2022 CLA CASE COMPETITION

COLLABORATE • LEARN • ADAPT

Case Title:

How Ethiopia used CLA in Implementing Community-Based Health Insurance

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A community-based health insurance member uses his insurance to obtain prescribed medications at the Mehoni Primary Hospital pharmacy. Credit: Ayenew Haileselassie, Abt Associates.

Summary:

Health is under-financed in Ethiopia limiting health care access by poor and marginalized populations. Without financial risk protection mechanisms, these populations pay out of pocket when seeking care, which is prohibitive for most, and catastrophic for many. To improve access, USAID ' s Health Financing Improvement Program (the Program) strengthens the Government of Ethiopia ' s (GOE) health care financing initiatives for reducing financial barriers. Community-Based Health Insurance (CBHI) is an initiative aimed at increasing access to health care, protecting households from financial hardship, and improving the health status of Ethiopians. GOE had ambitious targets: rapid expansion of CBHI to all regions and city administrations, and to cover 80% of woredas and 80% of the target population. But there was a simultaneous need to address challenges identified in the pilot, maintain buy-in from autonomous levels of government and different ministries, and adapt the rural pilot program to Ethiopia ' s urban and pastoral populations.

Program management made Collaborating, Learning, and Adapting (CLA) practices an integral part of its support for CBHI since the beginning. It facilitated collaboration among government stakeholders — the Ministry of Health, Ethiopian Health Insurance Service, and Ministry of Finance and the autonomously operated Regional, Zonal, and Woreda (district) Health Bureaus. All of these stakeholders and USAID collaboratively developed a learning agenda to support GOE and the Programs shared objectives. The learning agenda included questions that specifically addressed CBHI expansion.

Through integrated performance review mechanisms including results tracking, joint supportive supervision, and research activities – autonomous stakeholders institutionalized a CLA culture across CBHI implementation.

Which two subcomponents of the Collaborating, Learning & Adapting (CLA) Framework are most reflected in your case? Please reference them in your submission.

- Internal Collaboration
- External Collaboration
- Technical Evidence Base
- Theories of Change
- Scenario Planning
- M&E for Learning
- Pause & Reflect
- Adaptive Management
- Openness
- Relationships & Networks
- Continuous Learning & Improvement
- Knowledge Management
- Institutional Memory
- Decision-Making
- Mission Resources
- CLA in Implementing Mechanisms

1. WHAT: What is the general context in which the case takes place? What organizational or development challenge(s) prompted you to collaborate, learn, and/or adapt?

Public health care in Ethiopia is under-financed. In 2019 per capita spending on health from government, donor, personal, and insurance combined was USD 36.30, with 30.5 percent paid by patients out of pocket (MOH 2022). The per capita number of visits to a health care facility was 0.6 in 2018, substantially below the World Health Organization's recommended rate of 2.5–3.0, largely due to lack of financial resources (MOH 2014). Without financial risk protection individuals must pay out of pocket, which can be catastrophic and impoverishing for many.

To address these challenges, the GOE — with continued USAID support — introduced a range of health care financing (HCF) reforms to increase availability of health resources, utilization of modern health care services, and protection from health care-related financial risk. The USAID Ethiopia Health Financing Improvement Program (the Program), implemented by Abt Associates, collaborated with the GOE to expand implementation of CBHI. For a small annual contribution, rural and urban populations can enroll in CBHI, protecting households against catastrophic financial risk.

The Program's predecessor project supported the GOE in piloting and rolling out CBHI in select woredas (districts) in four regions in 2018. GOE had ambitious expansion targets aiming for all regions and city administrations, covering 80% of woredas and 80% of the target population. However, CBHI implementation has been challenged by the poor quality of available health services, the uneven capacity of government personnel in autonomous institutions at all levels to generate timely data and to use the data for decision-making — as well as a general lack of understanding about the benefits of health insurance.

2. WHY: Why did you decide to use a CLA approach? Why was CLA considered helpful for addressing your organizational or development challenge(s)?

USAID, the Program and GOE stakeholders needed to maintain momentum for scale up while also ensuring that the pilot's concerns were addressed, the pilot's processes were appropriately adapted for non-rural contexts including pastoral and urban populations. Collaborating learning and adaptation (CLA) had been at the core of the design, development, and rollout of Ethiopia's CBHI program since it was initiated because CBHI implementation necessitated effective multisectoral collaboration with diverse stakeholders at all levels: national, subnational, and community. Additionally, CBHI required 1) continuous learning on the performance of CBHI schemes, especially by local offices that administer the program for the target population and 2) adaptations to various geographic settings and socio-cultural contexts: regions, and urban, rural, and pastoral communities.

The Program, USAID, and GOE stakeholders had identified gaps in knowledge and experience in the initial stages of CBHI design therefore needed an intentional approach to learn and adapt the CBHI offering, including its structure, cost, and acceptability . CBHI implementation includes developing legal frameworks, designing scale up and expansion strategies, revisiting CBHI design features, supporting policy dialogue and advocacy. These activities need grounding in a strong evidence base. An intentional CLA approach helped CBHI program implementation to go beyond traditional Monitoring, Evaluation and Learning (MEL) to become a framework for collaboration that translates data to learning and uses learning to improve CBHI activities. The CLA process has been instrumental in ensuring stakeholders understand the evidence behind CBHI performance and use these to support decisions.

3. How: Tell us the story of how you used a collaborating, learning and/or adapting approach to address the organizational or development challenge described in Question 2.

To develop the learning agenda and identify learning questions, the Program solicited input from multiple stakeholders during a consultative workshop attended by USAID, the Ministry of Health (MOH), the Ethiopian Health Insurance Service (EHIS), consortium partners, and the Abt headquarters team. This collaborative process facilitated buy-in and engagement, ensuring the learning agenda reflected key CBHI knowledge needs. It also enabled the Program to use intentional learning to develop solutions with stakeholders to address knowledge gaps and inform evidence-based programmatic adaptation. Learning questions included:
What are the major constraints of CBHI in the urban setting?
What are best practices and lessons learned from implementation of CBHI in pastoral settings?

The Program team—jointly with USAID, the MOH, EHIS, and Regional Health Bureaus (RHBs)—plan and co-implement CBHI activities, review accomplishments, and learn from evidence gathered to measure progress toward achieving performance indicator targets. To enhance implementation and institutionalization of CBHI, the Program collaborates with EHIS and the MOH at the federal level to develop CBHI legal frameworks, strategies, and manuals, while building the capacity of their staff through training and knowledge sharing. In addition, the Program collaborates with RHBs to adapt the prototype legal frameworks, strategies, and other documents, such as standard operating procedures, to the regional context and to design appropriate HCF structures for each regional context.
Here's how:
CLA in action:
1. Evidence gathered through routine MEL activities has been used as feedback to continuously adapt and improve elements of CBHI design and implementation. For example, routine data related to enrollment and re-enrollment in health insurance, and the number of woredas covered by CBHI have been used as evidence to learn about the performance of CBHI schemes and follow up on tackling the challenges of CBHI expansion into more woredas. Joint supportive supervision of CBHI schemes, performed quarterly, has facilitated timely learning and served as an additional feedback mechanism to improve performance of CBHI schemes.
2. The Program and GOE stakeholders have used various platforms for learning and adaptation. National, regional, zonal, and woreda levels review meetings have proved useful for participating stakeholders to review the performance of CBHI implementation and jointly identify problems and propose solutions that address implementation bottlenecks, make evidence-driven adaptations to implementation modalities to improve performance. Examples of targeted studies to answer learning agendas:
• An assessment of the pilot zonal CBHI pool in East Gojjam zone (Amhara region) produced lessons for replicating zone-level pools elsewhere and for establishing pools at regional and federal levels. Assessment findings were used as input for a review of an EHIS directive on the establishment of higher-level CBHI pools since evidence showed zone-level pools (aggregated woredas) perform better than individual woreda-level pools. Consequently, Amhara, Oromia, and SNNP regions used the study's recommendations to establish zonal pools.
• A study on CBHI implementation in urban settings assessed the relevance of design features of CBHI schemes; efficiency of membership contribution collection, level of subsidy, and its disbursement; and the financial sustainability of the schemes. The evidence generated was shared with national and regional stakeholders and informed the design of legal frameworks, scaling strategies, and ways to tailor CBHI to urban contexts.
• A study captured evidence on the financial performance of CBHI schemes, analyzed alternative scenarios, and suggested a breakeven contribution amount per household for rural and urban schemes for 2020–2024. In its prototype guide, EHIS used the suggested amounts as the minimum contributions. Regions adapted the prototype and revised the contribution amounts for their rural and urban CBHI schemes.
• A rapid assessment reviewed CBHI implementation experiences in pastoral settings and found that some CBHI parameters do not fit the pastoralist way of life, for example pastoral households split and rejoin so individual rather than household ID cards are necessary. The Program is working with EHIS and RHBs to modify their directives in a way that appropriately revises CBHI implementation parameters for pastoral settings.

4. ORGANIZATIONAL IMPACT: How has collaborating, learning and adapting affected your team and/or organization? If it's too early to tell, what effects do you expect to see in the future?

CLA has broadened collaboration for CBHI implementation at federal, regional, zonal, and woreda levels while introducing a culture of learning so that lessons and program adjustments are documented and shared across stakeholders at all levels. CLA is now an integral part of the planning, execution, and reporting processes of CBHI activities. The intentionality of CLA implementation and the experience and knowledge gained by the staff and GOE stakeholders through the process greatly contributed to creating a learning organization/program within EHIS and health offices at the federal, regional, zonal, and woreda levels which was critical to successful scale up. Within the government level, CLA has helped improve accountability and ownership of the CBHI program by the political leadership. CLA created a platform for stakeholders to reach consensus and take responsibility in addressing bottlenecks for improving performance through evidence-based decisions.

The evidence generated from the assessment of the East Gojjam CBHI zonal pool has improved institutional knowledge and once the MOH endorses the directive, it will be used to guide the scale-up and expansion of zonal pooling in the country. The evidence generated from the assessment of the urban CBHI scheme shows that CBHI implementation in urban context has challenges requiring specific adaptation from rural and pastoral schemes. Per the findings of the assessment, the Program is working with the GOE to revisit the role of CBHI boards; make community mobilization part of the entire system; review the structures at woreda levels; revise the contribution amount; make changes in infrastructure and human resources for proper management of data; and identify main sources of risks of fraud and design and implement ways to mitigate risks.

5. DEVELOPMENT IMPACT: How has using a CLA approach contributed to your development outcomes? What evidence can you provide? If it's too early to tell, what effects do you expect to see in the future?

Currently, 82% (907) of woredas in the country, implement CBHI compared to 60% (667) in 2018. Similarly, the percentage of population enrolled in CBHI increased from 13% to 42%. The per capita health service utilization has also improved, from 0.67 to 1.09, exceeding the Program's life-of-project target of 0.8 visits. The increased health service utilization rate is partly explained by the rapid expansion of the CBHI program in rural and urban areas. Increased utilization is also due to the financial protection that CBHI provides, which contributed to increased demand for health care services by beneficiaries. In CBHI woredas, coverage resulted in a significant rise in outpatient visits made by the insured population from 8.5 million in 2019 to 13.7 million in 2021. A recent study conducted by MERQ Consultancy and the Ethiopian Health Insurance Agency (formerly EHIS) and funded by the Bill and Melinda Gates Foundation shows that CBHI member households in general have a higher outpatient health service utilization rate than non-member households.

2019/2020 National Health Accounts data show that out-of-pocket spending as a share of total health spending decreased to 30.6% in 2019, from 33% in 2017 with analysis trends suggesting a further decease in 2021. The MERQ Consultancy study shows that CBHI helped reduce members' out-of-pocket health expenditures (308 Ethiopian Birr among members versus 509 Ethiopian Birr for non-members) and increased their financial risk protection compared to non-members (1 US Dollar = 39.15 Ethiopian Birr (2021 annual average exchange rate). Sustaining established CBHI schemes and expanding the schemes is critical to maintaining this progress.

6. ENABLING CONDITIONS: How have enabling conditions - resources (time/money/staff), organizational culture, or business/work processes - influenced your results? How would you advise others to navigate any challenges you may have faced?

Several factors related to data use culture, process, and resources enabled the implementation of CLA approach. Throughout CBHI design and implementation, an open culture has been instituted among GOE stakeholders, encouraging them to share ideas and opinions via consultative reviews, thematic meetings, and technical working groups. The CBHI implementing team also exchanges information on CBHI implementation updates weekly.

Enabling factors include:

• Leadership commitment – MOH leadership at federal, regional, zonal, and woreda levels has been unfailing in its commitment to the use of CLA, as well as the process by which the CBHI implementation team generates and uses evidence to jointly learn and identify lessons and adjust activities to improve the performance of CBHI schemes.

• Resources allocated to research – The resources that both the Program and MOH have allocated to conduct studies and generate evidence are critical to successful CBHI implementation

• Skills base transfer – It has been unique to have a dedicated MEL team that served as designer, coordinator, and/or active facilitator for CLA integration from CBHI inception through expansion. Transferring skills to GOE stakeholders has enabled the CLA approach to be institutionalized and sustained throughout CBHI implementation.

Challenges include:

• Although CLA is integral to Program implementation, its full application is resource intensive. The Program's budget for planned research and learning activities was cut early in 2021/22 and this has limited CLA activities.

• Using a collaborative approach to produce deliverables such as assessment reports, manuals, and guidelines needs a longer time than does unilateral production. The Program learned to factor in sufficient time to finalize deliverables produced jointly.

• The deteriorating security situation in Tigray, Amhara, and Afar regions has posed challenges to joint collaboration and learning.

• Restrictions necessitated by the COVID pandemic required collaboration and learning activities to be managed virtually