



INNOVATIONS FOR SUCCESSFUL SOCIETIES

BEST-LAID PLANS: ETHIOPIA ALIGNS HEALTH CARE WITH NATIONAL GOALS, 2014 – 2018

SYNOPSIS

Ethiopia's Federal Ministry of Health was struggling to meet its goals in 2014 despite impressive gains in the health of its citizens during the previous 20 years. A new minister and his leadership team reached out for ideas by engaging Ethiopia's regions, districts, and communities—an essential step in a large and ethnically diverse society. They then developed an ambitious transformation program to help realize the government's national aspirations for health care, including commitments made to achieving the Millennium Development Goals. To bring their vision to fruition, however, the minister and his team had to link priorities to the budget process and use the health budget as a management tool. The ministries of health and finance matched goals and targets to available resources and worked to create actionable plans. And health officials took steps to build cooperation and extend coordination at every level of government in Ethiopia's federal system. Technical and capacity constraints—plus unexpected political upheaval beginning in late 2015—slowed implementation, but in 2018 a new administration was taking steps to address those challenges.

Gordon LaForge drafted this case study based on interviews conducted in Addis Ababa, Ethiopia, in October 2018. Case published January 2019.

INTRODUCTION

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. Though reductions in child mortality, maternal mortality, and communicable disease during the 20 years since the end of the Ethiopian Civil War had been dramatic, around 190,000 children were still dying every year.¹ Moreover, 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 Benishangul-Gumuz,

an impoverished region bordering Sudan, it was nearly 17%.²

Kesete gathered senior staff in early 2014 to start brainstorming a new five-year development plan that would set priorities and targets and address the implementation challenges the sector faced. The previous five-year plan—the final one in a 20-year health sector development strategy—was scheduled to expire in 2015. 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, and to determine how to make effective use of scarce resources.

If handled well, the planning process could foster cooperation with the health departments of the country's nine regions and two chartered cities—Addis Ababa and Dire Dawa—as well as the hundreds of districts (*woredas*) and thousands of neighborhoods (*kebeles*) constituting Ethiopia's federal system. 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.³ 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.

Further, to move from paper to results, the ministry had to track expenditure and performance. Without the ability to do so, it would be hard to use the budget as a management tool because there would be no way to know whether officials spent resources for the purposes planned and little flexibility to redirect moneys to high-impact programs or emerging problems. Although the government had some of the key elements of such a system in place, much more remained to do.

THE CHALLENGE

Ethiopia had come a long way in 20 years. The civil war of 1974–91, which coincided with catastrophic drought and famine in the 1980s, had left 1.4 million dead and most of the country's nearly 50 million people with no access to health care. When the conflict ended, life expectancy was 45 years. Maternal mortality was among the highest in the world. And 20% of children were dying before the age of five.⁴

Under the government of Meles Zenawi, who became prime minister in 1995 after an interim government displaced a socialist military junta, Ethiopia adopted a strategy to expand primary care access and strengthen service delivery. The government's Health Sector Development Plan, finalized in 1997, laid out priorities, targets, and programs for the sector in

successive five-year segments. Aided by outside support and explosive economic expansion—annual GDP growth averaged 10.9% from 2004 to 2014—public expenditure on health nearly doubled from 1995 to 2013.⁵ And assistance from foreign governments and nongovernmental organizations (NGOs) gradually rose from US\$6 million to US\$883 million during the same period.⁶

Ethiopia's health situation improved dramatically. Total annual per-capita health spending rose to US\$61 in 2014, from US\$21 in 2000 in purchasing-power-adjusted dollars—with out-of-pocket expenditure accounting for about a third.⁷ The number of physicians and nurses increased to roughly one per 28,500 people and one to 2,300 people, respectively—still low but an improvement over previous years.⁸ To reach the 80% of Ethiopians who lived in rural areas, the government built thousands of new health facilities and launched the Health Extension Program, which trained and deployed 38,000 government-salaried health workers to communities across the country to provide curative and preventive services (text box 1).

By 2013, there were more than 16,000 health posts, more than 3,000 health centers, and more than 300 hospitals. Nearly 90% of Ethiopians living in rural areas had access to primary health care within a two-hour walk from their homes, although the quality and efficiency of the facilities were uneven.⁹ The average Ethiopian was living to age 64, up from 47 in the 1990s.¹⁰ HIV prevalence among Ethiopians aged 15 to 49 years fell to 1.1%—half of what it had been in 1995.¹¹ Although there was some skepticism about the figures, by official accounts Ethiopia met the fourth UN Millennium Development Goal, reducing its under-five-years-of-age mortality rate by 67% from the 1990 estimate,¹² as well as the fifth goal, with maternal mortality falling 69% during the same period.¹³

Those were remarkable gains for such a large and diverse country. Ethiopia was the second-most-populous nation in Africa, with an estimated 95 million people in 2013. It was

Box 1. The Health Extension Program

The backbone of Ethiopia's primary care system was the Health Extension Program. Launched in 2003 as the flagship initiative in the government's reach for universal health coverage, the program recruited some 38,000 young women from villages and gave them one year of practical health training, then deployed them back into their village health posts to promote health and provide basic services. In teams of two, the health extension workers spent half their time in the health post, delivering selected preventive and curative health services—part of a defined benefits package—at no charge, and the other half conducting home visits to educate villagers about, among other things, contraceptives, disease prevention, hygiene, and the kinds of help they could expect to receive at health facilities. The workers represented the health sector in the neighborhood (*kebele*) administration, and they participated in planning discussions and gathered health data from the patients who visited health posts.

In 2012, the government began organizing a network of volunteers to bolster the Health Extension Program. Health extension workers identified model households that had adopted good health practices such as sleeping under mosquito nets. The health workers tapped the matriarchs of those households to spread health awareness in their communities based on the idea that, as Minister Kesetebirhan later wrote in an op-ed, “model families create model communities, which lead to model districts and eventually a model country.”¹ According to the Federal Ministry of Health, by 2015 that network of community health leaders, called the Health Development Army, was 3 million strong.

¹ <https://qz.com/1072337/ethiopia-built-an-army-to-tackle-maternal-mortality-this-is-how-they-did-it/>.

rapidly urbanizing, though most Ethiopians still lived in rural areas. The economic base of the regions varied widely—from pastoralism in the remote Somali region to a burgeoning consumer sector in the relatively affluent capital, Addis Ababa (figure 1). Occasional outbreaks of violence among communities and with neighboring countries continued to attract international concern.

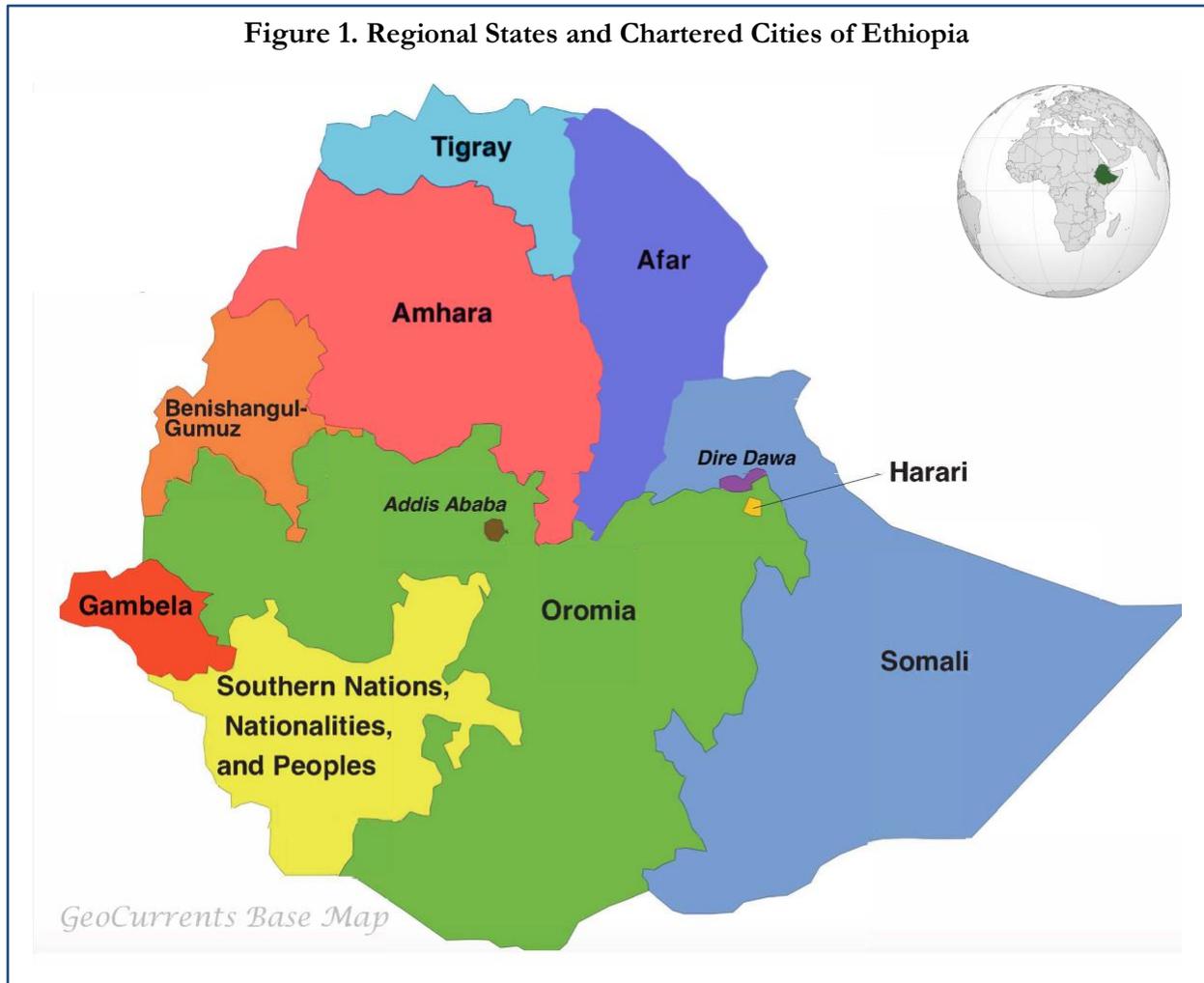
As they began to lay out a strategy for the future, Kesete's team was up against several challenges that would stand in the way of achieving the targets they set. Four were especially difficult: navigating intergovernmental relationships; closing skill gaps, especially at the local level; improving the quality of information; and streamlining highly fragmented funding streams.

Ethiopia's federal system was the biggest and most intractable of those challenges. The nine regions were semiautonomous, each with the power to establish its own government and raise its own revenues. (The 1994 Ethiopian

Constitution even went so far as to grant each region the right to secede, though that right had not been exercised in the wake of Eritrea's 1993 breakaway.)

In the health sector, the health ministry and the regional health bureaus set priorities, provided technical support, and marshaled the funding for investments and activities, but district health offices managed and coordinated most of the operating budget as well as health-care-service delivery. Under a system of fiscal decentralization, the regions received from the federal government large block grants for all spending categories, but there were no strings attached. Federal officials could not compel their regional counterparts to adopt certain priorities, implement preferred programs, or spend their money in specified ways.

Capacity was the second big challenge. At the district level, a sizable number of the officials managing health budgets lacked the training or incentives to effectively carry out that work. “You might have good people at the national and



regional levels, but in the districts they're harder to come by," recalled Sentayehu Tsegaye, a medical doctor and adviser to the health minister who had been a World Health Organization (WHO) technical assistant in district health offices in the late 2000s. One analysis found that in some regions, only a quarter of health posts met efficiency standards.¹⁴

Though the problem was especially acute at the district level, finding and retaining motivated, technically capable officials was a governmentwide challenge. "Skills are a big problem here—in all sectors," said Addis Tamire Woldemariam, Kesete's chief of staff. "Unless you have competent people managing programs and providing services, it's difficult to move anywhere." An unofficial estimate by the

Ethiopian finance ministry determined that poor project management caused program delays that annually wasted 20 billion birr (the equivalent of US\$978.3 million in 2014).

Talented people who entered government ministries typically left after only short stints to work at international NGOs, which offered better salaries, benefits, and facilities. Paradoxically, several of the organizations had the goal of building technical capacity into the government and had embedded their own staff as advisers in the health ministry, the regional health bureaus, and the district health offices.

Variation in quality of services sparked several studies to try to identify sources of inefficiency, some of which had more to do with the facilities themselves than with personnel.

Only half of rural clinics had regular electricity or a functional generator with fuel, and one-third had no access to emergency transportation.¹⁵

Lack of information posed a third challenge. 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 Zemenfeskus, the medical doctor who headed the Federal Ministry of Health Quality Services Directorate. "People are happier guessing than measuring."

Officials reported that the data in the Health Management Information System, the government's primary source of information on

the quality of service delivery, often failed to convey the realities in the health facilities. Lack of technical capacity was part of the issue: for instance, nurses would wrongly record vital signs, or health workers would fail to gather patient data. However, there was strong pressure to report improved performance—whatever the actual situation. Many hospital executives and district health officials were political appointees and wanted to show they had done their jobs well. Because of skepticism about the quality of the data, some health officials expressed doubt that the country had achieved the reductions in mortality required by the fourth and fifth Millennium Development Goals.

Box 2. Community-Based Health Insurance

Out-of-pocket expenses incurred by health-care consumers represented a relatively large share of health expenditure in Ethiopia. Still, cost-recovery rates were extremely low in health facilities. A Clinton Health Access Initiative study estimated that the government or hospitals subsidized roughly 80% of hospital costs. Spending the night in a hospital with three meals could cost only 10 birr (36 US cents). To improve cost recovery and meet the goal of universal health coverage, the government recognized it needed a countrywide health insurance system.

The Ethiopian Health Insurance Agency, part of the Federal Ministry of Health, designed two insurance arrangements: The first, Social Health Insurance, would cover Ethiopia's formal employees via payroll taxes. For various governance reasons, that program stalled. The second, Community-Based Health Insurance (CBHI), was for the more than 80% of Ethiopians in the informal sector—farmers, goatherds, small traders, and others on the margins of the revenue and employment system. According to Halima Abate Hallalo, a senior expert in the Ethiopian Health Insurance Agency, each household would pay premiums of US\$10 to US\$15 per year to access basic services at public health facilities. The Federal Ministry of Health paid a 25% subsidy for all enrollees (it dropped to 10% in 2017) and completely subsidized the premiums of those whom the regional health bureaus identified as indigent.

In 2011, a national coordination unit under the health insurance agency piloted the CBHI in 13 districts. The results were promising: 52% of people in those districts signed up. The insurance agency expanded the program, helping set up CBHI arrangements in more districts. But expansion revealed issues with the CBHI. Each district administered its own CBHI program and purchased services from the public health facilities. There was no monitoring of premium collection or disbursement, and some districts were in dire straits, with premiums insufficient to cover risk. Districts in one region were reluctant to pool premiums with those in another, and smaller pools meant less ability to mitigate risk and sustain coverage. Still, in 2018, the insurance agency calculated that CBHI arrangements would collect nearly 1 billion birr (US\$35.7 million) in premiums and would have enrolled beneficiaries in 534 districts—around half of all those in the country. "It's impressive," said Halima. "The premiums are growing, and the public is delighted with the services they're receiving."

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. In the Ethiopian government's parlance, there were three channels of funding for the health sector, each of them constituting roughly a third of total government and donor expenditure in the sector.¹⁶ So-called channel one consisted of transfers from the Ministry of Finance and Economic Development, with money coming from public funds and international donor assistance—some of it for general purposes and some earmarked primarily for recurrent expenditures such as health worker salaries and operational expenses. Channel two consisted of on-budget donor assistance either through the Millennium Development Goals (MDG) Performance Fund—a multidonor general-purpose pool the health ministry managed and allocated—or earmarked for specific priorities, such as support for HIV/AIDS interventions from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Channel three comprised the donor assistance managed and administered outside government financial management and reporting frameworks. The government did not always know where money was going. There was no single budget-reporting document that accounted for all funding sources, and there were inefficiency and duplication.

In 2013, the international donor assistance that was spread throughout the three channels accounted for 36% of total health spending; the government covered roughly 30% from revenues it collected; and the rest was paid by health-care consumers—mostly in the form of fees for services.¹⁷ A new community health insurance system, subsidized by the federal government, was beginning to help citizens cover costs (text box 2).

The new strategy would not only have to set priorities and targets; it would also have to address the underlying implementation challenges.

FRAMING A RESPONSE

To lay out guidance for creating the new plan, Kesete turned to two trusted aides: Sentayehu, one of his technical advisers, and Kahsu Bekuretsion, another senior adviser with an extensive background in health policy planning.

Sentayehu and Kahsu drew up a step-by-step blueprint and created a flowchart to guide the process. They chose two tools to assist them in their work: the balanced scorecard—a system for translating a high-level vision into ground-level programs tied to performance indicators—and the OneHealth Tool, software UNICEF had developed to help planners in low- and middle-income countries budget and measure the effectiveness of their policies.

Kesete then brought in two more technical assistants—Amsalu Shiferaw from UNICEF and Sofonias Getachew from WHO—both of whom had extensive policy and planning experience in the Ethiopian health sector. Along with the team leaders and Addis, the minister's chief of staff, they formed the core group that would draft the plan and shepherd it into creation, gradually shaping it into a full-fledged transformation agenda. "It was an all-star team," recalled Addis. "These people had been involved in [the previous five-year plans], they had real hands-on planning experience, and they were committed and energetic, which they had to be because there was a lot of analysis and legwork."

The first step was to gather performance reviews from the previous five-year plans and conduct trend, situational, and stakeholder analyses. The team members read reports and surveys and even conducted a few of their own. They looked at sociodemographic changes, disease patterns, and fertility and injury rates. They accounted for the number of health facilities, the supporting infrastructure, and financing capacity.

The team took all of that data and analysis and during a five-day retreat at a hotel outside Addis Ababa, hammered out the foundation of

the plan. Following the balanced-scorecard approach, they defined the higher-level principles from which actions would flow. First came vision, then mission, core values, strategic pillars, and strategic objectives, with the content of each category stemming from the order before it.

To decide what those principles and targets should be, the planners considered not only their deeply informed analysis of the Ethiopian health sector but also international commitments—such as the Millennium Development Goals—and national aspirations. In the preceding months, the

Box 3. The Visioning Exercise

Before starting work on the five-year plan, the health ministry conducted a series of studies and planning sessions to envision where the Ethiopian health sector should be in 20 years. The effort unofficially began in 2011, when the Gates Foundation's point person in Ethiopia, Mary Taylor, was discussing an expansion of Ethiopia's flagship primary health-care initiative, the Health Extension Program, with then health minister Tedros Adhanom. Since 1997, the health ministry had created five-year development plans, but it had yet to articulate longer-term goals. And after several years of explosive economic growth, in which health-care facilities and services expanded quickly but haphazardly, Tedros told Taylor he wanted the ministry to slow down and think critically about what longer-term vision it was working toward.

When Kesetebirhan Adamsu, who was deputy minister under Tedros, became health minister in 2012, he turned those preliminary discussions into a visioning exercise focused on the concrete question of what it would take for Ethiopia to have a high-quality and resilient primary health-care system by 2035. Kesete formed a special committee of ministry officials and in-country health experts to think about that question. With support from Taylor and two facilitators from Yale University and UNICEF, the committee met around twice a month, its participants thinking creatively about what the system should be like in the future. The work of the committee culminated in a report and a conference hosted by the Harvard T.H. Chan School of Public Health at Harvard University in Boston.

Kesete briefed Ethiopia's council of ministers on the conference and the visioning exercise, the feedback was positive. Encouraged, he expanded the exercise into a ministrywide effort to look at the entire sector. He tasked Sentayehu Tsegaye, a senior adviser in the ministry, to lead the effort. Sentayehu instructed the health ministry directorates to form technical working groups, which created 20-year goals and targets and produced the analysis and metrics behind those targets. Sentayehu was the central node by his supporting the working groups and collecting the information and then each week briefing the health ministry management team, which would review progress, approve priorities, and suggest alterations.

The feedback loop of priority setting, analysis, and consultation strengthened; and the exercise grew to encompass multiple strains of planning and research in the ministry. The general goal was universal health-care coverage by 2035, but the scope was vast. Taylor enlisted public health experts at Yale, Harvard, and the JSI Research & Training Institute, Inc., to work with government officials in the management of research grants that contributed to the exercise. Those studies resulted in reports on the tracking of health-care resources, the primary care system, and health extension workers. The visioning exercise lasted almost three years and laid the groundwork for the five-year Health Sector Transformation Plan in important ways: the ministry generated data and analysis; it honed the priorities and goals for the sector; it built consensus for an evidence-based planning approach; and it refined a consultative process that became a major feature of planning in the health sector.

health ministry had collaborated with public health specialists from the Bill & Melinda Gates Foundation, Harvard, and Yale to conduct a visioning exercise to map out a strategic direction for the sector's next 20 years. In addition, the government had recently created a national Growth and Transformation Plan that set forth how the country would reach middle-income status. Recalled Addis: "We considered this long-term vision: When Ethiopia becomes a middle-income country, what kind of health sector should we have then? And what targets would we want to achieve on the path toward that by 2020?" (text box 3).

During those five days at the hotel, the team worked backward from that vision to develop high-level themes called *pillars*. The minister would ultimately approve four: service delivery, health system capacity, governance, and quality.

As disagreements arose over what to include in the pillars—equity, the supply chain, the health regulatory system—Addis played mediator and conducted problem-solving sessions with the team. "Whenever you do these kinds of exercises, you have this intellectual pull and push: personal opinions, expert opinions, and some of your background come into play," he said. "We let everyone have a free discussion, allowed it to flow."

The team also devised 15 strategic objectives corresponding to the four pillars, as well as a raft of initiatives and programs corresponding to the objectives (text box 4). The team reported that deciding the pillars was the most difficult aspect because there were so few of them and because, under the balanced-scorecard approach, all of the objectives and initiatives should flow naturally from them.

After Kesete signed off on the initial draft, the core technical team began a nearly-yearlong consultation process with stakeholders across the health sector. The plan would work only if regional and district officials were on board, because under Ethiopia's decentralized system, the regions, districts, and health service providers would implement the plan, not the health

ministry. "Commitment is a function of clarity and buy-in," said Addis. "We had taken great

Box 4. The Health Sector Transformation Plan (2016–20)

The plan began with four pillars of excellence:

- Excellence in health service delivery
- Excellence in quality improvement and assurance
- Excellence in leadership and governance
- Excellence in health system capacity

Interwoven through the plan were four transformation agendas:

- Transformation in equity and quality of health care
- Information revolution
- *Woreda* (district) transformation
- The caring, respectful, and compassionate health workforce

Flowing from the four pillars were 15 strategic objectives:

- Improve health status.
- Enhance community ownership.
- Improve efficiency and effectiveness.
- Improve equitable access to quality health services.
- Improve health emergency risk management.
- Enhance good governance.
- Improve regulatory system.
- Improve supply chain and logistic management.
- Improve community participation and engagement.
- Improve resource mobilization.
- Improve research and evidence for decision making.
- Enhance use of technology and innovation.
- Improve development and management of human resources in health.
- Improve health infrastructure.
- Enhance policy and procedures.

pains to create a very clear plan. And then we spent a lot of time getting buy-in.”

Addis first presented the draft to the Federal Ministry of Health executive committee, which comprised the minister, two deputy ministers, and the heads of five semi-independent health agencies under the ministry’s purview, including the Ethiopian Health Insurance Agency and the Ethiopian Public Health Institute. The core technical team then presented the draft to the Joint Steering Committee—the primary body for aligning health policy across all levels of government. The steering committee, which typically met every two months, consisted of the directors of the five health agencies, the directors of each of the health ministry’s 22 directorates, and the top officials from each regional health bureau. “From the early stages, the regions were involved,” said Addis. “They owned the plan.”

The team also had prepared a draft budget for the plan, making calculations with the OneHealth Tool. Members of the core technical team recalled that there was little debate over the plan’s priorities, goals, or initiatives, but that the estimated budget had caused alarm. The total cost of executing the plan came to US\$18 billion over five years—roughly 25% of the projected budget for the country’s entire five-year Growth and Transformation Plan, recalled Addis. (The health budget had averaged 8% of the total government budget during the previous eight years.) There was no way they would commit such a huge proportion to health. As a result, the core technical team revised the budget downward by nearly 40%.

The second issue involved the plan’s targets, which the planners set as nationwide averages to accommodate varying conditions in the regions. The targets were ambitious and included the halting of new HIV infections, eradication of malaria in half the regions, and reduction of maternal mortality by 50%. That many of the targets were clearly unattainable within five years generated vigorous debate between steering

committee members about the effects such things would have in different regions. “Some said: ‘Let’s set an ambitious target. It will force us to stretch to try to reach it,’” recalled Amsalu, the technical expert from UNICEF who served on the core technical team. But several regions objected, arguing they were too capacity or resource constrained to meet such targets. Core ministry officials persuaded the regions by promising support and with cajoling from Kesete, who had visited health facilities all over the country and understood the unique challenges each region faced.

In the end, the minister and his staff kept the ambitious targets. “Unless you really stretch the targets and try to compel people to use resources efficiently, there is no way to tackle the big problems we have in Ethiopia,” said Addis. “So, the targets were to keep people awake — that despite the achievements, the country still had a long way to go.” (text box 5)

In discussions with the steering committee, the core technical team decided to call the new plan the Health Sector Transformation Plan both to signify its alignment with the governmentwide Growth and Transformation Plan and to highlight its ambitious nature.

The core technical team then presented the draft at numerous forums and workshops with various stakeholders in government and the health sector: the Joint Consultative Forum, a body comprising health ministry officials, NGOs, and development partners who met regularly to review health policy and reforms; the Joint Core Coordinating Committee, a technical body attached to the consultative forum that provided feedback; other ministries in the government, such as the ministries of education, foreign affairs, and women and social affairs; medical associations and other professional groups; private sector associations; civil society groups; and academics. The core technical team, with the minister signing off, tweaked the plan based on input from those various stakeholders. “The plan

Box 5. Defining Stretch Targets

The plan that Kesete’s team devised was highly ambitious. Under the first strategic objective, *Improve health status*, there were nine specific targets to achieve by the end of 2020.

- Increase life expectancy at birth to 69 years from 64.
- Reduce maternal mortality from 420 per 100,000 to 199.
- Reduce younger-than-five-years, infant, and neonatal mortality rates from 64, 44, and 28 years to 30, 20, and 10 years, respectively, per 1,000 live births.
- Reduce childhood stunting, wasting, and underweight in children younger than five years from 40%, 9%, and 25% to 26%, 4.9%, and 13%, respectively.
- Reduce HIV incidence by at least 60% compared with 2010 and achieve zero new infections among children.
- Reduce the number of TB deaths and rate of infection by 35% and 20%, respectively, compared with 2015.
- Reduce malaria incidence and mortality by at least 40% each compared with 2015.
- Stabilize, then reduce, deaths and injuries from traffic accidents.
- Reduce the percentage of premature mortality from cancer and other noncommunicable diseases by 12.5% from its 2015 level.

generated commitment from people at all levels of government, from health system stakeholders, and from development partners,” said Addis.

As a final step, the core technical team presented the plan at a Joint Assessment of National Health Strategies and Plans gathering of international experts. The experts provided extensive written feedback for each section of the plan, which the core technical team recalled was constructive and helpful. Kesete accepted most of the feedback, and the core technical team revised the plan accordingly.

The experts raised two major critiques. First, in echoing the steering committee, they said the targets were overly ambitious. The ministry acknowledged that but kept the targets. Second, the experts said the document seemed to be more a continuation of past development trends than it seemed to be a new framework. What about the Health Sector Transformation Plan, they asked, was transformational?

Kesete took on that question himself. Working with the core technical team, the minister came up with what he called the Four Transformation Agendas. The agendas were cross-cutting themes interwoven through the

objectives and initiatives in the plan and representing the ways the government would transform the health sector. Their themes directly addressed the implementation challenges the sector faced: decentralization, quality, data, and human resources.

The first was *woreda* transformation. The district was the fundamental unit for delivering health services, and the law gave districts high levels of autonomy that the ministry could not usurp. Thus, the government’s approach should be to focus on guiding each district to become an independent unit capable of delivering health care for its people. The second agenda comprised quality and equity. During the previous decade, access had increased, but it was unequal; and in many cases, services were shoddy. The third agenda was an information revolution by way of harnessing technology to improve the quality of data and enhance service delivery.

The final transformation agenda had to do with the development of a caring, respectful, and compassionate workforce. This was a personal passion for Kesete. “The minister was a strong believer in human capital,” recalled Addis. “He recognized that if you don’t have a health

workforce that is compassionate, caring, and respectful, then whatever investment you put into the sector would fail to bring the satisfaction of citizens.” Because the health sector had only limited control over many aspects of human resources (e.g., salaries were the purview of the civil service ministry, and training was in part under the education ministry), that proposal would pose special challenges.

The core technical team and Kesete himself wrote the four transformational agendas, which became the plan’s focus. The ministry’s directorates also created their own five-year plans to fit with this program. For example, the IT directorate detailed how it would improve digital systems to support the information revolution; the quality services directorate had a plan for improving quality; the special health systems support directorate had a plan for equity; and so on. Now, in October 2015, after a year and a half spent creating the plan, the health ministry would get to work making it a reality.

GETTING DOWN TO WORK

With the creation of the Health Sector Transformation Plan, the Ethiopian government now had a map to guide management of the health sector from 2015 to 2020. An intensive effort to implement the plan followed, focusing on three main activities: First, the Federal Ministry of Health had to win adoption of the plan across Ethiopia’s several hundred districts, which bore the responsibility of enacting many of the initiatives and programs the plan contained. Second, the ministry had to translate the transformation agenda into annual plans and had to support the regions and districts as they established their own yearly work schedules. And third, the health ministry, along with the finance ministry’s budget office, had to match the plans to funding sources and then monitor expenditures to make sure officials spent the money in the ways intended. As Addis would later recall, “Developing the plan was probably 10% of the headache. Ninety percent was implementing it.”

Enlisting regions and districts

The minister’s office led an effort to make sure every region and district was aware of the new five-year plan. Under Ethiopia’s fiscally decentralized system, the finance ministry disbursed health sector funds to the regions in the forms of both general-purpose block grants and earmarked grants. The ministry determined each region’s relative share of the subsidy according to what was called a *per-capita relativity-based formula*, whose elements consisted of a region’s population, ability to spend, and revenue collection capacity. Regions then made transfers to the districts as general-purpose grants.

After receiving the transfers, however, the regions and the districts could themselves decide how to allocate their budgets. “We can encourage them to follow national plans, but once they get the money they might pursue their own priorities,” said Sharew Erkehun Asfaw, leader of the program budget monitoring and evaluation and budget consolidation team in the finance ministry.

That was why inclusive planning processes and orientation workshops were so crucial. Throughout fiscal year 2015–16, officials from the health ministry and the five government-funded health agencies conducted several orientation workshops for officials from the regional health bureaus to make sure those officials were aware of the new five-year plan. In turn, those regional officials—in some cases with technical assistance from health ministry officials—conducted trainings, workshops, and town hall–style discussions for thousands of health workers and district-level health officials across the country.

The regional governments were elected political bodies, so the ministry also engaged the local offices of the ruling party to support training activities. And the minister himself visited the regional governments to generate top-level political pressure for the plan. Colleagues remembered him as the rare high-level official who took an interest in basic operational details. He often surprised regional officials with his

knowledge of the specific issues they faced. “He was deeply involved and extremely technically capable, very detail oriented,” recalled Addis. “There was strong political mobilization behind the plan. Kesete went to the regions and made the regional presidents aware of the plan and its priorities and the importance of achieving the targets.” That broader political mobilization helped ensure that local government leaders who were outside the health sector knew about the plan and that it reflected the will of the ruling party.

The health ministry estimated that by October 2016, around 16,000 health workers across Ethiopia had received training in the plan’s contents—and the number would have been greater had larger political events not derailed the effort.

Creating plans: Top-down, bottom-up

Every region and every district, with support from the Federal Ministry of Health Policy and Planning Directorate, would create an annual plan that aligned with national priorities and at the same time addressed the specific concerns of that region or district. This was the main tool the federal government used for pushing the districts to bring their district health priorities into line with national ones. Technical assistants from the health ministry, development partners, and cross-government consultative bodies helped the districts create their plans, but the federal government had no legal authority to tell them what to prioritize or where to allocate the money they received.

Years earlier, the health ministry had honed that process—an approach health officials called *top-down, bottom-up*. Priorities, guidance, and assistance descended from the federal government to the regions and districts; area-specific information about needs, problems, and challenges ascended from the communities and districts; and annual plans for each district synthesized the two flows.

The process began every year with a large, three-day-plus gathering of officials from the health ministry, regional health bureaus, district health offices, hospitals, health facilities, development partners, NGOs, and other stakeholders in the sector. The participants would review past performance and any challenges encountered in achieving the targets in the previous year’s plan and the current five-year goals.

After that review, the health ministry created what it termed an *indicative plan*, which set forth national priorities and listed key indicators derived from the new five-year plan. It was up to the districts to decide which of those priorities to focus on and to set what they thought were attainable targets for the indicators. When district health offices needed extra capacity in order to make their choices and fill out a planning template the ministry provided them, technical advisers would lead three- to five-day orientation sessions and guided their district colleagues through the process. Usually, the district health officials spent two weeks gathering data and evidence from the health posts in their areas and another week developing their plans by using the template.

To identify impediments to progress on any one indicator, the officials, with the support of a technical adviser, used the Marginal Budgeting for Bottlenecks tool, a planning and budgeting aid that WHO, the World Bank, and UNICEF had developed jointly.¹⁸ The tool helped identify the factors, or bottlenecks, that impeded the effectiveness of high-impact interventions in maternal and child mortality; helped determine measures that would alleviate the bottlenecks; and helped decide whether the dedication of resources to that effort would net an adequate improvement in outcomes. For instance, measles vaccination was falling short of the 80% target. Was that because there weren’t enough health workers to give shots to children? Or was the supply of vaccines insufficient? “The [tool] helps

you elicit discussion among experts to figure out where the problem is and then where you should allocate money to fix that problem,” said Sentayehu. (Later, the OneHealth Tool provided an easier way to do much the same thing.)

The result was the so-called core annual plan for a district. The districts would present their plans, including budget estimates, to their regional health bureaus, each of which aggregated all of the plans into a regional core plan. Those plans in turn went to the Federal Ministry of Health. Officials at each level of the chain checked the quality and alignment of the plans. Development partners, through the Joint Consultative Forum and its technical arm, the Joint Core Coordinating Committee, also commented on the plans. And from all of those regional plans, the health ministry created one core annual plan for the nation: top-down, bottom-up.

There were many difficulties with this process. District-level planners might not know exactly how much funding they had available from implementing partners. High levels of turnover of district-level staff because of low salaries and inadequate training was another problem. District planners were unable to access data gathered from health facilities. And the core plans did not include the operational details necessary for implementing interventions.

To solve that last problem, each district was supposed to produce, in addition to the core plan, a comprehensive annual plan, which was a microlevel blueprint of how exactly the district would implement the activities it had committed to in the core plan. For example, to attain measles immunization coverage of 90%—a national target—a district might commit in the core plan to establishing three new immunization sites. The comprehensive plan would include such details as number of vaccines, number of health workers, and locations of sites. But in many districts—even some that had the help of a technical adviser from the federal health ministry or an NGO—planners failed to follow through. Most district planning staffs were small, consisting of only five or six people who perhaps lacked the time,

motivation, or subject-matter expertise to draw up the more-detailed plan.

Despite such constraints, this planning process did in effect constitute a governance structure that encouraged districts to implement national health priorities. Under the law, districts were free to set whatever priorities and pursue whatever targets they wished. But the top-down, bottom-up planning encouraged alignment, thereby enabling the federal government to steer the diverse country toward common health priorities.

To maintain alignment between plans, budgets, and activities throughout the year, the health ministry held Joint Steering Committee meetings with ministry directors and regional health officials every two months to review how the regions were progressing with their budgets and programming. The regional health bureaus did the same—with district health officials—in quarterly meetings. And development partners engaged through quarterly meetings with the Joint Consultative Forum and regular meetings with the regional health bureaus.

Linking to the budget

With annual plans and cost calculations in place, the next step was to find the money to implement them. In Ethiopia, this was a complicated matter. The health sector was highly dependent on aid, with more than a third of total health-care spending coming from international donors, not all of which provided their support through the national budget.¹⁹ Assistance was fragmented because moneys were disbursed across the regions through various funding channels that had different implementers and different reporting frameworks. For officials in the health and finance ministries, the challenge was to identify where the money was and then direct it toward the strategic plan’s priorities.

The health ministry collaborated with the finance ministry to match priorities to the funds available. The finance ministry managed channel one funding, which drew on national government revenue and some donor resources. The health

ministry managed channel two funding, which included multidonor, general-purpose MDG Performance Fund monies and other sources earmarked for specific priorities. The health ministry also had to anticipate when off-budget donor contributions—channel three—might enable it to shift money around.

In October 2015, after publication of the new five-year plan, the finance ministry's budget preparation and administration directorate—a team of around 20 working in a ramshackle annex—began updating the medium-term-expenditure framework, a rolling, multiyear guide used to forecast expenditure priorities across the government and set ceilings for the next five years. The team submitted the new framework to the Council of Ministers for approval by January 8, with the first year of the framework becoming the preliminary budget for the year.

Then the action switched back to the health ministry. Equipped with the finance ministry's spending ceilings, officials at health spent the next two and a half months developing their own budget to send back to the finance ministry. A joint meeting between officials from the two ministries followed, at which Kesete's deputies defended their requests and negotiated.

In late May, the finance ministry submitted the final budget to the Council of Ministers, which approved it within a week. The prime minister sent the budget to parliament, which debated it for the month of June, though in the end it could only accept or reject it, not modify it. On July 8, 2016, the budget went into effect.

Filling resource gaps

Government revenues covered only a modest portion of Ethiopia's health budget, so a crucial element of each year's financial negotiation involved assessing how much the ministry could draw from external sources. Identifying funding and then allocating it were assigned to a unit called the resource mobilization directorate.

The MDG Performance Fund—the on-budget, multidonor, general-purpose fund that

the health ministry administered—was a backstop. It was entirely under the ministry's control. "It was our preferred funding channel," said Abduljalil Reshad, who was director of resource mobilization from 2009 to 2016. "It was flexible. We could draw from it to address high-level priorities that were underfinanced." In 2013–14, 12 donors contributed US\$133 million to this pool.²⁰

The resource mobilization director annually took the ministry's list of proposed priorities to a meeting with MDG fund donors to get their endorsement. Kesete and the minister before him, Tedros Adhanom, who established the MDG fund and in 2016 became director general of WHO, were both influential and respected in the global public health field; their reputations and relationships with NGO leaders and foreign governments helped convince international donors to put non earmarked funds into the hands of the health ministry. "A senior WHO official once told me: 'People don't give money to systems. They give money to people,'" said Abduljalil. "With Tedros and then Kesete, it was not difficult to persuade partners to go through the MDG fund."

Despite encouragement to channel aid through the MDG fund, the finance ministry estimated that around 40% of international-donor-assistance spending was of the channel three variety—totally outside government management.²¹ There was no accounting mechanism at the district level for that assistance.

To try to get a handle on that funding and its effect on the budget, the health ministry starting in 2011 conducted an annual resource-mapping exercise to identify external assistance and better align those funds with priorities in the annual plans. The goal of the exercise was to identify the funding to the sector in all three channels in order to avoid duplication, ensure efficiency, and enable the districts to learn where they had resources on which they could draw to fund their plans' priorities.

Previously, the exercise had failed to identify most of the external assistance. But in 2016, a

small team in the resource mobilization directorate developed a new, Excel-based reporting form with drop-down menus categorized by focus area and activity type. The team disseminated the form to donor organizations (the development partners) and implementing organizations (the implementation partners) working in the health sector. The development partners provided information about funding, about the implementing partners, and about program activities; and the resource mobilization team triangulated the information to get a complete picture of which districts donors were spending money in, how much they were spending, and on what programs and activities.

The resource mobilization director urged reluctant donors to fill out the reporting tool, gathering information from 132 of them and identifying nearly US\$1 billion in assistance. That was more than double the number of participants and about a third more in funding than in the previous year's exercise. The total map had 40,000 lines of data on programming and spending.

The team presented the map to the health ministry's deputy minister, who approved it and authorized the team to present the data to the regional health bureaus, which in turn could present it to the district officials—the end users—thereby enabling the latter to use the resource map to identify sources of financing for their plans' priorities. "The goal was for the regional health bureaus to be able to see which donors were operating in their region and in what capacity, so they could negotiate with those donors if they wanted them to help the district meet certain priorities," said Abduljalil.

Training in how to interpret the map, however, was only an hour long. According to a technical adviser who had been on the resource-mapping team and participated in the training, regional health officials did not have enough time to understand the map. "I don't think any of the regional health bureaus used the data," the adviser said.

Monitoring expenditure

Using the budget to help achieve priorities required close-to-real-time information on expenditure at the program level. Ethiopia's monitoring systems were fragmented, however, and the essential loop—from plan to budget, to expenditure, to performance and then to management review and adaptation—was incomplete.

Part of the problem was that the federal government used the method of *program-based budgeting*—which directed resources to services or initiatives focused on clear outcomes—but the regions and districts still used *line item budgeting*, which simply listed the things departments paid for—such as health worker salaries, medicines, and equipment—without providing clarity on what objectives those expenditures served. That disparity made association of spending with specific achievements at the regional and district levels difficult. "We can't prove what expenditure is correlated with what outcomes," said Sharew, leader of the budget management team in the ministry of finance. "For maternal mortality, for example, we know how much we are spending at the federal level but not at the regional or district level."

Furthermore, to track spending, most of the government used an outdated public financial management system called the *integrated budget and expenditure system* (IBEX). It was a nonnetworked software program into which budget officials at each government entity entered data (initial budget, adjusted budget, and actual expenditure) to produce reports that they would send to the finance ministry. The IBEX program did not interface with other systems—for instance, those of the National Bank of Ethiopia or Commercial Bank of Ethiopia, through which some health payments flowed.

The finance ministry was replacing IBEX with an integrated financial management information system (IFMIS), which was networked, which allowed for real-time budget monitoring and procurement and execution

approval by budget supervisors, and which was in line with international best practices. IFMIS extended the finance ministry's ability to identify fraud, waste, and abuse and to reduce government offices' reporting burdens.

The finance ministry was rolling out IFMIS to replace IBEX, and in 2014, the Federal Ministry of Health became one of the first government bodies to adopt the new system. But capacity constraints and a troubled rollout process prevented regional health bureaus and district health offices from doing likewise.

Ethiopia had first considered adopting IFMIS in 1998. After three failed bid attempts with international contractors—all of them reportedly caused by management problems within the government—the ministry negotiated a contract with United States–based tech company Oracle to provide the software and with Transnational Computer Technology, a California-based IT services provider that worked in Africa, to customize the system and help roll it out across the Ethiopian government.

The project's launch in 2010 was rocky. Staff recalled a long list of snags and false starts: there was high turnover of personnel within the finance ministry and among the consultants, some of whom were unqualified for their jobs; the testing of customized features took longer than expected; problems with the user interface surfaced; and public employees at all levels at first resisted the new system, which required them to develop new ways of working.

In 2014, the finance ministry finally piloted IFMIS in six government line ministries, among them the Federal Ministry of Health's finance directorate, which was responsible for executing the budget. The consultants made minor tweaks based on the pilot, but overall, the software performed well, recalled project managers in the finance ministry.

Implementing the system across the whole government would prove much harder, however. Some government agencies—especially at the regional and district levels—lacked necessary computer hardware and suffered from electricity

or network outages frequent enough to render IFMIS useless. Whereas training a new user in IBEX took one day, with IFMIS it took seven days at the very least, followed by weeks of technical support. The IFMIS project team in the finance ministry acknowledged that the target of scaling up to 125 departments by the end of 2018 was unrealistic and that governmentwide adoption by 2022 was all but impossible.

Further, for monitoring performance, as opposed to expenditure, the new information system was of limited help. IFMIS tracked only the financial details of programs—not whether a program met outcomes, whether it progressed as it should, or whether officials had implemented it in the first place. For that information, the finance ministry relied on surveys—usually, the Ethiopia Demographic and Health Survey and the National Health Accounts—and quarterly reports issued by the health ministry. Shortcomings plagued those reviews. The finance ministry's budget team often found not only that the information on program outputs and outcomes was dubious but also that the financial data in the reports was wrong or contradicted what was in IFMIS, said Sharew.

Part of the problem was that the health ministry struggled to meet the demand that it deliver separate reports to parliament and the prime minister's office in addition to the finance ministry. The budget team in the finance ministry had the power to penalize the health ministry for providing inaccurate information but never did. "It's hard to expect quality reporting when the government is demanding so many reports from them," said Sharew. He and other officials in the finance ministry lobbied parliament and the prime minister's office to streamline their information requests, but as of 2018 there had been no change.

Focusing on performance

The health ministry continued to wrestle with the problem of assessing performance in a highly decentralized political system with data quality and use issues and without widespread

internet coverage. (According to international NGO Freedom House, Ethiopia's internet penetration rate was only 12% in 2016, making it one of the least-connected countries in the world.²²)

The Health Information Technology Directorate began developing technology solutions that promised to make a difference. Director Eyob Kebede, a former computer science professor and IT researcher, focused his staff on creating a master facilities registry, an analytics platform of ambulance and hospital services data, and, most important, the e-Community Health Information System (eCHIS).

The eCHIS was a point-of-service application whereby health workers could record their activities and gather patient data. Previously, health workers had done all of that manually, and there was no systematic way to track whether they were administering services correctly or for whatever reason or whether they were manufacturing or falsifying reports.

The new system called for each health worker to have a tablet computer equipped with the eCHIS application and a fingerprint scanner to identify patients so as to preclude the possibility of creating nonexistent patients or misidentifying a patient. The app had different modules for each of the 16 service packages health extension workers covered and made it easy for health workers to enter data about patients' health and demographic situations. Workers could enter the information, and when they were connected to the internet, the data would automatically upload to a central database. And the updated information would aggregate to the health ministry, regional health bureaus, and district health offices.

OVERCOMING OBSTACLES

Only a month into implementation of the new five-year plan, things began to go awry.

In November 2015, a so-called master plan to expand the capital district of Addis Ababa into

the surrounding region of Oromia triggered protests among farmers of the Oromo ethnic group, Ethiopia's largest. The government claimed the goal of the master plan was to facilitate the development of infrastructure because Addis Ababa had grown rapidly during the previous decade. But the Oromo people—long aggrieved over what rights groups called systematic marginalization and over persecution by the Tigrayan ethnic group, which constituted only 6% of the population but dominated the security forces and the multiethnic ruling coalition—said the plan threatened local farmers with eviction.

Unrest spread to Amhara, home of the second-largest ethnic group, and broadened to encompass demands for broader political rights. A violent, sweeping police crackdown followed, leaving hundreds dead and thousands of dissidents and opposition leaders in jail.

On October 9, 2016, for the first time since the end of the civil war in 1991, the government declared a state of emergency. It imposed curfews, internet blackouts, bans on opposition activity, and domestic travel restrictions. Meanwhile, expressions of violence and discontent continued to flare across the country.²³

Amid the turmoil, implementation of the new five-year health plan ground to a halt. As the *Economist* reported, “district officials . . . were often the first targets of violent unrest.”²⁴ Training and other dissemination activities largely ceased. In November 2016, Kesete left the government during a sudden cabinet reshuffle, turning down reassignment to a nonhealth position. Many senior officials in the health ministry also left. Several regional health bureau heads and other top officials either resigned or were forced out. And in the districts, insecurity and political bloodletting disrupted normal operations.

The new health minister, Yifru Berhan Mitke, dean of the health sciences college at Addis Ababa University and a medical doctor,

entered the ministry as an outsider. For a new minister there was a lot to learn, and amid the tumult, the new team neglected the five-year plan.

In February 2018, with violence and unrest continuing to simmer, Prime Minister Hailemariam Desalegn, who had succeeded to the post after his predecessor Meles Zenawi's untimely death, abruptly resigned. His replacement, Abiy Ahmed, 42, a popular Oromo representative in the ruling coalition, took immediate steps to calm the country. He freed political prisoners, ended press censorship, reinstated opposition groups, and promised free elections in 2020—reforms constituting what the *Economist* called “the most radical liberalization in Ethiopia’s history.”²⁵

Abiy also reshuffled the cabinet, appointing a new health minister, Amir Aman Hagos, a medical doctor who had had a lengthy tenure in the ministry, most recently as deputy minister. Amir had extensive international ties as chair of the African Centers for Disease Control and cochair of a WHO partnership to strengthen health systems in low-income countries. He had been involved in the creation of the five-year Health Sector Transformation Plan, and he refocused the ministry and the sector on it. “The previous change in leadership [from Kesete to Yifru] contributed to a lack of harmonization, and everyone started running in their own directions and trying to carry out their own priorities,” recalled Samuel, head of the health ministry’s quality services directorate. “But now, the ministry of health under Amir Aman is very much focused on addressing the transformation agendas of the [five-year plan].”

ASSESSING RESULTS

Though the political turmoil of 2015–17 derailed implementation of the Health Sector Transformation Plan, the agenda’s success had been uncertain from the beginning. Both an international experts committee and the Ethiopian government itself had recognized the goals and timeline were ambitious. “The [plan] is a wish list. How can you meet all these targets in

five years with the obstacles and constraints we have?” said Halima Abate Hallalo, a medical doctor, public health specialist, and senior expert in the Ethiopian Health Insurance Agency.

So, it was no surprise that the midterm review meeting for the five-year plan, held in June 2018, found the sector was falling short. A draft report by the Federal Ministry of Health showed nearly every indicator below target. In mid 2018, the tuberculosis case detection rate was 60%; the target, 83%. Also in mid-2018, the percentage of births attended by skilled health personnel fell from 71% in 2017 to 67%—well below the 81% target.²⁶

The independent midterm review team, which comprised Ethiopian health sector experts from the World Bank, WHO, and other international organizations, determined that the sector continued to suffer from “inadequate budget allocation to operating expenses.” The team wrote further that “many health facilities are underutilized due to facility readiness gaps (lack of water and electricity) and limited functionality due to lack of human resources such as pharmacy and laboratory technicians. There are shortages in the supply of drugs and supplies, which led to inefficiency in service delivery.”²⁷

But the failure to meet the targets obscured the successes. The effort produced important innovations in processes and systems: By incorporating district governments into the planning process, embedding technical assistants in district health offices, and conducting training and workshops for lower-level health workers and planners, the federal health ministry had strengthened community involvement and ownership of planning and priority setting. Those steps were essential for aligning different levels of government behind agreed priorities.

The tracking of expenditure remained difficult because the effort to implement an integrated financial system was troubled, and it clashed with district budget practices. The government was moving toward program-based budgeting, which the federal health ministry had already adopted and which better linked

expenditure to results and outcomes. But districts still used line-item budgets and an expenditure tracking system that failed to link spending to specific programs or initiatives. It would take more time to resolve that issue as well as to improve the quality of data on performance. “We can’t prove what expenditure is correlated with what outcome,” said Sharew, budget management team leader in the ministry of finance. “For maternal mortality, for example, we know how much we are spending at the federal level but not at the regional or district level.”

New community-level applications held the promise of gathering accurate data about where interventions—and funding—were most needed. In mid 2018, the ministry launched pilot tests of the eCHIS application and was preparing a purchase order for 16,000 tablet computers. The goal was to distribute 40,000 tablets to health extension workers in health posts across the nation. “If deployed well, this will be a breakthrough, an actual revolution in data collection for the health system,” said Eyob, head of the health IT directorate in the ministry.

In a sector dependent on assistance from the rest of the world, consultative forums involving donors, growth in contributions to the MDG Performance Fund, and improvements to the resource-mapping exercise that helped identify off-budget donor contributions were positive steps toward making resource use more efficient. The sector’s financing remained fragmented, however. There was still funding for which the health ministry could not account.

Though there were promising signs in 2018, it would take time for those efforts to bear fruit. The new health minister, Amir, had refocused the sector on the five-year plan, but the violent unrest had left many district health offices gutted. “The lower administrative structure has almost completely collapsed,” a prominent Oromo activist told the *Economist* in mid 2018.²⁸ Because those lower levels were most responsible for

implementing health priorities, the national agenda would continue to flag.

REFLECTIONS

In the face of Ethiopia’s decentralized federal system, the health ministry–directed planning process was a noteworthy innovation. Planners used international best practices such as the balanced scorecard and conducted extensive analyses of available data to create clear, well-structured plans. With no constitutional or financial power to compel regions and districts to adopt national health priorities, the federal government relied on consultation and the provision of technical assistance to create alignment and gain buy-in from lower levels. Planners engaged every stakeholder in the sector—from physicians and international donors to village-level health workers.

Senior health officials recalled that if there was a weakness in the process, it was that they had been overly optimistic. The targets were ambitious—their realization possible only with political stability and strong commitment from the Federal Ministry of Health. Sentayehu Tsegaye, MD, a leader on the team that developed the five-year Health Sector Transformation Plan, acknowledged that the planners should have anticipated risks and thought about ways to mitigate them. Even with the extensive consultations and analyses in the planning process, failure to take into account the fragility of the country’s political situation had been a major blind spot.

Despite the care that had gone into their crafting, the plans and systems could not fulfill their potential without trained, committed people’s use of them. Ethiopia had won wide acclaim for its innovative Health Extension Program, which mobilized tens of thousands of young women to provide basic health services at the village level. But there was no similar mobilization of professionals at the district,

regional, or even federal levels to carry out the sophisticated tasks necessary to implement the measures aimed at increasing the efficiency and effectiveness of the entire health-care system—and in fact, the unrest of 2015–17 had weakened even the existing bureaucracies.

The government—at all levels—was struggling to improve the quality of its workforce. “The economy is growing, but the capacity of civil servants is not,” said Sharew Erkehun Asfaw, team leader in the finance ministry budget preparation and administration directorate, in a 2018 interview. There were marked gaps in education, remuneration, and skills development; and performance management within the government was weak. Civil servant salaries and benefits were far below those for similar positions at nongovernmental organizations, many of which provided technical assistance and professed a commitment to strengthening the government’s

workforce capacity yet at the same time lured top talent from the ministries.

Officials clamored for increases in salaries and benefits, but in 2018, Prime Minister Abiy Ahmed’s reformist government was in dire economic straits. Inflation was 14%, and foreign currency-denominated debt was equal to 350% of annual export earnings, triggering a warning from the International Monetary Fund with regard to risk of “debt distress.”²⁹ There was little room to raise the pay and incentives of civil servants.

Addis Tamire Woldemariam, MD, former ministry chief of staff who had been deeply involved in launching the health sector reforms, acknowledged that without the needed expertise, even the best-laid plans would falter: “If you don’t solve the problems around human capital, you can’t talk about transformation.”

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