is one of the most popular governance instruments used to coordinate public interests for vertical or sector-specific programs, particularly in federalist countries.[26] However, a document review revealed that there are limited global resources that analyze co-financing experiences within the domestic health sector. This is particularly true for low- and middle-income countries. Countries considering if and how to structure co-financing arrangements would benefit from a more systematic review of low- and middle-income country experiences including an examination of best practice and lessons learned.

One multiple country report cited examples of where central governments are using earmarked grants to increase or influence financing for health at the subnational level, or both; the examples from Kenya, Indonesia and Nigeria are cited here.[27] Kenya is increasingly using conditional grants to earmark some central government resources for the health sector, but most of these conditional grants in Kenya do not yet require matching contributions from the counties.[28] In Indonesia, the central government provides earmarked funding for health to support disadvantaged districts, with the expectation that the district co-finance 10% of activities.[29] In Nigeria, states that receive funds from the Basic Health Care Provision Fund are supposed to provide 25% co-financing, but enforcement has been a challenge.[30]

Brazil and India are two other countries that offer examples of how national and subnational entities can develop co-financing arrangements in support of the health sector. To facilitate implementation of its Family Health Strategy, Brazil set a minimum threshold for health care spending for each level of government and offered additional financial and pay-for-performance incentives for municipalities to improve the quality of services provided. By law, the federal government, state government and

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[25] Nonvignon J, Aryeetey GC, Adjagba A, Asman J, Sharkey A, Hasman A, Pallas SW, Griffiths UK. The political economy of financing traditional vaccines and vitamin A supplements in six African countries. Health Policy Plan. 2023 Nov 28;38(10):1154-1165. doi: 10.1093/heapol/czad079. PMID: 37667813; PMCID: PMC10711745.

[26] OECD (2019), Effective multi-level public investment, OECD principles in action, https://www.oecd.org/effective-public-investment-toolkit/Full_report_Effective_Public_Investment.pdf

[27] ThinkWell and World Health Organization. 2022. A balancing act: Health financing in devolved settings. A synthesis based on seven country studies. Washington, DC: ThinkWell.

[28] Mbuthia B, Vilcu I, Ravishankar N, Ondera J. Purchasing at the county level in Kenya. Washington DC: ThinkWell; 2019.

[29] World Bank. Indonesia: Health Financing System Assessment [Internet]. World Bank Group; 2016. Available from: https://pubdocs.worldbank.org/en/841891492102642178/110298-HFSA-Indonesia-Published.pdf

[30] Uzochukwu B, Onwujekwe O, Mbachu C. Implementing the Basic Health Care Provision Fund in Nigeria: A Framework for Accountability and Good Governance. Policy Brief [Internet]. London: RESYST; 2015. Available from: https://assets.publishing.service.gov.uk/media/57a08991ed915d622c0002ab/Nigeria-brief.pdf

municipalities are required to spend at least 15%, 12% and 15%, respectively, of total revenue on health and in support of Brazil's Family Health Strategy.[31]

In India, the National Rural Health Mission was initiated in 2005, in which states were required to contribute a least 15% of the central government's allocation or to increase their health budgets by 10% every year from 2007 to 2012.[32] There were multiple issues with these arrangements: the state contribution was not required to be additional; the expected increase in central funds did not materialize; and certain lower-income states were not able to meet their matching contributions and thus could not receive the full contribution from the central government.[33] The National Rural Health Mission has since been brought under the National Health Mission. Both the National Health Mission and the publicly funded health insurance program called the Pradhan Mantri Jan Arogya Yojana or PM-JAY are funded by both the state and central governments using a specific ratio[36] that is predetermined by the MOF. The current national: subnational ratio for cost-sharing is 60:40 for states and union territories with a legislature, except for three Himalayan states and North-Eastern states where the ratio is 90:10.[37,38]

The Challenge Initiative (TCI) in Nigeria is an example where development partner resources helped incentivize sub-national government co-financing. The TCI was introduced in Nigeria in 2017 to expand access to quality family planning services, with seed funding from the Bill & Melinda Gates Foundation (BMGF).[34] Under TCI's co-financing strategy, state governments were required to allocate funds that met or exceeded minimum co-financing targets. These targets were increased incrementally every year. Recurrent spending on human resources, health systems, delivery of care, or general operations did not count towards the government's domestic funding responsibility. Failure to meet a spending target could result in a reduction of the state's current or future allocation, e.g., by holding back or deducting future Challenge Fund disbursements proportional to the amount of co-financing requirement the state had not fulfilled.[35] TCI provided resource mobilization coaching to ensure that funding was integrated into existing state family planning work plans, annual operational plans, and costed implementation plans.[36] Advocacy core groups (ACGs) were also formed, with membership from health ministries, religious and civil society organizations, to enhance accountability and identify internal and external champions. The monitoring and accountability framework for the co-financing arrangement involved a detailed system for tracking and evaluating the co-financing process and results. It included monthly reviews of government expenditures against predetermined benchmarks and a web-based dashboard with algorithms to estimate co-financing ratios and project funding for future years.[37]

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[31] Massuda A, Malik AM, Lotta G, Siqueira M, Tasca R, Rocha R Brazil's Primary Health Care Financing: Case Study. Lancet Global Health Commission on Financing Primary Health Care. Working Paper No. 1. 2022

[32] Rao MG, Choudhury M. Health Care Financing Reform in India's Decentralized Health Care System. https://www.elibrary.imf.org/downloadpdf/book/9781616352448/ch015.xml

[33] Ibid.

[34] Meet the Challenge 2020 Report, The TCI Initiative- Nigeria, https://tciurbanhealth.org/wp-content/uploads/2020/12/MeettheChallenge12-3.pdf

[35] The Challenge Initiative. TCI Nigeria Co-financing Strategy: Accelerating Sustainable Scale of Family Planning through Innovative Financing. Abuja, Nigeria: Johns Hopkins Center for Communication Programs; 2020.

[36] Igharo V, Ananaba U, Omotoso O, Davis T, Kioko M, Finkle C. Innovations in Public Financing for Family Planning at Subnational Levels: Sustainable Cofinancing Strategies for Family Planning With Nigerian States. Glob Health Sci Pract. 2024. doi: 10.9745/GHSP-D-22-00242. https://www.ghspjournal.org/content/early/2024/04/12/GHSP-D-22-00242

[37] Meet the Challenge 2020 Report, The TCI Initiative- Nigeria, https://tciurbanhealth.org/wp-content/uploads/2020/12/MeettheChallenge12-3.pdf

ANALYTICAL FRAMEWORK FOR ASSESSING CO-FINANCING AGREEMENTS

From the global review, the following five pillars for successful implementation of co-financing arrangements emerged. These pillars are used to analyze the Ethiopia experience with co-financing and to inform recommended future action for the country:

1	**Strong political commitment and sustained stakeholder engagement.** Strong political leadership and commitment from the national and subnational authorities are critical in achieving a sustained contribution to the co-financing agreements; key leaders should be engaged at all levels from the start. In addition, stakeholders from diverse sectors, such as the public sector, private sector, and civil society, should be engaged in devising and executing public investment plans, and leaders should seek a balance when incorporating stakeholders' views. [38]
2	**Clearly defined roles and responsibilities.** To ensure that the funds are used effectively and efficiently, co-financing arrangements should clearly establish outcomes and goals for public investment and outline the mechanisms to achieve them. [39] This includes clearly defining the roles and responsibilities for both national and subnational levels, including financing expectations and conditions for termination, within the co-financing agreement. Ideally, these roles and responsibilities for both national and subnational levels are captured in a declaration, memorandum of understanding, or roadmap.
3	**Established frameworks for monitoring and accountability.** A monitoring and accountability framework to track co-financing commitments and enforce incentives or penalties based on performance is essential for accountability. [40] This framework should include regular monitoring and evaluation of the co-financing projects to track progress, ensure compliance with agreed-upon terms, and assess the impact of the investments. Monitoring and evaluation mechanisms with clear indicators help improve the effectiveness of public investments. Linking objectives and outcomes provides valuable information for future investment decisions. However, it requires capacity-strengthening efforts and additional costs that must be weighed against the need for effectiveness. [41]

[38] OECD (2019), Effective multi-level public investment, OECD principles in action, https://www.oecd.org/effective-public-investment-toolkit/Full_report_Effective_Public_Investment.pdf
[39] Ibid.
[40] Ibid.
[41] OECD (2018), Rethinking Regional Development Policy-making, OECD Multi-level Governance Studies, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264293014-en

4	**Ability to track commitments through the financial management systems.** Sound and transparent financial management at all levels of government are needed to ensure proper use of funds and accountability. The ability to mobilize resources within the planning and budgeting cycle as well as track expenditures through public financial management systems is a critical enabler for implementing successful co-financing arrangements. [42]
5	**Opportunities for Capacity Strengthening.** The expertise of public officials and institutions involved in public investment should be strengthened to ensure that they have the necessary skills and knowledge to manage and oversee co-financing arrangements. [43] Co-financing arrangements that include elements of capacity strengthening for public servants on institutional arrangements, technical capabilities, economic resources, and policy practices that influence public investment, as well as support to strengthen underlying systems for public financial management transparency and accountability, can result in more effective public sector investments.

[42] OECD (2019), Effective multi-level public investment, OECD principles in action, https://www.oecd.org/effective-public-investment-toolkit/Full_report_Effective_Public_Investment.pdf
[43] Ibid.

ETHIOPIA'S EXPERIENCE WITH CO-FINANCING IN THE HEALTH SECTOR

Summaries of the four co-financing arrangements reviewed in Ethiopia—the Seqota Declaration, the Malaria IRS Initiative, the Health Infrastructure Project, and the Family Planning Compact agreement—are presented below. Two of these arrangements (with the exception of the Seqota Declaration—Nutrition Program and Family Planning Compact agreement) were initiated by the MOH-E and negotiated between the national and regional governments during Joint Steering Committee (JSC) meetings (see Box 3) or through high-level leadership engagement with regional bureau heads.

Box 3. MOH-RHBs Joint Steering Committee

This forum brings together the MOH-E, MOH-E agencies, and the RHBs. The meetings are chaired by the Minister of Health, and participants include State Ministers of Health, RHB Heads, heads of departments/services of the Ministry, director generals, monitoring and evaluation (M&E) heads of MOH-E agencies and plans, and M&E heads of RHBs. The committee meets at least every two months to facilitate smooth, effective implementation of Health Sector Transformation Plan (HSTP) priority activities. JSC meetings focus on the implementation and progress of the plan and the challenges faced during the course of its implementation. The committee is also responsible for: updating the plan; introducing new initiatives, policy guidelines, and programs; and creating systems and mechanisms for communication and information/experience sharing.

Source: Ethiopia Health Sector Transformation Plan 2

Regions receive financial transfers from the Ministry of Finance (MOF) through block grants, and there is no mechanism to earmark or allocate funds within these block grants for a specific purpose, such as a health initiative or program[44]. To establish co-financing arrangements, the MOH-E must therefore utilize its own sector resources or, as in all of the cases outlined below, the development partner funds it manages and distributes directly to regions and woredas. The SDG Fund (see Box 4) is often the source of funding for the MOH-E to draw upon to establish co-financing arrangements in the sector.

Seqota Declaration—Nutrition Program

In July 2015, the GOE announced its commitment to nutrition by issuing the Seqota Declaration to eliminate child undernutrition and end stunting in children under two years of age by 2030. The Seqota Declaration is based on the 2013 "Cost of Hunger" study, revealing child undernutrition in Ethiopia costs 16.5% of GDP annually.[45] This highlighted that eliminating stunting is crucial to the country's growth and transformation agenda.

[44] Although, when distributing these block grant funds to woredas, the regions have the authority to prioritize specific interventions and programs.

[45] Big Win Philanthropy. Supporting the Government of Ethiopia to end child undernutrition: Seqota Declaration. https://www.bigwin.org/case-study/supporting-the-government-of-ethiopia-to-end-child-undernutrition-seqota-declaration/

Box 4. Overview of the SDG Fund

The SDG Fund is a financial mechanism established by the GOE to assist in implementing the Sustainable Development Goals. It is supported by a wide range of donors, including UK Aid, the World Bank, Gavi Vaccine Alliance, the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the Korean International Cooperation Agency (KOICA), Irish Aid, BMGF, Government of Italy, Government of Spain, the Royal Kingdom of the Netherlands, and European Union. The SDG Fund is managed by a Steering Committee that includes two co-chairs: the MOH-E as the Government representative and a rotating donor representative. The Fund is administered by the UNICEF Country Office. In 2022/23, the fund raised and used ~$88 million USD, while $92.5 million USD was pledged from bilateral and multilateral contributors in 2023/24. The SDG Fund is a type of non-earmarked money (Channel 2a) that is managed through the Sage 50 Peachtree accounting system and used for interventions and activities that have significant funding gaps based on priorities and predetermined criteria. As a result, the allocation will be made first for each executive office at the MOH-E, and then, after donor approval, it will be shared/allocated to regional health bureau (RHB) directorates via their respective executive offices at the MOH-E. However, 75% of the budgeted funds are only authorized for purchasing items and equipment.

The Seqota Declaration Implementation Plan is a 15-year program that aims to implement high-impact nutrition-specific and nutrition-sensitive interventions. The program is being implemented in three phases. The first phase, the innovation phase, was piloted in 40 woredas along the Tekeze River basin from 2016 to 2020. The expansion phase is currently underway and is expected to reach 700 more woredas by 2025.

The Seqota Declaration is a high-level government commitment, and the guiding documents are the declaration roadmap and investment framework. The investment framework has a cost breakdown for each year of implementation attached to specific interventions. The launch of the initiative in July 2015 was led by Deputy Prime Minister Demeke Mekonnen and included the federal ministers of health, water, agriculture, finance, education, and social affairs, the regional presidents of Amhara and Tigray, and their respective teams. However, the Food and Nutrition Policy came into effect only in 2018, after the Seqota Declaration innovation phase was initiated. Currently, an inter-ministerial committee has been established, composed of representatives from 14 ministries, and a proclamation is underway to establish a council that will manage this committee, which will be overseen by the Prime Minister. National and regional Program Delivery Units also were established to coordinate Seqota Declaration performance, and include experts in WASH, public health, agriculture, communication, and M&E. Regional Program Delivery Units have a senior advisor to the Regional President, ensuring nutrition remains a priority.

The financing mechanism for the declaration is a fund with matching contributions from the national and subnational governments. The first step is for the subnational level to propose their contribution to the national government. The woreda uses the woreda-based planning process, which includes the incorporation of costed activities from the different sector offices, to allocate and communicate its contribution. The Costed Woreda-based Investment Plans get aggregated and submitted—first to the woreda cabinet for approval, then to the regional finance bureau for approval and signature by the

regional bureau president—and then the regional plan is sent to the MOH-E (Nutrition Program). The budget includes the amount that the woreda will contribute. The MOH-E/Nutrition Program confirms that the budget allocated is aligned with the interventions and objectives in the implementation plan. These comprehensive, costed nutrition plans promote increased awareness and ownership at the woreda level of the contribution to nutrition by various government sectors and development partners.

The MOH-E then obligates the 1:1 matching fund amount to the specific woreda, which is transferred through the government channels to the woredas. The national level contribution for the Seqota Declaration is allocated from the MOF to the MOH-E separate from the funds that the Nutrition Program receives during the annual budget allocation. The woreda finance bureau then allocates the national matching funds to the sector offices as per the approved costed woreda-based plan. The initial arrangement was a 1:1 matching, i.e., for every 1 Ethiopian Birr allocated by the Woreda, the MOF and MOH-E will match that amount. However, the allocation from the MOF and MOH-E has remained stagnant every year despite the increasing allocations from the woredas.

Initially funds were tracked using the Integrated Financial Management Information System (IFMIS) at the national level and through annual reports at the subnational level. Data challenges uncovered during 2023 led to the development of the Resource Tracking and Partnership Management Tool (RTPM),[46] a stakeholder mapping tool designed for the Seqota Declaration to track partners, their performance, and financing across sectors. The RTPM, along with the Unified Nutrition Information System (UNISE) to capture nutrition-specific and nutrition-sensitive indicators, have now been piloted.

Malaria Insecticide Residual Spray (IRS) Initiative

In January 2019, a co-financing arrangement was agreed to by the Global Fund, MOH-E, and RHBs in eight malaria-endemic regions (all regions other than Harari) to increase domestic financing for the malaria IRS Initiative.

The Malaria IRS co-financing arrangement was developed following JSC consultations (see Box 4) and was endorsed through a guideline (Internal Directive No. 1/2012 E.C approved by the MOH-E). This ratified guideline governs and guides the mobilization, allocation, and general administration of IRS resources. It also specifies the roles and obligations of RHB and MOH-E in managing the co-financing arrangement.

There are two co-financing allocation percentages: for the IRS chemical purchases, a 5% regional and 95% national split is the agreed-upon arrangement, while operations expenditures are split 50% regional and 50% national. The regional contributions are allocated from the RHB budget. The MOH-E utilizes the Global Fund and SDG Fund (see Box 4) resources to finance the remaining 95% of the cost of procuring chemicals and 50% for operational expenses.

[46] The RTPM includes, for woreda project implementation, the following categories of information: sector initiative; the woreda's nutrition category; target group, stockholders, and partners information; the woreda's project implementer and resources; meeting minutes; meeting and action points; the strategic objective; a key performance indicator target entry; a measurement matrix for a specific stockholder; and a report. It also includes multiple ways of viewing reports and exporting data to MS Excel for further analysis.

To support the financial administration of the operational expenses, the MOH-E transfers Global Fund and SDG Fund resources to the RHBs' accounts. RHBs then provide a receipt voucher to the MOH-E to certify receipt of money, and the transaction is documented in the Integrated Budget and Expenditure System (IBEX) and Peachtree (an accounting system used to manage development partner resources through Channel 2b[47]). The 5% regional share for IRS chemical purchases is transferred to the MOH-E's Yellow Fever account. The MOH-E then provides a receipt voucher to RHBs to validate the receipt of money, and the transaction is recorded in IFMIS and Peachtree. The RHBs and MOH-E shares are then transferred from the Yellow Fever account to the Ethiopian Pharmaceutical Supply Service (EPSS) special bank account for the procurement of IRS chemicals. Based on each RHB's demand and request, the EPSS procures the chemicals and distributes them to each region through its regional hubs. The MOH-E receives a statement of expenditure from both parties (RHB and EPSS), which it then compiles into a report using the Peachtree accounting system and IFMIS.

Each year, seven regions—Oromia, Amhara, SNNPR, Afar, Somalia, Benishangul-Gumuz, and Gambela—dedicate funds for IRS chemical procurement (the exception being Tigray, which is due to the internal conflict). These regions allocate close to ETB 45.5 million per year in total. In addition, following an Ethiopian parliament vote, around 340 woredas contributed approximately ETB 68 million ($1.3 million USD[48]) yearly for IRS operations, with each woreda allocating approximately ETB 200,000 ($3,846 USD) per year. The fixed amount was determined by the Parliament, irrespective of the number of households sprayed; however, any unspent funds would be returned to each woreda at the end of the year. As a result, a total of ETB 113.5 million ($2.2 million USD) was raised in 2014 EFY (2021/22). However, this amount was less than the expected amount of resources to be mobilized (ETB 156.5 million/$3 million USD) since some regions and some woredas in these regions have not allocated the funds to the program as promised. Directive No. 1/2012 does not specify the consequences of subnational authorities failing to meet the 5% threshold. However, based on the interviews with key informants, the 5% RHB share is expected to be transferred by the end of the first quarter of each year. If RHBs fail to transfer their share, the MOH-E will take responsibility for paying for the chemicals, but only if sufficient funds are available. Otherwise, the procurement will be canceled, and the MOH-E will not subsidize the region for chemical purchases. This situation has not occurred to date.

Health Infrastructure Project

The MOH-E allocates a substantial budget for the Health Infrastructure Executive Office each year, but this amount is insufficient to build, renew, and improve health facilities as needed. To augment the national government budget, a co-financing arrangement was proposed at the JSC meetings (see Box 4), and an agreement was reached between the MOH-E and RHBs. The MOH-E and RHBs agreed to contribute to this arrangement which will be used to build and maintain primary health care units in each region's woredas and kebeles. The parties in the arrangement were in charge of monitoring the funds, executing them according to agreed-upon deadlines and specifications, generating reports, reviewing performances regularly, and ordering audits when funds are suspected of misuse. According to the JSC

[47] Funds directly deposited into the MOH-E account by the development partners and managed by the MOH-E are referred to as channel two funds. Channel 2b funds are those that are earmarked for a specific health program/initiative.
[48] The 2015 and 2016 EFY exchange rates from the Commercial Bank of Ethiopia were used.

agreement, the MOH-E and RHBs agreed to a 50/50 split. The RHBs contribute 50% of the funds from their treasury budgets with the remaining 50% coming from the MOH-E's SDG Fund (see Box 4).

The MOH-E allocates budget for building or maintenance of primary health care units (PHCUs), based on the plans submitted by each woreda to the RHB and MOH-E, and transfers its 50% share to the RHB bank account created for this purpose. The RHB records the funds, including its 50% share, in IBEX and Peachtree, and uses the funds following government accounting regulations. Furthermore, RHBs deliver both the deposit receipt voucher and the statement of expenditure report to MOH-E to confirm receipt of the funds and their use for the agreed purpose. The MOH-E then summarizes the overall performance in a program report, which is subsequently shared with the MOF and donor partners contributing to the SDG Fund.

The co-financing of health infrastructure has been successful in many regions, and has supported building new health facilities, upgrading existing ones to comprehensive health centers, and ensuring safe water supply availability. However, there are challenges with timely disbursement and liquidation of funds. The MOH-E contribution is negatively affected by delayed SDG Fund disbursement from partners, the recent decline of the SDG Fund, and the increasing inflation rate within the country. RHBs face challenges with timely liquidation of money from the SDG Fund due to capacity gaps at the subnational level.

The Family Planning Compact Agreement

The Ethiopia Family Planning Compact Agreement was initiated through a series of meetings involving partners and the MOF, including negotiations at the legislative level chaired by the MOH-E. This three-year agreement, signed in June 2015 EFY (June 2023), aims to provide high-quality voluntary reproductive health services, with a particular focus on family planning (FP) commodity procurement. The compact agreement aims to secure the funding needed to procure sufficient FP commodities to meet current and near-future demand, reduce stockouts, and support Ethiopia's HSTP II FP objectives.

During the 2015 EFY (2022/23), the total demand for FP commodities in Ethiopia was valued at $41.1 million USD. However, only $17.4 million USD was available, leading to a financial gap of $23.7 million USD. The $17.4 million USD was sourced from various channels, including the Ethiopian government's treasury ($2.0 million USD), the SDG Fund ($8.7 million USD), UNFPA ($4.7 million USD), and BMGF ($2 million USD).

To bridge the funding gap, a memorandum of understanding (MOU) was developed and signed to ensure a continuous and regular supply of various FP commodities over the next three fiscal years, starting with 2016 EFY (2023/24). The government and donors will co-finance FP commodities, with the amount provided by the GOE dependent upon the resources available from donors who have agreed to sign the MOU. This includes USAID, BMGF, The Susan Thompson Buffett Foundation (STBF), and the David and Lucile Packard Foundation. The government's contributions will increase year-on-year, while donor contributions will decrease over the three years. The funds will supplement government finances and provide free access to FP commodities through the Exempted Health Services package.

Each year, the MOH-E will request the release of an agreed-upon co-financing amount from the MOF, and the MOF will allocate the agreed-upon funding to the MOH-E via Channel 1[49] within one month following donor contributions. The MOH-E has committed to spend 100 percent of the funds on the purchase, transportation, and technical support related to FP commodities. The MOH-E records transactions using IFMIS and reports quarterly on the procurement, storage, distribution, consumption, and utilization of these commodities during FP Technical Working Group meeting.

SUMMARY OF FINDINGS BY KEY THEMATIC AREAS

Key thematic areas are discussed below by analyzing findings from Ethiopia's co-financing experience, using global lessons and best practices through document reviews and stakeholder interviews.

- Strong political commitment and sustained stakeholder engagement;
- Clearly defined roles and responsibilities;
- Established frameworks for monitoring and accountability;
- Ability to track commitments through the financial management systems; and
- Opportunities for capacity strengthening.

Strong political commitment and sustained stakeholder engagement

All four co-financing efforts in Ethiopia required strong political leadership and commitment from national and regional authorities. The Health Infrastructure Project and the Malaria IRS Initiative were established by leveraging the JSC: an existing stakeholder engagement platform that brings together the national and subnational entities. For the Seqota Declaration initiative, the Deputy Prime Minister initially signed the roadmap and has remained the Seqota Declaration initiative's patron. To sustain stakeholder engagement, the Seqota Declaration initiative established National and Regional Program Delivery Units to continue to engage political leadership and built upon the woreda-based planning process to further strengthen the continuous involvement of stakeholders at all levels. The FP Compact Agreement was established through high level engagement with the GOE and its development partners.

Clearly defined roles and financial responsibilities

In Ethiopia, four different approaches were used to document the roles and financial responsibilities among those engaged in co-financing agreements in the health sector: a declaration or roadmap, an MOU, a directive, or an allocation letter (see Table 1 below for details on these documents).

All these documents are guiding documents for the parties engaged in co-financing mechanisms, with some having higher enforcing power than others. Declarations are high level political commitments that can be translated into roadmaps and implementation plans. They are the most effective in bringing together stakeholders and resources due to their high level of engagement and establishment. The MOUs reviewed during this assessment were signed between the national government (MOH-E, MOF)

[49] Resources from the treasury and external aid, including earmarked and unearmarked funds, that flow through the MOF to the MOH-E and to regions directly are referred to as channel one funds.

and international development partners. These documents clearly outline the roles and responsibilities of each party, the financing expectation, and conditions for termination. MOUs are more readily available and can be established between any parties who have reached a consensus on the approach to a shared goal. Directives and allocation letters are used by participating government entities – usually between the national and subnational levels—to communicate commitments, requests or allocations based on the agreed-upon contribution amounts.

The Seqota Declaration initiative uses a declaration and roadmaps, the Malaria IRS initiative uses a directive and an allocation letter, the Health Infrastructure project uses an allocation letter, and the FP Compact Agreement uses an MOU. The roles and responsibilities of the participating entities are more clearly outlined in the MOU than in any of the other documents. However, financial responsibilities are clearly outlined in all the documents reviewed (see Annex 4 for a list of which documents were sourced for each co-financing arrangement). Two of the co-financing agreements (the Seqota Declaration and the Health Infrastructure project) also required costed implementation plans to increase awareness of the contribution made by various government sectors and development partners toward the shared goal.

Table 1: Description of allocation request letters, declarations/roadmap, and MOUs

	Declaration/ Roadmap	**MOU**	**Directive**	**Allocation Letter**
Description	Declarations are high-level commitments made to address global or national challenges. They are more forceful than the other approaches in that they carry a certain level of commitment and authority within government. Roadmaps are translations of declarations that outline the strategic goals, objectives, and activities to be undertaken in the arrangement.	MOUs are signed between a national and/or regional government and/or development partners. These documents outline each party's roles and responsibilities. They can be negotiated and adjusted by multiple parties before finalizing an agreement and can be revised as per established consensus.	A formal document that communicates the roles and responsibilities of national and regional entities in implementing an agreed-upon initiative within the bounds of the guiding proclamation.	A formal document used by the national government to request subnational governments to allocate resources to specific projects or initiatives as per an agreement that has been established either through a JSC meeting or written format.

Content	The following are specified in a roadmap document: • Strategic objectives and goals • Key activities and timelines • Resource allocation plan • Roles and responsibilities • Monitoring and evaluation framework	The content typically includes • Rationale and objective • Roles and responsibilities • Duration of the agreement and financial contributions • Process and metrics for monitoring • Dispute resolution mechanisms • Termination conditions	The national government frequently uses it to designate roles and responsibilities, specify commitment and allocation of resources, and provide guidance surrounding the utilization of funds as per the proclamation agreed upon.	It specifies the allocation of resources to a particular project or initiative, including the amount, type, and duration of the allocation. This document type communicates a request for a share of the expected allocation from the subnational government, instructions on depositing funds, and the timeline. The instructions include resource usage, restrictions, reporting requirements, accountability measures, and allocation duration.
Use	Declarations convey a firm stance, opinion, or commitment on a particular issue. Roadmaps are used to chart the step-by-step implementation of declarations.	Primarily provides a framework for cooperation, resource sharing, and implementation of the agreed-upon activities.	Primarily used for communication between national and subnational governments to communicate clear resource allocation and utilization expectations.	Primarily used for communication between national and subnational governments to communicate clear resource allocation and utilization expectations.

Legally binding	Declarations are high-level commitments and can serve as the basis on which to build legally binding agreements or implementation plans for entities to assume roles and responsibilities.	It is legally non-binding, but parties may choose to make it legally binding by including a provision in the agreement.	The directive is based on a proclamation making the directive a legally binding document.	It establishes a legal obligation for the national and subnational entities to utilize allocated funds for the agreed-upon activities only according to the agreed-upon terms.
Signatory authority	Signed by representatives of sector ministers and regional bureaus, usually Ministers of Health and/or Finance and regional bureau heads.	Signed by representatives or authorized individuals from each party involved in the agreement.	Signed by the authority responsible for managing the allocation and overseeing the co-financing mechanism.	Signed by the authority responsible for making the allocations and the authority responsible for executing the activities.

Established framework for monitoring and accountability

All four of the Ethiopian co-financing agreements reviewed have frameworks to monitor performance. Monitoring includes tracking what is spent against the commitments made (and the ability to easily track those is discussed in more detail below) and compiling reports to communicate and review performance against those commitments. However, none of the co-financing agreements assessed have an accountability framework that holds contributors accountable to deliver on their commitments. These agreements do not have an incentive mechanism to motivate high-performing regions and woredas to maintain their performance and low-performing regions and woredas to start meeting their commitments. There were also no consequences or penalties for either the national and regional/woreda-level governments for failing to meet their co-financing commitments.

Most of the co-financing arrangements reviewed are not yet fully funded. In the Ethiopian co-financing initiatives examined, there was a failure to meet co-financing levels from either the national level (under the Seqota Declaration Initiative) or the subnational level (under the Malaria IRS and the Health Infrastructure Initiatives). In the Seqota Declaration example, the subnational level has continued to increase its investments even as the national level (matching) commitment has flatlined. The Malaria IRS Initiative reported that there is inconsistency among regions when allocating their share of the arrangement, and the Somali region was the only region among the eight that has consistently met the agreed-upon contribution amount so far. In this case, the MOH-E has supplemented those woredas that

have failed to meet their commitments. Gambella and Benishangul-Gumuz regions, in particular, were also unable to continue contributing their portion owing to restricted budget capacity and urged that the MOH-E reconsider their share in light of their current financial condition. As a result, the MOH-E examined these two regions' contributions to IRS chemical procurement and reduced the required contribution by more than three-fourths in the 2014 EFY (2021/23). Similarly, for the Health Infrastructure Initiative, most of the regions have committed to funding the program, but some have reported failure to meet the target set due to financial constraints, other high-priority initiatives, and lack of the leadership's ownership and commitment. Despite the failure of these regions to meet their commitments, there have not been any penalties or consequences from the national government. The agreements between the national and regional governments do not dictate these accountability measures.

Ability to track commitments through the financial management systems

All the mechanisms reviewed and the discussions with key informants highlighted the need to strengthen resource tracking and data management systems that are specific to or can accommodate the co-financing mechanisms. The Seqota Declaration is the only co-financing mechanism from those reviewed that has its own resource tracking system (the Resource Tracking and Partnership Management Tool). The RTPM is a web-based tool that runs through an application[50] that provides users at the woreda, regional, and national levels with access to budget and expenditure data at each level of government disaggregated by funding source and Seqota Declaration objectives. The RTPM tool took time to fully implement owing to insufficient budgets, a lack of adequately qualified personnel, and a high turnover of trained personnel.

The Malaria IRS and Health Infrastructure Initiatives utilized existing financial management systems: IFMIS, IBEX, and Peachtree. Funds from the treasury are tracked and reported through the IFMIS system, which is currently only available at the national level. Funds from the regional, zonal, and woreda levels are tracked using the IBEX, which does not accommodate program-based budgeting and spending categories and rather provides budget and expenditure reports by expenditure items such as salary, allowances, infrastructure, and pharmaceuticals. Hence, subnational governments use an inefficient and time-consuming Excel-based manual approach to track program-specific expenditures from source documents. Peachtree, on the other hand, is an accounting and financial software that is especially designed to streamline financial operations but is limited to the management of donor funds. The use of existing financial systems allows for ease of implementation and streamlines budgeting and expenditure tracking efforts; however, the existing systems do not capture the required level of detail needed to thoroughly track, report and monitor co-financing arrangements. While a new tool designed for a co-financing arrangement (similar to what was done for the Seqota Declaration) can alleviate these challenges, the effort required to set up and institutionalize such tools can be resource intensive and may be faced with pushback as it goes against the country's effort to streamline data collection and reporting for health.

[50] https://seqota.ephi.gov.et

Opportunities for capacity strengthening

The Seqota Declaration Initiative's approach showed the importance of a phased approach. In the innovation phase, the woredas were struggling to meet the commitment percentage for the first three years, but with continued guidance and support from the national and regional governments, the woreda contributions surpassed the national contributions during the final two years of the innovation phase. Hence, there is a need for a gradual increase in the subnational level's share of co-financing. In addition, all the mechanisms we assessed highlighted the importance of continued capacity strengthening support in the form of training and supportive supervision. Training and support were provided by the national government in the Malaria IRS and Health Infrastructure Initiatives on the use of government systems to track contribution and expenditures. Routine and integrated supportive supervision are carried out frequently to provide real-time support and enable problem solving. The Seqota Declaration initiative has provided several capacity-strengthening courses (on the use of the RTPM) to the implementing regions and woredas. Capacity-strengthening exercises help subnational entities to understand their financial duties and more effectively track their contributions and expenditures.

RECOMMENDATIONS

Outlined below are two sets of recommendations: implementation- and policy-level recommendations.

Implementation-level recommendations (#1-5) are intended for those parties seeking to establish a co-financing agreement within the health sector and are feasible within the current policy and regulatory environment in Ethiopia. These recommendations highlight the key thematic areas that have been identified as preconditions for successful co-financing arrangements:

- Strong political commitment and sustained stakeholder engagement
- Clearly defined roles and responsibilities
- Established framework for monitoring and accountability
- Ability to track commitments through the financial management systems
- Opportunities for capacity strengthening

The implementation-level recommendations reinforce the successes Ethiopia has already achieved through co-financing arrangements (i.e., to clearly define roles and responsibilities of involved parties) and highlight opportunities for stronger alignment with global best practices (i.e., to introduce enforcement mechanisms as part of frameworks for monitoring and accountability) to fully realize the benefits of co-financing arrangements. These recommendations are geared toward the current co-financing environment that tends to rely on external support either through the Global Fund grant or SDG Fund to unlock domestic financing, such as the forthcoming pilot in TB,[51] but include some practices that would also be relevant to continuation of such efforts using only domestic financing.

Policy-level recommendations (#6-8) are intended for policy makers and are focused on the enabling environment needed in order to establish a large-scale co-financing scheme or policy that is supported primarily through domestic financing. Specifically, these recommendations are meant to inform ongoing intra-governmental negotiations to finance the revised Exempted Health Services list. This reform calls for coordinated financing from the central level (through PBB) and the regional level (through locally generated revenue and the treasury block grant) to support the set of interventions that should be provided to patients free of charge at the point of care.

Implementation-Level Recommendations:

Recommendation 1. Identify the most impactful agreement documentation

When establishing a co-financing arrangement, the involved parties should pursue an agreement document that maximizes the political commitment within GOE structures. A Declaration is the strongest form of political commitment. The MOH-E should engage the MOF to develop a Declaration,

[51] The MOH-E, in collaboration with the NTP and SAEO, are introducing a co-financing pilot focused on increasing regional financing for the TB program. The pilot will provide financial incentives (through increased allocation of funds from the Global Fund and/or the SDG Fund) to the Oromia Regional Health Bureau and Sidama Health Bureau for increasing their investment in TB interventions at the regional and woreda levels, respectively. This will be an opportunity to test, refine and learn from the use of a co-financing enforcement mechanism that deploys incentives within the Ethiopian context.

demonstrating the highest level of government commitment to co-financing a policy. Once a Declaration has been made, the development of a roadmap should be chaired by the SAEO with support from the Finance Executive Office in the MOH-E, and in consultation with regional health and finance bureaus, zonal administrators, and city administrators, among others. If a Declaration and roadmap are not possible, a directive should be developed between national and subnational government levels within the health sector. This document can also define the co-financing commitments by both levels of government, though it will not carry the same level of political commitment as a Declaration and roadmap. If development partner resources are involved, then MOH-E, MOF, and/or RHBs should use an MOU to define the terms of the co-financing agreement. Once a Declaration/roadmap, directive, or MOU have been signed, the MOH-E should then engage regions using an allocation letter to cascade and facilitate implementation.

Recommendation 2. Implement the monitoring and accountability framework outlined in the agreement documents

The co-financing agreement documents – whether Declaration/roadmap, directive, MOU or allocation letter – should have an accountability framework with clearly defined roles and responsibilities. They should formalize the terms and conditions of collaboration and lay out clear expectations of each party's involvement and commitment to the achievement of the overarching policy objective (see Recommendation 2a). In addition, they should outline the plan for routine reporting of co-financing commitments and performance evaluation (including what information will be reported and through what platforms and processes for dispute resolution -- see recommendations 2b and 2c) and plans for both capacity strengthening and risk mitigation (see recommendation 2d). In addition, the agreement documents should outline how CSOs, professional associations, community representatives, and advocacy groups can participate in the monitoring and evaluation process.

Recommendation 2a. Develop costed implementation plans to clearly define roles and responsibilities

The development and use of costed implementation plans at the national and subnational levels will strengthen the sense of accountability, as they will increase awareness of the commitments and contributions made by various government sectors and development partners toward the shared goal. Ideally, these plans would draw from existing government planning and budgeting processes and can be compiled by focal persons within national programs, RHBs and technical working groups that have stewardship for advancing the objectives of the co-financing arrangement. The expected financial commitments at the national and subnational levels should be estimated, and stakeholders including those from MoF should reach a documented conclusion that these estimated amounts are realistic and achievable within the available fiscal space. If possible, such documentation should explain any steps to expand the overall funding envelope and thus ensure that the co-financing commitment is not an "unfunded mandate". I.e., the co-financing agreement should not put large additional financing requirements on a system that has the same overall funding envelope.

Recommendation 2b. To overcome system limitations, develop and implement tools to monitor resource mobilization and expenditure

Due to the limitations with the current public financial management systems, the MOH-E and regions should support the use of additional tracking tools and approaches that support the monitoring of costed implementation plans for a particular co-financing arrangement, where needed. For example, the MOH-E, NTP and two regions have agreed to pilot a TB resource tracker that will allow Ethiopia to better track regional contributions to TB co-financing commitments.

Recommendation 2c. Leverage existing governance platforms to monitor accountability frameworks

Once accountability frameworks have been established, they will need to be regularly monitored. Where possible, existing governance forums, mechanisms, and systems should be utilized to monitor co-financing commitments, which should be captured in the "one plan, one budget, one report" national approach. For example, progress against a declaration, directive, MOU, or allocation letter can be monitored as part of the routine MOH-RHB JSC meetings. JSC meetings are a forum to monitor and discuss the challenges faced during the course of the co-financing implementation and can also be used as a forum for managing dispute resolution. In addition, annual and biannual health sector and program-specific review meetings should be used to monitor overall progress toward agreed-upon targets and co-financing objectives. The health sector and program-specific review meetings also create opportunities to inform CSOs, professional associations, community representatives, advocacy groups and development partners of the co-financing perform and strengthen their awareness of the accountability framework.

Recommendation 2d. Identify capacity needs and design responsive capacity-strengthening support related to accountability measures

Any successful co-financing arrangement should include a commitment to capacity-strengthening support, particularly for regional bureaus, related to skills needed for strong tracking and accountability. This might include a capacity assessment and a needs-based capacity strengthening and risk mitigation plan that deploys both training and mentorship in advocacy and financial management to plan, mobilize, track, and report co-financing commitments.

Recommendation 3. Ensure that the accountability framework includes effective enforcement mechanisms

The federal government can hold regions accountable for spending *earmarked* federal funds as intended, but it cannot force a region to uphold a co-financing commitment derived from the region's locally generated revenue or its use of the treasury block grant. In Ethiopia, there is neither a precedent nor a mechanism to require regions to return federal resources if regions do not meet their co-financing agreements. The mechanism to hold subnational entities accountable to their co-financing commitments must be designed to reflect these constraints.

Therefore, the one tool available for use at the federal level – in order to ensure accountability at the subnational level – is the withholding of current or future federal earmarked funds. Under one option, national commitments could be disbursed only following allocation of regional commitments; this would create an opportunity to withhold the national allocation if the regional allocation is not forthcoming. Alternatively, the national commitment in subsequent years could reflect the past performance of the subnational level. The latter may be a better option as it allows RHBs to plan for the reduced national contribution in subsequent years in order to avoid service interruptions. To ensure accountability and reduce risks, such enforcement measures should be identified and documented in the co-financing agreement document(s).

Recommendation 4. Consider the use of regional co-financing incentives

The federal government should consider the use of incentives as part of the co-financing agreement with a regional bureau. When the RHB advocates and secures the committed amount from the finance bureau for the co-financing arrangement, the national level could provide incentives in the form of increased financial resources using either treasury or development partner funds (such as those from the SDG Fund or the Global Fund Grant). A small percentage (5 – 10%) of the national fund could be linked to performance and made available or unlocked when regions meet their commitments. This increased allocation for the following year's budget can be made available in conjunction with capacity-strengthening opportunities so that the additional management burden of administering any increased funding does not act as a disincentive.

Recommendation 5. Regional enforcement penalties and co-financing incentives should account for socioeconomic disparities

One concern with the use of both penalties (recommendation 3) and incentives (recommendation 4) is that they can disadvantage regions with lower socio-economic status. These regions tend to have a lower economic base for generating local resources and may have higher competing demands on public sector budgets to meet the needs of a more vulnerable population base. In this case, the co-financing requirements and commitments should take these disparities into consideration. In lower socio-economic regions, especially those that are of high programmatic interest, the co-financing penalties and incentives may want to focus more on conditionalities of how the funds received from the federal level are spent by regions rather than requiring all regions to mobilize additional resources. In other words, lower socio-economic regions that spend the federal funds they received well will continue to get additional funding, even if they cannot mobilize their own resources.

Policy Level Recommendations:

Recommendation 6. Pursue nationally financed program-based budgeting to enable large scale co-financing arrangements

Within current domestic funding arrangements, the federal government in Ethiopia cannot allocate domestic funding to the subnational level using a health earmark. The mechanics outlined above – in which the national-level earmark drives accountability – therefore apply to donor-funded pools such as the SDG Fund (which are managed and disbursed by the federal government). However, earmarking the MOH budget at the central level is possible, and NTP has advocated successfully for a TB line item in the MOH budget in order to mobilize domestic resources for TB centrally. When these funds were approved and allocated, the NTP had the latitude to spend those resources centrally or to send them down to subnational levels, so long as the funds were spent toward the agreed-upon items listed in the budget.

Co-financing related to central funds is more feasible administratively when there are larger pools of central funds that can be distributed across the large number of regions and woredas. Therefore, commodity procurement, with its larger amounts of money, may be a more logical starting point than TB public health activities (where the current amounts are much smaller[52]). A possible PBB solution would be to 'earmark' central funds to support the Exempted Health Services with the explicit goal that these funds would support regions to meet a specific health goal. The PBB funds could go to EPSS to procure commodities on regions' behalf, with regions potentially making a co-financing contribution to EPSS, e.g., with funds flowing directly from their block grant from treasury. Such arrangements should still embrace the PBB principles of greater flexibility and autonomy for managers.

In the longer-term, it will be critical for the GOE to establish a robust national-to-subnational channel for earmarked health funding. To this end, the MOH-E and MOF are negotiating the allocation of national resources for the health sector through PBB that will earmark funding for the Exempted Health Services policy. The MOH-E and MOF should continue to pursue this PBB reform to allow for co-financing arrangements with regions and woredas. Without this change, it may not be possible to establish a large-scale co-financing scheme or policy that is supported solely through domestic funds.

[52] However, this approach can still be tested with the larger donor pools of money for TB public health activities; see piloting-related recommendations above. By leveraging existing and better funded channels (GF, SDG Fund) that already have to send money to the regions, the TB pilot will test whether the NTP can leverage more local investment in TB if it ties those funds to co-financing incentives. In the longer term, the REHF may be the best opportunity to create a centrally funded pool that could be used to support co-financing arrangements with regions that are not limited to commodities.

Recommendation 7. Strengthen public financial management systems to monitor program-based budgeting and expenditure

Transparent and accountable financial management systems – with the capability to track and report on co-financing commitments and expenditures, and to estimate co-financing proportions and project funding for future years – are essential for both co-financing and PBB initiatives. The MOF, in collaboration with the MOH-E, should prioritize implementation of IFMIS at all levels of government that can support robust program-based budgeting and tracking. If this is not feasible, the MOH-E should ensure that the newly-initiated Health Resource Tracking System (HRTS) supports the health sector to track and monitor the utilization of co-financing arrangements.

Recommendation 8. Develop a Co-financing Implementation Guide

Despite the growing interest in using co-financing within the Ethiopian health sector, the country does not have a clear guiding framework for how to establish and structure these mechanisms at federal and regional levels. In alignment with the HCF Strategy, SAEO should lead a process to develop an Implementation Guide for co-financing negotiation and enforcement within the health sector between the partners and government and between different levels of government. A co-financing Implementation Guide would outline the required steps and timeline to select, negotiate, implement, and monitor co-financing agreements among different levels of government moving forward and provide templates. It also would ensure that future co-financing arrangements build on previous lessons learned and align with global best practices within the Ethiopian context. In particular, the development of an Implementation Guide would facilitate more discussion within the MOH-E and regional bureaus about the appropriate accountability mechanisms to ensure these arrangements are motivating to all parties and that mechanisms for enforcement of co-financing arrangements are both practical and impactful.

ANNEXES

Annex 1. National policies and strategies reviewed

The following Ethiopian policies and strategic documents were reviewed:

- Health Policy of the transitional Government of Ethiopia (Published on 12/31/1993)
- Public Health Proclamation- Proclamation No. 200/2000 (03/09/2000)
- A Proclamation issued to provide a system for the determination of the division of federal subsidies and joint revenues (Proclamation No. 1250/2021) (07/02/2021)
- Growth and Transformation Plan (GTP) 11(2015/16–2019/20)
- Health Sector Transformation Plan (HSTP)-2 (2020/21-2024/25)/ (2013 - 2017 EFY)
- Health Sector Development Programme IV (2010/11 - 2014/15 EFY)
- Health Care Financing Strategy (2022- 2031)
- TB National Strategic Plan (NSP)
- National Health Accounts (2019/2020)

The Ethiopian policies and strategies reviewed that highlight the need for innovative and increased domestic financing options, which create opportunities for co-financing mechanisms, are discussed below:

Policy/Strategy	Description	Opportunities
Growth and Transformation Plan-GTP 11 (2015/16–2019/20)	The primary goal of GTP II is to act as a catalyst in achieving the national vision of attaining low middle-income status by 2025. This will be achieved by sustaining an all-encompassing and rapid economic growth that will accelerate economic transformation and the country's journey towards renaissance.	• The general objective of this plan is to strengthen primary health care to enhance the health outcomes of all citizens by ensuring that they have equal access to quality health care services. • Major targets focus on primary health services and a subset of the exempted health services, including TB. • The implementation strategy highlights the need to progressively increase domestic financing alongside external resources and health care financing system development.

Health Sector Transformation Plan 2 (2020/21-2024/25)/ (2013 - 2017 EFY)	This document outlines the strategic direction of Ethiopia's health sector, including objectives, strategies, and policies related to health financing.	• Health financing improvement is among the 14 strategic directions, with the aim to ensure a transition to more sustainable financing for health through gradual replacement of resources from external sources to domestic sources. • Major strategic initiatives identified in the health financing strategic direction that are relevant to the co-financing mechanism are: a) design and implement innovative resource mobilization, b) reform the role of MOH-E in health financing to improve mobilization and allocation of resources, and c) reform public financial management and health financing to improve efficiency and accountability.
Health Care Financing Strategy (2022-2031)[53]	The HCF Strategy is a critical document that provides a roadmap for mobilizing and managing financial resources for the health sector.	• This national strategy is specifically aimed at increasing funding for health care services by mobilizing domestic resources. • The strategy's main objective is to mobilize sufficient resources through traditional and innovative means. It emphasizes the importance of generating additional funds through innovative financing mechanisms, a critical necessity given the current decline in donor financing within the country. • The strategy projects that all levels of government (federal, regional and woreda) will need will to progressively increase their share of the health sector budget.

[53] Ministry of Health, Ethiopia, 2022.Health Care Financing Strategy, 2022 – 2031. https://p4h.world/app/uploads/2024/04/Health-Care-Financing-Strategy-English-30May2022.x23411.pdf

Annex 2. List of interviewed stakeholders

Role in co-financing	Department/Organization	Person Interviewed
Influence on co-financing mechanisms	MOH-E leadership/Strategic affairs leadership	Ermias Dessie
	Oromia RHB	Deraro Bedada & Tariku Tessema
Implementing/overseeing the co-financing mechanisms	Head of National TB, Leprosy and other lung disease desk	Taye Letta
	Nutrition executive office: Implementation Advisor Multisectoral and Seqota Declaration Coordination Desk	Bisrat Haile
	Malaria insecticide residual spray campaign: Senior Grants Management Coordinator	Mulugeta Anshiso
	HIV/AIDS Program Multisectoral Response HIV/AIDS Sr. Expert	Atsedewoyin Wuhabi
	Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) CCM	Abayneh Admas
	Health Infrastructure Executive Office	Samuel Kebede
	Reproductive Health, Family Planning and Youth Health Expert IV	Genet Deres
	Family Planning and Youth Health Advisor	Birikty Lulu

Annex 3. Interview Questionnaire

Key Informant Interview Guide for co-financing arrangement

Introduction

One way to share costs between national and subnational government levels would be through a co-financing arrangement. Under such an arrangement, the national government would provide TB funding to the subnational governments only if the region/woreda provides some predetermined amount. Co-financing allows for reduced dependency on a single source of funding to achieve sustainable financing and promote accountability and ownership among stakeholders.

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. In this assessment, we plan to assess the legal and regulatory environment to institutionalize the co-financing mechanism between these two entities.

Respondent information

Name:

Institution:

Designation:

Length of stay at this position:

Date of Interview:

Start Time:

End Time:

Questions

1. Are you aware of any co-financing arrangements for TB or any other health areas?

If Yes, continue with Question number 2. If No, proceed to question number 16

2. Which legal frameworks and/or policies did the entities use to establish the co-financing commitments?

3. What is the type of document signed by the participating entities? Such as legally binding contracts, MOUs, or other types of documents?

4. What were the roles and responsibilities of each party engaged in the co-financing arrangement?

5. What was the share of contribution for the entities engaged?

6. Have commitments been met consistently by all entities?

7. What is the percentage breakdown between the national government and subnational entities? How was this breakdown decided?

8. How much resource has so far been generated through this mechanism? Do you know where these funds are generated?

9. Is there a specific agreement on what the funds should be spent on, i.e., on which interventions?

10. What are the legal and policy challenges you may have faced in initiating and continuing the mechanism to fund the declaration?

11. What type of PFM system do you utilize to track the subnational and national contributions? Is there any alignment between these tracking systems?

12. What are the monitoring mechanisms used for this arrangement?

13. Are there any incentives for those regions/woredas who meet the set percentage target for the co-financing?

14. Have there been any capacity strengthening activities provided to guide the subnational entities to track their contribution?

15. What worked well and what did not? Do you have any recommendations for programs considering establishing a co-financing mechanism to increase domestic resources?

16. Are you aware of any co-financing arrangements between the national and regional governments in the non-health sector?

If Yes, start from question 2 and proceed to question 15. If No, proceed to question number 17.

17. Would Regional Health Bureaus and finance offices be interested in exploring the possibility of establishing a co-financing mechanism for TB and other critical health areas? What will be the single most important motivation for regions to engage?

18. Which legal frameworks and/or policies do you anticipate will pose a challenge in the implementation of co-financing mechanisms between the national and regional governments for TB or any other critical health areas?

19. Are you aware of any mechanism where the national government incentivizes the regions to meet/exceed a set target?

20. Is there anything you feel is relevant for us to know that we might not have raised in our discussion?

Annex 4. List of documents and co-financing agreements reviewed, in addition to those mentioned in Boxes 2 and Annex 1.

Policies reviewed

The Seqota Declaration: Committed to ending stunting in children under two by 2030. https://www.bigwin.org/nm_pent_bigwp/wp-content/uploads/2019/10/ExtendedNote.pdf

Ministry of Health. 2021. Seqota Declaration, Roadmap for Expansion and Scale Up Phases 2021-2030. Federal Democratic Republic of Ethiopia.

Ministry of Health. Expansion and Scale-Up Phase of the Seqota Declaration: Considerations for an Investment Plan to Achieve Ethiopia's Food and Nutrition Goals.

Multisector Programmes at the Subnational Level: A Case Study of the Seqota Declaration in Naedir Adet and Ebinat Woredas in Ethiopia (Authors Lillian Karanja Odhiambo, Dr Charulatha Banerjee, Natalie Sessions, Jeremy Shoham, and Carmel Dolan from ENN and Dr. Sisay Sinamo and the Programme Delivery Unit, Ethiopian Government)

Data DENT, Ethiopian Public Health Institute. 2022. Financing a Nutrition Information System – Insights from a Financing Landscape Assessment in Ethiopia.

MOUs/Allocation request letters reviewed

Seqota Declaration:

- MOH-E to Oromia Regional Health Bureau allocation request letter
- Gamo Woreda Finance Bureau allocation letter
- Sector based budget share of regions to the Seqota Declaration for the EFY 2015

Malaria IRS Program:

- MOH-E to Somali Regional Health Bureau allocation request letter
- MOH-E to Jijiga Regional Health Bureau allocation request letter
- Office memo from DCPD to Finance and Procurement Directorate communicating the allocation request amount for Oromia, Amhara, Tigray, Afar, SNNPR, Somali, Benishangul Gumuz, and Gambella Regional Bureaus
- Directive No. 1/2012- Directive for allocation and utilization of the funds for Malaria IRS

Health Infrastructure:

- MOH-E to Oromia, Amhara, SNNPR, Sidama, Somalia, Afar, Benishangul, Gambela, Harari Regional Health Bureaus, and Dire Dawa City Administration allocation request letter for 2014 EFY

- Ethiopia Family Planning Compact Memorandum of Understanding for Interim Financing for Family Planning Commodities Among: The Ministry of Health of Ethiopia Ethiopian Ministry of Finance Development Partners