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BEST LAID PLANS: ETHIOPIA ALIGNS HEALTH CARE WITH NATIONAL GOALS, 2014–2018 (SHORT VERSION)

This summary draws on an ISS case study with the same title can be found on the ISS website. Gordon LaForge drafted the full case study based on interviews conducted in Addis Ababa, Ethiopia in October 2018. Case published January 2019. Summary published in May 2019.

BACKGROUND

When Kesetebirhan Admasu, a medical doctor and veteran public health leader, stepped in to lead Ethiopia's Federal Ministry of Health in 2012, he faced a daunting agenda. The demographic disparities in citizen health and well-being were vast. For instance, in Addis Ababa, the booming capital, the rate of mortality among children younger than five years of age was 5.3%—low for sub-Saharan Africa; yet in the impoverished region bordering Sudan, it was nearly 17%.

Kesete gathered senior staff in early 2014 to brainstorm a new five-year development plan to address the challenges the sector faced. As part of a larger agenda to transform Ethiopia into a middle-income country by 2035, the new plan aimed to define priorities, which included delivering on the government's commitments under the United Nations' Millennium Development Goals.

The ministry had to figure out how to link its priorities to the budget process and use the health budget as a management tool.

KEY ISSUES

- In 2013, the year before Kesete began work on his new plan, 48% of total health sector budget spending was by the regions, and 29% was by the districts. To reach the targets it defined, the ministry needed health officers in the regions and districts to share its vision—a tall order in a society with entrenched ethnic rivalries and deep economic disparities. The Federal Ministry of Health lacked strong central control in Ethiopia's decentralized federal system.

- Lack of information was a major impediment. Even assessment of the scale of the health-care system's deficiencies was difficult because of sketchy data. "We have a poor attitude toward data and information use as a nation," said Samuel Zemenfeskudus, the medical doctor who headed the Federal Ministry of Health Quality Services Directorate. "People are happier guessing than measuring."
- A sizable number of the officials managing health budgets lacked the training or incentives to effectively carry out that work. At the district level there were not enough trained personnel and people who had the right skills tended to leave for the international NGO sector, after only a short stint in the public service.
- The fourth big challenge was harmonization of funding sources. Health-care financing was fragmented, with more than 130 different NGOs or foreign government aid agencies operating in the country's health sector.

REFORM STRATEGY

To reach its goals in a system in which it lacked centralized budget control, Ethiopia's health ministry had to focus on guiding the country's nine governing regions and two chartered cities—Addis Ababa and Dire Dawa—and hundreds of districts, or *woredas*—to become independent units capable of delivering health care for their people by addressing *local needs* but within a framework of *national goals*.

Kesete assembled what his chief of staff called an *all-star team* of experienced ministry executives to draw up the Health Sector Transformation Plan, a step-by-step, five-year blueprint for 2015–20. Some of its main objectives were to narrow the gaps between urban and rural health outcomes for key indicators such as mortality for children younger than five years of age, to meet commitments made to achieving UN Millennium Development Goals, and to align the health sector with the government's overall aim to become a lower-middle-income country by 2035.

The ministries of health and finance matched the goals and targets to available resources and worked to create actionable plans, and health officials took steps to build cooperation and expand coordination at every level of government through the budgeting process. The health ministry also sought to implement improved systems for the monitoring of expenditures and performance.

ACTIONS TAKEN

The groundwork for the Health Sector Transformation Plan began in 2011—when Kesete was still deputy health minister—in discussions between then health minister Tedros Adhanom and a Bill & Melinda Gates Foundation representative about long-term health planning. Under Kesete's ministership, beginning in 2012, the dialogue led to a three-year process that honed priorities and goals for the sector, built consensus for an evidence-

based planning approach, and refined a consultative process that became a major feature of planning in the health sector.

Kesete's team began developing the formal plan in 2014 by scrutinizing available data. Then the team gathered for a five-day retreat wherein, following the balanced-scorecard approach—an international best practice—it defined the higher-level principles from which actions would flow. First came vision and then mission, core values, strategic pillars, and strategic objectives, with the content of each category stemming from the element preceding it. The team then presented the plan to a panel of international experts and made refinements based on those experts' critique.

Once the Health Sector Transformation Plan was in place, officials from the health ministry and five government-funded health agencies spent fiscal year 2015–16 conducting orientation workshops for regional health officials. Kesete visited regional governments to generate high-level political pressure for the plan. The process of creating annual plans followed a long-established top-down, bottom-up practice whereby priorities, guidance, and assistance descended from the federal government to the regions and districts, which in turn provided area-specific information about needs, problems, and challenges.

The system helped make sure that budget plans comported with broader goals. Importantly, the health ministry assigned staffers to guide budget planning by the districts, which often lacked technical expertise. Once plans were in place, regular rounds of meetings at all levels reviewed progress and programming. Although the local and regional governments could still spend their money as they wished to, the coordination efforts helped them understand how they fit into the national plan and encouraged them to support the plan's framework and budget accordingly.

In addition, as the health ministry built support for ambitious and costly goals, it sought to get a better handle on resources and how they were being used. Among the measures the health ministry took were the development and distribution of an Excel-based reporting tool for the international donors that provided much of the health programs' funding. The intention was to provide a clearer picture of the amounts of money that donors were spending and for what purposes. The ministry also encouraged donors to channel more of their spending to a Millennium Development Goals fund that permitted discretion in the how the money was spent.

Seeking better ways to allocate—and measure the effects of—its own spending, the health ministry became one of the first in the government to pilot the finance ministry's new, integrated financial management information system (IFMIS), which enabled budget supervisors to monitor budgets in real time and maintain oversight of procurement and execution. The IFMIS enhanced the finance ministry's ability to identify fraud, waste, and abuse and to reduce government offices' reporting burdens.

Another health ministry innovation was the establishment of an e-Community Health Information System (eCHIS). The eCHIS was a point-of-service computer application whereby health workers could record their activities and gather patient data. Previously, health workers had done such work manually, and there had been no systematic way to track whether they were administering services correctly or providing accurate reports.

RESULTS

Only a month into implementation of the new five-year health plan, things began to go awry as unrest broke out over an unrelated government plan to expand the capital district of Addis Ababa into the surrounding region of Oromia. Amid the turmoil, implementation of the health plan ground to a halt, and Kesete left the government during a sudden cabinet reshuffle. Many senior officials in the health ministry and top regional officials also left. In the districts, insecurity and political bloodletting disrupted normal operations. Under Kesete's replacement, the Health Sector Transformation Plan languished. Technical problems, including shortcomings in adopting the IFMIS, also hobbled implementation of the plan.

In early 2018, a new, reform-minded prime minister appointed Amir Aman Hagos as health minister. Amir Aman, who had had a lengthy tenure in the ministry, brought a renewed—and sorely needed—focus on the health plan. After a midterm review of the plan in June 2018, the ministry found nearly every indicator below target. An independent midterm review team determined that the health sector continued to suffer from "inadequate budget allocation to operating expenses" as well as from gaps in human and material resources, some of which the unrest had exacerbated.

LESSONS LEARNED

- Senior health officials said that in developing the Health Sector Transformation Plan, they had been overly optimistic and too ambitious. Sentayehu Tsegaye, a leader on the team that developed the plan, acknowledged that the planners should have anticipated the risks that the country's political situation posed with regard to sustainability.
- The plans and systems, no matter how well crafted, could not fulfill their potential without trained, committed people using them. At all levels of Ethiopia's health bureaucracy were marked gaps in education, remuneration, and skills development; and performance management within the government was weak.
- The most-notable success of the planning effort involved incorporation of district governments into the planning process. Embedding technical assistants into district health offices and conducting training and workshops for lower-level health workers and planners proved crucial to both the strengthening of community involvement.

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