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MINISTRY OF HEALTH-ETHIOPIA

Ministry of Health-Ethiopia
Stakeholder Engagement & Advocacy Plan for TB Domestic Resource Mobilization and Sustainability

June 2024

USAID
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This document is made possible by the generous support of the American people through the US Agency for International Development (USAID) contract no. 7200AA18D00025 task order no. 7200AA20F00009. The contents are the responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.

About HS4TB

The US Agency for International Development (USAID) Health Systems for Tuberculosis (HS4TB) project seeks to transform the way country leaders and health system managers understand and work toward TB control and elimination. HS4TB is a five-year USAID contract focusing on health systems priorities that most directly support achievement of TB outcomes, with a focus on health financing and governance in the USAID TB priority countries. The project helps countries increase domestic financing, use key TB resources more efficiently, build in-country technical and managerial competence and leadership, and support policy formation and dissemination. HS4TB is led by Management Sciences for Health (MSH) in partnership with Open Development.

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Submission

Submission Date: June 2024

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Acronyms

CBHI	Community-based Health Insurance
CSOs	Civil Society Organizations
DPCLEO	Disease Prevention and Control Lead Executive Office
DRMS	Domestic Resource Mobilization and Sustainability
EHIS	Ethiopia Health Insurance Service
EPSS	Ethiopian Pharmaceutical Supply Service
FAQs	Frequently Asked Questions
GOE	Government of Ethiopia
HIBP	Health Insurance Benefits Package
HI	Health Insurance
MOH-E	Ministry of Health-Ethiopia
MOE	Ministry of Education
MOLSA	Ministry of Labor and Social Affairs
MOM	Ministry of Mines
MOWCYA	Ministry of Women, Children, and Youth Affairs
MAF	Multisectoral Accountability Framework
NTP	National TB Program
OOP	Out of Pocket
RHBs	Regional Health Bureaus
REHF	Resilience and Equity Health Fund
SEAP	Stakeholder Engagement and Advocacy Plan
TWG	Technical Working Group
TB	Tuberculosis

TBLLD-NSP	Tuberculosis, Leprosy, and other Lung Diseases National Strategic Plan
WorHO	Woreda Health Office
WHO	World Health Organization

Acknowledgment

The USAID HS4TB Project would like to express its gratitude to everyone who contributed to the development of the Stakeholder Engagement and Advocacy Plan (SEAP) for TB Domestic Resource Mobilization and Sustainability. We appreciate the leadership and technical guidance provided by the National TB Program (NTP). The primary authors of this plan, Zewdu Tesfaye, Yemelaknesh Wolde, and Henock Tariku, deserve special recognition. Valuable technical assistance was also provided by Abebe Alebachew, Sarah Scheening, Anteneh Kassa, and William Wells, who helped shape the content. Saba Waseem and Chris Welch provided oversight and review, ensuring the accuracy and relevance of the SEAP, for which we are grateful.

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Introduction

Ethiopia has made remarkable progress in reducing tuberculosis (TB) incidence and deaths over the last decade, largely through the efforts of the government and its partners, and by following globally recommended TB policies. As a result, nearly two million cases of TB have been identified and treated in the last two decades[1]. All the major TB indicators—incidence, prevalence, and mortality—have decreased by more than half since 1990[2].

Despite this progress, Ethiopia remains among 30 countries with the highest burden of TB and multidrug-resistant TB, with an estimated TB incidence of 119 per 100,000 population in 2021[3]. It is also one of the countries with the highest burden of TB and TB/HIV co-infection globally[4]. TB is the fifth overall leading cause of death and the fourth leading cause of death among communicable, maternal, neonatal, and nutritional diseases in Ethiopia[5].

The country has ambitious plans to eliminate TB as a public health problem. In 2015, Ethiopia adopted the global END TB Strategy, with the aim of reducing deaths attributed to TB by 95 percent and reducing the number of people who develop TB every year by 90 percent by 2035 (compared to 2015 levels) respectively. This translates to less than 10 cases per 100,000 population by 2035. While Ethiopia is on track to meet the END TB targets of reducing TB incidence (i.e., 8 percent annual decline), the country is still a long way from meeting the 2025 milestone of reducing TB-related mortality (i.e., 7 percent annual decline).

The most recent Tuberculosis, Leprosy, and other Lung Diseases National Strategic Plan (TBLLD-NSP) (July 2023 to June 2030) outlines the country's priority strategies and required budget for meeting the targets defined by the World Health Organization's END TB Strategy and ending the TB epidemic. Under the TBLLD-NSP, the country has developed a plan to reduce TB incidence and mortality to 73 and 4 per 100,000 population, respectively by 2030. The total anticipated financial need for implementing the national TBLLD-NSP strategies and plans requires an investment of US$ 805 million over seven years[6].

Despite the high burden of TB in Ethiopia, it only receives 1.8 percent of the total health expenditure (from domestic government, out-of-pocket expenditure, and donor financing), which amounts to US$ 66 million annually[7]. This means that half of the interventions included in the TBLLD-NSP are not being implemented. Not only does this financing deficit threaten the country's ability to meet its commitment to end TB by 2035, but it also has implications for Ethiopia's most vulnerable households and communities.

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[1] Ministry of Health. 2019. End Term Review TBL-NSP. Addis Ababa, Ministry of Health

[2] Deribew, A., Deribe, K., Dejene, T., Tessema, G. A., Melaku, Y. A., Lakew, Y., Amare, A. T., Bekele, T., Abera, S. F., Dessalegn, M., Kumsa, A., Assefa, Y., Kyu, H., Glenn, S. D., Misganaw, A., & Biadgilign, S. Tuberculosis Burden in Ethiopia from 1990 to 2016: Evidence from the Global Burden of Diseases 2016 Study. Ethiop J Health Sci. 2018. 28(5): 519–528.

[3] Global tuberculosis report 2022. Geneva: World Health Organization; 2022.

[4] Tanimura, T., Jaramillo, E., Weil, D., Raviglione, M., & Lönnroth, K. (2014). Financial burden for tuberculosis patients in low- and middle-income countries: a systematic review. The European respiratory journal, 43(6), 1763–1775. https://doi.org/10.1183/09031936.00193413WHO. 2021. Global TB Report.

[5] Institute for Health Metrics and Evaluation (IHME). 2020. Ethiopia. Seattle, WA: IHME. https://www.healthdata.org/ethiopia

[6] MOH-E, Tuberculosis, Leprosy, and Other Lung Diseases National Strategic Plan, July 2023 to June 2030.

[7] MOH-E, Ethiopia Health Accounts, 2019/2020

The TIME analysis in the TBLLD National Strategic Plan[8] for July 2023 – June 2030 reveals insights on the impact of the implementation of key TB interventions on mortality and disability.

The implementation of full interventions (which includes scaling up molecular test utilization, active TB case finding among Key and Vulnerable Population, and active TB case finding (ACF) plus treatment of latent TB infection) of the best-case scenario would lead to a substantial reduction in both incidence and mortality rates. If full intervention is not implemented, an estimated 110,000 lives will be unnecessarily lost due to TB over the seven-year period between 2023 and 2030. Similarly, full intervention implementation can prevent an additional 182,421 Disability Adjusted Life Years (DALYs) from being lost during the period of 2024-2030. The TB Domestic Resource Mobilization and Sustainability (TB-DRMS) Roadmap was developed by the Ministry of Health-Ethiopia (MOH-E) with support from the USAID-funded Health Systems for TB (HS4TB) Project in 2022. The overarching objective of the roadmap is for Ethiopia to finance 20 percent of the funding required for the TB program from domestic sources by June 2026. From 2022 to 2026, Ethiopia aims to raise the proportion of the domestic government health budget allocated[9].

This level of domestic investment in TB will support the Government of Ethiopia (GOE) to meet its co-financing commitment with the Global Fund: that, beginning in 2024, the domestic co-financing commitment will increase to US$13.3 million annually for TB.[10] While the co-financing commitment with the Global Fund allows Ethiopia to include investments in human resources and operating expenses that support TB programming, the dearth of domestic financing for TB (as well as HIV) commodities has been highlighted. The GOE also recently committed to mobilize US$6 million in additional resources for TB as part of a new co-financing arrangements with USAID through the Support Wide Scale Interventions to Find TB (SWIF TB).[11]

To realize these co-financing commitments and increase domestic resources for TB interventions, the NTP needs to maintain active involvement in the broader health financing landscape, consistently advocating for the inclusion and prioritization of TB, and be prepared to adapt funding strategies within the framework of the larger health financing initiatives. As outlined in the TB DRMS Roadmap, this includes closely monitoring the financing reforms at the central and subnational levels such as the revision of the Exempted Services, revision of the Health Insurance Benefits Package (HIBP), and proposals to establish a Resiliency Health and Equity Fund to leverage excise and other taxes earmarked for the health sector.

Objective of the Stakeholder Engagement and Advocacy Plan

For the NTP to effectively advocate for the TB program under these health financing initiatives, it is critical to have a comprehensive stakeholder engagement and advocacy plan (SEAP). The overall objective of the SEAP is to advocate for increased domestic TB financing through implementation of the TB DRMS Roadmap strategies. Effective stakeholder engagement will enhance the acceptance of the roadmap's priority strategies and contribute to its successful implementation. Following the *Three T's*

[8] MOH-E, Tuberculosis, Leprosy, and Other Lung Diseases National Strategic Plan, July 2023 to June 2030
[9] Tuberculosis Domestic Resource Mobilization and Sustainability Roadmap for Ethiopia, January 2022. https://pdf.usaid.gov/pdf_docs/PA00ZW7S.pdf
[10] MOH-E letter to the Global Fund on August 9, 2023
[11] USAID Secures $18 Million in New Funding to Accelerate Efforts to End TB, March 14, 2024. Available at https://www.usaid.gov/news-information/press-releases/mar-14-2024-usaid-secures-18-million-new-funding-accelerate-efforts-end-tuberculosis

Approach (as outlined in Annex 2 of the TB DRMS Roadmap), the SEAP supports the NTP and other TB advocates to *target* an audience, *tell* the message, and *time* the communication to work collectively to advance a specific objective.

First, the SEAP identifies the "decision makers" (*target audience*) who play a critical role in policy, planning, and approval processes. It then examines the varying levels of influence and engagement these decision makers have with respect to mobilizing domestic TB financing. The SEAP also identifies advocates who can support the NTP to influence decision makers. Many of the key advocates in Ethiopia that can be engaged alongside the NTP as TB advocates are members of the NTP Technical Working Group (TWG) (see Box 1).

Second, the SEAP crafts compelling arguments and key messages that can be used by advocates to persuade (*tell*) decision makers to implement the initiatives outlined in the TB DRMS Roadmap. These messages highlight the importance of increased domestic financing for TB for the country in terms of human cost as well as the economic returns and benefits.

Third, the SEAP identifies the most appropriate channels and opportune windows (*timing*) to communicate these messages. The delivery of advocacy messages should align with the government's annual planning and budgeting decision making processes.

Box 1. List of member organizations of the NTP Technical Working Group (TWG)

Government

- Disease Prevention and Control Lead Executive Office (DPCLEO) – NTP (Chair)
- Armauer Hansen Research Institute (AHRI)
- Ethiopia Public Health Institute (EPHI)
- Ethiopia Pharmaceutical Supply Service (EPSS)

Development Partners

- Center for Disease Prevention and Control – Ethiopia (CDC- Ethiopia)
- Clinton Health Access Initiative – Ethiopia (CHAI – Ethiopia)
- Country Coordinating Mechanism (CCM)
- Digital Health Service
- German Leprosy & Tuberculosis Relief Association (GLRA)
- ICAP (Columbia University)
- KNCV Foundation
- United States Agency for International Development (USAID)
- USAID Eliminate TB (ETBE) Project
- USAID Sustaining Technical and Analytical Resources (STAR) Project
- USAID Urban TB Local Organizations Network (LON) Project
- World Health Organization (WHO)

Private Providers and Associations

- Voluntary Health Service
- Organic Health
- Ethiopian Healthcare Federation

Updating the SEAP to Reflect Emerging Priorities and Reforms

The SEAP is intended to be a dynamic document and should be updated annually to reflect GOE policies, reforms, and priorities. Each year, the SEAP will prioritize those Strategic Initiatives (SI) within the TB DRMS Roadmap that have the greatest likelihood for impact based on the overall health financing agenda.

Currently, the GOE is undertaking three major health financing reforms that will have significant implications for health and TB financing: (1) revisions to the Exempted Health Services list, (2) finalizing a comprehensive positively listed package of interventions under the Health Insurance Benefits Package (HIBP), and (3) the introduction of Resilience and Equity Health Fund (REHF) to bring additional, domestic resources to the health sector.

The MOH-E is reviewing the list of priority or "exempted" health services[12] according to disease burden, utilization rate, and cost, and it is estimating the investment needed to fully cover these services at no cost to patients. TB services are "exempted" from cost-sharing and cost-recovery fees in Ethiopia. This means the services are provided "free" of charge to all citizens, irrespective of income, through the public health sector. However, the exempted service policy is not a panacea.

A misalignment between the ambition of the exempted service policy and available financing can lead to stockouts of commodities or leave facilities to subsidize services through their own cost recovery mechanisms. TB has been relatively spared from these pressures, given its almost complete dependency on donors to finance TB commodities. However, this will become a more significant challenge for the TB program as the country comes to rely more heavily on domestic financing for TB commodities.

Further, under the current exempted services policy, patients must pay for medical costs leading up to their TB diagnosis, such as chest X-ray (CXR) and other TB screening-associated costs, as well as non-exempted medical and non-medical costs associated with TB care. While services not included in the exempted service policy (such as CXR) are included in the HIBP, low levels of HIBP coverage and ongoing challenges to standardize and finance HIBP benefits have limited the impact of this reform on lowering out of pocket (OOP) costs for presumptive TB patients.

To ensure the exempted services policy is fully supported with the available fiscal space and development partner support and aligned with public health priorities, the MOH-E is revising the Exempted Health Services list, focusing on commodity inputs. While some health services have been eliminated from the Exempted Health Service list, all five TB interventions have remained on the list at an estimated annual commodity cost of $29.4 million, and the inclusion of CXR under the revised Exempted Health Service list would further lower OOP costs to presumptive TB patients. A 2020 cross-sectional survey of 787 TB patients from the Afar and Oromia regions found that only six percent of TB patients were covered by health insurance.[13]

To finalize the package of exempted services, the GOE will determine its overall contribution to financing the exempted service package (vis-à-vis external partner contributions) and will determine how that commitment will be financed in the context of Ethiopia's decentralized system (i.e., the level of co-

[12] "Exempted" health services refer to those selected priority health services which are provided free of charge to the patient at the point of care. These services are mostly limited to Maternal and child health services, family planning, immunization, nutrition, Malaria, TB, HIV/AIDS and NTD services and can differ slightly among regions.

[13] Assebe LF, Negussie EK, Jbaily A, et al Financial burden of HIV and TB among patients in Ethiopia: a cross-sectional survey BMJ Open 2020;10:e036892. doi: 10.1136/bmjopen-2020-036892

financing between the central and subnational levels). Proposed exempted health service financing approaches include increasing central government budget allocation through dedicated financing for program-based budgeting (PBB), exploring regional co-financing arrangements, and establishing a REHF to bring additional, domestic resources to the health sector. The MOH-E is planning for two financing scenarios, reflecting optimistic and conservative fiscal space projections. These scenarios are focused on first meeting the financing needs of the Exempted Health Services list but may also offer possible financing options to support TB public health activities that sit outside the Exempted Health Service list as the available fiscal space improves. Policy implications for the TB program include potential shifts of lower-priority interventions to cost-sharing categories, requiring advocacy for increased domestic co-financing and prioritization of critical TB services.

In light of this reform agenda, the NTP and TB advocates should continue to engage in this reform agenda to advocate for the continued inclusion of TB as an exempted service. Similarly, the HIBP for community-based health insurance (CBHI) and social health insurance (SHI) has been undergoing a revision process to convert the negatively listed package into a comprehensive explicit positively listed package of interventions. This redesign process was initiated in early 2020 and currently is in the final phases of review. The HIBP and exempted services revision lists will be reviewed to ensure complementarity and coverage of priority interventions, including TB, in either of these packages. The NTP and TB advocates should continue to engage with the HIBP reform to advocate for the inclusion of diagnostic services—known to be a major driver of OOP medical costs for patients prior to their TB diagnosis and treatment. Further, it will be important for the NTP and TB advocates to plan for how the CBHI scheme can promote greater coverage of TB-susceptible populations. [14]

In addition, the MOH-E developed and submitted a concept note on the REHF to the Ministry of Finance (MOF) for endorsement. The concept note outlined the need for innovative financing approaches including funds collected from sin (excise) taxes, corporate social responsibility, and sector ministries, such as transportation and mining, to enhance emergency preparedness and response, finance high impact public health services, and reach vulnerable populations and underserved geographic areas. It was approved recently, and a team of experts is currently working to shape the legal framework for presentation to MOH-E leadership and subsequently to the Ministry of Justice for endorsement. Once the REHF has legal backing, a guideline for implementation will be developed to define which interventions under the three components will be funded. The NTP and TB advocates should engage in this phase of the process to ensure public health and community level TB interventions are given priority. Strengthening public health initiatives and social protection programs tailored to local contexts and leveraging innovative financing options, through regional co-financing and the REHF, are also essential.

Aligning the SEAP with the Next Annual Budget Planning Cycle

Once these critical reforms have been finalized, the SEAP should be updated in preparation for the government's next planning and budgeting process, which begins in November and concludes in July, to support activities from July to June. The updated SEAP should include clear messages for advocates and decision makers on the implications for TB financing with regards to the exempted service and

insurance package reforms, including expectations for financing of specific components of the TB response from these reforms across all levels of government, and should focus on advancing the implementation of SI 1 and SI 2 in the TB DRMS Roadmap:

> *SI 1. Increase allocation of general government revenues to health, and specifically TB, at federal and regional levels through evidence-based advocacy, enhanced exempted-service policy, and co-financing*
>
> *SI 2. Explore the potential for eventual integration of TB services into social and community-based health insurance benefits packages in the long term*

In the interim, the NTP and TB advocates should engage with decision makers at all levels of government to advocate for dedicated resources for TB at both the central level (through the dedicated TB line item in the MOH-E budget) and at the subnational level (though dedicated funding for TB interventions in *woreda* and regional health budgets). This will be particularly important for enabling the GOE to meet its TB co-financing commitments with the Global Fund grant (US39.9 million from 2024-2026) and the USAID SWIF TB initiative (US$6 million through 2027). To incentivize subnational investment in TB, the NTP has agreed to leverage the Global Fund grant to pilot a co-financing mechanism with two regions, Oromia and Sidama, in 2024, and to track the commitment and expenditure data from the national and regional using a TB resource tracking template, developed by HS4TB in close collaboration with NTP. The information provided in this document will assist advocates in refining their messages to build a stronger case for investing in TB and for drawing attention to the human cost of inaction.

Stakeholder Identification – Targeting

Tables 1 and 2 below list stakeholders—identified as either "decision makers" or "advocates"—who can influence the implementation of the TB DRMS Roadmap based on their roles and responsibilities.

Table 1. Stakeholders – Decision Makers and Influencers

Stakeholders	Roles and Responsibilities
Policy Makers: ● Prime Minister's Office (PMO) ● Parliamentarians (Budget and Social Standing Committee) ● Council of Ministers	- Review and approve legal and policy frameworks to implement health financing reforms and initiatives - Review and approve the legal and policy frameworks to institutionalize co-financing mechanisms and domestic resource mobilization strategies - Review and approve tax reforms to establish an earmarked budget for health and TB
Budget Approvers: ● Finance Institutions at All Levels Regional, Zonal and	- Support requests and negotiation of health- and TB-related budgets from the government treasury - Support the development of health and TB program budgets - Regularly review and update health and TB financial management policies

Woreda Cabinets and Councils	- Develop legal/tax reforms necessary to establish an earmark for health and TB - Analyze and report on financial trends in health and TB programs and identify opportunities for financial efficiencies - Provide technical assistance to MOH-E on health and TB financial management systems - Influence the inclusion of specific TB interventions in the budget preparation circular to bring more focus and priorities - Increase the health sector budget ceiling for the next year during the Macroeconomic and Fiscal Framework (MEFF) preparation - Submit and convince the executive body (council of ministers and cabinets) to endorse the program and sub-program budget at the value presented and agreed upon during the health annual budget negotiations
MOH-E Leadership: ● Minister ● State Ministers of Programs and Operations	- Highest level of authority to carry out direct communication and negotiation with MOF and the Bureau of Finance (BOF) - Develops strategies to ensure the sustainability of health and TB programs - Ensures domestic resources are mobilized for TB by focusing on national TB control plans that are well-coordinated, evidence-based, and sustainable - Advocates for an increase in public health and TB funds and supports innovative financing mechanisms - Monitors and evaluates resource mobilization efforts to maximize their impact
MOH-E - Strategic Affairs Executive Office	- Provides guidance and technical support to the design and implementation of health and TB financing strategies - Supports the development of legal and policy frameworks to institutionalize co-financing mechanisms - Coordinates with subnational entities to guide the budget development and implementation processes - Oversees and guides the financial management systems and resource allocations, including the *woreda*-based planning process from the national level - Supports tracking, collection, allocation, and use of domestic resources - Provides technical support on technical assessments/studies in the health financing space - Supports efforts to identify and close funding gaps for financing essential health services, including the TB program - Supports the integration of TB interventions into ongoing health financing reforms and initiatives - Directs and supports implementation of the TB DRMS Roadmap initiatives, including co-chairing the Steering Committee

MOH-E - Disease Prevention and Control Lead Executive Office (DPCLEO)	- Requests, negotiates and acquires budget funds from the MOH-E senior management for programs within the directorate, including TB - Assists with domestic resource tracking, collection, allocation, and use of the disease areas under the DPCLEO, including TB - Directs and supports implementation of the TB DRMS Roadmap initiatives, including co-chairing the Steering Committee
Sub-national health sector leadership, heads and deputies of: ● Regional Health Bureaus (RHB) ● Zonal Health Department (ZHD) ● *Woreda* Health Office (WorHO)	- Provides health leadership and decision making at the subnational level - Implements the necessary policies and legislation to reduce the burden of TB - Ensures subnational domestic resources are mobilized for TB by coordinating with TB control plans that are evidence-based, and sustainable - Advocates for an increase in public TB funds and supports innovative financing mechanisms - Oversees the subnational implementation of the TB DRMS roadmap initiatives and ensures that progress is made in its implementation
Ethiopia Health Insurance Service (EHIS)	**Resource mobilization functions** - Expands health insurance (HI) geographic coverage, membership enrollment, and renewal coverage for paying and indigent households - Establishes and enforces compulsory HI membership - Revises the HI membership premium contribution to a sliding scale - Develops and executes efficient and effective contribution collecting procedures/ systems - Promotes community engagement platforms (community health facility scheme, community scorecard, public facility forums) **Pooling functions** - Reinforces HI risk-mitigation measures (copays, bi-pass fees, and mandatory membership) - Enhances HI financial and data management, as well as claim audits - Establishes regional and national HI pooling **Purchasing functions** - Assesses, implements and scales up additional provider payment mechanisms (capitation, P4P) - Revises health insurance benefit package - Establishes a mechanism for engaging and collaborating with private healthcare institutions

	- Collaborates with relevant stakeholders to improve the quality of healthcare services available to HI members - Strengthen drug and service availability through private provider engagement and collaboration with pharmaceutical companies
Other Line Ministries: ● Ministry of Labor and Social Affairs (MOLSA) ● Ministry of Women, Children, and Youth Affairs (MOWCYA) ● Ministry of Mines (MOM) ● Ministry of Education (MOE) ● Police Commission ● Prison Administration ● Administration for Refugee and Returnee Affairs	- Support the DRMS initiative through financial contribution to the Multisectoral Accountability Framework (MAF) - Support efforts to reduce the indirect costs faced by TB patients - Advocate for a supportive policy environment and increased government investments in TB control - Help identify the most vulnerable populations for targeted TB investment
Influencers (Close to Decision Makers)	
Ethiopian Pharmaceutical Supply Service (EPSS)	- Carries out procurement and distribution of TB commodities at the federal level - Pushes for secured budget line items for TB commodities

Table 2. Key Stakeholders - Advocates

Stakeholders	Roles and Responsibilities
The National TB Program (NTP)	- Track TB financial commitments and allocations from various sources - Provide guidance and direction on the efficient allocation of domestic resources - Lead the TB TWG - Facilitate the mainstreaming of finances for TB from priority, non-health sectors and line ministries - Provide technical assistance in the creation of a proclamation and the updating of mainstreaming guidelines for strategic sectors - Create a legal framework to mandate and standardize practice across industries - Assign a TB mainstreaming account code and expense title - Lead, organize, monitor, and assess TB DRMS Roadmap implementation
TB Technical Working Group (see Box 1 for membership)	- Provides technical advice on TB-related domestic resource mobilization strategies - Works with relevant stakeholders to ensure that TB-related domestic resource mobilization efforts are in line with global standards - Monitors and evaluates the progress of domestic resource mobilization strategies - Identifies gaps in resources, sets action plans to increase resource mobilization - Supports capacity building initiatives to ensure that domestic resource mobilization is successful
Development partners and donors	- Provide grants and technical assistance to support efforts to mobilize domestic resources for TB control - Advocate for a supportive policy environment and increased government investments in TB control - Provide assistance to build capacity to effectively use and manage domestic resources - Advocate for sustainable funding sources for TB control programs
Private health sector	- Contributes to TB DRMS through advocacy, raising awareness, and providing financial resources - Provides technical assistance for initiatives that aim to improve access to TB diagnosis and treatment services - Raises awareness of TB among the general public to reduce stigma and increase access to quality TB care

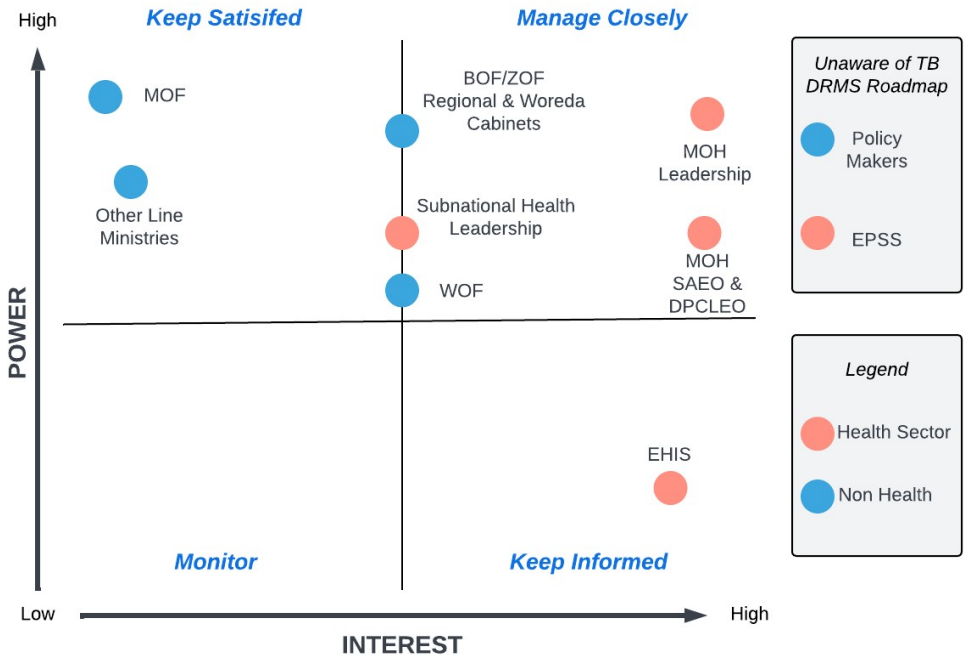
	- Collaborates with the public sector to ensure adequate funding for TB prevention and control activities - Consult on and advocate for financial policies (e.g., under social health insurance) that would allow private healthcare providers to be fairly compensated if they contribute meaningfully to TB objectives
Non-Governmental Organizations (NGOs)	- Provide technical support to MOH in the TB response and collaborate with civil society organizations (CSOs) and other organizations to ensure implementation of the DRMS mechanisms identified - Support national TB resource mobilization initiatives by providing guidance to member organizations on the best practices for fundraising and resource mobilization
Civil Society Organizations (CSOs) and professional associations	- Advocate for increased visibility, funding, and political commitment to TB - Collaborate with government, international organizations, and policymakers to promote effective TB prevention and control measures, involving stakeholders and communities and enhancing resource allocation - CSOs and professional associations mobilize resources for TB prevention and control by collaborating with donors, foundations, and private sector partners to secure funding for programs, research, and capacity building
Communities	- Participate in increasing awareness on the impact of TB - Communities can support fundraising efforts and advocate for increased resource allocation for TB programs, ensuring they are allocated to the most needy communities - Enhance TB control efforts by actively monitoring and evaluating programs, identifying service gaps, patient challenges, and areas for improvement, and enhancing resource allocation - Help to monitor and evaluate TB programs
Industrial Parks and Other Parastatals	- Collaborate with MOH-E or NTP to develop/ revise and execute TB DRM strategies - Allocate human and financial resources to TB preventive and control programs - Establish key alliances with NGOs and international organizations to streamline the support for TB preventive and control efforts

Analyzing Decision Makers' Level of Influence and Interest

In order to prioritize stakeholder engagement, decision makers are mapped across four quadrants based on: (1) their level of influence or power over the government's budget planning and approval process, and (2) their level of interest in supporting the implementation of the selected initiatives in the TB

DRMS Roadmap (see Figure 1). Those who are unaware of the DRMS Roadmap, and therefore their level of interest is not yet known, are captured to the right of the figure.

Figure 1. Power/Interest Grid for Key Stakeholders (Decision Makers)



Definitions:

Level of Influence/Power:

- High: A stakeholder with high influence has a significant amount of control over key decisions and/or can cause others to take action
- Medium: A stakeholder with medium influence is often part of the decision-making process
- Low: A stakeholder with low influence can offer opinions on decisions and express their concerns, but their ideas may not always be taken into consideration

Level of Interest:

- High: Plays a *leading* role in mobilizing domestic resources for health and TB and is *supportive* of government-led efforts to mobilize resources for health and TB
- Neutral: Aware of the initiative, yet neither supportive nor resistant
- Low: Aware of the initiative and potential impacts and is resistant to change; often concerned that TB is already better funded than other health and social sector initiatives
- Unaware: Not aware of the initiative and potential impacts

Based on the above mapping, the SEAP classifies its engagement strategy into the following three categories:

1. Manage closely (high priority): For stakeholders that can exert a large influence on the implementation of the select interventions and who also have a high interest in engaging with the advocates. A tailored engagement approach will be developed.
2. Engage (medium priority): For stakeholders with a higher level of influence but who are neutral, lack interest, or lack awareness of the TB DRMS Roadmap. Advocates should engage in broad-based communication to help them value the TB investment.
3. Inform (low priority): For stakeholders with low levels of influence and little interest in the implementation of the strategic initiatives and who may be interested only in obtaining information about what is happening Advocates should simply provide periodic information on its objectives and activities, such as publications or reports.

Engagement Messages – Telling

The engagement messages aim to communicate the context around why TB is a serious concern in recent years, particularly in low- and middle-income nations with limited resources like Ethiopia, and why health financing initiatives matter for TB and how they can be leveraged to advocate for TB programming. Table 3 below provides a repository of frequently asked questions (FAQs) and messages that advocates can pull from for particular advocacy objectives within the broader concept of increasing allocation of general government revenues to TB.

Table 3. FAQs and engagement messages

FAQs	Messages
Why should TB be considered as a priority area of investment in health?	• TB is a significant public health problem in Ethiopia because of its high prevalence and the impact it has on the population. Ethiopia is one of the countries with the highest TB burdens in the world with an estimated 143,000 new cases reported in 2021 alone, according to the WHO. • TB is a disease that can be steadily reduced by intensive effort. These short-term investments result in lower human and financial costs in the longer term. TB programming is already reducing the TB burden by ~7% per year, and the GOE has committed to end TB by 2035. • TB disproportionately affects people living in poverty with inadequate access to healthcare and nutrition. People in these vulnerable population groups are more prone to infection and more likely to suffer from complicated cases of TB. Hence, investment in TB contributes to alleviating inequities in health. • In addition to its health impact, TB also has significant social and economic consequences. People with TB often experience stigma and discrimination, which can lead to isolation and exclusion from their communities. TB can also cause a significant economic burden on individuals and their families, as well as on the health care system and the broader economy. In addition to the medical benefits, addressing TB is a crucial poverty-reduction strategy.

What is the socio-economic impact of TB in Ethiopia?	The socioeconomic impact of TB in Ethiopia includes: • **Loss of Income**: TB can lead to loss of income due to patients being unable to work as a result of the symptoms or time taken off to seek medical care, throughout the disease management phases. In a study done by van den Hof et al, researchers found that the median income for TB and multidrug-resistant TB patients fell from US$43 and US$54 before TB illness, respectively, to zero during the time of interview[15]. • **Increased direct and indirect health costs:** Despite TB services being designated as exempted services, individuals seeking care face significant expenses. The mean patient cost of TB per episode was estimated at US$115 and among this expense, the direct cost accounted for US$ 52 and the indirect cost accounted for US$ 63. The incidence of catastrophic health expenditure for TB was 40% with varying rates ranging from 59% among the poorest income quintile to 20% among the richest income quintile[16]. • **Stigma and discrimination:** In Ethiopia, TB is a disease burdened with significant stigma, leading individuals affected by it to experience discrimination on social and economic fronts. This discrimination manifests in various ways, such as denial of healthcare services, limited employment opportunities, and social isolation. Stigma was also highly associated with factors such as educational attainment, poverty, and limited awareness regarding TB[17]. • **Reduced productivity:** TB has an impact on productivity and a loss of work due to illness and the lengthy treatment duration for the disease. Consequently, a decline in individual productivity impacts the workforce and has a negative effect on the broader economy. • **Increased healthcare burden:** TB case management requires a comprehensive approach including access to diagnostic, treatment, and socio-economic support. Additionally, this burden is usually magnified as TB co-exists with other health conditions such as HIV/AIDS, malnutrition, and other comorbid conditions such as diabetes.
What will be the return on investment with increased domestic resource allocation to TB?	• Investing in TB can have potential returns in improved health outcomes, productivity gains, reduced healthcare costs, and social and economic benefits. While predicting the exact return on investment for increased domestic TB financing may depend on a number of factors, the Global Fund estimates that every dollar invested in fighting HIV, TB, and malaria results in US$31 in health gains and economic returns[18]. The Copenhagen Consensus Center has estimated that each dollar spent on TB will

[15] van den Hof, S., Collins, D., Hafidz, F. et al. The socioeconomic impact of multidrug resistant tuberculosis on patients: results from Ethiopia, Indonesia and Kazakhstan. BMC Infect Dis 16, 470 (2016). https://doi.org/10.1186/s12879-016-1802-x
[16] Assebe LF, Negussie EK, Jbaily A, Tolla MTT, Johansson KA. Financial burden of HIV and TB among patients in Ethiopia: a cross-sectional survey. BMJ Open. 2020 Jun 1;10(6):e036892. doi: 10.1136/bmjopen-2020-036892. PMID: 32487582; PMCID: PMC7265036.
[17] Datiko DG, Jerene D, Suarez P. Stigma matters in ending tuberculosis: Nationwide survey of stigma in Ethiopia. BMC Public Health. 2020 Feb 6;20(1):190. doi: 10.1186/s12889-019-7915-6. PMID: 32028914; PMCID: PMC7006204.
[18] The Global Fund to Fight AIDS, Tuberculosis and Malaria, Investment Case Seventh Replenishment 2022, https://www.theglobalfund.org/media/11798/publication_seventh-replenishment-investment-case_report_en.pdf

	generate US$46 of social benefits for the world.[19] The Lancet estimated that "TB care would result in good returns on investment—ranging from US$1 to US$49 per dollar spent using a labor-dominated approach and from US$2 to US$24 per dollar spent using the equal contribution of labor and capital approach."[20,21]
What are the consequences of inaction in TB investment?	• If full intervention (which includes scaling up molecular test utilization, active TB case finding among KVP, and active TB case finding (ACF) plus LTBI treatment) as presented in the NSP is not implemented, an estimated 110,000 lives will be unnecessarily lost due to TB over the 7-year period between 2023 and 2030. • Full intervention implementation can prevent an additional 182,421 DALYs from being lost during the period of 2024-2030.
Doesn't TB already receive significant support from external partners?	• The country needs to spend an estimated US$124 million annually to be on track to end TB. Currently, Ethiopia is spending US$65 million annually on TB, inclusive of government, external support and OOP spending. This means that half of the interventions that are needed to end TB are not being implemented. • Out of the roughly US$65 million spent annually on TB, 88% comes from external support and OOP spending (44% each); only 12% comes from domestic resources. • OOP spending—the least equitable and efficient type of health financing—is nearly a third higher for TB (43.7%) than OOP spending for health in general (31%).[22] • Despite the high burden of TB in Ethiopia, TB receives a relatively small share of overall health sector resources, accounting for only 2% of total health expenditure. • While HIV and TB contribute to similar levels of disease burden in Ethiopia (4.5%and 3.5% of DALYs, respectively), funding for HIV is four times larger than for TB (9.2 and 2.1% of total health expenditure, respectively) (National Data Management Center for Health, July 2021).
Which platforms should be leveraged for advocating for increased domestic funding for TB?	• *Annual planning and budgeting processes* (see Table 4 below for details) enable TB advocates to establish the need for more funding by developing evidence-based plans for how the funds would be allocated, used, and tracked over time, ensuring accountability. They also help organizations quantify the resources required to combat TB and track progress against targets, ensuring that commitments are met, and scarce resources are used efficiently.

[19] Tuberculosis. Copenhagen Consensus Center. https://copenhagenconsensus.com/halftime-sustainable-development-goals-2016-2030/tuberculosis

[20] Ahmad Fuady, Call for more investment in cost-effective tuberculosis care https://doi.org/10.1016/j.lanwpc.2021.100157

[21] Labor-dominated (if the economic growth is dominated by labor) or equal contribution of labor and capital (contributed equally by physical capital and labor)

[22] MOH, Ethiopia National Health Accounts Reports 2019/20

	• *Annual program/health sector review meetings* are useful to assess progress against targets for TB funding, identify gaps, and propose solutions to fill those gaps. They are also an ideal platform for government representatives to be directly engaged and committed to increasing domestic funding for TB. • *Partner forums*, such as the Joint Core Coordinating Committee (JCCC), the Joint Consultative Forum (JCF), and the Joint Steering Committee (JSC)[23], are critical for identifying barriers and creating solutions, as well as for developing strong relationships with governments and coordinating advocacy efforts. They are also crucial in developing strategies to raise TB awareness and knowledge, as well as in sharing best practices.
What are the health financing initiatives/ reforms that could be leveraged to advocate for TB?	**Exempted Health Services Revision:** • Increased domestic financing in Exempted Health Services, including TB services, ensures progress towards sustainable service provision and reduced payment at the point of care. • Preserving TB activities in the Exempted Health Services list is the first priority. Continue monitoring and advocating for priority TB interventions to be included in the revised Exempted Health Services list. • When prioritizing the Exempted Health Services list, averted costs were not a prioritization criterion; this omission tends to disfavor interventions such as DR-TB treatment that are more expensive for the individual but that have critical public health impacts (e.g., in preventing onward transmission). • Particular attention should be given to the inclusion of CXR films which are currently included in the revised but not yet finalized Exempted Health Services list. Domestic financing for CXR is particularly important given that it is one of the only TB commodities that does not receive dedicated donor support and therefore is a significant driver of medical OOP costs for TB patients. • The financing of the Exempted Health Services list is an important opportunity to establish the start of new domestic financing flows for commodities, and to meet Global Fund and SWIF TB co-financing commitments. The MOH-E estimates that domestic co-financing for commodities for earmarked programs is at 8%. For TB specifically, domestic co-financing for commodities is closer to 0.05%. Advocacy for domestic financing for TB commodities (particularly first line drugs) should take place as part of the government's co-financing commitments with development partners.

[23] This forum brings together the MOH-E, MOH-E agencies, and the RHBs. The meetings are chaired by the Minister of Health, and participants include State Ministers of Health, RHB Heads, heads of departments/services of the Ministry, director generals, monitoring and evaluation (M&E) heads of MOH-E agencies and plans, and M&E heads of RHBs. JSC meetings focus on the implementation and progress of the plan and the challenges faced during the course of its implementation. The committee is also responsible for: updating the plan; introducing new initiatives, policy guidelines, and programs; and creating systems and mechanisms for communication and information/experience sharing.

	HIBP Redesign: ● Incorporating TB interventions, specifically those that are not covered under the exempted services, into the health insurance benefits package will help reduce the cost of pre-diagnostic services for TB patients. ● Increasing targeted enrollment and renewal of insurance membership of TB vulnerable groups into the insurance scheme will reduce the financial burden faced by this group (CBHI enrollment period is from November to March for one month in different regions). ● Strengthening financing of the exempted health services and incorporating TB services within health insurance benefit packages will safeguard TB patients from catastrophic out-of-pocket expense. **Resilience and Equity Health Funds:** ● Innovative financing mechanisms such as earmarking excise taxes for health can increase domestic financing for the TB program. The REHF could mobilize an additional US$48-96 million for the health sector and may emerge as a potential solution to alleviate donor dependence and support context-specific interventions for TB services. ● One of those three priority areas for investment under the REHF is targeting equity in health service provision for vulnerable populations and underserved geographic areas, which are population groups where TB is prevalent. TB primarily affects people with a low socioeconomic status, who are among the most vulnerable groups in the population. **In addition to the Exempted Health Services revision, HIBP redesign, and REHF discussed above, the additional reforms are:** ● Strategic Purchasing Reform: Allocative and technical efficiency in the use of existing funds also increases domestic resources for TB. ● Promotion of Private-Public Partnership: Private sector resources can be leveraged to increase access to TB service. ● Public Financial Management Reform: Efficiency can also be gained by instituting appropriate public financial management systems.
Why advocate for an increase in the budget line dedicated to TB or inclusion within the program-based budgeting (PBB)?	Establishment of a budget line dedicated to TB, or inclusion of TB category(ies) within the PBB framework ensures sustainability. As regions aspire to move towards PBB, inclusion of TB in this process will be critical to: ● Incorporate funding for TB services and activities, and thus extend the TB financing conversation beyond the planning for commodities alone. (The message: Functional TB programs require much more than just commodities.) ● Encourage sub-national entities to allocate more funding for TB. ● Allow easier tracking of funds for better forecasting of expenses and increased accountability for performance.

What are the preparatory steps that could be followed to communicate a clear advocacy message for increased TB financing?	The preparatory steps for a clear advocacy messaging should include: • Generate evidence through research • Clearly define the goal of the advocacy • Identify target audiences and champions • Design compelling engagement messages • Align and engage with ongoing health financing/health sector initiatives and reforms • Identify appropriate communication channels • Engage with decision makers • Monitor and evaluate the impact of advocacy
Why should TB drugs/commodities have a dedicated commitment from domestic financing?	The exempted service revision is focused on estimating the cost for drugs and supplies for the selected nine program areas, one of which is TB and leprosy. The rationale for this was that commodities are the main cost drivers, and other costs of service provision, such as human resources, are currently already funded through domestic funds (block grants). Currently, the majority of TB commodities are financed through donor funds, which are diminishing. Hence, to ensure sustainability, public financing of TB commodities is essential.
How can TB services (clinical services such as pre-diagnostic services) be made available through the insurance system to alleviate payment at the point of care?	• The revision of the exempted services and health insurance benefits package are reforms that are happening simultaneously. Alignment between the exempted service list and the insurance benefit package is under review to make these two complementary. It is expected that any intervention excluded from the exempted services will be covered by insurance. • Increasing insurance coverage to the most vulnerable populations will assist in reducing the cost incurred by patients at the point of care for pre-diagnostic services.
What is co-financing?	• Co-financing refers to a funding mechanism where multiple parties, such as government, donors, and organizations, can contribute financial resources toward healthcare programs or services. Domestically, co-financing can be very powerful when implemented between different levels of government, e.g., the national government contributes some money to a particular goal but only if the subnational government matches that with their own financial contribution to the same goal.
How can co-financing be leveraged to increase domestic funding?	• Co-financing allows for reduced dependency on a single source of funding to achieve sustainable financing and it promotes accountability between stakeholders.

Stakeholder Engagement Timeline

Engagement of the different stakeholders should be done at opportune windows to influence the domestic government budget cycle and increase domestic resources allocation for health and TB. The

table below outlines the budget preparation, approval, and execution phases where there are opportunities for engaging decision makers and leveraging the support of influencers.

Table 4. GOE Annual Budget Planning and Approval Timeline

Step 1: The Ministry of Finance (MOF) issues the Budget Preparation Circular	
Date	November – December 31, before fiscal year
Description	The budget circular, prepared by the country's treasury, defines the key priorities for the following fiscal year. Priorities can be determined at the program and sub-program levels (for example, health, TB). The budget planning circular provides no budgetary information, such as budget ceilings.
Advocacy Audience	MOF
TB Advocacy Objective	Convincing the Treasury to include specific TB interventions in the budget preparation circular communicated to MOH-E, so that the budget circular may subsequently function as an advocacy resource for TB.
Advocacy Priority Level	Low
Step 2: Macroeconomic and Fiscal Framework (MEFF) preparation/ update and approval	
Date	December - January 31, before fiscal year
Description	The MEFF guides budget development. MOF first prepares or updates the MEFF which forecasts government revenue and expenditure for the coming three years on a rolling basis. Based on this, MOF prepares or updates its three-year Medium Term Expenditure Framework (MTEF) and **establishes a budget ceiling** for each line ministry and region, including health. The MTEF encompasses the expenditure budget ceiling, the split of aggregate expenditures between federal and regional, and the split of federal expenditures between recurrent and capital for each sector for the next three years, among other things. Each year, the MOF can change the next-year ceiling or future yearly spending values relative to the amounts from the previous year's MEEF in advance. The MOF analyzes health sector performance data when determining these amounts each year.
Advocacy Audience	MOF
TB Advocacy Objective	Convincing the MOF to increase the health sector budget ceiling for the following year in comparison to the previous year's MEFF preparation/ revision, at a level equivalent to the proposed increase in the TB budget.
Advocacy Priority Level	Low
Step 3: Call for Budget Preparation, Budget Planning, and Approval by Top Leadership	
Date	February – March 31, before fiscal year
Description	MOF prepares an annual fiscal plan based on this three-year MEFF. This includes identifying the amount of resources (foreign and domestic) known as the resource envelop, the amount of money needed known as the expenditure requirement, determining the block grant amount for regional governments and administrative councils from all sources (domestic and foreign), and splitting the federal share between capital and recurrent budget. Following this,

	the MOF produces the yearly subsidy budget totals and informs the regional governments and administrative councils by February 8 at the latest. This is the beginning point for budget planning. MOF/BOF sent **a budget preparing call letter** to all public bodies. The letter covers recurrent and capital budget ceiling, priority areas to be addressed in budget preparation, and the deadline for public entities to submit budget requests to the appropriate finance institutions (BOF, Zonal Office of Finance [ZOF], *Woreda* Office of Finance [WOF]) in all jurisdictions. Public entities (MOF, RHB, ZHD, and Woreda Health Office [WorHO]) are obligated to respond to the budget preparation request by drafting their budget and action plan in accordance with the rules. Budget preparation operations are carried out by all public entities, including a mid-year program review for the current fiscal year and a work plan for the future fiscal year. The MOH-E's senior leadership, in collaboration with the Strategic Affairs Executive Office, established ceilings for each executive office, including Maternal and Child Health, Disease Prevention and Control, and others. Each executive office develops detailed budgets for health-care programs and sub-programs such as TB. In the health sector, the strategic affairs and planning directorates consolidate the budget and propose it to top management. Strategic affairs/planning teams at all levels of the health sector, as well as senior management teams, are in charge of reviewing, revising, and certifying the draft annual work plan and budget. The plan is reviewed and approved by the health sector's top leadership.
Advocacy Audience	The health sector's top leadership and senior management teams
TB Advocacy Objective	Convincing top management in the health sector to raise the TB program's budget ceiling in light of its yearly planning and budgeting proposal.
Advocacy Priority Level	High
Step 4: Budget Submission and Hearings with the Finance Institution	
Date	April 30, before fiscal year
Description	The phase consists of the health sector's senior leadership submitting the agreed-upon work plan and budget proposal to the finance institution, as well as holding a budget hearing with finance. In or around April of each year, financial institutions at each level of government organize budget hearings during which all sector offices, including the health institutions at each level, present and justify their budget proposal. This is a critical opportunity for the health institution at each level to make its case for additional spending on health and priority programs. Hence, these hearings involve a budget defense, in which health program (including TB) presents and justifies the proposed activities and level of resources needed to fund them. In the budget review, finance institutions weigh heavily on past budget execution and evidence of impact. Based on this review process and considering current national priorities, the health programs at each level (federal, regional, zonal and woreda) revise their proposed budgets.
Advocacy Audience	All level finance sector senior management team including the sector minister, heads, deputies and the budget directorate directors.
TB Advocacy Objective	Defend the general health budget as well as the particular TB budget from being reduced and promote greater funding for both.
Advocacy Priority Level	High

Step 5: Budget review and approval by executive bodies /council of ministers and cabinets/	
Date	May 31, before fiscal year
Description	Once the recommended budgets are compiled, the finance institution at each level presents the budget to each level of government's relevant executive bodies (to cabinets and council of ministers). The Treasury utilizes the sectoral work plan budget to develop budget estimates that are disaggregated at the program level. Hence, at this step, the TB budget estimates are consolidated with the other sub-programs in the program to which TB belongs. The budget estimates list target outputs at the sub-program level in a separate section of the document, such as early Antiretroviral Therapy initiation to all TB/HIV co-infected individuals; TB and MDR TB case detection, diagnosis and treatment; TB preventive therapy service for high-risk group initiated; as well as number of newly diagnosed TB cases. At the federal level, the budget (including regional block grants) is first sent to the Council of Ministers (chaired by the Prime Minister) for endorsement and then sent to the Federal Parliament for approval. At the regional level, finance institutions submit the budget to the regional cabinet (consisting of an administrator and the heads of the sector bureaus) for endorsement before it is passed to the Regional Council (consisting of elected representatives from zone, woredas and city administrations) for approval. After council approval, ZOF and WOF are notified of their approved budget allocations.
Advocacy Audience	All level finance institutions/ Treasuries
TB Advocacy Objective	Convince the Treasury to submit and defend the TB program and sub-program budget to the executive body (council of ministers and cabinets) at the value presented during the health annual negotiations.
Advocacy Priority Level	Moderate
Step 6: Budget review and approval by legislators / parliament or councils	
Date	June 30, before fiscal year
Description	After the recommended budget has been reviewed and adjusted by the respective executive body at all levels, it is presented to legislative bodies, including the federal House of Peoples' Representatives, regional zonal and *woreda* councils, for budget approval and annual appropriation of the approved budget at all levels. Health institution representatives, budget and social standing committees engage in the review and endorsement of the budget process. And finally, legislative bodies at each level of authority examine, amend, and approve the budget.
Advocacy Audience	The executive body particularly the budget and social standing committees at all levels
TB Advocacy Objective	Persuade the executive body/budget and social standing committees to lobby legislative bodies to defend the program budget, which includes the TB sub-program, to be approved at the amount initially indicated in the health sector annual work plan.
Advocacy Priority Level	Moderate
Step 7: Notification, modification and execution of approved budgets	
Date	July 31 of fiscal year

Description	As soon as the budgets are officially approved, all level finance institutions inform/ notify the health institutions of their final budget to execute during the fiscal year. Each **health** institution then may **revise** and adjust allocations across programs or activities as needed within a month. Regions develop financial action plans, indicating monthly disbursement requirements, and submit them to MOF to guide the budget execution process. Based on the action plans, budgets are disbursed by MOF to BOF and to the different central-level ministries on a monthly basis. Similarly, BOF disburses funds to the regional sector bureaus, zones, *woredas*, and city administrations on a monthly basis. Monthly reports on expenditure are sent by MOH, ZHDs, and WorHOs to their respective finance institutions.
Advocacy Audience	The health sector's top leadership and senior management teams
TB Advocacy Objectives	Convince the top management teams of the health institutions to examine and amend the TB budget across programs to cover any gaps generated by the budget allocation.
Advocacy Priority Level	Moderate
Step 8: Performance review and budget control	
Date	July – June 30 of fiscal year
Description	This includes activities such as ensuring that budget use is in accordance with laws and regulations, ensuring that disbursements are made in accordance with budget, ensuring that public property are kept safe, and ensuring that recording and accounting procedures are up to standard. The office of the general auditor is in charge of auditing public bodies and reporting its findings to the House of Peoples' Representatives.

Annex A – Analysis of Stakeholder Level of Interest and Level of Influence

Decision Makers

Stakeholders	*Level of interest*	*Level of influence*
Policy Makers: · *Prime Minister Office (PMO)* · *Parliamentarians (Social Standing Committee)* · *Council of Ministers*	*Unaware*	*High*
Ministry of Finance (MOF)	*Low interest, health sector seen as well supported*	*Very High*
Bureau of Finance (BOF) / *Zonal Office of Finance (ZOF)*	*Neutral*	*High*
Woreda Office of Finance (WOF)	*Neutral*	*Medium*
Regional and Woreda Cabinets	*Neutral*	*High*
National health sector leadership (Minister, State Minister of Programs, and Operations)	*Supportive*	*High*
Strategic Affairs Executive Office	*Supportive*	*Medium*
Disease Prevention and Control Lead Executive Office (DPCLEO)	*Supportive*	*Medium*
Sub-national health sector leadership (Head and deputies of RHB, ZHD, & WorHO)	*Neutral, supportive of health but neutral on prioritization of TB*	*Medium*
Other line Ministries (Ministry of Labor and Social Affairs (MOLSA), Ministry of Women, Children, and Youth Affairs (MOWCYA), Ministry of Mines (MOM), Ministry of Education (MOE), Police Commission, Prison Administration, Administration for Refugee and Returnee Affairs)	*Low*	*Medium*
Ethiopia Health Insurance Service (EHIS)	*High*	*Low*
Ethiopian Pharmaceutical Supply Services (EPSS)	*Unaware*	*Low*