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ACRONYMS:

ACT	Artemisinin-based Combination Therapy
AFP	Acute Flaccid Paralysis
AHOTP	Accelerated Health Officers Training Programme
AMDD	Averting Maternal Death and Disability
ANC	Antenatal Care
ARM	Annual Review Meeting
AYFRHS	Adolescent- and Youth-Friendly Reproductive Health Services
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPR	Business Process Re-engineering
BSS	Basic Social Services
BTS	Blood Transfusion Service
CCM	Country Coordinating Mechanism
CCS	Country Cooperation Strategy
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CIDA	Canadian International Development Agency
CSO	Civil Society Organization
DaO	Delivery as One
DFID	Department for International Development
DHS/ EDHS	Demographic and Health Survey/Ethiopian Demographic and Health Survey
DRS	Developing Regional States
EHAQ	Ethiopian Hospital Alliance for Quality
EHNRI	Ethiopian Health and Nutrition Research Institute
EHRIG	Ethiopian Hospital Reform Implementation Guidelines
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Programme on Immunization
ERCS	Ethiopia Red Cross Society
ERP	Enterprise Resource Planning
FHAPCO	Federal HIV and AIDS Prevention and Control Office
FMHACA	Food, Medicine and Health Care Services Administration and Control Agency

FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	Good Manufacturing Practice
GoE	Government of Ethiopia
GPW	General Programme of Work
GSM	Global Management System
GTP	Growth and Transformation Plan
HACT	Harmonized Approach to Cash Transfers
HEW	Health Extension Workers
HIVDR	HIV Drug Resistance
HMIS	Heath Management Information System
HPMF	Hospital Performance Monitoring and Improvement Framework
HPN	Health, Population and Nutrition
HQ	The Headquarters
HRH	Human Resources for Health
HSDP	Health Sector Development Plan
HSFP	Health System Funding Platforms
IDSR	Integrated Disease Surveillance and Response
IEOS	Integrated Emergency Obstetrics and Surgery
IHP	International Health Partnership
IHRs	International Health Regulations
IRS	Indoor Residual Spraying
IST	Intercountry Support Team
JANS	Joint Assessment of National Strategies
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financial Arrangement
JRM	Joint Review Missions
LDC	Least Developed Country
LF	Lymphatic Filariasis
LLINs	Long-lasting Insecticidal Nets

MDG	Millennium Development Goal
MDR-TB	Multidrug Resistant Tuberculosis
mhGAP	Mental Health Gap
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MOFED	Ministry of Finance and Economic Development of Ethiopia
MOSS	Minimum Operation Security Standards
MPS	Making Pregnancy Safer
MTCT	Mother-to-Child Transmission
MTR	Mid-Term Review
MTSP	Medium Term Strategic Plan
NBTS	National Blood Transfusion Services
NER	Net Enrolment Rate
NNP	National Nutrition Programme
NNS	National Nutrition Strategy
NTD	Neglected Tropical Disease
NTP	National Tuberculosis Programme
ODA	Official Development Assistance
OOP	Out-of-Pocket
PFSA	Pharmaceuticals Fund and Supply Agency
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PMTCT	Prevention of Mother-to-Child Transmission
PSPP	Patient Safety Pilot Project
RDT	Rapid Diagnostic Test
RH/MNCH	Reproductive Health/Maternal, Neonatal and Child Health
RNI	Rate of Natural Increase
RO	Regional Office
RRT	Rapid Response Team
RTI	Road Traffic Injury
SANA	Situational Analysis and Needs Assessment
SNNPR	South Nation Nationality People's Representative
SO	Strategic Objective
STHs	Soil-Transmitted Helminths

STI	Sexually-Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFR	Total Fertility Rate
TWG	Technical Working Group
UNDAF	United Nations Development Assistance Framework
UNSG JAP	UN Secretary-General's Joint Action Plan
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative

PREFACE:

The WHO Country Cooperation Strategy (CCS) is a medium-term strategic document for WHO cooperation with the Government of Ethiopia. It complements the WHO African Region Strategic Directions 2010–2015, the Medium Term Strategic Plan (MTSP) 2008–2013 and the 11th General Programme of Work (GPW) 2006–2015. The CCS effectively informs the operational planning process for the development of biennial workplans. The CCS aims to achieve greater relevance and focus in the determination of country priorities and, hence, ensure greater efficiency in the utilization of resources allocated for WHO country office activities.

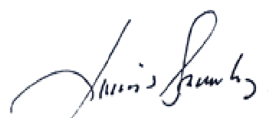
The new WHO Country Cooperation Strategy for the period 2012–2015 was developed on the basis of lessons from the implementation of the CCS 2008–2011. The strategic priorities and main focus areas have been updated to guide the work of WHO in alignment with the country's UNDAF 2012–2015, the Government Growth and Transformation Plan (GTP) 2010/11–2014/15, the Health Sector Development Programme IV 2010/11–2014/15 (HSDP IV) and the 2015 health-related MDGs.

The new global health context, the principles of alignment, harmonization and efficiency, as formulated in the Paris Declaration on Aid Effectiveness and other initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+) are also taken into consideration to strengthen collaboration with all stakeholders putting health at the centre of sustainable development.

The CCS 2012–2015 focuses on: (i) supporting the strengthening of health systems and services in line with the Primary Health Care approach; (ii) contributing to the reduction of the burden of communicable and noncommunicable diseases and conditions/injuries; (iii) contributing to the reduction of maternal, newborn and child mortality and improved sexual and reproductive health; and (iv) strengthening partnership, coordination and resource mobilization.

I commend the efficient and effective leadership role played by Ethiopia in conducting this important exercise of developing WHO's Country Cooperation Strategy 2012–2015 which will contribute to efforts towards reaching the health-related MDGs.

I am confident that the entire WHO staff, particularly the WHO country team in Ethiopia, will increase their contributions and ensure effective implementation of the Country Cooperation Strategy by supporting the Government of Ethiopia in its efforts to improve people's health and development.



Dr Luis G. Sambo
WHO Regional Director for Africa

ACKNOWLEDGEMENTS:

This Country Cooperation Strategy document is the product of a collaborative effort between the different levels of the WHO, the Federal Ministry of Health and partners. We would like to express our appreciation to all who played a supportive role during the preparation of this document.

EXECUTIVE SUMMARY:

Ethiopia is the third most populous country in Africa with a predominantly young population and high rate of natural increase. The economy is highly dependent on agriculture. Yet the country faces frequent droughts and is vulnerable to climate change. About 80% of diseases are attributable to preventable conditions that are related to personal and environmental hygiene, infectious diseases and malnutrition. Environmental risk factors alone account for 31% of the total disease burden in the country.

Major achievements of the country include availability of a comprehensive national health sector development programme, progress in tackling priority communicable diseases (mainly malaria and HIV), increment of per capita health expenditure, availability of primary health care units and a wonderful expansion of the Health Extension Programme and its 33 000 health extension workers (HEWs). The decrement in under-five mortality is also a major achievement. Challenges include insufficient funding of the health sector, weak implementation capacity, shortage of the required workforce (particularly midwives and anesthesiologists) and slow implementation of the new Health Management Information System (HMIS). Maternal and neonatal deaths and low prevention of mother-to-child transmission (PMTCT) coverage also remain a major challenge. These issues are the main priorities of the current Health Sector Development Plan (maternal, newborn and child health; HIV, TB and malaria and nutrition).

The Country Cooperation Strategy (CCS), which is aligned with the General Programme of Work (GPW), the WHO Medium Term Strategic Plan (MTSP), the Health Sector Development Plan (HSDP) of Ethiopia and the UNDAF, is a framework for WHO cooperation with the Government of Ethiopia and serves as a tool to guide planning, budgeting and resource allocation for WHO-supported programmes. The WHO African Region Strategic Directions 2010-2015 and the health MDGs were also used to guide CCS preparation. This third generation CCS covers the period 2012-2015.

During the preparation of the cooperation strategy, lessons were drawn from our past experiences, strengths and weaknesses as well as the country's achievements and the challenges it continues to face. Availability of WHO

technical expertise at country as well as regional and global levels, extensive field presence, logistic capacity, established working relations and good understanding of the working environment and partners have been great assets. The ongoing collective effort for harmonization and alignment led by the Federal Ministry of Health (FMOH) is a great foundation.

Based on the situational analysis and comparative advantage highlighted above, four strategic priorities and fourteen main focus areas were prioritized as stated below. The modalities for implementing each main focus area are stated as strategic approaches:

(a) Support the strengthening of health systems and services in line with the Primary Health Care approach: (i) strengthen leadership and management capacity to enhance governance; (ii) strengthen national capacity to ensure equitable access to and utilization of quality health services; (iii) strengthen development and management of critical health care resources; and (iv) improve quality of hospital care.

(b) Contribute to reducing the burden of communicable and noncommunicable diseases and conditions/injuries: (i) support the strengthening of capacity for implementation of International Health Regulations (IHRs) within the platform of Integrated Disease Surveillance and Response as well as capacity for emergency preparedness, response and recovery; (ii) support the strengthening of prevention, control and treatment of HIV/AIDS, tuberculosis and malaria; (iii) support the strengthening of health promotion, prevention and control of noncommunicable diseases and conditions/injuries and the control, elimination and eradication of neglected tropical diseases (NTDs); (iv) support the strengthening of health promotion, healthy and safe environment, food safety and proper nutrition as well as climate change adaptation for public health.

(c) Contribute to reducing maternal, newborn and child mortality and improved sexual and reproductive health (SRH): (i) strengthen support to improve access to SRH information and quality services, including adolescent-friendly SRH services with focus on the lifecycle approach; (ii) strengthen national capacity to improve access to skilled attendance of deliveries through addressing the three delays, quality newborn care, and referral linkages; (iii) strengthen capacity to scale up high impact child survival interventions with particular focus on neonatal mortality reduction; and (iv) strengthen immunization service support and the introduction of new vaccines and cold chain management .

(d) Support the strengthening of partnership, coordination and resource mobilization: (i) strengthen existing partnerships in and outside the UN system, civil society organizations and training and research institutions and foster new partnerships; (ii) continue to support harmonization and alignment efforts for health; (iii) support resource mobilization efforts and effective utilization of resources.

For an efficient implementation of the CCS, the WHO country office (WCO) will continue to advocate for and play a critical role in communicable and noncommunicable disease prevention and control activities and in the improvement of maternal and child health. WHO will support health system strengthening and all WHO contributions will be delivered in alignment with the national health development plan. The technical expertise of the Organization will be used to leverage its support to the different areas of work. In addition, it will advocate and continue working with the Ministry of Health (MOH) to increase awareness, raise more resources and improve coordination and partnership.

This CCS will undergo a mid-term review after two years of implementation and a final evaluation at the end of four years.

SECTION 1:

INTRODUCTION

The General Programme of Work (GPW) of the World Health Organization (WHO) reflects the values and principles of the WHO Constitution, the Alma Ata Declaration on Primary Health Care (PHC) and the United Nations Millennium Declaration. It describes the responsibilities of WHO as the world's lead health agency and sets the broad directions for its future work. The Medium Term Strategic Plan (MTSP) emanating from the 11th GPW provides the Organization with strategic directions over a period of six years for advancing the global health agenda as well as guiding preparation of three biennial programme budgets and operational plans.

The Country Cooperation Strategy (CCS) is a framework for WHO cooperation with the Government of Ethiopia and serves as a tool to guide planning, budgeting and resource allocation for WHO-supported programmes. Ethiopia has already formulated two generations of CCS. The first covered the 2002-2005 period. It was later updated in 2007 for the 2008-2011 period. This third CCS 2012-2015 is timely as it is aligned with the country's health sector plan, harmonized with the United Nations Development Assistance Framework (UNDAF) and coincides with the WHO African Region Strategic Directions, namely:

(i) Ethiopia Fourth Health Sector Development Plan (2010/2011-2014/2015) which outlines the country's priorities and strategies and an important component of the Government of Ethiopia's Growth and Transformation Plan (GTP).

(ii) WHO Africa Region Strategic Directions for the period 2010-2015 which focus on six priority areas, namely:

(a) Continued focus on WHO's leadership role in the provision of normative and policy guidance as well as the strengthening of partnership and harmonization.

(b) Supporting the strengthening of the health system, based on the Primary Health Care approach.

(c) Putting the health of mothers and children first.

(d) Accelerated action on HIV/AIDS, malaria and tuberculosis.

(e) Intensifying the prevention and control of communicable and noncommunicable diseases.

(f) Accelerating the response to determinants of health.

(iii) UNDAF (2012-2016) and its Action Plan which are being finalized.

Under the strong leadership of the WHO Representative (WR), the WHO country office (WCO) has gone through a series of consultations and strategic dialogue within the Organization as well as with the Federal Ministry of Health (FMOH) and partners. An analytical approach was adopted to identify the health needs and priorities of the country. In addition, the UNDAF preparation process, the last health sector Annual Review Meeting (ARM) organized in October 2011 and the review meetings contributed in identifying issues and setting priorities.

It is worth noting that the process of identification of the strategic agendas has taken into account the need to address some core values such as health as a fundamental human right, equity and gender equality. The principles of alignment and harmonization with the national priorities used laid a basis for WCO collaborative programmes and its operations in the country.

The current CCS formulation process has also taken into account global, regional and country- level developments, primarily:

(a) The need to accelerate the attainment of the MDGs, particularly the UN Secretary-General's Joint Action Plan (UNSG JAP) for Women's and Children's Health.

(b) The Health System Platform initiative of GAVI, GFATM and World Bank facilitated by WHO.

(c) The global financial crisis and its perceived impacts on the countries and the Organization.

(d) The WHO country office commitment to the MDG fund managed by the Federal Ministry of Health.

(e) The ongoing WHO reform process and the renewed interest for greater country focus.

SECTION I:

HEALTH AND DEVELOPMENT CHALLENGES

2.1 Macroeconomic, Political and Social Context

Ethiopia is a large country with an area of over 1.1 million square kilometers and a population of 79.4 million (male-to-female ratio of 1.02), making it the third most populous country in Africa.[1] The country is home to diverse nations, nationalities and peoples with more than 80 different languages. Approximately 84% of the population lives in the rural areas, making Ethiopia one of the least urbanized countries. The average size of a household is 4.7[2].

The age structure of the population has remained predominately young, with 44% of the population under the age of 15 years and over half (52%) falling within the age group of 15 to 65 years. While the male-to-female sex ratio is almost equal, women in the reproductive age group constitute nearly a quarter of the population. The annual rate of natural increase (RNI) is 2.6%[3] while the total fertility rate (TFR) is 4.8 births per woman[4].

Ethiopia's economy depends heavily on the agricultural sector which contributes over 45% of Gross Domestic Product (GDP) and 80% of exports, and accounts for 83.4% of the labour force. Frequent droughts coupled with poor farming practices make the economy very vulnerable to climate change[5]. An estimated 29.2% of Ethiopians were living below the poverty line in 2009-2010. However, this is a significant reduction from the very high level of 49.5% in 1994/95[6].

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1 Statistics Abstract ; Central Statistical Agency of Ethiopia; 2009 .

2 Statistics Abstract; Central Statistical Agency of Ethiopia; 2009.

3 Population and Housing Census 2007.

4 Ethiopia Demographic and Health Survey 2011; Central Statistical Agency, ICF International, March 2012.

5 Health Sector Development Programme 4, Federal Ministry of Health; 2010.

6 Ministry of Finance and Economic Development of Ethiopia (MOFED) 2008.

According to the UNDP, in 2010, Ethiopia ranked 174 out of 187 countries with comparable data in the Human Development Index (HDI). In the same year, according to the World Bank, total health expenditure, as a percentage of GDP, was 4.9%.

The Federal Democratic Republic of Ethiopia is composed of nine Regional States and two City Administrations; these are subdivided into 817 administrative Woredas (districts). The Woreda is the basic decentralized administrative unit with an administrative council composed of elected members. The 817 Woredas are further divided into about 16 253 villages called Kebeles, the smallest administrative unit in the governance structure[7]. Ethiopia has a federal government, exercising decentralization by devolution.

In response to its economic and social challenges, Ethiopia has developed a comprehensive five-year plan called the Growth and Transformation Plan (2010/2011-2014/2015). The Government of Ethiopia and partners are fully committed to implementing the said plan that aims, among other things, at achieving 11% annual average economic growth, addressing emerging development bottlenecks and meeting the MDG targets[8].

2.2 Major Determinants of Health

Economic growth, income distribution, geographical difference, education, gender, food and nutrition behaviour, lifestyle-related factors, environmental factors related to water and sanitation, waste management, food safety and air quality are some of the major determinants that have direct impact on health outcomes of different socioeconomic groups of a country. Ethiopia recognized the profound effect of the social determinants of health (SDH) on health and its overall development endeavours.

Since the commencement of major health sector reforms in 1993, Ethiopia's efforts have been directed towards improving the standards of living, particularly the health of the population, throughout the country (MOFED, 2010). This is being done through a combination of strategies and approaches which include health-specific strategies and those intended to influence the performance of other determinants of health, including education, poverty reduction, and access to good sanitation and safe water.

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7 Health Sector Development Programme 4, Federal Ministry of Health; 2010.

8 Growth and Transformation Plan; Ministry of Finance and Economic development; Nov, 2010.

As part of its action on the SDH, for instance:

(i) By the end of 2010, urban and rural access to safe water coverage within a distance of 0.5 km and 1.5 km was 91.5% and 65.5%, respectively.

(ii) During 2009/2010, the Gross Enrolment Rate (GER) for primary school (grades 1-8) reached 95.9 per cent (93.per cent for girls and 98.7 per cent for boys). During the same year (2009/2010), the Net Enrolment Rate (NER) stood at 89.3 per cent (87.9 for boys and 86.5 percent for girls).[9]

(iii) The percentage of stunted children declined from 58% to 44 % between 2000 and 2011. Similarly, the percentage of underweight children declined from 41% to 29% in the same period[10].

The Government has developed a National Nutrition Strategy (NNS) and is implementing a National Nutrition Programme (NNP) to accelerate progress and address malnutrition using a comprehensive and harmonized approach[11].

However, major gaps in addressing the SDH prevail, impacting the health outcomes. About 80% of diseases are attributable to preventable conditions that are related to personal and environmental hygiene, infectious diseases and malnutrition. Environmental risk factors alone account for 31% of the total disease burden in the country[12]. The general literacy rate remains very low at 36%, pointing to the need to focus on this aspect of educational development[13], despite an improved gross enrolment rate for primary school (see above).

Ethiopia is a country where cultural and social barriers to gender equality are very strong, resulting in poor sexual and reproductive health indices and high prevalence of harmful traditional practices, including early marriage, female genital mutilation, gender-based violence, etc. This gender disparity negatively impacts the well-being and health of the poor, diminishing their productivity. The high total fertility rate (TFR) and rate of natural increase (RNI) mean greater demand for social services, especially education and health.

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[9] Ethiopia 2010 MDG Report; Ministry of Finance and Economic Development, 2010.

[10] Ethiopia Demographic and Health Survey 2011; Central Statistical Agency, ICF International, March 2012.

[11] Ethiopia 2010 MDG Report; Ministry of Finance and Economic Development, 2010.

[12] Country profile of environmental burden of diseases, WHO 2009.

[13] Ethiopia 2010 MDG Report; Ministry of Finance and Economic Development, 2010.

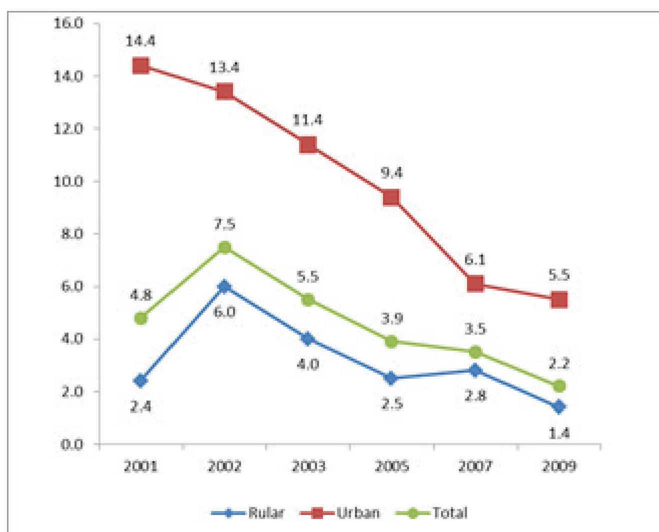
2.3 Health Status of the Population

2.3.1 Burden of communicable diseases

The focus is on HIV/AIDS, tuberculosis, malaria and neglected tropical diseases (NTDs) like trachoma, onchocerciasis, schistosomiasis, soil-transmitted helminths (STHs), lymphatic filariasis, dracunculiasis, leishmaniasis, and podoconiosis.

2.3.1.1 HIV/AIDS, tuberculosis and malari

Figure 1: Trends in HIV prevalence (%) among ANC clients in rural and urban sites with at least 4 consecutive data points in Ethiopia, 2001-2009.



The HIV/AIDS pandemic remains a major public health problem in Ethiopia and is being addressed as a top priority in the health sector agenda. Figure 1 clearly shows declining trends of adult HIV prevalence over the last decade, with a marked decline particularly in urban settings. HIV prevalence among young people aged 15-24 years also dropped from 12.4% in 2003 to 2.6% in 2009, indicating a decline in new infections. According to new estimates produced using DHS-2011 and ANC-2009, adult HIV prevalence was 1.5% in 2011 (4.2% for urban and 0.6% for rural areas) and is higher among females (1.9%) than males (1%)[14].

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[14] Ethiopia Demographic and Health Survey 2011; Central Statistical Agency, ICF International, March 2012.

The above-mentioned trends can be explained by notable efforts which have been made in response to the HIV/AIDS pandemic. Very significant progress is acknowledged in areas such as community mobilization, HTC and HIV care/ART scale up. However, there is a need to address critical challenges such as patient retention, monitoring of HIV drug-resistance (HIV/DR) and limited laboratory capacity while accelerating HIV prevention. The PMTCT programme remains a national key challenge, with only 20% of mothers and 12% of newborns reported to have received complete ARV prophylaxis[15]. However, the Government has recently adopted the 2010 WHO PMTCT guidelines and is moving towards an accelerated approach to PMTCT scale up. The national STI programme and interventions targeting the key populations at high risk also deserve greater attention.

The incidence and prevalence of TB in Ethiopia is estimated to be 261 and 394 per 100 000 population, respectively[16]. TB was the third leading cause of hospital admissions and a leading cause of inpatient deaths in 2008-2009[17]. These high mortalities are associated with a high TB/HIV co-infection rate (15%) and the emergence of multidrug resistant TB18. The country has made significant progress in increasing the number of detected TB cases from 71 331 in 1999 to 153 194 in 2011. The decrease in the estimate of TB incidence after the recent National TB Prevalence Survey improved the case detection rate of all forms of TB from 50% to 72%. However, the survey result has shown that only very few cases of smear-positive TB cases in the communities were detected by the routine health services delivery mechanisms. The situation was found to be worst in the pastoralist areas where the magnitude of undetected smear-positive TB cases was higher than in the agrarian and urban areas of the country. While the Stop TB strategy is a key approach in the country, the pace of expansion of community TB care remains very slow, TB control in the congregate settings is not addressed and the monitoring system remains weak.

About 75% of Ethiopia’s land is malarious and 68% of the population is at risk of malaria infection. Malaria prevention and control interventions, including mass distribution of LLINs, scale up of indoor residual spraying (IRS), introduction of rapid diagnostics tests (RDTs) at community level and adoption of artemesinin-based combination therapies (ACTs), have been scaled up since 2005, leading to reduction in the burden of the disease, on

[15] Annual Performance Report of Multispectral HIV/AIDS Response for 2009/10, FHAPCO, August 2010.

[16] Global Tuberculosis Control 2011, WHO.

[17] Health and health-related indicators; Federal Ministry of Health 2010.

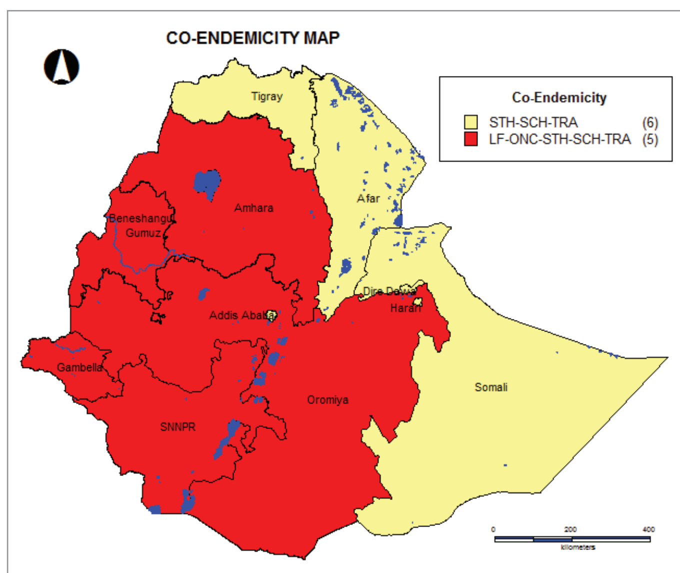
[18] Tuberculosis prevention and control programme; Special issue for World TB Day 24th March 2011, FMOH.

on average, by about 50%[19]. Despite the above achievements, malaria remains a major public health problem and one of the top causes of outpatient visits.[20] Challenges include the development of vector resistance to multiple recommended insecticides for IRS and low mosquito net utilization rate. Other challenges include lack of appropriate and quality data information, and sustainability of funding.

2.3.1.2 Disease surveillance, prevention, control and eradication

The Federal Ministry of Health has drafted a five-year (2011-2015) National Neglected Tropical Disease Master Plan. A group of eight diseases contribute to much of the neglected tropical disease (NTD) burden. These are trachoma: onchocerciasis, schistosomiasis, soil-transmitted helminths (STH), lymphatic filariasis, dracunculiasis, leishmaniasis and podoconiosis. These diseases are highly associated with poverty and poor living conditions. They are referred to as silent and hidden diseases. The NTDs classified as preventive chemotherapy (STH, schistosomiasis, trachoma, onchocerciasis and LF) and case management (leishmaniasis, podoconiosis and dracunculiasis) diseases have varied levels of endemicity across the regions.

Figure 2: Co-endemicity map of onchocerciasis GW and LF



[19] Otten et al. Initial evidence of reduction of malaria cases and deaths in Rwanda and Ethiopia due to rapid scale-up of malaria prevention and treatment; Malaria Journal 2009, 8:14.

[20] Health and health- related indicators, FMOH 2006 / 2007; 2007/ 2008/; HSDP IV Annual Performance Report 2010/2011.

Most of the NTDs overlap in their endemicity as seen in the co-endemicity map for Preventive chemotherapy diseases below. Five of the PCT NTDs are co-endemic in six of the regional states (Amhara, Oromia, B-Gumuz, Gambella, SNNP and Harari) and two city councils whereas the three NTDs (trachoma, STH and schistosomiasis) are co-endemic in Tigray, Afar and Somali.

Visceral leishmaniasis (VL), the fatal form of the disease, is endemic in five regions of the country (Tigray, Amhara, Oromia, SNNPR and Somali). The number of VL cases treated in the last four years in the country is increasing (1936 cases in 2008, 1083 in 2009, 1936 in 2010 and 2032 in 2011). The VL/HIV co-infection rate ranges from 18.5% to 40% in Humera/Tigray and 15% to18% in Libo/Amhara[21], making the control programme challenging.

Although the total number of reported cases of dracunculiasis is declining (from 24 cases in 2009 to 21 in 2010 and 8 in 2011), Ethiopia remains among the few countries in the world where the disease is still endemic. It is estimated that up to one million cases of podoconiosis (non-filarial elephantiasis) exist in Ethiopia[22]. The socioeconomic impact of the disease is high, affecting 70% to 90% of the economically-active age group and resulting in loss of 45% of productive work days.

Integrated Disease Surveillance and Response (IDSR) serves as a vehicle for International Health Regulations (IHRs). Ethiopia has developed a five-year strategic plan and started implementing it as regards 20 priority diseases that are epidemic prone, have public health significance and are targeted for eradication and elimination. The country completed IHR core capacity assessments and, based on the assessment results, a plan of action has been developed within the framework of IDSR.

Limited access to timely and adequate information on some of the most important diseases has affected the design and implementation of effective intervention strategies. Mapping of selected diseases and strengthening of capacity for early detection of outbreaks, reporting and timely response will continue to be important issues to be addressed.

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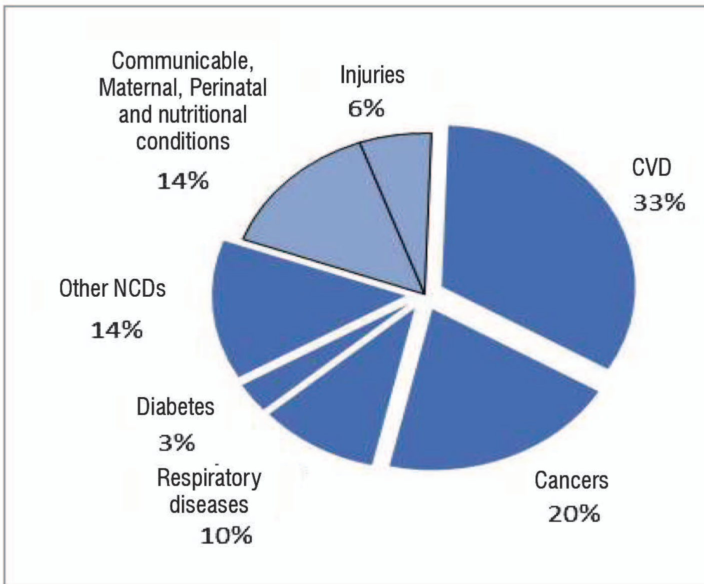
21 MhGAP Implementation Programme for Ethiopia, 2010.

22 Davey, Tekola, & Newport, 2007.

2.3.2 Chronic and noncommunicable diseases

An assessment report by the FMOH in 2008 has shown that noncommunicable diseases such as cardiovascular diseases, diabetes mellitus and cancers, along with injuries, are among the major contributors to the high level of mortality and morbidity in Ethiopia (HSDP 4). NCDs are estimated to account for 34% of all deaths in Ethiopia.

Figure 3: Proportional mortality (% of total deaths, all ages)



Source: NCD country profiles 2011; WHO.

Tobacco consumption in Ethiopia is increasing and the current prevalence of daily tobacco smoking across all age groups and sexes is 2.4% with higher prevalence in males (4.5%). The prevalence of other behavioural and metabolic risk factors including physical inactivity, raised blood pressure and overweight is also increasing (17.9%, 35.2% and 7.2% respectively). The fast expansion of khat use both in rural and urban areas is considered to be among risk factors.

There is an increasing trend of mental health problems with prevalence ranging from 3.5% to 17%.

The only specialized hospital for mental disorders cannot address the needs of the country in terms of mental health. In order to overcome this, WHO and FMOH are currently implementing the WHO Mental Health Gap Action

Programme (mhGAP) aimed at integrating mental health into PHC through a decentralization process. There is a high level of stigma and marginalization of people with this disease, coupled with a huge service gap (75%) for provision of sufficient mental health care[23].

Road traffic injuries (RTIs) account for over a third of all injuries in Ethiopia and affect all age groups across both sexes. In 2010, RTIs and fatality rates of registered vehicles were around 900 and 70 per 10 000 respectively. In addition, other intentional and unintentional injuries contribute to the burden of diseases. WHO estimates that about 10% of the Ethiopian population has some form of disability[24].

2.3.3 Maternal, child and adolescent health

Maternal and child health are among the country's priority health programmes and efforts are being implemented to reduce maternal and child mortality. Despite regional variability, the remarkable decline in under-five and infant mortality has put the country on track to possibly achieve MDG4 (EDHS 2000, 2005, 2011). However, the decline in neonatal mortality during the same period was minimal and continues to contribute significantly towards childhood deaths. Similarly, there has been no improvement in the maternal mortality rate (MMR) (EDHS 2000, 2005, 2011).

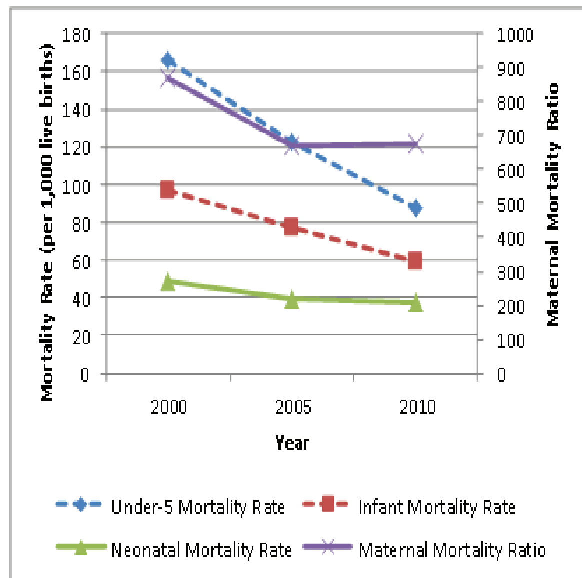


Figure 4: Trend analysis of under-five, infant, neonatal and maternal mortality

While there has been an improvement in antenatal care from 28% to 34% and delivery care from 6% to 10%, there has been no improvement in maternal mortality (EDHS 2005, 2011). Inadequate and delayed utilization of skilled

23 MhGAP Implementation Programme for Ethiopia, 2010.

24 World Report of Disability 2011, WHO/World Bank.

care, limited availability of emergency obstetric and newborn care (national EMOC assessment), low postpartum visit - only 36.2% of mothers attend postnatal care within 42 days of delivery (health and health service indicators (2009-2010) and insufficient practices of appropriate infant and young child feeding may have contributed to the stagnation in maternal and neonatal mortality progress. The nutritional status of children under five years of age for the three indices, weight for age (underweight), height for age (stunted), weight for height (wasting), were 29%, 44% and 10% respectively. Wasting and underweight have not shown significant change since the 2005 EDHS, though stunting has decreased from 51% to 44%[25]. Poverty and inadequate capacity and poor practices of health workers are some of the reasons for minimal improvement in nutritional status.

Immunization coverage has steadily increased over the years, with DPT3 coverage at 86% and measles vaccine coverage at 81% in 2010[26]. The increment in coverage is similarly observed through surveys, but there are wide disparities between administrative and survey coverage figures. Despite this improvement in coverage and because of the size of its population, Ethiopia still has a large number of unimmunized children mostly in specific zones. This has resulted in the outbreak of vaccine-preventable diseases such as measles and pertussis, affecting wider age groups including adults. Large disparities exist in service coverage among regions, with immunization coverage as low as 44% in Afar (compared to the national average of 86%) and 59% of zones in the country achieving more than 80% coverage, due to geographic access, security, human resource capacity, health infrastructure (including availability of functional cold chain systems) and lifestyle, among other factors. The last imported case of wild poliovirus was in April 2008. Although acute flaccid paralysis (AFP) surveillance has remained certification level standard at national level since 2004, there are gaps in some bordering regions and zones with threat of undetected importation and circulation of wild poliovirus. According to the 2007 national census, adolescent and young people of ages 10 to 24 make up 35% of the total population. Adolescents in Ethiopia are faced with many sexual and reproductive health problems, for example, the adolescent pregnancy rate is 17% and only 12 % of young women aged 15-24 years who are sexually active use modern contraceptives (2005 EDHS).

In addition, youths in Ethiopia have limited access to sexual and reproductive health information as well as quality adolescent- and youth-friendly reproductive health services, coupled with the widespread culture of early marriages.

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[25] Ethiopia Demographic and Health Survey 2011; Central Statistical Agency, ICF International, March 2012.

[26] HMIS administrative data 2010.

2.3.4 Environmental health

Water and sanitation coverage nationwide are at 68.5% and 60.0% respectively[27], although utilization seems low especially for existing latrines. In addition, water quality is of concern as evidenced by frequent outbreaks of water-related epidemics in both rural and urban areas. The 2004 national rapid water quality assessment result showed that 28% of the improved sources of water were not in line with national water quality standard in terms of microbiological quality.

Indoor air pollution from use of biomass fuel is one of the environmental risk factors contributing to 4.9% of the national burden of disease28. High fluoride levels in groundwater are a particular problem in the Rift Valley regions where approximately 14 million Ethiopians suffer from problems related to high fluoride levels. According to WHO (2009), environmental risk factors account for 31% of the total disease burden in Ethiopia.

The 2010 Situational Analysis and Needs Assessment (SANA) on Health and Environment linkage identified the major risk factors affecting human health in the country as indoor air pollution, soil degradation, deforestation, biodiversity loss, drought, disease vectors and poor housing.

2.3.5 The health of specific vulnerable populations

Ethiopia has a large and extremely vulnerable population with over five million citizens facing high levels of malnutrition, poor access to health services, inadequate safe water supply, and poverty. Natural disasters like floods, drought and human epidemics namely cholera, malaria and measles have led to widespread health vulnerabilities in diverse population categories. Moreover, conflicts, cross-border tensions (increasing number of refugees) and massive population movements of daily laborers have greatly contributed to increased vulnerability of various segments of the population to risks of communicable diseases including meningitis, malaria and diarrhoeal diseases. Coverage and access of health services in pastoralist areas as well as the Developing Regional States (Gambella, Benishangul-Gumuz, Afar and Somali) is very low, making the population vulnerable to various health problems.

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[27] HSDP 3: Annual Performance Report: EFY 2002 (2009/2010).

[28] WHO 2007 estimate.

2.4 National Responses to Overcoming Health Challenges

2.4.1 National development policies and responses

Ethiopia has developed a five-year national poverty reduction strategy called the Growth and Transformation Plan (GTP) as a means of ensuring economic growth, achieving the MDGs and addressing the determinants of health. The seven pillars of the GTP are (i) sustaining rapid and equitable economic growth; (ii) maintaining agriculture as a major source of economic growth; (iii) creating conditions for the industry to play a key role in the economy; (iv) enhancing expansion and quality of infrastructure development; (v) enhancing expansion and quality of social development; (vi) building capacity and deepening good governance; and (vii) promoting gender and youth empowerment and equity.

2.4.2 National health policies, strategies and plans

Ethiopia developed its current national health policy in line with the Primary Health Care approach in 1993. In addition, the country has a national drug policy, a national HIV policy and an antiretroviral drug supply and use policy, as well as specific strategic and operational plans. The Health Sector Development Plan (HSDP) is prepared in cycles of five years; the first cycle began in 1997. The development of the fourth one (HSDP 4 -2010/11-2014/15) has been an all-inclusive process which extensively utilized the Joint Assessment of National Strategies (JANS) tool to comply with agreed upon priorities and implementation modalities. The JANS is a shared assessment of a national strategy or plan used jointly by partners and government.

The priorities of HSDP 4 are maternal and newborn health, child health, HIV/ AIDS, TB, malaria and nutrition (HSDP IV, 2010).

2.5 Health Systems and Services Response

Although a significant improvement has been recorded in the health systems, addressing the overall health needs of the people has been a challenge. The performance of priority programmes has been challenged by the limited capacity at the decentralized levels. Major response has mainly been in terms of policy reforms, management of health service delivery through

decentralization, human resource development health financing, medicines and health technologies supply systems, as well as strengthening of partnerships for health and information for health planning and management.

2.5.1 Management of health services delivery

Health care delivery is organized into a three-tier system (FMOH, 2011) that puts the health extension programme, an innovative community-based service delivery, as a corner piece. Service delivery is characterized by a Primary Health Care Unit (PHCU) comprising five satellite health posts and one health centre to serve 5000 and 25 000 people respectively; a district hospital that serves 100 000 people; a general hospital that serves a million people; and a specialized hospital that serves 5 million people. The growing countrywide network of healthcare facilities has enhanced physical access to health services, particularly in respect of primary health care. Geographical coverage of public health centres is 86%, reaching most of the rural areas in the country. The rapid expansion of both profit and not-for-profit private facilities accounts for about 11% of health service coverage and utilization and has enhanced public private partnerships in health (FMOH, 2011). However, at the health service delivery points, public health facilities account for about 89% of health care services in Ethiopia. While all primary health care activities, including priority national programmes, are organized and integrated at the district level, challenges of this devolved system include local capacity for organization, planning and management and the service referral systems that have not developed as expected. Despite the above achievements, OPD attendance per capita fluctuated around 0.3 visits per person per year over five years (2005/6–2010/11).[29]

Although Ethiopia is moving towards greater decentralization of the health care system, many aspects of hospital management, which are integral to hospital quality and efficiency, are largely still under the responsibility of government agencies at the regional and federal levels. The current key performance indicator data is inaccurate as all hospitals have not been trained on data collection, analysis and reporting nor has the reported data been audited in any way. Infection prevention in hospitals is an issue of concern as well. To boost the sharing of best practices and improvement of hospital quality, FMoH, in collaboration with other partners, has created a new model called Ethiopian Hospital Alliance for Quality (EHAQ) in which the hospital industry learns from its own success through facilitated networks.

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[29] HSDP 4: Annual Performance Report , EFY 2003 (2010/11).

Ethiopia has recently conducted a reform and restructuring process called Business Process Re-engineering (BPR). This has resulted in a new division of labour. Accordingly, the Pharmaceuticals Fund and Supply Agency (PFSA) is mandated to handle supplies issues. The Food, Medicine and Health Care Services Administration and Control Agency (FMHACA) is mandated to handle regulatory functions in health, food and medicine. The Ethiopian Health and Nutrition Research Institute is mandated to address health emergencies, nutrition, research and laboratories, thus showing the emphasis placed on these areas. To ensure a population-centred approach, the department in charge of health promotion and disease prevention is organized into urban, rural and pastoralist health.

2.5.2 Human resource development

Ethiopia's concern has been the general shortage, skill-mix and distribution of its health workforce, with too few physicians and midwives to meet the country's needs. Currently, 45% and 28% of the total number of physicians and nurses respectively are working in Addis Ababa city administration whereas the big regions like Oromia, Amhara and southern nations and nationalities that account for 80% of the country's population altogether constitute only 15%, 18% and 5% of the number of physicians respectively. The creation of a cadre of health extension workers (HEW) at the community level is one way to address this challenge. To respond to the health workforce shortage and distribution, a number of new training institutions have been established and the capacities of existing schools have been strengthened. The training of health professionals by private schools has been liberalized, resulting in increasing numbers of mid-level health workers.

Furthermore, the training of health officers, who provide intermediate care in health centres, has been accelerated. Physician training has been expanded with an increase in medical schools from three to 23. In spite of the huge investment and success in the training and deployment of low and mid-level health workers, the shortage of doctors, midwives and anaesthesia professionals remains a challenge. In order to meet the shortfalls and geographical imbalances, the Ministry of Health, in collaboration with the Ministry of Education and development partners, has embarked on an innovative medical doctors training programme in local health training institutions.

2.5.3 Health information and management systems

Ethiopia has undertaken an extensive reform of the health management and information systems. The reform involved standardization of tools and guidelines for routine data collection and aggregation, performance monitoring and quality improvement, as well as integrated supportive supervision, evaluation and inspection. The community health information system with family folder as its framework has been developed and is being operationalized to ensure standardized data collection and management that guarantees better health information for decision making, improved health systems performance and health status of the population. Currently, the HMIS is being implemented in about 60% of the health facilities (health centres and hospitals).

Though registration of vital events has not started in Ethiopia, the preliminary steps towards realizing it are being undertaken through the HIS strategy that is being finalized.

2.5.4 Blood transfusion services

Adequacy and universal access to a safe blood supply still remain a challenge in Ethiopia. Of the estimated annual national blood requirement of 100 000 units of blood[30], only 44 686 units were collected by the Ethiopian Red Cross Society –Blood Transfusion Service (ERCS-BTS) in 2010[31] . Up to 70% of these units were collected and utilized in Addis Ababa alone while the residents of the remaining regions could only access 30%. In addition, blood from the ERCS caters for the needs of 52% of the hospitals in the country while the rest organize their own blood sourcing mechanisms, thus compromising the quality of the blood supply. Over 70% of blood donors are family replacement donors[32]. Selection of donors at reduced risk of infection is challenging particularly because of the high prevalence of hepatitis B and C as well as HIV in the potential blood donor population. Testing for markers of these diseases is seldom universal. Additionally, blood transfusion is mainly emergency- driven and unnecessary transfusions are not uncommon. FMoH is in the process of restructuring to revert the services to its own management in a bid to integrate the service into the mainstream health care

30 2007/08 FMoH core indicators.

31 Ethiopia Red Cross Society data.

32 Ethiopia Red Cross Society data.

delivery system so as to improve on efficiency and effectively manage the 26 blood banks being established in the country to address issues of access. Establishment and strengthening of an NBTS will require unprecedented technical support.

2.6 Medicines and Health Technologies

2.6.1 Essential drugs and medicine policy

The improvement in the availability and access to essential medicines in the health system is partially attributable to the efforts made by the Pharmaceuticals Fund and Supply Agency (PFSA) to establish different hubs in different parts of the country, the training of health professionals in supply management and rational use of drugs and the increase in the number of local pharmaceuticals manufacturing plants. However, since most of the local manufacturers are not GMP compliant, their international competitiveness is limited. To ensure the availability of safe, effective and quality medicines in the health system, through the establishment of a strong regulatory system, the Food, Medicine and Health Care Services Administration and Control Agency, has developed a number of guidelines and model legislation and provided support to regional states. Also, WHO, in collaboration with the Federal Ministry of Health (FMoH) has conducted two studies, namely (i) study on the assessment of the pharmaceutical sector and (ii) study on human resources for the pharmaceutical sector with the aim of identifying challenges and recommending solutions for the improvement of the sector.

2.6.2 Laboratory services and medical equipment

The new master strategic plan for laboratory services is being implemented. The Ethiopian Health and Nutrition Research Institute (EHNRI) is putting in place a regional laboratory network but its efforts are being hampered by challenges such as inadequate human resources, limited laboratory supplies chain management and poor maintenance of laboratory and other medical equipment. Cold chain management also remains a critical issue. Currently, the country is working to develop national donation guidelines which will facilitate the standardization of medical equipment.

2.7 Healthcare Financing

Although per capita health expenditure in Ethiopia increased from US$ 7.14 in 2005 to US$ 16.1 in 2007/2008, high out-of-pocket (OOP) spending (37%) is a major obstacle to accessing basic services particularly by the poor. Government's contribution to the health sector was 21% in 2007/2008, down from 31% of total health expenditure in 2004/2005[33]. The major mode of financing the public health sector has been through budget allocation of revenue mobilized from the general tax and donor support. To ensure and improve the mobilization of sustainable financing for the sector, the country has designed social health insurance policy options, including mandatory social insurance and voluntary community-based health insurance systems.

2.8 Contribution of the Country to the Global Health Agenda

In line with the primary health care approach, Ethiopia has been implementing a health extension programme for the provision of preventive and basic curative services by community health workers at village level. Each village (called kebelle) with an approximate population of 5000 has two female health extension workers with one year pre-service training and additional integrated refresher training. The programme is also being implemented in urban areas of the country (which constitute 16% of the population). In the same vein, Ethiopia has managed to use some of the assistance provided for specific diseases, for instance by the Global Fund, for the flexible strengthening of the health system. Ethiopia is also a pioneer in signing a national International Health Partnership (IHP) compact. It is among the countries that used the JANS tool to prepare a sector plan.

2.9 Similarities with other Countries

The population dynamics, disease burden, response and related challenges in Ethiopia are similar to those in other counties, particularly the least developed countries (LDCs) in the southern hemisphere. Thus:

(a) Achieving the MDG relating to the reduction of maternal mortality in the face of health system bottlenecks remains a challenge.

[33] Ethiopia's fourth national health accounts, 2007/2008. April 2010.

(b) With only 16% of the population living in urban areas, Ethiopia is one of the least urbanized countries. Burkina Faso, Burundi, Malawi, Rwanda and Uganda are the other countries in Africa with a similar or lower rate of urbanization.

(c) Communicable diseases are major contributors to the burden of health problems in the country as mentioned in the previous sections. Ethiopia ranks 7th among the 22 high burden tuberculosis (TB) countries globally and third in the African Region. Ethiopia also has one of the highest numbers of cases of multidrug resistant tuberculosis (MDR-TB) in Africa after South Africa, Nigeria and DRC. A lot of challenges remain in TB control.

(d) Ethiopia has the sixth highest burden of leishmaniasis globally and the second in Africa after Sudan.

(e) The presence of pastoralist communities in Ethiopia presents unique challenges to health service delivery and calls for innovative approaches. The Sahel part of north-central Africa, the Maasai area of Kenya and northern Tanzania, the Kalahari Desert in South-West Africa share similar features.

(f) The national health system has inadequate human and financial resource and limited infrastructure especially with regard to laboratories and other health technologies and information and communication systems.

2.10 Summary

Table 1: Summary of key achievements, opportunities and challenges

Achievements /opportunities:

1. Availability of country's comprehensive health sector development programme with clear priorities and directions for the period of the new CCS.
2. Encouraging developments in tackling priority communicable and noncommunicable diseases which resulted in a reduction in morbidity and mortality.
3. In an effort to ensure the generation and availability of a comprehensive health information system and as part of the sector wide reform, the groundwork for standardized and comprehensive health information has been laid.
4. Per capita health expenditure increased from USD 7.14 in 2005 to USD 16.1 in 2007/2008, up by USD 8.95 (NHA4, Apr 2010). Overall government expenditure on health has increased by 71%. The main expenditure sources are out-of-pocket health expenditure (OOP) and external donor support which account for 37% and 39% respectively of total health expenditure.
5. Availability of primary health care units increased from 20% to 100% for health posts and from 18% to 100% for health centres through the expansion of 15 000 health posts and 3 200 health centres respectively.
6. Hospitals (all types) increased from a total of 79 to 116 by the end of 2009/2010.
7. To address the health workforce crisis, a number of new training institutions have been established and their capacity enhanced.
8. According to the 2009 HRH profile update (WHO in collaboration with FMOH), improvement has been observed over the years. Staff density has risen from 0.25 in 2003/2004 to the current 0.84 in 2008/2009, ranging from 2.8 in Harari to 0.47 in Somali region. To date, 31 831 primary health workers (HEWs) have been trained in the agrarian communities, representing a density of 1:2,437 (target: 1:2,500).
9. A significant decrease in under-five and infant mortality rates was observed between 2005 and 2010.
10. Prioritization of maternal and newborn health at global and national levels provides an opportunity for reducing maternal and child mortality. According to the 2009 ANC surveillance survey report, the HIV prevalence trend at national level on 62 sites (both urban and rural) that had four rounds of consecutive data from 2003 to 2009 showed a considerable decline from 5.5% in 2003 to 2.2% in 2009, including in 15-24 years old , which is an indication of a reduction in new HIV infections. The trend in urban sites (n=34) showed a marked decline from 11.4% in 2003 to 5.5% in 2009. It is also consistent in rural sites (n=28) where prevalence declined from 4.0% in 2003 to 1.4% in 2009.
11. Launched in 2005, the free ART programme has been expanded considerably from only three health facilities in 2005 to 550 health facilities by 2009 and the number of people started on ART also increased from 900 in 2005 to more than 250 000 by 2010. Access to HIV testing and counseling has also increased significantly, facilitating the necessary linkages between prevention and treatment.
12. Health facility-based morbidity/ mortality surveys indicate that in 2009 malaria deaths in all age groups fell by 55%, malaria inpatient cases by 44 %, and malaria outpatient cases by 28%.
13. In 2010, the estimated annual incidences were 163 and 378 TB cases/100 000 population for smear-positive and all forms of TB respectively.
14. Decentralization and integration of visceral leishmaniasis treatment centres from 3 to 16 in the VL endemic regions.
15. Scaling up of community IDSR in SNNPR from 2 pilot woredas to 67 woredas.
16. of a five- year strategic framework for NCD prevention and control.
17. About 100 non-specialized health workers trained in delivering mhGAP package.
18. About 30 specialized and non-specialized health workers training as trainers of trainers and supervisors.

Challenges:

1. Inadequate funding of the health sector. The latest NHA in the country revealed that priority health services such as maternal, child health and nutrition remained underfunded and donor dependent. The high out-of-pocket (OOP) spending (37%) presents a major obstacle to accessing basic services particularly by the poor.
2. Limited planning, management, implementation and monitoring and evaluation capacity at the regional, zonal and woredas levels.
3. Inadequate capacity in programme coordination resulting in fragmentation and high transaction cost and overburdening of health workers, in particular health extension workers.
4. Shortage of health workforce, low workforce density and disparity in workforce distribution and skill-mix (WHO recommended average level of health workforce density of 2.5 per 1000 population, in order for the country to ensure delivery of essential health services and thus to achieve the MDG targets).
5. Inadequate implementation of the HMIS.
6. Deepening of the gap between patients started and currently on ART and important missed opportunities for PMTCT are key challenges in the HIV response.
7. Despite the significant decline in under-five and infant mortality rates between 2000 and 2010, the neonatal mortality rate is not showing any significant decrease. High maternal and neonatal mortalities, high unmet needs for family planning, shortage of skilled birth attendants, weak referral system, inadequate midwifery skills at health centre level, inadequate availability of BEmONC and CEmONC equipment and high HIV prevalence remain major challenges of the health care systems in Ethiopia. Only 2% of health centres provide BEMOC services in the country. PMTCT of HIV remains as low as 8.2%.
8. Synergy between health nutrition activities implemented at community level is difficult due to lack of integrated tools for implementation, monitoring and evaluation.
9. Less priority is given to NTD and NCD prevention and control.

SECTION 3:

DEVELOPMENT COOPERATION AND PARTNERSHIP

3.1 The Aid Environment in the Country

In line with the effort to implement better harmonization and alignment with the national plan and monitoring and evaluation with the national system, Ethiopia has become a pioneer in signing a national IHP compact with key partners in the health sector. The continued leadership led to the signing of a Joint Financial Arrangement (JFA) which paved the way for a one fund managed by the government system (MDG pooled fund).

Comprehensive and reliable information on the magnitude and modality of aid transfer is not easily available, while the available information is not up-to-date. Nevertheless, available sources show that, in 2008, Ethiopia was the largest receiver of net Official Development Assistance (ODA) disbursements in Africa (USD 3 327 000 000), followed by Sudan and Tanzania (OECD, 2010). However, Ethiopia's ODA per capita is still significantly lower than the sub-Saharan African average. According to the World Development Indicators Report 2008, in 2006, Ethiopia's aid (including food aid and off-budget transfers) was 13% of GDP, about USD 25.2 per person. Although exact figures are not easily available, the health sector appears to get a significant share of the total aid to the country. For example, the fourth national health accounts review indicated that partners contributed USD 466 628 078 for the health sector during the Ethiopian fiscal year (July 2007-June 2008).

Apart from direct budget support to the different levels of the government through the Ministry of Finance and Economic Development, implementation through civil society organizations (CSOs) and self-implementation, partners channel their funds through various modalities including:

(a) MDG Performance Pool Fund: Set up under the framework of the IHP compact and its Joint Financial Arrangement (JFA) it is a pooled funding mechanism managed by the FMOH using Government's

procedures, and provides specific federal grants for public goods and capacity building activities for health system strengthening. It is one of the Government of Ethiopia's (GoE) preferred modalities for scaling up development partner's assistance in support of the Health Sector Development Plan (HSDP). Various partners including GAVI, Irish Aid, Spain, UK, UNFPA, DFID and WHO are contributing to this fund. Additional partners like the World Bank, UNICEF, Italy and AusAid are also considering joining this mechanism.

(b) Health Pool Fund (HPF): It is part of HSDP's wider pooled funding scheme and supports implementation activities with focus on procurement of technical assistance. In 2009/2010 EFY, it was funded by Italian Cooperation, DFID and Royal Netherlands Embassy. Though expected to be a transitional and temporary mechanism, the HPF is likely to continue due to some of its advantages in procurement of services over the Government's system.

(c) Protecting Basic Services (PBS): This is a basket fund for basic services (like health and education). It is managed and monitored using World Bank procedures. The World Bank and other international development partners (DFID and CIDA) provide funds, through government channels, targeted at protecting and promoting basic services for the poor.

Approximately 14% of funding to the health sector is through pooled funds (10% through MDG Performance Pool Fund and 4% through Protecting Basic Services). Pooled funds are the FMOH's preferred aid modality.

3.2 Stakeholder Analysis

Partners working in the interrelated areas of health, population and nutrition (HPN) are bilaterals, multilaterals, UN agencies, civil societies and NGOs. The list of major donor agencies with their areas of contribution/participation can be seen in the table below. Though indicative of the major players in the health sector, the table is not exhaustive. A number of nongovernmental organizations including CSOs which are active players in the sector are not mentioned.

Table 2: Areas of contribution/participation of main development partner

Programme area	Multilateral	Bilateral
HIV/AIDS, Malaria and TB prevention and control.	UN System/UNDAF, WB/EMSAPII, Global Fund	Italian Development Cooperation, , CDC, USAID (including PMI and PEPFAR), CIDA, SIDA,GIZ, Bill and Melinda Gates Foundation, RNE, Irish Aid, GF
Food and Nutrition, including promotion, relief, recovery and development.	WHO, WFP, FAO, UNICEF, IOM, IAEA, UNFPA, WB, AfDB, IFAD, OCHA, UNHCR, UNESCO	USAID, SCF UK ,SCF US, ACF, World Vision, Goal, Concern ADRA, IMC, Care, Merlin
Health System strengthening, monitoring, HMIS and quality assurance.	WHO,UNICEF, UNFPA, WB, Health Metrics Network, GFATM, GAVI	CDC, Tulane University Ethiopia, GF, IDC, Irish Aid, IC, USAID
Support to Maternal and Child Health Services, and health protection of women/ girls based on gender equality.	WHO, UNICEF, UNFPA. WB	USAID, SIDA, DFID, RNE Irish Aid, JICA, AEICD
Support to Health Extension Programme	WHO, UNICEF, UNFPA	USAID, DFID, GTZ
Strengthening health care referral system	WHO, UNICEF, UNFPA	Clinton Foundation, USAID
Capacity building for Human Resource Development in the health sector.	WHO, UNFPA	USAID, Tulane University, IC, Irish Aid
Strengthening control of vaccine-preventable and other major communicable diseases.	WHO, UNICEF,GAVI	EU, JICA, CDC, Rotary, IFF, IM, Russian Global Fund, Irish Aid, AEICD
Capacity development for health laboratories and research performance.	WHO	USAID, CDC, JICA, Irish Aid
Support to appropriate and widely disseminated IEC/BCC programmes	WHO, UNICEF, UNFPA, GFATM	
Capacity building for adequate and timely availability/distribution of health commodity supplies.	WHO, UNICEF, UNFPA	Royal Netherlands Embassy, Irish Aid, DFID, USAID, PFSCMS
Water, hygiene and sanitation	UNICEF, WHO	RNE, Irish Aid, AEICD, USAID

3.3 Coordination and Aid Effectiveness in the Country

The International Health Partnership (IHP) framework that was signed in Addis Ababa on 26 August 2008, set out the framework for increased and more effective aid, and accelerated actions toward the achievement of the health Millennium Development Goals (MDGs). Eleven partners including WHO and GoE representatives (MOH and MOFED) have signed this instrument. The Joint Financing Arrangement (JFA) refers to an arrangement that sets out the jointly agreed terms and procedures for MDG Fund management, including planning, financial management, governance framework and decision making, reporting, review and evaluation, audit and supply chain management.

A review of the HSDP governance mechanisms was done in 2010 through a very participatory approach. Currently, the following mechanisms are in place.

Joint Consultative Forum (JCF): The consultative forum consists of the appropriate representatives of the Government, the donor community, nongovernmental organizations, the private sector and the civil society. This forum is chaired by the Minister of Health. WHO is an active member of the forum. JCF serves as a joint forum for dialogue on sector policy and reform issues between GoE, development partners and other stakeholders. It serves as the highest joint governance body which guides, oversees and coordinates the FMOH and development partners in implementing HSDP.

Joint Core Coordinating Committee (JCCC): The JCCC serves as a technical body and is chaired by the Director-General of Planning and Financing. To date, the JCCC has played a critical role in organizing the HSDP Mid-Term Reviews and Final Evaluation, coordinating and managing preparatory works for the Joint Review Missions (JRMs) and Annual Review Meetings (ARMs) and analysis of draft review reports before their submission to higher bodies. Its activities include: assisting MOH in organizing and coordinating the monitoring, review and evaluation missions and meetings of the HSDP, assisting the FMOH in preparing HSDP 4 and the consecutive plans (phases), assisting in strengthening Government-DP partnership and commitment through dialogue and joint review exercises, assisting in strengthening Government-private sector and NGOs partnership, facilitating analytical studies, and operational oversight of all pooled funds. Members are from the FMOH and health development partners including the WHO.

Annual Review Meetings (ARM): The ARM is a forum where all stakeholders are involved in reviewing HSDP implementation. The ARM is designed to be retrospective, looking back at performance and looking forward over the

coming fiscal year plan and budget. Though the main focus of the ARM is assessing the implementation of HSDP, aid flow and utilization is also part of the review.

Joint Review Missions (JRM): The JRM is a joint review mechanism between partners and the MOH that assesses the performance of the health system over a one-year period. JRMs have generated relevant information on the performance of the health system.

The Health, Population and Nutrition (HPN) partners' forum is a mechanism where partners working in the area of HPN meet every month with the aim of coordinating their support to the country. WHO is an active member of the above committees and mechanisms.

3.4 UN Reform Status and the UNDAF

The United Nations Development Assistance Framework for Ethiopia (UNDAF 2012–2015) has been developed in response to Ethiopia's five-year national development plan – the Growth and Transformation Plan (GTP), which is the first in a series of three five-year plans to propel the country's transformation to middle-income country status by 2025.

The UNDAF is anchored in and aligned with the Growth and Transformation Plan (GTP), and various sector development plans. It builds on the achievements and progress made over the last decade and leverages the UN's position as a trusted and neutral partner of the Government of Ethiopia and its people. It is developed within the Delivery as One (DaO) framework to ensure a harmonized, coherent and more effective approach to UN's contribution to the implementation of the GTP.

The UN will support six out of seven GTP pillars by harmonizing its contribution to these goals through four mutually reinforcing UNDAF pillars, namely (i) Sustainable Economic Growth and Risk Reduction, (ii) Basic Social Services, (iii) Governance and Capacity Development and (iv) Women, Youth and Children. The Basic Social Services (BSS) thematic area is composed of three subgroups - Health and Survival; HIV and AIDS and Education. Health and health-related issues are covered under the health and survival subgroup, which addresses health, nutrition and WASH together.

WHO is actively involved in the development of the UNDAF where it co-chairs the BSS thematic working group and convenes the health and survival subgroup. Additionally, the government ministries are involved at the thematic and subgroup levels.

The United Nations Country Team (UNCT) selected three flagship joint programmes in priority areas like Maternal and Newborn Health (MNH), Support to Developing Regional States (DRS) and Gender. WHO is an implementing partner of MNH and DRS, while supporting the Gender Joint Programme.

3.5 Summary

Table 3: Key development cooperation achievements, opportunities and challenges

Opportunities/achievements
(a) Potential funds on areas including health/ Emerging global health initiatives. (b) Ethiopia has signed the global IHP compact and developed a country compact which has been signed by WHO among 11 partners. (c) The Joint Financial Arrangement (JFA) has paved the way for the existence of a pooled fund managed by the Government (MDG pooled fund) (d) Annual Review Meetings where federal and lower levels of the health systems with partners review performance of health system in the past and agree on the coming year's plan. (e) New partners supporting the health agenda (e.g. Australia). (f) Joint missions (Government and partners) (g) Launching of one UN fund. (h) Three UN joint programmes underway.
Challenges
(a) Global financial crisis. (b) Harmonization and alignment commitments. (c) Strengthening of monitoring and follow-up capacity. (d) Expanding and developing new partnerships in health.

In the next CCS cycle, WCO will continue to play an active role in the coordination forums.

SECTION 4:

REVIEW OF WHO COOPERATION OVER THE PAST CCS CYCLE

4.1 External Review

A joint meeting with the FMOH was conducted where the national officials highlighted the Strengths, Weaknesses, Opportunities, and Threats (SWOT) of WHO presence in Ethiopia. The directorates and general directorates of the MOH (Health Promotion and Disease Prevention, Medical Services Directorate and Policy, Plan and Finance General Directorate) and agencies and institutions (Ethiopian Health and Nutrition Research Institute and Food, Medicine and Health Research Administration and Control Agency) actively participated in this meeting. In addition, stakeholder analysis was done for the UN as part of the preparation for the new UNDAF and provided useful information to complement the external review. During the past CCS cycle (2008-2011), the WCO collaborated with FMOH, donors, partners and, to a limited extent, civil societies and academia. Such collaboration was based on the second cycle of the CCS (CCS II) and biennial plans, which were prepared in consultation with the concerned bodies and were in alignment with the national priorities. In addition to joint preparation of the WCO biennial plan, various technical experts of the office played an active role in the preparation of the MOH annual and strategic plans.

In line with the principles of the International Health Partnership (IHP), the country office contributed to the enhancement of harmonization, alignment and national ownership. The World Health Organization was one of the first signatories of the national IHPs which paved the way for aligning with the principles of one plan, one budget and one report. Following this, WCO again became one of the pioneer partners in signing the Joint Financial Arrangement, an arrangement that sets out jointly agreed terms and procedures for the MDG Fund management. The office was a contributor to the MDG pooled fund.

WHO is regarded as having strengths in many areas. Availability of WCO technical expertise in various health programmes with technical support to national counterparts appears to be the most noted strength. The global experience of the Organization to support the Government in key areas including capacity building in the area of guidelines development, norms and standards setting is an advantage. Like other UN organizations, recognition by donors and national counterparts as a credible partner, with extensive field presence, logistic capacity, established working relations and good understanding with the Government, are also positive attributes of the WHO. Other areas of strength are resource mobilization efforts including support to the country on the same, alignment to national priorities and support to harmonization and alignment efforts.

A number of weaknesses of the WHO have however been noted. Declining proportion of assessed contribution is a concern of the Government. The distribution of financial resources across different programmes is viewed as not equitable when viewed from the national priority areas. Though not a major concern, administrative and procedural complexities are cited as factors negatively affecting performance.

Though the WHO is appreciated for its capacity building efforts, the coordination of training activities under different programmatic areas appears less than satisfactory. Most capacity building training programmes are short term as well.

While the contribution of WHO to health system strengthening is appreciated, the Organization is said to spend a major share of its financial and technical resources on specific disease control programmes.

4.2.1 WHO contribution

WHO provided technical and financial support for the implementation of the Health Sector Development Plan 3 (HSDP 3). The CCS II was fully aligned with the HSDP 3. A key technical role was played in the review and development of national policies, strategies, guidelines, manuals, and service delivery reforms (HRH Strategic Plan, "Ability to Pay" study which is a mechanism towards establishment of health insurance schemes, National Malaria Strategic Plan (2010-2015), Essential Drugs and Medicines Policy, Comprehensive ART/HIV Care Guidelines, review of TB control programme and development of the TBL Manual, TB/HIV implementation guidelines, guidelines for Childhood TB and MDR-TB, Situational analysis and needs assessment on health and environment assessment (SANA) Standards for blood transfusion, protocol for management of common obstetric problems at

health facility level, National Paediatric Referral Care Protocol, National tool for the planning, implementation and monitoring of the standards for quality adolescent- and youth-friendly reproductive health services (AYFRHS), essential medicine list, National Strategy for Noncommunicable Diseases, NTD Strategic Plan, National Community Led Total Sanitation and Hygiene guideline, legislation of Universal Iodization of Salt, among several other guidelines and training materials). Through the provision of WHO strategic guidance to guide the national health agenda, and with specific involvement of national counterparts in the adaptation process and roll out, local ownership was facilitated in the development of national policies, guidelines and manuals. The development of annual plans of the health sector initiated through district (Woreda) - based planning is done with full participation and technical support from WHO at the different levels.

Support was provided for implementation of the priorities of the HSDP 3 with a focus on strengthening the health service delivery system through the Health Extension Programme in order to ensure equitable access and delivery of appropriate promotive, preventive and curative services. Tools and guidelines for strengthening capacity of health extension workers such as The Family Planning Decision Making tool, Community Case Management of Pneumonia, health promotion tool kit and Integrated District Health Management materials were developed with direct technical support from WHO. National efforts to accelerate reduction of maternal, newborn and child mortality in Ethiopia were supported through the Making Pregnancy Safer (MPS) strategy, scale up of newborn and child survival interventions, as well as efforts to achieve targets for polio eradication, measles pre-elimination, and maternal and neonatal tetanus elimination, in order to achieve MDGs 4 and 5. Capacity building was undertaken to strengthen service delivery in several aspects including emergency preparedness and response to outbreaks such as cholera and other diarrhoeal diseases, H1N1, meningococcal meningitis, measles and wild poliovirus importation. Coordination mechanisms for eradication and control of neglected tropical diseases, blood safety, and emergency and humanitarian action were strengthened with WHO playing a key coordination role.

Support was further provided for monitoring and assessment of implementation of the HSDP through HMIS design, roll-out and assessment of its implementation and data quality; strengthening of the integrated disease surveillance system; and implementation of the International Health Regulations (IHRs) through country capacity assessment and training at different levels involving other sectors. Several assessments were undertaken with technical and financial support from WHO that included the noncommunicable diseases assessment, national emergency obstetric and newborn care (EmONC) assessment, EPI cold chain and vaccine

management assessments, situation analysis of the national PMTCT of HIV/AIDS programme response in the broader RH/MNH context in Ethiopia, occupational safety assessment, Joint Review Missions and Annual Review Meetings.

4.2.2 WHO alignment to national health priorities and contributions

The second generation CCS was developed in close consultation with key stakeholders including and mainly with the Federal Ministry of Health. The period was selected to address the need for alignment with the HSDP 3 (July 2005-June 2010) and UNDAF.

WHO played a key role in coordinating and facilitating resource mobilization efforts. There was strong WHO participation in all GAVI and GFATM proposal development processes as well as Government proposals for other partners. Significant amounts of financial resources were mobilized through WHO for support to government health programmes.

Evaluations of biennial workplans for the past CCS cycle indicate achievement of the majority of planned activities.

Key contributing factors towards effective WHO support to the Government's priorities included an enabling partnership environment with the Government and stakeholders for coordination of activities and availability of 164 technical and administrative staff. A total of 32 technical staff are stationed at zonal level, including six Regional Coordinators. The country office has a total of 76 Minimum Operating Security Standards (MOSS) compliant vehicles to facilitate WHO activities.

4.2.3 Areas where WHO contribution was required, but was insufficient to achieve the stated objectives

WHO is expected to play a key role in strengthening the health system. However, the health system in Ethiopia remains constrained by a shortage of skilled manpower and weak managerial capacity at the peripheral level that undermine all efforts to enable the system to be more responsive so as to ensure equitable access to quality services. Access to life saving interventions such as emergency obstetric care remains limited. The promotion of healthy environment and tackling of modern environmental hazards were additionally constrained due to inadequate attention given to them by all the necessary stakeholders.

Allocation of financial resources through WHO to some programmes was insufficient to contribute towards implementing all key planned activities. In addition, support to operational research as well as to other sectors was limited.

4.2.4 WHO as a member of the UNCT

WHO collaborated effectively with other UNCT partners through the UNDAF framework to collectively support the national health priorities, as stipulated in the HSDP 3 and 4. WHO is a member of most of the Thematic Areas of Work: Social Basic Services and Human Resources Development; Enhanced Economic Growth; Emergency Preparedness and Response; HIV and AIDS and Governance and Human Rights.

The EmONC assessment conducted in 2009, jointly supported by UNICEF, UNFPA, WHO and Averting Maternal Death and Disability (AMDD), provided the basis for a flagship Joint Programme on MNH in line with Delivering as One (DaO) under the implementation of the UNDAF and the Health Four (H4) initiative for the improvement of Maternal and Newborn Health. WHO is also participating in the implementation of the nutrition and food security joint programme under the Spanish MDG-F and the Developing Regional States joint programme.

4.2.5 WHO as a broker for health among partners and across sectors

WHO played a key role in fostering partnerships among various stakeholders in health by actively participating, coordinating and providing essential qualified technical input. WHO serves as a member and/ or secretariat of the Country Coordinating Mechanism (CCM) for GFATM, the Health, Population and Nutrition (HPN) Group, and the HIV Partners Forum through which policy advice is given in a sustained, integrated and coordinated manner.

Ethiopia was the first country to sign a national International Health Partnership (IHP+) compact in August 2008 followed by the signing of the JFA on 15 April 2009 that sets the rules and procedures for the management of a pooled funding mechanism for implementation of the HSDP. WHO provided significant support in implementation of the IHP in Ethiopia through consultations with regional and global teams, and assessment of the commitment of development partners as well as the host country.

WHO achieved its role in providing health-related information and data to the Government and partners, including disease outbreaks within and across borders of international concern.

4.2.6 Areas in which WHO has a comparative advantage and should focus on, and areas from which it should shift its focus, during the next CCS cycle

The comparative advantage of WHO is in the setting of policies, standards and norms in all aspects of health and this should remain a key focus of the Organization's support to the Government. The generation of evidence for better planning and decision making through operational research and documentation and dissemination of best practices will need to be strengthened during the next CCS cycle to facilitate work in setting norms and standards. Further focus is needed in strengthening surveillance, monitoring and evaluation, support to academic institutions and collaboration in addressing determinants of health.

SECTION 5:

STRATEGIC AGENDA FOR WHO COOPERATION

5.1 Introduction

The strategic agenda for the period 2012-2015 is in harmony with the 2010-2015 Strategic Directions for WHO which emphasizes six priority areas to achieve sustainable health development in the African Region: (i) continued focus on WHO's leadership role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization; (ii) supporting the strengthening of health systems based on the primary health care approach; (iii) putting the health of mothers and children first; (iv) accelerated actions on HIV/AIDS, malaria and tuberculosis; (v) intensifying the prevention and control of communicable and noncommunicable diseases; and (vi) accelerating response to the determinants of health.

The CCS agenda is also in line with the new six priority categories and the eight strategic priorities reflecting the WHO reform as listed in the below table:

Table 4: WHO new priority categories and strategic priorities

Six priority categories	Eight strategic priorities
(i) Communicable diseases	(i) Unfinished health-related MDGs and future challenges (the post-2015 Development Agenda
(ii) Noncommunicable disease	(ii) Noncommunicable diseases and mental health
(iii) Promoting health through the life course	(iii) Universal health coverage
(iv) Health systems	(iv) Implementing the International Health Regulations (2005)

(v) Preparedness, surveillance and response	(v) Increasing access to essential, high-quality, effective and affordable medical products
(vi) Corporate services	(vi) Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries
	(vii) Strengthening WHO's governance and WHO's role in health governance
	(viii) Reforming WHO management: alignment HQ-ROs-SRs-WCOs; improving effectiveness of secretariat support to countries; strategic communication and knowledge management; and improving accountability, risk management, transparency and GBS oversight

The priorities of the country, as indicated in the National Health Sector Development Programme and UNDAF (2012-15) have been the basis for preparation of the WHO priorities in the CCS period, taking into consideration the comparative advantages and strategic directions of the Organization. The Ethiopian Growth and Transformation Plan (GTP) considers the agricultural sector as the major driver of its economic growth. Its emphasis on giving priority to the expansion of small-scale irrigation could create some health issues. Working across all sectors is necessary so as to integrate health into all policies.

5.2 The Strategic Agenda

Based on the foregoing, four strategic priorities and 12 main focus areas were prioritized as stated in the table below. The modalities of implementing each main focus area are stated as strategic approaches:

Table 5: Strategic priorities and main focus areas for WHO cooperation

Strategic priorities	Main focus
(i) Support the strengthening of health systems and services in line with the primary health care approach	• Strengthen leadership and management capacity to enhance governance. • Strengthen national capacity to ensure equitable access to and utilization of quality health services including hospital care. • Strengthen the development and management of critical health care resources.
(ii) Contribute to the reduction of the burden of communicable and noncommunicable diseases and conditions/ injuries	• Support the strengthening of the capacity for implementation of IHR within the platform of integrated disease surveillance and response as well as capacity for emergency preparedness, response and recovery. • Support the strengthening of prevention and control of HIV/AIDS, tuberculosis and malaria. • Support the promotion of healthy and safe environment, food safety and proper nutrition as well as climate change adaptation for public health and prevention and control of noncommunicable diseases including mental health and injuries, and the control, elimination and eradication of NTDs .
(iii) Contribute to the reduction of maternal, newborn and child mortality and improved sexual and reproductive health.	• Support FMOH to improve access to SRH information and quality services with focus on the lifecycle approach. • Strengthen national capacity to improve maternal and child health interventions, including access to skilled attendance of deliveries and to scale up high impact child survival interventions. Strengthen immunization systems, including surveillance and cold chain management, and support the introduction of new vaccines.

Strategic priorities	Main focus
(iv) Support the strengthening of partnerships, coordination and resource mobilization	- Strengthen existing partnerships in and outside the UN system, civil society organizations, training and research institutions; and foster new partnerships. - Continue to support the harmonization and alignment efforts for health. - Support resource mobilization efforts and effective utilization of resources.

Strategic priority I: Support the strengthening of health systems and services in line with the primary health care approach

Main focus 1.1: Strengthen leadership and management capacity to enhance governance

(a) Support the review and update of the current health policies as well as the development and implementation of strategic plans at all levels.

(b) Support the integrated management and provision of comprehensive essential health services with focus on the district health systems in line with the decentralization of the health systems of the country.

(c) Facilitate the updating, implementation and enforcement of public health acts, laws and regulations.

Main focus 1.2: Strengthen national capacity to ensure equitable access to and utilization of quality health services including hospital care

(a) Provide support to design and implement appropriate health service delivery mechanisms for pastoralist communities and the Developing Regional States (DRS).

(b) Provide support to scale up coverage of essential health services in the framework of the country's Primary Health Care Unit (linking five health posts to a health centre) through improved service organization, integration and management.

(c) Provide support to strengthen the referral system at all tiers of the health system.

(d) Provide support in documenting and disseminating best practices related to Ethiopian Hospitals Alliance for Quality (EHAQ), Monitoring of hospital performance and scaling up of patient safety initiative including infection prevention, and provision of basic essential items.

Main focus 1.3: Strengthen the development and management of critical health care resources

(a) Facilitate the implementation of the Human Resource Strategy (2009-2020) with focus on capacity building of priority health professionals (HEWs, midwives, anesthetists, Emergency Obstetric and Surgical Care providers), generation of evidence and maintenance of the HR observatory.

(b) Provide support for the implementation of the health care financing schemes. Priority areas would include: improve capacity for resource mobilization; implementation of insurance schemes; costing and expenditure tracking, including the institutionalization of the NHA to inform achievements, gap analysis and future strategies.

(c) Support the design, evaluation and implementation of the integrated health information system, and operational research so as to assist in planning monitoring and evaluation, generation and dissemination of data/information related to social determinants of health.

(d) Support the improvement of access to quality medicines, laboratory supplies and safe blood supply, through capacity building (institutional and human resource), development of appropriate strategies and plans.

Strategic priority II: Contribute to the reduction of the burden of communicable and noncommunicable diseases and conditions/injuries

Main focus 2.1: Support the strengthening of the capacity for implementation of IHR within the platform of integrated disease surveillance and response as well as capacity for emergency preparedness, response and recovery

(a) Provide support to Government to strengthen national and sub-national capacity to implement IHR within the framework of IDSR by scaling up community IDSR and implementation of IHR plan of action.

(b) Provide support to Government to strengthen national and sub-national capacity for emergency preparedness, response and recovery including finalization of the Public Health Emergency Management (PHEM) guideline, training of the Rapid Response Team (RRT), provision of emergency drugs and supplies and supportive supervisions.

(c) Provide support to strengthen surveillance through training of health workers, scaling up of CIDSR and supportive supervision.

Main focus 2.2: Support the strengthening of prevention and control of HIV/AIDS, tuberculosis and malaria

(a) Support the acceleration of health sector HIV prevention interventions including for elimination of MTCT, while sustaining capacity building efforts for HIV/AIDS treatment scale-up and laboratory strengthening.

(b) Provide support to strengthen national capacity for tuberculosis diagnosis, enhancing case detection, expansion of community DOTs, improvement of treatment success rate and addressing HIV-TB co-infection and MDR-TB issues.

(c) Provide support to strengthen national capacity to scale up and sustain malaria control interventions towards pre-elimination and address strategic information gaps.

Main focus 2.3: Support the promotion of healthy and safe environment, food safety and proper nutrition as well as climate change adaptation for public health and prevention and control of noncommunicable diseases including mental health and injuries, and the control, elimination and eradication of NTDS

(a) Provide support in developing the programme management and coordination guideline and in the preparation of the national and sub-national plan of action for the implementation of noncommunicable and mental health programmes.

(b) Provide support to Government for the implementation of integrated NTD control, elimination and eradication efforts, including mapping, establishing or scaling up of services, monitoring and evaluation and improving surveillance.

(c) Provide support to ensure healthy and safe environment, including water, sanitation and hygiene, scale up the nutrition programme and enhance food safety interventions.

(d) Facilitate the preparation of the Joint Plan of Action (JPOA) and implementation of health and environment activities within the context of the Libreville Declaration and Luanda Commitment, including climate adaptation for public health.

Strategic priority III: Contribute to the reduction of maternal, newborn and child mortality and improved sexual and reproductive health.

Main focus 3.1: Support FMOH to improve access to SRH information and quality services with focus on the lifecycle approach

(a) Provide support for the development of norms, standards, tools and guidelines to improve the quality of FP/SRH and adolescent-friendly SRH services.

(b) Provide support to MOH for policy, advocacy, research, monitoring and evaluation and other relevant areas pertaining to SRH issues.

Main focus 3.2: Strengthen national capacity to improve maternal and child health interventions, including access to skilled attendance of deliveries, and to scale up high impact child survival interventions

(a) Provide support for strengthening partnership, evidence generation, setting norms and standards, advocacy and resource mobilization, including ensuring quality child and neonatal health/nutrition services especially community-based integrated services.

(b) Build capacity of health care providers for provision of quality essential and emergency maternal and neonatal care, including PMTCT, through interventions that reach from the household to the tertiary level.

(c) Provide support for capacity building of health care providers, tutors and programme managers on key child health interventions including Integrated Management of Childhood and Neonatal Illnesses, quality Paediatric Referral Care and management of severe acute malnutrition.

Main focus 3.3: Strengthen immunization systems including surveillance and cold chain management, and support introduction of new vaccines

(a) Provide support to increase immunization coverage nationally and reduce the number of unvaccinated children through focused technical support to poorly performing zones, improved monitoring and introduction of new vaccines.

(b) Facilitate the development of policy and strategies for the provision of cold chain, maintenance, monitoring and reporting.

(c) Provide support for the implementation of immunization and surveillance

activities towards achieving global and regional accelerated disease control targets (polio eradication, measles elimination and maintaining maternal and neonatal tetanus elimination).

Strategic priority IV: Support the strengthening of partnership, coordination and resource mobilization

Main focus 4.1: Strengthen existing partnerships in and outside the UN system, civil society organizations, training and research institutions; and foster new partnerships

(a) Facilitate the engagement of all stakeholders, including public and private institutions, to strengthen health systems.

(b) Advocate for and forge new partnerships through networking within UN, bilateral and multilateral development agencies.

(c) Facilitate the dissemination and monitor implementation of Regional Committee resolutions at country level.

Main focus 4.2: Continue to support harmonization and alignment efforts for health

(a) Facilitate monitoring and evaluation and provide guidance on the implementation of the IHP at country level.

(b) Support the implementation of the one plan one budget and one report principle including the commitment to the IHP compact and the JFA.

Main focus 4.3: Support resource mobilization efforts and effective utilization of resources

- Improve the capacity of the country office for resource mobilization and management.
- Mobilize national partners in support of fundraising efforts using the partnership approach and promote joint/common proposals.
- Advocate for the increasing of domestic investments in health to achieve the MDG and other HSDP targets.

5.3 Validation of the CCS Strategic Agenda with National Health Strategic Plan Priorities

The current national strategic plan of the health sector of Ethiopia, called the fourth Health Sector Development Plan (HSDP 4), covers the July 2010-June 2015 period. As can be seen in the table below, the strategic priorities and main focus areas of the CCS are in alignment with the strategic objectives of the HSDP 4.

Table 5: Alignment of CCS strategic priorities with HSDP 4 strategic objectives

CCS3 Strategic priorities	HSDP4 Strategic objectives
1. Support the strengthening of health systems and services in line with the primary health care approach	• Improve access to health services • Improve community ownership • Maximize resource mobilization and utilization • Improve quality of health services • Improve pharmaceutical supply and services • Improve regulatory system • Improve evidence-based decision making, through harmonization and alignment • Improve health infrastructure • Improve human capital and leadership
2. Contribute to the reduction of the burden of communicable and noncommunicable diseases and conditions/injuries	• Improve health emergency preparedness and response • Improve access to health services particularly • Nutrition • Hygiene and environmental health • Prevention and control of major communicable diseases • Prevention and control of noncommunicable diseases
3. Contribute to the reduction of maternal, newborn and child mortality and improved sexual and reproductive health.	• Improve access to health services, particularly maternal, neonatal, child and adolescent health
4. Contribute to the strengthening of partnership, coordination and resource mobilization for health service delivery	• Maximize resource mobilization and utilization • Improve evidence-based decision making, through harmonization and alignment

5.4 Validation of the CCS Strategic Agenda with UNDAF Priorities

The table below shows that the strategic priorities of the CCS are in alignment with the UNDAF outcomes.

Table 5: Alignment of CCS strategic priorities with UNDAF health outcomes

UNDAF Priority health-related Areas and Outcomes	Strategic priorities CCS 2012-2015
(i) Sustainable Economic Growth	
Outcome: By 2015, national and sub-national institutions and vulnerable communities have systematically reduced disaster risks and impacts of disasters and improved food security.	Support the strengthening of health systems and services in line with the primary health care approach.
(ii) Basic Social Services	
Outcome: Improved access to HIV prevention, treatment, care and support by 2015.	Contribute to the reduction of the burden of communicable and noncommunicable diseases and conditions/injuries.
Outcome: By 2015, the Ethiopian population, in particular women, children and vulnerable groups,* have improved access to and use of quality health, nutrition and WASH services.	Contribute to the reduction of maternal, newborn and child mortality and improved sexual and reproductive health.
(iii) Governance	
Outcome: By 2015, the capacity of national, local and community institutions is strengthened for-evidence based development management.	Contribute to the strengthening of partnership, coordination and resource mobilization.
(iv) Women, Youth and Children	
Outcome: By 2015, women, youth and children are increasingly protected and rehabilitated from abuse, violence, exploitation and discrimination.	Contribute to the reduction of maternal, newborn and child mortality and to improved sexual and reproductive health.

SECTION 6:

IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATION FOR THE ENTIRE SECRETARIAT

Ethiopia is currently facing a high burden of communicable and noncommunicable diseases, nutritional disorders as well as unacceptable levels of infant and maternal morbidity and mortality. Consequently, WHO has a key role to play in leading the health sector response to address these public health challenges so as to contribute to the attainment of the PRSP goals and the MDGs in Ethiopia. To this end, the WCO will continue to advocate for and play a key role in communicable and noncommunicable disease prevention and control activities and the improvement of maternal and child health. This will be done through greater focus on its core functions, health system strengthening in line with the public health approach and active collaboration with other key players involved in the health sector agenda.

This Country Cooperation Strategy serves as the reference document for realizing the above expectations. In addition, the CCS will be used to develop the country office biennial plans, and will also be used by the regional office, including the IST, and headquarters to guide planning and implementation of prioritized areas for support and subsequent monitoring and evaluation of their outcomes and impact. Furthermore, it will serve as a major resource mobilization tool.

6.1 The Role and Presence of WHO According to the Strategic Agenda

6.1.1 WHO's role

In accordance with the General Programme of Work (GPW) and the regional strategic directions, the role of the WHO in the four years of the CCS will be:

(a) Support the country in policy revision, strategic and operational plan development and monitoring by harnessing the technical expertise at the country, regional and HQ levels and, under exceptional circumstances, provide operational support.

(b) Promote the agenda of alignment with national plans among partners, harmonization of procedures and national ownership in accordance with International Health Partnership.

(c) Continue to support the pooled funding mechanism which is managed by the Government (MDG pooled fund).

(d) Provide support for the implementation of IHR for the effective management of public health emergencies.

(e) Support national effort to ensure equitable access to PHC services in accordance with the Ouagadougou Declaration.

(f) Generate evidence and information that will guide programme planning and implementation and work with other partners to support the strengthening of health systems.

(g) Strengthen existing partnerships and forge new ones particularly with teaching institutions and professional associations so as to build capacity for research and contribute to the improvement of the quality of education.

(h) Provide support for scaling up evidence-based interventions.

(i) Support resource mobilization efforts.

(j) Strengthen programme accountability and reporting of outcomes through existing partnership accountability mechanisms by applying as much as possible a Harmonized Approach to Cash Transfers (HACT).

The technical expertise of the Organization will be used to leverage its support to the different areas of work.

6.1.2 WHO's presence

Although there is an increasing trend in financial resource flow to Ethiopia with health taking a significant share, the national strategic plan is indicative that there is a significant resource gap to meet the national health development goals. The country office will be vigorously working on mobilizing resources by engaging other partners through existing frameworks and instruments.

WHO will continue to focus on its core functions. The existing human resources in technical areas will place the WHO at country level in a relatively

advantageous position. The country office will use available resources within the country and will work with other levels of the Organization to support the required assistance to the country, as follows:

(a) The Regional Office (RO) and the Intercountry Support Team (IST) are expected to provide timely technical support and facilitate intercountry sharing of experiences and information on matters of public health importance. It is also expected to support resource mobilization and advocacy efforts.

(b) The Headquarters (HQ) is expected to develop global guidelines, provide technical assistance and support resource mobilization efforts and networking, particularly with the Global Health Initiatives.

The resource requirement for the four year period is expected to be US$ 70 million. WHO, in its facilitating role for the Health System Funding Platforms (HSFP) supported by GAVI, GFTAM and the World Bank, will ensure that resource allocation to the health system building blocks is efficient and yielding the needed results.

The resources to support the delivery of the technical programmes will be effectively managed using the Organization's Global Management System (GSM). The GSM will ensure administrative and operational efficiency as it will allow expenditures only on the basis of approved and funded workplans; the implementation of results-based management through the allocation of resources against results to be delivered; support the reform process by reducing layers of administration; make information available to programme managers across the Organization; and support joint planning at all levels.

6.2 Using the CCS

Once the CCS is finalized, the different levels of the Organization will assume the following responsibilities in addition to the ones mentioned in the previous section.

The country office will disseminate the document to all partners working in the country, use the CCS priorities to develop and revise the workplans, to prepare the UNDAF action plan and for advocacy and resource mobilization.

The RO and HQ will widely disseminate the CCS document, use the CCS for advocacy and resource mobilization and ensure that the CCS priorities are used as the basis for operational support planning.

6.3 Monitoring and Evaluation of the CCS

This CCS will undergo a mid-term review after two years of implementation and a final evaluation at the end of four years. Key implementation milestones are presented in the Annex.

Annex :

MILESTONES OF THE COUNTRY COOPERATION STRATEGY

Strategic priorities	Milestones
Support the strengthening of health systems and services in line with the primary health care approach	- Ethiopian health policy revision facilitated and updated by 2014. - Best practices on the implementation of the Ouagadougou Declaration through strengthening district health systems issued in 2013. - Guidelines for the implementation of public health acts, laws and code of practice revisited and published by 2012. - Guidelines for the development of a series of health services delivery modes for pastoralist communities issued and disseminated by the beginning of 2012. - Best practices on implementation of integrated health services through improved facility–community interface and on retention of health workforce produced by 2014. - Guidelines for the development of a national referral system issued and implemented by the end of 2012. - A national health account institutionalized starting 2013. - Evaluation report on the implementation of health care financing reforms documented and promoted by 2013. - A national comprehensive health information system established and functional starting 2012. - Guidelines for the development of health systems research developed, published and disseminated by the end of 2012. - All hospitals and health units performing blood transfusion will have access to a safe blood supply through an efficient nationally-coordinated blood transfusion service by 2015. - National and regional Health Promotion partnerships, networks and alliances will be established/ strengthened to support health promotion planning and implementation for the prevention and control of communicable and noncommunicable diseases by 2013.

Support the strengthening of health systems and services in line with the primary health care approach	Major risks and priority health issues will be addressed through community-based and media communication and promotional activities throughout the CCS period. Knowledge, attitude and practice of lifestyle related to healthy/unhealthy diets will be conducted and documented by 2013. Unsafe sex practices through social and cultural research methods will be documented by 2013. Revision of the Ethiopian National Drug policy facilitated and the development of an updated version finalized and presented for Government's approval by 2015. Operational research on selected traditional medicines enhanced throughout the CCS period. The extent of the availability of counterfeit drugs in the domestic market established through post-marketing surveillance by 2013. National pharmacovigilance system strengthened by 2013. National system for the monitoring of antimicrobial drugs with special focus on ARV, antimalarial and anti-TB drugs resistance strengthened by 2015. Number of GMP-compliant local pharmaceuticals manufacturers increased by 2015. Evidence on equity and SDH generated and disseminated by 2013.
Contribute to the reduction of the burden of communicable and noncommunicable diseases and conditions/ injuries	Community IDSR will be scaled up nationwide throughout the CCS period. All disease outbreaks will be investigated and timely responded to throughout the CCS period. National leishmaniasis guideline revised and disseminated by 2012. Leishmaniasis disease mapping and entomological survey completed and disseminated by the end of 2012. LF, STH and SCH mapping will be conducted by 2012. Country Certification for guinea-worm disease eradication will be achieved by 2015. NCD programme designed and established in FMoH, plan of action developed at national and sub-national levels by 2013. Mental health action programme (mhGAP) scaled up in all regions and integrated into PHU by 2015. National water quality monitoring and surveillance Strategic Action Plan implemented in 80 woredas (districts) by 2015. Implementation of Community Led Total Sanitation and Hygiene supported in agrarian and semi-urban settings of the country throughout the CCS period.

Contribute to the reduction of the burden of communicable and noncommunicable diseases and conditions/ injuries	- Health and Environment Strategic Alliance Joint Action Plan implementation ensured by 2015. - HIV testing and prevention job aid piloted by 2012 and rolled out in high prevalence areas by 2013. - 2010 ART guidelines adopted by 2012. - At least five best practices on health sector HIV/AIDS prevention, treatment and care documented annually. - 2010 PMTCT guidelines implemented in all regions by 2013. - Drug resistance survey conducted by 2012. - Normative tools, operational guidelines and strategic documents (strategic and implementation plans) for the introduction and scale-up of new technologies reviewed/ developed by 2012. - Two best practices on TB control documented annually. - 300 health workers (capacity building) will have been trained by 2013. - Malaria risk mapping will have been launched by 2012. - The health facility-based impact survey will have been conducted by 2013. - At least two best practices documented annually.
Contribute to the reduction of maternal, newborn and child mortality and improved sexual and reproductive health.	- Job aids on FP methods for primary care service providers by 2012. - National adolescent-friendly SRH services training material revised/updated by 2013. - Documentation of best practices for long-term Family Planning methods carried out by 2013. - National policy on Maternal Death Audit (MDA) developed by 2013. - MNH service delivery guidelines for the different levels of service delivery points developed by 2013. - National IMNCI guidelines revised/updated by 2012. - National Paediatric Hospital Care guidelines revised/ updated by 2013. - IMNCI TOT training for 100 tutors and programme managers by 2013. - Revise, print and distribute 3000 sets of IMNCI job aids and 2000 copies of the Paediatric Hospital Care protocol by 2013. - Rotavirus vaccine introduced by 2013. - 95% DPT-HepB-Hib3 national coverage by 2015. - Revised cold chain standard operating procedures by 2013. - Wild polio-free status maintained by 2015.

Support the strengthening of partnership, coordination and resource mobilization	- Participation in UNDAF planning and implementation and joint programmes continued throughout the CCS period. - Participation in partners' and Government's coordination forums strengthened throughout the CCS period. - Coordination mechanism for collaboration with research and training institutions established by 2012. - Technical support for the mobilization of resources provided throughout the CCS period.