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Synthesis Report

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Cover Picture: Awassa Health Center Client Waiting Area constructed with fees retained

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Acronyms and Abbreviations

EFY	Ethiopian Fiscal Year
ESHE	Essential Services for Health in Ethiopia
FMOH	Federal Ministry of Health
HCF	Health Care Financing
M&E	Monitoring and Evaluation
RHB	Regional Health Bureau
SNNPR	Southern Nations Nationalities and Peoples Region
TOT	Training of Trainers
USAID	United States Agency for International Development
WoFED	Woreda Finance and Economic Development
WorHO	Woreda Health Office
ZHD	Zonal Health Department

Executive Summary

Essential Services for Health in Ethiopia (ESHE) is a United States Agency for International Development (USAID)-financed bilateral project. The Project's aim is to improve health sector performance, with an overall objective of "Increased Use of Primary and Preventive Health Care Services in Ethiopia." The two major components are child health and health care financing (HCF) reform. The HCF component aims to improve availability of financing and allocation and use of available resources for enhancing accessibility, equity, and quality of health care. The Project has been supporting implementation of the government Health Care Financing Strategy developed by the Federal Ministry of Health (FMoH) and endorsed by the Council of Ministers in Ethiopian Fiscal Year (EFY) 1998.

With technical assistance from ESHE, the regional governments of Amhara, Oromia, and Southern Nations, Nationalities, and Peoples' (SNNP) designed and ratified legal instruments, brought political commitments through continuous dialogue and consultations, and put in place HCF reform operational frameworks and guidelines. It also provided capacity-building support in the form of training, operational guidelines, and supportive supervision.

ESHE began in November 2003 and will end September 2008. During its initial phase, the Project established a baseline for focus woredas in the three focus regions. The HCF reform component is region-wide in scope and the end-line survey assessed HCF reform implementation status throughout the three regions. Survey samples included both focus and non-focus woredas (78 total) in the three regions.

The instruments developed for the HCF survey enabled the Project to collect data from health centers, woreda health offices (WorHOs), and woreda finance and economic development offices (WoFEDs) in the 78 woredas: 24 each from Amhara and SNNP, and 30 from Oromia. Overall reform implementation status and performance data were also gathered from the three regional health bureaus (RHBs). In addition, secondary sources were reviewed. These sources included ESHE baseline survey reports, HCF reform implementation status assessment reports, periodic project plans and reports, and relevant regional and federal government documents.

This report synthesizes region-specific findings and provides a comprehensive view of HCF reform implementation and performance across the three Project regions.

Overall, HCF reform is in full implementation. Government authorities at various levels own the process and government support is encouraging.

One development during HCF reform initiation was deepening of the decentralization process. The baseline survey revealed that in all three ESHE

focus regions, WorHOs were not members of the woreda cabinet. Health offices and health centers had limited or no role in woreda budget allocation and financial decision making. This was one of the reasons for inadequate budget allocations. The current survey found that all WorHOs are members of their woreda cabinets, and both health offices and health centers play a significant role in the planning and budgeting processes in context of the ongoing fiscal decentralization.

As a result, share and absolute amount of resources for health services at the woreda level have steadily increased in the past four years. Compared with the baseline period, total woreda health budgets for recurrent and capital costs have almost doubled in the sampled woredas. Per capita health budgets in the sampled woreda more than doubled compared with the baseline. It is now higher than the national average in two of the three regions.

Revenue retention and utilization is a fundamental financing development introduced in the Ethiopian health sector in the last two years. In the three ESHE regions, regional laws allow health facilities to retain and use their internal revenue as additive to their government budget. The survey reaffirmed that retention is occurring in all 78 surveyed health centers. The amount of retained revenue in the surveyed woredas in the first half of EFY 2000 (2007/8) alone nearly exceeds total revenue retained in all the prior years. Health centers put in place the required finance structure and staffing, and used essential financial procedures, formats, receipts, and basic accounting procedures. The survey revealed that health centers are using retained revenue in quality improvement areas, such as increasing the availability of essential drugs and supplies and making medical improvements. They are using retained revenues to improve their infrastructure, information systems, and human resource capacity.

Although implementation status varies among regions, encouraging developments are observed in systematizing the fee waiver system aimed at protecting the poor. The surveyed woredas were at different stages of implementing the fee waiver system. In Amhara, all the surveyed woreda administrations identified fee waiver target households, and allocated budget for reimbursement to health centers for fee waiver services. Under-coverage may be a challenge in Amhara, as less than 4 percent of the households are certified for the benefit. There is a strong need to fully implement the fee waiver system in Oromia and SNNP, and expand coverage to reach a number of poor people in Amhara. There is also a need to undertake periodic studies on how the new fee waiver system is improving access to and use of health care services by the poor and improving their overall health status.

Similarly, the exemption system is being standardized in the three regions. Immunization, family planning, and maternal health-related services are major areas of exemption. The list has been standardized and the population is being informed through appropriate mechanisms.

Ethiopia has a long tradition of patients paying for health care in the form of user fees. However, fees have never been systematically revised to reflect increasing health care costs. The need for revising user fee levels was substantiated by relevant stakeholders during the baseline survey. To this end, user fee setting and revision were considered as one reform component. The authority for deciding user fee revision and preparatory measures to introduce it were defined by regional laws and operational guides. In SNNP, the law allows health facilities to determine user fees. In Amhara and Oromia, this authority lies at the regional level. Thus far, only 17 of the 78 health centers (22 percent) in the study have revised user fees. There is strong need for further study on the implication of user fee revision on utilization of services and revenue of health centers.

Creation of health facility governance bodies and putting in place organizational structures and staffing ensure health facility autonomy for reform implementation. While operations vary, almost all health centers have established governing bodies, and are providing leadership and policy direction, and are making important decisions. Health centers are allowed to have administration and finance managing units. Creation of such structures increased the stewardship role of health facilities and improved allocation and use of financial and non-financial resources.

HCF reform improved monitoring and evaluation capacity and practice at all levels. Health facilities increasingly and regularly report their physical and financial performances. WorHOs are conducting regular supervision, during which HCF reform-related issues are checked and support provided as needed.

1. Background

1.1. Health Care Financing

Essential Services for Health in Ethiopia (ESHE) is a United States Agency for International Development (USAID)-financed bilateral project. The Project's aim is to improve health sector performance, with an overall objective of "Increased Use of Primary and Preventive Health Care Services in Ethiopia." The two major components are child health and health care financing (HCF) reform. The HCF component aims to improve availability of financing and allocation and use of available resources for enhancing accessibility, equity, and quality of health care. The Project has been supporting implementation of the government Health Care Financing Strategy developed by the Federal Ministry of Health and endorsed by the Council of Ministers in 1998.

As the strategy indicates, the objectives of implementing the reform include increasing available resources for health services, increasing efficiency of resource utilization in health, promoting continuity of health services through sustainable financing, improving quality and coverage of health services, and ensuring equitable distribution of health services.

Since ESHE began in late 2003, it has supported the FMoH and Ethiopia's three largest regions (Oromia, Amhara, and SNNP) in initiation and implementation of HCF reform, development of legal instruments and operational guides, capacity building in the form of training, regular supervision, and on-the-spot technical support. In 2004, the Project established HCF baseline data by conducting a survey in focus woredas and health facilities in the three regions.

Although there have been spillover effects of ESHE child survival interventions in other regions, woredas, and health facilities, ESHE interventions focused on selected (focus) woredas in the three regions. HCF reform, however, has been country- and region-wide in scope. In addition to sharing prototype legal frameworks and implementation manuals, the Project organized and conducted training programs.

Beginning in mid-2004, Amhara, Oromia, and SNNP regional governments, in collaboration with ESHE, carried out advocacy activities with key regional authorities to facilitate HCF reform implementation. Technical and steering committees were established and legal HCF reform documents were prepared through consultative workshops.

Amhara, Oromia, and SNNP Regions endorsed the *Health Service Delivery and Administration Proclamations* in 2004 and 2005. Subsequently, the regional cabinets ratified HCF reform regulations, which further detailed the proclamations.

Following endorsements of the proclamations and regulations, Amhara, Oromia, and SNNP RHBs issued HCF reform directives. They include implementation details on all reform components: revenue retention and utilization, fee waivers and exempted services, and organization and management of health center management committees and hospital boards. To further facilitate implementation, RHBs, with ESHE technical assistance, developed and endorsed other operational guides, such as the *HCF Implementation Manual*, *HCF Reform Implementation Training of Trainers (TOT) Facilitator's Guide*, and *Accounts Reform Manual for Health Centers*.

To build implementers' capacity, relevant documents were distributed and TOT and roll-out trainings provided. Legal framework documents were disseminated by the RHB to regional, zonal, and woreda cabinet members and health facilities through dissemination workshops. HCF reform TOTs were delivered for participants from the regional bureaus of health and finance and their zonal level counterparts. Moreover, TOT participants, assisted by ESHE organized a four-day training program for woreda administrations, WorHOs, WoFEDs, and health centers. Through a two-day workshop, hospital board members and primary health care unit management committees were oriented on HCF reform and progress to-date and their roles and responsibilities.

Currently, the various reform components are well underway in the focus regions. In October 2007, the Project assessed progress in focus woredas, studying both the status and provision of support for reform implementation. The reform is basically region-wide in scope and Project support reaches all woredas and health facilities in the focus regions. Accordingly, the Project undertook the HCF reform end-line survey in 78 woredas drawn from throughout the three regions. Methodology in selecting sample woredas is discussed below. Woreda administrators and heads of WorHOs, WoFEDs, and health centers were interviewed. RHBs were interviewed about the overall status, institutionalization, and other HCF reform issues.

1.2. Purpose of the Survey

The end-line survey was expected to show HCF reform implementation status. Comparisons were made with baseline data when possible and necessary. The survey had three specific objectives:

- To generate evidence on the overall progress, performance, and status of HCF reform in the three ESHE regions.
- To gauge Project performance against baseline data.
- To draw lessons for future HCF policy reform in the three regions and beyond.

2. Survey Methodology

2.1. Scope, Sampling Method, and Size

The ESHE end-line survey collected data on the overall status of the HCF reform implementation in the three focus regions. The method for identifying survey woredas and health centers was systematic sampling. The total number of woredas covered was 78. In determining the sample size, the following issues were considered:

i. Survey Woredas: The Project originally planned and budgeted for surveys only for 24 ESHE focus woredas in each of the three regions for which baseline data were available. A progress assessment in October 2007 looked only at focus woredas. However, because HCF reform is region-wide, it was more logical and reasonable to assess both ESHE focus and non-focus woredas.
ii. Time: HCF reform implementation began in early 2007. To permit a reasonable time for implementation the end-line survey could not begin until mid-2008.

2.2. Sampling Frame and Technique

A systematic technique was used to select sample woredas in the three regions. A major consideration was accessibility, especially of older ones, which had standard health centers when HCF reform began. Newly established woredas were excluded, as they may have lacked the standard health facility when reform began and may not have fully implemented reform. Specific considerations used to identify sample woredas were:

- Amhara: The sampling frame was all woredas and health facilities. Both ESHE focus and non-focus woredas had an equal chance of being sampled. A **systematic sampling technique** was used with specific consideration for identifying woredas: 91in all zones were found appropriate and were taken as sample frames.

  The woredas were listed alphabetically, divided by 24 (the sample size determined for the region by the HCF team and Project management), and every fourth woreda selected. Then, the first and last were used to bring the sample size to 24 woredas. Accordingly, 14 non-ESHE and 10 ESHE woredas were identified.

- Oromia: Its four relatively inaccessible zones (Borena, Guji, West Wellega, Kelem) were excluded as they were difficult to cover given the short survey period and limited resources. The remaining 131 woredas in the 11 zones were taken as the sampling frame. The 11 sample frame zones (131 woredas) were clustered into three groups based on their geographic locations. 30 woredas were selected randomly, 10 were ESHE focus and 20 were non-focus woredas.

SNNP: The144 woredas found appropriate were taken as the sample frame. They covered all zones. The woredas were listed alphabetically, divided by 24 (the sample size determined for the region by the HCF team and Project management), and every fourth woreda selected. Then, the first and last were used to bring the sample size to 24 woredas. Accordingly, 14 non-ESHE and 10 ESHE woredas were identified.

2.3. Instruments and Methodology

2.3.1. Questionnaires

Various data collection instruments were developed by the Project team based on the baseline survey instruments, the recent HCF implementation status assessment survey instruments, and feedback during various ESHE exercises. Draft instruments were further reviewed, then finalized incorporating technical review comments. The survey instruments were:

RHB Questionnaire: Overall reform implementation, political commitment, ownership, and government leadership were examined. A questionnaire developed for interviewing the three RHBs gleaned information about their role in implementing the reform, including supervision and provision of technical and managerial support.

Woreda-level Survey Instruments: These were developed to collect data about the actual implementation status and achievements of all HCF reform components from key relevant government entities at the woreda level. They also assessed the effect implemented HCF reforms had on improving regional quality, accessibility, and equity of health care services.

Four woreda-level survey instruments were developed, for health centers, woreda administration, WorHOs, and WoFEDs.

2.3.2. Review of Secondary Data

The survey used diverse secondary data generated by stakeholders. Documents were from the FMoH, RHBs, zonal health departments (ZHDs), WorHOs, and health facilities, as well as ESHE Central and regional Project reports, annual plans, and periodic reports. Various legal and operational documents reviewed and approved by appropriate regional governments were also valuable sources. Routine monitoring and supervision reports of the Project team and government counterparts, various review and consultative meeting documents, and other relevant materials were also used.

The ESHE *HCF Baseline Survey Regional and Synthesis Report* and the *HCF Implementation Progress Assessment Report* of October/November 2007 were extensively used. Baseline and end-line data were also compared.

2.3.3. Data Collection Process and Participation

Respondents in each region were from RHBs, woreda administrations, WorHOs, WoFEDs, and health centers in the sample woredas. The survey was administered by Project staff. RHBs and/or ZHDs assigned technical staff who served in the survey teams.

The survey team had three sub-teams, each composed of RHB technical persons and ESHE Central and Regional HCF Specialists. Sub-teams conducted in-depth interviews with heads and/or other relevant staff from each respondent organization. The survey was conducted in May through July 2008 (May 15-27 in SNNP, June 1-17 in Oromia, and June 24–July 7 in Amhara Region).

2.4. Scope

The survey covered 78 ESHE focus and non-focus woredas in the three regions, and gathered data from urban, relatively better-off woredas and remote rural woredas (see Annex for full list). It was agreed that the scope would cover the three regions as much as possible. Thus, region-wide data that enabled the survey to generate region-wide evidence was gathered.

Table 1: ESHE Project End-line Survey Sample Size and Locations

Region	Woredas			Health Centers
	ESHE focus	Non-focus	Total	
Amhara	10	14	24	24
Oromia	10	20	30	30
SNNP	10	14	24	24
Total	**30**	**48**	**78**	**78**

3. Description and Analysis of Key Survey Findings

3.1. Decentralized Planning and Budgeting

In the last two decades, Ethiopia has been engaged in a number of political and policy reforms. A major reform was decentralization, which devolved power to woredas from regional authorities. Fiscal decentralization, which began in EFY 1995 (2002/3), devolved revenue and expenditure decision making from federal and regional authorities to local/woreda administrations. This has been the most important component.

Lower-level government authorities are allowed to collect their own revenue, to allocate it to sectors of their priority, and to manage financial and non-financial resources under their jurisdictions. By assigning revenue and expenditure

responsibilities and decision-making authority to lower government bodies, fiscal decentralization can substantially improve a state's ability to effectively identify and address its citizens' needs.

The three ESHE regions embarked on implementation of the HCF reform within the framework of the broader decentralization process. The reform aimed to increase resources available to the health sector and improve allocative and utilization efficiency. Quality, equity, and accessibility of health care services would thus improve.

However, realization of decentralization objectives requires operational mechanisms and enhanced implementation capacity. In addition, it requires defining the necessary governance and accountability system at each level. In view of this, the Government introduced decentralized planning and budgeting that defined operational frameworks for local authorities.

3.2. Role of Woreda Administrations, WorHOs, WoFEDs, and Health Facilities

In the decentralized planning and budgeting system, woreda level government offices and institutions have different roles and responsibilities. ESHE provided support to the various entities in budget development/preparation, defense, allocation and utilization; financial management (utilization plan, salary payment, purchasing, bill settlement, use of financial documents and settlement, bookkeeping); and monitoring and reporting (financial and physical performance, regularity of monitoring and reporting).

Project 2004 baseline survey showed the health sector (WorHOs and health centers) financial role was negligible and limited to participation in preparation of the financial utilization plan and requests for utilization of their budget. This was especially true for health centers. At the woreda level, financial management was done by the woreda finance and planning office, where WorHOs and health centers had no influence.

The baseline survey revealed WorHOs identified insufficient budget allocations for health (77 percent), absence of health representation in the budget defense and approval process (43 percent), and inequitable allocation for health (44 percent) as major challenges. In Oromia, only 33 percent of surveyed health centers were involved in the planning and budgeting process by identifying and submitting their budget needs to WorHOs. In SNNP, only 12 out of 21 reported having a role in the budget planning process. The baseline was similar in Amhara, as the WorHO was not a member of the woreda cabinet and the health sector was not directly represented in this decision-making body. Currently, WorHOs in all 78 survey woredas are members of the woreda cabinet and all health center heads interviewed disclosed they now play a role in all stages of the decentralized planning and budgeting process in their respective woredas.

Associated with the HCF reform introduction was putting in place the necessary governance system and financial management capacity. Health centers now are allowed to have their own financial management structure and they are staffed accordingly. Their governing body, that makes important decisions at the health facility level, is integral to realizing health facility autonomy. About 94 percent of the surveyed health centers reported preparing their annual operations plans. Although health center governing bodies were established recently, 46 percent reported their governing bodies had approved their EFY 2000 annual operations plan.

Although legal and operational frameworks were developed and put in place in health facilities, and trainings were provided to all relevant staff in ESHE focus and non-focus woredas and health centers, noticeable differences were observed in the level of the two groups' performance in various HCF components. In EFY 2000, in non-ESHE woredas, planning and budgeting decisions, such as approval of the plan and budget, are made by health center heads (six health centers, or 12.5 percent), non-specified bodies (nine, or 18.8 percent), internal management of health centers (15, or 31.3 percent), and health center governing bodies approved the budget and plan for the remaining 18 (37.5 percent) of the 48. Health centers internal management (12, or 40 percent) and governing bodies (18, or 60 percent) approved the plan and budget in ESHE focus woredas in that same year. Similar differences are observed in performance of other reform areas, possibly the result of regular visits and follow-up by ESHE cluster staff.

An increasing number of health facilities are managing their finances as well as procuring services and commodities. Of 76 valid responding health centers, 38.5 percent reported handling payment of salaries, 62.8 percent are making their own drug procurements, and 44.9 percent are settling their bills. These developments are encouraging compared with baseline indicators, when health facilities had no autonomy and used the woreda finance pool for all financial management, payment, procurement, and bill settlement.

In all 78 surveyed woredas, woreda administrations and WoFEDs were important in the planning and budgeting process, as was the case for the baseline.

3.3. Health Budget Trends at Woredas and Health Centers

In the three years surveyed, the total average woreda budget and health budget showed substantial increases (Table 2). For example, on average, the total woreda government budget increased by 16 percent in nominal terms during EFY 1998 to 1999. It further increased by about 57 percent in EFY 2000. The average health budget in the two years grew by 15 percent and 45 percent in EFY 1999 and 2000, respectively. On average, health's share of the total woreda budget was about 10 percent in each of the past three years, higher than the 8 percent baseline average for 1995. WorHO membership in the woreda cabinet,

the financial management and accounting capacity building provided to health and finance staff, and the large number of policy advocacy workshops were the major contributors to this encouraging, albeit modest, development during these last few years.

Table 2: Comparison of Total Average Woreda and Health Budgets in Surveyed Woredas, EFY 1998–2000

Woreda Budgets	Budget Amount (Birr) (Average of 60 sampled woreda budgets)			Change from Prior Year (%)	
	1998	1999	2000	1999 Vs. 1998	2000 Vs. 1999
Total Woreda Budgets	9,602,206	11,099,991	17,439,764	16	57
Woreda Health Budget a. Recurrent	796,540	935,745	1,256,549	17	34
b. Capital	129,195	127,447	287,833	-1	126
Total Woreda Health Budget	925,735	1,063,192	1,544,382	15	45
Health Budget as Share of Woreda Budget	10%	10%	9%		

3.4. Trends in Health Budget

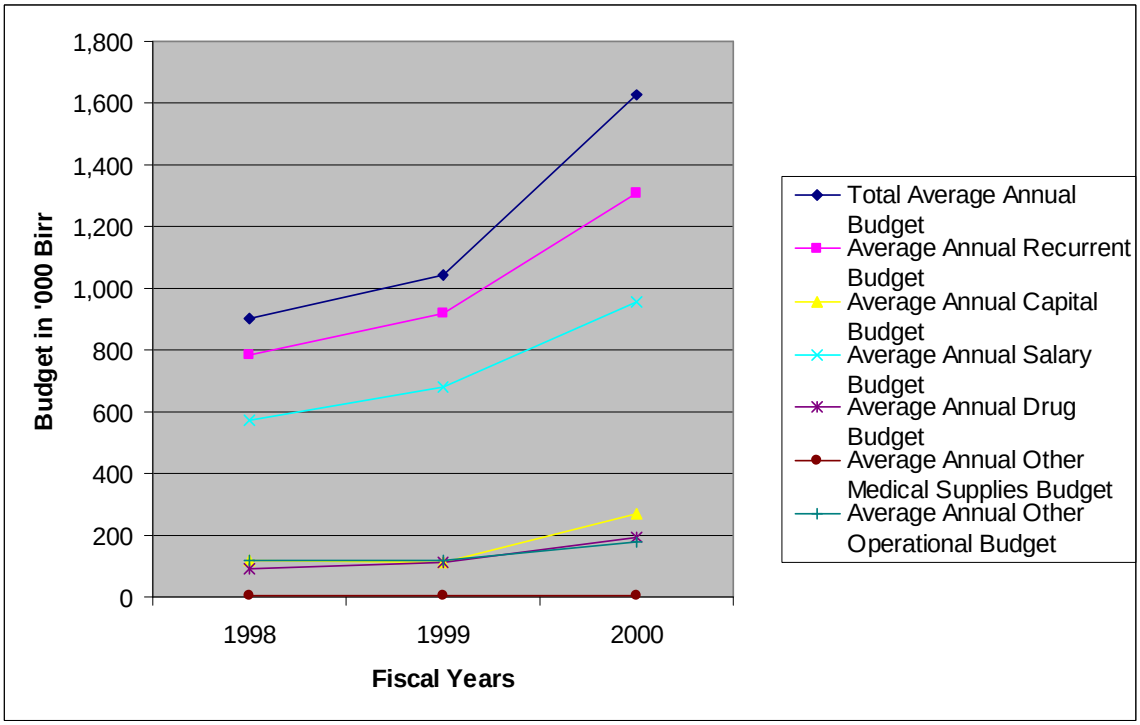
As shown in Table 3 and Figure 1, total health budget increased substantially in EFY 1999 and EFY 2000. In each of the three years surveyed, the recurrent costs proportion of the health budget was high. It was about 87 percent of the total budget in EFY 1998, increased to 88 percent in EFY 1999, and declined slightly to about 81 percent in EFY 2000. Salaries were the largest recurrent cost, accounting for a stable 73 percent of the average woreda recurrent budget in EFY 1998 and EFY 2000; 74 percent in EFY 1999; and 59-66 percent of the total average health budget. The share for drugs was relatively stable, increasing marginally from about 10 percent in EFY 1998 to 12 percent in EFY 2000. Other medical supplies and operational costs accounted for about 12 percent in EFY 1999 and EFY 2000, a decline from about 13 percent, EFY 1998.

Table 3: Share of Major Budget Components in Total Woreda Health Budget in Surveyed Woredas, EFY 1998–EFY 2000

Woreda Health Budget Category	Total Average Annual Budget (Birr)			Proportional Share of Health Budget (%)		
	1998	1999	2000	1998	1999	2000
Total average annual woreda health budget (recurrent + capital)	909,742	1,029,730	1,628,212	100.0	100.0	100.0
Average annual woreda health capital budget	120,860	110,932	268,153	13.3	10.8	16.5
Average woreda health recurrent budget	788,882	918,798	1360,059	86.7	89.2	83.5
Salaries	570,899	682,339	957,305	62.8	66.3	58.8
Drugs	91,733	115,303	208,971	10.1	11.2	12.8
Medical Supplies	5,280	3,325	9,601	0.6	0.3	0.6
Other operational	120,970	117,831	184,182	13.3	11.4	11.3

The average EFY 2000 per capita government health budget in surveyed woredas was Birr 10.47. Per capita budget across the three regions differed. On average, it was higher for Amhara (Birr 21.52), followed by SNNP (Birr 13.19), then Oromia (Birr 9.8). The regions' average and individual regional figures are much higher than the baseline figure of Birr 4 per capita.

Figure 1: Health Budget Trend by Major Budget Categories, EFY 1998–2000



After a slight decline from EFY 1998 to EFY 1999, the average capital budget substantially increased in EFY 2000. This might be attributed to vigorous Government efforts to implement the accelerated expansion of the primary health care program.

3.5. Challenges

The survey identified problems and challenges in HCF reform implementation. At the WorHO level, of 73 valid respondents (multiple responses), 56.4 percent reported limited knowledge of the HCF reform as the major problem, followed by inadequate budget (55 percent), and limited technical capacity (43 percent). Insufficient attention by woreda officials, shortage of critical staff, and high staff turnover were 40 percent, 30 percent, and 27 percent respectively.

3.6. Major Steps and Solutions to Overcome Challenges

WorHOs reported providing guidance and support for the reform implementation during their regular supervisory visits to health facilities. Of the 78 WorHOs, 89.7 percent (70) reported they follow up health facility implementation of the reform. Of these, 56.0 percent use checklists. Follow-up includes revenue retention and use; use of appropriate finance formats and procedures; fulfillment of critical staff positions; proper and timely collection and depositing of health facility revenues; implementation of the fee waiver system, including targeting and serving the poor; and reimbursement by WoFED or woreda administration. Establishment and functioning of health center governing bodies was also their area of support and follow-up to health facilities.

4. Revenue Retention and Utilization

4.1. Start-up of Revenue Retention

Revenue retention and utilization is the foundation of all HCF reform components. It diverges greatly from government's consolidated financial management system, which requires all revenues to be channeled to the central treasury and all public institutions to receive their operational funds in the form of a budget.

The revenue retention and utilization component and legal instruments developed and ratified in the three regions allowed revenue retention and utilization by health facilities. During start-up, as the baseline survey revealed, health facilities were not retaining their internal revenue. Now, all 78 surveyed health centers reported revenue retention. Most have started utilizing internal revenue following endorsement by the WorHOs and appropriation of the same by woreda cabinets and councils.

4.2. Sources of Health Center Revenue

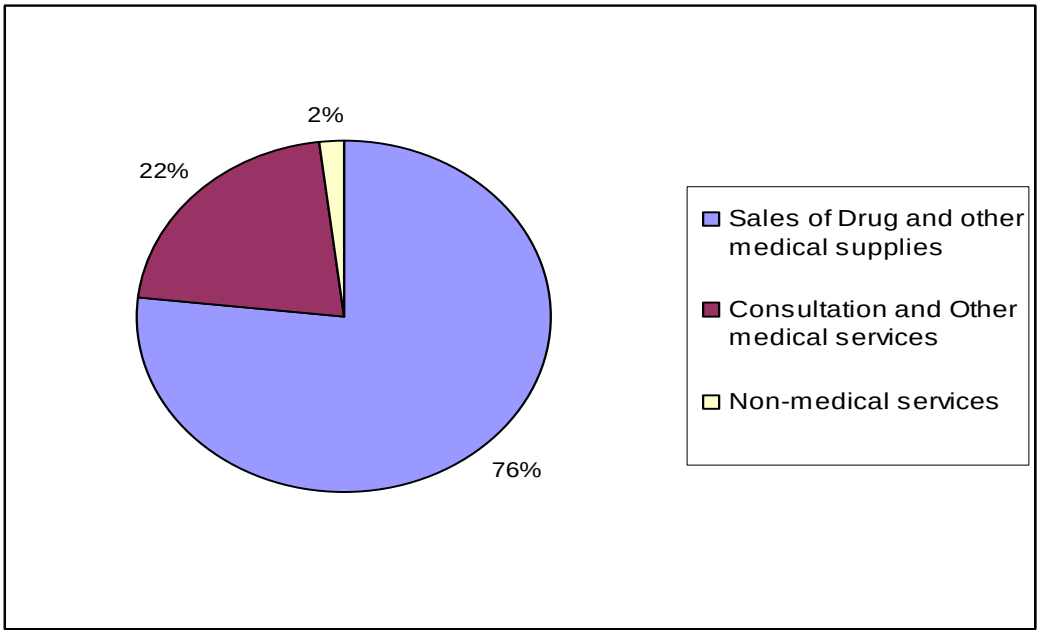
Revenue retention began in most of the surveyed health centers in EFY 1999. The average total internal revenue retained was Birr 88,850. Revenue is expected to gradually increase as health facilities improve quality and demand increases. The average revenue collected and retained in the first half of EFY 2000, Birr 70,844, approaches the amount collected in all of EFY 1999. This significant amount enables health facilities to purchase critically needed goods and services that are essential for improving health care.

Major sources of revenue are the sale of drugs and other medical supplies, fees for consultation, and non-medical services, which include income from sale of items such as trees and grasses (hay). In EFY 1999, drugs accounted for 77 percent of health center average internal revenue. This fell to 74 percent in the first half of EFY 2000 because of increased revenue from non-medical source, from 2 percent in EFY 1999 to about 7 percent in EFY 2000.

Table 4: Average Health Center Internal Revenue by Source in Surveyed Woredas, EFY 1999 and First Half of EFY 2000

Source of Revenue	Amount (Birr)	Proportion by Source (%)	Amount (Birr)	Proportion by Source (%)
	1999		1st Half of 2000	
Sale of drugs and other medical supplies	68,056	76.60	52,104	73.55
Consultations and other medical services	19,129	21.53	13,819	19.51
Non-medical services	1,665	1.87	4921	6.95
Total	**88,850**	100	**70,844**	100

Figure 2: Shares of Health Center Retained Revenue Sources in Focus Regions, EFY 1999



Appropriate Procedures and Accounting Formats: Regional laws and guidelines require health centers to open separate bank accounts for internal revenues. Of 78 health centers, 71 (91 percent) opened separate bank accounts for depositing revenues. The remaining seven health centers (9 percent) reported depositing revenue in the WoFEDs or micro-finance institutions in their localities.

As part of regional laws that allow health facilities autonomy in managing their finances, health centers are expected to handle deposits into and withdrawals from their special accounts. Of 66 health centers that responded, only 4 percent reported WorHO heads are account signatories. In the remaining health centers, only health center and administration and finance heads were reported as signatories.

Retained Revenue Utilization: Both the finance and health financing laws in the three regions require appropriation of all budgets before revenues can be utilized, including internally-generated revenues. Steps must be followed in preparation and approval of the plan and budget. In EFY 1999, health facilities that utilized retained revenue numbered eight. On average they spent Birr 90,239 in the reporting year. In the first half of EFY 2000, health centers that utilized internal revenue increased to 46, and average spending was Birr 133,772.

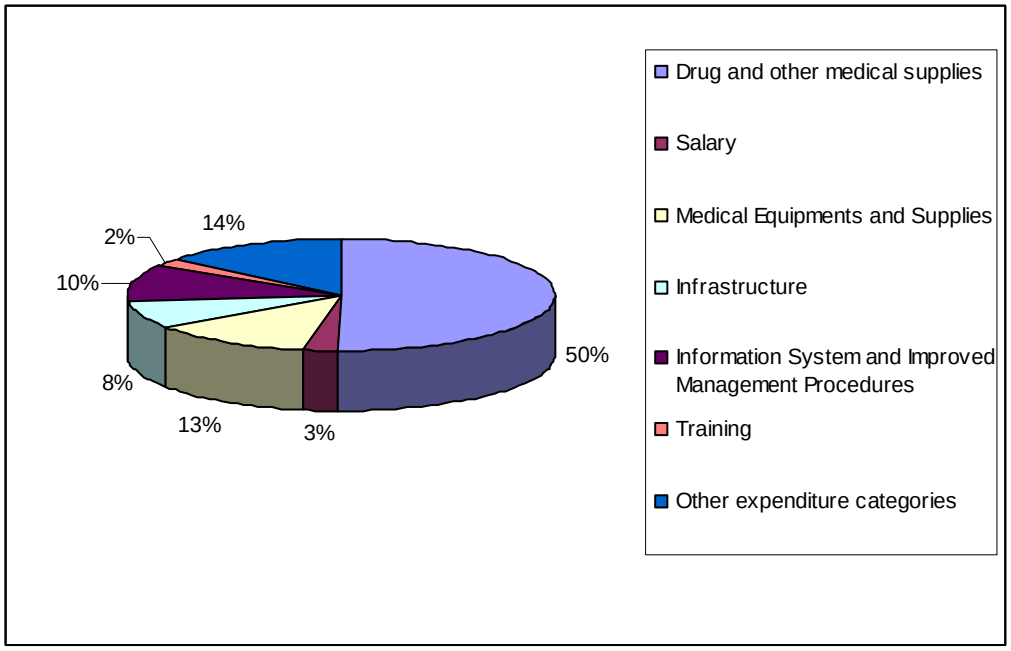
Overall, revenue retention put more resources at the disposal of health facilities to cover non-salary recurrent costs and capital investments. This allowed them to procure goods and services critical for health care services, that were not previously available due to budget shortfalls. In SNNP, 79 percent was spent on drugs, important to clinical and quality improvements.

In EFY 1999 and the first half of EFY 2000, the major spending was for drugs and medical supplies (Table 5). In the first half of EFY 2000, on average, drugs and other medical supplies accounted for 50 percent of the total (Figure 3). Medical equipment and information systems were 13 percent and 10 percent respectively. When health facilities have more resources at their disposal, they use them for quality improvement.

Table 5: Retained Revenue Spending by Major Areas in Surveyed Woredas, EFY 1999 and First Half of EFY 2000 (in Birr)

Areas	**1999**	**1st Half of 2000**
Drugs and other medical supplies	37,800	67,145
Medical equipment and supplies	7,068	16,761
Infrastructure	3,694	10,546
Information system and improved management procedures	8,296	13,856
Training	6,262	3,326
Other	27,119	22 138
Total	**90,239**	**133,772**

Figure 3: Retained Revenues Spending by Major Expenditure Items, First Half of EFY 2000



4.3. Challenges

Although revenue retention is going well in health facilities in the three regions, its implementation is not without challenges. Of 78 surveyed health centers, 53 (about 68 percent) cited lack of access to training as a problem. Since training was given to staff in focus and non-focus woredas, this could be due to high staff turnover and/or specific issues such as lack of basic accounting or specialized health and finance trainings. Training was followed by slow decision making by health center governing bodies and inadequate financial skills by health facility staff, each mentioned as a challenge by 34 (about 44 percent) of the health centers. Difficulty in understanding/interpreting the implementation guideline was also indicated as a limiting factor by 31 (40 percent) of the health centers.

5. Fee Waiver and Exemption

5.1. Implementation

The ESHE baseline survey and other documents indicate many operational difficulties, which resulted in under-coverage and leakage. Issuing of certificates at time of sickness (time of need) was found to be expensive and ineffective for poor households. Another challenge was fee waiver certificates were issued by many Government offices, although these issuers were not obliged to bear the cost borne by health facilities.

The new fee waiver system was developed to improve the system so the poor would be able to obtain health care services at no cost. The new system uses clearly-defined legal instruments and operational mechanisms to separate financers and providers of health care services by obliging fee waiver certificate issuers to bear the cost.

The survey showed the new fee waiver system not fully functional in all health centers. Only 49 (63 percent) reported the new system is operational and 29 (37 percent) not yet functioning. Implementation varies widely among regions. In SNNP, 37.5 percent reported providing fee waivers according to the new system. The remaining 62.5 percent have not begun the service.

Of woreda administrators asked about implementation, 66 (87 percent) reported they had started, fee waiver selection committees are formed (67 percent), and kebele administrations are submitting names of beneficiaries. However, only 43 (56.6 percent) reported having a beneficiary list, and 24 (32 percent) reported having issued certificates to beneficiaries. On the other hand, 56 (73.7 percent) reported having allocated a budget for fee waiver services. Administrators reported signed agreements with health centers (43.4 percent), fee waiver beneficiaries began receiving services (57.9 percent), and requests for fee waiver reimbursement were received (46 percent).

The majority of the health centers (45, or 58 percent) reported not receiving the list of fee waiver beneficiaries from woreda administrations. Thirty-seven (47 percent) had submitted reimbursement requests for services rendered to fee-waived beneficiaries. Only 21 (27 percent) had been reimbursed at the time of the survey.

In the absence of a fully functioning new fee waiver system in some woredas, health centers were interviewed as to how the poor are receiving free health services. Twelve (15 percent) identify the most needy using their own criteria. This screening only provides for those who appear in health facilities and request such services. Thirteen health centers (17 percent) provide no fee-waived services.

5.2. Fee Waiver Selection Criteria

Of 76 woreda administrators, 36 (47.4 percent) rank households and take the poorest from the list; 14 (18.4 percent) and 10 (13.2 percent) provide kebeles with predetermined quotas in the form of absolute numbers or percentages of the population, respectively. On average, total outpatient health service users (excluding those exempted) in the first half of EFY 2000 is 7,733, of which fee-waived users were 217 (2.8 percent). In the same period, an average of 51 patients were provided inpatient services by health centers, of which seven (7.3 percent) were fee-waived. Use of health services by fee waiver beneficiaries

varies among regions. In Amhara, where fee waiver system reform has been fully implemented, the proportion of fee-waived beneficiaries using the services is relatively higher (5.5 percent) than in the other two regions, which are at an earlier implementing stage.

5.3. Exempted Health Care Services

The baseline survey showed a wide range of health care services had been provided freely to all citizens regardless of income level or other considerations because of the public health nature of such services and/or the services are unaffordably high for most. There was also lack of standardization on types of services provided. In addition, some services that had been provided freely by health facilities to all citizens were not clearly defined by law and not adequately budgeted. The HCF legal framework and operational guides clearly defined categories and financing of free services.

Health facilities are providing exempted services per the respective regional legal provision that standardized the exempted service list. In EFY 1999, on average, each of the surveyed health centers provided exempted services to 17,712 users. In the first half of EFY 2000, on average, it was 10,513 users. In EFY 1999, 59 percent were immunization related, 32 percent were family planning and maternal health related, and 11.2 percent were other services including TB treatment, leprosy, HIV/AIDS testing and counseling, and fistula.

Table 6: Average Health Centers Exempted Services in Survey Woredas, EFY 1999 and First Half of EFY 2000

Type	Average Services Provided, by Year	
	1999	**1st half of 2000**
Immunization – Polio	1,912	1,020
Immunization – BCG	1,244	622
Immunization – Pentavalent	2,005	1,021
Immunization – Measles	940	466
Immunization – TT1	1,544	460
Immunization – TT2	2,253	1,424
Immunization Sub-total	**9,898**	**5,013**
Prenatal service	1,347	697
Delivery services	371	204
Postnatal services	439	207
Family planning	3,668	2,352
Family Planning and Maternal Health Sub-total	**5,825**	**3,460**
TB	126	77
Leprosy	10	27
HIV/AIDS prevention	1,806	1,871
Fistula	1	1

Other	46	64
Other Services Sub-total	**1,989**	**2,040**
Total	**17,712**	**10,513**

6. User Fee Setting and Revision

In Ethiopia, user fees were introduced in public health facilities with the introduction of modern health services more than a half century ago. The baseline survey and other health sector documents revealed user fees, never systematically revised, do not reflect the cost of delivering health services and do not provide the market signal and incentives for providers and users. It was agreed during HCF reform initiation that user fee revisions should be carefully considered and preparation care taken to avoid complications and difficulties in delivery and use. Legal provisions were effected to revise fees and responsibilities of various entities in the process. Amhara and Oromia Regions gave the responsibility of user fee revision to the regional governments. SNNP allowed health facilities to introduce user fee revisions. In both cases, the process and important considerations before introduction were clearly indicated.

Regarding status, only 17 health facilities (22 percent) reported revising user fees in the past two years. In 11 percent, the final decision was made by the health center governing body. In a quarter of them, it was by the facility head. The major consideration of 14 of these health centers was the cost of delivering services. No adequate data were generated to determine the effect of user fee revision on revenue and use of health care services mandating further study. It is too early to see the impact of user fee revision on improvement of health care services.

The need for user fee revision was supported by most health centers (74.5 percent) that have not yet revised fees. Escalating costs of delivering health care services was cited as the major reason to revise services.

7. Health Facility Governance and Management

7.1. Establishment and Operation of Health Center Governing Body

Health facility autonomy was important for improving health service quality following HCF reform implementation. Establishment of a health facility governance body was an important mechanism for introducing autonomy, and more accountability and transparency.

In most health facilities, governance bodies are in place. Of the responding 63 health center heads, 95.2 percent reported having governing bodies. The extent of their functions varies; most of them met at least once and made decisions on health center plans and budgets, periodic reports, and other issues that health center management brought to their attention.

As governing bodies were very recently introduced, it is still premature to discuss their weaknesses and problems. However, problems such as absenteeism, inappropriate delegation, and lack of adequate priority, capacity, and confusion on the role of governing body were some challenges.

7.2. Health Center Organizational Structure and Staffing

It was understood from the outset that HCF reform implementation requires necessary organizational set-up and staffing. Establishment of health center administration and finance unit and filling of critical positions with competent staffing were essential. Regional governments recognized the need for such structure and staffing. The survey assessed creation of these structures and whether required staffing was fulfilled.

In contrast to the baseline period, all surveyed health centers reported they have health center heads, and all except one attended the HCF training. Of 78 health centers 74 (94.9 percent) reported having finance and administration, accountant and cashier positions and 77 (98.7 percent) had daily cash collectors. 83 percent (63) of health centers reported challenges of low budget allocation while 36 percent faced the challenge of high staff turnover.

8. HCF Reform Implementation Status

8.1. Status of Implementation

Overall status in the three regions was assessed through interviews with the RHBs of Amhara, Oromia, and SNNP as well as their woreda administrations, WorHOs, WoFEDs, and health centers. Although implementation status varies among regions and health facilities, all respondents reported major HCF reform components (revenue retention and utilization, systematizing fee waiver and exemption, user fee revision, and enhancing health facility autonomy through introduction of a health facility governance system) made good progress. Improving financing and health facility governance are in turn improving the quality of health care services.

The three RHBs reaffirmed that technical and capacity-building support at all levels has been instrumental. Woreda administrations, WoFEDs, WorHOs, and health centers had similar responses. Most had attended at least one training, orientation, consultation, or policy dialogue workshop in the past four years and understand HCF reform. They also attested the various forums enhanced understanding of HCF issues and political commitment, ownership, and leadership.

8.2. Institutionalization of Reform Implementation

The end-line survey showed strong ownership, political commitment, and leadership by all levels of government. The reform is considered an important component of health sector development programs in all three regions. RHBs reported following-up implementation and providing technical and administrative support to the WorHOs and health facilities as required and necessary. In Oromia, advocacy and consultation forums were attended by regional government authorities from various levels and were chaired by the regional president. The RHB felt this showed strong political commitment and leadership.

Institutionalization mechanisms and levels vary. In Amhara, a HCF expert was assigned to the RHB to serve as key person for implementation. Focal persons assigned to zones, woreda, and health facilities in Amhara are facilitating reform implementation and liaising with the regional population and other development partners. In Oromia, two experts were assigned to the RHB but there is no formal structure at zonal and woreda levels. In SNNP, focal persons are assigned to the RHB. There are no formal point persons to follow-up reform implementation at zonal and woreda levels.

Institutionalization of HCF reform by putting in place the necessary organizational arrangement and staffing at different levels is essential. Understanding and mechanisms of reform vary across regions. There is a need to organize experience-sharing among the three regions and to design the most appropriate and practical way of institutionalization.

9. Monitoring and Evaluation and Supervision

Successful reform implementation and achievement of envisaged long-term objectives is only possible with timely and regular monitoring and evaluation (M&E). The necessary M&E framework has been put in place and capacity-building support provided to public health administrators and other relevant authorities. The end-line survey assessed M&E practices, including supportive supervision.

Most health centers (99 percent) reported reporting to higher-level WorHO supervisors regarding programmatic performances. Of these, only 50 percent submit financial reports to both WorHOs and health center governing bodies. The health sector, including health centers, use a single-pool financial management system. Health centers were not in a position to submit financial reports to WorHOs. In addition, WorHOs had nominal interest in financial performance and required reports. Financial reporting, therefore, was on an ad hoc, fragmented basis.

Currently, all health centers have their own finance staff (accountant and/or cashier) and manage their financial resources. It is encouraging that half started submitting financial reports. The remaining half must be encouraged to regularly submit similar reports to WorHOs. Most WorHOs (76 percent) regularly supervise

health facilities and follow-up progress in implementation of various HCF reform components.

A relatively higher number of health centers (64 percent) regularly report to their WoFED regarding their financial performance. Most WoFEDs monitor progress of health centers' budget utilization and financial management.

10. Conclusion and Recommendations

The HCF end-line survey showed implementation well underway in the three regions. Although there are differences in status among regions, woredas, and health centers, components are progressing well. Interviews with RHBs, woreda administrators, WorHOs, WoFEDs, and health centers revealed technical assistance during development of legal frameworks and operationalization of reform were instrumental for reform initiation and implementation.

- **Decentralized Planning and Budgeting:** The role and capacity of WorHOs and health centers substantially improved. WorHOs, now members of their woreda cabinet, are important to budget allocation. Health centers, in addition to their involvement in planning and budgeting, are managing their financial resources, including payment of salaries and procurement and purchase of goods and services.

  There have been tremendous increases in the planning and budgeting capabilities of the health sector and understanding of health issues by the woreda finance offices and administrators. Additional development of health facility-level planning and budgeting guidelines and capabilities as well as integration of the health facility plan with the ongoing woreda planning exercise is needed.

- **Revenue Retention and Utilization:** Revenue retention and utilization has started in all health centers surveyed. This component is being implemented in all eligible health facilities in the three focus regions. Revenue being collected, retained, and used by health facilities is gradually increasing. At the current level of health facilities capacity and financial utilization trends, revenue retained and utilized is significant to effect quality health service. In some health facilities, off-setting the health budget, especially on non-salary operational budgets, is observed, contrary to the law that retained revenues are to be additive. Utilization of revenue for quality improvement is promising, as most health facilities allocated and used revenues for drugs, medical equipment, health information system, and other areas that will improve health service quality.

  There is, therefore, a strong reason to continue building health facility capacity to ensure proper utilization of retained revenue in areas of quality improvement. In addition, there is a need for continuous dialogue and

consultation with woreda decision makers so they maintain an adequate operational budget for health and ensure retained revenue is additive to the government health budget.

- **User Fee Setting and Revision:** All health facilities voiced the need for user fee revision. Although health centers in Amhara and Oromia are not supposed to do user fee revisions, revisions are observed in some health facilities. In SNNP, regional law permits health facilities to undertake user fee revision. However, preparatory measures and consideration taken before user fee revision and standardization are weak.

  Much is being done to systematize and create capacity to undertake user fee revision by responsible authorities at all levels. This endeavor must be supported with evidence of health care services costs and the ability and willingness of health care users to pay.

- **Fee Waiver and Exemption:** A list of exempted services has been standardized in all three focus regions. Major areas are immunization, family planning, and maternal health-related services. The three regions are making efforts to systematize the fee waiver system.

  Fee waiver implementation varies among regions. Woredas in Amhara are ahead of the other two regions in terms of selecting eligible people and providing services to those certified. In Amhara, slightly over 3 percent is covered by the fee waiver system. Level of utilization is also encouraging, as fee-waived patients account for 5.5 percent of health service users in EFY 2000. Oromia and SNNP also show encouraging achievements. In Amhara, the effort should be on ensuring inclusion of more health facilities, including an increased number of fee-waived beneficiaries comparable to the level of the Region's poverty. In Oromia and SNNP, the focus should be on facilitating full implementation of the new fee waiver system in all woredas and health facilities.

  There is need for regular follow-up to ensure standard services are provided by all health facilities under the regional exemption system. There is also need to update the exempted services list through regular study of public health issues in the regions and the country.

- **Health Facility Autonomy and Management:** This is being gradually ensured through establishment of health center governance bodies. Almost all surveyed health centers have governing bodies that make important policy and leadership decisions.

- **Ownership and Institutionalization efforts**: Overall political commitment and ownership of HCF reform in the three regions is encouraging. Government authorities are driving its initiation and implementation. In the

three regions, the need to create a HCF unit or assign a responsible focal unit or person is unarguably underscored. Understanding and levels of institutionalization vary among regions.

There is a strong need to systematically lead institutionalization efforts through consultation and sharing of experiences among regions.

- **M&E and Supervision:** Health centers showed encouraging progress in regularly submitting fiscal and financial reports to their governing bodies and WorHOs. In addition, most reported regularly supervising health facilities and follow-up implementation of various reform components.

- **M&E Framework**: This must be revised, updated, and integrated into the broader health sector M&E framework and health management information system to improve institutionalization and ownership at all levels.

Annex: Survey Regions, Zones, Woredas, and Health Centers

Amhara Region

S. No.	Zone	Woreda	Health Center
1	North Wollo	Meket	Flakit
2		Gubalafto	Sanka
3		Delanta	Wogel Tena
4		Wadla	Kone
5	South Wollo	Segnogebeya	Albuko
6		Tenta	Ajibar
7		Kutaber	Kutaber
8	North Gondar	Chilga	Aykel
9		Gondar Zuria	Maksegnit
10		Tacharmachiho	Sanja
11	South Gondar	East Estie	Estie
12		Libokemkem	Addis Zemen
13		Lay Gayint	Nefas Mewcha
14	West Gojjam	Y/Densa	Adet
15		Jabitehnan	Jiga
16		Womberma	Shindi
17	East Gojjam	D/Markos Town	D/Markos
18		Enemay	Bichena
19	North Shoa	Efratana Gidim	Ataye
20		Asagirt	Asagrt
21		Angolalana Tera	Chacha
22	Hemira	Sekota	Sekota
23	Oromia	Kamissie Town Administrat	Kamissie
24	Awi	Injibara Town	Injibara

Oromia Region

S. No.	Zone	Woreda	Health Center
1	East Shoa	Boset	Welenchi
2	East Shoa	Liben-chiquala	Adulala
3	East Shoa	Gimbichu	Chefe Donsa HC
4	East Shoa	modjo town	Modjo
5	West Shoa	Dendi	Ginchi HC
6	West Shoa	Holeta town	Holeta HC
7	North Shoa	Yaya Gulele	Fital HC (Yaya Gulele)
8	North Shoa	Kuyu	Gerbeguracha HC
9	North Shoa	Dera	Gundo Meskel
10	North Shoa	wuchale	Muke Turi HC
11	S/W/Shoa	Dawo	Busa
12	S/W/Shoa	Woliso City Adm.	Woliso
13	Arsi	Merti	Abomsa
14	Arsi	Ziway Dugda	Ogelcho

15	West Arsi	Arsi Negele	Arsi Negele
16	West Arsi	Gedeb Asassa	Assassa
17	West Arsi	Shalla	Aje
18	Bale	Robe City Admin	Robe
19	Bale	Goro	Goro
20	Ilubabor	Bure	Bure
21	Ilubabor	Chora	Chora
22	Horo Guduru Wellega	Jima Rare	Wayu HC
23	East Wellega	Gudeya Bila	Gudeya Bila
24	East Wellega	Sibu Sire	Sire
25	East Hararghe	Babile	Babile
26	East Hararghe	Gursume	Gursum
27	Jimma	Sokoru	Sokoru
28	Jimma	Mana	Yabbu
29	West Hararghe	Doba	Doba
30	West Hararghe	Darolebu	Micheta

Southern Nations, Nationalities and Peoples Region

S. No.	Zone	Woreda	Health Center
1	Wolayta	Humbo	Tebela
2		Bombe	Bombe
3		Boditi	Boditi
4		Areka	Areka
5		Soddo	Soddo
6	Guraghe	Mihur Aklil	Hawariyat
7		Kebena	Wosherbe
8		Enemore&Ener	Gunchire
9		Mareko	Koshe
10		Cheha	Emdibir
11		Wolkitie	Wolkitie
12	Gamo Gofa	Kucha	Selamber
13		Boreda	Zafine
14		Sawla	Sawla
15		Zala	Galma
16	Gedeo	Wonago	Wonago HC
17		Yirgachefe Town	Yirgachefe HC
18	Silte	Lanforo	Lanforo
19		Dalocha	Dalocha
20	Kembata Tembaro	Durame Town	Durame HC
21	Hadiya	Misrak Badewacho	Shone HC
22	Amaro Sp. Woreda	Amaro	Kele HC
23	Konso Sp. Woreda	Konso	Karat HC
24	Alaba Sp. Woreda	Alaba City	Alaba HC