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ASSESSMENT OF THE CONTRIBUTION OF REVENUE RETENTION AND UTILIZATION ON QUALITY IMPROVEMENT AT HEALTH CENTERS IN ETHIOPIA

December 2022

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USAID Health Financing Improvement Program

The USAID Health Financing Improvement Program supports the Ethiopian government in its efforts to further strengthen and institutionalize health care financing reforms and initiatives to provide accessible, high quality, primary health care services for all Ethiopian citizens with reduced financial barriers. Led by Abt Associates, the program is implemented in collaboration with core partners Breakthrough International Consultancy, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard T.H. Chan School of Public Health.

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Cover Photo: A laboratory technician at Awbare Health Center in Somali Region uses equipment purchased with retained revenue. Photo credit: Ayenew Haileselassie, Abt Associates.

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ACRONYMS

AACA	Addis Ababa City Administration
CASH	Clean and Safe Health Facility Initiative
CSC	Community Score Card
EFY	Ethiopian Fiscal Year
EHCRIG	Ethiopian Health Center Reform Implementation Guideline
FGD	Focus Group Discussion
G.C.	Gregorian Calendar
HCF	Health Care Financing
HIT	Health Information Technology
HMIS	Health Management Information System
KII	Key Informant Interview
MOH	Ministry of Health
RHB	Regional Health Bureau
RRU	Revenue Retention and Utilization
SNNP	Southern Nations and Nationalities Peoples'
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

INTRODUCTION

Revenue retention and utilization (RRU) is a first-generation health care financing (HCF) reform that Ethiopia has been implementing since 2008. The reform allows health facilities to retain and use the user fees they collect from the provision of health services, as well as medicines and other health supplies and commodities, after meeting all regulatory requirements. The retained revenues can be used for activities on a positive list, as stated in the health service delivery and administration legal framework and directive of each regional government and city administration. The revenues cannot be used for activities stated on negative lists in the region's regulation and directives.

To learn about the extent to which RRU has contributed to the quality of health facility service delivery, the United States Agency for International Development (USAID) Health Financing Improvement Program conducted this assessment in Addis Ababa City Administration (AACA) and Amhara, Oromia, and Southern Nations and Nationalities Peoples' (SNNP) regions, which started implementing the RRU reform more than five years ago.

OBJECTIVES

The objective of the assessment is to generate evidence on the link between RRU and the quality of health services delivered, and to estimate the effect of RRU on the quality of health services at the health center level, compared to expenditures made using funds that health centers receive from treasury.

METHODOLOGY

The mixed-method study design used by the assessment consisted of the collection and analysis of longitudinal quantitative data from health facility financial and routine reports, supplemented by qualitative data from key informant interviews (KIIs) and focus group discussions (FGDs) with relevant stakeholders at different levels of the health system. The KIIs were conducted at the woreda, zonal, and regional levels in each study area (AACA, Amhara, Oromia, and SNNP), and the FGDs were conducted at health centers with health center staff and health center governing board members. The study team prepared tools to collect quantitative data on RRU and the expenditure of treasury funds/budget on six dimensions of quality (safety, effectiveness, patient centeredness, timeliness, equity, and efficiency) and other expenditures for the past five years. In addition to the tool for collecting information on various expenditure items, there was a tool for extracting information on the health center quality indicators from the routine health information system and health center reform reports. The researchers also developed guides for the KIIs and FGDs.

Health center staff in the sample regions were trained to collect the quantitative data, with periodic support from investigators and USAID Health Financing Improvement Program regional staff. A descriptive analysis of RRU and treasury expenditures over the last five years was carried out by the research team. The study's principal investigator and co-investigators conducted the KIIs and FGDs, for which written informed consent was obtained. With permission, notes were taken during the interviews and later were translated.

FINDINGS

During the 2015-2020 period, health centers' RRU expenditure has increased significantly, by 79%, while treasury expenditure increased only by 47.7%. On average, RRU is mostly expended on safety (57%) followed by effectiveness (24%). Expenditure on patient-centered activities saw the smallest increase of the quality dimensions considered. Expenditures on medicines and supplies constitute more than 90% of the expenditure on safety. The qualitative surveys (KIIs and FGDs) show findings similar to those of the quantitative analysis. Examination of expenditures from treasury sources show safety again constitutes the highest share (57%) of the total expenditure over the five years, and expenditure on effectiveness the second largest share (21%). In terms of covering health center non-salary operating and capital costs, RRU expenditure constitutes an average 55-60%, while treasury expenditure covers the remaining 40-45%.

A positive relationship between RRU expenditure and quality score was observed for the period of the study: like RRU expenditure, the quality of care score has also increased, by 10%, although the improvement varies across quality dimensions. As expected, the improvement in the safety dimension was the highest (22%) followed by effectiveness (20%). This relationship is in line with the magnitude of expenditure made in each of these two quality dimensions.

1. INTRODUCTION

1.1 BACKGROUND

The Ethiopian government, recognizing the critical role that health care financing (HCF) policies and strategies play in a society, developed the Ethiopian Health Care Financing Strategy in 1998. The strategy aimed at increasing financial resources available to health services, improving efficiency in utilization of health resources, and enhancing the continuity, quality, and equity of health services through sustainable financing. The main first-generation HCF reforms are revenue retention and utilization (RRU) by health facilities, systematization of the fee waiver system, standardization of exempted services, outsourcing of non-clinical services, revision of user fees, and the establishment of private wings in public hospitals, and of health facility governance boards [1, 2].

The RRU HCF reform aims to address the wide disparity between health system financing needs and the inadequate expenditure on health, by making available additional funds. RRU allows health facilities to retain and utilize the user fee revenue they collect from the provision of health services, medicines, and other health supplies and commodities after meeting all regulatory requirements and gaining approval of the respective government administrations as part of its facility annual budget [3]. Implementation of the RRU reform began in 2008 in what were Ethiopia's four largest regions at the time: Amhara, Oromia, Southern Nations and Nationalities Peoples (SNNP),[1] and Tigray, and then expanded to the remaining five regions and the two city administrations (Addis Ababa City Administration (AACA) and Dire Dawa). The retained revenues are meant to be additive to the government budget that health facilities receive from the Treasury, and are meant to be used to improve the quality of health services. The retained revenues must be spent on items and activities on positive lists as stated in health service regulations and directives of each regional government and city administration. Items on the positive lists include: improve supply/availability of essential drugs and medical supplies; improve availability and functioning of medical equipment; improve physical infrastructure and functionalities of health facilities; improve health information systems; provide short-term on-the-job training; conduct (operational) research to improve staff efficiency in the health facility; strengthen health education activities; and put in place disease control programs and prevention services. Retained revenues cannot be used for activities on negative lists in the region's or city administration's regulation and directives. These activities include: foreign trips and training; long-term (more than three months) training programs; payment for hired consultants; and any kind of subsidy payment for a third party [2].

In order to learn about and generate evidence on the extent of the contribution of RRU to the quality of health services provided at the health center level, this study sought to answer the following research questions:

- How much was the RRU expenditure on each of six selected dimensions of quality during 2008 to 2012 Ethiopian fiscal years (EFYs)[2]?
- How much was the treasury expenditure (i.e., funds allocated to health centers by the treasury) on each of the six dimensions of quality during the same period?

[1] At that time, SNNP included what have since become Sidama and South West Ethiopian Peoples' regions.
[2] Ethiopia has its own calendar which is different from the Gregorian calendar (G.C.) used in the United States and elsewhere. The EFYs included in this report have the equivalent G.C. years as follows: 2008 EFY (2015/16 G.C.), 2009 EFY (2016/17 G.C.), 2010 EFY (2017/18 G.C.), 2011 EFY (2018/19 G.C.) and 2012 EFY (2019/20 G.C.).

- Which dimension(s) of quality have benefited more from RRU? and
- What was the effect of expenditures from RRU and treasury on selected quality indicators?

The United States Agency for International Development (USAID) Health Financing Improvement Program (the Program) conducted this assessment in AACA, Amhara, Oromia, and SNNP, where the RRU reform has been implemented for at least five years. The principal investigator was Workie Mitiku, and Dr. Desalegn Tigabu, Kassahun Emiru, and Engida Abdella, were co-investigators.

1.2 LITERATURE REVIEW

According to the World Health Organization 2010 report on health system financing [4], a good health system is one that delivers quality services to all people, when and where they need them, without financial hardship. Hence, achieving universal health coverage needs a robust financing system to mobilize and utilize resources for health services. The success of a financial reform or intervention should be assessed by measuring the levels of quality service delivered and the health gains.

Despite appreciable attention given to the link between health outcomes and health spending globally, only a limited number of studies focus on the impact of supply-side health financing reform in general and on the role of RRU in particular on the quality of health service delivery and health outcomes in both developed and developing countries [5-7]. Despite this paucity of literature, most developing country health facility budgets are inadequate, and this is believed to impair quality in service delivery and health outcomes [5, 8].

The Ethiopian Ministry of Health (MOH) defines quality as the "comprehensive care that is measured safe, effective, patient centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently."[9] This definition clearly indicates six dimensions of quality: safety, effectiveness, patient centeredness, timeliness, equity, and efficiency.

The assessment uses definitions of the United States Institute of Medicine for the six dimensions of quality as outlined in the Ethiopian National Health Care Quality Strategy [9].

- Safe: Avoiding injuries to patients from the care that is intended to help them; the World Health Organization defines "patient safety" as the prevention of error and adverse effects to patients associated with health care;
- Effective: Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit;
- Patient-centered: Providing care that respects and responds to individual patients' preferences, needs, and values, ensuring that patient values guide clinical decision;
- Timely: Reducing wait times and sometimes harmful delays for both those who receive and those who give care;
- Equitable: Providing care that doesn't vary in quality because of personal characteristics of the patient such as gender, ethnicity, geographic location, and socioeconomic status [9, 11]; and
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy when delivering health care services.

According to the Donabedian model, there are three categories of information that can be drawn on to evaluate the quality of health care services: structure, process, and outcome:

- Structure refers to the setting in which care is delivered; it includes buildings, staff, financing, equipment, and supplies.

- Process refers to what transpires between providers and patients in the delivery of care, including appropriateness of medical care provided; and
- Outcome looks into the effects of health care on the health status of patients and populations, such as recovery, restoration of function, and survival [10].

Using these categories to describe and evaluate quality of care is a widely accepted approach and one of the few points of consensus in the quality of health care evaluation field [11]. The categories are also mutually reinforcing – i.e., good structure increases the likelihood of good process, and good process increases the likelihood of good outcome [12].

This assessment used all three Donabedian categories and the United States Institute of Medicine's six dimensions of quality outlined in the Ethiopian National Health Care Strategy as its approach.

2. OBJECTIVES OF THE STUDY

The general objective of the assessment is to understand and generate evidence on the extent to which the implementation of the RRU HCF reform has changed the quality of health service delivery at the health facility level. Specific objectives are as follows:

- To show the relationship between the variables that measure quality and the amount of retained revenue utilized in health centers;
- To quantify which of these quality indicators has been most affected by RRU expenditures; and
- To explore the perception of health managers/workers at different levels on RRU's role in improving health service quality.

3. METHODOLOGY

3.1 STUDY DESIGN

Because the RRU HCF reform was implemented throughout the country there is no natural or purposeful control group against which to compare the effect of RRU on service quality. Hence, this study used a mixed-method study design consisting of longitudinal quantitative data collection and analysis supplemented by qualitative information collected in key informant interviews (KIIs) and focus group discussions (FGDs) with stakeholders at regional, zonal, and woreda health offices and with governing board members and management staff at health centers. The premise is that this mix of methods gives a more complete and synergistic understanding of the effect of RRU on quality [13].

3.1.1 DATA COLLECTION SOURCES AND TOOLS

The sources of quantitative data for the assessment were health center records on RRU from 2008 to 2012 EFY. Additional sources were facility records on government treasury budget expenditures and routine health management information system (HMIS) data on quality indicators and performance reports in each sampled health center for the same period. The tool developed for quantitative data collection from these records is attached in Annex A, by selected dimensions of quality and other expenditures. The research team conducted a desk review of health service quality indicators from the routine HMIS and health center reform guideline standards and key performance indicators. The selected data elements/indicators were later classified according to the six quality dimensions. The final list of quality indicators that served as a data collection tool is attached in Annex B. Regional/city administration proclamations, regulations, and directives on HCF were also sources of information in each study area.

In addition to the quantitative data, the study team conducted KIIs and FGDs at different health system levels with stakeholders who are involved in RRU implementation. These include health center management staff, health center governing board members, and health office staff at woreda, zone, and regional levels. KII and FGD guides are attached in Annexes C and D. Sixteen KIIs were conducted at woreda, zonal, and regional health office levels, and five FGDs were conducted at health centers, in all four study areas.

3.1.2 DATA COLLECTION PROCEDURES

For the qualitative data collection (KIIs and FGDs), the researchers used semi-structured pre-tested qualitative interview tools. The in-depth KIIs did purposive sampling of managers at regional health bureaus (RHBs), zonal health departments, and woreda health offices who had worked in HCF or health service delivery for at least five years. To encourage the free flow of information and to understand the dynamics of information exchange, separate FGDs were held with governing board members and health center management team members. The interviews and discussions were conducted at the respondents' health centers and offices. To ensure participants' full participation, comfort, privacy, and confidentiality, only researchers and participants were present during data collection.

3.1.3 DATA COLLECTION QUALITY ASSURANCE MEASURES

Quality of quantitative data collection was ensured by training the finance and health information technology (HIT) staff of each sampled health center on the data collection tools; central and regional Program staff who are knowledgeable about the subject matter were available via the telephone to provide backup for the data collectors in the sampled health centers. Quantitative data was collected by

the respective trained health center finance and HIT staff. Quality of qualitative data collection was ensured as only the principal investigator and co-investigators undertook the KIIs and FDGs.

3.2 SAMPLING

3.2.1 SAMPLING METHOD

Many health facilities have implemented RRU. To select health centers for the study, the study team in consultation with the Program first targeted regions that had implemented the reform for more than five years (AACA, Amhara, Oromia, SNNP, and Tigray) so that longitudinal data could be collected. Of these, Tigray was excluded for security reasons. Also excluded were regions that have implemented the reform for less than five years, for lack of longitudinal data. As per the Program's database, health centers with a functional governing board were included in the study population while those without a functional governing board were not included. The total number of health centers in the four targeted areas with a functional governing board at the time of the study was 2,894 (97 in AACA, 836 in Amhara, 1,246 in Oromia, and 715 in SNNP).

Selection of specific sample health centers was as follows: First, the zones/sub-cities in the four study areas were classified into two groups: best performing and weak performing. A performance assessment report of the sample regions from the MOH Health Sector Transformation Plan I period was used to categorize the zones. The number of model woredas in the 2011 EFY period was used and zones with many model woredas (above the third quartile) were classified as high performing and those below the median as weak performing. In each study area, one best performing and one weak performing zone/ sub-city administration was selected randomly. Thus, in total, eight zones/sub-city administrations (four best performing and four weak performing) were selected. From each zone/sub-city, a list of all health centers was obtained.

3.2.2 SAMPLE SIZE

The health centers sampled were selected assuming that RRU implementation results in a 50% improvement in the quality dimensions, at a 95% confidence interval and 11% margin of error. The total 2,894 health centers with a functional governance board gave a sample size of 77 health centers. These 77 health centers were proportionally allocated to the three regions and AACA. As the total number of qualifying facilities were few in AACA, the sample size allocated to the city was doubled to six health. The remaining samples were allocated to the three regions in line with their health center population size: 32 sample health centers for Oromia, 21 for Amhara, and 18 for SNNP. Of the 77 health centers, it was only possible to collect data for 73. Data for the remaining four health centers, all in Oromia, could not be collected because the health center staff that were invited to be trained in data collection and carry out the data collection did not attend the training or obtain the data collection instruments.

3.3 ANALYTICAL FRAMEWORK

Due to data limitations, four quality dimensions were analyzed for expenditures and six dimensions were analyzed for quality indicators.[3] The assessment analyzed the trends and averages in expenditures

[3] It was possible to categorize the different expenditures from RRU and treasury into four dimensions: effectiveness, safety, patient centeredness, and efficiency. It was not possible to disaggregate and categorize expenditures into timeliness and equity dimensions. The expenditures categorized into each of the four dimensions are shown in Annex A. Categorization of expenditures into quality dimensions was informed by the Organization for Economic Cooperation and Development and the European Observatory's publication on health systems and policies: Improving health care quality in Europe, Health Policy Series #53.

made from health centers RRU and treasury in general and in each of four dimensions of quality over the 2008-2012 EFY period to understand which of the quality dimensions were the focus of the expenditures. Expenditures both from RRU and treasury were categorized into the four dimensions of quality. The quality indicators collected from the HMIS were categorized into the six quality dimensions, as explained in Section 5.2 below.

This quantitative descriptive analysis reveals the focus of expenditures from RRU and treasury over time in each quality dimension. In addition, it compares expenditures from RRU and treasury by dimension of quality at the health center level. This comparison provides evidence on the role and importance of RRU and treasury expenditures on quality improvement in general and on each of the quality dimensions. The RRU and treasury coverage of non-salary and capital costs over time also were analyzed to understand the extent to which RRU is compensating for the reductions in treasury allocations to health centers (if there is any). Expenditures from RRU and treasury were also combined to investigate the focus of these two expenditures together on the dimensions of quality as opposed to expenditure from each individual source. Further, a comparative trend analysis was done between overall expenditure from RRU and quality scores over the period of the study to investigate the existence of a positive relationship. Qualitative survey (KII and FGD) results were tabulated to distill the major findings with respect to the contribution of RRU to health service quality and the challenges encountered in implementing RRU. A particular effort was made to identify RRU contributions and challenges that are common across sample regions. Further scores, on a scale of 1 to 5, on stakeholders' perceptions of the contribution of RRU across the three Donabedian approaches to quality assessment (structure, process, and outcome) and the dimensions of quality (safety, effectiveness, efficiency, patient centeredness, equity, and timeliness) were tabulated. These perceptions of the contribution of RRU and challenges were compared with the RRU quantitative findings whenever possible to understand the extent to which one complements the other.

4. LIMITATIONS OF THE STUDY

The assessment depended on the availability of five years of expenditure data and quality indicators collected at the facility level through routine HMIS and performance reports, which helped to identify the focus of the expenditures and how such expenditures affect quality of care. While this analysis was complemented by stakeholder perceptions provided in KIIs and FGDs, the study did not include a patient perception survey, or a thorough look at the process of care that affects health service quality. It focused instead on structural quality indicators with some process and outcome quality indicators. In addition, there is a difference of categorization of expenditure items and quality indicators among the dimensions of quality.[4] Nevertheless, this does not affect the conclusions on the overall effect of RRU on the overall quality score.

[4] For example, medicine and supplies are categorized in the safety dimension of quality in expenditures from RRU and treasury. However, they are categorized under the effectiveness dimension in the quality indicators.

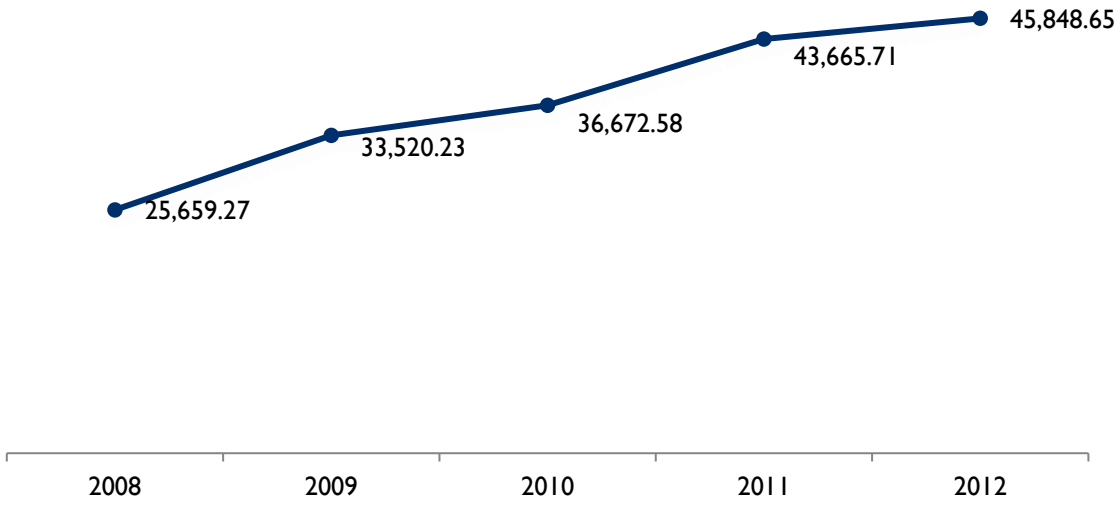
5. FINDINGS

5.1 RRU EXPENDITURE

5.1.1 QUANTITATIVE ANALYSIS

Expenditure from RRU on quality dimensions in the 73 sampled health centers has increased substantially (by 79%) during the five-year period under investigation, going from Birr 25.66 million in 2008 EFY to Birr 45.85 million in 2012 EFY. Figure 1 shows the trend of expenditure from RRU during the period.

Figure 1: RRU expenditure, 2008-20012 EFY ('000 birr)



Expenditure on the safety dimension of quality constitutes more than half of the total expenditure from RRU, increasing from 53% in 2008 EFY to 69% in 2012 in EFY (Figure 2). The second highest expenditure by dimension of quality was effectiveness, which averaged about 25% of total RRU expenditure through most of the period, although it dropped to 17% in 2012. The remaining quarter of total expenditure from RRU was shared by efficiency, all other expenditures,[5] and patient centeredness; efficiency (much of it on the health care information system) and other expenditures consumed an average 7% and 12% of total RRU expenditure, respectively, and patient centeredness received lowest expenditure (almost 0%).

[5] Other comprises expenditures that do not fall in the quality dimensions categories. They include office equipment, office supplies, food supplies during delivery/childbirth, and others. It was not possible to disaggregate expenditure made for equity and timeliness from the other quality expenditures.

Figure 2: Share of quality dimension to RRU expenditure

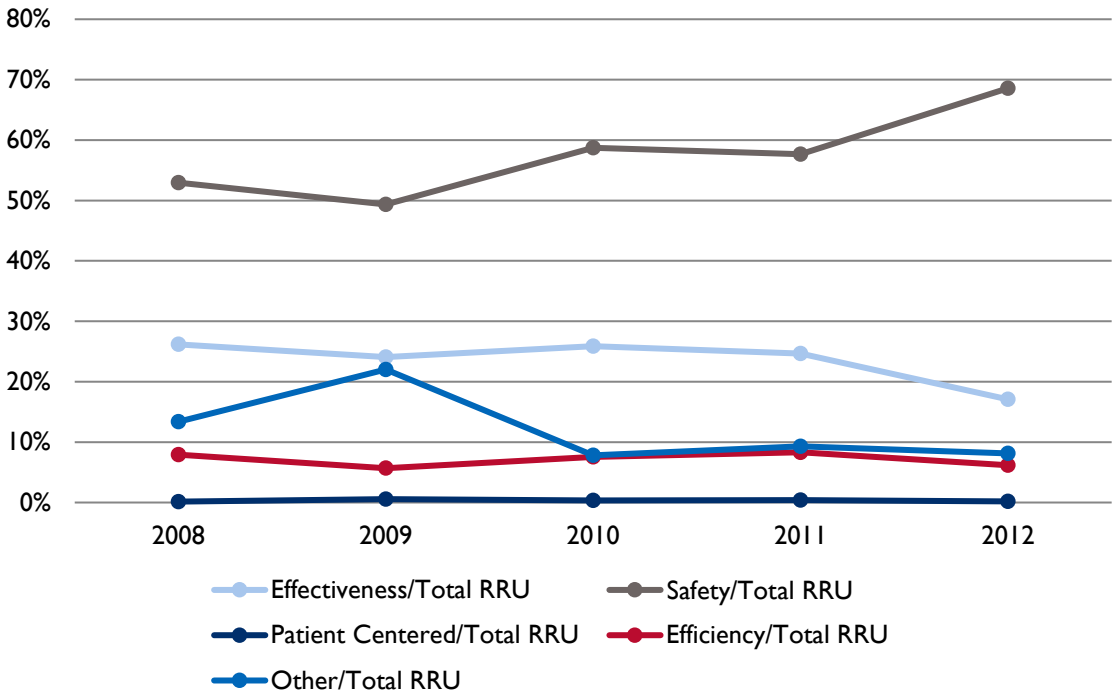


Figure 3 illustrates the total average share of each quality dimension to RRU expenditure for the combined study years. The overall combined expenditure on the safety dimension of quality constitutes more than half of the total expenditure from RRU (57%). The overall combined expenditure on the remaining dimensions and other are effectiveness (24%), other (12%), efficiency (7%), and patient centered (0%).

Figure 3: Average share of quality dimensions to RRU expenditure, 2008-2012 EFY

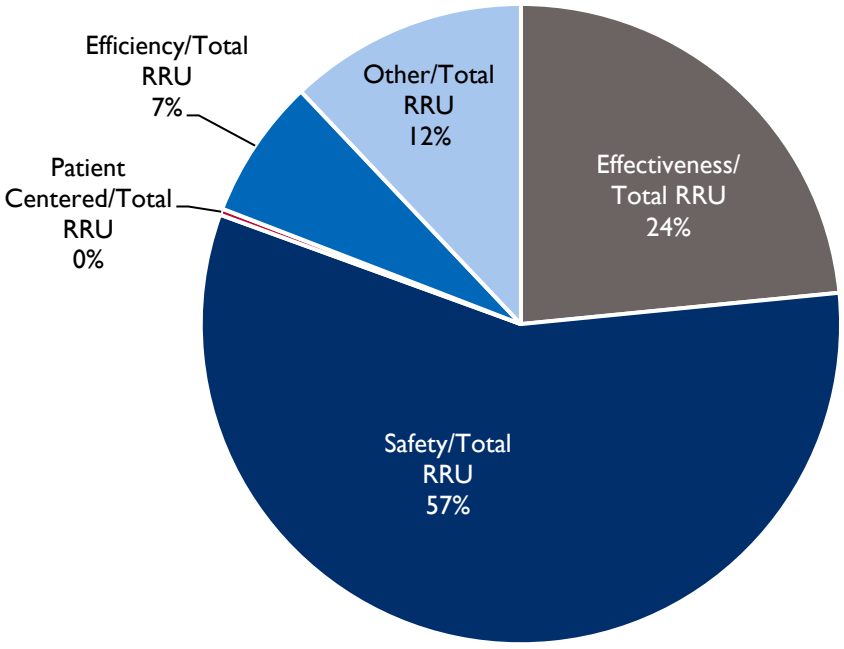
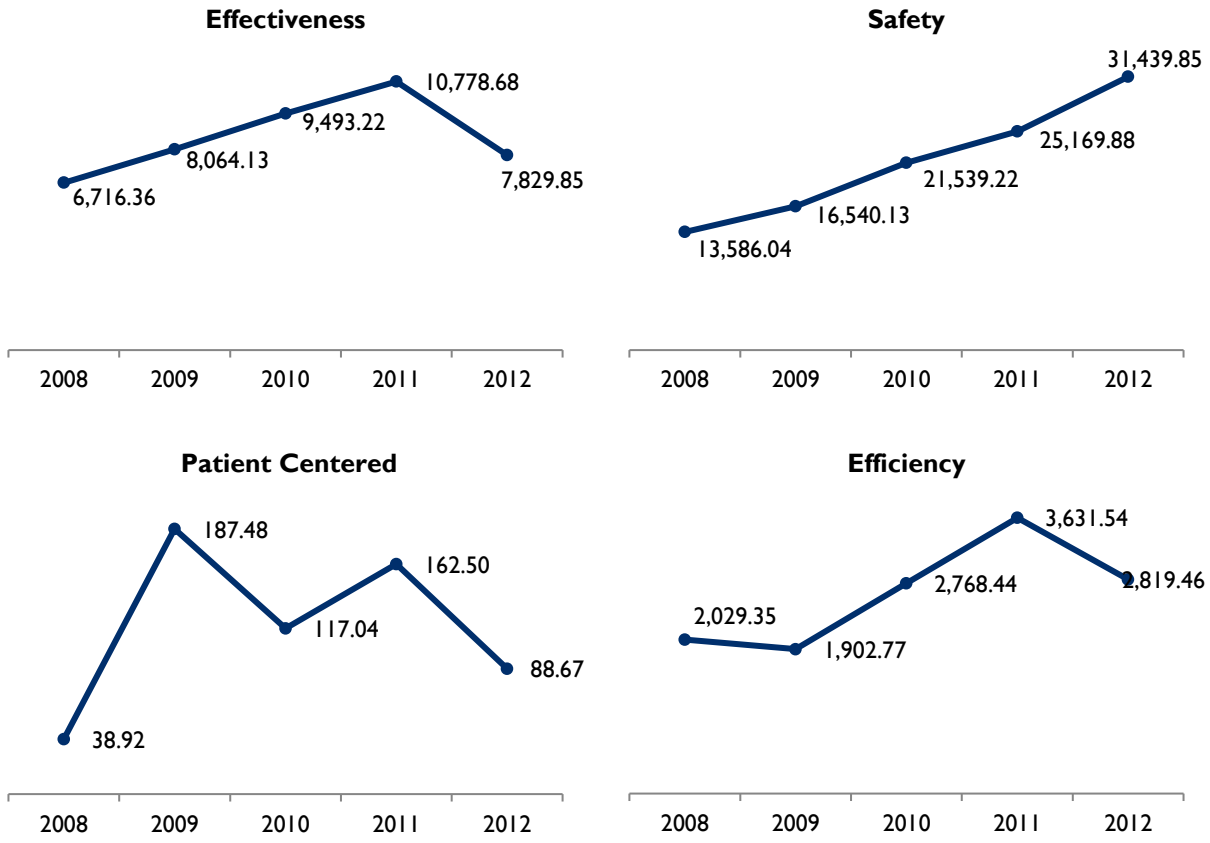


Figure 4 shows trends in expenditure from RRU for each of the four quality dimensions separately.

Figure 4: Expenditure from RRU by selected quality dimensions, 2008-2012 EFY ('000 birr)



Medicine and supplies receive about 95% of the quality expenditure on the safety dimension, while infection prevention and control and water supply receive the remaining 5% (4% to infection prevention and control and 1% to water supply). Within effectiveness, expenditure on renovation and construction of buildings is the highest (36.5%) followed by expenditure on health education (27%); expenditure on medical equipment is also significant (19%). Under efficiency, expenditure on the health care information system is the most significant (92%) while expenditure on research constitutes the remaining 8%. Regarding expenditure on other areas, office supplies constitute the highest share (42%) followed by office equipment and furniture and other, each constituting 16%. Expenditure on patient centeredness is entirely on public forums to gather feedback from the general population. Table 1 shows the share of expenditure from RRU in each of the quality dimensions, disaggregated by type of expenditure.

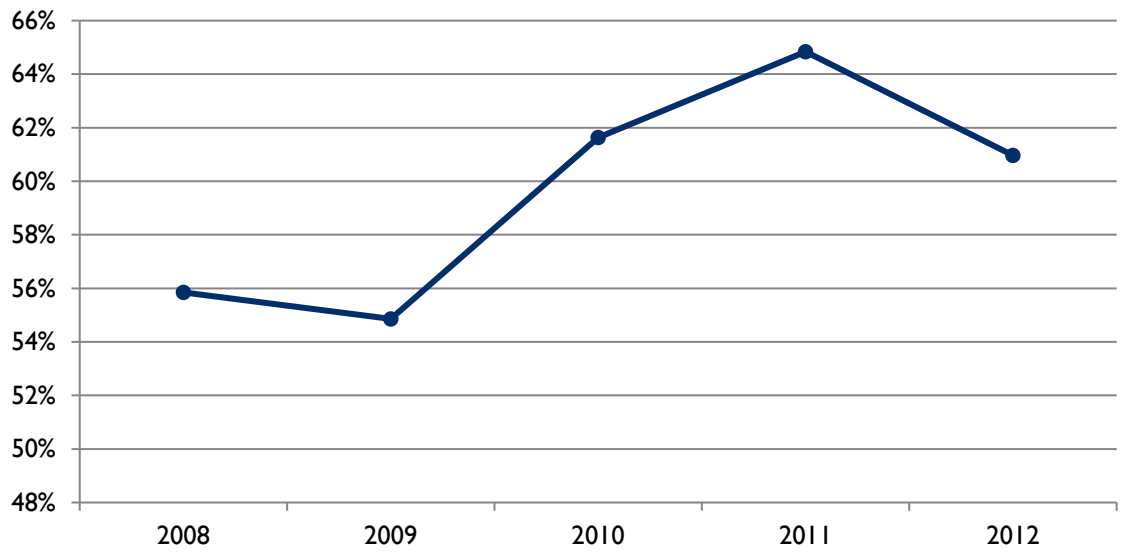
Table 1: Share of RRU expenditure by quality dimensions, 2008-2012 EFY (%)

Year	2008	2009	2010	2011	2012	Average
Effectiveness						
Medical Equipment	22.88	16.11	16.28	12.90	27.61	19.16
Buildings	38.92	44.06	39.34	43.41	16.76	36.50
Generator/Solar Panel	9.05	6.08	13.93	11.95	8.03	9.81
Training	3.61	6.73	5.99	5.21	9.37	6.18
Conferences	0.89	1.23	0.77	1.24	2.00	1.22
Health Education	24.65	25.38	23.80	25.29	36.23	27.07

Year	2008	2009	2010	2011	2012	Average
Safety						
Medicines and Supplies	91.76	93.95	95.02	95.40	95.41	94.31
Water Supply	1.52	1.70	1.07	1.13	0.95	1.27
Infection Prevention and Control	6.34	4.21	3.65	3.21	3.43	4.17
Patient-Centered						
Public Forums	100.00	100.00	100.00	100.00	100.00	100.00
Efficiency						
Research	14.92	6.25	8.08	4.54	4.77	7.71
Health Information System	85.08	93.75	91.92	95.46	95.23	92.29
All Other						
Office Equipment and Furniture	17.71	16.41	28.73	18.34	15.39	19.32
Office Supplies	61.44	52.32	43.55	53.70	58.50	53.90
Delivery Food Supplies	3.04	3.24	7.80	6.03	6.88	5.39
Other[6]	17.02	21.26	19.92	21.93	19.23	19.87

Expenditure from RRU is a significant contributor to the health centers' non-salary operating[7] and capital expenditures.[8] It constitutes 55-60% of these expenditures. The remaining 40-45% is covered by treasury. Figure 5 shows the share of expenditure from RRU on non-salary operating and capital health costs.

Figure 5: Share of RRU total/non-salary operating and capital expenditure



[6] Other here refers to expenditures other than furniture, office supplies, and delivery of food supplies.
[7] Non-salary operating expenditures include all expenditures other than salary and capital expenditures that are used to run the health centers in a given calendar year.
[8] Capital expenditure includes buildings and medical equipment that were bought or built during the study period.

5.1.2 QUALITATIVE (KII AND FGD) FINDINGS

5.1.2.1 CONTRIBUTION OF RRU

As explained during the KIIs and FGDs, the annual facility budget allocated by treasury does not cover non-salary operational and capital costs, particularly medical equipment. As per the KIIs, most of the budget (as much as 90% in Gursum woreda, Oromia) allocated by treasury goes to salaries. RRU is the main source of funding for other operational costs. It has enabled health centers' procurement of drugs and supplies, construction or renovation of buildings such as maternity homes, access to water and sanitation services, and cleanliness of the compound. An estimated 70-90% of health centers' needs for drugs and other supplies are fulfilled through RRU according to a KII in Amhara; an FGD in a health center in Oromia revealed that "the performance of the health center is directly linked to RRU." In addition to procurement of drugs and supplies, sustaining health posts' cold chain system, procuring motorbikes to expand health promotion and disease prevention services, and conducting regular community forums to get feedback on health center services is possible through RRU funding. As stated in the FGD with senior management and the governing board of Shegole Health Center (AACA), RRU also enables facilities to invest in new initiatives coming from the city administration or the MOH. For example, the Clean and Safe Health Facility Initiative (CASH) was implemented and engagement in the Ethiopian Primary Healthcare Alliance for Quality was possible because of RRU, which helped improve patient satisfaction in the facilities. RRU also allowed health facilities to invest in priorities they themselves identified. Generally, as described by a key informant from Kembata-Tembaro Zone, SNNP, "visible change and success has been achieved at the facilities through RRU." As a result of RRU and the quality of service improvements, patient flow has increased. A key informant from Bahir Dar City, Amhara, stated that "health-seeking behavior of the community has increased as a result of provision of quality services through RRU." RRU also had a positive impact on CBHI membership renewal due to improvement in quality of health services (Awi Zone KII). It also helped reduce the time patients must wait to get their patient card—caused by the increased service utilization by CBHI members—by enabling the hiring of contract workers in the record room to facilitate identification and issuance of cards (Dangela Town, KII). Equity in health service utilization is also believed to have been addressed through RRU, as it is the poor who mostly use these health centers (Bahir Dar City Administration KII). It generally "built the trust of the community through availing the necessary inputs to the facilities" (Bahir Dar City Administration KII).

RRU has also played a critical role in improving health service quality by making use of it as explained by the Kirkos sub-city health office KII in AACA. One example is the procurement of an ultrasound machine and recruitment of a radiologist to provide the service in a health center. This has in turn reduced the costs and time that patients would have incurred because of referrals to higher-level facilities. The availability of these new services, in addition to availability of drugs and supplies, also has contributed to quality improvement and to patient satisfaction, as shown in periodic patient satisfaction surveys conducted in the facilities (Awi Zone KII). Even without the introduction of new services, the availability of drugs and supplies has significantly reduced the referral of patients to private facilities, where the patients would have incurred higher costs. In some facilities, such as in Kirkos sub-city, RRU has been used to make facilities convenient for disabled people.

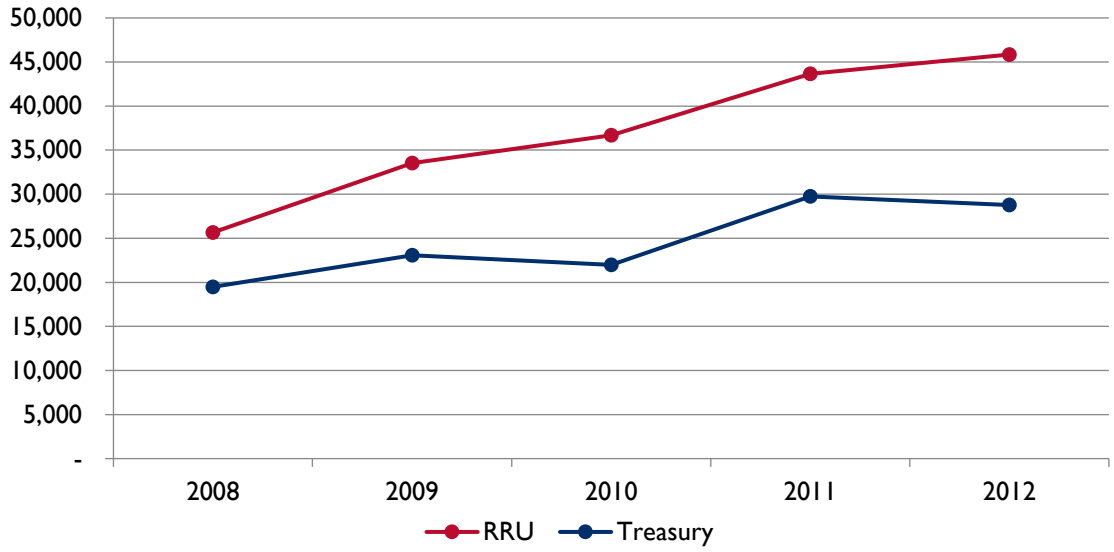
RRU has also motivated facility staff by covering the costs of short-term trainings such as in infection prevention and allowing them to participate in experience-sharing visits and cluster meetings. Health center staff also provide supportive supervision at health posts, which in turn positively affects provision of quality services through the knowledge acquired in such forums. This staff motivation has been maintained by the continuous availability, through RRU, of the inputs needed to work and provide quality health services. In fact, the availability of inputs through RRU has built staff confidence to prescribe the necessary drugs that improve health outcomes (Awi Zone KII). In short, the availability of inputs to provide services made possible by RRU such as drugs and supplies has enabled facility staff to

focus on their core functions instead of worrying about securing the inputs (Dangela Health Center FGD).

5.1.2.2 CHALLENGES OF RRU

The implementation of RRU has encountered various challenges. As per KII and FGD findings, some of the challenges are common across the four sample regions and some are region specific. Limited or absence of health bureau reimbursement or allocation of budget to health centers for the exempted services they provide and budget offsetting (decreasing treasury budget allocation as internal revenue increases) are the major challenges in all sample regions. A triangulation was made between the claims of budget offsetting during KIIs at different health centers and their treasury expenditure over time. As Figure 6 shows, the aggregate expenditure from treasury of sampled health centers declined in EFY 2010 and 2012 compared to the previous year, while RRU has increased consistently throughout the study period. The reduction in treasury expenditure for non-salary operational and capital expenditures and steady increase in RRU expenditure confirms that there is budget offsetting. This finding warrants future study of each health center's non-salary operational and capital expenditure of RRU and treasury funding to understand the severity of the budget offsetting.

Figure 6: RRU and treasury non-salary operational and capital expenditures, 2008-2012 EFY ('000 birr)



The study also found that another serious challenge to the implementation of RRU in the three regions (Amhara, Oromia, and SNNP) is finance staffs' limited understanding of HCF issues at health centers and in the finance sector, because of high staff turnover. Periodic trainings/orientations and supportive supervision, intended to build finance staff capacity, has not resolved this issue. The high turnover of finance staff at the facility level is partly explained by the low salary scale compared to the salary scale at other sector offices for people with the same educational background and experience. An inadequate supply of required drugs and supplies by the Ethiopian Pharmaceuticals Supply Agency also has hindered the optimal use of internal revenue in Amhara and Oromia regions. Except in Oromia, which has revised its user fees, low user fees compared to the cost of supplies for laboratory services has decreased the revolving amount of internal revenue that is available to make necessary purchases, especially in AACA, Amhara, and SNNP. The functionality of facility governing boards is yet another issue: in AACA, boards were dissolved by proclamation in 2011 EFY (Proclamation No. 64/2011EFY); in the other three regions, high turnover (Amhara) and irregular meetings (Oromia and SNNP) due to board members' competing tasks mean RRU is not approved on time.

In AACA, some health centers deposit internal revenue in a type B account; the unutilized revenue is transferred to treasury at the end of the year, and it is often difficult for the facilities to get back the revenue in the new year. Lack of or weak periodic internal audits at the facility level in Oromia and SNNP were also stated as a challenge to monitoring and controlling RRU. Further, providing ceilings in the amount of internal revenue that woreda finance offices can collect and use are challenges in AACA, Oromia, and SNNP. Frequent changes announced in HCF guidelines, such as in the percentage of RRU that can be used to purchase drugs and supplies and in activities on the positive and negative lists, but unaccompanied by orientation for staff in the woreda health and finance offices has made it difficult for the staff to understand and implement the guidelines in Oromia Region. Delays in reimbursing health facilities for the services they render to CBHI scheme beneficiaries also presents a challenge to using the revenue in a timely way in Amhara Region. Finally, negative lists can negatively affect facility performance. For example, the list does not allow facilities to spend any retained revenue on financial incentives to improve health staff performance (SNNP), to pay per diems to staff involved in the procurement of drugs since they must travel away from their duty station (Oromia and Amhara), or to purchase laptops, which are essential in rural areas where electricity is not reliable (Oromia).

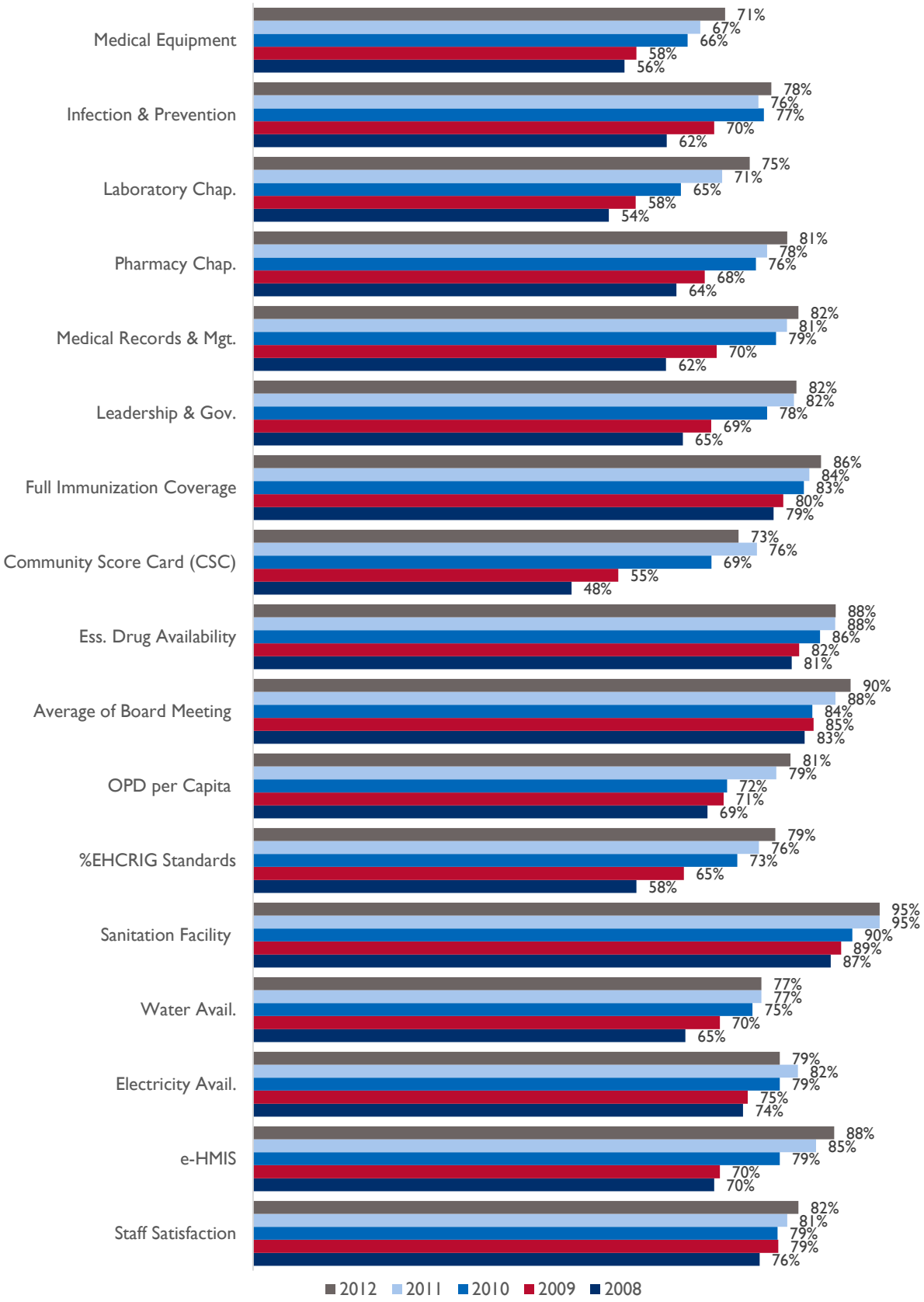
5.2 ACHIEVEMENTS IN QUALITY INDICATORS

5.2.1 QUANTITATIVE FINDINGS

To assess the status of quality indicators over the study period, 25 indicators from the district health information system were selected and data were gathered from the sampled health centers. The 25 indicators represent the six dimensions of quality (safety, efficiency, patient centeredness, timeliness, equity, and effectiveness). Figure 7 shows progress[9] in 17 selected quality indicators (of the 25) over the period 2008-2012 EFY; as shown, there is progress toward meeting all indicator targets, although the extent of improvement varies by indicator. For example, improvement in average scores on the community score card (CSC) is the highest (25 percentage points) compared to the lowest improvement in availability of electricity (only 5 percentage points) between 2008 and 2012 EFY.

[9] The score given for each quality indicator in the sample health centers is computed into a percentage by the authors to observe progress overtime. The data used in the figures are the average figures for all health centers in the sample. For example, the essential drug availability indicator score was 81% in 2008 EFY and increased to 88% in 2012 EFY. It means, on average, that only 81% of the essential drugs were available in the health centers in 2008 EFY and this has increased to 88%. Of the 25 quality indicators, only 17 selected indicators are shown to showcase several while keeping the figures visible.

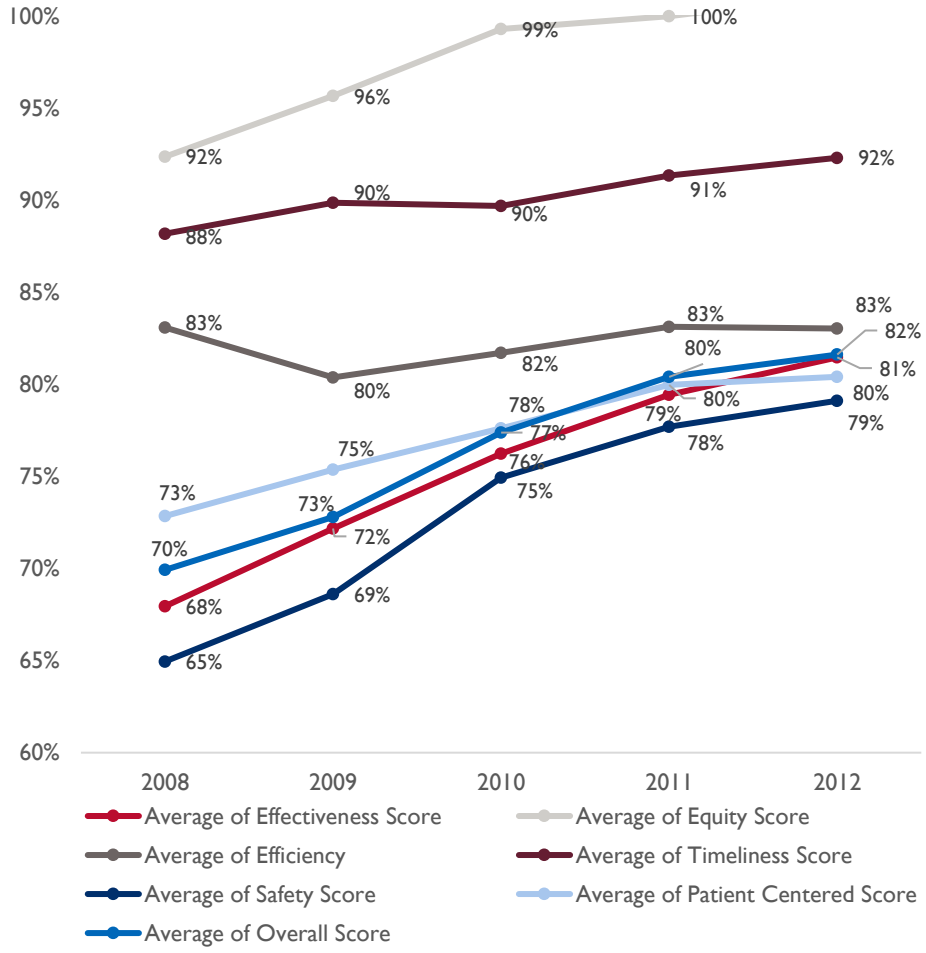
Figure 7: Progress toward meeting 17 quality indicator targets, 2008-2012 EFY



The study team categorized the 25 indicators into the six dimensions of quality. ***Effectiveness and efficiency*** comprise the following indicators: percentage of Ethiopian Health Center Reform Implementation Guideline (EHCRIG) operational standards for health center reform met, percentage of essential drugs available, outpatient attendance per capita, percentage of leadership and governance chapter[10] operational standards met, percentage of medical record management chapter operational standards met, percentage of pharmacy service chapter operational standards met, and percentage of laboratory service chapter operational standards met. This group also includes health budget utilization (both treasury and RRU). Full immunization coverage for children under one year old, and ratio of outpatient attendance per capita by gender indicators represent ***equity***. ***Patient centeredness*** covers average community score card rate, staff satisfaction rate, percentage of patient flow chapter operational standards met by a health center, and percentage of service quality improvement and documentation and reporting chapter operational standards met. ***Safety*** encompasses percentage of infection prevention and patient safety/CASH chapter operational standards met, percentage of medical equipment and facility management chapter operational standards, health centers implementing comprehensive laboratory quality management system, availability of water supply, implementation of an electronic HMIS (e-HMIS), availability of fully functional network infrastructure, availability of electricity, and availability of sanitation facility. Finally, t***imeliness*** includes health center waiting time to treatment and number of facility board meeting sessions conducted yearly. Figure 8 shows the progress made in the six quality dimensions and overall average score over the study period.

[10] Chapter refers a bundle of indicators within each major indicator. For example, leadership and governance has a set of indicators within it. It is the aggregate of these indicators that measure leadership and governance.

Figure 8: Progress toward meeting quality indicator targets by quality dimension and overall average score, 2008-2012 EFY



The study revealed a rise of 10% in the overall quality score over the five years, albeit with variation across the quality dimensions. Of the six dimensions, the most progress (22%) has been made in safety, followed by effectiveness (20%), patient centeredness and equity (10%), and timeliness (5%); there was no improvement in efficiency.

5.2.2 QUALITATIVE FINDINGS

The findings of the qualitative survey, which show informants' perceptions about the effects of RRU on quality are similar to the quantitative findings. The opinions voiced in the 16 KIIs by informants from the four regions who have different levels of responsibility (regional, zonal, and woreda health offices) resulted in the following average scores: for safety, 4.25 (out of 5), followed by effectiveness and equity (4.18), patient centeredness (4.12), timeliness (3.93), and efficiency (3.68). As expected, the perceptions of the KII informants show that RRU has had a greater effect on the structure of the facility (score of 4.56 out of 5) than on the outcomes (4.06) and the process of (3.75) health services in the facility. These scores on the Donabedian categories of quality assessment and the Ethiopian National Health Care Quality Strategy's six quality dimensions from the KIIs are shown in Table 2.

Table 2: Summary of perceived effect of RRU on quality of health services

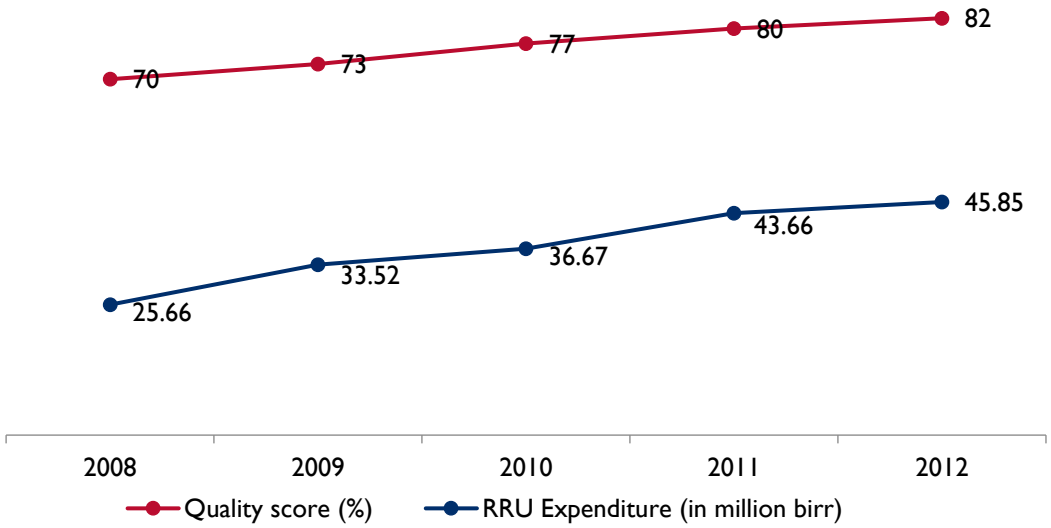
Region	Name of KII Institution	Donabedian Category			MOH/US Institute of Medicine					
		Structure	Process	Outcome	Effectiveness	Efficiency	Time	Patient centered	Equity	Safety
Amhara										
	RHB	5	5	3	5	3	2	5	5	5
	Bahir Dar City Admin.	5	5	5	5	4	5	5	5	5
	Awi Zone	5	3	5	4	3	4	3	5	3
	Dangela Town	5	5	4	5	4	4	5	4	5
Oromia										
	East Harerge Zone	4	3	4	3	3	4	4	3	5
	West Harerge Zone	5	5	5	5	5	5	5	5	5
	Gursum Woreda	5	2	4	4	4	4	4	5	4
	Chiro Woreda	5	4	5	4	5	5	4	5	5
AACA										
	Kirkos Sub-City	5	5	5	5	4	5	5	4	5
	Gulele Sub-City	5	2	3	3	3	3	4	3	3
	RHB	3	4	5	4	3	4	4	5	4
SNNP										
	RHB	4	4	3	5	4	4	4	3	3
	Kembatatembaro Zone	5	4	4	3	3	4	4	5	4
	Hadiya Zone	3	4	3	3	2	2	2	3	4
	Damboya Woreda	5	2	4	5	5	4	5	3	5
	Hossana Town	4	3	3	4	4	4	3	4	3
Average Score		**4.56**	**3.75**	**4.06**	**4.18**	**3.68**	**3.93**	**4.12**	**4.18**	**4.25**

5.3 RELATION BETWEEN RRU AND QUALITY IMPROVEMENT

The relationship between expenditure from RRU and quality dimensions is positive, as shown in Figure 9. The quality score covers average scores of all six dimensions of quality in the sampled health centers. As expenditure from RRU has increased in the health centers (and provided all other factors

that may affect quality remain constant) in the five years under investigation, the quality score has also increased.[11]

Figure 9: Relationship between RRU expenditure and quality scores, 2008-2012 EFY



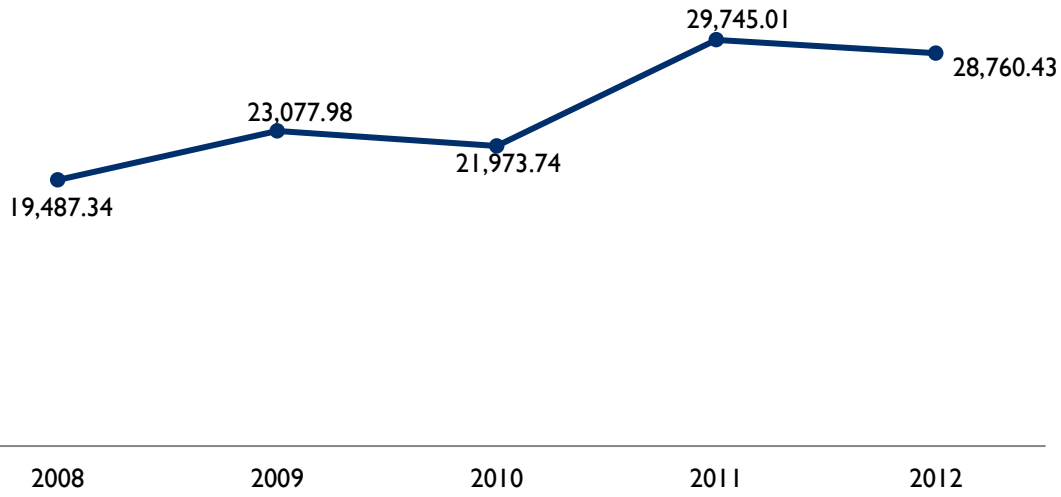
In terms of individual dimensions of quality, the findings from quantitative data and the perceptions reported in the qualitative survey show that safety is first in terms of both expenditure from RRU and progress made toward indicators of health service quality. Effectiveness comes next. There is expenditure from RRU on the efficiency dimension, but its quality achievement is minimal or non-existent. In contrast, expenditure from RRU on patient centeredness is minimal (10%). Its progress on quality might be attributable to other activities conducted by health centers or the absence of indicators to capture the contribution of RRU expenditure to this dimension; as discussed above, conducting public forums was used as a proxy.

5.4 TREASURY EXPENDITURE

Health center expenditure from treasury[12]has continuously grown during the period studied (Figure 10). In 2008 EFY, it was Birr 19.5 million; it reached Birr 29.7 million in 2011 EFY and declined slightly to Birr 28.8 million in 2012. The overall increment of expenditure from treasury in the five-year period was 47.7%.

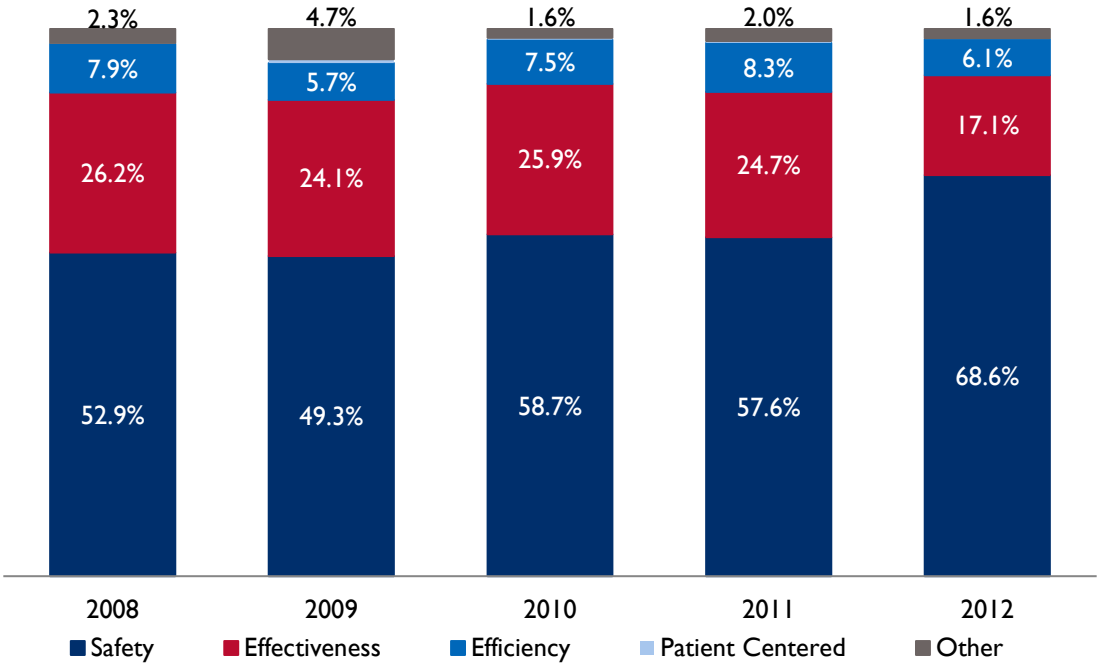
[11] The effects of other factors (other than expenditure) that may affect quality have not been controlled for or have not been taken into consideration.
[12] Treasury expenditure includes all operating and capital expenditures other than salary.

Figure 10: Treasury expenditure, 2008-2012 EFY ('000 birr)



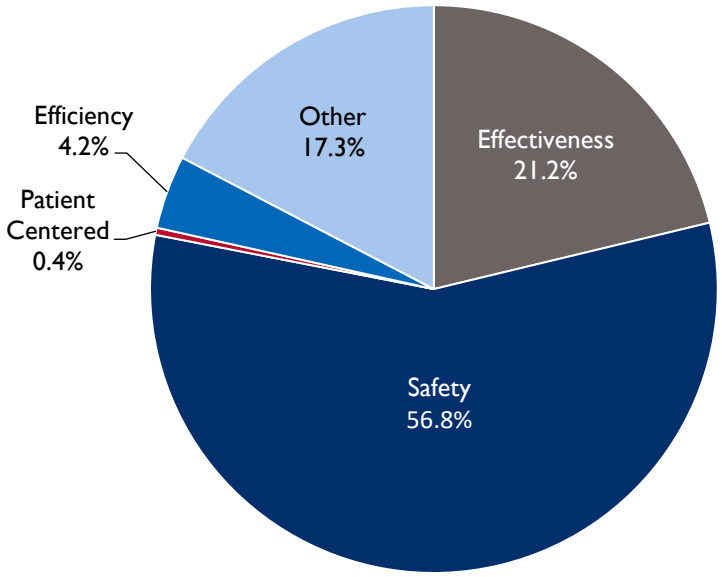
The expenditure from treasury on the safety dimension (49.3%-68.6%) constitutes a substantial proportion of the overall expenditure from treasury. By 2012, its share has grown to 68.6%. About a quarter of the treasury expenditure in 2008-2011 was for effectiveness; this share declined to 17.1% in 2012, due mainly to the rise in the share of expenditure on safety. Efficiency received expenditure from treasury from 5.7.%-8.3%, while patient centeredness received with the lowest share (.2%-.6%) of all the quality dimensions. Average expenditure from treasury on the others was 2.4%. Figure 11 shows the trends in treasury expenditure on the different quality dimensions in 2008-2012 EFY.

Figure 11: Trends in shares of expenditure from treasury on quality dimensions, 2008-2012 EFY (%)



The average shares of the quality dimensions for all five study years combined are summarized in Figure 12. In 2008-2012 EFY, 56.8% of expenditure from treasury was on safety, followed by effectiveness at 21.2%. Efficiency and patient centeredness were at 4.2% and 0.4%, respectively. The share of expenditure from treasury on others averaged 17.3%.

Figure 12: Average shares of expenditure from treasury on quality dimensions, 2008-2012 EFY



Trends in the amount of expenditure from treasury in the four dimensions of quality during the period of investigation are shown in Figure 13. As shown in the figure, the amount of expenditure for safety has increased throughout the period while expenditure in effectiveness, efficiency, and patient centeredness fluctuates in the study period.

Figure 13: Trends in treasury expenditure in four quality dimensions, 2008-2012 EFY ('000 birr)

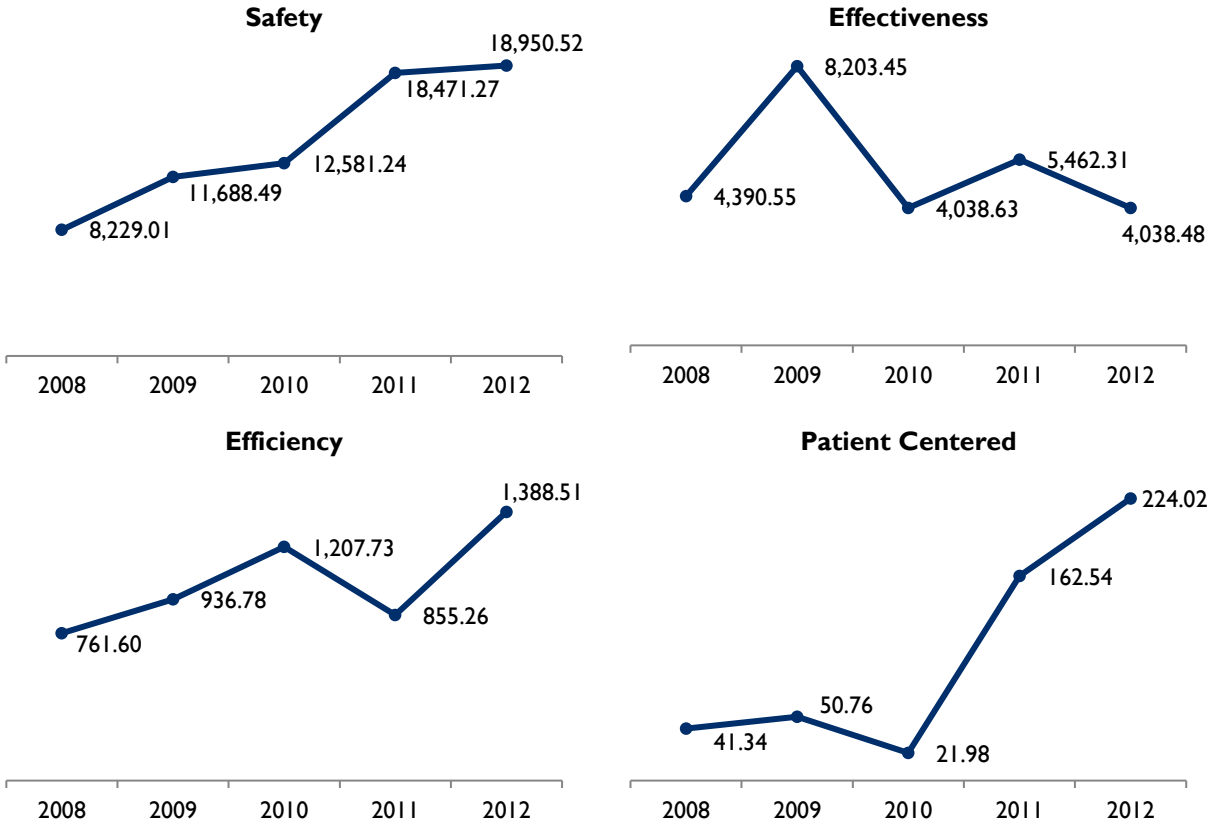


Table 3 summarizes the shares of expenditure from treasury expenditure on the major categories in each of the four quality dimensions over the 2008-2012 EFY period.

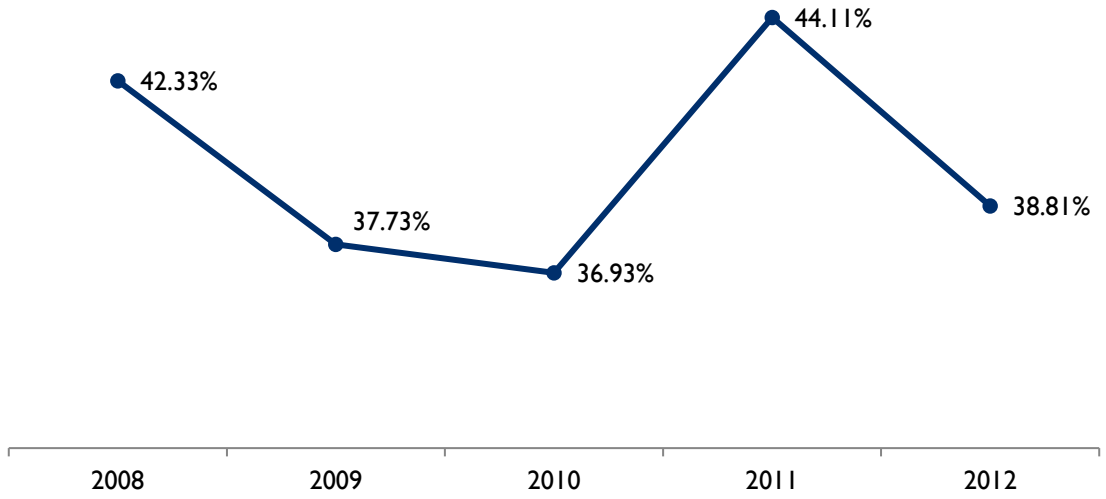
- Safety: Medicines and supplies constitute 88.9% of the expenditure on safety. The other two components within safety receive a low share of expenditure, infection prevention and control at 8.18%, and water supply at 2.85%.
- Effectiveness: Medical equipment and health education receive about 25.77% and 22.56% of expenditure from treasury on effectiveness respectively. The share going to building renovation and construction varied significantly from year to year but its average share over the five years was 27.80%. Expenditure on generator/solar panel also varied; the average share was 13.10%. The share spent on conferences was negligible, at 0.47%.
- Efficiency: The health information system consumes 97.32% of expenditure from treasury in the efficiency dimension; only 2.68% goes to research.
- Other: About 51.38% of the expenditure from treasury on items categorized as all other is spent on office supplies, 9.37% on office equipment and furniture, and 4.14% on delivery/childbirth food supplies. The three categories together receive 64.89% of the 'all other' expenditure. The remaining 35.11% of other total expenditures were spent on items that were different types and were not categorized.

Table 3: Share of treasury expenditure by quality dimension, 2008-2012 EFY

Quality Dimension	2008	2009	2010	2011	2012	Average
Effectiveness						
Medical Equipment	25.89	15.15	32.46	21.37	34.01	25.77
Buildings	12.53	54.28	25.62	28.93	17.62	27.80
Generator/Solar Panel	22.59	8.58	5.36	19.67	9.30	13.10
Training	7.69	5.76	11.61	9.43	17.04	10.31
Conferences	0.92	0.41	0.21	0.40	0.40	0.47
Health Education	30.39	15.83	24.75	20.20	21.61	22.56
Safety						
Medicines and Supplies	93.16	88.62	89.14	89.53	84.43	88.97
Water Supply	1.87	2.29	1.84	1.82	6.43	2.85
Infection Prevention and Control	4.97	9.10	9.01	8.65	9.14	8.18
Patient Centered						
Public Forum	100.00	100.00	100.00	100.00	100.00	100.00
Efficiency						
Research	1.93	1.96	1.02	3.77	4.70	2.68
Health Information System	98.07	98.04	98.98	96.23	95.30	97.32
All Other						
Office Equipment and Furniture	5.04	9.59	17.89	3.89	10.42	9.37
Office Supplies	67.57	36.91	42.29	57.57	52.58	51.38
Delivery Food Supplies	1.54	7.26	4.50	2.61	4.80	4.14
Other	25.85	46.24	35.32	35.93	32.20	35.11

Expenditure from treasury constituted between 37% and 44% of the non-salary operating and capital expenditure of health centers during the study period (Figure 14); this makes the expenditure from treasury a major contributor to their financing.

Figure 14: Share of treasury expenditure on non-salary operating and capital expenditure, 2008-2012 EFY



5.5 RRU AND TREASURY EXPENDITURES COMBINED

The combined expenditures from RRU and treasury show that there is no difference in terms of priority expenditure in relation to dimension of quality (Table 4).

Table 4: Percentage share of each quality dimensions to total RRU and treasury expenditure, 2008-2012 EFY

Quality Dimension	2008	2009	2010	2011	2012	Average
Effectiveness/(Total RRU + Treasury Total)	25%	28%	23%	22%	16%	23%
Safety/(Total RRU + Treasury Total)	48%	50%	58%	59%	67%	57%
Patient Centeredness/ (Total RRU + Treasury Total)	0%	00%	00%	00%	00%	00%
Efficiency/(Total RRU + Treasury Total)	6%	5%	7%	6%	6%	6%
Other/(Total RRU + Treasury Total)	21%	17%	12%	12%	11%	15%

Expenditure on safety and effectiveness constitutes the highest share of total expenditure (RRU and treasury). Expenditure on other (such as office furniture and supplies) constitutes a significant share while expenditure on patient centeredness remains the lowest share among the four dimensions of quality covered in this study. Expenditure on efficiency is encouraging compared to expenditure on patient centeredness. Table 4 also shows the trend of the share of each of the quality dimensions to total non-salary RRU and treasury expenditures.

6. CONCLUSION

RRU expenditure significantly (79%) increased between 2008 and 2012 EFYs. Treasury expenditure for non-salary operating and capital expenditure has also increased (47.7%) over the period, though at a lower rate than the RRU. RRU average expenditure on safety (57%) constitutes the highest average share followed by RRU expenditure on effectiveness (24%). RRU expenditure on patient centeredness constitutes the least of the quality dimensions considered. Expenditure from RRU on medicines and supplies constitutes more than 90% of its expenditure on safety. Expenditure from RRU on other areas (other than quality improvement activities), mainly office supplies, equipment, and furniture, is significant (12%).

The findings of the qualitative survey (health administrator, manager, and worker perceptions) produced findings similar to the quantitative findings. Regarding the perceived effect of RRU, the KIIs gave a high score to safety (4.25 out of 5), followed by effectiveness and equity (4.18). As expected, the KIIs also revealed that RRU has more effect on the structure of the facility (4.6) than on outcome (4.0) or process (3.75) of health services in the facility.

Like expenditure from RRU , the highest share of expenditure from treasury goes to safety (57%), and effectiveness gets the second largest share (21%).

In terms of covering the non-salary operating and capital cost of health centers, expenditure from RRU constitutes on average 55-60%, and expenditure from treasure covers the remaining 40-45%.

A positive relationship between expenditure from RRU and the quality score was observed by the study. Like expenditure from RRU , quality scores have increased. The overall quality score increased by 10% in 2008-2012, although there is variation across the quality dimensions. As expected, the improvement in the safety dimension of quality was the highest (22%) followed by effectiveness (20%). This relationship is directly in line with magnitude of expenditure made in each of these two quality dimensions.

The findings of the qualitative survey reaffirmed the critical contribution of RRU to the quality improvement of the health centers as the annual treasury allocation to facilities is not adequate to cover non-salary operational and capital expenditures. RRU is the main source of funding for non-salary operational costs. RRU has made possible the procurement of drugs and supplies, construction or renovation of buildings such as maternity homes, access to water and sanitation services, and cleanliness of the facility compound. In fact, an FGD revealed that "the performance of the health center is directly linked to RRU." RRU also allowed facilities the opportunity to invest in new initiatives coming from the city administration or the MOH. For example, implementation of CASH was possible because RRU contributed to the increase in patient satisfaction in the facilities. As a result of RRU and service improvements, patient flow has increased. In fact, as explained in one KII (Bahir Dar City Administration health office) "health-seeking behavior of the community has increased as a result of provision of quality services through RRU." RRU also has had a positive impact on CBHI membership renewals due to improvement in the quality of health services.

Despite the successes of RRU, the qualitative sessions revealed emerging challenges to its implementation. Limits on or absence of reimbursement for the exempted services that facilities provide and budget offsetting (decreasing the treasury budget as internal revenue increases) are the major challenges in all sample regions. Finance staff's limited knowledge of HCF issues at the health facility and finance sector levels because of high turnover is another major challenge, highlighted during the FGDs at health facilities in the three regions (Amhara, Oromia, and SNNP); this gap is not remedied by periodic trainings/orientations or supportive supervision to build staff capacity, and thus it affects the smooth implementation of RRU.

The negative list is considered too restrictive in some places, as it does not allow provision of incentives such as allocating a certain percentage of retained revenue to bonuses for best-performing staff or to payment of per diems for staff who travel when conducting drug procurement.

7. RECOMMENDATIONS

Based on the challenges established by the quantitative findings and in KIIs and FGDs, the following major recommendations are offered to increase the effectiveness of RRU in improving the quality of health service delivery. As the challenges affect every dimension of quality, the recommendations are mostly to improve quality of health services in general rather than targeting a single dimension of quality.

1. As health centers do annual planning and allocation of their RRU budget, they should consider the six dimensions of quality by allocating a minimum percentage of RRU budget to each dimension, based on their priorities, to balance quality improvement.
2. RHBs in consultation with regional finance bureaus should provide periodic training for new facility board members, and health and finance office staff at different levels (zone and woreda) to familiarize them with the priority areas of RRU expenditure and the financial rules and procedures governing the use of RRU.
3. The RHBs with the approval of the regional offices of the Civil Service Commission should regularly revisit the salary scale for health center finance staff to bring it in line with the salary scale of finance office staff in the region. Improving the salaries of health center finance staff is expected to reduce turnover.
4. The internal audit section of the health centers and the woreda finance offices should audit the health centers regularly (once in a year in the case of the woreda finance office) to identify any facility misuse of RRU to cover the costs of items that are not on the positive list.
5. Woreda health offices should conduct quarterly supportive supervision and coaching at the facility level and use regular performance review meetings to monitor performance of the facilities in improving the quality of health services using RRU.
6. Woreda health offices should remind the woreda finance offices that internal revenue is supposed to be additive to the treasury budget; there should be no budget offsetting when allocating the treasury budget to health centers.
7. The MOH and RHBs should ensure that a sufficient budget is allocated to the RHBs and woreda health offices to cover the costs of health center reimbursement requests for providing exempted services.
8. The RHBs (in regions where user fees have not been revised) should revise user fees taking into consideration the cost of health services and the population's ability and willingness to pay. Revision of user fees together with other factors that promote quality will help ensure the continuation of RRU to improve quality of health services.
9. The AACA Finance Bureau should harmonize the different types of bank accounts into one type (type A) that allows health centers to carry forward unspent revenue from the end of one year to the next year and use it when and as appropriate.
10. The Ethiopian Pharmaceuticals Supply Agency should address the shortage of drugs and supplies to meet the requests of health centers, as the safety and effectiveness dimensions of quality of care are directly linked to the availability of drugs and supplies at the facility level.

11. The MOH in consultation with RHBs should move the following items from the negative list to the positive list:
    a. Payment of a certain amount or percentage of RRU to motivate and reward best performing staff in the form of a bonus or as decided by the MOH and RHBs; and
    b. Payment of a per diem to staff assigned to procure drugs and supplies to cover the costs of meals and other expenses when they travel outside of their duty station in the conduct of their work.

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ANNEX A: RRU AND TREASURY EXPENDITURES DATA COLLECTION TOOL

Region:----------

Woreda:----------

Name of Health Center:----------

Name and Mobile # of contact person in the Health Center:----------

1. **Effectiveness: Expenditures from RRU and non-salary Treasury Sources to improve quality of care, 2008-2012 EFY in'000 Birr**

#	Expenditure Item/Year	2008		2009		2010		2011		2012	
		RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury
1	Purchase and maintenance of medical equipment										
2	Refurbishment, renovation, and construction of buildings										
3	Purchaser of generator/solar panel and its consumables										
4	Expenditures incurred for training of staff in quality improvement										
5	Expenditures to participate in quality summits/conferences										
6	Expenditures for health education, disease control and preventive services										

2. Safety: Expenditures RRU and Non-Salary Treasury Sources, 2008-2012 EFY in'000 Birr

#	Expenditure Item/Year	2008		2009		2010		2011		2012	
		RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury
1	Expenditure incurred for the purchase of essential -medicines and supplies										
2	Expenditure incurred for provision of water supply to the facility										
3	Expenditures on infection prevention and control										

3. Patient-Centered: Expenditures from RRU and Non-Salary Treasury Sources, 2008-2012 EFY in'000 Birr

#	Expenditure Item/Year	2008		2009		2010		2011		2012	
		RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury
1	Budget utilized for conducting public forums/patient feedback on quality of health care										

4. Efficiency: Expenditures from RRU and Non-Salary Treasury Sources, 2008-2012 EFY in'000 Birr

#	Expenditure Item/Year	2008		2009		2010		2011		2012	
		RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury
1	Budget allocated and utilized for research in the facility										
2	Budget allocated and utilized for health care information system to improve procedures										

5. Other (expenditures incurred that don't fall into the four dimensions of quality): Expenditures from RRU and Non-Salary Treasury Sources, 2008-2012 in'000 Birr

#	Expenditure item/Year	2008		2009		2010		2011		2012	
		RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury	RRU	Treasury
1	Transferred to Health Posts										
2											
3											

6. Health facility total annual expenditure, 2015/16-2019/2020 in'000 Birr

Expenditure Item	2008	2009	2010	2011	2012
Salary					
Non-Salary operating expenditure					
Capital Expenditure					
Total					

ANNEX B: QUALITY INDICATORS DATA COLLECTION TOOL

S. No	Name Indicator	2008 EFY		2009 EFY		2010 EFY		2011 EFY		2012 EFY	
		Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report
1	Proportion Births Attended by Skilled Health Personnel										
2	Health Centers implementing comprehensive Laboratory Quality Management System (LQMS)										
3	Outpatient attendance per capita										
4	Proportion of availability of essential drugs for Health Center										
5	Health facility uses EMR (Electronic Medical record)										
6	Health facilities with electricity & IT networking										
7	Health facility with adequate water and sanitation facilities										
8	Proportion of Board meeting sessions conducted timely										
9	Patient satisfaction rate										
10	Essential lab test availability										
11	Proportion of Budget Utilized										
12	Percentage of EHSTG operational standards for hospital reform met										
13	Percentage of non-Functional medical equipment										
14	Outpatient waiting time in minutes (annual average)										
15	Percentage of outpatients not seen on same day										

S. No	Name Indicator	2008 EFY		2009 EFY		2010 EFY		2011 EFY		2012 EFY	
		Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report	Health Facility Annual Report	Approved Woreda Report
16	Proportion of SLIPTA standards met										
17	Staff satisfaction rate										
18	% of Leadership and Governance chapter operational standards met by a health center										
19	% of patient flow chapter operational standards met by a health center										
20	% of medical record management chapter operational standards met by a health center										
21	% of pharmacy service chapter operational standards met by a health center										
22	% of laboratory service chapter operational standards met by a health center										
23	% of infection prevention and patient safety/CASH chapter operational standards met by a health center										
24	% of medical equipment and facility management chapter operational standards										
25	% of service quality improvement, documentation and reporting chapter operational standards										
26	Health center waiting time to treatment										
27	Outpatients seen per OPD on the same day										
28	Community score card										
29	Staff satisfaction rate										
30	Proportion of infants fully immunized										
31	Ratio of Outpatient attendance per capita Between Female and Male										

ANNEX C: KEY INFORMANT IN-DEPTH INTERVIEW GUIDES

The protocol for recruitment, enrollment, data collection, and documentation is as follows:

Pre-interview

- Familiarize yourself with interview guide.
- Practice interviewing
    - Brainstorm potential questions
    - Ask follow-up questions.
    - Probe for clarifications
- Practice using the audio recorder.
- Bring recorder, interview guide, and notebook.
- Arrive to the site and each interview on time.
- Set up recording equipment, secure physical space.
- Fill out key informant information sheet.
- Administer informed consent from participant.

Interview

- Record the interview.
- Take brief back-up notes during interview.
- Turn off audio recorder when finished.
- If a referral is made, schedule a time with prospect study participant.
- Write reflection as soon as possible after the interview.
- Upload the audio-recording to laptop and label the file name as {Study ID_location_date}

C.1 Key Informant Information Sheet

S. No	Interviewee Code	Key Informant Code	Sex	Age	Name of Facility/ Institution	Title/Position			How Long Have You Been Working in this RHB/ZHD/	How Long Have You Been Working in This Present Position	Interviewer (Code, 11, 12)
						Diploma	Degree	Master			
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											

S. No	Interviewee Code	Key Informant Code	Sex	Age	Name of Facility/ Institution	Title/Position			How Long Have You Been Working in this RHB/ZHD/	How Long Have You Been Working in This Present Position	Interviewer (Code, 11, 12)
						Diploma	Degree	Master			
23											
24											

Keynote for Code

O	Oromia
A (first)	Amhara
T	Tigray
S	SNNP
RB	Regional Health Bureau
Z	Zonal Health Department
W	Woreda Health Office
A (third)	First Woreda Health office interviewed
B	Second Woreda Health Office interviewed
1	First Interviewee
2	Second Interviewee

C.2 Key Informant Interview

FIRST: *Interviewer MUST verify that informed consent is signed by the interviewee*

Verification of informed consent? (CIRCLE ONE): YES NO

Interviewee position (circle one): a. Head of health office (Region Zone, Woreda)
b. CEO of Health facility c. Medical Director of health facility d. Other_____

General introduction:

Hello, my name is _____. Thank you for agreeing to talk to me/us today. We are here to talk with you as part of Health Financing Improvement Program that supports health financing reform in the country. As the (title of interviewee), your experience and thoughts about health facility Revenue Retention and Utilization (RRU) are critical to our understanding of the strengths and weaknesses of the RRU and its effect on service quality. We would like to thank you for agreeing to participate in this interview. Today, we would like to talk with you briefly about the RRU, and specifically about its contribution towards health service quality. We would like to learn about how the RRU is implemented in your (administration or facility) and its effects on the health facility performance and service quality. I/we will be asking you some questions which you are free to answer in any way you wish. You may also choose not to answer any question. We encourage you to feel free to say anything concerning the topic of discussion. If a question is unclear to you, you can ask me to explain it. Your participation is voluntary and confidential.

Whatever you tell us will be treated with utmost confidentiality. The information will only be used for the purposes of this evaluation.

I would like to request that you all allow me to record our discussion so that I don't miss anything. Your voice will not be heard by anyone other than the people here and our study transcriber. Your name and location will not be recorded and will not appear on the transcription. The tapes will be destroyed after we have prepared our transcripts.

Is it okay if I tape record our discussion? YES NO

C.3 ቁልፍ መረጃ ሰጭ ቃለመጠይቅ:

መጠይቅ

መጀመሪያ: *ቃለ መጠይቅ የሚያደርገው ሰው በእውቀት ላይ የተመሠረተ ስምምነት በቃለ መጠይቁ ላይ መስጠቱን መረጋገጥ አለበት*

የስምምነት ማረጋገጫ ሰጥቶል?(ምርጫው ይከበብ): **አዎ** **አልሰማማም**

ጤና ይስጥልኝ ፣ ስሜ _____ ነው። ዛሬ ከእኔ/ከኛ ጋር ለመነጋገር ስለተስማሙ እናመሰግናለን። እዚህ የመጣነው በሀገሪቱ የጤና በጀት መሻሻልን የሚደግፍ የጤና ፋይናንስ ማሻሻያ ፕሮግራም አካል በመሆን ከእናንተ ጋር ለመነጋገር ነው። እንደ ርዕስ በቃለ መጠይቁ ስለ ጤና ተቋማት ገቢ አሰባሰብ እና አጠቃቀም ተሞክሮዎን እና ሀሳብዎን ጠንካራ እና ደካማ ጎኖች እና በአገልግሎት ጥራት ላይ የሚያሳድረውን ተጽዕኖ ለመረዳት ነው:: በዚህ ቃለ መጠይቅ ላይ ለመሳተፍ ስለተስማሙ እናመሰግናለን። ዛሬ ስለ ገቢ አሰባሰብ እና አጠቃቀም እና በተለይ ለጤና አገልግሎት ጥራት ስላበረከተው አስተዋጽኦ በአጭሩ ልንጠይቅዎ እንፈልጋለን ። ገቢ አሰባሰብ እና አጠቃቀም በእርስዎ አስተዳደር ወይም ተቋም ውስጥ እንዴት እንደሚተገበር እና በጤና ተቋማት አሰራር እና በአገልግሎት ጥራት ላይ ስለሚያስከትለው ውጤት ለማወቅ እንወዳለን:: ጥያቄዎችን በሚፈልጉት መንገድ ለመመለስ ነፃ ይሁኑ በተጨማሪም አንዳንድ ጥያቄዎችን መልስ አለመስጠት ይቻላል። ውይይቱን በተመለከተ ማንኛውንም ነገር የመናገር ነፃነት እንዲሰማዎ እናበረታታለን አንድ ጥያቄ ግልጽ ካልሆነልዎ እንዲብራራ ሊጠይቁ ይችላሉ።

የእርስዎ ተሳትፎ በፈቃደኝነት እንዲሁም ምሥጢራዊነቱ የተጠበቀ ነው ነው። መረጃው ጥቅም ላይ የሚውለው ለዚህ ግምገማ ዓላማ ብቻ ነው::

ምንም ነገር እንዳያልፈን የሁላችንንም ውይይታችንን እንድቀርጽ እንዲፈቅዱልኝ ልጠይቃ እወዳለሁ። እዚህ ካሉት ሰዎችና ከጥናታችን ተሳታፊ ውጪ ማንም ሰው ድምፅዎን አይሰማም። ስም እና ቦታዎም አይመዘገብም፤ እንዲሁም በጽሑፉ ላይ አይታይም። ጽሁፎቻችንን ካዘጋጀን በኋላ የድምጽ መረጃዎቹ ይጠፋሉ።

C.4 Gaaffii Dhuunfaa

Jalqaba: Namni gaaffii gaafatu foormiin waliigaluu isaa ibsu nama gaafatamuun mallattaa'uu isaa mirkaneessuu qaba.

Mirkaneessa namni gaafatamu waliigaluu? (Tokkotti mari) Eeyye Miti

Gahee hojii nama gaafatamuu (Tokkotti mari): a. Ittigaafatamaa (Biiroo, Godina, Aanaa) b. Hojii gaggeessaa dhaabbata fayyaa c. Meedikaal daarekitarii dhaabbata fayyaa d. kan biroo

Seensa Waliigalaa

Akkam, maqaan koo ---------- jedhama. Har'a nu waliin haasa'uuf waliigaluu keef galatoomi. Nuti kan asitti argamnee haasa'uu barbaadneef qaama Sagantaa Fooyya'iinsa Faayinaansigii Fayyaa taanee riifoormii faayinaansingii fayyaa biyyoolessaa kan deeggarru dha.

Ati akka gaafatamaa tokkotti waa'ee galii dhaabbata fayyaa sassaabuu fi ittifayyadamuu ilaalchisee muuxannoo fi yaadni nuuf kennitu gama kanaan cimnaa fi dadhabbina jiru fi bu'aan inni qulqullina tajaajila fayyaa irratti qabu adda baasuuf hubannoo keenyaaf murteessaa waan ta'eefidha. Ati gaaffii fi deebii kana keessatti hirmaachuuf waliigaluu keef galatoomi jenna. Har'a kan waliin haasofnu gabaabbinaan waa'ee galii dhaabbata fayyaa sassaabuu fi ittifayyadamuu ta'ee addatti bu'aan inni qulqullina tajaajila fayyaa irratti qabu ta'a. Wanti barachuu barbaadnu naannoo/dhaabbata fayyaa keessan keessatti haala hojiirra oolmaa galii sassaabuu fi ittifayyadamuu fi dhiibbaan inni raawwii hojii dhaabbata fayyaa fi qulqullina tajaajila fayyaa irratti qabu maal akka ta'e baruufidha.

Nuti gaaffiilee muraasa waan sigaafannuuf bilisaa fi haala barbaaddeen nuuf deebisuu dandeessa. Gaaffilee dhiyaatan kana keessaa deebii itti kennuu kan hin barbaadne yoo jiraate dhiisuu ni dandeessa. Mata duree marii irratti gaggeessinu irratti ifa taatee akka gaafattu si jajjabeessina. Gaaffiin dhiyaate ifa kan hin taane yoo ta'e, ibsi akka itti kennamu na gaafachuu dandeessa. Hirmaannaan keessan fedhiin akka ta'ee fi iccitiin kan eegamudha. Odeeffannoon nuuf kennitu kamiyyuu iccitiin isaa kan eegamu dha. Odeeffannoon kunis dhimma gamaaggama jedhameef qofa kan oolu dha.

Mariin keenya harcaatii malee akka qabamuuf waraabuu waanan barbaadeef hunda keessan heyyaman gaafadha. Sagaleen waraabbame namoota asitti argamanii fi nama qorannoo kana barreessu irraan kan hafe qama kamiinuu kan dhageeffatamu miti. Maqaa fi iddoon teessoo keessanii kan hin waraabamnee fi barreeffama irrattis kan mul'atu miti. Meeshaaleen waraabbii sagalee akkuma sagaleen kun qaama afaan birootti jijjiiru fudhatameen kan dhabamsiifamu ta'a.

Sagalee marii keenyaa akkan waraabuuf heyyamtanii jirtuu? Eeyye Miti

C.5 Interview Guide at RHB and ZHO

1. RHB/ZHD/			
Name of Region/Zone/:			
Region/ :			
Number of Woredas in the RHB/Zone/:	Number of Health Centers/HP:	Number of Primary Hospitals:	Name of General Hospital:
Catchment population of the Zone/woreda/facility:			
Contact Person for the Assessment (Code):		Contact Person for the Assessment (Code):	
Name:		Name:	
Title/Position:		Title/Position:	
Mobile:		Mobile:	
Office Telephone:		Office Telephone:	
Date of Assessment (dd/mm/yy):		Date of Assessment (dd/mm/yy):	
Assessment Team Members (name):		Assessment Team Members (name):	

C.6 የቃለመጠይቁ መመሪያ በክልል እና በዞን ለሚደረግ

1. ክልል ጤና ቢሮ/ ዞን ጤና መምሪያ			
ክልል ጤና ቢሮ/ ዞን ጤና መምሪያ ስም:			
ክልል:			
የወረዳ ብዛት:	የጤናጣቢያ ብዛት:	የመጀመሪያ ሆስፒታል ብዛት:	የጠቅላላ ሆስፒታል ብዛት:
የአገልግሎት ተጠቃሚ ህዝብ ብዛት:			
ለመጠይቁ ተጠሪ መለያ:		ለመጠይቁ ተጠሪ መለያ:	
ስም:		ስም:	
የስራ ድርሻ:		የስራ ድርሻ:	
ሞባይል ቁጥር:		ሞባይል ቁጥር:	
የቢሮ ስልክ ቁጥር:		የቢሮ ስልክ ቁጥር:	
ቀን:		ቀን:	
የመጠይቅ ቡድን:		የመጠይቅ ቡድን:	

C.7 Gaaffii Sadarkaa Biiroo Eegumsa Fayyaa Naannoo fi Waajjira Eegumsa Fayyaa Godinaa

1. BEFN/WEFG			
Maqaa Godinaa:			
Naannoo:			
Baay'ina aanaalee:	Baay'ina BF/KF:	Baay'ina hospitaala sadarkaa jalqabaa:	Baay'ina hospitaala waliigalaa:
Baay'ina ummata godinaa/aanaa/dhaabbata fayyaa:			
Koodii nama odeeffannoo kenne:		Koodii nama odeeffannoo kenne:	
Maqaa:		Maqaa:	
Gahee hojii:		Gahee hojii:	
Lakk. mobaayilii:		Lakk. mobaayilii:	
Lakk. bilbila waajjiraa:		Lakk. bilbila waajjiraa:	
Guyyaa ragaan sassaabame (guyyaa/ji'a/waggaa):		Guyyaa ragaan sassaabame (guyyaa/ji'a/waggaa):	
Maqaa miseensota garee qorannoo:		Maqaa miseensota garee qorannoo:	

C.8 Interview Questionnaire

Interview questions	Probing questions
Rapport building session	**Self-introduction, objective of meeting, verbal consent, recoding** (*just reminder the above consent and objective of the study*)
1. Role in RRU *"To begin, can you please tell me about your role in RRU?"*	• Do you engage in the planning for RRU? • Do you conduct RRU supervision? • Do you train others in RRU?
2. Knowledge of RRU *"Let's briefly discuss the RRU in the (facility, Woreda, Zone, and Region).*	• How long RRU implemented in the ….? • How many facilities implemented RRU in the …(Woreda, Zone, Region) • How is the trend of RRU in the (facility, Woreda, Zone, Region)
3. Role on the facility *"Now we would like to discuss your overall impressions about implementation of RRU in the facility here. In your opinion, how is the RRU working here?*	• What are the advantages of RRU to the facility? • What are the challenges faced in the facility due to RRU?
4. Effect of RRU on health facility performance and service Quality *"Now let's talk about effect of RRU in the facility. We would like to know your opinion on this Health Financing Reform component. What, in general, is your opinion on RRU?*	• How do you think RRU effect the facility performance? • How do you think RRU effect health facility motivation? • How do you think RRU effect patient satisfaction? • What advantages do RRU bring for the health facility? • What drawbacks do RRU bring for the health facility itself? • For you, specifically, how do you think RRU influence your performance and motivation? • How does the positive and negative list of services for the RRU effect the delivery of quality health service? • How does RRU effect your relationship with the governance board? • How does RRU effect your relationship with the community and community representatives?

Interview questions	Probing questions
5. Perceived effect of RRU on Quality	• In your opinion, what is the effect of RRU on health service quality dimensions? Rate its contribution towards the following with a scale from 1 to 5 1. Donabedian trilogy a. Structure b. Process c. Outcome 2. Ministry of Health dimensions of quality a. Effectiveness b. Efficiency c. Timely d. Person centered e. Equity f. Safe • What other key contributions of RRU would you like to tell us
6. Future of RRU *"Now let's talk your recommendations for the future of the national RRU. How could the current RRU be improved?*	• How could RRU further improve health service quality? • How could RRU management improved? • How could RRU better benefit health facility staff?
7. Any other comment Are there any final thoughts you have about RRU?	

C.9 ቃለ መጠይቅ ስብስብ

የቃለ መጠይቅ ጥያቄዎች	ለውይይት የሚጋብዙ ጥያቄዎች
የመግቢያና የመተዋወቂያ ክፍለ ጊዜ	ራስን ማስተዋወቅ፤የስብሰባ ዓላማ፤ለመጠይቁ የቃላት ስምምነትን ማግኘት እና ቀረጻ መጀመር (ከላይ ያለውን ስምምነት እና የጥናቱን ዓላማ ለማስታወስ)
1. በገቢ አሰባሰብ እና አጠቃቀም አስተዋጽዎ "ለመጀመር እባክዎን በገቢ አሰባሰብ እና አጠቃቀም ውስጥ ስላለዎ ሚና ይንገሩኝ?"	• በገቢ አሰባሰብ እና አጠቃቀም እቅድ ውስጥ ይሳተፋሉ? • የገቢ አሰባሰብ እና አጠቃቀም ቁጥጥርን ያካሂዳሉ? • በገቢ አሰባሰብ እና አጠቃቀም ዙሪያ ሌሎችን ያሠለጥኑታል?
2. ስለ ገቢ አሰባሰብ እና አጠቃቀም እውቀት "ስለ ገቢ አሰባሰብ እና አጠቃቀም በተቋም፤በወረዳ፤ዞን ወይም በክልል ውስጥ በአጭሩ እንወያያለን፡፡	• ምን ያህል ጊዜ የገቢ አሰባሰብ እና አጠቃቀም (በተቋሙ/በወረዳው/በዞን/በክልል) ተተገበረ ? • በምን ያህል ተቋም ወይም ወረዳ ውስጥ ተተገበረ ? • የገቢ አሰባሰብ እና አጠቃቀም ተሞክሮ እንዴት ነው?
3. ገቢን መሰብሰብ እና በመጠቀም በተቋሙ ላይ ያለው ሚና "አሁን ስለ የገቢ አሰባሰብ እና አጠቃቀም አፈፃፀም አጠቃላይ ግንዛቤዎችዎን ለመወያየት እንፈልጋለን፡፡ በእርስዎ አስተያየት በተቋምዎ የሚሰራው እንዴት ነው?	• ገቢን መሰብሰብ እና መጠቀም ለተቋሙ ያለው ጥቅሞች ምንምን ናቸው? • በገቢ አሰባሰብ እና አጠቃቀም ምክንያት በተቋሙ ውስጥ ያጋጠሙ ተግዳሮቶች የትኞቹ/ምንምን ናቸው?
4. በጤና ተቋማት አፈፃፀም እና በአገልግሎት ጥራት ላይ የገቢ አሰባሰብ እና አጠቃቀም ውጤት "*አሁን በተቋሙ ውስጥ የገቢ አሰባሰብ እና አጠቃቀም ውጤት በጤና ፋይናንስ ማሻሻያ ክፍል ላይ ያለውን ተጽእኖ አስተያየትዎን ማወቅ እንፈልጋለን፡፡* *በአጠቃላይ የገቢ አሰባሰብ እና አጠቃቀም ውጤት "ላይ ምን አስተያየት አለዎት?*	• ገቢን መሰብሰብ እና መጠቀም በተቋም አፈፃፀም ለይ ያለው አስተዎጽኦ እንዴት ይመስልዎታል? • ገቢን መሰብሰብ እና መጠቀም የጤና ተቋማት የስራ ተነሳሽነት ላይ ያለው አስተዋጽኦ እንዴት ይገልጹታል? • ገቢን መሰብሰብ እና መጠቀም በጤና ተቋማት የታካሚ እርካታን ላይ የሚኖረው አስተዋጽ እንዴት ያስባሉ? • ገቢን መሰብሰብ እና መጠቀም ለጤና ተቋማት ምን ጥቅሞች አሉት? • ገቢን መሰብሰብ እና መጠቀም በተቋሙ ምን ዓይነት መሰናክሎች አስከትሎል? • ለእርስዎ, ገቢን መሰብሰብ እና መጠቀም በተለይም, በስራ አፈፃፀምዎ እና ተነሳሽነትዎ ላይ ያለው አስተዎጽኦ ምን ይመስላል? • በገቢን መሰብሰብ እና መጠቀም ሂደት የሚካተቱ እና የማይካተቱ አገልግሎቶች በጤና አገልግሎት ጥራት ላይ ያላቸው አስተዎጽኦ ምን ይመስላል? • ከተቋሙ ቦርድ ጋር ባለዎትን ግንኙነት ላይ ገቢን መሰብሰብ እና መጠቀም ምን አስተዎጾ አለው? • ከህብረተሰቡና ከማህበረሰብ ተወካዮች ጋር ባለዎት ግንኙነት ላይ ገቢን መሰብሰብ እና መጠቀም እንዴት አይነት አስተዋጾ አለው?

የቃለ መጠይቅ ጥያቄዎች	ለውይይት የሚጋብዙ ጥያቄዎች
5. በግንዛቤ ደረጃ ገቢን መሰብሰብ እና መጠቀም በጤና አገልግሎት ጥራት ላይ ያለው ውጤት	በአስተያየትዎ ውስጥ, በጤና አገልግሎት ጥራት ልኬቶች ላይ የ ገቢን መሰብሰብ እና መጠቀም ውጤት ምንድነው? (ከ 1 እስከ 5 ባለው ልኬት ተከትለው የአስተዋጽኦውን ደረጃ ይስጡ::) 1. በዶናቤዲያን ትሪሎጂ ፤ዋና የአገልግሎት ጥራት ልኬቶች ሀ. መዋቅር ለ. ሂደት ሐ. ውጤት 2. የጤና ሚኒስቴር የአገልግሎት ጥራት ልኬቶች ሀ. ውጤታማነት ለ. ውጤታማነት በውስን ሀብት(ግብአት እና ጊዜ) ሐ. ወቅታዊ መ. ሰው ተኮር/ሰውን ያማከለ ሠ. ፍትሃዊነት ረ. ደህንነቱ የተጠበቀ • ገቢን መሰብሰብ እና መጠቀምን የተመለከተ ሌሎች ቁልፍ አስተዋጽኦ ሊነግሩን ይፈልጋሉ?
6. የወደፊቱ የገቢ አሰባሰብ እና አጠቃቀም "አሁን ለብሔራዊ የገቢ አሰባሰብ እና አጠቃቀም ዙሪያ ለወደፊቱ ምክሮችዎን እንነጋገር :: የአሁኑ የገቢ አሰባሰብ እና አጠቃቀም እንዴት ሊሻሻል ይችላል?	• ገቢን መሰብሰብ እና መጠቀም የጤና አገልግሎትን ጥራት ይበልጥ ማሻሻል የሚችለው እንዴት ነው? • የገቢ አሰባሰብ እና አጠቃቀም አስተዳደር የሚሻሻለው እንዴት ነው? • የገቢ አሰባሰብ እና አጠቃቀም ሂደት የጤና ተቋማት ሠራተኞች የተሻለ ተጠቃሚ ሊደርግ የሚችለው እንዴት ነው?
7. ሌላ (ተጨማሪ) አስተያየት፤ ስለ የገቢ አሰባሰብ እና አጠቃቀም ያለዎት የመጨረሻ ሀሳቦች ይግለጹ?	

C.10 Gaaffilee

Gaaffilee	**Xiinxala gaaffilee**
Kutaa waliigaltee	**Of-beeksisuu, kaayyoo walgahii, heyyama afaanii, waraabuu (Heyyamaa fi kaayyoo qorannichaa)**
1. Gahee hojii galii sassaabuu fi itti fayyadamuu irratti qabdu *"Jalqabuuf, gaheen ati galii sassaabuu fi ittifayyadamuu irratti qabdu natti himi?"*	• Karoora galii sassaabuu fi itti fayyadamuu keessatti ni hirmaattaa? • Hordoffii galii sassaabuu fi itti fayyadamuu irratti ni gaggeessitaa? • Galii sassaabuu fi ittifayyadamuu irratti namoota biroof leenjii kennitee jirtaa?
2. Beekumsa galii sassaabuu fi ittifayyadamuu irratti qabdu *"Gabaabbinaan beekumsa galii keessaa sassaabuu fi ittifayyadamuu irratti sadarkaa dhaabbata fayyaa, aanaa, godinaa fi naannootti jiru.*	• Galii sassaabuu fi ittifayyadmuu yeroo meeqaaf hojiirra oolchanii akka jiran ….? • Galii sassaabuu fi ittfayyadamuu dhaabbilee fayyaa meeqa keessatti akka hojii oole(Aaanaa, Godina, Naannoo) • Galii sassaabuu fi ittifayyadamuu irratti tireendiin/adeemsi jiru maal akka fakkaatu (Dhaabbata Fayyaa, Aanaa, Godina, Naannoo)
3. Gahee hojii dhaabbata fayyaa *"Amma kan mar'atnu yaada waliigalaa hojiirra oolmaa galii keessaa sassaabuu fi ittifayyadamuu dhaabbata fayyaa asi jiruuti. Akka yaada keetti galii keessaa sassaabuu fi ittifayyadamuun asitti akkamitti hojjetamaa jira?*	• Faayidaaleen galii sassaabuu fi ittifayyadamuu dhaabbata fayyaa keessaniif qabu maal maal? • Rakkoolee galii sassaabuu fi ittifayyadamuu irratti dhaabbata fayyaa keessan keessatti mul'ate?
4. Bu'aa galii sasssaabuu fi ittifayyadamuun raawwii hojii dhaabbata fayyaa fi qulqullina tajaajila fayyaa irratti qabu. *"Mee bu'aa galii sassaabuu fi ittifayyadamuun raawwii hojii dhaabbata fayyaa irratti qabu yaa haasofnu. Wanti beekuu barbaadnu yaada ati kompooneentii riifoormii faayinaansingii fayyaa irratti qabdu. Akka waliigalaatti yaadni galii sassaabuu fi ittifayyadamuu irratti qabdu?*	• Bu'aa galii sassaabuu fi ittifayyadamuun raawwii hojii dhaabbata fayyaa irratti qabu? • Bu'aa galii sassaabuu fi ittifayyadamuun kaka'umsa hojjettoota dhaabbata fayyaa irratti qabu? • Bu'aa galii sassaabuu fi ittifayyadamuun ittiquufinsa dhukkubsataa irratti qabu? • Faayidaalee galii sassaabuu fi ittifayyadamuun dhaabbata fayyaaf qabu? • Miidhaa galii sassaabuu fi ittifayyadamuun dhaabbata fayyaa irratti qaqqabsiisu? • Si'iif addatti, bu'aan galii sassaabuu fi ittifayyadamuun hojii fi kaka'umsa kee irratti qabu? • Galii sassaabuu fi ittifayyadamuu keessatti tartiibni hojiiwwan heyyamamanii fi dhorkaman bu'aan isaan kenniinsa qulqullina tajaajila fayyaa irratti qaban akkam?

Gaaffilee	Xiinxala gaaffilee
	• Bu'aan galii sassaabuu fi ittifayyadamuu walitti dhufeenya boordii waliin jiru akkam? • Bu'aan galii sassaabuu fi ittifayyadamuu walitti dhufeenya hawaasaa fi bakka bu'aa hawaasaa waliin jiru akkam?
5. Bu'aawwan beekamaa galii sassaabuu fi itti fayyadamuun qulqullina tajaajila fayyaa irratti qabu	Akka yaada keessanitti, bu'aan galiin sassaabuu fi itti fayyadamuun qulqullina tajaajila fayyaa irratti qabu? Haala safartii armaan gadiiti kennameen gumaachi galii sassaabuu fi itti fayyadamuun qulqullina tajaajila fayyaa irratti qabu madaallii 1 hanga 5tti kenni 1. Akkaataa Trilojii Doonabeediiyaan tti/Donabedian trilogy a. Caasaa/ Structure b. Adeemsa /Process c. Firii /Outcome 2. Akkaataa Qulqullinaa Ministeerri Fayyaa Kaa'utti a. Bu'a qabeessummaa/Effectiveness b. Gahumsa/Efficiency c. Yeroo/Timely d. Maamilota/namoota irratti/Person centered e. Haqa qabeessummaa/Equity f. Miidhaa kan hingeesisne/Safe • Kan armaan olitti caqasameen alatti, faayidaa galiin keessaa qulqulina tajaajila fayyaa irratti qabu kan biroo yoo jiraate ibsaa.
6. Fulduree galii sassaabuu fi ittifayyadamuu "Amma immoo fulduree galii sassaabuu fi ittifayyadamuu irratti yaada isin qabdan haa mari'atnu. Gara fuuladuratti galii sassaabuu fi ittifayyadamuun akkamitti fooyya'uu danda'a.	Galii sassaabuu fi ittifayyadamuun qulqullina tajaajila fayyaa irra caalaa akkamitti fooyyessuu danda'a? Bulchiinsi galii sassaabuu fi ittifayyadamuu akkamitti fooyya'uu danda'a? Galii sassaabuu fi ittifayyadamuun faayidaa hojjatoota dhaabbilee fayyaa haala kamiin fooyyeessuu danda'a?
7. Yaadni hafe yoo jiraate Galii sassaabuu fi ittifayyadamuu irratti yaadni hafe yoo jiraate ibsaa.	

C.11 Interview Reflection Sheet

Participant ID number:

Type of participant:

Date of interview:

Place of interview:

Language interview was conducted in:

Interviewer ID number:

Interview highlights:

Please give a short collection of core findings from the interview you had just conducted. These five to ten bullet points should describe the essence of the participant's account and highlight what is distinctive about it.

Any surprising findings?

Do you think the participant was being forthcoming with his/her answers? Yes/No.

C.12 ቃለ ምልልስ መግለጫ

የተሳታፊ መለያ ቁጥር

የተሳታፊ ስራ ድርሻ (ዓይነት):

የቃለ መጠይቅ ቀን: -

የቃለ መጠይቅ ቦታ: -

ቋንቋ ቃለመጠይቅ የተካሂደበት: -

ቃለ-መጠይቅ ጠያቂው መለያ ቁጥር

የቃለ ምልልስ መጠቅለያ : -

እባክዎን ከተካሄደው ቃለ-መጠይቅ ዋና ዋና ግኝቶችን አጭር ማጠቃለያ ይስጡ፡፡ እነዚህም ከአምስት እስከ አስር በማይበልጥ የተሳታፊውን ሐሳብ ጠቅለል ባለመልኩ መግለፅ አለባቸው እናም ልዩ የሆኑትንም ሀሳቦች ጎላባለ ሁኔታ ይግለጹ.

ማንኛውም አስገራሚ/ለየት ያሉ ግኝቶች?

ተሳታፊው እርስዎ በሚጠብቁት መልኩ እየመለሱ ያለ ይመስልዎታል? አዎ አይ.

C.13 Argannoo Gaaffii Kan Irratti Cuunfamu/Interview Reflection Sheet

Lakkofsa eenyummaa hirmaataa:

Akaakuu :

Guyyaa Gaaffiin ittigaggeefame:

Bakka gaaffiin ittigaggeefame:

Afaan gaafichi ittiingaggeeffame:

Lakkofsa eenymmaa gaafataa/interviewer ID #:

Waa'ee gaafichaa:

Gaaffii gaggeessite irratti argannoo ijoo fi adda ta'e qabxilee 5 hanga 10 tti armaan gaditti caqasameen ibsi.

Argannoon addaa fi aja'ibsiisaa ta'e maalidha?

Namni gaafatame/hirmaatan gaaffii gaafatameef deebii kenneera jettee yaaddaa? Eeyye/Miti?

ANNEX D: FGD GUIDES FOR HEALTH FACILITY STAFF / GOVERNANCE BOARD

D.1 FGD on RRU with Health Facility Staff / Governance Board (English)

1. Ice breaker

   "*Before we begin, let's just go around the group and each person give us just a few words or one sentence on how you would describe the RRU here.*

   (Keep it to a few words per person or a single sentence)

2. Knowledge of RRU

   "Let's begin by briefly discussing the RRU services. How would you describe the RRU in your facility/woreda?"

   Probes

   The Revenue retention mechanism?

   Planning for Revenue utilization?

   Prioritization for revenue utilization? Anyone else involved in such prioritization?

   Negative and positive lists of RRU

3. Utilization of RRU

   "Now we would like to discuss your overall impressions about implementation of the RRU in your facility/woreda. In your opinion, how is the RRU being implemented?

   Probes

   What are the advantages of RRU to the facility?

   What are the challenges faced utilizing RRU?

4. Effect of RRU on health facility performance and quality

   "Now let's talk about the effect of RRU on your facility performance and service quality. We would like to know your opinion on this program impact. What, in general, is your opinion on its effect?

   Probes

   How do you think RRU affect the facility performance?

   How do you think RRU affect health facility motivation?

   How do you think RRU affect patient satisfaction?

   What advantages do RRU bring for the health facility?

   What drawbacks do RRU bring for the health facility itself?

For you, specifically, how do you think RRU influence your performance and motivation?

How does RRU affect your relationship with the governance board?

How does RRU affect your relationship with the community and community representatives?

5. Perceived effect of RRU on Quality

   In your opinion, what is the effect of RRU on health service quality dimensions? Rate its contribution towards the following with a scale from 1-5

   i. Donabedian trilogy
      a. Structure
      b. Process
      c. Outcome
   ii. Ministry of Health dimensions of quality
      a. Effectiveness
      b. Efficiency
      c. Timely
      d. Person centred
      e. Equity
      f. Safe

- Any other effect of RRU on quality?

6. Future of RRU

   "Now let's talk your recommendations for the future of the national RRU. How could the current RRU be improved?

   Probes

   How could RRU further improve health service delivery/quality?

   How could RRU management improved?

   How could RRU better benefit health facility staff?

   What if RRU ended? What effect would that have on this facility?

7. Any other comment

   Are there any final thoughts you have about RRU?

END OF SESSION

"Now we have come to the end of our discussion. Thank you for your active participation

D.2 የተመረጡ ቡድን ውይይት በገቢ አሰባሰብና አጠቃቀም ዙሪያ ከባለሙያዎች እና ከተቋም ቦርድ ጋር

1. አይስ ብሬከር/ማስጀመሪያ

ከመጀመራችን በፊት፤ ወደ ቡድኑ እንሂድ እና እያንዳንዱ ሰው ገቢን መሰብሰብ እና መጠቀም እንዴት እንደሚገልጹት በጥቂት ቃላት ወይም በአንድ ዓረፍተ ነገር ይሰጡናል?

(ለአንድ ሰው አንድ ዓረፍተ ነገር ወይም ጥቂት ቃላት ብቻ ይጠቀሙ/ይውሰዱ)

2. ገቢን መሰብሰብ እና መጠቀም ዕውቀት

"ስለ ገቢን መሰብሰብ እና መጠቀም አገልግሎቶችን በአጭሩ በመወያየት እንጀምር፤ በተቋምዎ / ወረዳዎ ውስጥ ገቢን መሰብሰብ እና መጠቀምን እንዴት ይገልፀውታል?

ለውይይት የሚጋብዙ ጥያቄዎች

- የገቢ አሰባሰብ ዘዴ ?
- የገቢ አጠቃቀም እቅድ?
- ለገቢ አጠቃቀም ቅድሚያ አሰጣጥ? በእንደዚህ አይነቱ ቅድሚያ አሰጣጥ ውሳኔ ላይ የሚሳተፈው ሰው ?
- የሚፈቀዱና እና የሚከለከሉ ዝርዝሮች ?

3. ገቢን መሰብሰብ እና መጠቀም አፈጻጸም

"አሁን በእርስዎ በተቋምዎ / በወረዳዎ ውስጥ ስለ ገቢን መሰብሰብ እና መጠቀም ትግበራዎች ስለ አጠቃላይ ግንዛቤዎችዎ መወያየት እንፈልጋለን፡፡

በግል አስተያየትዎ ገቢን መሰብሰብ እና መጠቀም እንዴት እየተተገበረ ነው?

ለውይይት የሚጋብዙ ጥያቄዎች

- የ ገቢን መሰብሰብ እና መጠቀም ምን ምን ጥቅሞች አሉት?
- የ ገቢን መሰብሰብ እና መጠቀም ትግበራ ያጋጠሙ ተግዳሮቶች ምን ምን ናቸው?

4. በጤና ተቋማት አገልግሎት አፈፃፀም እና ጥራት ላይ የገቢን መሰብሰብ እና መጠቀም ውጤት

"አሁን በክልልዎ በአገልግሎት አፈፃፀም እና በአገልግሎት ጥራቶች ላይ ስለ የ **ገቢን መሰብሰብ እና መጠቀም** ውጤት እንነጋገር፡፡

በዚህ የፕሮግራም ተፅእኖ እና ውጤት ላይ አስተያየትዎን ማወቅ እንፈልጋለን?

ለውይይት የሚጋብዙ ጥያቄዎች

- **ገቢን መሰብሰብ እና መጠቀም** በተቋም አፈፃፀም ለይ ያለው አስተዎጽኦ እንዴት ይመስልዎታል?
- **ገቢን መሰብሰብ እና መጠቀም** የጤና ተቋማት የስራ ተነሳሽነት ላይ ያለው አስተዋጽኦ እንዴት ይገልጹታል?
- **ገቢን መሰብሰብ እና መጠቀም** በጤና ተቋማት የታካሚ እርካታን ላይ የሚኖረው አስተዋጽ እንዴት ያስባሉ?
- **ገቢን መሰብሰብ እና መጠቀም ለጤና** ተቋማት ምን ጥቅሞች አሉት?
- **ገቢን መሰብሰብ እና መጠቀም በተቆሙ** ምን ዓይነት መሰናክሎች አስከትሎል?
- ለእርስዎ, **ገቢን መሰብሰብ እና መጠቀም** በተለይም, በስራ አፈፃፀምዎ እና ተነሳሽነትዎ ላይ ያለው አስተዎጽኦ ምን ይመስላል?

- ከተቋሙ ቦርድ ጋር በለዎትን ግንኙነት ላይ **ገቢን መሰብሰብ እና መጠቀም ምን አስተዎጾ አለው?**
- ከህብረተሰቡና ከማህበረሰብ ተወካዮች ጋር ያለዎትን ግንኙነት ላይ **ገቢን መሰብሰብ እና መጠቀም** እንዴት አይነት አስተዋጾ አለው?

5. በጥራት ላይ ገቢን መሰብሰብ እና መጠቀም ውጤት

በአስተያየትዎ ውስጥ, በጤና አገልግሎት ጥራት ልኬቶች ላይ የ ገቢን መሰብሰብ እና መጠቀም ውጤት ምንድነው?

(ከ 1 እስከ 5 ባለው ልኬት ተከትለው የአስተዋጽኦውን ደረጃ ይስጡ::)

i. በዶናቤዲያን ትሪሎጂ ፤ዋና የአገልግሎት ጥራት ልኬቶች

ሀ. መዋቅር

ለ. ሂደት

ሐ. ውጤት

ii. የጤና ሚኒስቴር የአገልግሎት ጥራት ልኬቶች

ሀ. ውጤታማነት

ለ. ውጤታማነት በውስን ሀብት(ግብአት እና ጊዜ)

ሐ. ወቅታዊ

መ. ሰው ተኮር/ሰውን ያማከለ

ሠ. ፍትሃዊነት

ረ. ደህንነቱ የተጠበቀ

- ገቢን መሰብሰብ እና መጠቀምን የተምለከተ ምን ሌሎች ቁልፍ አስተዋጽኦ ሊነግሩን ይፈልጋሉ?

6. የወደፊቱ የገቢ አሰባሰብ እና አጠቃቀም

"አሁን ለብሔራዊ የገቢ አሰባሰብ እና አጠቃቀም ዙሪያ ለወደፊቱ ምክሮችዎን እንነጋገር ::

የአሁኑ የገቢ አሰባሰብ እና አጠቃቀም እንዴት ሊሻሻል ይችላል?

ለውይይት የሚጋብዙ ጥያቄዎች

- ገቢን መሰብሰብ እና መጠቀም የጤና አገልግሎትን ጥራት ይበልጥ ማሻሻል የሚችለው እንዴት ነው?
- የገቢ አሰባሰብ እና አጠቃቀም አስተዳደር የሚሻሻላ እንዴት ነው?
- የገቢ አሰባሰብ እና አጠቃቀም ሂደት የጤና ተቋማት ሠራተኞች የተሻለ ተጠቃሚ ሊደርግ የሚችለው እንዴት ነው?
- የገቢ አሰባሰብ እና አጠቃቀም ስራ ቢቆም በዚህ ተቋም ላይ ሊያስከትል የሚችለው ውጤት ምን ሊሆን ይችላል?

7. ሌላ አስተያየት

ሰለ ገቢን መሰብሰብ እና መጠቀም መጨረሻ ሀሳቦች ካለዎት?

የክፍሉ ጊዜው መጨረሻ

አሁን ወደ ውይይትዎ መጨረሻ መጥተናል ሰለ ጉቡ ተሳትፎዎ እናመሰግናለን

D.3 Miiltoo 4: Galii sassaabuu fi ittifayyadamuu irratti, marii garee hojjatoota dhaabbilee fayyaa/boordii dhaabbillee fayyaa wajjin

1. Jalqabuuf/Ice breaker

   Osoo hinjalqabiin dura, namootni asijirtan hundi galii sassaabuu fi ittifayyadamuu jecha ykn hima tokkon ibsa.

   (namni tokko jecha ykn hima tokko qofa akka dubbatu taasisi)

2. Galii sassaabuu fi ittifayyadamuu irratti beekumsa (Knowledge) qabdan
   "Gabaabsinee, waa'ee galii sassaabuu fi ittifayyadamuu irratti haa mar'atnu. Dhaabbata fayyaa/aanaa keessan keeessatti galii sassaabuu fi ittifayyadamuu akkamitti ibsitu?"

   Dhimmoota kanatti aanu gaafadhu:

   Tooftaa galiin itti sassaabamu?

   Karoora ittifayyadama galii?

   Ittifayyadama galiif dursi ni kennamaa?

   Namoota asijirtan keessaa adeemsa dursa kennuu keessatti kan hirmaate jiraa?

   Tartiiba galii sassaabuu fi ittifayyadamuu hayyamamee fi dhorkame (Negative &positive lists of RRU)

3. Ittfayyadama galii

   "Amma raawwii sassaabii fi ittifayyadama galii dhaabbata fayyaa/aanaa keessanii irratti mari'atna. Akka yaada keessaniitti, sassaabbii fi ittifayyadamni galii haala kamiin hojiirra oolaa jira?

   Gaaffii armaan gadii gaafadhu:

   Dhaabbata fayyaa keessaniif galiin keessaa faayidaa akkamii qaba?

   Galii keessaa fayyadamuu irratti rakkoon isin muudate maal?

4. Bu'aan ittifayyadama galii raawwii hojii dhaabbata fayyaa fi qulqullina tajaajila fayyaa irratti qabu

   Gaheen ittifayyadamni galii raawwii dhaabbata fayyaa fi qulqulina tajaajila fayyaa jijjiiruu irratti qabu

   Amma, ittifayyadamni galii keessaa raawwii dhaabbata fayyaa fi qulqulina tajaajila fayyaa jijjiiruu irratti bu'aa inni qabu irratti haa mari'atnu. Dhimma kana irratti yaada qabdan nuuf ibsaa. Yaadni waliigalaa dhimma kanarratti qabdan nuuf ibsaa.

   Gaaffii armaan gadii gaafadhu:

   Akka yaada keessanitti,

   Ittifayyadamni galii keessaa haala kamiin raawwii hojii dhaabbata fayyaa akka miidhu?

   Ittifayyadamni galii keessaa haala kamiin kakka'umsa (motivation) dhaabbata fayyaa akka miidhu?

   Ittifayyadamni galii keessaa ittiquufinsa maammiloota dhaabbata fayyaa irratti miidhaa inni qabu?

   Galiin keessaa, dhaabbata fayyaa irratti faayidaa akkamii akka qabu?

Galiin keessaa, dhaabbata fayyaa irratti rakkoo akkamii akka fidu?

Keessattuu, galiin keessaa raawwii fi kaka'umsa hojii kee irratti bu'aa akkamii akka qabu?

Galiin keessaa, hariiroo ati boordii dhaabbataa wajjin qabdu haala akkamiin jijjiiree jira?

Galiin keessaa, hariiroo ati hawaasaa fi bakkabu'a haawaasaa wajjin qabdu haala kamiin jijjiiree jira?

5. Bu'aa beekamaa galii sassaabuu fi itti fayyadamuun qulqullina tajaajila fayyaa irratti qabu *(Perceived effect of RRU on Quality)*

   Akka ilaalcha mataa keetitti, bu'aan ittifayyadmni galii keessaa qulqullina tajaajila fayyaa irratti qabu maal? Bu'aa inni qabu 1-5 madaali.

   i. Akkaataa Trilojii Doonabeediiyaan tti/Donabedian trilogy
      a. Caasaa
      b. Adeemsa
      c. Firii
   ii. Akkaataa Qulqullina Ministeerri Fayyaa Kaa'uun
      a. Bu'a qabbeessumma
      b. Gahumsa
      c. Yeroo
      d. Maamilota/namoota irratti
      e. Haqaqabeessummaa
      f. Miidhaa kan hingeesisne

   Gahee galiin keessaa qulqullina tajaajila fayya irratti qabu biroo yoo jiraate ibsi

6. Fulduree/future galii sassaabuu fi ittifayyadamuu

   "Amma immoo fulduree galii sassaabuu fi ittifayyadamuu irratti yaada isin qabdan haa mari'atnu. Ittifayyadamni galii keessaa amma jiru, haala kamiin fooyya'uu danda'a?

   Gaaffii armaan gadii gaafadhu:

   - Ittifayyadamni galii keessaa qulqullina tajaajila fayyaa irracaala akkamitti fooyyessuu danda'a?
   - Bulchiinsi ittifayyadama galii keessaa akkamitti fooyya'uu danda'a?
   - Ittifayyadamni galii keessaa faayidaa hojjatoota dhaabbilee fayyaa haala kamiin fooyyeessuu danda'a?
   - Galii sassaabuu f ittifayyadamuun osoo dhaabbatee, maaltu ta'a? Osoo galiin keessaa adda citee dhaabbatni fayyaa keessan maal ta'a?

7. Yaadni hafe yoo jiraate

   Galii keessaa ilaalchisee dhimmi hafe jettan yoo jiraate?

XUMURREE JIRRA

Marii keenya xumurree jirra. Hirmaannaa hoo'aa taasiftaniif guddaa galatoomaa.

ANNEX E: PARTICIPANT INFORMATION SHEET AND CONSENT FORM FOR KII AND FGD

E.1 Title: Assessment of the Contribution of RRU on Quality Improvement at Health Facilities

Introduction.

Revenue Retention and Utilization (RRU) is one component of the first-generation health care financing reform in Ethiopia. As per the reform, health facilities are allowed to retain and utilize the user fees collected form the health services, medicines and other health supplies/commodities they provide after passing the necessary regulatory requirements. The reform has been implemented since 2008 in the country. The retained revenues are also expected to be utilized for positive lists as stated in health service regulation and directive of each regional government and city administration. On the other hand, the retained revenues are not allowed to be used for some activities. These activities are stated as negative lists in the regulation and directives of each region.

In order to learn and generate evidence on the extent of the contribution of RRU to quality of health services at health facility level, USAID- Health Financing Improvement Program (HFIP) commissioned this assessment in Addis Ababa City Administration, Amhara, Oromia and SNNPR that have started the implementation of the reform earlier.

Why are we doing this?

The objective of this assessment is to generate evidence on the link between RRU and quality of health services and estimate the effect of RRU on quality of health services at health center level compared to treasury expenditure.

What We are Asking of You.

This will be one of 20 one-on-one in-depth interviews or one of the 8 Focus group discussions taking place in Ethiopia with professionals at regional health bureau, Zonal Health Department, Woreda Health Office, Health facility board and Health facility senior management. We will be asking about RRU knowledge, utilization, and effect on quality. We are asking for your permission to audiotape these interviews so that we don't miss out on any of the information you provide. Each interview will last about an hour.

Potential Risks and Discomforts.

We foresee minimal risks with participating in this interview. However, in view of the potentially small numbers of participants in each locality and institution, participants may be easily identifiable. We will, therefore, take care to ensure anonymity is preserved when using direct quotes.

Potential Benefits of Taking Part in the Study.

The information and feedback you provide will help us try ensure that the long-term goals of RRU can be reached.

Confidentiality and Privacy.

Any information obtained during the consent processes and this discussion will remain confidential. Digital recordings of the discussions will be encrypted and stored on a password protected computer for one year, after which they will be destroyed. The only confidential data are information from the

consent forms, which will be stored in double-locked file cabinets. The consent forms will be destroyed after one year of completion of these activities.

Who is funding the study?

The study is being conducted by the USAID Health Financing Improvement Program.

Participation and Withdrawal.

Participation is voluntary. You can choose not to participate. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions you do not want to answer.

Who to Contact with Questions.

This study has been approved by the Institutional Review Board of the Ethiopian Public Health Institute [Reference Number (***)]. The study will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki.

If you have any questions or concerns about the research, please contact Workie Mitiku **(Principal Investigator)** at +251911 21 24 67, **Email: workie_mitiku@yahoo.com**

Rights of Research Participants.

You can decide you do not want to complete this group discussion at any time. If you have any questions about your rights as a participant, you can contact the chairperson of the Ethiopian Public Health Institute IRB.

Indicating Consent.

Please let us know if you have any questions before signing this consent form. Please initial next to each item to show that you agree/disagree to what is required:

Agree	**Disagree**	
		I agree to take part in the study, which has been fully described to me, by participating in this interview
		I understand that my participation in this study is completely voluntary, and there will be no penalty if I choose not to participate.

Please also provide a full signature to show whether you agree to this discussion being audio-taped.

Agree	**Disagree**	
		I agree to the interview being audio-taped

Declaration by Participant

By signing below, I, _____ ***(Participant's Full Name)*** agree to take part in this study.

I declare that:

- I have read this information and consent form.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressured to take part. I also understand that I do not give up any rights by signing below.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.

Participant's Signature	**Date (DD/MM/YYYY)**	**Signed at (Place)**
Research staff's Signature	**Date (DD/MM/YYYY)**	**Signed at (Place)**

አባሪ 5: የቁልፍ መረጃ ሰጪ ለጥልቅ ቃለ-መጠይቆችና ለተመረጡ ቡድን ውይይት ተሳታፊዎች

E.2 ርዕስ፡ በጤና ተቋማት ውስጥ የገቢ አሰባሰብና አጠቃቀም በጤና አገልግሎት ጥራት መሻሻል ላይ ያለውን አስተዋፅኦ ዳሰሳ

መግቢያ

ገቢ መሰብሰብና እና መጠቀም በኢትዮጵያ የመጀመሪያ ትውልድ የጤና እንክብካቤ የገንዘብ ማግኛ ስትራቴጂ አንድ አካል ነው፡፡ በስትራቴጂው መሠረት የጤና ተቋማት ለጤና አቅርቦቶችና አገልግሎቶች የተሰበሰቡ ክፍያዎች ማለትም መድሃኒቶች እና ሌሎች የጤና አገልግሎቶች እንዲሰበስቡና እንዲጠቀሙ ይፈቅዳል፡፡ገቢውን ለመጠቀም ግን አስፈላጊውን የቁጥጥር መስፈርቶች መከተል ይኖርባቸዋል፡፡ ማሻሻያው በአገሪቱ ውስጥ ከ 2008 ጀምሮ የተተገበረ ሲሆን በዚሁ መሰረት የተሰበሰቡ ገቢዎች እንዲሁ በጤና አገልግሎት ደንብ እና በእያንዳንዱ የክልል መንግሥት እና በከተማ አስተዳደር መመሪያ በተገለፀው መሰረት ጥቅም ላይ እንዲውል ተደርጉዋል፡፡ በሌላ በኩል የተሰበሰቡ ገቢዎች ለአንዳንድ ተግባራት እንዲጠቀሙ አይፈቀድላቸውም እነዚህ ተግባራት የእያንዳንዱ ክልል ደንብ እና መመሪያዎች ውስጥ መጠቀም የማይቻሉ ዝርዝሮች ሆነው ተገልጸዋል፡፡

በጤና ተቋማት ደረጃ ያለው ገቢ አሰባሰብና እና አጠቃቀምን በጤና አገልግሎቶች ጥራት ላይ የሚኖረውን አስተዎጾ ለማወቅ እና መረጃዎችን ለማመንጨት በዩ.ኤስ.ኤ.አይ.ዲ የጤና የገንዘብ ማሻሻያ መርሃ ግብር (ኤች.አፍ.አይ.ፒ.) በኩል ስራውን ቀድሞ በተጀመረባቸው በአዲስ አበባ ከተማ አስተዳደር፤በአማራ፤ኦሮሚያ እና በደቡብ ክልል ውስጥ ይህ ዳሰሳዊ ጥናት/ግምገማ ትግበራ ይደረጋል፡፡

ይህንን የምናደርገው ለምንድን ነው?

የዚህ ግምገማ ዓላማ በጤና ተቋማት የገቢ መሰብሰብ እና መጠቀም በጤና አገልግሎቶች ጥራት ላይ ባለው አገናኝ ሂደት ውስጥ መረጃ ማመንጨት እና የጤና አገልግሎቶች ጥራትን ከግምጃ ቤት ወጪ ጋር ንጽጽር ለማድረግ ነው

እኛ ለእርስዎ ምን እንጠይቃለን ?

ይህ በክልሉ የጤና ጥበቃ ቢሮ፤ በዞን ጤና መምሪያ ፤ በወረዳ ጤና ጽ/ቤት፤ በጤና ተቋማት ውስጥ ያሉ ቦርድ እና ባለሙያዎች ከሚደረጉ 20 የአንድ ለአንድ የትኩረት ውይይቶች መካከል አንዱ ወይም ከ 8 ቱ የትኩረት ውይይቶች መካከል አንዱ ሲሆን ስለ የገቢ አሰባሰብና አጠቃቀም እውቀትን፤ አጠቃቀምን እና በአገልግሎት ጥራት ላይ የሚደርሰውን ውጤት እንጠይቃለን፡፡ እርስዎ በቃለመጠይቁ የሚሰጡት መረጃዎች እንዳያመልጥ በድምጽ ለመቅረጽ ፈቃድዎን እንጠይቃለን ?

እያንዳንዱ ቃለ ምልልስ ለአንድ ሰዓት ያህል ይቆያል፡፡

ምቾት ሊነሱና እና ስጋቶች/ተግዳሮ ሊሆኑ የሚችሉ

በዚህ ቃለመጠይቅ ውስጥ በመሳተፍ አነስተኛ ስጋቶች እንጠብቃለን፡፡ በእያንዳንዱ የአከባቢ እና ተቋም ውስጥ ካሉ የተሳታፊዎች ቁጥር አንፃር ተሳታፊዎች በቀላሉ ሊገለጹ ይችላል የሚል ስጋቶችን ለማስቀረት ቀጥተኛ ጥቅሶችን ሲጠቀሙ ማንነትን እንዳይገለጽ በማድረግ እንጠብቃለን፡፡

በጥናቱ ውስጥ በመሳተፍዎ ሊገኙ የሚችሉ ጥቅሞች

የሚሰጡት መረጃ እና ግብረመልስ በገቢ አሰባሰብና አጠቃቀም የረጅም ጊዜ ግቦች ሊያመጡት እና ሊደረስበት የሚችሉትን ውጤቶች ለማረጋገጥ ይረዳናል.

ምስጢራዊነት እና ግላዊነት

በስምምነት ሂደቶች ወቅት የተገኘ ማንኛውም መረጃ እና ይህ ውይይት በሚስጥራዊ ሁኔታ ይቀጥላል፡፡ የውይይታችን የድምጽ ቅጂዎች በመተስጥር በተጠበቀ ኮምፒተር ለአንድ ዓመት ይቀመጣል፤ ከዚያ በኋላ ይጠፋሉ፡፡ ብቸኛው ሚስጥራዊ መረጃዎች ከስምምነት ቅጽ መረጃ ሚወሰዱት በጠንካራ በተቆለፈ ፋይል ካቢኔቶች ውስጥ ይቀመጣል፡፡ የእነዚህ እንቅስቃሴዎች ከተጠናቀቁ ከአንድ ዓመት በኋላ የስምምነት ቅጽ መረጃ እንዲጠፋ ይደረጋል፡፡

የጥናቱን ወጭ የሚሸፍነው ማነው?

ጥናቱ የሚከናወነው በዩ.ኤስ.ኤ.አይ.ዲ (የዩናይትድ ስቴትስ ኤጀንሲ ለአለም አቀፍ ልማት ድርጅት) የጤና ፋይናንስ ማሻሻያ ፕሮግራም ነው.

ስለለተሳትፎ እና ስለማቆረጥ

ተሳትፎው በፈቃደኝነት ነው:: ላለመሳተፍ መምረጥ ይችላሉ ::

ለመሳተፍ ከወሰኑ በኃላም በማንኛውም ጊዜ ተሳትፎዎን ማስቆም ይችላሉ:: በማቋረጥዎ ምንም አይነት ተጽዕኖ አይደርስዎበትም:: መልስ መስጠት የማይፈልጉትን ማንኛውንም ጥያቄ መልስ አለመስጠት ይችላሉ::

ጥያቄዎች ቢኖርዎ ሊያናግሩት ከፈለጉ

ይህ ጥናት በኢትዮጵያ የህዝብ ጤና ተቋም በተቋማዊ የግምገማ ቦርድ ውስጥ በፕሮቶኮል ቁጥር EPHI-IRበ…….ተቀባይነት አግኝቷል:: ይህ ጥናት የሚካሄደው በሄሊሲንኪንግ ዓለም አቀፍ መግለጫ ሥነምግባር መመሪያዎችና መርሆዎች መሠረት ነው::

ስለ ጥናቱ ማንኛውም አይነት ጥያቄ ወይም ስጋቶች ካሉዎት እባክዎን ወርቄ ምትኩን ያግኙ (የጥናቱን ተጠሪ) ስልክ ቁጥር: +251 911 21 24 67, ኢሜል: workie_mitiku@yahoo.com

የጥናት ተሳታፊዎች መብቶች.

በማንኛውም ጊዜ ይህንን የቡድን ውይይት ለማጠናቀቅ እንደማይፈልጉ መወሰን ይችላሉ:: እንደ ተሳታፊነትዎ ስለ መብቶችዎ ማንኛውም ጥያቄ ካለዎት የኢትዮጵያን የህዝብ ጤና ተቋም የጥናት ተቋማዊ ግምገማ ቦርድ ሰብሳቢ ማነጋገር ይችላሉ::

የስምምነትን መግለጫዎች

ይህንን ስምምነት ከመፈረምዎ በፊት እባክዎን ጥያቄ ካለዎት ያሳውቁን:: እባክዎን በፍላጎትዎ መሰረት እንደሚስማሙ / እንደማይስማሙ ለማሳየት በቀጣይ እንደአስፈላጊነቱ ይግለጹ::

እስማማለሁ	አልስማማም	
		ጥናቱ ሙሉ በሙሉ ተገልጾልኛል:: በመጠይቁም በመሳተፍ የጥናቱ አካል ለመሆን እስማማለሁ
		በዚህ ጥናት ውስጥ ያለኝ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት እንደሆነ ተረድቻለሁ እናም ላለመሳተፍ ከመረጥኩ ምንም ቅጣት አይኖርም::

እስማማለሁ	አልስማማም	
		ቃለ መጠይቁ በመቅረጸ ድምጽ መያዙን እስማማለሁ

የተሳታፊ መግለጫ

ከዚህ በታች በመፈረምኩት መሰረት እኔ _____ የዚህ ጥናት አካል ለመሆን እስማማለሁ

የተሳታፊ መግለጫዎች:

- ይህንን መረጃ እና የስምምነት ቅጽ አንብቤያለሁ ::
- ጥያቄዎችን እና ጥያቄዎቼን በበቂ ሁኔታ ለመመለስ የመጠየቅ እድል አግኝቻለሁ ::
- በዚህ ጥናት ውስጥ ለመሳተፍ በፈቃደኝነት እንጂ ምንም ጫና አልተደረገብኝም:: እንዲሁም ከዚህ በታች በመፈረሜ ማንኛውንም መብቶች እንደማይጣሱ እረዳለሁ::
- ጥናቱን በማንኛውም ጊዜ ለመተው እንደምችል እና በማንኛውም መንገድ ምንም አይነት ቅጣት ወይም ጭፍን ጥላቻ እንደማይደርስብኝ ተረድቻለሁ::

የተሳታፊ ፊርማ	**ቀን (ቀን/ወር/ዓመት)**	**የተፈረመበት ቦታ**
የጥናት አባል ፊርማ	**ቀን (ቀን/ወር/ዓመት)**	**የተፈረመበት ቦታ**

Miiltoo 5: Kutaa odeeffannoo hirmaattotaa, formii waliigaltee fedhii gaaffii gadi fageenyaan gaafatamu deebisuu fi marii garee irratti hirmaachuu

E.3 Mataduree: Qorannoo gumaacha galii sassaabuu fi itti fayyadamuun qulqullina tajaajila dhaabbileen fayyaa kennan fooyyessuuf qabu

Seensa

Galii sassaabuu fi itti fayyadamuun gosa riiformoota faayinaansii fayyaa dursa biyyattiin hojii irra oolchaa jirtu keessaa isa tokko. Riiformiin kun dhaabbileen fayyaa qarshii tajaajilaa fayyaa, gurgurtaa qoricha fi galii biroo irraa argame akkaataa ulaagaalee faayinaansii guutuun akka sassaabanii fi itti fayyadaman kan eeyyamu dha. Riiformichi biyyattii keessatti hojii irra ooluu kan jalqabe bara 2008 A.L.A eegaleeti. Galii sassaabuu fi itti fayyadamuun kan danda'amu dhimmoota qajeelfama kenniinsa tajaajila fayyaa fi bulchiinsa dhaabbilee fayyaa naannoolee fi bulchiinsa magaalotaa keessatti eyyamaman qofaaf ta'a. Karaa biraatiin, galii keessaa hojiiwwaan tokko tokkoof fayyadamuun dhorkaa dha. Hojiiwwan galii keessaa irraa akka itti hin fayyadamne dhorkaman qajeelfama naannoowwan fi bulchiinsi magaalaa baasan keessatti tarreeffamaniiru.

Bu'aa riiformiin kun qulqullina tajaajilaa dhaabbilee fayyaa keessatti kennamu fooyyessuu kessatti qabu adda baasuu fi ragaa barbaachisaa ta'an argachuuf, sagantaan dhaabbata "USAID- Health Financing Improvement Program (HFIP)" jedhamu qorannoon kun Bulchiinsa Magaalaa Finfinnee, naannoo Amaaraa, Oromiyaa fi Sabaaf Sablammoota Kibbaa keessatti akka gaggeeffamu deeggarsa godheera.

Maaliif qorannoo kana gaggeessinaa?

Kaayyoon qorannoo kanaa walitti dhufiinsa galii sassaabuu fi itti fayyadamuun qulqullina kenninsa tajaajila fayyaa waliin qabu irratti ragaa adda baasuu fi bu'aa riiformichi qulqullina tajaajila fayyaa sadarkaa buufata keessatti kennamu baajata idilee waliin tilmaamuuf.

Nuti maal akka si gaafannu?

Kun tokko tokkoon namoota 20 gaaffii gadifageenyaan gaafachuuf ykn tokko tokkoon garee nama 8 qabu wajjin marii gaggeessuuf yoo ta'u hirmaattonni hojjatoota biiroo eegumsa fayyaa, waajjira fayyaa godinaa, waajjira fayaa aanaa, koree boordii dhaabbilee fayyaa fi koree manaajimantii waliin kan gaggefamuu dha. Kan nuti gaafannu waa'ee beekumsa galii sassaabuu fi itti fayyadamuu akkasumas bu'aa inni qulqullina tajaajila fayyaa fooyyessuu keessatti qabuu dha. Deebii isin gaaffii gaafatamtaniif deebistan sirriitti qabachuuf sagalee keessan teeppii kanaan akkan waraabnu eeyyama isin gaafanna. Gaaffii keenya dheerina sa'aatii tokkoo kan fudhatu ta'a.

Miidhaa fi rakkoo muudachuu malu

Gaaffii fi deebi kana keessatti hirmaachuun rakkoo homaa akka hin qabne tilmaamna. Garuu, bakka namoonni xiqqoon qofti gaaffii fi deebii kana irratti hirmaatanitti, hirmaatonni laayyootti beekamutu mala. Kanaafuu, yeroo yaada keessan kallattiin barreeffama keessatti ibsinu maqaan namoota yaada kennanii akka hin beekamne ni godhama.

Bu'aa qorannoo kana keessatti hirmaachuun argamsiisuu malu

Odeeffannoo fi yaadni isin nuuf kennitanu galma yeroo dheeraa galii sassaabuu fi itti fayyadamuu milkessuuf gargaara.

Iccitii eeguu

Iccitiin odeeffannoon fedhii keessaniin kennitan fi yaadni mariin garee keessatti kaafame ni eegama. Mariin garee waraabame kompiitara paaswoordii qabu irra waggaa tokkoof ni kuufama, waggaa tokko booda ni dhabamsiifama. Foormiin waligaltee fedhii qorannoo irratti hirmaachuu ibsitu sanduuqa qulfii qabdu keessa waggaa tokkoof kaa'amuun, waggaa tokko booda ni dhabamsiifama.

Eenyu qorannoon kun akka gaggeeffamu qarshii ramade?

Qorannoo kana kan qarshiin deeggaruu fi gaggeessu "USAID- Health Financing Improvement Program" jedhama.

Hirmaachuu fi hirmaannaa addaan kutuu

Hirmaannaan fedhii irratti kan hundaa'u ta'ee hirmaachuu dhiisuu filachuu dandeessu. Hirmaachuuf yoo murteessitan, hirmaannaa keessan yeroo kamuu addaan kutuu/dhaabuu ni dandessu. Hirmaannaa addaan kutuun/dhaabuun rakkoo fidu hin qabu. Gaaffii deebisuu hin barbaanne deebisuu dhiisuu dandeessu.

Qorannoo kana irratti yoo gaaffii qabaattan

Qorannoon kun kan mirkanaa'ee Inistituutii Fayyaa Hawaasaa Itoophiyaatiin (EPHI), lakkoofsa****. Qorannoon kun kan gaggeeffamu haala sirna qajeelfama labsii waltawaa addunyaa Helsinkiitiin.

Yoo gaaffii ykn yaada qorannicha irratti qabaattan obbo Workqee Mitikkuu (Qorataa haadhoo) +251911212467, e-meeylii: workie_mitiku@yahoo.com irratti qunnamuu dandeessu.

Mirga hirmaattota qorannichaa

Yeroo barbaaddanitti marii garee fixuu dhiisuu murtessuu dandeessu. Yoo gaaffii mirgaa akka hirmaatatti qabaattan, walitti qabaa boordii Inistitutii Fayyaa Hawaasaa IRB qunnamuu dandeessu.

Fedhii waliigaltee ibsu

Osoo foormii fedhii waliigaltee hin mallateessiin dura yoo gaaffii qabaattan na beeksisaa. Tokko tokkoon qabxii armaan gaditti tarrefamaniitiif walii galuu ykn walii galuu dhiisuu filachuun mallattoo keessaniin mirkaneessaa.

Walii galuu	Walii galuu dhiisuu	
		Qorannoo kana keessatti qooda fudhachuuf walii galeera, qoranichis sirriitti naaf ibsameera, gaaffii fi deebii keessatti ni hirmaadha.
		Qorannoo kana keerssatti hirmaachuun fedhii akka ta'e fi hirmaachuu dhiisuun adabbii akka hin qabne hubadheera.

Sagalee kee teeppiin waraabuu akka eeyyamte mallatoo keetiin ibsi

Walii galuu	Walii galuu dhiisuu	
		Sagaleen koo teppiin akka worabamu wolii galeera

IBSA hirmattotaa

Kana mallatessuun, An, _____(**maqaa guutuu hirmaataa/hirmaattuu**) qorannoo kana keessatti qooda fudhachuuf walii galeera.

Ani kanan mirkanessu:

- Odeeffannoo fi foormii fedhii waliigaltee dubbiseera.
- Caarraa gaaffii gaafachuu argadheera, gaaffiin koo hunduu quubsaatti deebi'eera.
- Qorannoo kana keessatti hirmaachuun fedhii akka ta'e hubadheera, namni na dirqisiise hin jiru. Kan armaan gadii mallatessuun mirga koo dabarsee akkan hin kennine hubadheera.
- Hirmaannaa yeroo kamittuu dhaabuu filachuu nan danda'a, dhaabunis adabbii ykn rakkina jibbiinsa/narratti hin qaqqabsiisu.

Mallattoo hirmaataa/hirmaattuu	**Guyyaa (Guyyaa/Ji'a/Bara)**	**Iddoo mallattoon itti raawwate**
Mallattoo nama qorannoo gaggeessuu	**Guyyaa (Guyyaa/Ji'a/Bara)**	**Iddoo mallattoon itti raawwatame**