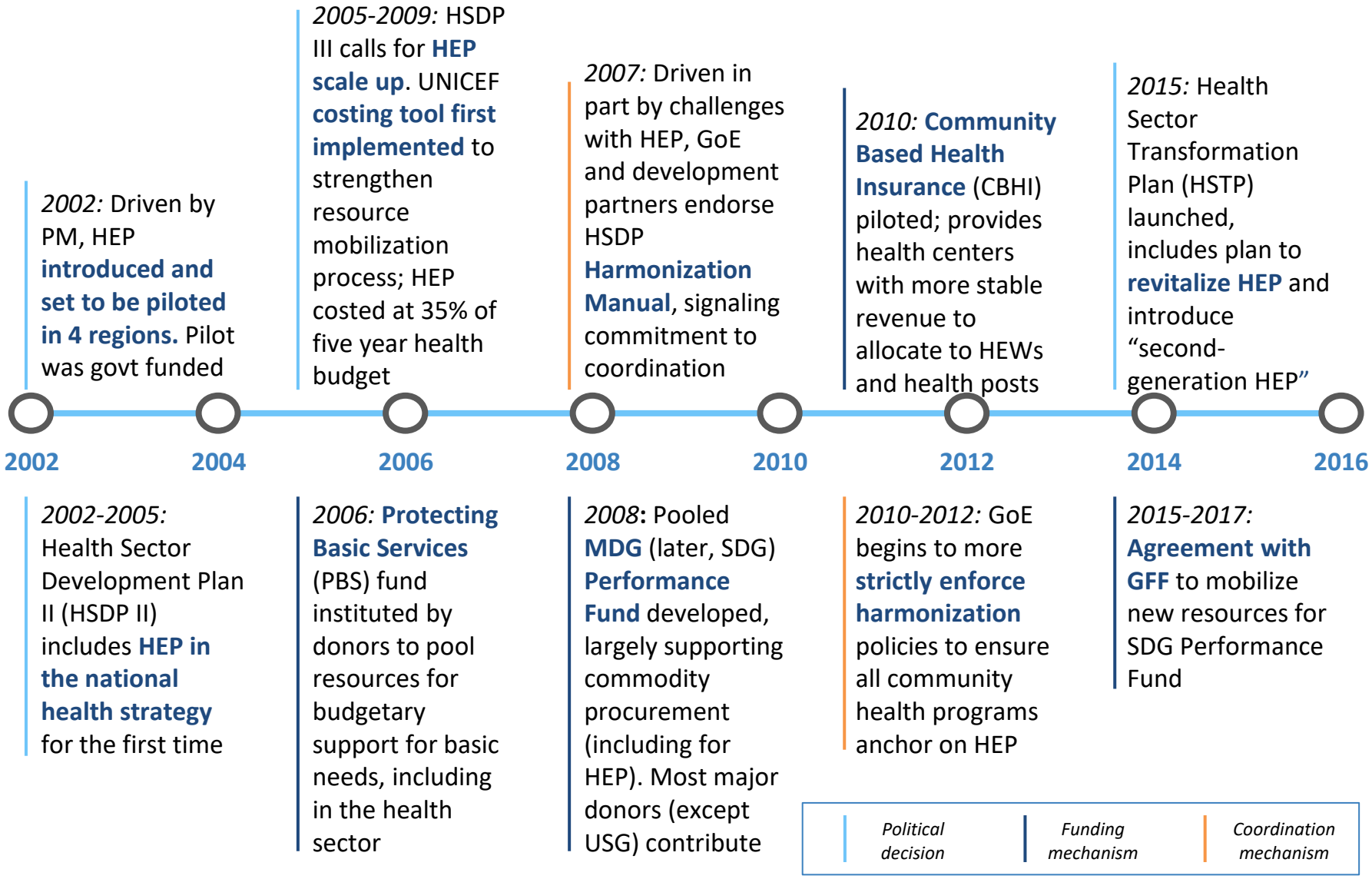
Financing Alliance for Health

Country Case Study: Ethiopia

The HEP began in 2002, with resource harmonization mechanisms introduced in 2007

Financing Alliance for Health



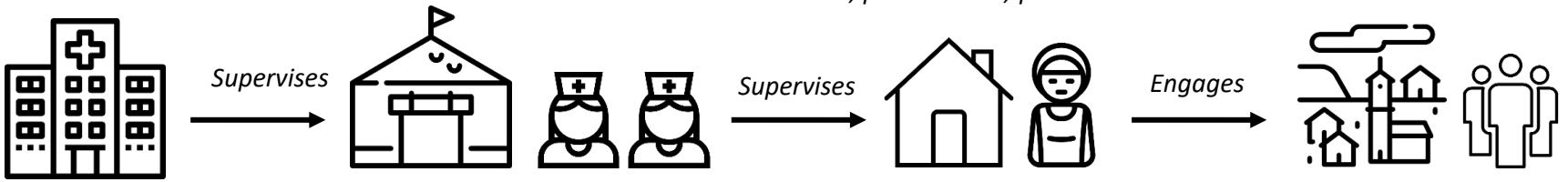
Source: HSDP I-IV; HSTP; HSDP Harmonization Manual; IHP, Roadmap for Enhancing Implementation of One Plan, One Budget, and One Report in Ethiopia (2012); expert interviews.

Ethiopia's CH system includes ~40,000 salaried HEWs who supervise ~4 million HDA volunteers

Financing Alliance for Health

Ethiopia Health Extension Program (HEP) operating structure (2003 – Present, HDAs introduced in 2011)

Delivers curative, preventative, promotive services



1 primary health center per 25,000 people

5 health posts per health center, each with 2 HEWs and covering 5000 people

HDA volunteers, leading one-to-five networks of 25 people within their own communities

Kebele community of ~1000 households

Health Extension Workers

- **# in workforce:** 40,000, mostly in rural areas (1:2500 population)
- **Time spent:** Full time, 50% at health post (curative services), 50% community promotion activities
- **Interventions:** 1) disease prevention & control 2) hygiene & environmental sanitation 3) family health 4) health education & communication
- **Selection:** Female aged 18-30 with 10th grade education + residence in the village + local language
- **Training:** 1 year theoretical + practical training
- **Health system linkage:** Refer clients to health centers
- **Incentives:** ~$83/month salary

Health Development Army volunteers

- **# in workforce:** 4M HDAs, (1:25 population)
- **Time spent:** A few hours a week, leading one-to-five network meetings and assisting HEWs
- **Interventions:** Promote healthy behaviors among neighbors and mobilize demand for PHC services
- **Selection:** Woman belonging to a "model family"; trusted by community members
- **Training:** 15-day training delivered by HEWs on high-impact maternal and newborn health services
- **Health system linkage:** Refer peers to health post
- **Incentives:** Unpaid, but receive nonfinancial incentives

The HEP is widely credited with improving Ethiopia's health outcomes (e.g., 2x increase in immunization, 2.5x increase in contraceptive prevalence, 10x increase in skilled attendants at birth.)

Sources: Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations (2015), A Comprehensive Description Of Three National Community Health Worker Programs And Their Contributions To Maternal And Child Health And Primary Health Care (2016), Health Extension Program: An Innovative Solution to Public Health Challenges of Ethiopia A Case Study (2012), Ethiopia Health Extension Program An Institutionalized Community Approach For Universal Health Coverage (2016), Flaticon, Community Health Systems Catalog Country Profile: Ethiopia (2017)

Financing to the health extension system comes through three channels, including via pooled funds

Financing Alliance for Health

	Channel 1: Ministry of Finance	Channel 2: Ministry of Health	Channel 3: Outside of GoE oversight
Description	Flows via Ministry of Finance. Includes unearmarked general budget support from donors (PBS) and GoE, and program-specific funds from some donors	Flows via Ministry of Health. Includes pooled donor funds (M/SDG fund) and program-specific funds from some donors	Flows from donors via implementing partners, largely outside of GoE oversight (but aligned with govt strategies)
*% of total health funding:**	50% (includes GoE and donor budget support funds)	25%	25%
Key mechanisms	**Promoting Basic Services (PBS):** Pooled donor fund launched in 2006 to provide general budget support for basic services (across sectors) via federal block grants. ~20% of PBS at woreda level used in health, largely for HEW salaries, and some for procurement	**M/SDG Performance Fund (MDG PF):** Non-earmarked pooled donor fund for health sector support, launched in 2008. Scope of activities determined through consultative process and joint financing agreement (JFA) each year. Funds supplies, training, construction (not salaries). Became SDG performance fund in 2015.	N/A
Major donor contributors	• *PBS:* CIDA, Italy, Netherlands, WB • *Other Channel 1:* Austria, Spain, Irish Aid, UNICEF, UNFPA, WHO	• *M/SDG PF:* DFID, Irish Aid, Italy, Spain, Netherlands, GAVI, UNFPA, WHO, WB • *Other Channel 2:* UNDPA, CIDA, Italy, USAID, WB, Global Fund	• USAID, PEPFAR, CDC (largest) • Most other bilateral and some multilateral donors provide some funds through channel 3

*Approximated based on Harvard/MoH data from 2010. . Source: Adapted from Harvard/BIC, "Ethiopia's Progress in Health Financing and the Contribution of the 1998 Health Care and Financing Strategy in Ethiopia" (2015). Estimates of % of funding through each channel are order of magnitude based on Harvard/MoH data from 2010. Indicative, not comprehensive.

Four key lessons have emerged from Ethiopia's HEP

Financing Alliance for Health

1. Strong **political commitment** from all levels – especially the top – is key to securing funding; govt resource commitments signal this to donors

2. Close, ministry-led **coordination** among donors, partners, and govt can help to secure funding and eliminate inefficiencies, while solidifying government leadership of CH

3. Mobilizing **local resources** – from local health facilities and from communities themselves – helps ensure programmatic and financial sustainability

4. Even if programs are donor dependent initially, thinking proactively about **innovative financing sources** can help to secure longer-term sustainability

Strong political will from PM and MoH, demonstrated through commitment to HEW salaries, drove the HEP

Financing Alliance for Health

Top-to-bottom support from Prime Minister to woreda administrations has driven success over time….

PM

- PM Meles Zenawi, inspired by agricultural extension agent model and best practices in India and Ghana, **conceptualized the HEP in the early 2000s**

MoH

- PM brought in MoH Dr. Tedros and his deputy in to help design pilot; Dr. Tedros became **champion for HEP throughout his tenure**

RHBs

- PM/MoH piloted HEP in 4 politically favorable regions to **build evidence** and test how **political leadership for HEP could cascade to lower levels**
- PM/MoH **met regularly with Regional Health Bureau (RHB) heads, who in turn discussed with woreda leads**

- HEP plays **central role in every health sector strategy, and resources continuously allocated** for scale up
- Buy-in at all levels secures **program sustainability despite leadership changes**

…and this commitment, demonstrated through pilot and govt salaries for HEWs, catalyzed donor funding

- GoE **self-funded pilot** to test and build evidence on the model before soliciting donor support
- Recognizing that prior vertical, NGO-funded, community based health volunteers were **inefficient and unsustainable**, GoE committed to put HEWs onto government payroll from the start

- Impact of pilot **piqued donor interest and fostered commitments to building upon and scaling HEP**
- **Salary payments demonstrated to donors that GoE was committed** to the HEP for the long run, encouraging them to fill in funding gaps

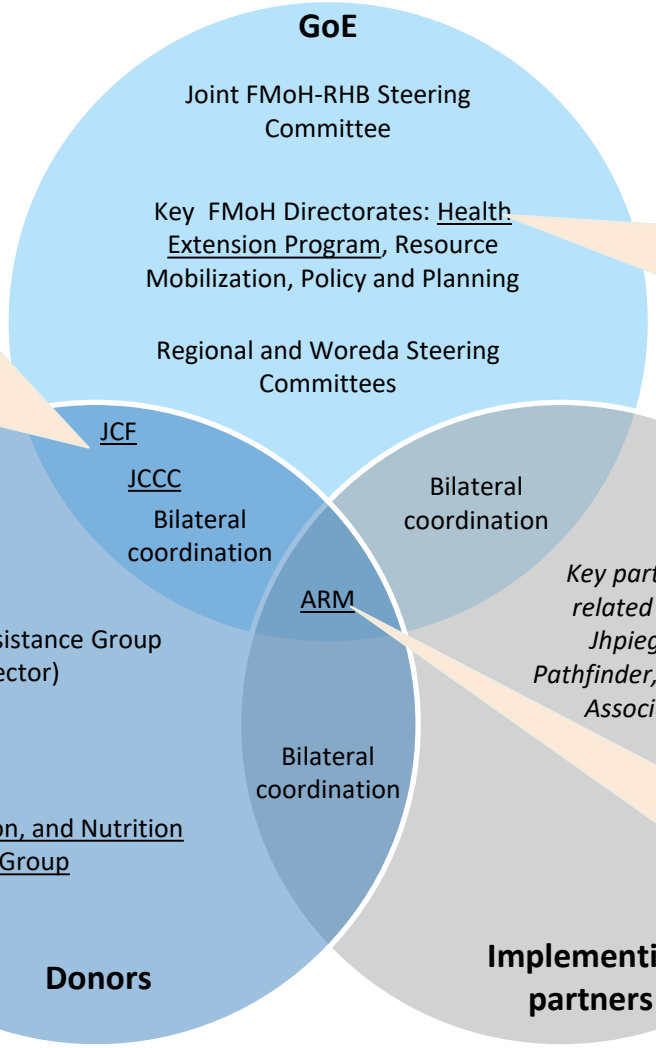
Source: Expert interviews.

Ethiopia mobilizes resources via strong coordination bodies, both within the MoH and with partners

Financing Alliance for Health

The Joint Consultative Forum (JCF), co-chaired by the HPN and the Minister of Health, is the highest governing body, and serves as a forum for **GoE and donor coordination on health policy and resource mobilization**. It oversees allocation of pooled funds.

The Joint Core Coordinating Committee (JCCC) is the technical arm of the JCF and provides operational oversight, including of funding allocation. It meets every 2 weeks; HEP is a key agenda item.



The FMoH has a **dedicated, central** directorate for health extension. The HEPD coordinates with other directorates (e.g., MCH, Disease Prevention and Control) on programming, and with the PPD and RMD on strategy and resource mobilization.

Key partners with HEP related work include: Jhpiego, JSI, CHAI, Pathfinder, PSI, UNICEF, Abt Associates, AMREF

The HPN donor group (members from all major health donors e.g., USG, DFID, GFATM, GAVI, WB, BMGF) allows **donors to coordinate** on filling resource gaps, and to engage as a single body with the GoE.

At the **Annual Review Meeting**, all stakeholders, including at the regional and woreda levels, come together to review annual health plans, including **budget, resource mapping, implementation plans, and M&E.**

Underline= highest leverage bodies for HEP

"Dr. Tedros took a very diplomatic approach to engaging [donors operating in siloes] to say: 'we are grateful for your support, but we need to strengthen the system.'" – Former Chief of Staff to the MoH

Indicative, not exhaustive. Source: Expert interviews; Harmonization Manual (2008); HSDP IV (2010).

These bodies supported the "One Plan" approach to ensure resource efficiency and govt ownership of HEP

Financing Alliance for Health

"One Plan, One Budget, One Report[1]"

- In 2007, the GoE and development partners endorsed the **HSDP Harmonization Manual**, in accordance with the IHP+ Global Compact on effective development cooperation
- It included **practical guidelines on bodies, mechanisms, and tactics** for collaboration, coordination, and alignment
- The manual signaled mutual commitment to a **singular, aligned health strategy and budget**, including for the HEP, and it fostered **government ownership of the HEP**, with donors and implementing partners in supporting roles

Strategic harmonization

- Donors and partners work closely with the MoH via coordinating bodies to design programs
- All CH programs must **build on** the HEP – e.g., through capacity building, training, or provision of additional commodities
- The government strictly regulates programs to ensure that there are **no parallel or redundant systems** to the HEWs and HDAs

Funding harmonization

- Use of pooled funds encouraged whenever possible
- Close coordination with government on independent (channel 3) donor funds in order to **fill resource gaps** and support harmonized strategy
- Programmatic alignment supports **resource efficiency**, as parallel systems are streamlined to support HEP

1. "One Report," referring to standardized M&E, is not discussed in detail here. Source: HSDP Harmonization Manual (2008); Expert interviews.

Local human and financial resources strengthen HEP system and complement donor/govt allocations

Financing Alliance for Health

CHWs trusted by the village attract **in-kind community contributions** to serve the common good

Contributions to the HEP:

- In-kind: food, drink, and accommodation for HEWs
- Contribute to construction of health posts in kebeles

Motivation behind contributions:

- Serving common good is a widespread mentality in rural communities
- HEWs grew up as "girls from that community", garnering respect and trust
- HDAs and their families serve as role models, encouraging support from neighbors

Volunteer **community-embedded HDAs** increase service quality and reach of HEP at low cost

Contributions to the HEP:

- Promote healthy behaviors, preventing diseases and reducing HEW workload
- Track and refer families in one-to-five networks to HEWs
- Assist HEWs in campaigns and visits from health posts

HDA in the 2nd generation HEP:

- 300K HDAs will be trained as level 1/2 workers, shifting basic services to HDAs and freeing up HEWs to perform advanced curative services

PHC financing reforms empower health centers financially, which trickle down to health posts

GoE's Health Sector Financing Reform (HSFR):

1. **Community Based Health Insurance** collects premiums from households and reimburses health centers
2. **Revenue retention** allows health facilities autonomy in budgeting decisions

These reforms give HCs more and more predictable resource flow, enabling more allocation for health posts (e.g., commodities)

Sources: Second Generation Health Extension Program brief; expert interviews.

New financing sources are needed to sustain the HEP as Ethiopia transitions away from donor support

Financing Alliance for Health

The FMOH plans to pursue several new financing modalities for the Health Extension Program

Innovative financing

- FMOH Resource Mobilization Directorate finalizing **Global Financing Facility** (GFF) agreement with WB
- GFF performance-based financing will help close resource gap for 2nd generation HEP

Private sector

- FMOH has plans to set up **CSR** arrangements with national, regional, and local companies
- Commercial Bank of Ethiopia upgrading 10 HCs; similar collaboration could be pursued for HEP/HPs

Government resources

- Plans to facilitate increased contributions from **regional and woreda-level administrations** to cover commodities
- FMOH intends to negotiate with **MOFED** to increase budget allocations to health and HEP,

Several challenges lie ahead that could hinder the HEP from achieving financing sustainability

- **Changes in political leadership of FMOH** entail shifts in strategic priorities and lack of follow-up from predecessors' efforts to bolster financing sustainability for the HEP
- Given health sector's significant investment in PHC in the past decade, there is an **intensified struggle for limited resources** coming from stakeholders who are fighting for more investment in facility-based care going forward
- The lack of user fees at the health post results in **lack of incentives for the private sector** to engage beyond CSR

Even with increased government and donor contributions, an estimated annual resource gap of ~725M USD or more will still exist for implementing primary care between 2016-2020.

Sources: Financing Ethiopia's Primary Care to 2035: A Model Projecting Resource Mobilization and Costs (2015), Scenario 1 and 2; expert interviews.

Other countries can apply these lessons based on their own contexts

Financing Alliance for Health

Lessons from Ethiopia	*Key considerations for other countries*
1 **Political commitment**	**In the absence of top-down political will, consider strategic evidence-based advocacy** • Different political contexts may require more advocacy with key actors, including the use of data and evidence on impact/cost-effectiveness
2 **Coordination & harmonization**	**Take steps to improve coordination, even if full harmonization is hard in near term** • Mechanisms for CH governance (i.e., dedicated directorate) and partner coordination (e.g., joint forum) are key first steps; govt must lead • If govt-led CH program is not yet at scale, link closely to partners' CH systems to provide leverage, maximize efficiency, and enforce govt ownership
3 **Local resources**	**Undertake local reforms to free up resources for CH, and embed CHWs in communities to catalyze support** • In decentralized systems, strengthening predictability of facility funding can trickle down • Embedding CHWs in communities can foster local buy-in and in-kind resource commitments
4 **New & sustainable funding sources**	**Create a plan for financial sustainability at the outset, including transition from donor support** • Include clear strategies (e.g., plans for donor sunset, mapping of innovative sources) as part of initial budgeting and resource mobilization plans

While Ethiopia's political context is unique, other countries can apply these general principles to mobilizing financing for their own community health systems.