

Ethiopia



<http://www.who.int/countries/en/>

WHO region	Africa
World Bank income group	Low-income
CURRENT HEALTH INDICATORS	
Total population in thousands (2012)	91729
% Population under 15 (2012)	43.29
% Population over 60 (2012)	5.17
Life expectancy at birth (2012) Total, Male, Female	65 (Female) 62 (Male) 64 (Both sexes)
Neonatal mortality rate per 1000 live births (2012)	29 [17-47] (Both sexes)
Under-5 mortality rate per 1000 live births (2012)	68 [52-86] (Both sexes)
Maternal mortality ratio per 100 000 live births (2010)	350 [210-630]
%DTP3 Immunization coverage among 1-year-olds (2012)	61
%Births attended by skilled health workers (2011)	10
Density of physicians per 1000 population (2008)	0.025
Density of nurses and midwives per 1000 population (2008)	0.202
Total expenditure on health as % of GDP (2011)	4.7
General government expenditure on health as % of total government expenditure (2011)	14.6
Private expenditure on health as % of total expenditure on health (2011)	42.3
Adult (15+) literacy rate total (2007)	39
Population using improved drinking-water sources (%) (2011)	49 (Total) 97 (Urban) 39 (Rural)
Population using improved sanitation facilities (%) (2011)	27 (Urban) 19 (Rural) 21 (Total)
Poverty headcount ratio at \$1.25 a day (PPP) (% of population) (2011)	30.7
Gender-related Development Index rank out of 148 countries	
Human Development Index rank out of 186 countries (2012)	173

Sources of data:

Global Health Observatory April 2014
<http://apps.who.int/gho/data/node.cco>

HEALTH SITUATION

The progress in health status of the population indicates that about 80% of diseases in Ethiopia are attributable to preventable conditions related to infectious diseases, malnutrition; and personal and environmental hygiene. The prevalence of TB in Ethiopia is estimated to be 241 with incidence of 247 per 100 000 populations. The adult HIV prevalence is 1.5% in 2011 (4.2% for urban and 0.6% for rural) and is higher among females (1.9%) than males (1%). Environmental risk factors contribute to 31% of the total disease burden in the country.

The health of women, neonates and children are areas of major concern. Ethiopia has reduced the under-five mortality rate by two thirds between 1990 and achieved MDG4 two years before the target year. However, the decline in neonatal mortality for the similar period has been minimal. There is great improvement in maternal mortality rate as Ethiopia is making a tremendous, concerted efforts and innovative interventions to achieve MDG 5. New vaccines, like pneumococcal and rotavirus vaccines were introduced into the routine immunization programme. Violence against women including harmful traditional practices still remains a challenge.

Due to economic development and urbanization, non-communicable diseases and its related risk factors are growing and becoming a double burden in the country. Ethiopia became the 42nd country in the African Region to ratify the WHO FCTC when Ethiopian House of Peoples' Representatives ratified it on 21 January 2014.

Utilization of health services for the country is 0.32 per capita. The low rate of utilization could indicate low availability, demand, and quality of services. Disparities among geographic areas and population groups are still recognized. Shortages of health workforce and funding as well as limited planning, implementation, and monitoring and evaluation capacity at the regional, zonal and district levels remain areas of future action.

Ethiopia has been experiencing repeated outbreaks of diseases like measles, meningitis, yellow fever and dengue; and prompt responses have been taken to effectively curb these crisis episodes.

HEALTH POLICIES AND SYSTEMS

The right to health for every Ethiopian has been guaranteed by the 1995 Constitution of the Federal Democratic Republic of Ethiopia (FDRE), which stipulates the obligation of the state to issue policy and allocate ever increasing resources to provide public health services to all Ethiopians. The Federal Ministry of Health (FMOH) of Ethiopia has prepared a comprehensive strategic plan, the Health Sector Development Programme (HSDP), in alignment with the national Growth and Transformation Plan (GTP). The national health sector development plan of 20 years has been divided in four series of five consecutive years to ensure the attainment of national goals and MDG targets. The current HSDP IV covers a five year period from July 2010 to June 2015. The governance mechanisms of HSDP IV include: Joint Consultative Forum, Joint Core Coordinating Committee, joint review meetings, and an annual review meeting. These and other strategies and approaches are directed towards improving the standards of living, particularly the health of the population throughout the country. By influencing the performance of health determinants like education, poverty reduction, and access to good sanitation and safe water.

Ethiopia follows a decentralized health care system, development of the preventive, promotive and curative health care delivery by public, private for profit and not-for profit players in the health sector.

The Ethiopian health care delivery, organized in to three tier-system, puts the health extension program, the innovative community-based service delivery (health development army), as a center of focus for the provision of primary health care services to broad masses. Primary health care (PHC) potential coverage stands at 90%, reaching most of the rural areas in the country. The growing countrywide network of healthcare facilities has enhanced access to health services. The rapid expansion of both private-for-profit and not for-profit health facilities accounts for about 11% of health service coverage and this has enhanced public-private-partnerships in health.

COOPERATION FOR HEALTH

The main bilateral partners include Austria, Japan, Ireland, Italy, the Netherlands, Spain, Sweden, French, EU, DFID and the USA. Multilateral partners include UN agencies, WB, AfDB, GAVI, Gates Foundation, GFTAM and NGOs. Health partners are governed through the Health, Population and Nutrition (HPN) partners' forum currently co-chaired by UNICEF and DFID (WHO will co-chair in 2015). Partners contribution represent 49.9% of the health sector expenditure (NHA 2014), while the household contribution is 33.7 % and government is at 15%. WHO Country Office Ethiopia actively participates in all planning, implementing, monitoring and evaluating of health sector development program in the country.

Ethiopia has become a pioneer in signing a national IHP compact with key partners in the health sector. The continued leadership has led to the signing of a Joint Financial Arrangement (JFA) that paved the way for a one fund managed by the government system (MDG pooled fund). Various partners are contributing to the pooled fund in support of HSDP.

Health Pool Fund (HPF) is part of HSDP's wider pooled funding scheme and supports the implementation of activities with focus on procurement of technical assistance, while Protecting Basic Services (PBS) basket fund is for basic services (like health and education) and managed and monitored through World Bank procedures. Approximately 14% of funding to the health sector is through pooled funds (10% through MDG performance pooled fund and 4 % through protection of basic services).

The United Nations Development Assistance Framework for Ethiopia (UNDAF 2012–15) has been developed in response to the five-year national development plan for Ethiopia – the Growth and Transformation Plan (GTP), that is the first in a series of three 5-year plans to drive the country's transformation to middle income status by 2025. 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. WHO Country Office Ethiopia is involved in the development, implementation and monitoring of the UNDAF; where it co-chairs the Basic Social Services Pillar. The WHO Country Cooperation Strategy in Ethiopia is aligned with the Health Sector Development Plan and UNDAF.

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2012-2015)	
Strategic Priorities	Main Focus Areas for WHO Cooperation
<p>STRATEGIC PRIORITY 1: Support the strengthening of health systems and services in line with the primary health care approach</p>	<ul style="list-style-type: none"> 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 development and management of critical health care resources
<p>STRATEGIC PRIORITY 2: Contribute to the reduction of burden of communicable, noncommunicable diseases and conditions/injuries</p>	<ul style="list-style-type: none"> 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.
<p>STRATEGIC PRIORITY 3: Contribute to the reduction of maternal, newborn and child mortality and improved sexual and Reproductive Health.</p>	<ul style="list-style-type: none"> 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 introduction of new vaccines
<p>STRATEGIC PRIORITY 4: Support the strengthening of partnership, coordination and resource mobilization</p>	<ul style="list-style-type: none"> Strengthen existing partnerships in and outside the UN system, civil society organizations, training and research institutions; and foster new partnerships Continue to support harmonization and alignment efforts for health Support resource mobilization efforts and effective utilization of resources