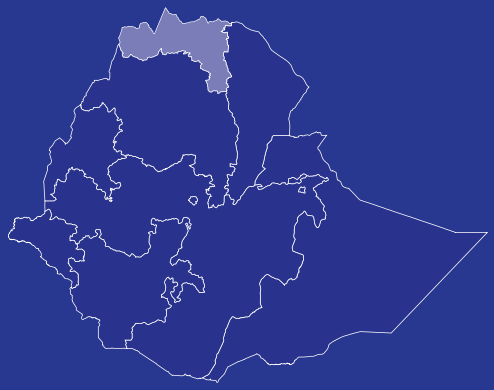
REGIONAL BRIEF



HSFR/HFG End of Project Achievement Highlights - Tigray

The USAID-funded HSFR/HFG project provides technical assistance to the Government of Ethiopia to implement and scale-up health care financing reforms across the country. The goal is to increase access to and utilization of health services through improved quality of health care and reduced financial barriers.

Project objectives are to:

- *Improve the quality of health services*
- *Improve access to health services*
- *Improve governance of health insurance and health services*
- *Improve program learning*

June 2018

THE REGIONAL CONTEXT

Tigray is northernmost of Ethiopia's nine regions. It is divided into seven administrative zones – South, South East, East, Central, North West, West, and Mekelle city – and has 52 woredas (34 rural and 18 urban). According to Ethiopian Central Statistical Agency projections, the region has a population of approximately 5.2 million people, the majority of whom are farmers.

About 30 years ago, there were only four hospitals and 10 health centers in the region, all in urban areas. Community ownership of health facilities was poor and private sector engagement in the health sector minimal. Since 1991, various regional government initiatives have significantly improved access to health services, with the addition of hospitals and health centers throughout the region and construction of health posts in each kebele. Today, there are 712 health posts, 204 health centers, 22 primary hospitals, 14 general hospitals, and one specialized hospital in Tigray.

Like other regions of the country, the health care system in Tigray has faced many challenges related to financing, including:

- Limited financial resources that cannot keep up with the population's increasing demand for health care services.
- Difficulties in properly managing financial resources (budget) in the health sector, particularly by heath facilities.
- Inefficient and inequitable use of health resources, especially favoring urban areas.
- Poor health service quality due to lack of trained and skilled professionals, and shortages of important drugs and medical equipment.

- Absence of prepayment mechanisms for households, which affects health service utilization and the welfare of household members.

To address these challenges, the Tigray regional government implemented the Federal Ministry of Health's health care financing reform initiatives and put in place the required legal frameworks to guide implementation of the reforms. The Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) project has since 2013 provided technical support to the regional health bureau (RHB), Ethiopian Health Insurance Agency (EHIA) branch offices, woreda administrations, woreda health offices, community-based health insurance (CBHI) schemes, and health facilities in the design, legislation, implementation, and evidence generation of these reforms. Project support included: capacity building such as training the leadership and staff at various levels of the regional government; integrated supportive supervision and mentoring; assistance with the development and adaptation of legal frameworks and implementation guidelines; and material support such as provision of motorcycles and computers to CBHI schemes; evidence generation through standardization of data collection instruments and collection, compilation, and analysis of data; and strengthening governance and networking through review meetings, experience-sharing visits, and high-level conferences and workshops.

MAJOR ACHIEVEMENTS

Health Facility Governance

The Ministry of Health's health facility governance reform allows for increased health facility autonomy through the establishment of governing bodies at health facilities to contribute to the proper and timely use of facility resources and respond to client needs. Called "governing boards" at hospitals and "management committees" at health centers, these governing bodies are mandated and authorized to ensure that facilities are fully implementing health care financing reforms, are offering the best patient care possible, and are functioning efficiently and effectively. This reform is considered critical because its implementation impacts the proper implementation of the other reforms, including the retention and use of revenue collected at health facilities, which is intended to improve the quality of services.

HSFR/HFG supported regional government efforts to implement governance reform. This included advocating to all relevant stakeholders on the importance of governing bodies, supporting the RHB in putting in place the required guidelines for the establishment and operation of health facility governing bodies, and providing training in the objectives, implementation procedures, and monitoring and review mechanisms of the reform in order to strengthen governing body capacity.

Mekelle Health Center Management Committee Helps Improve Service Delivery

Mekelle Health Center is located in Tigray's regional capital (Mekelle). It is one of many health facilities in the region that have benefited from having a fully functional management committee, the governing body of the facility. The management committee provides proper leadership to the implementation of various government reforms. This includes health care financing reforms such as the retained revenue and utilization reform aimed at improving the quality of service delivery at health facilities.

Informed decisions taken by the health center's management committee to use internal revenue have improved service delivery, which in turn has increased patient flow and mobilized still more revenue at the facility every year for the past five years. The health center's retained revenue increased from 0.85 million birr in 2013/14 to 1.4 million birr in just the first three quarters of 2017/18. This has provided more budget to improve availability of drugs and medical supplies; to build walkways, two additional blocks for maternal and child health services, and one documentation room; to purchase medical equipment; and to carry out other quality improvement initiatives.

The committee also closely monitors and addresses issues that impact the provision of quality health services.

HSFR/HFG strengthened the capacity of the management committee by training committee members on the objectives of the health facility governing board reform and their roles and responsibilities in its implementation. This strengthened their capacity to make informed, strategic decisions for the use of retained revenue and for better overall facility governance. The project also provided training in financial management procedures to key finance staff at the health facility which enabled the management committee to work with the health facility management team to implement appropriate financial management practices required under the reform.

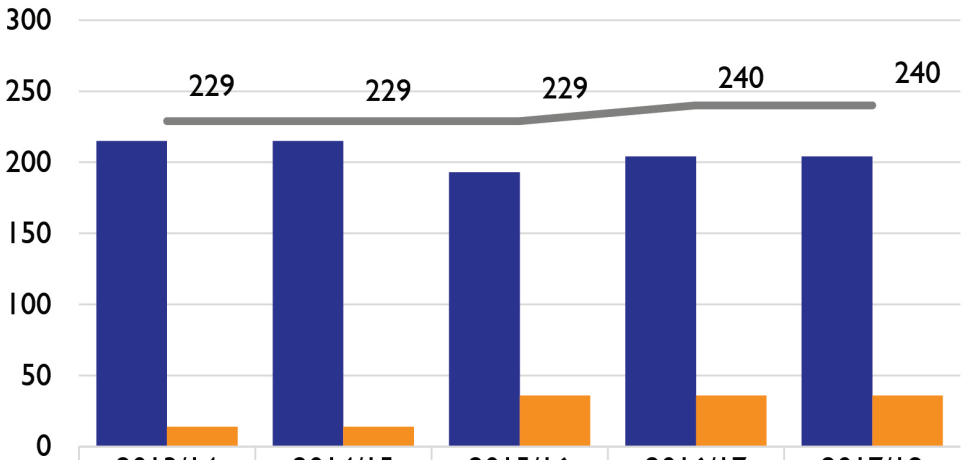
Since HSFR/HFG began in 2013, the number of health facilities with functional governing bodies has increased from 12 to 36 boards in hospitals and 108 to 204 management committees in health centers (Figure 1). Equally important, board and committee capacity to govern and oversee health care financing reform implementation has improved. Through HSFR/HFG support, health facilities now have functional governing bodies in place that are capable of making informed decisions about mobilizing and allocating resources at their facilities, as well as developing and administering facility budgets. HSFR/HFG collaborated with the RHB to train 1,603 board members. Although there are differences in their levels of performance, governing bodies in Tigray are able to advocate to regional and woreda administrations for the allocation of more resources from the government and non-governmental organizations to health facilities, mobilize resources from the community (cash, labor, and in-kind contributions), and prioritize the use of available resources according to need.

Revenue retention and utilization at health facilities

This reform allows hospitals and health centers to collect and retain revenue generated at the facility rather than remitting it to the treasury, and to use this revenue to make improvements in the quality of service delivery at the facility. HSFR/HFG technical support for this reform included: adaptation of the financial management manual to the regional context and training of key finance staff on the contents of the manual; technical assistance to health facilities and woreda health offices in the revenue retention and utilization (RRU) planning and budgeting process; and on-site technical support during supportive supervision visits.

The number of health facilities implementing RRU increased from 120 at the beginning of HSFR/HFG in 2014 to 240 in 2018. All health facilities in Tigray are now implementing this reform although there are differences in the magnitude of resources mobilized (retained) and in their utilization.

Figure 1. Number of Health Facilities in Tigary with Functional Governing Bodies

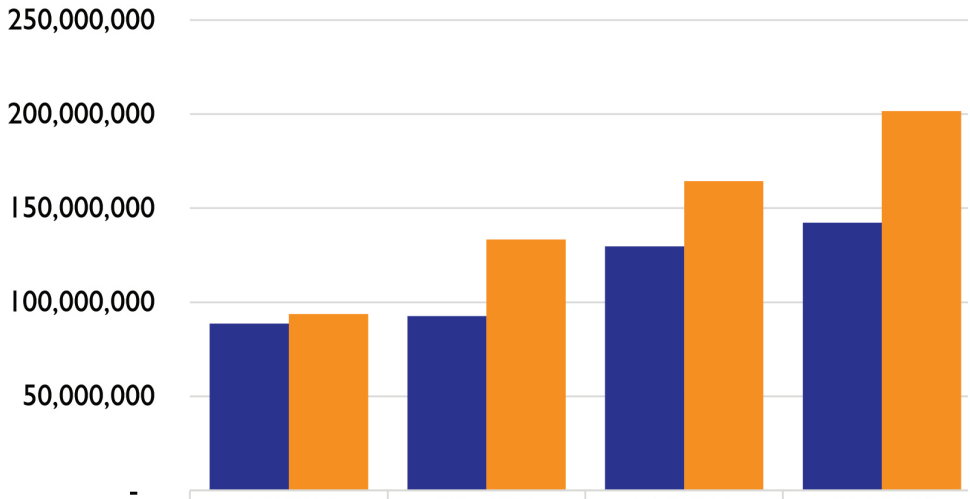


	2013/14	2014/15	2015/16	2016/17	2017/18
Health Center	215	215	193	204	204
Hospital	14	14	36	36	36
Total	229	229	229	240	240

Note:
The 36 hospitals indicated in 2015/16, 2016/17, and 2017/18 are 14 general hospitals and 22 primary hospitals.
The number of health centers with functional governing bodies in 2015/16 declined because some were upgraded to primary hospitals.

Figure 2 shows the total amount of birr retained and utilized by health facilities in the region over the last four years. In 2013/14, for example, over 88.5 million birr were retained and 93.6 million birr utilized; in 2016/17, 142.3 million birr was retained and 201.5 million birr utilized. This represents a more than 1.6 times the amount of revenue collected and more than doubling of the amount utilized over three years. The amount of money utilized exceeds the retained revenue for each year because facilities are allowed to carry over and utilize retained revenue from prior years.

Figure 2. Revenue Retained and Utilized by Health Facilities (birr)



	2013/14	2014/15	2015/16	2016/17
Retained Internal Revenue	88,592,435	92,548,971	129,659,038	142,314,924
Utilized Internal Revenue	93,663,664	133,383,958	164,353,609	201,570,728

Implementation of RRU at Maichew Lemlem Karl Hospital

Data from Maichew Lemlem Karl hospital illustrates Tigray region's health facilities performance in implementing RRU. Data collected since 2013 show that the hospital has generated more and more resources every year and has utilized most of the retained revenue, from 71 to 92 percent, in the same fiscal year. Over the five years, the hospital doubled the amount of revenue it mobilized and retained, from approximately 3.4 million birr in 2013 to nearly 8.8 million birr in 2017. In addition to purchasing drugs and medical supplies, the hospital used its retained revenue to construct a new surgical ward (450,000 birr), furnish the waiting room with comfortable chairs (120,000 birr), and acquire new medical equipment such as a clinical chemistry analyzer (1,200,000 birr) and a hormone analyzer (550,000 birr). These upgrades expanded the diagnostic and treatment capabilities at the hospital.

The Pentra C400 clinical chemistry analyzer (bottom) enables Maichew Lemlem Karl hospital to perform blood and urine tests, which help diagnose kidney and liver function problems, anemia, tuberculosis, and other health issues.

Community-based health insurance

To address the issue of high out-of-pocket spending for health services, a major financial barrier to care seeking, and to generate more resources for the health sector over the long run, the Ethiopian government piloted and scaled up CBHI for citizens in the agricultural and informal sectors. The implementation of CBHI in Tigray started in 2011 as part of the pilot.

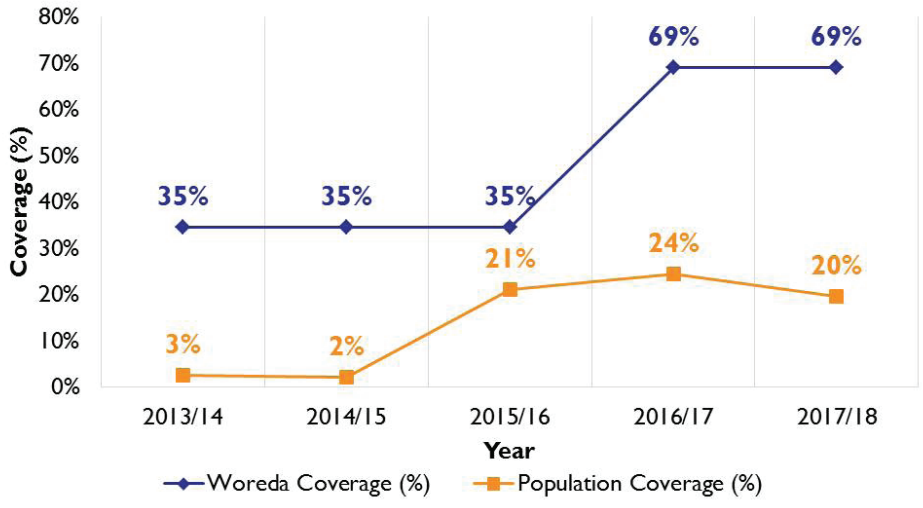
HSFR/HFG supported the government in developing and adapting the CBHI directive, manuals, and bylaws. It also provided training to RHB, woreda administration, woreda health office, and CBHI scheme staff and to woreda and kebele cabinet members on the concepts and principles of CBHI, the design parameters of CBHI in the region, implementation procedures and practices, CBHI financial management, and program monitoring, review, and reporting requirements. Further, the project supported the RHB in organizing high-level conferences that were important in advocating for CBHI to key stakeholders in the regions. Project engagement in community mobilization through the use of regional media was an important area of support which helped to expand and build membership to the CBHI schemes.

COVERAGE

CBHI implementation started in 2011 in the three pilot woredas of Aheferom, Kilte Awlalo, and Tahitay Adiabo. Based on the findings of the pilot evaluation conducted by HSFR/HFG, the project supported the scale-up of CBHI to 36 woredas in the region (34 rural and 2 urban). CBHI now reaches 69 percent of Tigray's 52 woredas, including all rural woredas. The Ethiopian government's Health Sector Transformation Plan sets a target of covering 80 percent of the woredas by 2020. With all rural woredas currently covered by CBHI, the region seems on track to achieve the target.

In terms of uptake of the program by the community, the population coverage ratio in 2016/17 was about 24 percent of the total population of Tigray, and it stands at 20 percent through the first three quarters of 2017/18[1] (Figure 3). In woredas that have established CBHI schemes, the enrollment ratio reached on average 57 percent of eligible households in 2016/17. Although the achievement in population coverage is low when compared to government targets, it is still promising and over one million beneficiaries have access to health services through the CBHI program.

Figure 3: CBHI Coverage, 2013/14-2017/18*



*Through March 31, 2018.

[1] The current enrollment ratio for 2017/18 is based on data as of March 31, 2018, i.e., for three-quarters of the year. Final figures for the year are expected to be available in June 30, 2018.

RESOURCE MOBILIZATION

The major sources of revenue for the CBHI schemes as outlined in the regional directive include contributions from households, the targeted subsidy from the regional and woreda administration for poor households, and the general subsidy from the federal government for the CBHI schemes. The magnitude of resources mobilized through CBHI schemes has increased significantly with more woredas implementing the program and an increasing number of households enrolling in the schemes every year. In the five years since 2013/14, CBHI schemes have mobilized close to 92 million birr in contributions from enrolled households (Figure 4).[2]

That said, some fluctuation in the amount of resources mobilized has been observed mainly due to a drop in enrollment in some CBHI-implementing woredas due to insufficient community mobilization by local authorities.

Furthermore, as some woredas have taken longer to launch their CBHI schemes, contributions collected from households that enrolled early on are reflected in their year of registration, affecting the total amount of resources mobilized in recent years.

Figure 4. Contributions from Enrolled Households (Birr)

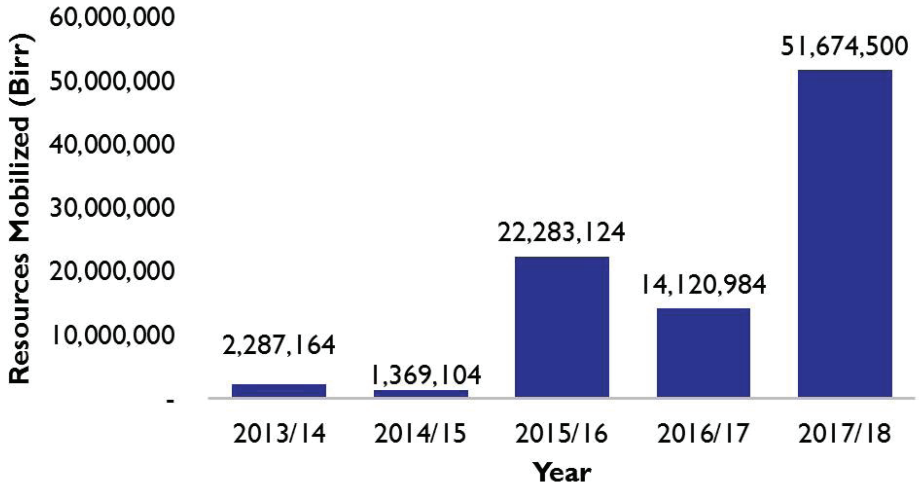
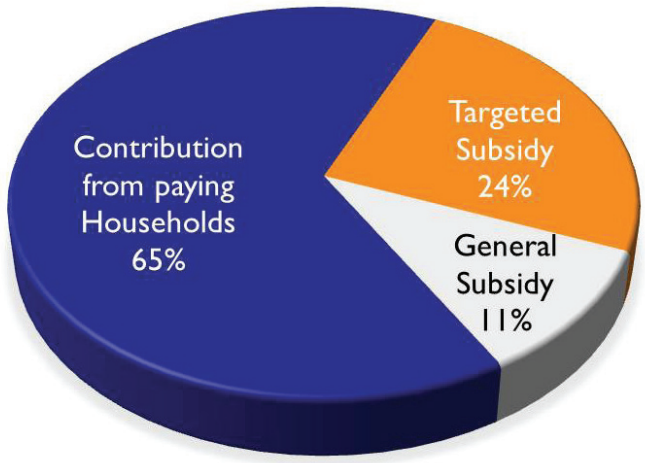


Figure 5. Share of CBHI Revenue Sources



During the same five-year period, CBHI schemes mobilized close to 34.6 million birr in targeted subsidy and 15 million birr in general subsidy (Figure 5).[3]

The total amount of resources mobilized from the three sources of revenue was about 141.3 million birr.

[2] Amount shown is as of March 31, 2018. The figure could increase, as enrollment and re-enrollment activities are underway at the time of this publication.

[3] The amount of general subsidy for 2017/18 has not yet been allocated to the schemes. The estimated figure shown here is based on the sum of the contribution collected from households and targeted subsidy allocated from regional and woreda administrations. This amount could change as registration and renewal are still underway at the time of this publication.

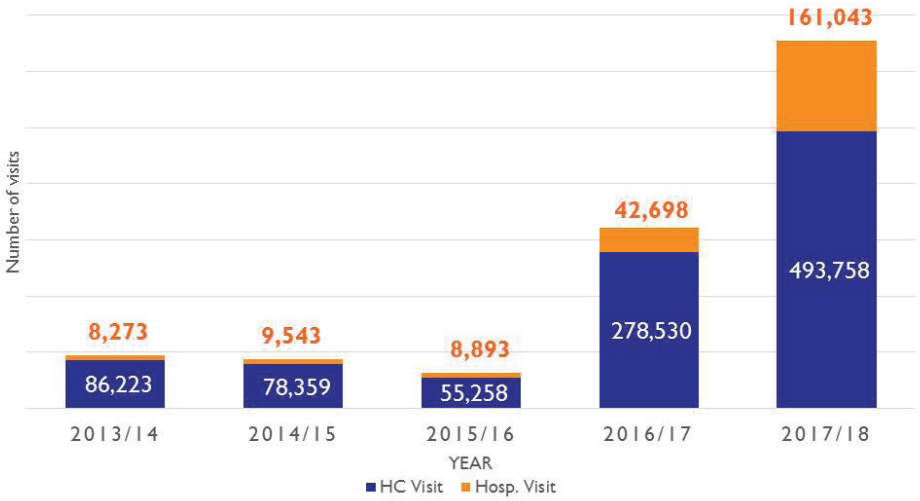
HEALTH SERVICE UTILIZATION

A primary goal of CBHI is to increase people's utilization of health care services. To facilitate this, CBHI schemes enter into contractual agreements with public hospitals and health centers. Over the past four years, CBHI beneficiaries in Tigray have sought care in 166 contracted health facilities (138 health centers and 28 hospitals). The majority of the visits (87 percent) are made to health centers, which is in line with Ethiopia's prevention-focused health policy that requires all first-time visits be at the primary health care level. There are also recent efforts to include private providers, particularly pharmacies, in the program, as they could fill gaps that may be created when prescribed drugs are not available in public facilities. The CBHI schemes of Hawzen and Raya Azebo woredas do this: they have contracted with private pharmacies to enable CBHI beneficiaries to obtain prescribed drugs without paying out of pocket when those drugs are not available at public facilities.

While the effect on the sustainability of the two CBHI schemes is a topic for future investigation, the price that these schemes have negotiated with the private vendors seems favorable to the schemes; it is lower than the price of drugs in public facilities in the case of the Hawzen CBHI scheme and has only a 10 percent mark-up in the case of the Raya Azebo scheme.

With respect to the CBHI goal of increasing utilization, the trend in total number of visits has been positive although there were fewer visits to health centers in 2015/16 due to drops in membership and poor health service quality as reflected in various platforms such as review meetings, where successes, failures and challenges are critically looked at by key actors of the program. As Figure 6 shows, the number of visits made by CBHI beneficiaries increased from 86,223 in health centers and 8,273 in hospitals in 2013/14 to 493,758 and 161,043, respectively, in the first three quarters of 2017/18. The sharp increase since 2015/16 is mainly due to the increased number of households enrolled in CBHI schemes and the partial resolution of the health service quality problems. A recent HSFR/HFG study that included four CBHI schemes in Tigray found that CBHI is contributing to a significant improvement in health service utilization of its beneficiaries: 0.78 visits for CBHI members as opposed to 0.49 visits for non-members.[4]

Figure 6: Health Service Visits by CBHI Beneficiries by Facility Type



[4] The HSFR/HFG study, "Community-Based Health Insurance Performance and Implementation Challenges: A Study of Data from Sample Schemes, Kebeles, and Health Facilities," assessed 30 CBHI schemes.

NETWORKING AND COMMITMENT

The main challenge to implementing the CBHI program has been having the full support and commitment of government leadership at all levels of the governance structure. HSFR/HFG in collaboration with the RHB and EHIA organized a Tigray Regional CBHI Conference on May 15, 2017, whose participants included high-level federal and regional officials. As a result, regional, zonal, and woreda-level leadership understand that CBHI is a core element of the woreda health transformation agenda, and woredas and kebeles are striving to achieve the targets set out in the Ethiopian government's Health Sector Transformation Plan.

The RHB used the conference as a platform for disseminating best practices to schemes and woreda officials. Schemes shared their successes and challenges, and best-performing schemes were publicly recognized, which motivated other woredas/schemes to improve their performance. The conference was particularly important since it was a strong signal of the regional government's full and strong support for the successful implementation of the CBHI program.

(Top) Regional and federal senior officials – Ato Atakelti Abraha, EHIA General Director; Dr. Amir Aman, Minister of Health; Ato Abay Weldu, Tigray Regional President; and Dr. Hagos Godefay, Tigray RHB Head – and other participants listen to reports on CBHI performance during the Tigray Regional CBHI Conference. (Bottom) Dr. Amin Aman, Minister, Federal Ministry of Health, provides directions to participants on the way forward at the end of the conference.

KEY LESSONS LEARNED

Key lessons learned from the implementation of various health care financing reforms in Tigray are as follows:

Health care financing reforms require strong government support and political commitment. Aheferom and Raya Azebo CBHI schemes provide a good example of the difference committed leadership makes to the success of reform implementation. Aheferom woreda administration was reluctant to provide the required leadership and, as a result, its CBHI enrollment is a low 25 percent of eligible households; in contrast, the Raya Azebo woreda administration was the main force behind mobilizing and sensitizing the community, and its CBHI enrollment is 80 percent.

Close partnerships between government and development partners, and collaboration across regional structures and EHIA branch offices, helps implementers to: avoid duplication of effort; maximize efficient use of financial resources; and, achieve better results in implementation, uptake of reforms, and accountability (which, in turn, also improves trust by the community in the reforms).

Institutionalization of reforms by establishing the required structures, particularly for CBHI, is critical to the sustainability of the program.

It is important to first consolidate successful health insurance implementation in rural woredas that have already started implementation before gradually expanding to other areas, particularly urban woredas.

To share and cross-fertilize knowledge and successful practices, it is important to compile and disseminate best practices of schemes and woredas in activities such as community mobilization for CBHI and photographing households for CBHI identification cards.

Continuous technical support to build the capacity of all implementers of reform is still important as there are some capacity problems in areas such as health insurance implementation and financial management, particularly at the woreda and health facility level.

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A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services.
The HFG project is a six-year (2012-2018), $209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.
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Cooperative Agreement Number:
AID-OAA-A-12-00080
Agreement Officer Representative Team:
Scott Stewart (GH/OHS) sstewart@usaid.gov
Jodi Charles (GH/OHS) jcharles@usaid.gov

Abt Associates
www.abtassociates.com
6130 Executive Boulevard
Rockville, MD 20852