**Economic evaluation of the Family Health Team at the Primary Health Care Unit health facilities in Addis Ababa: Costing and Cost Effectiveness Analysis preliminary findings**

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**Background**: The community Health Extension program packages were developed with the central philosophy of considering the community as the final end owners, producer and multiplier of health. To improve health service access for the urban poor living in cities/towns, family health team (FHT) was implemented to reach for the urban poor and economically disadvantageous groups.

**Objective**: The study aims to assess the cost and cost effectiveness of implementing FHT service delivery approach from the providers’ perspective.

**Methods**: Cost and effectiveness data were collected from five piloted health facilities (Gerji health center/HC, Selam HC, Entoto 2 HC, Woreda 06 HC and Woreda 12 HC) in Addis Ababa from the healthcare providers’ perspective. Cost data consisted of labor, medical supplies and medicines, equipment, trainings, preparation and program management resources. Four alternative service delivery strategies were identified for the analysis: households/community, school, youth center and workplaces. Micro costing ingredient approach was employed to compute the actual cost of FHT at the health facilities setting. Cost per household and per capita per year was the final costing summary while incremental cost effectiveness ratio (ICER) was computed as net cost per household reached.

**Findings:** The cost of FHT per household is 8,726 Ethiopian birr (ETB)/391 United States Dollar (USD) which ranges from 448.66 ETB (20.13 USD) to 41,019.06 ETB (1,840.24 USD). Per capita per year was from 72.70 ETB (3.26 USD) to 2,474.40 ETB (111.01 USD) across the piloted health facilities. The major cost drivers were consumables and labor cost (accounting for 87% of the total cost) while the lowest cost was for the program management and capital resources. In the base case analysis, implementing FHT was cost effective at the ICER of USD 28.45. The computed ICER for youth center, school and household were USD 4,622.28, USD 50,082.08 and cost saving respectively.

**Conclusions:** Implementing FHT is a cost effective strategy in terms of reaching more household at the low cost. Delivering the FHT service for the household is a cost saving strategy as compared to the other alternative modalities (providing FHT for the youth centers, schools and workplaces). Scaling up the FHT in urban based health facilities is the most economical and feasible intervention to reach more urban poor and economically disadvantaged groups.