ETHIOPIA HEALTH SECTOR FINANCING REFORM/HEALTH FINANCE AND GOVERNANCE/ (HSFR/HFG) PROJECT

SYNTHESIS OF DATA COLLECTED FROM HEALTH FACILITIES THROUGH SUPPORTIVE SUPERVISION

HSFR/HFG PROJECT YEAR 1 (2013/14)

August 2016
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ACRONYMS

ANC	Antenatal Care
BoFED	Bureau of Finance and Economic Development
CBHI	Community-based Health Insurance
EFY	Ethiopian Fiscal Year
EPI	Expanded Program on Immunization
F&A	Finance and Administration
FMOH	Federal Ministry of Health
FP	Family Planning
HC	Health Center
HCF	Health Care Financing
HCFS	Health Care Financing Strategy
HEW	Health Extension Worker
HFG	Health Finance and Governance
HMIS	Health Management Information System
HSDA	Health Services Delivery and Administration
HSFR	Health Sector Financing Reform
ISS	Integrated Supportive Supervision
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
PFL	Procurement, Finance, and Logistics
PFPA	Procurement, Finance, and Property Administration
PFSA	Pharmaceutical Fund and Supply Agency
PICT	Providers Initiated Counseling and Testing
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
RHB	Regional Health Bureau
SNNP	Southern Nations, Nationalities, and Peoples
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDRL	Venereal Disease Research Laboratory
WoFED	Woreda Finance and Economic Development
WorHO	Woreda Health Office
ZHD	Zonal Health Department

EXECUTIVE SUMMARY

The Ethiopian Federal Ministry of Health (FMOH) has adopted a principle called the "Three Ones" – one plan, one budget, and one report – in establishing its single shared monitoring and evaluation (M&E) system. Data collected and analyzed by the ministry's M&E as well as its Health Management Information System (HMIS) converge in "one report," with data reflecting information recorded at the time of service delivery or administrative transaction. However, the HMIS does not supply all of the information required to monitor health sector performance. Information from other sectors (e.g., education, agriculture, and water and sanitation) and from additional sources (e.g., demographic and health surveys, census figures, vital registration, and other national health surveys) are needed to provide a comprehensive picture of health status and needs. Furthermore, effective and continuously improving HMIS/M&E depends on ongoing supportive supervision and the feedback mechanism that it provides to track the progress and performance of various health sector reforms (e.g., business process re-engineering, balanced score card, hospital reform, and health care financing). The Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) project has been providing technical support to the FMOH and regional health bureaus (RHBs) to strengthen the health system in general and has particularly supported the implementation of health care financing reform (first generation) and health insurance initiatives (second generation), of which supportive supervision is an integral part.

The Ethiopian government has introduced a wide range of health care financing (HCF) reforms aimed at increasing the availability of resources for health and thereby protecting the population from catastrophic spending at time of sickness. These reforms include allowing health facilities autonomy to establish facility governance structures, retain and use resources generated at the facility level to improve the quality of health services, improve protection of the poor through a fee waiver system, and provide certain exempted services that are in effect public goods. They also allow public hospitals to establish private wings and outsource non-clinical services. These reforms were first implemented in Amhara, Oromia, and Southern Nations, Nationalities and Peoples (SNNP) regions and then expanded to all other regions and the country's two city administrations (Dire Dawa and Addis Ababa). Supportive supervision is used by HSFR/HFG to monitor the performance of health facilities in implementing these reforms; supervisors use a standard checklist developed under the project to review and offer feedback on facility progress.

This report synthesizes data collected from supportive supervision monitoring visits conducted under HSFR/HFG between August 1, 2013 and June 30, 2014 (HSFR/HFG Project Year 1 and Ethiopian Fiscal Year 2006), and presents key findings and recommendations. Project staff conducted supportive supervision visits at 549 health facilities (25 hospitals and 524 health centers (HCs)) in Afar, Amhara, Benishangul-Gumuz, Gambella, Harari, Oromia, SNNP, and Tigray regions, and Addis Ababa and Dire Dawa city administrations. Though there are variations among facilities and regions, findings indicate that: most of the facilities visited had the required management, finance, and administrative staff in place to implement HCF reforms; health facility finance staff had at least a diploma level of education; and half had received in-service training on HCF reform implementation and financial management. However, 88.0 percent of hospitals and 57.4 percent of HCs encountered staff turnover for various reasons, which resulted in skill and knowledge gaps in their financial management. In addition, 96.5 percent of facilities had established facility governing boards/bodies, and board/body members had received training on facility governance. However, only 84.0 percent of hospital governing boards and 57.5 percent of HC

governing bodies met on a regular basis.[1] The remaining ones either did not meet or held meetings on an as-needed basis due to scheduling challenges or frequent membership turnover. These findings indicate a need to regularly monitor, strengthen, and motivate board members to meet regularly and make timely decisions, particularly at the HC level.

Supportive supervision data also revealed that the government-allocated budget for hospitals grew on average from nearly 4.4 million Birr in 2007/08 to 7.7 million Birr in 2013/14 while the government-allocated budget for the HCs remained below 1 million Birr. In the same period, the non-salary recurrent budget allocated to health facilities as a proportion of the total health budget showed a declining trend in all regions which might be due to additional government investment in constructing and operationalizing new health facilities. On average, retained revenue covered nearly 27.8 percent of the total health budget allocated to hospitals and 21.0 percent of the annual budget allocated to HCs. Although the amount varies by region and by health facility, the share of government-allocated budget from treasury to the total annual budget of hospitals was found to be low in comparison to the government budget allocation from treasury for HCs. Supportive supervision findings indicate a strong need for continuous dialogue with regional councils and Bureau of Finance and Economic Development (BoFED) offices, as well as with their counterparts at the zonal and woreda levels to increase the budget for health facilities without offsetting the revenues generated from user fees.

A HCF legal framework developed, updated, and endorsed with technical support from USAID projects including HSFR/HFG, allows public health facilities implementing HCF reforms to collect, retain, and use the revenue they generate to make quality improvements at their facilities; this revenue is in addition to their government budget. A prototype legal framework was developed at the federal level and has since been adapted for use at regional levels. As per the HCF legal framework, all revenues must be appropriated before use. Accordingly, facilities are expected to estimate and report to their respective governance board/body the amount of revenue they anticipate collecting from all sources in the coming fiscal year. The governing board/body reviews and approves the budget before submitting it to the regional or woreda health office, which in turn submits it to the regional or woreda cabinet for endorsement, and subsequent submission to the regional councils (legislators) for incorporation into the annual budget appropriation. Results of supportive supervision indicate that the average amount of appropriated annual budget from retained revenue was 3,458,722 Birr for hospitals and 295,475.26 Birr for HCs. In the quarter preceding the supportive supervision visit, the average hospital used 865,504.83 Birr (25 percent of their appropriated budget) and the average HC used 94,175.34 Birr (31.9 percent of their appropriated budget). Based on these findings, facilities should work to ensure that retained revenue is used to improve the quality of health service delivery. In addition, they need to collaborate with health authorities at various levels to ensure proper and timely utilization of retained revenue.

The HCF Strategy (Federal Ministry of Health, 1998) emphasizes cost sharing between government and health care users but the national strategy and associated regional legal frameworks state that user fees need to be revised based on people's ability to pay as well as the cost of providing services. In most regions, regional councils are responsible for revising user fees. Findings from supportive supervision visits indicate that approaches to user fee revision, as well as the amounts of the revised fees, vary substantially by region and facility. Of the facilities visited, only six hospitals (24 percent) and 226 HCs (43.1 percent) had a revised user fee schedule in place. Regional councils and/or RHBs, authorized by the HCF legal framework to monitor user fee revisions process and implementation, need to better monitor user fee revision processes and applications, and ensure that standardized user fee revision approaches are used.

[1] Health facility board regular meeting schedules vary by region. Meetings typically take place monthly, or every two or three months depending on the legal and operational frameworks of the region.

HCF reform also entitles the poor to obtain health services through a new fee waiver system and the general public to obtain fee-exempted health services (e.g., pre- and postnatal as well as delivery services, and immunization for children under five years old). Facilities are reimbursed for providing fee-waiver services by their regional government and/or woreda/city administration, and by a Community-Based Health Insurance (CBHI) scheme, funded by the membership contributions of paying beneficiaries and by woreda and regional governments for indigents.

Of the 549 facilities visited, 323 provided services free of user fees: nine hospitals (36 percent) and 201 HCs (38.4 percent) were implementing the fee waiver system, and four other hospitals (16 percent) and 109 HCs (21 percent) were providing fee-waived services to indigent/non-paying households and costs facilities incurred was covered through targeted subsidy. Regarding reimbursement for provided to fee-waived beneficiaries, only a little more than half of the facilities in Addis Ababa and Benishangul-Gumuz (58.3 percent and 57.1 percent, respectively), half of the facilities in Dire Dawa city administration, and less than half in Tigray (45.6 percent), SNNP (16 percent), Amhara (17.7 percent), and Oromia (5.1 percent) regions were fully reimbursed costs incurred to provide services. This situation calls for continuous advocacy and dialogue with policymakers at all levels (federal, regional, and woreda) about the importance of full implementation of either the new fee waiver system or targeting and coverage of indigents under the CBHI program to ensure equity in health services provision.

In terms of exemptions, 344 (67.5 percent) of the facilities visited – 16 hospitals (64 percent) and 328 HCs (62.6 percent) – posted the list of exempted health services in their compound. Nearly 90 percent (490) provided these services free of charge to the general public. Concerns of health facility staff that provision of exempted health services would drain the facility's retained revenue, shortage of drugs and medical supplies in the market, and shortage of government allocated budget for drugs and medical supplies appeared to be major challenges to implementing the reform. Government authorities at different levels need to strengthen the availability of drugs and medical supplies, and allocate a budget to cover the provision of exempted services. This will enable the health system to improve the quality of and equity of and access to health care services.

The HCF legal framework also permits public hospitals to establish private wings/rooms on their premises to provide options for patients who can afford to pay higher or close-to-market rates and generate additional revenue for the hospital. This revenue funds motivation and incentive systems to encourage retention of health workers (mainly specialists). However, only nine public hospitals[2] had established a private wing/room. Challenges to implementing private wings/rooms included differences in medical care provided in public wards as compared to private wings/rooms, absence of clear guidance/criteria on the assignment of hospital staff to private wings/rooms, and disagreement and conflict among staff regarding revenue sharing.[3]

[2] Adigrat, Adwa, Alamata, Lemlem Kharl, St. Mary, and Suhul (Tigray), Felege-Hiwot (Amhara), Pawe (Benishangul-Gumuz), and Halaba Kulito (SNNP).

[3] To resolve these and other implementation challenges, the FMOH recently issued a comprehensive manual with guidance for establishing a private wing/room.

Another HCF reform is outsourcing non-clinical services, which is intended to produce efficiency gains by enabling health facilities to purchase non-clinical services from a third-party vendor (e.g., catering, laundry, and security) which allows hospital management and staff to focus on clinical services. Of the facilities visited for supportive supervision, only six hospitals (Arba Minch, Chencha, Durame, and Yirgalem in SNNP; Pawe in Benishangul-Gumuz; and Suhul in Tigray) were outsourcing non-clinical services. Arba Minch, Chencha, and Durame outsourced catering services. In terms of challenges with outsourcing, hospital administrators at Pawe and Suhul hospitals remarked on the absence of licensed catering vendors in their areas and Durame hospital reported difficulty overseeing the quality of outsourced catering services; so they outsourced the supply of food items but provided catering services themselves. Health facilities need clarity on the purpose of outsourcing and better understanding about how to make informed decisions regarding which services to outsource.

1. INTRODUCTION

The Ethiopian government endorsed a HCF Strategy in 1998 (FMOH, 1998). Through consecutive projects, USAID has provided technical support for the design and implementation of the HCF reforms derived from this strategy. When the USAID bilateral Health Sector Financing Reform (HSFR) project ended in July 2013, USAID continued its technical support through the Health Finance and Governance (HFG) project.

Ethiopia's HCF reforms include: allowing health facilities to establish facility governing boards/bodies; retaining and using revenue generated at the facility level to improve the quality of health services; improving protection of the poor through a fee waiver system; and providing services that have public health benefit such as prevention (e.g., immunization of children) and maternal health services (family planning, antenatal care (ANC), postnatal care (PNC), and delivery services) through an exemption system. The reforms also allow public hospitals to establish private wings/rooms and outsource non-clinical services.

HSFR/HFG uses quarterly supportive supervision as its principal tool for monitoring the progress of HCF reform in health facilities in all regions implementing HCF reforms in a fiscal/project year. A comprehensive supportive supervision checklist, updated annually, has been developed for use in monitoring each component of the reform. HSFR/HFG sets annual supervision targets (i.e., number of health facilities to be visited on a quarterly basis) per region. Project staff, in collaboration with RHBs and zonal health departments (ZHDs), conduct the supportive supervision visits each quarter to a representative sample of health facilities selected from each region.

Supportive supervision serves four main purposes, enabling the project to: gauge health facility progress in implementing HCF reforms; provide on-the-spot technical support and feedback to health facilities (by both project staff and government health officials who participate in visits); provide feedback to woreda, zone, and regional health officials on the status of HCF reform implementation and on implementation challenges experienced by health facilities; and generate evidence that is analyzed and shared quarterly with USAID, the FMOH, and other health sector stakeholders at quarterly review meetings and other platforms.

This report presents findings on progress and challenges in the implementation of HCF reforms using data gathered from hospitals and health centers (HCs) visited during supportive supervision conducted in Amhara, Benishangul-Gumuz, Harari, Oromia, SNNP, and Tigray regions and Addis Ababa and Dire Dawa city administrations in HSFR/HFG Project Year 1, August 1, 2013 through June 30, 2014 (EFY 2006).

2. METHODOLOGY AND LIMITATIONS

2.1 Methodology

HSFR/HFG targeted 947 sample health facilities in Afar, Amhara, Benishangul-Gumuz, Gambella, Harari, Oromia, SNNP, and Tigray regions and Dire Dawa and Addis Ababa city administrations for supportive supervision visits in project Year 1. HSFR/HFG covered 630 health facilities (41 hospitals and 589 HCs) which represented 66.5 percent of what had been targeted for the year. However, data is available for only 549 health facilities (25 hospitals and 524 HCs) visited in six regions and two city administrations (data for Afar and Gambella regions was not available) . This synthesis report presents the findings of the supportive supervision data that were collected from the facilities over the four quarters – 90 facilities in Q1, 134 facilities in Q2, 144 in Q3, and 181 in Q4.

Supervision visits were conducted in collaboration with government health staff at different levels. Data were collected using the supportive supervision checklist. Data entry, cleaning, and analysis were conducted using Statistical Package for Social Scientists (SPSS) software.

Simple descriptive statistics such as percentages and means as well as graphs (e.g., simple and cluster bar charts, simple and multiple line graphs, and pie charts) are used to present findings. When producing graphs, a pair-wise deletion approach is used, excluding an observation from analysis only when it has a missing value that would be needed to compute the variable under the analysis. This approach removes only the specific missing values from analysis as opposed to a list-wise deletion, which would remove the entire case. Scores are calculated for ordinal variables-users' perception for responses from health services providers on the contribution of revenue to the quality of health services. To obtain summary measures for the quality of health care indicators, the satisfactory response category is coded as "1" and no change as "0."

2.2 Limitations

Because the primary purpose of supportive supervision visits is to provide on-the-spot technical support to as many health facilities as possible and to generate evidence that gives a snapshot of HCF reform each quarter, HSFR/HFG project staff visit a number of different facilities once per year, sampled for the quarter. The number of health facilities visited in each region or city administration varies, for reasons including size of the region and number of health facilities; availability of government stakeholders; and availability of vehicles at the time of the visit. HSFR/HFG does not have the capacity to systematically follow up every health facility on a regular basis due to the high and ever-increasing number of health facilities implementing HCF reforms. Because the sample does not represent the population, the data do not measure HCF reform achievements/outcomes for each region or for the country as a whole. Rather, the data gathered during the supervision visits provide an illustrative snapshot of evidence for project management to use for assessing the performance and status of reforms at the time of the visit and for informing USAID, government, and other health sector stakeholders. In addition, supervision data collected do not include the amount of health budget allocated to woreda and regional levels as the visits were held at facility level and we were not able to do further analysis of the proportion of the government expenditure that went to health facilities.

3. SUPPORTIVE SUPERVISION FINDINGS

3.1 Coverage

As noted in Section 3, Methodology, HSFR/HFG sets supportive supervision targets at the beginning of each fiscal year, and, for project Year 1, planned to visit 947 health facilities in eight regions and the two city administrations. As shown in Table 1, project staff visited 630 health facilities (66 percent of the planned target) in eight regions and two city administrations. However, data for Afar and Gambella regions was not available. Supervision data obtained from 549 health facilities (25 hospitals and 524 HCs) is used for analysis in this report.

Table 1: Number and Type of Health Facilities Covered by Quarterly Supportive Supervision in Project Year 1 (August 1, 2013 - June 30, 2014)

Region/City Administration	Number of Health Facilities Targeted for Visit (Annual Target)	Number of Health Facilities Visited, by Type			% Health Facilities Visited
		Hospitals	HCs	Total	
Addis Ababa	58	0	12	12	21
Afar	19	14	37	51	268
Amhara	219	8	105	113	52
Benishangul-Gumuz	33	1	27	28	85
Dire Dawa	10	0	10	10	100
Gambella	38	2	28	30	79
Harari	8	0	8	8	100
Oromia	300	0	196	196	65
SNNP	194	10	115	125	64
Tigray	68	6	51	57	84
Total/Percentage	**947**	**41**	**589**	**630**	**66**

The number of health facilities visited by supportive supervision varied by region and by quarter. Of the 630 visits conducted, 99 (15.7 percent) were in the first quarter, 146 (23.2 percent) in the second quarter, 170 (26.9 percent) in the third quarter, and 215 (34.1 percent) in the fourth quarter; this means that over three-fifths of the facilities (61 percent) were visited during the third and fourth quarters.

3.2 Health Facility Management, Finance and Administration

The supervision checklist had questions related to facility management, finance and administration, type of positions filled, educational level of staff, training on HCF reforms and/or financial management provided to facility staff, and the magnitude of and reasons for staff turnover. Key findings are described in the following sub-sections.

3.2.1 Availability of Required Health Facility Management and Finance and Administrative Staff

As shown in Table 2, at the time of the supportive supervision visits, almost all hospitals and HCs (about 98 percent) had a facility head/CEO, about 88 percent had an accountant/ procurement, finance, and property administration (PFPA) officer, 72 percent had a PFPA owner/coordinator, and nearly 85 percent had a cashier on staff. In addition, 69 percent had a first daily cash collector, 35 percent had a second daily cash collector, and over half of facilities had an archiver/documentation officer.

Table 2: Percentage of Health Facility Positions Filled at Time of Visit, by Position and Health Facility Type

Type of facility	Head of facility/ CEO	PFPA owner/ coordinator	Accountant/ PFPA officer	Cashier	First daily cash collector	Second daily cash collector	Archiver
Hospital	91.7	96.0	95.8	95.8	96.0	96.0	91.7
HC	98.9	70.8	87.2	84.3	67.5	31.9	53.2
Total Average	**98.5**	**72.1**	**87.6**	**84.8**	**68.9**	**35.0**	**55.0**

Variations were observed among regions on the availability of health facility management and finance and administration staff required to implement HCF reforms (Table 3). Of the 25 hospitals visited, 24 (almost 96 percent) stated whether the human resources needed to implement HCF reform were available. All hospitals in Amhara (7), Benishangul-Gumuz (1), SNNP (10) and Tigray (6) had a PFPA owner/coordinator, and first and second daily cash collectors. Lemlem Karl hospital in Tigray and Chencha hospital in SNNP did not have a hospital CEO; Ataye hospital (Amhara) did not have a cashier or archiver; Karat hospital (SNNP) did not have an accountant/PFPA officer; and Halaba Kulito hospital (SNNP) did not have an archiver at the time of visit.

Table 3: Percentage of Hospital Positions Filled at Time of Visit, by Position and Region

Region	# hosp. visited	Head of facility/ CEO	PFPA owner/ coordinator	Accountant/ PFPA officer	Cashier	First daily cash collector	Second daily cash collector	Archiver
Tigray	6	83.3	100	100	100	100	100	100
Amhara	7	100	100	100	85.7	100	100	85.7
B-Gumuz	1	100	100	100	100	100	100	100
SNNP	10	90.0	100	90.0	100	100	100	90.0
Average for all regions	**24**	**91.7**	**100**	**95.8**	**95.8**	**100**	**100**	**91.7**

Similarly, as detailed in Table 4, almost 90 percent of HCs (494) had a facility head, 87.2 percent (479) an accountant/PFPA officer, 84.3 percent (463) a cashier; nearly 70.8 percent (396) a PFPA owner/coordinator, 67.5 percent (370) a first daily cash collector, 53.2 percent an (244) archiver, and 31.9 percent (175) a second daily cash collector.

Table 4: Percentage of HC Positions Filled at Time of Visit, by Position and Region

Region/City Administration	# HCs visited	Head of facility/ CEO	PFPA owner/ coordinator	Accountant/ PFPA officer	Cashier	First daily cash collector	Second daily cash collector	Archiver
Tigray	51	96.1	94.0	61.9	90.0	95.9	59.1	4.3
Amhara	105	98.1	82.9	92.4	88.6	98.1	78.1	89.7
B-Gumuz	27	92.6	48.1	100	96.3	96.3	74.1	88.9
Oromia	196	100	49.0	92.3	85.7	56.1	0	34.4
D. Dawa	10	100	90.0	80.0	90.0	100	100	40.0
Harari	8	100	50.0	100	75.0	100	60.0	87.5
SNNP	115	100	90.4	80.0	71.1	31.5	9.2	69.3
A. Ababa	12	100	75.0	83.3	100	91.7	91.7	100
Average for all regions	**524**	**98.9**	**70.8**	**87.2**	**84.3**	**67.5**	**31.9**	**53.2**

3.2.2 Educational Level of Health Facility Staff

Deployment and retention of qualified health facility finance and administration staff is considered a critical requirement for the implementation of HCF reforms. The aim has been to deploy diploma holders or higher for these positions.[4] Supportive supervision findings indicate variations between hospitals and HCs in the level of staff education.

In hospitals, over 87 percent of managers/CEOs and heads of finance and administration (procurement, finance, and logistics (PFL) process owner), 47.8 percent of accountants (PFL officers), 12.5 percent of cashiers, and 6.7 percent of first daily cash collectors had a first degree. In addition, 4.3 percent of the managers/CEOs, 12.5 percent of heads of finance and administration, 52.2 percent of accountants (PFL officers), 81.2 percent of cashiers, 66.7 percent of first daily cash collectors, 80.0 percent of second daily cash collectors, and 69.2 percent of archivers had a diploma. Other hospital management and finance and administration staff had less than a diploma level of education.

In HCs, nearly half of facility heads, 30.8 percent of heads of finance and administration, 10.2 percent of accountants, 6.1 percent of cashiers, 2.1 percent of first daily cash collectors, 1.2 percent of second daily cash collectors, and 2.1 percent of archivers had a first degree. A little over half of HC heads, 65.1 percent of heads of finance and administration, 86 percent of accountants, 76 percent of cashiers, 56.4 percent of first daily cash collectors, 32.5 percent of second daily cash collectors, and 43.5 percent of archivers had a diploma. Other HC management and finance and administration staff had less than a diploma.

These data show that visited facilities filled management and finance and administration positions with staff that satisfy the required level of education. However, these staff require training to become familiar with the HCF legal framework, implementation manual, and financial management manual.

[4] An Ethiopian "diploma" is equivalent to a U.S. associate degree (two years of community college). A "first degree" is equivalent to a U.S. bachelor's degree (four years of college/university).

3.2.3 Staff Trained in HCF Reform Implementation

HSFR/HFG and its predecessor HSFR project have provided training on HCF reform implementation for health facility staff and governing board/body members. With respect to hospital staff, 69.6 percent of managers/CEOs, 37.5 percent of heads of finance and administration (PFL process owners), 39.1 percent of accountants (PFL officers), and 11.8 percent of cashiers reported that they had received training on HCF reform implementation. At the HC level, 28.6 percent of heads, 37.6 percent of heads of finance and administration, 34.6 percent of accountants, 10.8 percent of cashiers, 4.8 percent of first daily cash collectors, 1.8 percent of second daily cash collectors, and 3.1 percent of archivers had received training. Oromia, SNNP, and Harari regions had the lowest percentages of trained HC staff, which might be attributed to high staff turnover (see sub-section 4.2.6 on staff retention).

These numbers show that the proportion of trained HC management and finance staff is low compared with hospital staff, but this is due to the increasing number of new HCs implementing reforms. Low levels of training have resulted in a significant gap in staff ability to successfully implement HCF reforms. Training needs to be provided to new health facility staff.

3.2.4 Staff Trained in Financial Management

Health facility financial management includes the planning, directing, organizing, controlling, and monitoring of facility financial resources. HSFR/HFG has been providing eight-day financial management training for key facility finance staff[5] to strengthen their capacities in these areas. To gauge training gaps, heads of health facilities were asked whether their key finance staff had received financial management training.

Data collected during supervision visits indicate that of hospital staff, 12 heads of finance and administration (50.0 percent), 11 hospitals accountants (47.8 percent), and three hospital cashiers (17.6 percent) had received training in financial management. Of all HC staff, 13 heads of HCs (3.3 percent), 140 heads of finance and administration (39.4 percent), 228 (52.0 percent) accountants, 97 cashiers (29.4 percent), 15 first daily cash collectors (6.3 percent), three second daily cash collectors (2.8 percent), and four archivers (2.1 percent)[6] had received this training. Financial management training is meant for health facility staff involved in the day-to-day management of facility funds, so more PFPA owners/coordinators, accountants, and cashiers received financial management training than training on HCF reform implementation. This is particularly evident in Dire Dawa city administration and Oromia, Harari, and Amhara regions.

[5] Key finance staff refers to the finance and administration head, accountant, cashier, and daily cash collectors/PFPA officers.

[6] HCF and financial management training are not intended for archivers. Archivers recorded here were staff reassigned/ demoted to the position after having received training in their prior positions.

3.2.5 Use of Financial Formats/Receipts and Related Challenges

During the introduction of HCF reforms, HSFR/HFG and the predecessor HSFR project supported RHBs in adapting Ministry/Bureau of Finance and Economic Development (MoFED/BoFED) financial management formats and receipts that are critical for health facility financial management. They included budget preparation and submission templates, receipt vouchers, payment vouchers, journal vouchers, ledgers, and transaction register. Health facilities were asked which financial formats and receipts were being used at the time of visit. Results indicate that all hospitals used receipt vouchers, payment vouchers, journal vouchers, revenue reports, expenditure reports, and trial balance sheets. Nearly 96 percent used a ledger, 91 percent used a transaction register, 88 percent used a budget preparation and submission format and a cash book; and 84 percent used petty cash books. All HCs used receipt vouchers, 97.3 percent used payment vouchers, 91.5 percent used revenue reports, 90.2 percent used expenditure report formats, 89.0 percent used transaction registers and ledgers, 85.0 percent used trial balance, 80.0 percent used journal vouchers, 74.4 percent used cash books, 70.2 percent used a budget preparation and submission format, and 42.4 percent used petty cash books. Thus, except for petty cash books in HCs, the majority of hospitals and HCs have been properly utilizing financial formats/receipts. This is encouraging, given that few staff were trained on financial management.

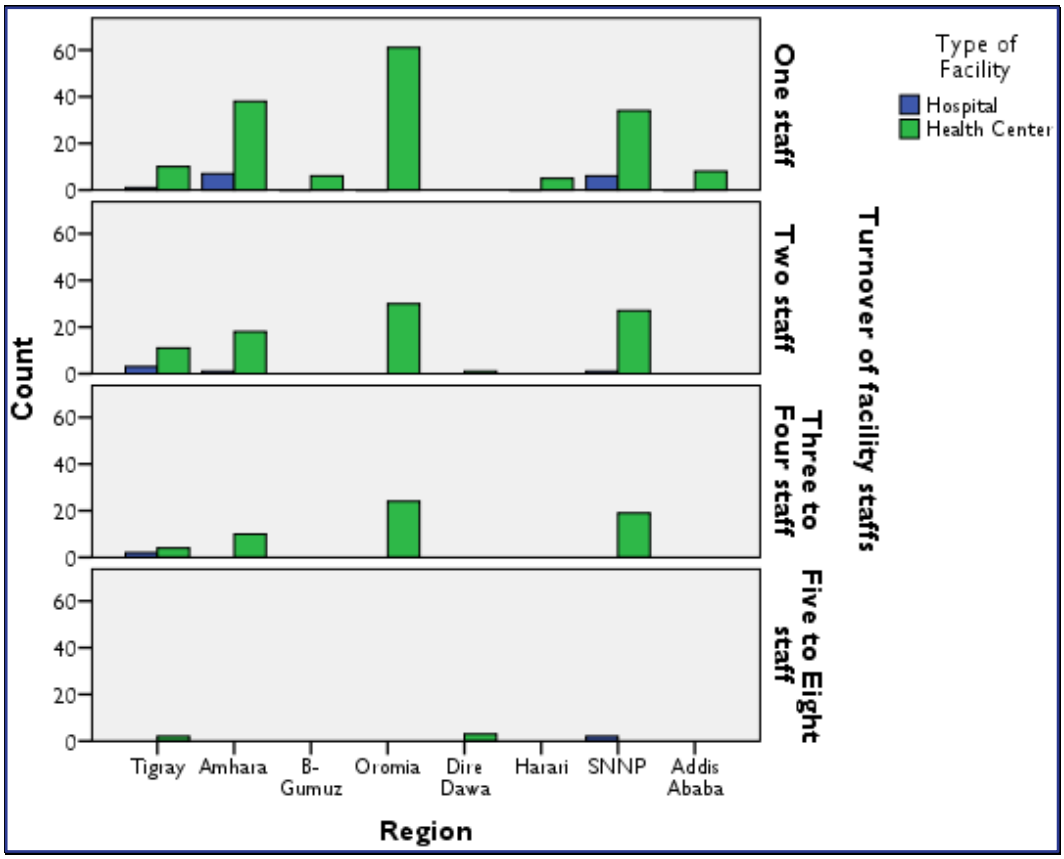
Only five hospitals (20.0 percent) and 197 HCs (37.6 percent) reported encountering problems in using financial formats/receipts: 83.3 percent of facilities in Addis Ababa, 66.7 percent in Tigray, 55.0 percent in SNNP, 37.5 percent in Harari, 35.3 percent in Oromia, 25.0 percent in Benishangul-Gumuz, and 20.4 percent in Amhara reported problems. Fewer key health facility finance staff in Addis Ababa city administration, Tigray, SNNP, Harari, and Oromia were able to use the available financial formats/receipts compared with other regions.

Major challenges reported by hospital staff included knowledge and skill gaps in producing financial reports (30 percent), difficulty in posting transactions (20 percent), and shortage of financial formats (20 percent). Chencha hospital in SNNP reported that some of the formats are not clear to them. For HCs, major problems were shortage of financial formats (47.2 percent), knowledge and skill gap posting transactions (44.6 percent), knowledge and skill gap producing financial reports (38.5 percent), and ambiguity in some of the formats (28.9 percent). Difficulties were partly due to lack of staff trained in financial management and/or the turnover of trained staff. Based on health facility responses, there are identified needs to provide onsite technical support on how to properly use financial formats/receipts, and to advocate to finance bureaus/offices on the need to provide sufficient financial formats/receipts to health facilities.

3.2.6 Health Facility Staff Retention/Attrition

Health facilities require a stable, highly trained, and fully engaged staff for effective day-to-day administration of activities, as well as for the smooth provision of health care services. Heads of facilities were asked about staff turnover – its magnitude, sections/divisions where it was most prevalent and the major reasons for it. Nearly 60 percent of visited health facilities (323) reported inordinate turnover of administrative, finance, and technical staff. Over 80.0 percent (22) of hospitals and 57.4 percent (301) of HCs reported staff turnover to be a problem. Heads of facilities were asked to provide the number of staff that left their facility. Thirty percent of HCs in Amhara, 26 percent in SNNP, 4 percent in Tigray; and 20 percent of hospitals in Oromia and 11 percent in SNNP reported one staff left. Thirteen percent of HCs in Tigray, 4 percent in Amhara, 4 percent SNNP; and 10 percent of hospitals in Oromia, 9 percent in SNNP, 6 percent in Amhara and 4 percent in Tigray reported two staff left. Nine percent of the HCs in Tigray, and 8 percent of hospitals in Oromia, 6 percent in SNNP, 3 percent in Amhara and 1 percent in Tigray reported that three to four staff left. Lastly, 9 percent of HCs in SNNP, and 1 percent of hospitals in Tigray and 1 percent in Dire Dawa City Administration reported that five to eight staff left. Turnover in hospitals was highest in Amhara, Oromia, and SNNP, and in HCs it was highest in Amhara, SNNP, and Tigray (Figure 1).

Figure 1. Health Facilities Staff Turnover Rate 2013/14 EFY



Health facilities were also asked which positions encountered the most staff turnover. Among facilities that reported turnover, 47.1 percent stated that the turnover rate was highest for the head of facility position, 26.4 percent stated it was highest for the PFPA officer/accountant, 18.5 percent stated turnover it was the same in all positions, and 8 percent reported that it was highest for the PFPA process owner/coordinator. There were regional variations. The highest turnover of heads of health facilities was reported in Harari (100 percent), SNNP (68.7 percent), Oromia (47.5 percent), and Amhara (36.8 percent), and the highest turnover of finance officer/accountant was observed in Tigray (56.2 percent), Benishangul-Gumuz (50 percent), Oromia (38.6 percent), Addis Ababa (37.5 percent), and Dire Dawa (25 percent). The highest turnover of PFPA process owners/coordinators was reported in Addis Ababa (37.5 percent), Amhara (17.1 percent), and Benishangul-Gumuz (16.7 percent). Reasons for health facility staff turnover reported include: transfer to other areas (56.8 percent), promotion to higher position (20.5 percent), demotion (10.1 percent), and professional development (9.5 percent).

3.3 Health Facility Governing Boards/Bodies

Health facility governing boards/bodies oversee the overall operation of their health facility. The HCF legal framework requires hospital boards to review hospital budget proposals against the facility's annual work plan, then endorse and submit the proposal to the RHB. HC governing bodies review and endorse their HC's budget proposal and submit it with the HC work plan to the woreda health offices (WorHO). Subsequently, the RHBs and WorHOs submit facility budgets to the BoFED or Woreda Finance and Economic Development (WoFED) office for further approval.

3.3.1 Establishment and Functioning of Health Facility Governing Boards/Bodies

Of the facilities visited during supportive supervision, all 25 hospitals and 96.4 percent of the 505 HCs had established a health facility governing board/body. All facilities in Amhara, Dire Dawa, Harari, and Tigray had done so as had 97.6 percent in SNNP, 96.4 percent in Benishangul-Gumuz, 92.9 percent in Oromia, and 91.7 percent in Addis Ababa. Only 19 facilities (14 in Oromia, three in SNNP, and one each in Benishangul-Gumuz and Addis Ababa city administration) had not.

Variations in regional legal provisions produce variations in the size and composition of governing boards/bodies. Three facilities (one in Oromia and two in SNNP) reported having only one or two governing board/body members, as the board was established at the woreda level (not at facility level). Twelve facilities (10 in Amhara and two in Benishangul-Gumuz) have had three or four governing board/body members at the time of visit. Most facilities reported having larger boards: a little over 48 percent of facilities (253) (89.3 percent in SNNP, 87.5 percent in Benishangul-Gumuz, 84.1 percent in Amhara, 45.5 percent in Addis Ababa, 18.2 percent in Tigray, and 7.1 percent in Oromia) had five or six members. And 49 percent of facilities (258) (all facilities in Dire Dawa and Harari, 92.3 percent in Oromia, 81.8 percent in Tigray, 54.5 percent in Addis Ababa, 9 percent in SNNP, 7.1 percent in Amhara, and 4.2 percent in Benishangul-Gumuz) had seven or more members.

Health facilities were asked to state how often their governing board/body members meet. Nearly 40 percent of boards met every month, 14 percent every quarter, and 5 percent every two months; 6.8 percent met on a bi-annual basis and 1.2 percent met only once a year. Nearly 25 percent of facilities stated that their boards meet on an as-needed basis; the remaining 8.7 percent reported that their board had not yet met during the fiscal year.

By region, all facility governing boards in Addis Ababa (10) and Dire Dawa (10), 87.5 percent in Tigray, 75.0 percent in Harari, 65.4 percent in Benishangul-Gumuz, and 60.0 percent in Amhara were meeting on a monthly basis. Nearly 30 percent (34) of boards in SNNP, 15 percent (27) in Oromia, 5.5 percent (six) in Amhara, 5.4 percent (three) in Tigray, and one each in Benishangul-Gumuz and Harari were meeting every quarter. Fifteen facilities in Oromia, seven in Amhara, three in Benishangul-Gumuz, and one in Harari reported that their boards met every two months. Thirty-five facilities met on a bi-annual basis: 29 (25 percent) in SNNP and six (3.3 percent) in Oromia; six facilities (5.2 percent) in SNNP met annually. A significant number – 128: 55 (30.2 percent) in Oromia, 40 (34.5 percent) in SNNPR, 26 (23.6 percent) in Amhara, four (7.1 percent) in Tigray, and three (7.7 percent) in Benishangul-Gumuz – met on an as-needed basis. In contrast, 32 facilities (17.6 percent) in Oromia, six (5.2 percent) in SNNP, five (4.5 percent) in Amhara, and two (7.7 percent) in Benishangul-Gumuz region reported not meeting. Overall, nearly 59 percent of health facilities governing boards/bodies held regular meetings (39.8 percent every month, 13.9 percent every quarter and 5 percent every two months).

Facilities were asked whether they kept governing board/body meeting records. Findings show that 91.2 percent did so. Disaggregated by type of facility, all hospitals and 87.9 percent of HCs were keeping meeting records. All HCs in Dire Dawa and Harari, 98 percent in Tigray, 97.1 percent in Amhara, 91.7 percent in Addis Ababa, 83.5 percent in SNNP, and 82.4 percent in Oromia) maintained records.

3.3.2 Training for Health Facility Governing Boards/Bodies

Of the total number of facilities that data is available for (549), all 25 hospitals and 501 HCs reported a *total* number of board members. On average, hospitals had seven board members and HCs had six. Twenty-two hospitals (88 percent) and 297 HCs (56.7 percent) reported the number of *trained* board members. Hospitals had on average four and HCs three trained board members. When trained board members are disaggregated by region, all facilities visited in Dire Dawa and Harari confirmed that their governing boards/bodies had received facility governance training, as did all hospitals and 84.2 percent of HCs in Tigray; 75 percent of hospitals and 79 percent of HCs in Amhara; 75 percent of HCs in Addis Ababa; 90 percent of hospitals and 70.4 percent of HCs in SNNP; Pawe hospital (one of the two hospitals in the region) and 63 percent of HCs in Benishangul-Gumuz; and half of the hospitals and 21 percent of HCs in Oromia. The lowest proportion of trained health facility governing board members might be attributed to high turnover of facility governing board/body membership as well as the increasing number health facilities becoming operational.

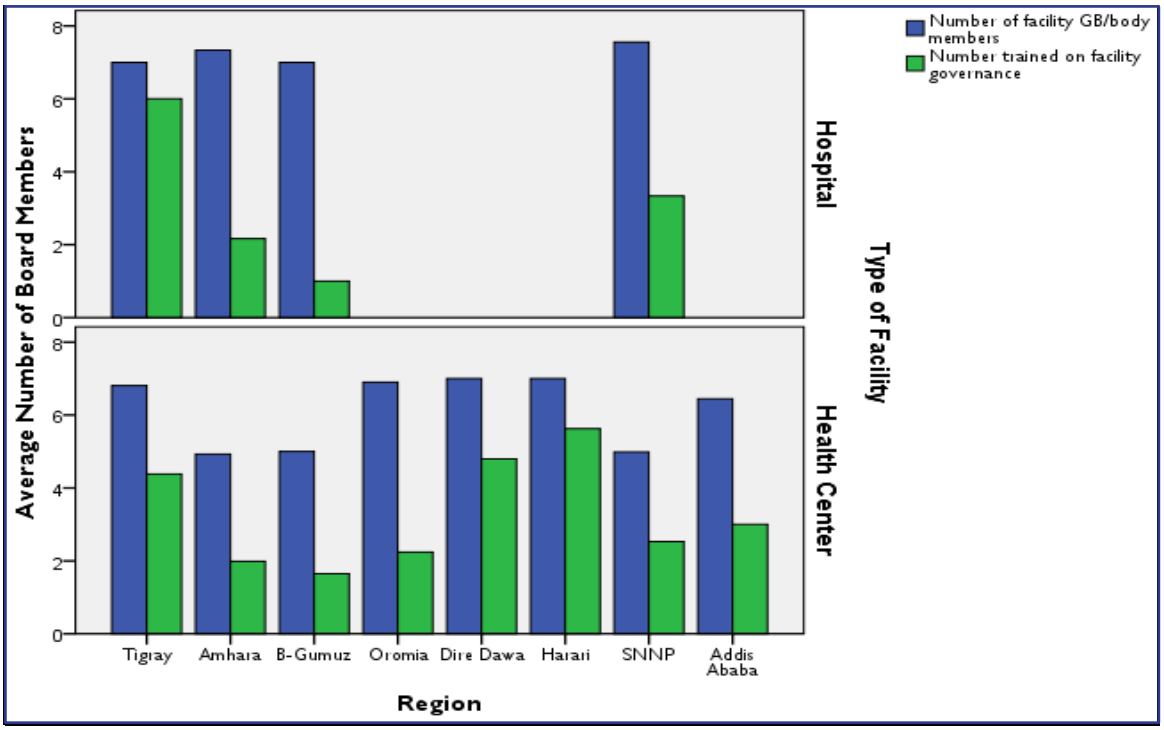
Facilities were asked to report on the number of governing board/body members trained on facility governance. Of the total facilities visited, 319 (58.1 percent) reported the number of governing board members who had received the training. Of these, 55.5 percent stated that one or two board members had received governance training, 26 percent stated three or four board members, 11 percent stated five or six board members, and 7.5 percent stated seven and above board members.

Disaggregated by type of facility, 36.4 percent of hospitals reported one or two board members had received governance training, 31.8 percent stated three or four board members, 13.6 percent stated five or six board members, and 18.2 percent stated seven and above board members had received training. Of the HCs visited, 56.9 percent reported one or two board members had received governance training, 25.6 percent stated three or four board members, 10.8 percent stated five or six board members, and 6.7 percent stated that seven or more had received training.

Disaggregated by region, 44.4 percent of health facilities in Addis Ababa reported that one or two members had attended governance board trainings, another 44.4 percent reported three or four, and the remaining 11.2 percent of facilities reported five or six members attended. In Amhara, 79.8 percent of facilities reported one or two board members, 13.5 percent three or four, and 6.7 percent five or six members attended. Almost 89 percent of facilities in Benishangul-Gumuz reported one or two board members had received training and the remaining 11.0 percent reported three or four members had. Sixty percent of facilities in Dire Dawa stated three or four board members, 20.0 percent reported five or six, and another 20 percent reported seven or more members attended. Only 12.5 percent of facilities in Harari reported one or two board members received training; 50.0 percent reported three or four members had received training and 37.5 percent stated seven or more members. The majority of facilities in Oromia (68.3 percent) stated one or two members had received training, 17.1 percent reported three or four members, 7.3 percent stated five or six, and 7.3 percent stated that seven or more members had received training. Over half of facilities in SNNP (51.1 percent) reported one or two members had received training, 44.4 percent reported that three or four members had, 2.2 percent stated that five or six had, and 2.2 percent reported that seven or more had. In Tigray, 31.5 percent reported five or six members had received training, 25.9 percent reported seven or more had received training, 22.2 percent reported one or two had received training, and 20.4 percent indicated that three or four board members had received training.

Three hospitals (0.5 percent) and 227 HCs (41.4 percent) stated that their governing board members had not received training. As stated elsewhere, the average number of facility governing board members who received training was lower than the average number of sitting board members in all regions and facilities (Figure 2).

Figure 2. Average Number of Facility Governing Board Members and Members Received Training on Facility Governance, 2013/14



3.3.3 Highlights of Health Facility Governing Board Decisions

Health facilities were asked what specific HCF-related decisions their governance board/body had made during the quarter preceding the supervision visit. Results indicate that facilities made decisions related to: budget approval (78.5 percent); assessing periodic performance of HCF reform (68.9 percent); mobilizing financial resources (49.7 percent); assigning staff through recruitment/transfer (32.3 percent); ensuring implementation of the new fee waiver system (29.7 percent); setting user fees (16.7 percent); outsourcing non-clinical services (3.3 percent); and establishing private wings (1.5 percent).

Ninety percent of hospitals stated that reviewing progress of HCF reform was a major agenda item during board meetings; a breakdown of other priority decisions were as follows: budget approval (77.8 percent), reviewing staff assignment through recruitment/transfer (57.1 percent), reviewing and following up implementation of the new fee waiver system (47.4 percent), mobilization of financial resources (44.4 percent), user fee setting (42.1 percent), establishment of private wings (29.4 percent), and outsourcing of non-clinical services (16.7 percent). HC governing bodies made decisions related to budget approval (78.6 percent), assessing overall progress of HCF reform (67.8 percent), mobilizing financial resources (50 percent), staff assignments through recruitment/transfer (30.9 percent), ensuring implementation of the new fee waiver system (28.8 percent), and determining revised user fees (15.5 percent). Only nine HCs (2.6 percent) reported outsourcing of non-clinical services as an agenda item.

Findings reveal regional variations regarding specific HCF-related decisions made by health facility governing boards/bodies (Table 5). Boards/bodies in Addis Ababa followed up on implementation of the new fee waiver system, approved the budget, and made staff assignments through recruitment/transfer. In Amhara, boards mainly approved the budget and assessed the progress of HCF reform. In Benishangul-Gumuz, boards/bodies approved the budget and followed up on implementation of the fee waiver system. Governing boards/bodies in Dire Dawa and Harari approved the budget, assessed progress of HCF reform, made staff assignments through recruitment/transfer, and followed up implementation of the fee-waiver system. In Oromia, boards/bodies undertook budget approval, assessed progress of HCF reform, and made staff assignments through recruitment/transfer. In SNNP, boards/bodies reviewed the status of HCF reform, approved the budget, made staff assignments through recruitment/transfer, and followed up on implementation of the fee-waiver system. Boards in Tigray approved the budget, assessed the status of HCF reform, made decisions regarding user fee revisions, and followed up on the implementation of fee waiver system.

Table 5. Percentage of Specific HCF-Related Decisions Made by Health Facility Boards, Disaggregated by Region

Specific decisions made by governing boards/bodies (type)	Addis Ababa	Amhara	Benishangul-Gumuz	Dire Dawa	Harari	Oromia	SNNP	Tigray
Budget approval	63.6%	77.7%	95.7%	100%	100%	81.9%	49.3%	100.0%
Assess progress of HCF reform	18.2%	75.7%	8.7%	80.0%	100%	74.6%	55.6%	90.9%
Follow up fee-waiver system	81.8%	3.9%	21.7%	80%	87.5%	19.2%	25.0%	83.6%
Decide on user fee revision	-	-	-	-	-	4.7%	21.7%	85.5%
Establish private wing/room	-	-	-	-	-	-	-	11.5%
Outsource non-clinical services	-	4.9%	-	-	-	-	2.9%	9.6%
Re-assign staff through recruitment/ transfer	54.5%	8.7%	-	80%	100%	36.9%	31.9%	56.4%

The HCF directive allows health facilities to pay an allowance to governing board/body members for their participation in board/body meetings; the allowance is paid at the time of meeting. Facilities were asked whether they paid these allowances. Responses indicate that nearly 61 percent of the facilities (320) paid allowances, while the remaining 39 percent did not do so either due to the facility's low revenue. Disaggregated by type of facility, 17 hospitals (68 percent) and 303 HCs (60.6 percent) paid allowances; all facilities in Dire Dawa and Harari, 90.9 percent in Addis Ababa, 88.5 percent in Benishangul-Gumuz, 68.3 percent in SNNP, 63.7 percent in Oromia, 57.5 percent in Amhara, and 10.5 percent in Tigray.

3.3.4 Major Challenges Encountered and Corrective Actions Taken

During supportive supervision visits, health facility respondents were asked to state the major challenges/constraints they encountered related to making boards effective. The major challenges reported were board members' busy work schedules (68.1 percent), lack of commitment (31.7 percent), members' departure from the woreda (27.4 percent), and absence of allowance (19.4 percent). These challenges were rated similarly in both hospitals and HCs. Compared by region, board members' busy work schedule was reported as the major challenge/constraint in Tigray (92.7 percent), Oromia (84.9 percent), Addis Ababa (81.8 percent), SNNP (78.7 percent), Amhara (38.9 percent), Harari (25 percent), and Benishangul-Gumuz (22.2 percent). In Oromia, almost 69 percent of facilities reported lack of commitment as a major challenge, whereas it was reported less frequently in Tigray (26.5 percent), SNNP (24.1 percent), and in Benishangul-Gumuz (15 percent). Turnover of governing board/body members was reported as challenge/constraint in Harari (87.5 percent), Tigray (40 percent), Oromia (36.8 percent), SNNP (28.6 percent), Addis Ababa (27.3 percent), Dire Dawa (20 percent), and Benishangul-Gumuz (18.5 percent). Over half of facilities in Tigray, Amhara (32.7 percent), Oromia (10.5 percent), and SNNP (3.6 percent) reported the absence of meeting allowances as a major challenge/constraint.

Supportive supervision teams also asked health facility respondents to list measures taken to address these challenges. In response, 8.3 percent stated that they had rearranged the board meeting schedule, 2.8 percent that they had discussed the issue with board members/facility administration, and 2.8 percent had replaced board members who had left the woreda. Only one hospital out of 22 (4.5 percent) and 17 HCs (3.2 percent) stated that no corrective measures were taken.

Only 19 HCs (3.6 percent) had not established a governance board/body; and these facilities were asked to state the reasons for not doing so. Of these, nine HCs (47.4 percent) did not state a reason. The remaining 10 HCs (52.6 percent) reported the following reasons: lack of knowledge and training (60 percent), lack of commitment (30 percent), and delays in the replacement of governing board/body members that had left the woreda (10 percent).

3.4 Government Budget Allocation to Health Facilities

Adequate budget allocation combined with improved budget management is one of the prerequisites for improving the quality of health care services in health facilities. To assess whether there was an increase in government budget allocation to health facilities over the past seven years (2007/08–2013/14), visited facilities were asked to state the amount of budget allocated to them. The number of hospitals and HCs that provided their government-allocated budget figures varied: 10 hospitals and 12 HCs provided government-allocated budget figures for 2007/08; 12 hospitals and 21 HCs provided the budget figures for 2008/09; 16 hospitals and 43 HCs provided budget figures for 2009/10; 18 hospitals and 91 HCs provided budget figures for 2010/11; 19 hospitals and 175 HCs provided budget figures for 2011/12; 23 hospitals and 288 provided budget figures for 2012/13; and 24 hospitals and 351 HCs provided budget figures for 2013/14. The data indicate that the average government-allocated budget for hospitals grew from nearly 6.2 million Birr in 2007/08 to 7.6 million Birr in 2013/14 and from 515,657.71 Birr to 960,613.00 Birr for HCs. Growth was not consistent, however: hospital budgets declined from 2007/08 to 2009/10, increased in 2012/13, and then declined in 2013/14. HC budgets showed a slight increase from 2007/08 to 2009/10 and bigger increases thereafter (Figure 3).

Figure 3. Trends of Government Budget Allocated to the Health Facilities 2007/08 – 2013/14

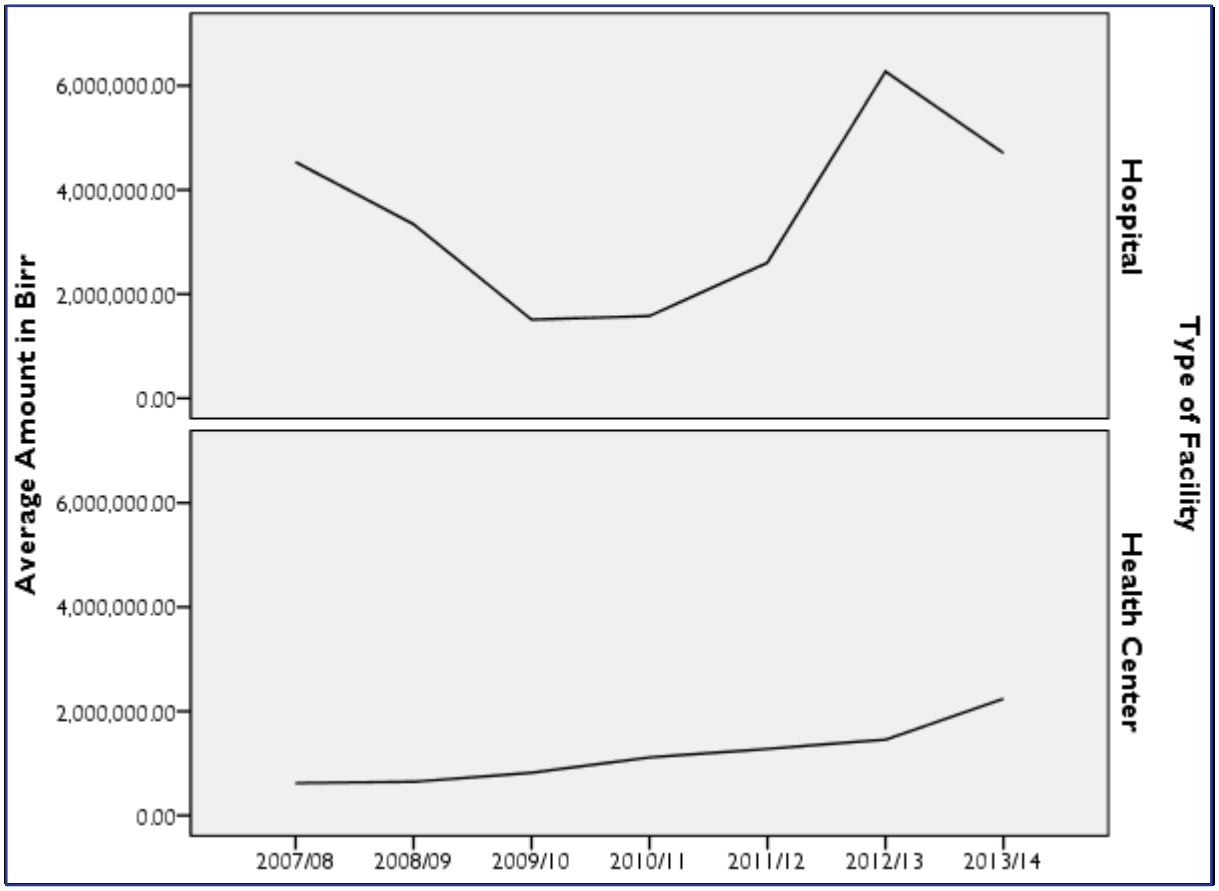
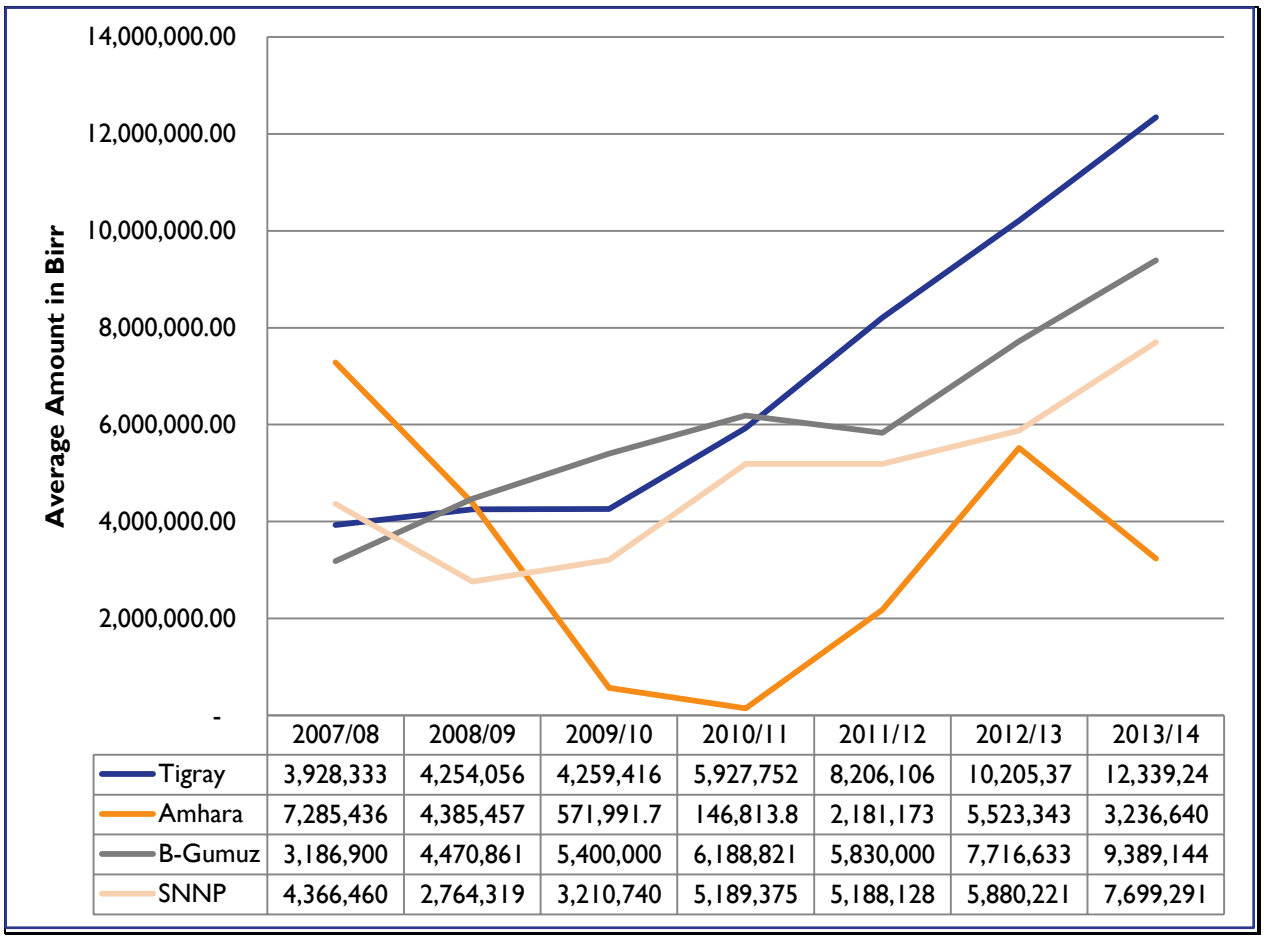


Figure 4 breaks out hospital budgets for four regions over the past seven years. Although fluctuations were observed in the amount of government budget allocated to hospitals over the period, overall increases in the amount of budget allocated to hospitals were observed in Benishangul-Gumuz, SNNP, and Tigray regions. In Amhara, the amount of government budget allocated to hospitals fell from 2007/08 to 2010/11, rose from 2010/11 to 2012/13, and declined again in 2013/14.

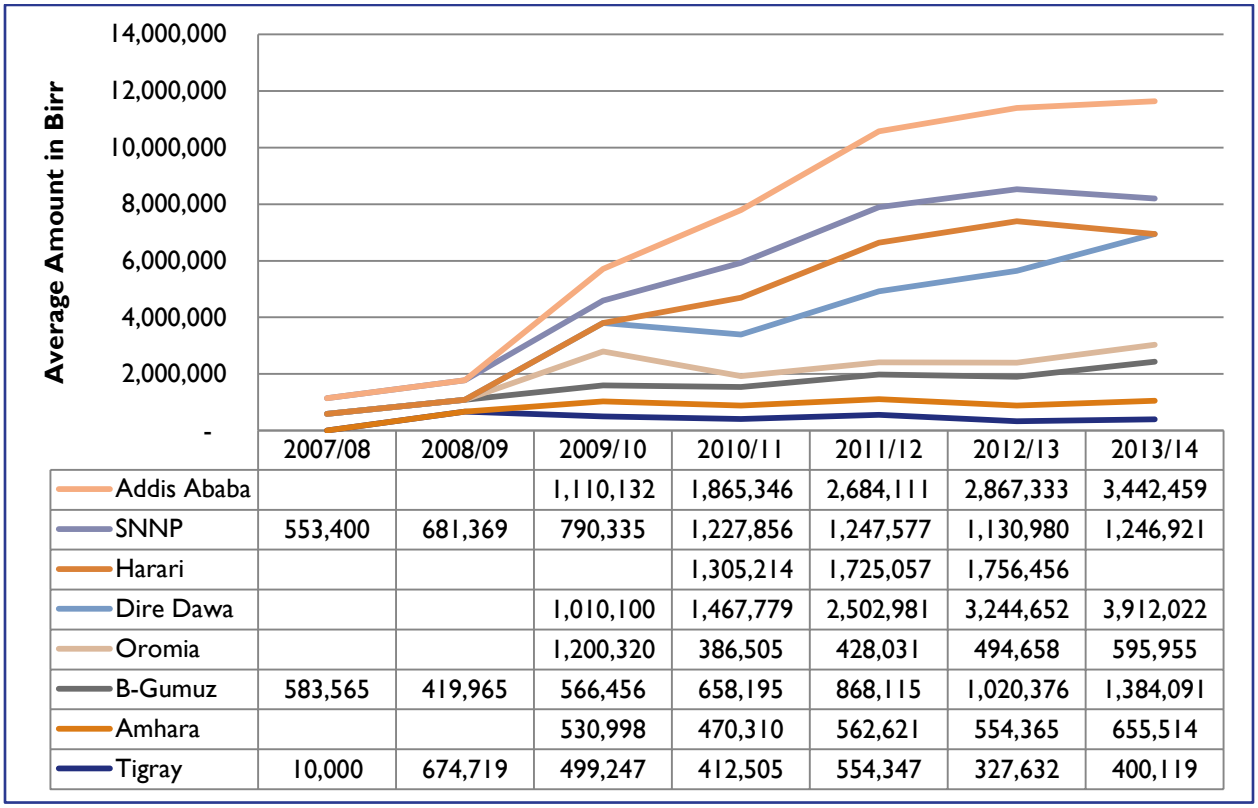
Figure 4. Average Amount of Governmet Budget Allocated to Hospitals by Region 2007/08 – 2013/14



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Tigray	3,928,333	4,254,056	4,259,416	5,927,752	8,206,106	10,205,37	12,339,24
Amhara	7,285,436	4,385,457	571,991.7	146,813.8	2,181,173	5,523,343	3,236,640
B-Gumuz	3,186,900	4,470,861	5,400,000	6,188,821	5,830,000	7,716,633	9,389,144
SNNP	4,366,460	2,764,319	3,210,740	5,189,375	5,188,128	5,880,221	7,699,291

Figure 5 breaks out HC budgets for six regions and the two city administrations. As with hospital budgets, government budgets allocated to HCs fluctuated over time and by region. HC budgets in Addis Ababa, Dire Dawa, Harari, and SNNP steadily increased starting in 2008/09. HCs in Amhara, Benishangul-Gumuz, Oromia, and Tigray received budgets of less than 2 million Birr total average from their governments. HCs in Harari region provided data only for three consecutive years (2010/11-2012/13); the allocated budget increased over these years.

Figure 5: Average Amount of Government Budget Allocated to HCs 2007/08-2013/14



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Addis Ababa			1,110,132	1,865,346	2,684,111	2,867,333	3,442,459
SNNP	553,400	681,369	790,335	1,227,856	1,247,577	1,130,980	1,246,921
Harari				1,305,214	1,725,057	1,756,456	
Dire Dawa			1,010,100	1,467,779	2,502,981	3,244,652	3,912,022
Oromia			1,200,320	386,505	428,031	494,658	595,955
B-Gumuz	583,565	419,965	566,456	658,195	868,115	1,020,376	1,384,091
Amhara			530,998	470,310	562,621	554,365	655,514
Tigray	10,000	674,719	499,247	412,505	554,347	327,632	400,119

HCF is much more than a simple budget allocation. Not only does the amount allocated to health facility budgets matter, but the autonomy/authority to manage the budget is also important. Facilities were asked whether they managed the government-allocated budget autonomously (i.e., paid staff salaries and other operational expenses). Of the facilities visited, 22 hospitals (88 percent) and 291 HCs (56 percent) managed the government-allocated budget themselves. By region, all facilities in Dire Dawa, 93 percent in Benishangul-Gumuz, 91.7 percent in Addis Ababa, 87.5 percent in Amhara, 62.4 percent in SNNP, 41.3 percent in Oromia, 20 percent in Harari, and 14 percent in Tigray managed the budgets themselves. Considering the low rate of autonomous budget management by health facilities in Oromia, Harari, and Tigray, it is recommended that regional governments and other relevant offices in these regions (BoFED and/or WoFED) allow facilities to manage government-allocated budgets themselves as this will have a positive impact on the timely and efficient use of resources by health facilities.

3.4.1 Proportion of Non-Salary Recurrent Budget from Total Recurrent Budget at Facility Level

This indicator shows the share of non-salary recurrent budget, which covers items such as drugs, medical supplies and equipment, as well as allowances for permanent staff who work extra hours and other administrative expenses, relative to the total recurrent budget at the facility level. The lesser the share of this budget, the less money there is to cover critical non-salary inputs to medical care. To enable the comparison of the non-salary and total recurrent budgets, facilities were asked to provide data on their total yearly recurrent budget and their budget for permanent staff salary and allowances, drugs and medical supplies, and other items.

Data provided by hospitals for 2007/08 to 2013/14 showed a declining trend for the non-salary percentage in Amhara and Benishangul-Gumuz (Table 6). In SNNP and Tigray, it has increased over the four years 2010/11 to 2013/14. On average, this share of the recurrent budget increased from 2011/12 onwards, helping to improve the quality of health care delivery in the hospitals.

Table 6. Proportion of Non-Salary Budget from the Total Recurrent Budget at Hospitals (Percentage), 2007/08-2013/14

Region	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Amhara	51.7	41.6	42.4	43.5	43.2	42.6	40.6
Benishangul-Gumuz	55.1	52.9	46.6	52.7	26.3	40.4	38.8
SNNP	38.1	43.0	34.8	34.2	44.4	43.8	45.6
Tigray	39.2	34.4	49.1	34.5	41.0	47.2	53.2
Average for all regions	48.7	42.7	45.1	42.3	45.0	45.2	46.2

Not all HCs visited provided the requested data. However, the data that were provided indicated that the proportion of non-salary recurrent budget allocated to HCs rose and then fell over the seven-year period (Table 7). The proportion of non-salary budget for all HCs that provided their disaggregated recurrent budgets varied by year: 43.4 percent in 2007/08, 37.9 percent in 2008/09, 46.1 percent in 2009/10, 39.4 percent in 2010/11, 39.6 percent in 2011/12, 39.3 percent in 2012/13, and 35.9 percent in 2013/14. It also varied across regions. In general, the proportion of non-salary recurrent budget allocated to the HCs was low compared to hospitals, except in 2009/10, when the proportion was higher by one percent (46.1 vs 45.1 percent).

Table 7. Proportion of Non-Salary Budget from the Total Recurrent Budget in HCs (Percentage), 2007/08-2013/14

Region	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Addis Ababa	NA	NA	62.0	36.7	44.6	42.1	40.1
Amhara	49.6	48.9	45.4	38.9	32.0	34.1	26.2
Benishangul-Gumuz	46.2	43.7	43.0	43.0	31.5	33.3	28.3
Dire Dawa	N/A	N/A	49.9	69.1	55.9	58.1	67.3
Harari	N/A	N/A	N/A	N/A	97.8	98.6	98.0
Oromia	N/A	N/A	33.9	31.3	33.2	33.2	31.7
SNNP	34.3	30.8	49.6	36.6	32.2	28.7	31.6
Tigray	39.2	27.4	39.2	26.4	32.8	35.1	41.6
Average for all regions	43.4	37.9	46.1	39.4	39.6	39.3	35.9

3.4.2 Proportion of Drug Budget out of the Total Recurrent Facility Budget

The quality of health services is compromised by inadequate and poorly maintained infrastructure and equipment, scarcity of trained health personnel, and unavailability of drugs and medical supplies. Therefore, the proportion of government budget allocated to drugs and medical supplies can be used as a proxy indicator for the quality of health care services in health facilities. Not all hospitals covered for supportive supervision provided data on the amount of budget allocated to drugs and medical supplies. Seven hospitals did for 2007/08, eight for 2008/09, seven for 2009/10 and 2010/11, 17 for 2011/12, 22 for 2012/13, and 21 for 2013/14. The data that were provided show that the amount of budget allocated to drugs and medical supplies varied over time (Table 8). The drug budget as a proportion of the total hospital recurrent budget in Amhara, Benishangul-Gumuz, and SNNP sharply declined from 2007/08 to 2011/12, increased in 2012/13, and declined again in 2013/14. The budget in Tigray fluctuated over the years. Since data for all 25 hospitals visited by supportive supervision were incomplete, comparison of drug budgets across the regions during seven consecutive fiscal years was impossible.

Table 8. Proportion of Drug Budget from Total Recurrent Budget in Hospitals (Percentage), 2007/08-2013/14

Region	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Addis Ababa	0	0	0	0	0	0	0
Amhara	11.3	4.0	3.8	3.6	1.3	2.8	2.7
Benishangul-Gumuz	9.0	8.1	5.5	4.0	0	0	0
Dire Dawa	0	0	0	0	0	0	0
Harari	0	0	0	0	0	0	0
Oromia	N/A	N/A	N/A	N/A	11.5	10.3	0
SNNP	7.2	6.6	0	0	1.5	11.0	3.7
Tigray	5.1	6.9	22.3	9.8	17.0	17.8	14.9
Average for all regions	10.3	6.0	14.8	7.9	10.1	11.1	8.3

Not all HCs visited could provide complete data on the government budget allocated to them – HCs are not independent cost centers and do not manage their budgets by themselves; they lack the finance personnel and financial documents needed to generate the disaggregated budget data requested at the time of visit. Only eight HCs provided data on the amount of government budget allocated to drugs and medical supplies in 2007/08, 16 HCs provided data for 2008/09, 33 HCs provided data for 2009/10, 64 HCs provided data for 2010/11, 138 HCs provided data for 2011/12, 180 HCs provided data for 2012/13, and 325 HCs provided data for 2013/14.

The proportion of government budget allocated to drugs and medical supplies in Amhara, Benishangul-Gumuz, and SNNP showed a declining trend from 2007/08 to 2010/11, then rose and fell again (Table 9). Lack of a complete dataset makes trend analysis and comparisons (by type of facility and region) impossible.

Table 9. Percentage of Government Drug Budget from Total Government Recurrent Budget at HCs (Percentage), 2007/08-2013/14

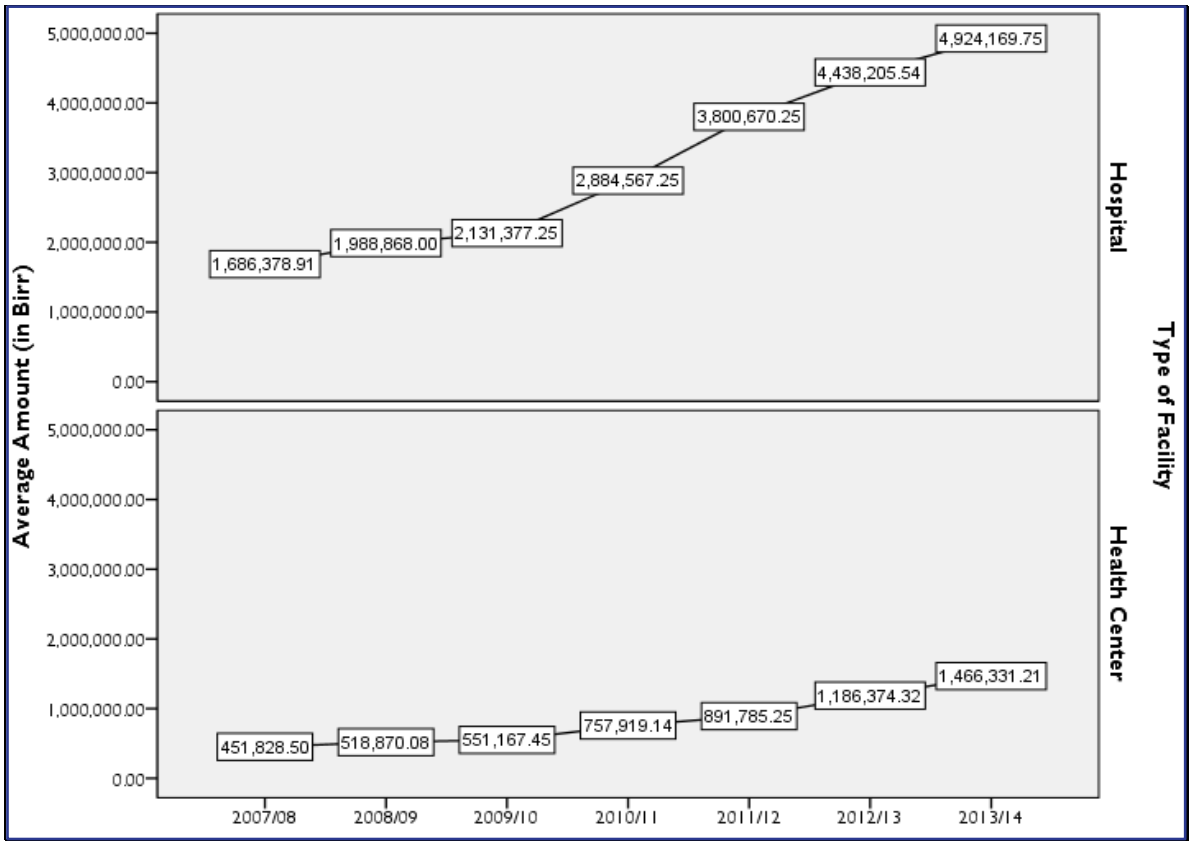
Region	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Addis Ababa	N/A	N/A	19.6	12.6	18.3	11.0	11.6
Amhara	7.9	4.0	4.1	2.9	1.9	4.8	1.8
Benishangul-Gumuz	6.3	6.0	5.9	3.2	4.5	2.2	1.0
Dire Dawa	N/A	N/A	20.0	5.3	14.2	11.4	17.4
Harari	N/A	N/A	N/A	N/A	16.4	21.5	60.2
Oromia	N/A	N/A	7.0	7.4	7.9	8.5	10.0
SNNP	10.9	7.2	6.8	2.0	4.0	5.1	4.0
Tigray	5.1	5.9	20.5	7.5	12.4	11.6	10.9
Average for all regions	8.3	6.2	10.2	5.1	9.1	10.0	7.9

3.4.3 Proportion of Government Budget Allocated to Health Facilities by Major Budget Categories

To examine and compare changes in government budget allocations to health facilities for the period 2007/08 through 2013/14, facilities were asked to state the amount of government-allocated budget they received broken down by major budget categories (i.e., salary, allowances, drug and medical supplies, and other expenditure items). As depicted in Figure 6, the average amount of government budget allocated to hospitals for permanent staff salaries increased appreciably over the period and the corresponding rate of increment for salary budget at hospitals was 17.9 percent from 2007/08 to 2008/09, 7.2 percent from 2008/09 to 2009/10, 35.3 percent from 2009/10 to 2010/11, 31.7 percent from 2010/11 to 2011/12, 16.7 percent from 2011/12 to 2012/13, and 10.9 percent from 2012/13 to 2013/14. The average amount of government budget allocated to HCs for permanent staff salaries also increased each year, though at smaller percentages than at hospitals; it was 451,000 Birr in 2007/08; 518,000 Birr in 2008/09; 551,000 Birr in 2009/10; 757,000 Birr in 2010/11; 891,000 Birr in 2011/12; 1,186,000 Birr in 2012/13; and 1,486,000 Birr in 2013/14. The associated percentage changes in this allocation in HCs was 14.8 percent from 2007/08 to 2008/09, 6.2 percent from 2008/09 to 2009/10, 37.5 percent from 2009/10 to 2010/11, 17.6 percent from 2010/11 to 2011/12, 33.0 percent from 2011/12 to 2012/13 and 23.6 percent from 2012/13 to 2013/14.

Again, the data indicate that government budget allocated to hospitals and HCs for permanent staff salaries showed an increasing trend. In contrast, the average amount of government budget allocated for non-salary expenditure items decreased; this reduction might be attributed to spending being shifted to the construction and operation of several new health facilities in recent years.

Figure 6. Trends of Goernment Budget Allocated to Facilities for Salaries to Permanent Staff 2007/08 – 2013/14



The average amount of government budget allocated to hospitals for permanent staff allowances was 565,000 Birr in 2007/08, 662,000 Birr in 2008/09, 516,000 Birr in 2009/10, 691,000 Birr in 2010/11, 485,000 Birr in 2011/12, 670,000 Birr in 2012/13, and 829,000 Birr in 2013/14 (Figure 7). The corresponding percent growth rate was 17.1 percent from 2007/08 to 2008/09, -21.9 percent from 2008/09 to 2009/10, 33.9 percent from 2009/10 to 2010/11, -29.9 percent from 2010/11 to 2011/12, 38.3 percent from 2011/12 to 2012/13, and 23.7 percent from 2012/13 to 2013/14. The average amount of government budget allocated to HCs for permanent staff allowances fluctuated as follows; 38,000 Birr in 2007/08, 36,000 Birr in 2008/09, 112,000 Birr in 2009/10, 90,000 Birr in 2010/11, 85,000 Birr in 2011/12, 83,000 Birr in 2012/13, and 102,000 Birr in 2013/14. The corresponding percentage change for government budget allocated to HCs for permanent staff allowances was -4.1 percent from 2007/08 to 2008/09, 207.2 percent from 2008/09 to 2009/10, -19.8 percent from 2009/10 to 2010/11, -5 percent from 2010/11 to 2011/12, -2.2 percent from 2011/12 to 2012/13, and 23.0 percent from 2012/13 to 2013/14.

Overall, the average amount of government budget allocated to health facilities (hospitals and HCs) for permanent staff allowances fluctuated over the period.

Figure 7. Trendsof Government Budget Allocated to Facilities for Allowance to Permaent Staff 2007/08 – 2013/14

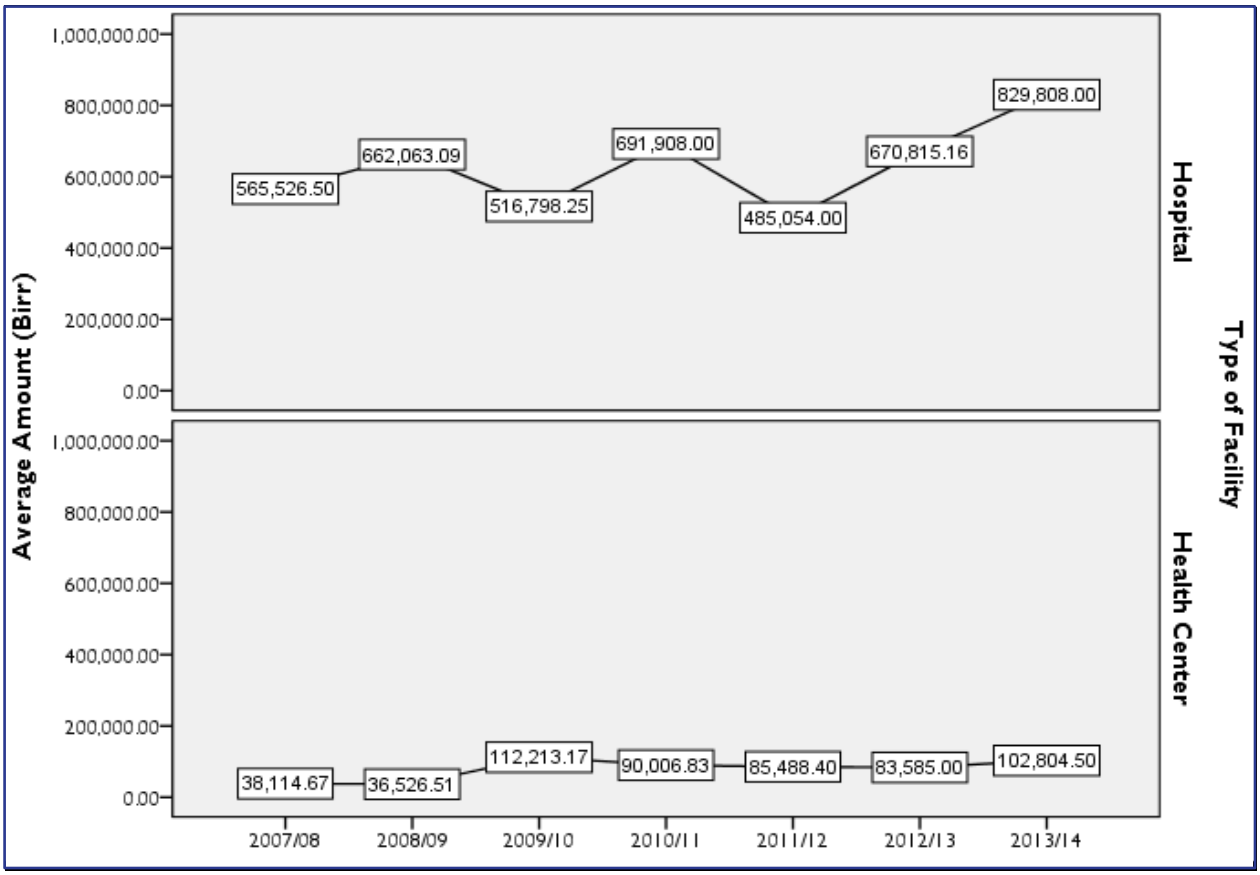
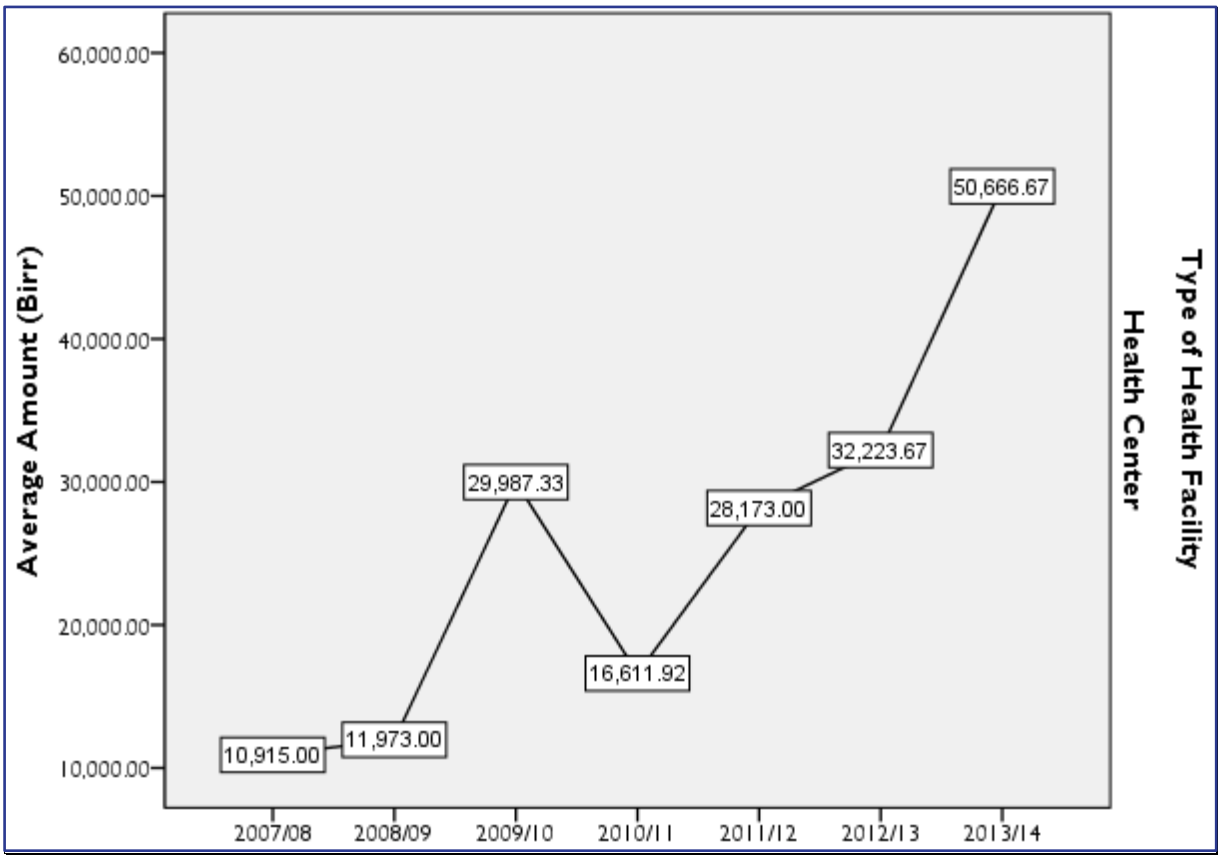


Figure 8 presents the average allocation to the visited HCs; the amounts were 10,000 Birr in 2007/08, 11,000 Birr in 2008/09, 30,000 Birr in 2009/10, 17,000 Birr in 2010/11, 28,000 Birr in 2011/12, 32,000 Birr in 2012/13, and 51,000 Birr in 2013/14. The percentage change was 9.7 percent from 2007/08 to 2008/09, 150.5 percent from 2008/09 to 2009/10, -44.6 percent from 2009/10 to 2010/11, 69.6 percent from 2010/11 to 2011/12, 14.4 percent from 2011/12 to 2012/13, and 57.2 percent from 2012/13 to 2013/14.

Figura 8. Trendsof Government Budget Allocates to Facilities for Drugs and Medical Supplies 2007/08 – 2013/14



3.5 Revenue Retention

Revenue retention is a key component of the Ethiopian government's HCF reform strategy. The HCF legal framework allows public health facilities to collect, retain, and use the revenue that they generate from different sources, in addition to the government budget allocations, to assist facilities in improving the quality of health services. The supportive supervision team questioned health facilities about revenue retention, such as whether they had started revenue retention, whether they had a detailed revenue retention plan broken down by revenue item, and the magnitude of revenue generated. A total of 545 facilities (99.3 percent) stated that they had started collecting internal revenue. Of these, 435 (79.8 percent) had detailed revenue retention plans.

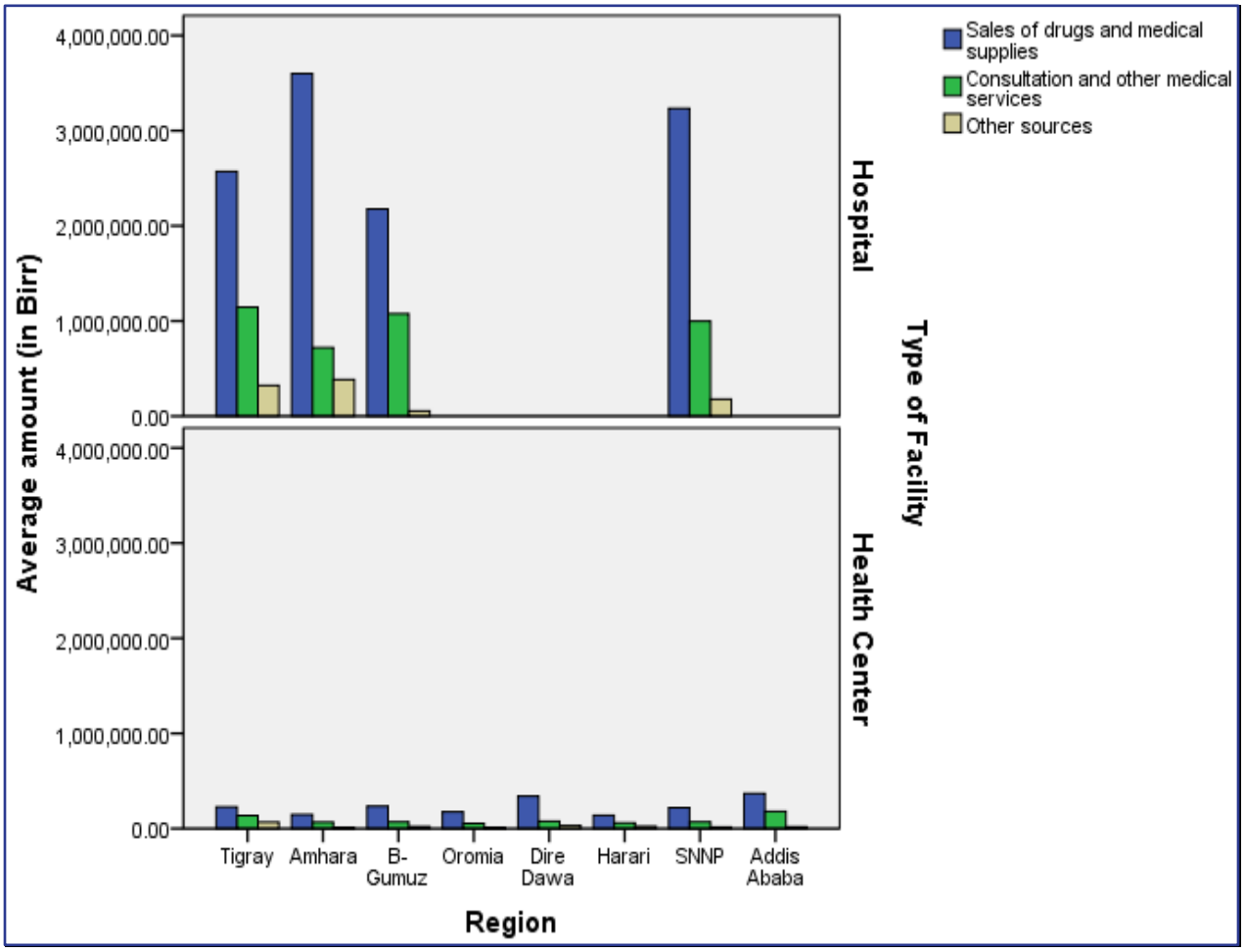
3.5.1 Health Facilities Planned Retained Revenue

Health facilities that had revenue retention plans in place were asked to state their planned revenue for 2013/14 by revenue source. Only 20 (80.0 percent) of hospitals and 415 (79.8 percent) of HCs had revenue retention plans with breakdowns by revenue source. By region, all 28 facilities in Benishangul-Gumuz had revenue retention plans with revenue sources indicated, as did 89.2 percent in Oromia, 89.1 percent in Tigray, 87.5 percent in Harari, 83.3 percent in Addis Ababa city administration, 80 in Dire Dawa city administration, 74.2 percent in SNNP, and 59.3 percent in Amhara. Facilities that had a revenue retention plan were also asked to state how much revenue they planned to generate from sales of drugs and medical supplies, fees for consultations and other medical services, and from other sources for 2013/14. Seventeen hospitals (68 percent) and 378 HCs (72.1 percent) provided data on their planned retained revenue. Hospitals planned to generate on average 4,421,758.89 Birr, with 3,123,142.23 Birr coming from sales of drugs and medical supplies, 955,403.41 Birr from consultations and other medical services, and 265,497.35 Birr from other services.[7] HCs planned to generate on average 280,366.22 Birr, with 194,557.28 Birr coming from sales of drugs and medical supplies, 71,322.86 Birr from consultations and other medical services, and 18,295.56 Birr from other sources.

[7] Includes rental of facility cafeteria, and sales of grass, eucalyptus trees, and other miscellaneous items.

As these numbers show, sale of drugs and medical supplies appears to be the major source of retained revenue in all health facilities, followed by consultations and other medical services, and other sources (Figure 9).

Figure 9. Average Amount of Planned Retained Dissagregated by Revenue Item, Type of Facility and Region, 2013/14



3.5.2 Actual Amount of Retained Revenue Generated in Health Facilities

To examine the contribution of each revenue item toward the total amount of revenue generated in health facilities, facilities were asked about the amount of resources they generated from each revenue item in the quarter(s) prior to the supervision visit. Of the facilities visited (549), 20 hospitals (80 percent) and 415 HCs (79.2 percent) reported the revenue they generated by source in each quarter.

In the first quarter of HSFR/HFG project Year 1, 18 hospitals generated an average of 559,388.10 Birr from sales of drugs and medical supplies, 220,986.84 Birr from consultations, and 63,056.31 Birr from other sources. During the same quarter, 310 HCs generated an average of 47,370.41 Birr from sales of drugs and medical supplies, 15,417.75 Birr from consultations, and 4,938.72 Birr from other sources.

In the second quarter, 15 hospitals generated an average of 525,293.80 Birr from sales of drugs and medical supplies, 297,674.19 Birr from consultations, and 38,226.93 Birr from other sources. During this same quarter, 161 HCs generated an average of 69,814.96 Birr from sales of drugs and medical supplies, 17,991.32 Birr from consultations, and 6,007 Birr from other sources.

In the third quarter, 15 hospitals generated an average of 579,562.35 Birr from sales of drugs and medical supplies, 261,996.21 Birr from consultations, and 27,695.78 Birr from other sources. In the same quarter, 103 HCs generated an average of 48,481.72 Birr from sales of drugs and medical supplies, 16,521.15 Birr from consultations, and 7,982.28 Birr from other sources.

In the fourth quarter, four hospitals reported that they generated 107,584.25 Birr from sales of drugs and medical supplies, 268,788.00 Birr from consultations, and 28,179.25 Birr from other sources. Over the same quarter, 17 HCs generated an average of 69,152.05 Birr from sales of drugs and medical supplies, 23,761.02 from consultations, and 22,679.41 Birr from other sources.

Facilities with no revenue retention plan (five hospitals and 109 HCs) were asked to provide the total revenue they estimated to generate in 2013/14. Of these, three hospitals and 82 HCs reported that they intended to generate, on average, 2,523,441.67 Birr and 186,956.21 Birr, respectively. Overall, the unavailability of complete data on the planned versus actual amount of retained revenue generated from the aforementioned sources prevented an assessment of health facilities revenue retention performance.

3.5.3 Share of Retained Revenue to Total Health Budget

The share of a total health facility budget that comes from retained revenue is an important indicator for predicting the amount of locally generated revenue that will be available to supplement government resources. This amount can be used to make quality improvements at the facility level. The HCF legal framework states clearly that locally generated revenue is not intended to replace the government-allocated budget, but rather to supplement it. Of the 25 hospitals visited for regular supportive supervision, 20 (80.0 percent) reported that they had a retained revenue utilization budget appropriated by their respective regional government. The total health budget and the retained revenue share of that budget is computed only for these hospitals. The "share of retained revenue" indicator is calculated by dividing the estimated retained revenue generated in hospitals during the year by the total health budget (government budget allocated to the hospital plus appropriated retained revenue for the fiscal year).

The share of retained revenue in the total health budget for hospitals is higher in Amhara (53.2 percent) than in SNNP (28.0 percent). Conversely, the average government budget allocated to hospitals in Amhara is lower (4.1 million Birr) than the budgets in Tigray (12.3 million Birr) and SNNP (7.7 million Birr.) Though it is difficult to draw inferences using incomplete supervision datasets, the higher the proportion of retained revenue is to the total health budget, the lower the government budget allocated to that facility, and vice versa. As shown in Table 10, the share of retained revenue is low in Benishangul-Gumuz (19.7 percent), Tigray (20.0 percent), and SNNP (28.0 percent) compared with Amhara (53.2 percent). The average total health budget (government-allocated budget added to retained revenue) for a hospital was higher in Tigray at 16.2 million Birr than in other regions: 12.6 million in Benishangul-Gumuz, 11.9 million in SNNP, and 6.2 million in Amhara. This indicates that the government-allocated budget, total appropriated retained revenue utilization budget total health budget, and retained revenue portion of the total health budget vary from region to region. In addition, of the total health budget allocated to hospitals, the government allocation covered over 70 percent of the health budget, while retained revenue covered the remaining amount. The data also suggest that, on average in 2013/14, hospitals had an appropriated retained revenue budget of 3.45 million Birr, and they collected about 3.27 million Birr; this amount was 94 percent of their appropriated budget from retained revenue.

Table 10. Share of Retained Revenue to Total Health Budget in Hospitals, 2013/14

Region	N	Average Gov't Budget Allocated to Hospital (Birr)	Average Appropriated Retained Revenue (Birr)	Average Health Budget (Gov't + Appropriated RR) (Birr)	Average Annual Retained Revenue Generated (Birr)	Share of Retained Revenue to Total Health Budget (%)
Amhara	8	4,086,906.62	2,099,610.75	6,186,517.37	3,292,448.86	53.2
Benishangul-Gumuz	1	9,389,144.00	3,307,961.00	12,697,105.00	2,497,304.00	19.7
SNNP	10	7,699,291.59	4,266,542.20	11,965,833.79	3,356,186.28	28.0
Tigray	6	12,339,246.02	3,949,630.16	16,288,876.18	3,259,248.34	20.0
Average for facilities visited	25	7,724,511.56	3,458,722.00	11,784,583.09	3,274,919.23	27.8

All HCs visited for regular supportive supervision had an appropriated retained revenue budget for 2013/14. As indicated in Table 11, the average amount of government-allocated HC budget varied from region to region; it was a high of 3,912,021.71 Birr in Dire Dawa city administration but only 400,119.42 Birr in Tigray region. The total appropriated budget for the HCs also ranged widely, from a high of 611,089.63 Birr in Addis Ababa city administration to a low of 180,499.91 Birr in Amhara region. The data also indicate that retained revenue on average represented 21 percent of the total health budget in 351 HCs: 56.7 percent of the health budget in Tigray, 49.5 percent in SNNP, 24 percent in Oromia, and 19.6 percent in Amhara. This implies that the government-allocated budget share for HCs is lower in those four regions. Conversely, the proportion of retained revenue to the total health budget is lower in Dire Dawa and Addis Ababa city administrations (10 percent and 11.9 percent, respectively). The average amount of government allocated budget to the HCs in Dire Dawa and Addis Ababa city administration was 3.9 million and 3.4 million Birr respectively. This amount seems to be in harmony with the total catchment area population of the facilities. The highest average proportion of retained revenue in the total health budget (and lowest share of government budget) was in Tigray region.

Table 11. Share of Retained Revenue to Total Health Budget in HCs, 2013/14

Region	Number of HCs	Average Amount of Gov't Allocated Budget (Birr)	Average Appropriated Retained Revenue (Birr)	Average Health Budget (Gov't + Appropriated RR) (Birr)	Annual Average Retained Revenue Generated[8] (Birr)	Share of Retained Revenue to Total Health Budget (%)
Addis Ababa	12	3,442,459.25	611,089.63	4,053,548.88	482,697.98	11.9
Amhara	87	655,514.34	180,499.91	836,014.12	164,159.12	19.6
Benishangul-Gumuz	25	1,384,091.23	300,536.77	1,684,628.00	291,590.00	17.3
Oromia	107	595,954.63	257,335.69	853,290.32	204,391.41	24.0
Dire Dawa	8	3,912,021.71	599,774.36	4,511,796.07	450,127.10	10.0
Harari	8	N/A	254,624.25	N/A	315,175.06	NA
SNNP	76	1,246,921.03	340,830.35	1,587,751.38	785,203.62	49.5
Tigray	36	400,119.42	457,790.02	857,909.44	486,140.15	56.7
Average for facilities visited	351	960,612.99	295,475.26	1,814,178.56	380,881.66	21.0

[8] The difference between appropriated retained revenue and annual average retained revenue might be attributed to planning issues e.g., over- or under-estimation of retained revenue during budget planning.

3.5.4 Management of Retained Revenue in Health Facilities

All facilities were asked if they had a safe deposit box in which to keep monies collected on site (i.e., internal revenue). Seventeen hospitals (89.5 percent) and 381 HCs (74.4 percent) responded that they had a safe deposit box. Nearly 64 percent of hospitals and 67.7 percent of HCs reported how much money they kept in their safe deposit box. Hospitals on average kept 14,500.85 Birr, and HCs kept 10.288.12 Birr. The facility governing board/body determines how much money can be kept in the safe box, taking into consideration the distance between the facility and the bank, the facility's daily income, and other factors. In general, facilities situated in regional, zonal, and woreda capitals, where banking services are easily accessible, deposit their revenue in a bank on a daily basis.

Of the total facilities covered, nearly 71 percent of hospitals and 95.6 percent of HCs had opened bank accounts, with 60 percent of hospitals and 94.5 percent of HCs having opened their account in government banks. Thirty-six percent of hospitals and 81 percent of HCs opened a "type A" account, only one hospital and 5.2 percent of HCs opened a "type B" account, and 4.7 percent opened both type A and B accounts. For both hospitals and HCs, the head of the facility, head of finance and administration/PFL owner, and selected case team members/PFL officer were authorized account signatories, with authority to withdraw money from the account.

Sixty-five facilities (12 percent) deposited their retained revenue in other places: 5.1 percent in microfinance institutions, 4.4 percent in a drawer, and 2.4 percent at their WoFED office.

Health facilities were also asked whether they use the government modified cash base accounting system. Seventeen hospitals (68 percent) and 431 HCs (82.3 percent) do: all facilities in Dire Dawa city administration, nearly 93 percent in Benishangul-Gumuz, 91.7 percent in Addis Ababa, 87.6 percent in Amhara, 85.7 percent in Oromia, 81.6 percent in SNNP, 54.4 percent in Tigray, and 12.5 percent in Harari. Seventy-seven facilities (14 percent) do not use this system because the reform had started only recently, and 24 (4.4 percent) did not respond to the question (missing cases).

3.6 Revenue Utilization

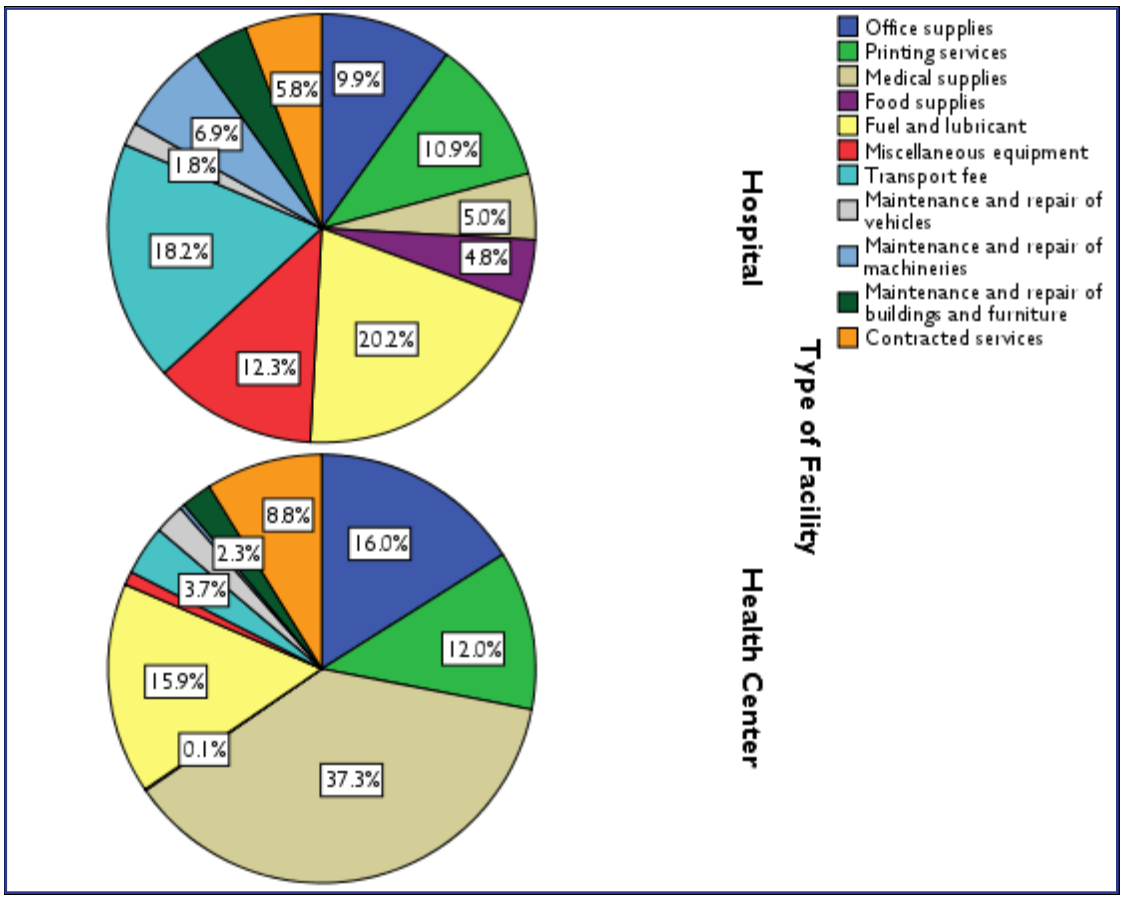
3.6.1 Magnitude of Budget Appropriated for Health Facilities from Retained Revenue

Facilities were asked to state the total amount of appropriated budget for 2013/14. Responses indicate that the average amount of appropriated budget was 3,458,722 Birr for hospitals and 295,475.26 Birr for HCs. Of the appropriated budget, on average, hospitals and HCs utilized 865,504.83 Birr and 94,175.34 Birr, respectively, in the quarter prior to the supportive supervision visit. This indicates that hospitals utilized 25 percent and HCs utilized 31.9 percent of their appropriated budget in the quarter. Health facilities were further asked to state how much of their retained revenue was not utilized and was deposited into their bank account or WoFED office at the time of visit. Hospitals had an average 1,655,099.48 Birr in their account, HCs 177,998.24 Birr. This represents the amount of retained revenue that was not utilized by the facilities in the preceding fiscal years and was deposited in their respective bank account.

3.6.2 Utilization of Government-Allocated Budget

Data were collected on actual expenditures the health facilities made from their government-allocated budget and their retained revenue in the quarter preceding the supervision visit. Figure 10 illustrates the breakdown of spending for hospitals and HCs. A breakdown of hospital spending of government-allocated non-salary budget is as follows: fuel and lubricant (20.2 percent); transport fee (18.2 percent); miscellaneous equipment (12.3 percent); printing services (10.9 percent); office supplies (9.9 percent); maintenance and repair of machines (6.9 percent); contracted services such as electricity, telephone, water, and other utilities (5.8 percent); drugs and medical supplies (5 percent); food supplies (4.8 percent); and other (6 percent). HCs spent the government-allocated budget mainly on drugs and medical supplies (37.3 percent); the rest was for the following items: office supplies (16 percent); fuel and lubricant (15.9 percent); printing services (12 percent); contracted services such as electricity, telephone, water, and other utilities (8.8 percent); transport fee (3.7 percent); maintenance and repair of buildings and furniture (2.3 percent); and other (4.0 percent).

Figure 10. Utilization of Government Allocated Budget in Health Facilities 2013/14



3.6.3 Utilization of Health Facility Internally Generated Revenue

As per the HCF Reform Implementation Manual, health facilities are allowed to use their retained revenue to improve the quality of health services in accordance with their annual plan and appropriated budget. Health facilities were asked to provide data on the utilization of retained revenue on select expenditure items related to quality improvement in 2013/14: 467 (85 percent) (23 hospitals (92 percent) and 444 HCs (84.7 percent)) had started using retained revenue at the time of the visit. All visited HCs in Dire Dawa city administration and Harari region were doing so, as were 91.2 percent in SNNP region, 90.3 percent in Oromia region, 86.0 percent in Tigray region, 83.3 percent in Addis Ababa city administration, and 72.4 percent in Amhara region. Facilities that had not yet started utilizing internal revenue were asked to state their main reasons for not doing so. Lack of awareness was the most common reason (42 percent), followed by delayed appropriation of the budget (21 percent), availability of sufficient government budget (16 percent), newly established HC (11 percent), inadequate manpower (5 percent), and amount collected was insufficient (5 percent).

Among facilities utilizing retained revenue, 17 hospitals (74 percent) and 382 HCs (86 percent) confirmed that their expenditure items were in line with their "positive lists." The guide for utilization of retained revenue for quality improvement (HSFR 2009) defines positive lists as a list of activities that have been identified as priorities for the utilization of retained revenue and approved by the regional and woreda councils. Activities are divided into three priority areas: The first includes pharmacy services, medical equipment and supplies, improving infrastructure and sanitation, strengthening promotion and prevention services, and improving the referral system and infection control. The second includes improving information system and financial management, expansion of rooms, basic capacity-building training for facility staff and operational research, construction and maintenance of supportive services, and outsourcing of non-clinical services. The third area includes office furniture, equipment, trainings not included in the second priority, transportation, operational costs, and staff incentives.

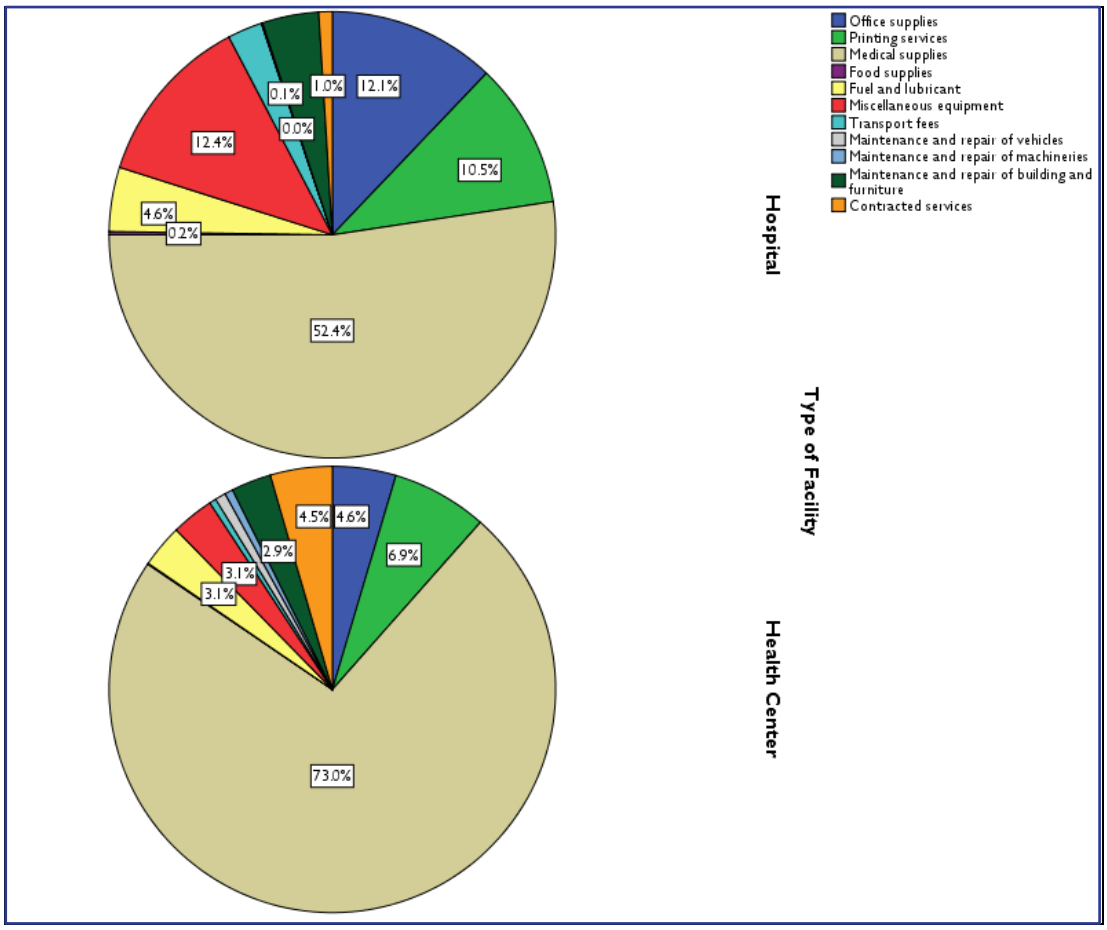
All 25 hospitals and 434 HCs (83 percent) stated that their respective governing board/body had approved the expenditure items prepared by the facility management committee (i.e., in line with the HCF directives in their respective regions). Of these, all hospitals and 403 HCs confirmed that their revenue utilization plan was submitted to their BoFED and/or WoFED before the beginning of 2013/14 for annual appropriation. All hospitals and 78.4 percent (411) HCs stated that their retained revenue utilization plan was appropriated by the regional/woreda council before the beginning of the year.

Of the appropriated retained revenue utilization budget (see Section 4.5.3), hospitals and HCs on average spent 865,504.63 Birr and 89,561.65 Birr from their retained revenue in the quarter preceding the visit. Over half (52.4 percent) of hospitals' retained revenue was used for the procurement of drugs and medical supplies, 12.4 percent for miscellaneous equipment, 12.1 percent for office supplies, 10.5 percent for printing services, 4.6 percent for fuel and lubricants, and 4.1 percent for maintenance and repair of buildings and furniture. Less than 3.9 percent of retained revenue was spent on transport fees, maintenance and repair of machines, maintenance and repair of vehicles, and food supplies.

In HCs, 73 percent of retained revenue was expended on drugs and medical supplies, 6.9 percent on printing services, 4.6 percent on office supplies, 4.5 percent on contracted services, 3.1 percent on fuel and lubricants, 3.1 percent on miscellaneous equipment, and 2.9 percent on maintenance and repair of building and furniture. Less than 2 percent of HC retained revenue was used on transport fees, maintenance and vehicle repair, and maintenance and repair of machines.

Figure 11 presents the total utilization of retained revenue by type of expenditure.

Figure 11. Utilizationof Retained Revenue in Health Facilities 2013/14



A major determinant of the quality and quantity of health care provided to patients is the availability of appropriate supplies and equipment (World Bank, 2010). Supportive supervision results suggested that a substantial share of non-salary health facility spending (government-allocated budget and retained revenue) goes toward procuring drugs and medical supplies. Having these items available builds consumer confidence in the quality of care provided by a health facility and encourages utilization. It also has a direct bearing on the performance of the health system. Supportive supervision data for 2010/11, 2011/12, and 2013/14 confirmed that of non-salary expenditure, health facilities spent the majority of government-allocated budget and retained revenue on procuring drugs and medical supplies.

3.6.4 Financial Performance Report

As per the HCF Reform Implementation Manual, health facilities are required to prepare periodic reports on the amount of revenue they collect and the purpose of their expenditures. Supportive supervision teams assessed how this is being done by health facilities. Results indicate that 92 percent of hospitals and 71 percent of HCs submitted a financial performance report on a monthly basis to their BoFED, RHB, Zonal Finance and Economic Development office, and ZHD (for hospitals) or WoFED and WorHO (for HCs).

Health facilities were also asked whether their revenue retention and utilization had been audited during the previous fiscal year (2012/13). Less than half of hospitals (12) and HCs (251) reported that financial audits took place, broken down as follows: Nine hospitals and 34 HCs were audited by a regional general auditor; 9 hospitals and 52 HCs by regional auditors; 4 hospitals and 42 HCs by zonal auditors; and 238 HCs by woreda auditors.

3.6.5 Observed Challenges/Constraints while Implementing Revenue Retention and Utilization

Facilities were asked about problems or challenges encountered in the implementation of revenue retention and utilization. Eight hospitals (32 percent) and 208 HCs (39.7 percent) stated that they had encountered problems or challenges: all 10 health facilities in Dire Dawa city administration, 26 (46 percent) in Tigray, 55 (44 percent) in SNNP, 82 (42 percent) in Oromia, and 4 (33 percent) in Addis Ababa city administration. Although their proportions were not as high, health facilities in other regions also reported having experienced implementation challenges.

Hospitals reported the following major challenges: delayed appropriation of revenue retention and utilization plan (Tigray); unavailability of drugs from Pharmaceutical Fund and Supply Agency (PFSA) (Benishangul-Gumuz and SNNP); insufficient financial staff; and delayed transfer of government-allocated budget. HCs reported the following challenges: delays in budget appropriation (19); awareness gap on HCF reform in general and financial management in particular (11); shortage of trained key finance staff (9); and absence of commitment among governing board/body members.

To address these issues, most facilities reported that they communicated with the woreda council, WoFED, and WorHO regarding the challenges, and advocated for the recruitment of key finance staff and reinforcement of facility governance structure. Less than 10 percent of facilities (29) in SNNP responded that they had not taken any action.

3.7 Provider Perceptions of the Quality of Health Care Services

The supportive supervision checklist incorporates Likert scale[9] questions to assess provider opinions on the quality of care given in health facilities. Structural indicators[10] were used as the scale items to assess health facility's ability to meet the health needs of individual patient or community. The total sum of all Likert items for each question is the sum of the ratings (judgment) provided by respondents on the quality of care.

Health providers in hospitals reported that utilization of retained revenue contributed greatly to improving the availability of essential drugs and supplies, infrastructure, general purpose equipment and medical equipment, laboratory services, and beds and other furniture, and increased staff satisfaction on services provided. It also improved hospital cleanliness; availability of electricity, landline telephone, and water supplies; and the cold chain system. The smallest proportion of hospital providers are of the opinion that retained revenue contributed to the availability of generators for use during power interruptions, the procurement of a weighing scale for children under five and adults, and/or improvements in hospital health management information system. HC providers reported that retained revenue was used mostly to ensure the availability of essential drugs and supplies and laboratory services, increase staff satisfaction on services provided, and ensure cleanliness of the facility. The revenue also paid for improvements in facility infrastructure, HMIS, water supply, furniture, and electricity. Table 12 details how health facilities scored on these perceived quality indicators.

Table 12. Scores on Quality of Care Indicators, by Type of Health Facility

Perceived Quality Indicators	Hospitals			Health Centers		
	N	Score=1	%	N	Score=1	%
Staff satisfaction increased	24	16	66.7	451	321	71.2
Availability of essential drugs and supplies improved	25	22	88.0	432	358	82.9
Cold chain system improved	25	14	56.0	439	158	36.0
Laboratory services improved	25	18	72.0	459	330	71.9
Availability of general purpose equipment improved	25	21	84.0	455	140	30.8
Availability of medical equipment--improved	25	19	76.0	458	89	19.4
Cleanliness of the facility improved	25	16	64.0	461	305	66.2
Facility's infrastructure improved	25	22	88.0	462	256	55.4
Availability of furniture improved	24	16	66.7	458	237	51.7
Availability of bed (inpatient, delivery and maternity care) improved	25	17	68.0	449	174	38.8
Availability of electricity	25	15	60.0	455	235	51.6
Availability of generator improved	25	12	48.0	455	100	22.0
Availability of water improved	24	14	58.3	457	242	53.0
Availability of landline telephone improved	25	15	60.0	435	159	36.6
Availability of weighting scale improved	25	5	20.0	438	110	25.1
Facility's health management information system improved	25	12	48.0	448	241	53.8

[9] The Likert scale uses statements that the respondent is asked to evaluate.
[10] Structural indicators describe the type and amount of resources used by the health system/facility to deliver quality health care services.

3.8 Fee Waiver and Exemption

3.8.1 Fee Waiver System

The new World Health Organization/World Bank universal health coverage (UHC[11]) framework requires countries to adequately track disadvantaged populations in terms of achieving equitable access, effective coverage, and financial risk protection within their own settings (International Journal for Equity in Health, 2014).

Ethiopia's HCF strategy of 1998 (Federal Ministry of Health, 1998) allows the poorest people to access health care through the new fee waiver system. The rationale for waivers is to mitigate the negative consequences of user fees on the poor. Regional HCF reform legal frameworks also exempt the poorest people from paying user fees. The cost of fee waivers is covered by an appropriate public body pursuant to the regulation issued by regions subsequent to their respective HCF proclamations. Regions have their own fee waiver beneficiary selection criteria. Community and government structures at the grassroots level – got/mender (sub-kebele), kebele, and woreda – are responsible for identifying waiver beneficiaries. Waivers are provided to all poorest household members. As per a Health Services Delivery and Administration (HSDA) proclamation and regulation, the woreda administration is responsible for fully compensating service providers for the revenue they forgo by providing health care services to fee-waived beneficiaries free of charge.

To assess health facility performance in providing services for which fees are waived, facilities were asked whether they were implementing the new fee waiver system. Of the 549 facilities visited, nine hospitals (36.0 percent) and 192 HCs (36.6 percent) reported providing fee-waived services through the new fee-waiver system. In addition, four hospitals (16 percent) and 109 HCs (21 percent) reported providing the same services to indigent/poor households under the community-based health insurance (CBHI) program. In total, 13 hospitals (52 percent) and 310 HCs (57.4 percent) were providing fee-exempted services to the poorest segment of the population at the time of visit. However, five hospitals (20 percent) and 54 HCs (10.3 percent) have been implementing the traditional fee waiver system – serving patients who possess a support letter from the woreda or kebele administration – while others (7 hospitals and 169 HCs) did not report about provision of free services for the poor.

Of the facilities implementing the new fee waiver system, only five hospitals (55.6 percent) and 143 HCs (71.1 percent) received the list of waiver beneficiaries from their woreda/city administration. Of these, two hospitals (40 percent) and 134 HCs (93.7 percent) provided data on the total number of fee-waiver beneficiaries selected for 2013/14.

[11] UHC is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access (World Health Assembly, 2005).

The number of waiver beneficiaries selected varied across regions. One hospital in SNNP received a list of 868 waiver beneficiaries, and a hospital in Tigray, received a list of 608 beneficiaries. Five HCs in Harari received, on average, a list of 1,315; 41 HCs in Amhara 1,194; 11 HCs in Addis Ababa city administration 1,070; 21 HCs in Benishangul-Gumuz 891; 18 HCs in Tigray 842; 25 HCs in SNNP 240; and 13 HCs in Oromia region 133. Overall, the average numbers of waiver beneficiaries selected and sent to hospitals and HCs were 738 and 813, respectively, for 2013/14 (Table 13).

Table 13. Number of Facilities Implementing the New Fee Waiver System and Average Number of Waiver Beneficiaries Included in List Submitted to Facilities, by Region

Region	# Facilities Visited		# Facilities situated in CBHI woredas		# Facilities Implementing New Fee Waiver System		# Facilities Received List of Waiver Beneficiaries		Average # of Waiver Beneficiaries in List Submitted to Facilities	
	Hospital	HCs	Hospitals	HCs	Hospitals	HCs	Hospitals	HCs	Hospitals	HCs
Addis Ababa	0	12	0	0	0	11	0	11	0	1,070
Amhara	8	105	3	45	0	43	0	41	0	1,194
B-Gumuz	1	27	0	0	1	22	0	21	0	891
Oromia	0	196	0	59	0	19	0	13	0	133
Dire Dawa	0	10	0	0	0	10	0	0	0	--
Harari	0	8	0	0	0	7	0	5	0	1,315
SNNP	10	115	1	2	2	42	1	25	868	240
Tigray	6	51	0	3	6	38	1	18	608	842
Total/Average	25	524	4	109	9	192	2	134	738	813

Among facilities that received a list of waiver beneficiaries, all hospitals and 123 HCs (nearly 92 percent) had signed agreements with their respective woreda/city administrations on the provision and reimbursement of fee-waived services.

A successful waiver program requires that the value of the services waived equals the funding available for the program (World Bank, 2003). Health facilities were asked how much budget was allocated for waiver beneficiaries by their respective woreda/city administration. Of facilities that signed contract agreements with their administration to provide free services in return for reimbursement by the administration, only 79 HCs (64.2 percent) provided data on the amount of budget the administration allocated for waiver beneficiaries. On average, 57,168.75 Birr was allocated for 2013/14.

Reimbursement for waived services requires keeping records of beneficiaries served at health facilities. Doing so minimizes misunderstandings between service providers and woredas/city administration that finance the services. All facilities visited were asked whether they have a fee waiver registry book. Among facilities providing free services either through the new fee waiver system or the traditional fee waiver system, all 18 hospitals and 208 HCs (58.6 percent) had a fee waiver beneficiary registry book at the time of the visit.

Of the facilities that had a fee waiver beneficiary registry book, nine hospitals (50 percent) and 131 HCs (63 percent) reported the number of waiver beneficiaries served in the quarter preceding the supervision visit. Hospitals on average served 667 waiver beneficiaries and HCs served 468 (Table 14).

Table 14. Average Number of Waiver Beneficiaries Served in the Quarter Preceding Supervision Visit, Disaggregated by Type of Facility and Region

Region/City Administration	Type of Facility	Number of Facilities	Average Number of Waiver Beneficiaries Served
Addis Ababa (no hospitals visited)	HCs	11	779
Amhara	Hospital	1	321
	HC	33	99
Benishangul-Gumuz	Hospital	1	372
	HC	21	136
Oromia (no hospitals visited)	HC	20	2,234
Dire Dawa	HC	9	289
SNNP	Hospital	7	295
	HC	37	68
Total/Average	Hospitals	9	667
	HCs	131	468

Facilities without registry books used other mechanisms to identify waiver beneficiaries and estimate associated costs. These included collecting receipt vouchers from each of the facility's units/departments, collecting and counting a support letter sent from woreda/city administration in the card rooms, and counting the number of fee waiver beneficiaries served from the general patient registry book. These alternative approaches are more difficult and time consuming ways to estimate costs incurred providing fee-waived services. To maximize efficiency, facilities should maintain a separate registry book for waiver beneficiaries.

Of facilities that reported the number of waiver beneficiaries served in the quarter preceding supervision visit, 23 hospitals (92.3 percent) and 472 HCs (90.4 percent) submitted a request for reimbursement of waived services to their respective woreda/city administration. Most facilities use a fee-for-service rate when requesting reimbursement. However, 21 (nearly 12 percent) of the facilities (9 HCs in Amhara, and 3 hospitals and 9 HCs in SNNP) used a case-based fixed rate. Only two hospitals (16.7 percent) and 102 HCs (72 percent) received reimbursement, with regional variation: one hospital and 25 HCs in Tigray; one hospital and 19 HCs in SNNP; 20 HCs in Amhara; 16 HCs in Benishangul-Gumuz; 10 HCs in Oromia; 7 HCs in Addis Ababa and 5 HCs in Dire Dawa city administration.

Health facilities were asked whether they experienced problems or challenges in implementing the new fee waiver system. Those reporting challenges were 2 hospitals and 21 HCs in SNNP; 5 hospitals and 17 HCs in Tigray; 21 HCs in Amhara; 14 HCs in Oromia; 10 HCs in Dire Dawa; 1 hospital and 7 HCs in Benishangul-Gumuz; 9 HCs in Addis Ababa; and 1 HC in Harari.

Facilities implementing the new fee waiver system listed the following major implementation challenges: no proper selection of waiver beneficiaries at kebele level (43.3 percent); facility did not receive reimbursement on time (38.9 percent); facility was not aware of the budget allocated for waiver beneficiaries (38.9 percent); facility did not receive reimbursement until end of 2013/14 (31 percent); fee waiver ID cards were not properly distributed to beneficiaries by woreda/city administrations (30.5 percent); and beneficiaries did not know they had been selected for fee-waived services (9.4 percent). In general, the responsible government body (RHB/woreda council) should advocate to kebele administrations for fair and equitable selection of waiver beneficiaries; health facilities should submit all expense claims for reimbursement to the woreda finance offices on a timely basis; and the latter should promptly reimburse facilities expenses incurred to provide the services.

3.8.2 Exempted Health Services

An exempted service is one that is provided free of charge to all people, irrespective of their income. The purpose of providing exempted health services is to promote the consumption of specific health services, including those whose benefits are undervalued by the population, those that have externalities, and those that are purely public goods (World Bank, 2003). The definition, as well as the purpose, of providing exempted health services corresponds with the HSDA legal framework documents ratified and currently being implemented in Ethiopia. These services are of a public health nature, have externalities to the public, have more social importance and, therefore, citizens need to be encouraged to use or consume them. With minor variation across regions, the list of exempted services in Ethiopia include: tuberculosis (TB); ANC and PNC; immunization of children under five years old; delivery; family planning, voluntary counseling and testing (VCT); prevention of mother-to-child transmission (PMTCT) of HIV; malaria, leprosy management; epidemic follow-up and control; and fistula management. Most regions include abortion on the list of exempted health services both in hospitals and in HCs in defined circumstances. Facilities are allowed to perform an abortion only if the pregnant woman experienced preeclampsia or eclampsia; the fetus has incurable deformity; or if the woman is under 18 years old, was raped, or has a mental disorder.

The HSDA proclamation and regulation states that an RHB proposes a list of health services to be exempted, and the regional government reviews and approves the list. The HCF legal framework states that maternal health services (ANC, delivery, PNC, family planning) are exempted from fees only at the primary health care unit level (HCs and health posts). TB, expanded program on immunization (EPI), VCT/provider-initiated counseling and testing (PICT), PMTCT, epidemic control, and fistula are exempted both in hospitals and in HCs. However, the lists of exempted health services are not uniform throughout all regions/city administrations. The HCF legal framework suggests that health facilities post the list of exempted health services so they are visible to those seeking services.

Facilities were assessed on their implementation of exemptions. Of the 549 facilities visited, 24 hospitals (96 percent) and 466 HCs (nearly 89 percent) provided exempted health services free of charge. However, facilities in Tigray, Dewhan (Eastern zone), Hagereselam (South West zone), and Hawzen (Eastern zone) charged users for some exempted health services. Dewhan HC charged for HIV/AIDS, maternal and child health (MCH), delivery, and abortion services; Hagereselam HC charged for MCH, antiretroviral therapy, TB, and leprosy services; and Hawzen charged for MCH, TB, and leprosy services. Similarly, Hiwot Amba (Kirkos) and Woreda 2 HCs (Nefas Silk Lafto) in Addis Ababa charged for delivery and PNC services; Tibeb Bekechenie (Gulelie) and Woreda 2 HCs charged for PMTCT service; and Woreda 2, Woreda 8 (Yeka), and Tibeb Bekechenie HCs charged for TB and leprosy services (mainly for supplies).

As per the HCF implementation manual, health facilities are required to post the list of exempted health services in their compound. Of the facilities visited, 344 (nearly 63 percent) posted a list – 16 hospitals (64 percent) and 328 HCs (62.6 percent). The percentages disaggregated by region are as follows: all facilities in Benishangul-Gumuz; 84.2 percent in Tigray; 76 percent in SNNP; 75 percent in Addis Ababa; 70 percent in Amhara; 41.3 percent in Oromia; 25 percent in Harari; and 20 percent in Dire Dawa city administration.

Of facilities providing exempted health services, 371 (75.7 percent) maintained records of exempted health services. Of these, 322 (86.8 percent) reported utilization and expenditure data on exempted health services to the ZHD/WorHO. Over 99 percent of facilities (17 hospitals and 303 HCs) confirmed that they procured drugs and medical supplies using their internal revenue. Of these, 16 hospitals (94.1 percent) and 182 HCs (60.1 percent) notified their RHB and WorHO about the burden of the costs of exempted health services.

Health facilities were asked to list major problems encountered in providing exempted health services. The following problems were reported: fear that providing exempted services would drain their retained revenue (44.9 percent); shortage of drugs and medical supplies (12 percent); shortage of government allocated budget for drugs and medical supplies (9 percent); some services are not fully exempted (7.8 percent); and absence of reimbursement for costs incurred to provide these services (4.8 percent). A little over one-fifth of facilities (21.5 percent) stated that they experienced no problem while providing these services.

3.9 User Fee Setting and Revision

User fee setting and revising is also a component of HCF reform in Ethiopia. According to the HCF strategy and subsequent regional legal frameworks, user fees need to be revised based on people's ability to pay and the cost of providing health care services. The strategy emphasizes cost sharing between government and health care users. In most cases, drug prices reflect the cost of the drug and a markup of up to 25 percent on the procurement price of the drug. As per HCF regional legal frameworks, regional councils are responsible for revising user fees. The regional council in SNNP granted the right to revise user fees to the facility governing boards/ bodies; however, facilities are required to inform the council through the RHB regarding the revisions they have made. In other regions/city administrations, the health bureau submitted the list of revised user fees to regional council for approval.

Of the facilities visited for supportive supervision, six hospitals (24.0 percent) and 226 HCs (43.1 percent) had revised user fees. When disaggregated by region, all facilities in Benishangul-Gumuz, 86.7 percent in Amhara, 66.7 percent in Tigray, 37.6 percent in SNNP, and 25 percent in Addis Ababa city administration had done so. No facility in Dire Dawa city administration and Harari region had revised their user fees.

To assess facility awareness of regional HCF legal frameworks related to revising user fees, all facilities that had revised user fees were asked to state which institution or organization has the authority to revise user fees. Two hospitals (Pawe in Benishangul-Gumuz and Adigrat in Tigray) reported that the RHB submitted the proposed user fees and that the regional council made decisions regarding the revision of user fees. Karat hospital (SNNP) reported that the hospital governing board made decisions regarding the revision of user fees. For HCs, 45.6 percent reported the regional council as their decision maker on the revision of user fees, 35 reported the RHB, 28.3 percent facility management, 5.8 percent the facility governing board/body, and 2.2 percent the ZHD/WorHO.

Almost 98 percent of HCs in Amhara and nearly 20 percent in Tigray reported that the regional council revised user fees. All HCs in Benishangul-Gumuz, nearly 42 percent in Amhara, and 29.7 percent in Tigray mentioned the RHB as responsible for the revision of user fees. All HCs in Addis Ababa, nearly 76 percent in Tigray, 62.8 percent in SNNP, 22.2 percent in Oromia, and 2 percent in Amhara reported facility management as the decision maker. Only 30.2 percent of HCs in SNNP recognized the facility governing board/body as the decision-making organ on user fee revision. Variations in facility responses might be due to a low level of knowledge on regional HCF legal framework.

Of the facilities that revised user fees (232), four hospitals (66.7 percent) and 133 HCs (58.8 percent) specified the date on which they revised user fees. When disaggregated by type of facility, one hospital and six HCs had revised user fees in 2009/10, two HCs in 2010/11, 19 HCs in 2011/12, 63 HCs in 2012/13, and three hospitals and 43 HCs in 2013/14. The largest proportion of hospitals and HCs had revised user fees in 2012/13 and 2013/14.

In terms of regions, only seven facilities in Tigray reported revising user fees in 2009/10; one facility each in Tigray and SNNP in 2010/11; and nine facilities in Amhara, five in SNNP, three in Tigray, and two in Oromia in 2011/12. In 2012/13, 37 facilities in Amhara, 13 in SNNP, 11 in Tigray, and one each in Oromia and Addis Ababa revised user fees. Nearly one-fifth of facilities (18 in Amhara, 13 in Tigray, 11 in SNNP, and two each in Oromia and Addis Ababa) revised user fees in 2013/14.

Health facilities were asked to state the three major factors that they considered in revising user fees. Five hospitals (83.3 percent) and 75 HCs (one-third) responded. Three hospitals reported the escalating costs of drugs and medical supplies; one hospital each reported community ability to pay for services and the need to increase facility retained revenue. Over half of HCs (53.3 percent) stated the increasing costs of drugs and medical supplies; 25.3 percent reported the need to increase facility retained revenue; and 24 percent cited the community ability to pay.

All facilities in Addis Ababa city administration, nearly 56 percent of facilities in SNNP, 40.5 percent in Tigray, and only 6 percent in Oromia considered the escalating costs of drugs and medical supplies as a major factor. And 24.3 percent of facilities in Tigray and 16.3 percent in SNNP took into consideration community ability to pay. In addition, 24.3 percent of facilities in Tigray and 16.3 percent in SNNP reported the need to increase facility retained revenue.

Facilities were asked to state their previous and revised user fees for 16 selected services[12] in public hospitals, as well as the percentage change. Only SNNP and Tigray regions responded. Findings from SNNP indicate that the highest percentage of change in user fee charges in hospitals was for issuing medical certificate for legal purposes, followed by consultation, pregnancy test, stool examination, microscopic urine analysis, and medical certificate for employment. In Tigray, the only user fee category revised was consultation services. The percentage change in user fees for other service categories in SNNP was below 10 percent. Table 15 compares previous user fees with revised fees for hospitals in SNNP and Tigray.

Table 15. Comparison of Previous and Revised User Fees in Hospitals for Select Health Services, by Region (SNNP and Tigray) and Type of Service

Type of Service	Region	# Hospitals	Previous User Fee (Birr)[13]	Revised User Fee (Birr)	Percentage Change
Consultation	SNNP	4	5.25	8.33	58.70
	Tigray	1	7.00	10.00	42.90
Deep stick urine analysis	SNNP	3	4.67	5.00	7.10
Microscopic urine analysis	SNNP	1	4.50	5.00	11.10
	Tigray	1	7.00	7.00	0.0
Stool examination	SNNP	1	4.00	5.50	37.50
	Tigray	1	7.00	7.00	0.0
White blood cell count	Tigray	1	28.00	28.00	0.0
Pregnancy test	SNNP	1	10.25	15.00	46.30
	Tigray	1	9.00	9.00	0.00
Widal test	SNNP	3	12.00	13.00	8.30
	Tigray	1	15.00	15.00	0.00
Venereal Diseases Research Laboratory (VDRL) test	Tigray	1	15.00	15.00	0.00
Erythrocyte Sedimentation Rate	SNNP	1	7.33	8.00	9.10
	Tigray	1	7.00	7.00	0.00
X-ray	Tigray	1	30.00	30.00	0.00
Bed/admission	Tigray	1	20.00	20.00	0.00
Employment certificate	SNNP	1	45.00	50.00	11.10
	Tigray	1	25.00	25.00	0.00
Medical certificate for legal purpose	SNNP	1	50.00	100.00	100.0
	Tigray	1	30.00	30.00	0.00
Minor operation	Tigray	1	35.00	35.00	0.00
Major operation	Tigray	1	200.00	200.00	0.00
Dressing	Tigray	1	15.00	15.00	0.00

[12] Select services include: consultation; deep stick urine analysis; microscopic urine analysis; stool examination; WBC count; pregnancy test; Widal test; VDRL; ESR; X-ray; bed/admission; medical certificate for employment; medical certificate for legal matters; minor operation; major operation; and dressing.
[13] Average figures for previous and revised user fees are used for comparison.

As shown in Table 16, the highest of percentage change in user fee charges in Amhara HCs was on consultation, followed by pregnancy test, Venereal Diseases Research Laboratory (VDRL), deep stick urine analysis, Widal test, and microscopic urine analysis. In SNNP, minor operation, major operation, dressing, x-ray, stool examination, consultation, certificate for legal matters, and microscopic urine analysis had the highest percentage change. HCs in Tigray had the highest percentage increase in user fees for consultation, certificate for legal matters, Widal test, minor operation, employment certificate, microscopic urine analysis, and dressing in their sequence. In Oromia, deep stick urine analysis, consultation and certificate for legal matters were the services with highest percentage increase in user fees.

Table 16. Comparison of Previous and Revised User Fees in Health Centers for Selected Health Services, by Region and Type of Service

Type of Service	Region/City Administration	# Health Centers	Previous User Fee (Birr)[14]	Revised User Fee (Birr)	Percentage Change
Consultation	Amhara	4	3.00	5.50	83.30
	Oromia	4	2.50	3.00	20.00
	SNNP	39	3.50	4.85	38.60
	Tigray	9	3.90	7.40	89.70
Deep stick urine analysis	Addis Ababa	3	5.33	6.66	25.00
	Amhara	10	4.00	5.70	42.50
	Oromia	3	3.00	5.00	66.70
	SNNP	32	4.53	6.10	34.70
	Tigray	17	7.50	7.70	2.70
Microscopic urine analysis	Addis Ababa	1	4.00	5.00	25.00
	Amhara	10	6.30	8.00	27.00
	SNNP	17	4.20	5.75	36.90
	Tigray	19	6.40	8.75	36.70
Stool examination	Addis Ababa	2	2.50	3.00	20.00
	SNNP	24	3.83	5.40	41.00
	Tigray	23	5.52	6.70	21.40
White blood cell count	Addis Ababa	1	5.50	11.50	109.10
	Amhara	1	15.00	14.50	-3.30
	SNNP	14	6.10	7.30	19.70
	Tigray	12	7.40	9.93	34.20
Pregnancy test	Amhara	10	6.00	10.50	75.00
	SNNP	33	7.74	8.82	14.00
	Tigray	23	6.85	8.89	29.80
Widal test	Addis Ababa	8	8.00	9.85	23.10
	Amhara	1	9.00	12.00	33.30
	SNNP	25	8.33	10.50	26.10
	Tigray	16	8.00	11.80	47.50
Venereal Disease Research Laboratory test	Addis Ababa	2	4.00	6.00	50.00
	Amhara	4	4.25	7.00	64.70
	SNNP	14	8.57	10.58	23.50
	Tigray	11	8.80	9.65	9.70

[14] Average figures for previous and revised user fees are used for comparison.

Type of Service	Region/City Administration	# Health Centers	Previous User Fee (Birr)[14]	Revised User Fee (Birr)	Percentage Change
Erythrocyte Sedimentation Rate	SNNP	6	6.40	6.83	6.70
	Tigray	11	7.27	8.70	19.70
X-ray	SNNP	1	4.00	6.00	50.00
Bed/admission	SNNP	8	10.25	13.00	26.80
	Tigray	18	9.30	11.65	25.30
Employment certificate	Addis Ababa	1	28.00	35.00	25.00
	SNNP	17	19.53	26.12	33.70
	Tigray	23	15.50	21.45	38.40
Certificate for legal matters	Oromia	1	30.00	32.50	8.30
	SNNP	27	22.60	31.00	37.20
	Tigray	12	16.50	26.20	58.80
Minor operation	SNNP	5	19.00	36.00	89.50
	Tigray	2	28.00	40.00	42.90
Major operation	SNNP	5	27.50	45.00	63.60
	Tigray	3	170.00	166.67	-2.00
Dressing	SNNP	29	5.71	8.65	51.50
	Tigray	19	5.68	7.68	35.20

Facilities were asked to list the major problems encountered while implementing user fee revisions. Of 232 facilities (42.2 percent) that made revisions, only 21 (9.1 percent) reported the problems they encountered. Of these, eight facilities (38.1 percent) stated that the community had complained about increased consultation fees, four facilities (19 percent) stated that the community complained about frequent increases in the price of drugs, four facilities (19 percent) stated that the community complained about the overall revised fees, two facilities (9.5 percent) stated that the community complained that the user fees for injections are too high. One facility (4.8 percent) reported complaints about revised fees for dressing, one facility (4.8 percent) emergency examination, and one facility (4.8 percent) medical certificate for legal purposes.

Facilities that have not revised user fees 282 (51.4%[15]) were further asked whether they intended to revise user fees in the future. Only 99 facilities (35.1 percent) (seven hospitals (63.6 percent) and 92 HCs (19.5 percent)) stated that they intended to revise user fees.

Finally, those facilities that intend to revise user fees (99) were further asked to state why they intended to revise user fees. Of the 95 facilities that responded to the question, nearly 82.1 percent (78) stated that existing user fees were too low to cover procurement costs; 6.3 percent wanted to increase retained revenue; 3.2 percent wanted to make their fees similar to those of neighboring facilities; 2.1 percent stated they wanted revenue to improve the quality of services; and another 2.1 percent wanted compensation for the costs they incurred in providing exempted health services. One facility (1.1 percent) stated that they intended to revise user fees because it had been a long time since they had done so and drug costs had dramatically increased; one facility (1.1 percent) levied suitable user fees; and another one facility (1.1 percent) increased in the level of community income and their ability to pay.

[15] 35 facilities (6.4 percent) did not state whether they revised user fees.

3.10 Outsourcing of Non-Clinical Services

Outsourcing, or the purchase of specific non-clinical services from specialized service providers, is an important component of health sector reform. As per the HCF regulation, non-clinical services that can be outsourced include infrastructure and fixed asset maintenance and services, and support services such as cleaning, gardening, catering, printing, security, transport, and legal services. Objectives of outsourcing are to allow hospital management and staff to focus on their core health care service provision, and to reduce costs and improve the quality of such auxiliary services. To assess the implementation of this reform component, questions on this subject were incorporated into the supportive supervision checklist.

Of the facilities visited, only six hospitals (Arba Minch, Chencha, Durame, and Yirgalem in SNNP; Pawe in Benishangul-Gumuz, and Suhul in Tigray) were outsourcing non-clinical services at the time of visit. Arba Minch, Chencha, and Durame hospitals outsourced catering services. Pawe, Suhul, and Yirgalem outsourced the supply of food items (with the hospitals themselves handling food preparation).

These hospitals were further asked to state the body responsible for approving outsourcing. Four (Arba Minch, Durame, Pawe, and Suhul) responded that hospital governing boards were responsible; Yirgalem hospital reported that it was the hospital CEO; and Chencha hospital stated that the management committee was responsible.

The hospitals were asked to list the major benefits of outsourcing. All except Suhul hospital stated that outsourcing improved the quality and reduced the cost of non-clinical services. All but Yirgalem hospital said that outsourcing improved efficiency and effectiveness of hospital staff. Arba Minch and Chencha (SNNP) and Suhul (Tigray) stated that outsourcing added external expertise to hospital operations and enabled facility management to focus on health care service provision.

The hospitals were also asked to list major problems encountered in outsourcing. Two (Pawe and Suhul) reported absence of licensed providers as the major problem, and Durame stated that ensuring quality of outsourced food and catering services was problematic. Three (Arba Minch, Chencha, and Yirgalem) did not report any problems.

3.11 Establishment of Private Wing/Room in Public Hospitals

Private wings/rooms within the premises of public health facilities provide diagnostic and treatment services at market or near-market rates. The purposes of private wings are to: encourage the retention of health workers (mainly specialists) by allowing them to work and earn additional income in their off-work hours; provide choices to patients who otherwise use private providers in public hospitals; and generate additional revenue for health facilities. Of the 25 hospitals visited, only nine (Adigrat, Adwa, Alamata, Lemlem Kharl, St. Mary, and Suhul in Tigray; Felege-Hiwot in Amhara, Pawe in Benishangul-Gumuz, and Halaba Kulito in SNNP) had established a private wing. Adigrat, Adwa, Alamata, and Suhul hospitals (Tigray) established a private wing/room in 2010/11; Pawe (Benishangul-Gumuz) in 2011/12; and Lemlem Kharl (Tigray) in 2012/13. The remaining three hospitals (Arba Minch and Chencha in SNNP, and Felege-Hiwot in Amhara) did not report the year in which they had established a private wing/room.

The nine hospitals were asked to state the number of people served (repeat and new users) in their private wing/room during the quarter preceding the supervision visit. Only three hospitals did so. Alamata, Pawe, and Adigrat hospitals served on average 963, 906, and 735 patients, which generated 189,977.60 Birr, 57,927.00 Birr, and 159,946.11 Birr, respectively. The average user fee/patient per bed day in the private wing/room was highest in Adigrat hospital (217.61 Birr/patient) followed by Alamata (197.30 Birr/patient), and Pawe (63.94 Birr/patient).

Hospitals that established a private wing/room were asked whether they opened a separate bank account to manage the revenue generated. Five hospitals (Adwa, Alamata, Lemlem Kharl and St. Mary in Tigray and Pawe in Benishangul-Gumuz) reported having done so. Adigrat and Suhul in Tigray, Felege-Hiwot in Amhara, and Halaba Kulito in SNNP did not respond to this question.

Hospitals that established private wings/rooms were asked if doing so had negatively impacted service provision in their regular ward. Six hospitals (Pawe in Benishangul-Gumuz; and Adigrat, Adwa, Alamata, and Lemlem Kharl in Tigray) reported that the private wing/room had not negatively impacted service provision in the regular ward. These hospitals were further asked whether they face any challenges implementing the private wing/room reform in their hospital. Three hospitals (Alamata and Suhul in Tigray; and Pawe in Benishangul-Gumuz) reported problems in revenue sharing among hospital staff. Respondents from Suhul hospital reported absence of clear work schedule in the general ward. Hence, there is a need to advocate on the importance of establishing private wings/rooms; strengthen hospital boards to overcome problems; and revise the private wing manual at the central level and facilitate its adaptation by the regions so as to overcome the stated challenges.

3.12 Supportive Supervision

HSFR/HFG institutionalized regular supportive supervision, a process that promotes effective implementation of interventions by encouraging on-the-spot technical support and opportunities to recognize best practices, identify and correct problems, address weaknesses, and provide on-site training. Regular supportive supervision also generates evidence to inform management decisions and to update government officials at all levels, USAID, and key stakeholders on the status of reforms. With the involvement of all stakeholders (federal, regional, and woreda officials; development partners; health professionals; program officers; and administrators), the FMOH developed a standard and comprehensive HMIS/M&E system, and selected performance indicators. Only a few HCF indicators are incorporated into the FMOH HMIS/M&E system. Accordingly, HSFR/HFG has advocated for incorporating HCF indicators into the RHBs' Integrated Supportive Supervision (ISS) checklist which is being used by the RHBs and implementing partners to gauge progress in the health system in general and it has succeeded in some regions. HSFR/HFG has its own supportive supervision checklist aimed at overseeing the implementation of HCF reform in health facilities.

In 2013/14, a total of 549 health facilities (25 hospitals and 524 HCs) were covered through supportive supervision. Facilities were asked whether they received technical support from their respective RHB, ZHD, WorHO, or WoFED office in the quarter preceding the HSFR/HFG project supervision visit. Of all facilities visited, 459 (83.6 percent) confirmed that they had been visited and received technical support. Of these, nine were hospitals (36 percent of the 25 visited) and 450 were HCs (85.9 percent of those visited). When disaggregated by region, all facilities in Dire Dawa city administration; 187 (95.4 percent) in Oromia; 114 (91.2 percent) in SNNP; 49 (86.0 percent) in Tigray; 10 (83.3 percent) in Addis Ababa city administration; 84 (74.3 percent) in Amhara; and 5 (62.5 percent) in Harari received technical support. Of the 25 hospitals that received technical support, eight (nearly 89 percent) reported being visited by the RHB, five (55.6 percent) by the ZHD, and two (22.2 percent) by the WoFED. Out of 450 HCs, 153 (34 percent) of HCs reported that they were visited by the RHB, 240 (53.3 percent) by the ZHD, 386 (85.7 percent) by the WorHO, and 107 (23.7 percent) by the WoFEC.

Facilities were asked if the supervising bodies used checklists while visiting their facility. Nearly 88 percent (402) (all nine hospitals and 393 HCs (87.3 percent)) confirmed that the supervising bodies used a checklist. Facilities were asked whether the checklist incorporated questions about HCF activities. Eight hospitals (nearly 89 percent) and 307 HCs (78.1 percent) reported that the supervision checklist did contain such questions. This implies that the HCF reform indicators are well integrated into the RHB, ZHD, and WorHO checklists, paving the way for the institutionalization of the reform.

Eight out of the nine hospitals (88.9 percent) and 402 out of 450 HCs (89.3 percent) reported that they received feedback during supportive supervision visits, while one hospital (11.1 percent) and 48 HCs (10.7 percent) reported that they did not receive feedback. Of the facilities that received feedback, seven hospitals (87.5 percent) and 248 HCs (61.7 percent) received written feedback, and four hospitals (50.0 percent) and 141 HCs (35.1 percent) received oral feedback on the observed gaps; only 75 HCs (18.6 percent) had on-the-spot discussions—(broader than oral feedback)with supervisors regarding their strengths, observed gaps, and the way forward to overcome challenges-at the end of the supervision visit.

Finally, facilities were asked whether changes were made as a result of the supportive supervision visit. All eight hospitals and 331 of the HCS (82.3 percent) that reported receiving feedback also reported that they made positive changes following the supportive supervision visit. Four hospitals stated that supportive supervision led to improvements in asset and financial management, three hospitals (37.5 percent) reported improvements in documentation and HMIS, and one hospital (12.5 percent) reported the construction of additional rooms. Similarly, 155 HCs (38.5 percent) stated that supportive supervision brought improvements in service provision, asset and financial management (24.3 percent), documentation and HMIS (19.7 percent), human resources (9.2 percent), facility management committee/governing board (5.4 percent), and construction of additional rooms (2.9 percent).

4. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

4.1 Health Facility Finance Structure and Staffing

Key Findings: Though regional variations were evident, the majority of health facilities visited during HSFR/HFG supportive supervision had the required administration and finance staff at the time of the supervisory visit. Large numbers of health centers have become operational in the last few years; as a result, a greater proportion of health facilities' PFPA owner/coordinator, PFPA officer/accountant, and cashier received financial management training than training on HCF reform implementation. Five hospitals (20 percent) and 197 HCs (37.6 percent) encountered problems using financial formats/receipts, and 323 (nearly 59 percent) of all facilities were challenged by staff turnover.

Recommendations: Woreda offices and health facilities need to regularly and expeditiously fill vacant finance and administration positions and communicate with RHBs on organizing training on HCF reform implementation and financial management. RHBs in turn should play a leadership role in organizing training and reorientation sessions for existing staff (e.g., hospital accountants) as well as newly recruited staff, in collaboration with the HSFR/HFG project and other partners.

4.2 Health Facility Governance

Key Findings: Per the HCF legal framework, health facilities are allowed to be autonomous by establishing and operationalizing their own governing boards. All hospitals and 96.4 percent of HCs visited have established governing boards/bodies. However, a significant number of the governing boards/bodies (41.1 percent) do not function as expected due to board members' busy schedules and lack of commitment, frequent member turnover, and the absence of allowances paid for attending meetings.

Recommendations: Functioning of facility governing boards/bodies needs to be regularly monitored by the regional and/or woreda administration and reported to relevant local government authorities. Vacant board positions need to be filled immediately. To motivate board members to fulfill their board responsibilities, there needs to be initial training for new board members and refresher training for continuing members. Health authorities at all levels (woreda, zonal, regional, and federal) need to be vigilant about member training and board functioning, including monitoring the regularity of board meetings and decision-making processes and outcomes made by boards.

4.3 Government Budget and Financial Management

Key Findings: The average annual government budget allocated to hospitals fluctuated over time – first declining from Birr 4.4 million in 2007/08 to Birr 3.1 million in 2009/10, but thereafter steadily increasing. The amount of government budget allocated for HCs remained below Birr 1 million, yet began to slowly increase after 2011/12.

The average share of retained revenue from the visited facilities' total health budget was nearly 27.8 percent in hospitals and 21.0 percent in HCs in 2013/14. This shows that the government allocation was higher in hospitals than in HCs. Some HCs reported that they experienced budget offsetting (operational budget such as drugs and medical supplies, duty allowance, and other operational expenses) due to the revenue they generated. Of the total health facilities visited, 88 percent of hospitals and 56 percent of HCs manage the government-allocated budget autonomously, i.e., they paid staff salaries in their facility and used the government-allocated budget for other operational expenses. All health facilities in Dire Dawa city administration, 93 percent in Benishangul-Gumuz, 92 percent in Addis Ababa, 87.5 percent in Amhara, and 62.4 percent in SNNP have been fully managing the government-allocated budget. In contrast, only 41 percent in Oromia, 20 percent in Harari, and 14 percent in Tigray do so.

Recommendations: The regional HCF legal frameworks allow health facilities to use retained revenue as additive to the government budget. Therefore, continuous dialogue with regional council and BoFED offices as well as with their counterparts at the zonal and woreda levels is needed to increase the budget for health facilities (for drugs and medical supplies, duty allowance, and other operations) without offsetting retained revenue. There is also a need to jointly work with decision makers (regional and woreda administration) in Tigray, Harari, and Oromia to enable facilities to manage the government-allocated budget themselves, as is happening in other regions. It is believed that facility-level budget management will ultimately improve timely budget execution and health service delivery.

4.4 User Fee Setting and Revision

Key Findings: The major source of health facility retained revenue is user fees. To ensure that user fees reflect the current cost of service delivery and community ability to pay, they must be revisited regularly. Of the facilities visited, only six hospitals (24.0 percent) and 226 HCs (43.1 percent) reported having revised user fees; the approaches to user fee revision and the amounts of revised fees varied from region to region and from facility to facility. A significant number of respondents from health facilities had a limited understanding of the regional legal and operational frameworks, as well as their mandates on user fee revisions.

The reasons facilities reported for revising user fees were the following: the rising price of drugs and medical supplies such as reagents, households' ability to pay, and the desire to increase retained revenue.

Recommendations: Health facilities need to know and adhere to regional legal and operational frameworks when revising user fees. Authorities need to monitor user fee revision processes and applications, and ensure standardized user fee revision approaches are used. Hence, regional councils and/or RHBs should provide region-specific guidance as well as standardized user fee revision modalities to health facilities. Depending on the regional HCF legal framework, RHBs and health facilities need to generate reliable evidence on the cost of services as well as households' ability and willingness to pay for the services as part of the user fee revision process.

4.5 Retained Revenue Utilization

Key Findings: Revenue retention and use at health facilities has been institutionalized in all regions, and health facilities have been generating and using a considerable amount of financial resources. Of the total facilities visited for supportive supervision, 467 (a little over 85 percent) had started using retained revenue to make quality improvements. Among facilities using retained revenue, 92.0 percent of hospitals and 84.5 percent of HCs used their revenue in accordance with the law.

Recommendations: Health facilities governing boards/bodies and government authorities at all levels need to regularly monitor the amount of retained revenue expended and ensure proper and timely use of retained revenue in the facilities where utilization is lagging. Facilities need to make sure that retained revenue is used for improving the quality of health service delivery.

4.6 Fee Waiver System

Key Findings: Of the facilities visited, only 13 hospitals (54.2 percent) and 301 HCs (354.8 percent) were implementing the new fee waiver system. Of these, 4 hospitals and 109 HCs are situated in the CBHI implementing woredas and received reimbursement through targeted subsidy. Seven hospitals (28 percent) and 169 (32.2 percent) HCs had not yet started to provide waived services. Five hospitals (almost 20 percent) and 54 HCs (10.3 percent) are still implementing the traditional fee waiver system.

Nine hospitals and 131 HCs reported that they served, on average, 667 and 468 waived patients, respectively, in the quarter preceding the supervision visit. Seven hospitals in SNNP, on average, served 295 waived patients, and one hospital each in Benishangul-Gumuz and Amhara regions served 372 and 321 patients, respectively. In Oromia region, 20 HCs served 2,234 patients. Eleven HCs in Addis Ababa and nine in Dire Dawa city administration treated 779 and 289 patients, respectively. Many fewer waived patients were served in Benishangul-Gumuz, Amhara, and SNNP: in those regions, 21, 33, and 37 HCs treated 68, 99, and 136 patients, respectively.

A little over 92.0 percent of hospitals and 90.4 percent of HCs requested reimbursement of waived services from their respective woreda/city administration. In some regions, hospitals submitted their reimbursement request to the RHB. Of those that submitted requests, 16.7 percent of hospitals and 72.0 percent of HCs received reimbursements. Notably, reimbursement is weak in regions other than Addis Ababa and Dire Dawa city administrations and Benishangul-Gumuz region (Afar, Amhara, Oromia, Harari, SNNP, Gambella, and Tigray).

Recommendations: HSFR/HFG should continue advocacy and dialogue with policymakers at all levels (federal, regional, and woreda) on the significance of full implementation of CBHI in four regions (Amhara, Oromia, SNNP, and Tigray) and the fee waiver system in areas where there is no CBHI program (Afar, Benishangul-Gumuz, Gambella, and Harari regions; and Addis Ababa and Dire Dawa city administrations) to ensure equity in the provision of health services. Furthermore, there is also a need to organize awareness creation events for all actors (FMOH, the Ethiopia Health Insurance Agency, RHBs, and woreda administrations) on the provision of fee-waived services to the poorest households' either through CBHI or the new fee waiver system, and strengthen reimbursement to health facilities providing these services.

4.7 Exempted Health Services

Key Findings: Approximately 96 percent of hospitals and 89 percent of HCs provide fee-exempt maternal health services (ANC, delivery, PNC, and family planning) and TB, EPI, VCT/PICT, PMTCT, leprosy, epidemic control, and fistula). Variations were observed in the free provision of drugs and medical supplies related to these services. The major challenges facilities encountered while providing exempted health services included the following: fear that provision of exempted health services could drain retained revenue (44.9 percent); shortage of drugs and medical supplies (12.0 percent); shortage of government-allocated budget (9.0 percent); some services are not fully exempted (7.8 percent); and absence of reimbursement for costs incurred to provide services (4.8 percent). About 21.5 percent of facilities reported encountering no problem in providing exempted services.

Recommendations: To achieve HCF reform goals as well as the Millennium Development Goals of reducing maternal and under-five mortality rates, health facilities should provide exempted health services free of charge for users. This is clearly stated in regional health financing legal frameworks, and health facilities must adhere to these legal provisions. However, exempted services should be funded mandates and government authorities at different levels need to allocate an adequate budget for provision of these services. Health facilities should maintain records on the exempted health services provided, the number of beneficiaries served, and the costs incurred, and report this to the RHB and/or WorHO on a regular basis to inform evidence-based dialogue and policy decisions.

4.8 Private Wings/Rooms

Key Findings: Of all public hospitals visited for supervision, only nine (Adigrat, Adwa, Alamata, Lemlem Kharl, St. Mary, and Suhul in Tigray, Felege-Hiwot in Amhara, and Pawe in Benishangul-Gumuz) have established private wings/rooms. Six hospitals (Adigrat, Adwa, Lemlem Kharl, St. Mary, and Suhul in Tigray, and Pawe in Benishangul-Gumuz) provide only outpatient services, while two (Alamata in Tigray, Felege-Hiwot in Amhara) provide both out- and inpatient services.

Of facilities that have established a private wing/room, five hospitals (Adwa, Alamata, Lemlem Kharl, and St. Mary in Tigray; and Pawe in Benishangul-Gumuz) have a separate bank account for the deposit and management of revenue generated. There is broad agreement that private wings/rooms help to retain health professionals, provide alternative service to patients, and generate additional revenue for health facilities. However, facilities reported that they provide unequal quality of care in the two wards (better in private wing than the general ward), and there is an absence of clear work schedules in the general ward and problems in revenue sharing amongst hospital staff which has caused tension and conflict of interest among staff.

Recommendations: Hospitals are better positioned than the HCs to provide services through private wings/rooms; however, hospital boards, ZHDs, RHBs, and the FMOH need to make sure that doing so will not result in conflict of interest among staff. They also need to ensure that private wings/rooms are not competing with regular wards for patients, nor are they compromising service quality in the regular ward. Hospitals also need to inform patients about the availability of the private wing/room as an option and operate transparently to avoid conflict among staff.

4.9 Outsourcing of Non-Clinical Services

Key Findings: Of the total facilities visited, only six hospitals (Arba Minch, Chencha, Durame, and Yirgalem in SNNP, Pawe in Benishangul-Gumuz, and Suhul in Tigray) outsourced non-clinical services. Of these, three hospitals (Arba Minch, Chencha, and Durame) outsourced catering services and three (Pawe, Suhul, and Yirgalem) outsourced the supply of food items. The absence of licensed providers to outsource to (Pawe and Suhul) and problems with quality assurance (Durame) were reported as the greatest challenges to outsourcing. Arba Minch, Chencha, and Yirgalem did not report any challenges.

Recommendations: Outsourcing could substantially improve health system performance; however, it is complex and is not a sole solution. In addition, not everything can or should be contracted out. Health facilities need clarity on the purpose of outsourcing and to make informed decisions on what services to outsource. Availability of competent bidders for the required services should be studied prior to outsourcing.

4.10 Supportive Supervision

Key Findings: A total of 444 health facilities (approximately 79 percent) – 23 hospitals and 421 HCs – confirmed that they received on-site supervision and technical support by health bureaus/offices. Supervisees stated that their supervisors used checklists when visiting their facility, and that the checklist included questions on HCF activities. This implies that, in many regions, HCF reform indicators are well incorporated into the RHB ISS checklist, while in others (RHBs and the FMOH), they are not.

Recommendations: There is a need to strongly advocate for the immediate incorporation of additional HCF indicators into the ISS checklists of the FMOH and of RHBs that have not yet done this. Data collected during government ISS should also be compiled, analyzed, and shared with health authorities at all levels.

ANNEX A: ETHIOPIAN HEALTH SECTOR FINANCING SUPPORTIVE SUPERVISION CHECKLIST
(FOR HEALTH CENTERS AND HOSPITALS ONLY)

A. Background Information

1. Region: _____

2. Zone/Sub-city: _____

3. Woreda: _____

4. Name of facility _____

5. Type of facility: a) Hospital b) Health Center

6a. Name of first respondent: _____ 6b. Position _____

7a. Name of second respondent: _____ 7b. Position_____

8. Contact Address (Tel): _____ Mobile Phone: _____

9. Supervision Date (E.C): _____ (DD/MM/YY)

10. [16]Quarter supervision conducted: _____

11. Name of Supervisor (s): _____

[16] July-Sept (Q I); Oct-Dec (QII); Jan-March (QIII); and April-June (QIV)

B. Human Resources/Staffing

1. Indicate facility's human resources: financial personnel, including their level of education and training on HCF reform and financial management.

S/N	Position	Is this Position Filled? 1) Yes 2) No	Level of Education	Type of Profession	Trained in:	
					HCF Reform 1) Yes 2)No	Financial Management 1) Yes 2) No
1.1	Head of the facility					
1.2	Head, finance & admin/PFL owner					
1.3	Accountant/PFL officer					
1.4	Cashier					
1.5	Daily cash collector					
1.6	Archiver					

2. Which financial formats/receipts are being used by this facility?

S.N	Format/Receipt type	Being Used by Facility 1) Yes 2) No	Remark
2.1	Budget preparation & submission		
2.2	Cash book		
2.3	Receipt vouchers		
2.4	Deposit receipt voucher / receipt voucher		
2.5	Petty cashbook		
2.6	Payment vouchers		
2.7	Journal voucher		
2.8	Transaction register		
2.9	Revenue report		
2.10	Expenditure report		
2.11	Ledger		

3. Did you face any problems while making use of these financial formats and receipts?

1) Yes 2) No

4. If yes, what are the challenges/problems you encountered?

   a. Don't yet use some of these formats 1) Yes 2) No

   b. Some of the formats are not clear 1) Yes 2) No

   c. Shortage of financial formats 1) Yes 2) No

   d. Difficult to post transactions 1) Yes 2) No

   e. Difficult to summarize income and expenses 1) Yes 2) No

   f. Other (specify) _____

5. Does this facility encounter staff turnover (head of facility, head of Finance & Admin/PFL Owner, Accountant/PFL Officer)?

   1) Yes 2) No

6. If yes, how many trained staff left the facility during current fiscal year? _____

7. In which section/division is the turnover more common?

   1. Head of facility
   2. Finance staffs
   3. Turnover is same

8. What is the major reason for staff turnover?

   1. Professional development/joined university or college
   2. Promotion to a higher position
   3. Transfer to other areas
   4. Other (specify) _____

C. Health Facility Governance

1. Have you established a health center /hospital governing body/board?

   1) Yes 2) No→ Q12

2. If yes, when did governing body/board start its function? _____
   (month and year in E.C)

3. What is the total number of facility governing board/body members? _____

4. How many of them are trained on facility governance/HCF? _____

5. How often does the health facility governing body/board meet?

   1. Every month
   2. Every two months
   3. Quarterly
   4. Bi-annually
   5. Board did not yet meet during this EFY
   6. As needed

6. Are there records of these meetings? (i.e., minutes)

   1) Yes 2) No

7. Have meetings been held in the last quarter? 1) Yes 2) No

8. What specific HCF-related decisions have been made by the governing board/body during the last quarter?

   a. Budget approval 1) Yes 2) No
   b. Fee waiver system implementation 1) Yes 2) No
   c. User fee setting 1) Yes 2) No
   d. Establishment of private wing 1) Yes 2) No
   e. Outsourcing of non-clinical services 1) Yes 2) No
   f. Assess the overall progress of the reform 1) Yes 2) No
   g. Other (Specify)_____

9. Do you currently pay allowance for governing body/board members as per the directive?

   1) Yes 2) No

10. What are the major challenges/constraints of the facility governing board/body observed so far?

    a. Busy work schedule 1) Yes 2) No

    b. Absence of allowance during regular meetings 1) Yes 2) No

    c. Some governing board/body members left the Woreda 1) Yes 2) No

    d. Other (specify): _____

What measures were taken to overcome these challenges/constraints?

a. _____

b. _____

c. _____

11. If your answer for question 1 (under this section) is no, what are the major reasons for not establishing facility governing body/board until now?

    a. _____

    b. _____

    c. _____

D. Revenue Retention

1. When did you start revenue retention? _____

   (month and year in E.C)

2. Do you have a revenue retention plan with breakdowns for this EFY?

   1) Yes 2) No→ Q4

3. If yes, how much revenue have you planned for this fiscal year, and how much did you retain in the last quarter?

S/N	Revenue Items	Plan (2004 EFY)	Actual amount collected during			
			QI	QII	QIII	QIV
3.1	Sales of drug & medical supplies (1436)					
3.2	Consultation & other medical services (1437)					
3.3	Other (1489)					
3.4	Total					

4. If no, what is the total estimated revenue to be generated by facility during this fiscal year?

   _____ETB

5. Do you have a safe deposit box to put the retained revenue? 1) Yes 2) No

6. How much money have you kept in your safe box at a time? _____ (ETB)

7. Have you opened a bank account? 1) Yes 2) No

8. If no, why not? _____

9. In which bank did you open your bank account? 1) Government 2) Private

10. What is the type of account you opened? 1) A Type 2) B Type

    3) Other specify _____

11. Do you use other mechanisms to deposit the retained revenue? 1) Yes 2) No

12. If yes, which institution(s) are you using now? Specify:_____

13. Do you apply the governments' modified cash base accounting system in your health facility?

1) Yes 2) No

14. How much is the government budget allocated to this facility in the last four years and current EFYs?

a) In 2000 EFY_____ Birr)

b) In 2001 EFY_____ Birr)

c) In 2002 EFY_____ Birr)

d) In 2003 EFY_____ Birr)

e) In 2004 EFY_____ Birr)

15. Does this facility currently manage government allocated budget by itself (pay staff salary and operational expenses by itself)?

1) Yes 2) No

16. How much of the government budget was allocated for the following major expenditure items during the last four years and current EFYs?

S/N	Major expenditure items	In Ethiopian Fiscal Year				
		2000 (a)	2001(b)	2002 (c)	2003 (d)	2004 (e)
15.1	Recurrent budget					
15.2	Salaries to permanent staff (6111)					
15.3	Allowances to permanent staff (6121)					
15.3	Drugs & medical supplies (6214)					
15.4	Other operational expenses					

E. Utilization of Retained Revenue

1. Have you started utilizing the retained revenue? 1) Yes 2) No

2. If no, why not? _____

_____

3. If yes, were your expenditure items in line with the positive list? 1) Yes 2) No

4. Did the health facility governing board/body approve the expenditure items prepared by the facility management committee?
(**Interviewer:** Ask for the procedures used and check whether they are in accordance with the regional HCF directive) 1) Yes 2) No

5. Did you submit your retained revenue utilization plan to BoFED and/or WoFED before the beginning of this fiscal year (after being seen by facility governing board)?
1) Yes 2) No

6. Is your retained revenue utilization budget appropriated by Regional/Woreda Council?
1) Yes 2) No

7. What is the total amount of the appropriated budget (from retained revenue) for this fiscal year?
_____ (ETB)

8. How much of the appropriated budget was utilized in the last quarter?
_____ (ETB)

9. How much of the facility's retained revenue is not used and deposited in your bank account and/or at WoFED? _____ (ETB)

10. Who are the signatories authorized to withdraw money from the bank?

    a. Head of the facility 1) Yes 2) No

    b. Head of finance and admin/PFL owner 1) Yes 2) No

    c. Selected case team/ PFL officer 1) Yes 2) No

    d. Accountant 1) Yes 2) No

11. Could you please tell us the actual expenditures of this facility during last quarter (from government allocated budget and retained revenue)?

S.N.	Expenditure Items	Expenditures from Government Allocated Budget (in Birr) (a)	Expenditures from Retained Revenue (in Birr) (b)	Remarks
11.1	Goods and supplies (6200)			
11.1.1	Uniforms, clothing, bedding (6211)			
11.1.2	Office supplies (6212)			
11.1.3	Printing (6213)			
11.1.4	Medical supplies (6214)			
11.1.5.	Educational supplies (6215)			
11.1.6	Food (6216)			
11.1.7	Fuel and lubricant (6217)			
11.1.8	Other materials & supplies (6218)			
11.1.9	Miscellaneous equipment (6219)			
11.2	Travel & entertainment services (6230)			
11.2.1	Per Diem (6231)			
11.2.2	Transport fees (6232)			
11.2.3	Official entertainment (6233)			
11.3	Maintenance and repair services (6240)			
11.4	Contracted services (6250)			
11.4.1	Loading and unloading (6255)			
11.4.2	Fees and charges (6256)			
11.4.3	Electric charges (6257)			
11.4.4	Telephone charges (6258)			
11.4.5	Water and other utilities (6259)			
11.5	Fixed assets and construction (6300)			
11.6	Other payments (6400)			
11.7	Miscellaneous payments (6419)			
11.8	Allowance for governing board/body (			

12. Do you submit your financial performance report on a monthly basis? 1) Yes 2) No

13. Indicate to which organizations/bodies you submit your actual financial performance reports and the frequency of reporting using the table below.

S/N	Organizations/Bodies Receiving Report	Frequency of Reporting		
		Monthly	Quarterly	Annually
13.1	Governing board/body			
13.2	WorHO			
13.3	WoFED			
13.4	ZHO			
13.5	RHB			

14. How do you perceive the contribution of the revenue utilization in your health facility?
Interviewer: Use the following perception categories and associated ranking system (put √ mark) in the table below.

S/N	Perception Categories	No Change	Satisfactory
14.1	Staff satisfaction increased		
14.2	Availability of essential drugs and supplies improved		
14.3	Cold chain system improved (as a result of kerosene availability, etc.)		
14.4	Laboratory services (with all required materials) improved		
14.5	General purpose equipment (such as autoclave, refrigerator, etc.) available and functional		
14.6	Cleanliness of facility improved		
14.7	Infrastructure improved		
14.8	Availability of furniture improved		
14.9	Availability of bed (inpatient, delivery and maternity) improved		
14.10	Availability of electricity		
14.11	Availability of generator (to be used at time of power interruption) improved		
14.12	Availability of water improved		
14.13	Availability of landline telephone improved		
14.14	Availability of weighing scale (for under-five children and adults) improved		

15. Did you encounter any problems/challenges while implementing revenue retention and utilization?

1) Yes 2) No

16. If yes, list the major three problems/challenges you encountered:

a. _____

b. _____

c. _____

17. What measures have you taken to overcome the problems/challenges?

    a. _____

    b. _____

    c. _____

F. Fee Waiver and Exemption

1. Is the new fee waiver system being implemented in your health facility?
   1) Yes 2) No → Q4

2. If yes, did you receive a list of fee waiver beneficiaries from Woreda/City administration?
   1) Yes 2) No

3. If yes, what is the total number of fee waiver beneficiaries selected for this fiscal year?
   _____ (# fee waiver beneficiaries)

4. If no to Q1, does the traditional fee waiver system, which serves patients who possess a support letter from either Woreda or Kebele administration, still functioning? 1) Yes 2) No

5. Have you signed an agreement with Woreda/City administration on provision of and reimbursement for fee-waived services? 1) Yes 2) No

6. How much is the budget allocated by Woreda/City administration for fee waiver beneficiaries (at Woreda/City administration level[17])? _____ (in Birr).

7. Do you have a fee waiver beneficiary registry book? 1) Yes 2) No

8. If yes, what is the total number of fee-waived service users in the last quarter during this fiscal year?
   _____ (# fee-waived service users)

9. Have you submitted request for the reimbursement of fee-waived services to the Woreda/City administration during the last quarter? 1) Yes 2) No

10. What type of payment mechanism(s) are being used for reimbursement of waived services?

    1. Fixed rate
    2. Fee for service
    3. Other (specify) _____

[17] The Woreda/City administration could allocate a lump sum of money for fee waiver beneficiaries to be served in more than two health facilities. Please don't record this amount more than once in that specific Woreda to avoid double counting.

11. Did you receive the reimbursement for fee waiver beneficiaries? 1) Yes 2) No

12. If no to Q7, how do you identify fee-waived users and associated costs to request for reimbursement? _____

_____

13. Have you experienced any problems/challenges in relation to implementation of the new fee waiver system? 1) Yes 2) No

14. If yes, what are the major challenges/constraints?

a. New fee waiver system is not yet being implemented 1) Yes 2) No

b. No proper selection of waived beneficiaries 1) Yes 2) No

c. Waived beneficiaries don't know they have been selected 1) Yes 2) No

d. Unaware budget had been allocated for waiver beneficiaries 1) Yes 2) No

e. Did not get reimbursement on time 1) Yes 2) No

f. Did not get reimbursement until now 1) Yes 2) No

g. Other (specify): _____

_____

15. Does this facility provide exempted health services? (If Yes, encode 1 and if No, encode 2, in front of each service, and underneath consultation and drugs and supplies)

S.N	Type of Service	Is this service free of charge? If yes, write 1 and if no write 2 for each service	
		Consultation (a)	Drugs and supplies (b)
15.1	TB		
15.2	Family Planning		
15.3	Antenatal Care		
15.4	Postnatal Care		
15.5	Extended Program on Immunization		
15.6	Delivery		
15.7	VCT/PICT		
15.8	PMTCT on HIV/AIDS		
15.9	Epidemic Control		
15.10	Fistula		
15.11	Abortion		

16. Is the list of exempted health services posted at the health facility?

1) Yes 2) No

Interviewer: Please check whether list of exempted services includes TB, FP, ANC and PNC, EPI, delivery, leprosy, VCT, PMTCT of HIV/AIDS, epidemic control, and fistula.

17. What are the major problems you encountered while providing exempted health services?

a. _____

b. _____

c. _____

G. User Fee Revision

1. Have you ever revised user fees? 1) Yes 2) No → Q 9)

2. If yes, who decided to make a user fee revision? _____

3. When did you revise user fees? _____ (month and year in E.C)

4. What factors were considered during user fee revision?

a. _____

b. _____

c. _____

5. Indicate the previous and revised user fees, including percentage of increase made on user fees, in the following table.

S/N	Areas User Fee Revisions Made	Previous User Fee in ETB (a)	Revised User Fee in ETB (b)	Change in %	Remark
6.1	Consultation fee				
6.2	Laboratory services:				
6.2.1	• Urine analysis				
	◦ Deep stick				
	◦ Microscopic				
6.2.2.	• Stool examination				
6.2.3.	• WBC count				
6.2.4.	• Pregnancy test				
6.2.5.	• Widal test				
6.2.6.	• VDRL				

S/N	Areas User Fee Revisions Made	Previous User Fee in ETB (a)	Revised User Fee in ETB (b)	Change in %	Remark
6.2.7.	• ESR				
6.3	X-ray				
6.4	Bed/admission				
6.5	Medical certificate :				
6.5.1	• Employment				
6.5.2	• Other cases				
6.6	Minor operations				
6.7	Dressing				

Note: VDRL – Venereal Disease Research Laboratory, ESR – erythrocyte sedimentation rate, and WBC count – White Blood Cell count.

6. List the three major problems encountered while implementing user fee revision:

   a. _____

   b. _____

   c. _____

7. Do you think that user fees should be revised in the future? 1) Yes 2) No

8. If yes, why?

   a. _____

   b. _____

   c. _____

H. Outsourcing of Non-clinical Services

1. Has your health facility started outsourcing of non-clinical services?

   1) Yes 2) No→ Go to next Section

2. If yes, which services are being outsourced?

   a. _____

   b. _____

   c. _____

3. Who approved outsourcing of the above services?

   a. _____

   b. _____

   c. _____

4. What benefits has the health facility experienced from outsourcing these services?
   a. _____
   b. _____
   c. _____
5. List three major problems encountered while implementing outsourcing of non-clinical services:
   a. _____
   b. _____
   c. _____

I. Establishment of Private Wing/Room in Public Hospitals

1. Has your health facility established a private wing/room? 1) Yes 2) No

2. If yes, when did you establish a private wing/room in this hospital?
   _____ (month and year in E.C.)

3. Which clinical focus is chosen to be provided by private wing/room?
   a. Outpatient service only
   b. Inpatient service only
   c. Both outpatient and inpatient services

4. How many people have been served in your private wing/room during the last quarter?
   _____ (repeat and new users)

5. Do you have a separate account for the private wing/room? 1) Yes 2) No

6. If yes, what is the total amount of revenue generated from your private wing/room during the last quarter? _____ETB

7. Do you think that the private wing/room has negatively impacted regular services provision?
   1) Yes 2) No

8. If yes, in what ways?

   a. _____

   b. _____

   c. _____

9. What measures has the hospital taken to overcome these problems?

   a. _____

   b. _____

   c. _____

10. What are the benefits of the private wing/room in this hospital?

   a. _____

   b. _____

   c. _____

11. Did you face any problems/challenges while implementing the private wing in this hospital?

   1) Yes 2) No

12. If yes, list the three major problems/challenges you encountered:

   a. _____

   b. _____

   c. _____

J. Supportive Supervision

1. Did your facility receive supportive supervision during the last quarter (by RHB, ZHO, WorHO, and/or WoFED)? 1. Yes 2. No

2. Who conducted these supportive supervision visits in the last quarter?
   a. RHB 1) Yes 2) No
   b. ZHO 1) Yes 2) No
   c. WorHO 1) Yes 2) No
   d. WoFED 1) Yes 2) No

3. Did the supervising bodies use a checklist while visiting this facility? 1) Yes 2) No

4. Did the checklist include questions regarding HCF reform activities? 1) Yes 2) No

5. Did you receive feedback regarding your performance from the supervising bodies? 1) Yes 2) No

6. In what form did you receive feedback? (Interviewer: Please check the availability of any written feedback in the facility)
   1. Written feedback
   2. Verbal feedback
   3. On-the-spot discussion of strengths and observed gaps
   4. Other (specify) _____

7. Have changes been made as a result of supportive supervision visits?

8. If yes, give some recent examples:
   a. _____
   b. _____
   c. _____

ANNEX B: NUMBER OF HEALTH FACILITIES VISITED FOR REGULAR QUARTERLY SUPPORTIVE SUPERVISION BY TYPE OF FACILITY, REGION, AND QUARTER (HSFR/HFG PROJECT YEAR 1)

Quarter Supervision Conducted	Region	Type of Health Facility		Total
		Hospital	Health Center	
Quarter I, August-Sept	Amhara	0	15	15
	Oromia	0	43	43
	SNNP	0	20	20
	Addis Ababa	0	12	12
	Total	**0**	**90**	**90**
Quarter II, Oct-Dec	Benishangul-Gumuz	1	27	28
	Oromia	0	54	54
	SNNP	0	52	52
	Total	**1**	**133**	**134**
Quarter III, Jan-March	Tigray	0	44	44
	Amhara	8	23	31
	Oromia	0	31	31
	Dire Dawa	0	10	10
	Harari	0	8	8
	SNNP	0	20	20
	Total	**8**	**136**	**144**
Quarter IV, April-June	Tigray	6	7	13
	Amhara	0	67	67
	Oromia	0	68	68
	SNNP	10	23	33
	Total	**16**	**165**	**181**
Overall Total		**25**	**524**	**549**

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