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Ethiopia's Community-based Health Insurance: A Step on the Road to Universal Health Coverage



Executive Summary

Ethiopia has been implementing Community-based Health Insurance (CBHI) schemes as pilots since 2011 with the objective of drawing lessons for eventual scale-up countrywide. The 13 districts' schemes¹ have produced preliminary findings with encouraging results. Ethiopia is second most populous nation in Africa and its achievements will have significant implications in the region. The overall enrollment rate in the pilot districts reached approximately 52 percent of the target population; of which 85.0 percent are paying members and the remaining have subsidized membership. The amount of premiums collected including the payment for indigents through targeted subsidies, has reached over Birr² 41.5 million (US\$2.3 million), and recent monitoring data show that health service utilization is increasing due to improved access to health services. The schemes have reimbursed health facilities a total of Birr close to 30 million birr (US\$1.7 million) for the health services utilized by members and their family members. The increased and improved cash flow has had a positive effect on the availability of drugs and other supplies, which in turn has improved the quality of health services the facilities provide. Triggered by the pilot's early successes, the government of Ethiopia decided to expand the pilot to 161 woredas³ in July 2013.

¹ South Achefer, Fogera, Tehuledere, Deder, Gimbichu, Kuyu, Limu Kossa, Yirgalem, Damot Woyde, Damboya, Ahferom, Kilde Awlaelo, and Tahtay Adiabo have a total population of over 1.7 million people.

² Ethiopian currency, Average exchange between January 2011–July 2014 Birr 18.05 = US\$1

³ Woredas are third-level administrative divisions of Ethiopia. Woredas are composed of a number of kebeles, wards or neighborhood associations (kebele is Amharic for “neighborhood”), the smallest unit of local government in Ethiopia.

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Introduction

In the last 10 years, Africa has witnessed a renewed interest in CBHI schemes as countries leverage communities to expand risk-pooling coverage to informal sectors and the rural population. CBHI schemes, also known as mutual health organizations, are not-for-profit mechanisms of health financing grounded in principles of solidarity and risk sharing. Among African countries, Ethiopia's experience can provide good lessons around how governments can pursue universal health coverage (UHC) through a series of complementary measures including strengthening health governance at the facility level and implementing national health financing reform. The Ethiopian approach promises to expand access to health services and improve health outcomes particularly for women and children.

Ethiopia is second most populous nation in Africa and the lessons learned from the CBHI pilots can be applied to other countries in the region. Other African countries that have successfully used CBHI schemes include Rwanda and Ghana.

Since 1993, Ethiopia's Federal Ministry of Health (FMOH) has pursued an aggressive health policy (Transitional Government of Ethiopia 1993) to mobilize and efficiently use domestic and donor resources, provide quality health services, and ensure access to health care for all segments of

Figure 1: Map of Ethiopia with Regional Division



the population according to ability to pay (FMOH 1998, 2010, Zelelew 2012).

To achieve these goals, the government of Ethiopia has intensively implemented several major health sector reforms, including the construction of health facilities particularly at the primary level, equipping facilities, and developing human resources, including training adequate numbers of health personnel to staff the new facilities.

To address resource constraints, the Council of Ministers approved a comprehensive health care financing strategy (FMOH 1998) in June 1998 to identify financial options to increase resources for the health sector, enhance efficiency in the use of available resources, promote sustainability, improve the quality and coverage of health services, and ensure equitable distribution. Many related health financing reforms are being implemented, including:

- ▶ Allowing public health facilities to keep and use their revenue for health service quality improvement;
- ▶ Increasing health facilities' autonomy by establishing and operating health facility governing boards;
- ▶ Improving the fee waiver system to protect the poor and standardizing the exemption system; and
- ▶ Systematizing user fees based on evidence as well as patients' willingness and ability to pay. In addition in 2008, a complementary health insurance strategy has been put in place providing overall guidance for expanding risk-pooling in Ethiopia.

These health financing reforms are generating remarkable change in the Ethiopian health system. A mid-term evaluation of the Health Sector Financing Reform (HSFR) project⁴ conducted in 2011 indicated outstanding results in all major reform components (USAID 2011).

⁴ USAID has supported the initiation and implementation of health financing reforms through consecutive bilateral agreement with the government of Ethiopia.

Box 1: Ethiopia Country Profile

Area: 1.1 million sq km (437,794 sq miles)

Population: 91,730, 000 (2012)

GDP: \$41.61 billion (2012)

GDI per capita: \$380 (2012)

Life expectancy at birth: 62 (2011)

Population living in poverty: 29.6 percent
(under the national poverty line)

Source: http://data.worldbank.org/country/ethiopia#cp_wdi.

For example, interviews with users revealed that improved availability of drugs and medical supplies has increased client satisfaction (Rosapep et al. 2012). These accomplishments are largely attributed to health facilities' new ability to retain revenues at the facility level and use them to purchase drugs and medical supplies, as well as to improve their buildings. The implementation of governance boards at hospitals and health centers was another success because it has given local facilities more autonomy and control of resources, especially those generated on site.

Despite these significant reform efforts, health service utilization rates remain low, at 0.36 contacts per person per year (FMOH 2010a). The cost of services, and specifically how much individuals or families pay out of pocket (OOP) at the time of service, is a major barrier to use. The FMOH's introduction of CBHI pilots aims to address this issue. The recent lessons from the CBHI pilots are the focus of this case study.



CBHI increased income for health facilities ensuring availability of drugs

Developing the Health Insurance Strategy

A series of technical and policy consultation and dialogue processes contributed to the development of Ethiopia's Health Insurance Strategy (FMOH 2008). The recommendations of a technical committee endorsed the introduction of two separate health insurance programs to support the move towards UHC. CBHI aims to reach and cover the very large rural agricultural sector and small and informal sector in urban settings. The FMOH decided to start by piloting CBHI (FMOH 2011, Zelelew 2012), and later establish SHI, which targets formal sector employees and their families.⁵

The Health Insurance Strategy indicates that the overall objective of insurance is to promote equitable access to sustainable quality health care, increase financial protection, and enhance social inclusion for the majority of Ethiopian families via the health sector. Specific CBHI objectives are to: (1) improve financial access to health care services, (2) improve quality of health care services, (3) increase resource mobilization in the health sector, (4) strengthen community participation in the management of health services, and (5) strengthen national capacity for policy development and scale-up of health insurance coverage in the rural and urban informal sectors.

Starting with CBHI Pilots

Following the development of the Health Insurance Strategy, the FMOH took a first step toward initiating the CBHI pilots by preparing a road map and identifying key stakeholders from federal to grassroots (*kebele*) levels, and defining their respective roles.

⁵ As of the beginning of 2014, the final versions of the operational documents for the SHI portion of the Health Insurance Strategy are being finalized. The Ethiopian Health Insurance Agency is setting up and staffing branch offices in the regions. Next steps include the training of these newly engaged human resources.



Tehuledere CBHI scheme launching

Based on this road map, 13 pilot and four control *woredas* were selected from four regions (Amhara, Oromia, Southern Nations, Nationalities, and Peoples [SNNP], and Tigray). Committees at federal, regional, *woreda*, and *kebele* level were established to facilitate policy development, implementation, and monitoring and evaluation of the schemes.

A CBHI National Coordination Unit was set up under the supervision of the FMOH/Ethiopian Health Insurance Agency (EHIA) to serve as the executive unit. Regional CBHI implementation units were established to serve as executive secretariats to Regional Steering Committees⁶ led by the Regional Health Bureaus. The committees provide technical and operational support in the design and implementation of CBHI in each region. *Woreda* Health Insurance Steering Committees are composed of relevant sector offices, and facilitate the design and set-up of CBHI in their *woredas*. *Kebele* Health Insurance Initiative Committees facilitate the design and set-up of CBHI at

⁶ The Regional Steering Committees are the counterparts of the FMOH/EHIA in the pilot regions. They play a key role in assessing the policy implications of CBHI pilots and lessons learned, which will contribute to the nationwide scale-up of CBHI in Ethiopia.

community level. Each *woreda* has a single health insurance pool and *kebele* sections form the network of local schemes.

Determining the CBHI Framework

Based on the results of the initial feasibility studies, the FMOH made several high-level policy decisions. One was that CBHI schemes should not be left to the management of members only, but rather would be integrated with government structures at *woreda* and *kebele* levels. Furthermore, the FMOH decided that participation in the pilots should be designed the schemes in such a way collectively at a community/*kebele* level. To reduce barriers to access, the Ministry prohibited schemes from charging copayments.

Following the policy guidance from the ministry, the EHIA and the CBHI National Coordination Unit worked on fundamental details of the CBHI pilots which included:

Membership:

- ▶ Enrollment is done on a household,⁷ not on an individual basis, to reduce the possibility of adverse selection.
- ▶ Indigents are eligible to be members of CBHI schemes. The *kebele* screens applications from poor households and the *woreda* makes the final determination of who is eligible.

Benefit package:

- ▶ The CBHI benefit package covers all outpatient and inpatient services at the health center and nearby hospital level except false teeth, eye glasses, and cosmetic procedures

Financing of CBHI schemes (contributions and subsidies):

- ▶ Membership is at the household level and not individuals. Contributions vary by region and range from Birr 10.50 (US\$0.56) to Birr 15.00 (US\$0.80) per month per household.
- ▶ The federal government provides a 25 percent general subsidy for all members.

⁷ A “household” is defined by each community for its CBHI.

- ▶ Woredas and regions finance a solidarity fund for indigents (an estimated 10 percent of the population) from their own budgets.
- ▶ The provider payment method is fee-for-service.
- ▶ With the exception of some ancillary service to be purchased from private facilities, public facilities are generally designated providers of services for members. at the pilot phase while the mechanism on how to accredit and engage providers is being worked out.

Risk management:

- ▶ After joining a CBHI scheme, members have a one-month waiting period before they can use covered services.
- ▶ Beneficiaries are allowed to access hospitals without penalty with a health center referral. Members who bypass the referral system are required to pay an OOP bypass fee of 50 percent.

Implementing the CBHI Pilots

Implementation began with training for different stakeholders, introducing CBHI design concepts and strengthening implementation and monitoring capacity. The CBHI National Coordination Unit prepared specific materials on financial and administrative management, and monitoring and evaluation, as well as a communications strategy. A training-of-trainers approach was used, with roll-out trainings for the *Woreda* Health Insurance Steering Committee and *Kebele* Health Insurance Initiative Committee members in all of the pilot areas.

Kebele-level discussions ultimately determined where pilot schemes were initiated. In early 2011, communities in the 13 pilot *Woredas* held General Assembly meetings where board members were elected. The CBHI National Coordination Unit assessed the readiness of each participating health center and gaps were identified in the areas of utilities, supplies, equipment, and human resources. These gaps were subsequently filled in collaboration with federal, regional, and *woreda* public agencies.

A General Assembly and Board of Directors oversee the governance of CBHI schemes at the *woreda* level. The General Assembly is composed of 8–10 *woreda* public sector representatives and 3–5 delegates from



Community members discussing decision to enroll in scheme at Durebete with the RHB deputy head and Kebele chairman.

each *Kebele* with a CBHI pilot scheme. Boards have 9–12 members who are elected during the General Assembly meeting. Of these, three are from *woreda* sector offices and 6–9 are elected by the assembly to represent *kebele* sections.

An executive body under the Board of Directors manages daily operations of the scheme at *woreda* and *kebele* levels. At *woreda* level, the government pays for three professionals (coordinator, accountant and information specialist) in each pilot *woreda* and use government administrative staff at the *kebele* level. At the *woreda* level, this body is responsible for:

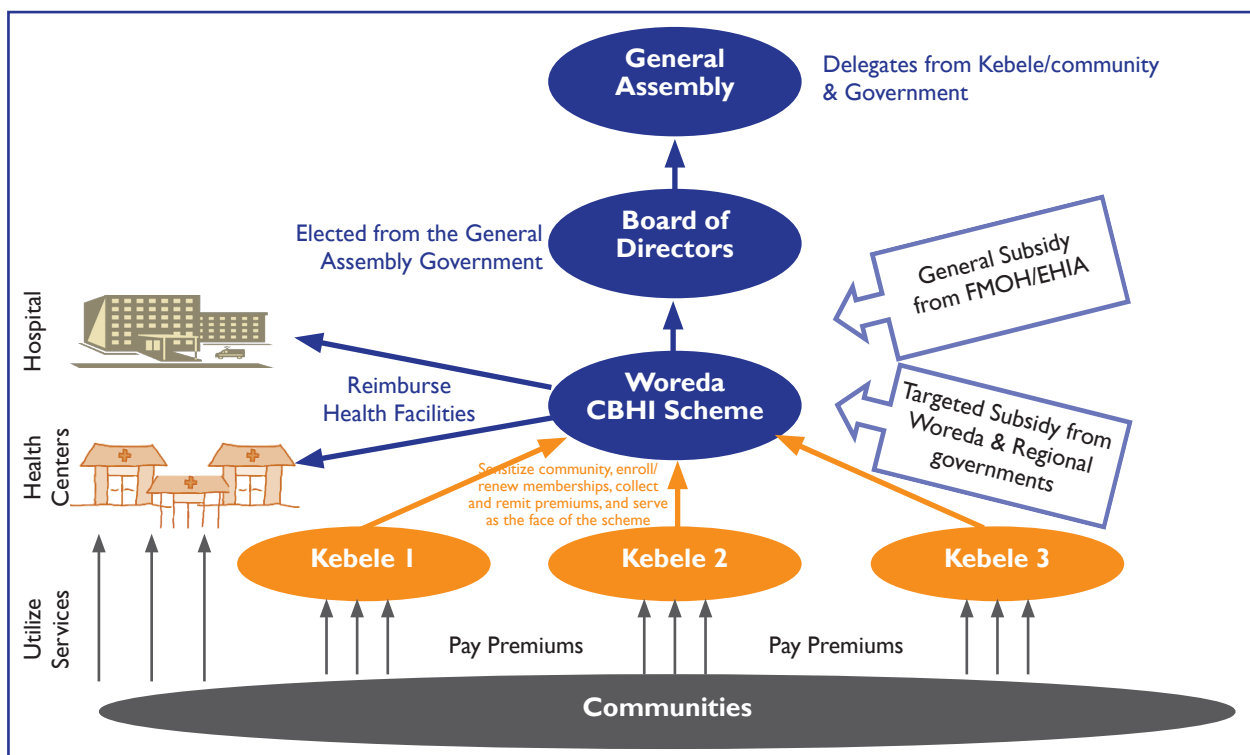
- ▶ Signing agreements with health care providers/ health facilities;
- ▶ Reimbursing health care providers;
- ▶ Administering the fund (keeping financial records; preparing financial statements);

- ▶ Managing the database (which contains data on members, contributions, and utilization).

At the *kebele* level, the executive body is responsible for registering members, collecting premiums, and channeling funds to each *woreda* scheme. A communication specialist based at the *woreda* level provides support for community mobilization activities. Figure 2 illustrates the structure and relationships of the above-described entities.

The General Assembly and subsequent decisions on the bylaws and selection of board of directors heralds the official start of each scheme. The CBHI pilot schemes can then start registering members and collecting contributions. As of January 2011, all the pilot *woredas* started registering members. Service delivery began in the SNNP region in April 2011, in Amhara and Oromia in July, and in Tigray in December. The encouraging achievements of the schemes are discussed in the next section.

Figure 2. Flow of Finance, Governance, and Organizational Structure of CBHI Schemes



Note: EHIA: Ethiopia Health Insurance Agency

Impact and Achievements To Date

The roll-out of CBHI and the improved access to health care is expected to help in reaching the coverage goals and statistical targets defined by the FMOH. While impressive advances in key health indicators have been made in recent years, the national targets indicate that there is a considerable road ahead. For example, the MDG target for maternal mortality is 290 per 100,000 live births, while the national target is 267/100,000 (2012a, 2012c). The data from the latest Demographic and Health Survey, shows that while maternal mortality in Ethiopia has improved from the 1990 level of 871 per 100,000 live births, it had only decreased to 676/100,000 by 2011 (Central Statistical Agency and ICF International 2012).

CBHI enrolment status: Routine monitoring data show remarkable CBHI enrollment numbers in the three years since the pilot schemes became operational. Between January 2011 and July 2014, 157,553 households registered and approximately

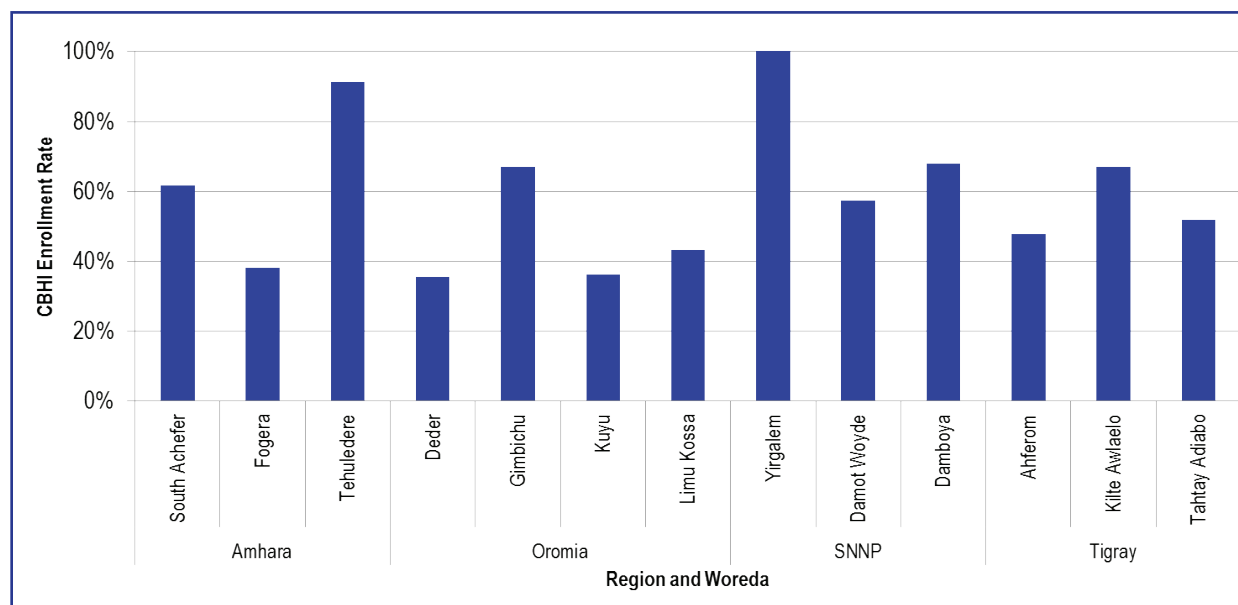
Box 2: Health Data

Child mortality 88/1,000
 Vaccination coverage 24%
 Maternal mortality 676/100,000
 % of births with skilled attendant 10%
 HIV prevalence 1.5%

Source: DHS 2012

Birr 30 million (US\$1.67 million) was collected from members. The average enrollment rate in the pilot *woredas* was 52.4 percent of the eligible households. Figure 3 shows a variation in enrollment rates among pilot *woredas*. Six *woredas* had enrollment rates higher than 60 percent, with Yirgalem reaching 100 percent enrollment and Tehuledere reaching 91 percent. Deder had the lowest enrollment rate, only 35 percent. Some of the variations among pilot *woredas*/regions may be due to differences in levels of engagement between *woreda/kebele* officials and differences in effort applied to community mobilization.

Figure 3. CBHI Enrollment Rate by *Woreda* (January 2011–July 2014)



Source: HSRF/HFG CBHI Monitoring Database

Of the total CBHI registered households, an average of 85 percent are paying members while the remaining 15 percent are indigents and eligible for free CBHI membership (and subsequent treatment free of charge). Indigents are defined in multiple ways and eligible families generally are selected by the community. Figure 4 shows the breakdown of the percentage of paying versus indigent households by *Woreda*. It is interesting to note that the SNNP region not only had the highest enrollment rates as a percentage of total families in the region, but also had the lowest percentage of indigents as members of the scheme. In contrast, Tigray had some of the lowest overall enrollment rates but the highest percentage of indigent households. In terms of covering the premium payments for the indigents, the Regional and *Woreda* governments paid a total of Birr 12.1 million (US\$670,672) to the schemes.

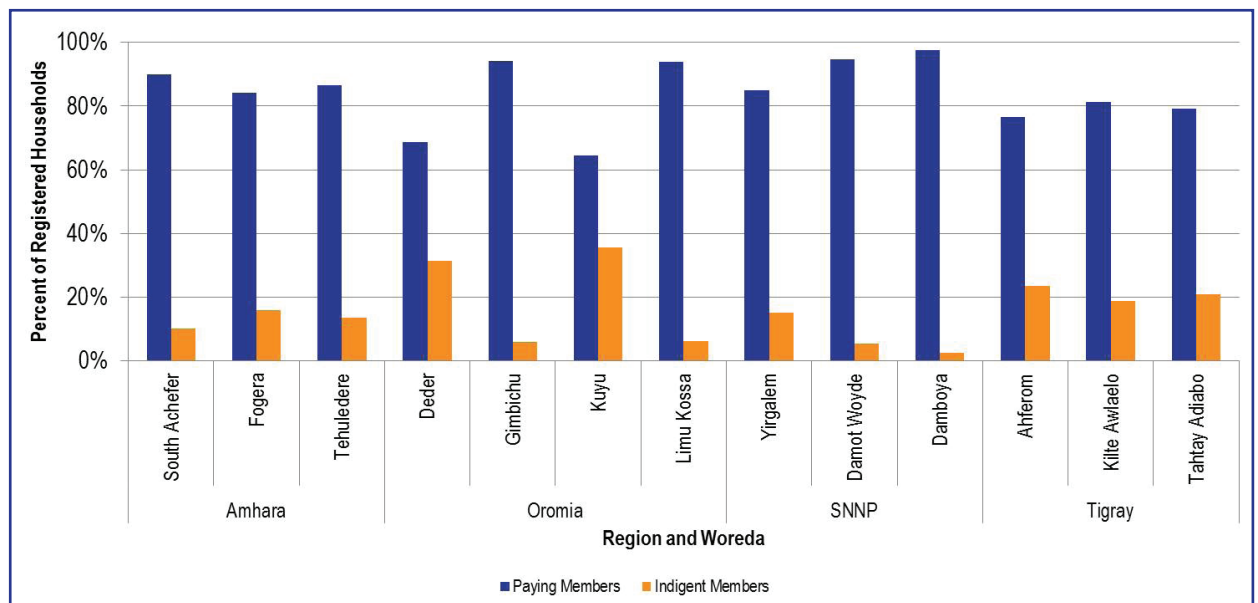
Health service utilization: Health service utilization has increased among CBHI members due to improved access to health services. In the past three years, a total of 909,599 CBHI

beneficiaries have utilized health services (new and repeat visits). A recently completed evaluation of the CBHI schemes revealed that the intensity and frequency of health service utilization has significantly increased among members of the schemes (USAID/HSFR/HFG, 2015).

The reimbursements of health facilities for services rendered for members, coupled with the ability of health facilities to retain and use revenues collected, has increased the resources of health facilities. The increased cash flow has a positive effect in the availability of drugs and other supplies, which in turn boosts health service quality although rooms for improvement exist.

CBHI schemes financing: Schemes have reimbursed approximately Birr 30 million (US\$668,500) for the services used by their beneficiaries. The total amount reimbursed to providers is approximately 72 percent of total premiums collected including the targeted subsidies paid on behalf of indigents. While overall the balance indicates the ability of the schemes

Figure 4. Percentage of Paying Versus Indigent Households by *Woreda* (July 2014)



to cover costs, a closer look at the balances by individual schemes indicates that there are four schemes not being able to cover their respective reimbursements due to health facilities without the general subsidy (See Figure 5). This indicates the need to maintain the current general subsidy and in the future revisit the premiums vis-à-vis the level and cost of the benefits package to ensure sustainability of the schemes.

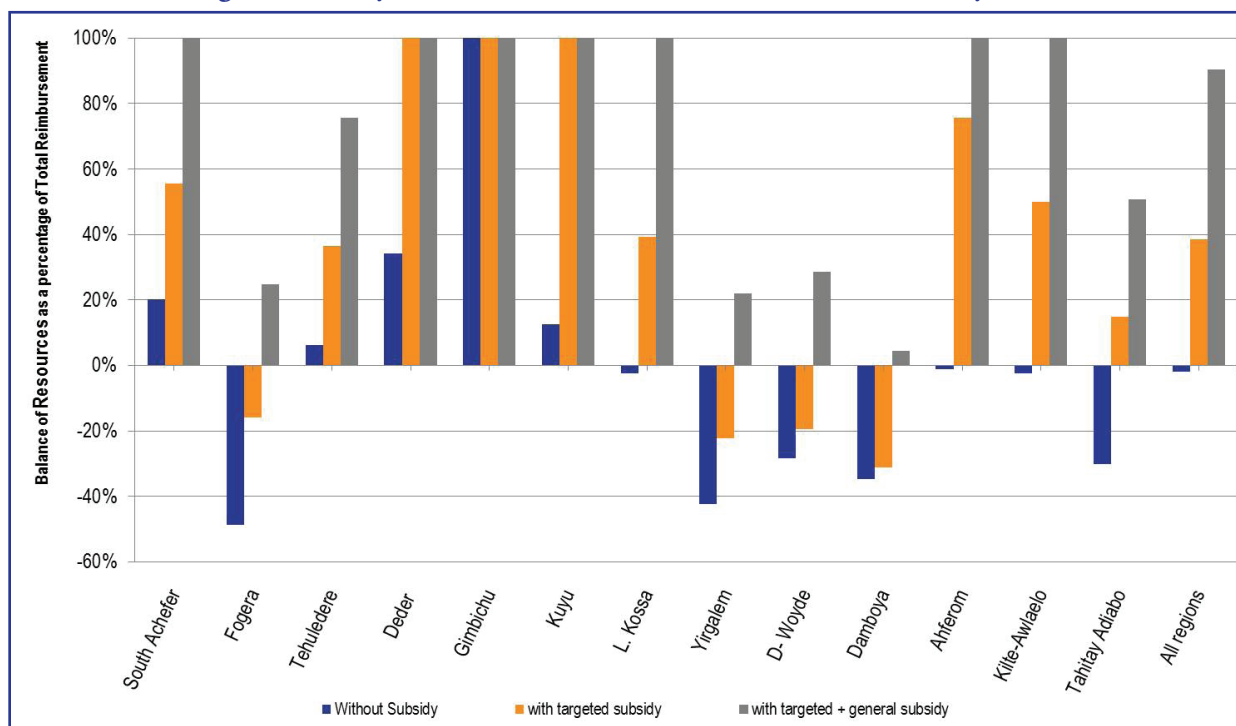
This also brings about the need to explore mechanisms to pool risks at the regional and eventually at the national level when scaling up the schemes.

In terms of premiums, there is a variation in premium rates across regions. Premiums are highest per person in Oromia. The annual average premium per household ranges from Birr 126 (US\$ 6.98) in SNNP to Birr 180 (US\$9.97) in Oromia. The CBHI evaluation indicated more than

80 percent of the CBHI members indicated the premiums are affordable. While 40 percent of the non-members indicated affordability as an issue, the focus group discussions with non-members brought to light that doubt over the benefits and competing priorities as the underlying factors (USAID/HSFR/HFG, 2015).

Women and children are empowered and better served: Because CBHI scheme members can access health services with no fee at time of service, women and children in particular are benefiting from this system. A mother and her children can access health services without asking the male head of household for money by simply taking her CBHI membership card to the facility (Alemu 2014). Ethiopia is one of the countries strongly behind a Promise Renewed, and the CBHI roll-out is expected to contribute substantially to child survival and maternal health outcomes

Figure 5. Ability of Schemes to Finance Health Service Costs (July 2014)



Source: BIC, Evaluation of Community-Based Health Insurance Schemes in Ethiopia, draft report, figures updated using recent data



Mahder Tamirat, CBHI member in Yirgalem SNNPR

Expansion of CBHI: The government of Ethiopia, encouraged by the early successes of the CBHI pilots, began in July 2013 expanding the pilot initiatives to an additional 161 *woredas*. Since the CBHI pilot design integrates the schemes with government structures at the *woreda* and *kebele* levels, this facilitates scale-up since the *kebele* and *woreda* administrative structures provide a sound foundation.

“We are at a crucial juncture in our final sprint towards the 2015 Millennium Development Goals and the 2035 vision of ending preventable child deaths. Much will depend on country-level leadership and action on child survival. I strongly believe we can only accelerate our progress if we renew our commitments and live up to providing increased, sustained and more harmonized leadership and support.”

Ethiopia’s Minister of Health Kesetebirhan Admasu,

Source: USAID Press Office, Jan 2013

Lessons Learned

Strong government commitment is essential to successful pursuit of UHC. The favorable policy environment that provided a legal framework by which to launch and implement CBHI schemes and financial support to the schemes were critical to their success. The government of Ethiopia has a strong commitment to achieving UHC through improved financial risk protection.

The federal government has backed its policy with financial support. General government subsidies cover a quarter of CBHI premiums, and targeted subsidies cover premiums for indigents. Operating costs at *kebele* and *woreda* levels for managing the schemes are also covered by the government budget. Furthermore, public monies financed block grants that have been used by health facilities to make the necessary quality improvements identified by the gap analysis while starting the roll out of the CBHI schemes (Ekblad et al. 2013). These include infrastructure, supplies, drugs, and human resources, which improve quality and build the confidence of the community and enhance enrollment in CBHI schemes.

Integrating CBHI schemes with government structures can be beneficial. In the Ethiopian model, the management and operation of CBHI schemes is not left to the community alone, but is integrated into the existing government structure at the *woreda* and *kebele* levels. This has facilitated informational campaigns, registration of members, collection of contributions, and monitoring of health service providers. The schemes remain community based as the higher governance structures (General Assembly and Board of Directors) are a community and government partnership.

Broad community involvement is necessary. The involvement of the community, i.e., community leaders, religious leaders, elders, and others in addition to government structures at *woreda* and *kebele* levels in sensitization and awareness-creation activities have facilitated the acceptance of the schemes and increased enrollment rates. Previous positive experience by community members

with other solidarity-based community-based organizations and associations outside of health also contributed to enhanced community participation and enrollment in the CBHI schemes.

CBHI results in enhanced accountability of health facilities. As a result of the CBHI pilot schemes, involved communities have started to claim their right to the entire package of services covered by the scheme. This leverage has forced public health facilities to respond to community demands and provide the range of services as agreed with the CBHI schemes. In effect, CBHI schemes have provided impetus to improving the range of services offered, their quality, and the effective use of resources.

Quality is important (Mebratie et al. 2013). One of the initial challenges was that some health facilities lacked the necessary infrastructure (potable water, electricity), which significantly affects the delivery of quality health services. In the case of Ethiopia, public funds were made available by FMOH and Regional Health Bureaus to support catchment health facilities in fulfilling the necessary infrastructure requirements.

The need to address capacity at local level should not be sidelined. In Ethiopia, some local structures did not initially have the ability to register members, collect contributions, issue membership cards, and perform other necessary actions. Through the CBHI National Coordination Unit, trainings were provided to implementers at woreda and kebele levels on various topics. These trainings were consolidated by follow-up visits and supportive supervision enabling bringing the capacity of these local structure to perform the required tasks.

Resistance to change can be overcome. Implementers of the CBHI pilots noted a “wait and see” attitude by some community members, sometimes compounded by a visible lack of commitment on the part of government officials. Cabinet members representing the pilot *woredas* and *kebeles* supported the sensitization and awareness-creation activities, resulting in improved community participation and eventual enrollment. Furthermore



Income from CBHI ensured availability of lab reagents

the Minister of Health contacted and discussed the issue with Regional Presidents to facilitate the implementation of CBHI in some pilot regions where implementation was slow.

Sustained technical assistance is essential. Ethiopia's roll-out of the Health Financing Strategy, including establishment of the CBHI pilots, has benefited from support, not only from USAID through a series of bilateral projects including HSFR, but also with support from the multi-donor-financed MDG basket fund. The FMOH is able to tap into international expertise and learn from the lessons of others on its road to achieving UHC in Ethiopia.

Methodology and Acknowledgments

This This case study was prepared from a desk review of secondary sources (mainly technical documents) produced by stakeholders of the Ethiopian CBHI pilots (including planning, policy, and strategy documents from the FMOH) and the USAID/HSFR project (such as periodic reports and various technical documents). The authors are very grateful to those involved in reviewing the draft paper including, François Diop, Leulseged Ageze, Andrew Won and Christine Ortiz. The Case study also benefited from editorial support by Linda Moll and formatting by Maria Claudia De Valdenebro.

Finally, the authors express their gratitude to the Africa Bureau Case Studies Team for selecting Ethiopia's case to be included in the group along



About HFG

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a five-year (2012-2017) global health project. To learn more, please visit www.hfgproject.org.

The HFG project is a five-year (2012-2017), \$209 million global project funded by the U.S. Agency for International Development.

The HFG project is led by Abt Associates Inc. in collaboration with Broad Branch Associates, Development Alternatives Inc., Futures Institute, Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.



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January 2015

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