

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

Advancing Health in Ethiopia

WITH FEWER RESOURCES, AN UNCERTAIN GHI STRATEGY,
AND VULNERABILITIES ON THE GROUND

Authors

J. Stephen Morrison
Suzanne Brundage

June 2012



50
YEARS | CHARTING
OUR FUTURE

CSIS | CENTER FOR STRATEGIC &
INTERNATIONAL STUDIES

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

Advancing Health in Ethiopia

WITH FEWER RESOURCES, AN UNCERTAIN GHI STRATEGY,
AND VULNERABILITIES ON THE GROUND

Authors

J. Stephen Morrison
Suzanne Brundage

June 2012



50 | CHARTING
YEARS | OUR FUTURE

CSIS | CENTER FOR STRATEGIC &
INTERNATIONAL STUDIES

About CSIS—50th Anniversary Year

For 50 years, the Center for Strategic and International Studies (CSIS) has developed practical solutions to the world's greatest challenges. As we celebrate this milestone, CSIS scholars continue to provide strategic insights and bipartisan policy solutions to help decisionmakers chart a course toward a better world.

CSIS is a bipartisan, nonprofit organization headquartered in Washington, D.C. The Center's more than 200 full-time staff and large network of affiliated scholars conduct research and analysis and develop policy initiatives that look to the future and anticipate change.

Since 1962, CSIS has been dedicated to finding ways to sustain American prominence and prosperity as a force for good in the world. After 50 years, CSIS has become one of the world's preeminent international policy institutions focused on defense and security; regional stability; and transnational challenges ranging from energy and climate to global development and economic integration.


Former U.S. senator Sam Nunn has chaired the CSIS Board of Trustees since 1999. John J. Hamre became the Center's president and chief executive officer in 2000. CSIS was founded by David M. Abshire and Admiral Arleigh Burke.

CSIS does not take specific policy positions; accordingly, all views expressed herein should be understood to be solely those of the author(s).

© 2012 by the Center for Strategic and International Studies. All rights reserved.

Cover photo: A young teacher in front of a school in Ethiopia, photo by Dietmar Temps, <http://www.flickr.com/photos/deepblue66/3239513212/>.

Center for Strategic and International Studies
1800 K Street, NW, Washington, DC 20006
Tel: (202) 887-0200
Fax: (202) 775-3199
Web: www.csis.org



ADVANCING HEALTH IN ETHIOPIA

WITH FEWER RESOURCES, AN UNCERTAIN GHI STRATEGY, AND VULNERABILITIES ON THE GROUND

J. Stephen Morrison and Suzanne Brundage¹

Over the last decade, the United States' health partnership with Ethiopia has contributed to significant health gains in a country long known for having some of the poorest health and development indicators in the world.

Between 2003 and 2011, the United States made significant health investments in Ethiopia, providing more than \$1.4 billion through the President's Emergency Plan for AIDS Relief (PEPFAR). In 2010 alone, PEPFAR's annual budget reached \$290.3 million, representing nearly three-fourths of the United States' total bilateral health dollars flowing into the country. In the eight and a half years of the Global Fund's operations in Ethiopia, over \$1.1 billion has been expended toward programs to fight AIDS, tuberculosis (TB), and malaria. This is the single largest Fund commitment worldwide; it derived one-third of its funds from U.S. contributions and reflected the active support of the United States.

These bilateral and multilateral commitments yielded meaningful results. In 2005, fewer than 1,000 Ethiopians were receiving antiretroviral (ARV) treatment,² but by 2011, thanks in a significant degree to PEPFAR, more than 237,000 individuals had access to these life-saving drugs. Similarly, while the Global Fund remains the largest funder of malaria control across Ethiopia, having distributed an aggregate \$330 million, the President's Malaria Initiative (PMI) has complemented that effort by taking a targeted approach in the Oromia region, which covers roughly one-third of Ethiopia's population and terrain. Between 2007 and 2010, PMI invested over \$78.7 million dollars in Ethiopia, resulting in the distribution of 3.4 million insecticide-treated bed nets and 3.2 million rapid diagnostic tests, and the provision of 3.9 million treatment doses of Artemisin-based combination therapies (ACTs), making it one of the most striking scale-ups of malaria control interventions worldwide.

¹ J. Stephen Morrison is senior vice president and director of the Global Health Policy Center at the Center for Strategic and International Studies (CSIS) in Washington, DC. Suzanne Brundage is the former assistant director of the CSIS Global Health Policy Center.

² Tedros A. Ghebreyesus, "Ethiopia extends health to its people: An interview with Dr. Tedros A Ghebreyesus," *Bulletin of the World Health Organization* 87, no. 7 (July 2009): 495–496, <http://www.who.int/bulletin/volumes/87/7/09-050709/en/index.html>.

Today, of course, times have changed. In the midst of tight budgets, in Addis Ababa, Washington, Geneva, and other donor capitals, the steep and remarkable trajectory of U.S. and other external commitments, conspicuous over the past decade and fundamental to advancing Ethiopian public health, will not continue. What then can the United States realistically expect to achieve in its ongoing engagement in health in Ethiopia? What should be the core considerations to guide future U.S. efforts?

Those are the questions we set out to answer through three visits to Ethiopia in 2011, as well as consultations with senior officials in Washington and the Global Fund in Geneva. The findings and conclusions we present here remain preliminary in important respects, owing to the fluid, somewhat clouded, and mixed picture in Ethiopia, with respect to both the U.S. and Global Fund programs.

The concrete parameters of U.S. involvement continue to evolve, including deliberations over funding pipelines, revised targets, and revised downward allocations for the near to medium term. The planning period for PEPFAR for 2012/2013 has been extended, and the country operational plan is not likely to be approved until June or July 2012. The Global Health Initiative (GHI) implementation plan for Ethiopia has not been formally completed or released to the public, which complicates reaching informed judgments about the meaning and impact of GHI over time: indeed, at this late point, it is even debatable whether such a plan was ever actually mandated by Washington. Funding levels for Global Fund operations in Ethiopia are also undergoing a complex review, and public announcements on commitments for the next phase in combatting HIV/AIDS and malaria are expected in June. While there has been increasing concern expressed by U.S. officials over the government of Ethiopia's weak transparency regarding the expenditure of funds and the quality of its HIV/AIDS-prevalence data, at the same time the Obama administration is moving ahead in partnering with the Ethiopian government (along with India) in the Call to Action summit on child survival to be held in Washington in mid-June 2012.

These considerations notwithstanding, the United States can and will, we believe, continue to make a substantial contribution to health in Ethiopia, even in the face of flat or contracting resources, in partnership with the Ethiopian government, the Global Fund, the United Kingdom, and perhaps also the World Bank. Working bilaterally and multilaterally, the United States can help expand treatment, care, and prevention for HIV/AIDS, tuberculosis, and malaria, while at the same time offer modest but meaningful support in reducing maternal and newborn mortality.

Below are four steps to create a more strategic U.S. approach to health in Ethiopia.

1. **The United States will need to be increasingly aggressive in aligning its PEPFAR investments with the Global Fund in Ethiopia, if it is to ensure that a declining resource base has the maximum impact on reducing HIV/AIDS, TB, and malaria.**

Ethiopia's HIV-prevalence rate remains comparatively modest, at 1.5 percent,³ with the epidemic concentrated in urban and peri-urban centers. Under increasing pressure to realign investments globally to high-burden and high-need countries, the U.S. State Department will significantly reduce its health commitments to Ethiopia next year, from \$189 million in FY2012 to a request of \$54 million for FY2013.⁴ Final figures have not yet been decided, but a dramatic reduction would be in part due to recent findings that globally PEPFAR has accumulated \$1.46 billion of unspent funds, with \$138 million of that "bad pipeline" coming from Ethiopia.⁵ The bilateral health dollars of the U.S. Agency for International Development (USAID) will also be reduced slightly, decreasing from \$120.5 million in FY2012 to a FY2013 request of \$107 million.⁶

The Global Fund program in Ethiopia has signed agreements totaling \$1.3 billion and expenditures of \$1.14 billion. That program has undergone an extensive review of past performance, including \$129 million in undisbursed funds in the Round 2 HIV program completed in 2011. There is also active deliberation over proposals for the next phase of programming in HIV/AIDS and malaria. This process began in 2011 and became even more complicated as the crisis around the Global Fund worsened in late 2011 and reform efforts intensified.⁷ It is expected that a major new commitment on HIV/AIDS and malaria will be announced in June. The HIV/AIDS portion is expected to be significantly lower than originally proposed: there will be a scale-down, in effect, but still sufficient new commitments to move Ethiopia toward universal coverage for antiretroviral therapy (ART) in 2014.

PEPFAR and the Global Fund remain vital instruments to achieve Ethiopia's health goals and U.S. global targets. President Obama committed on December 1, 2011, to increase the number of persons in developing countries receiving U.S.-supported ART from 4 to 6 million by the end of 2013. PEPFAR managers in Ethiopia and their Global Fund counterparts will be under increasing pressure to expand treatment with fewer resources.

The U.S. embassy in Ethiopia is making a major push to reduce vertical transmission of HIV, from mother to child, by supporting the government of Ethiopia's plans to improve coverage and expand

³ Central Statistical Agency and ICF International, *Ethiopia Demographic and Health Survey 2011* [hereafter DHS 2011] (Addis Ababa: Central Statistical Agency, March 2012), p. 231, <http://measuredhs.com/pubs/pdf/FR255/FR255.pdf>.

⁴ U.S. Department of State, *Executive Budget Summary: Function 150 & Other International Programs: Fiscal Year 2013* (Washington, DC: Department of State, February 2012), p. 153, <http://www.state.gov/documents/organization/183755.pdf>.

⁵ John Donnelly, "U.S. Reveals Nearly \$1.5 Billion in Unspent AIDS Money," *Global Post*, April 17, 2012, <http://www.globalpost.com/dispatches/globalpost-blogs/global-pulse/us-reveals-nearly-15-billion-unspent-aids-money>.

⁶ U.S. Department of State, *Executive Budget Summary: Function 150 & Other International Programs Fiscal Year 2013*, p. 150.

⁷ See J. Stephen Morrison and Todd Summers, *Righting the Global Fund* (Washington, DC: CSIS, February 2012), http://csis.org/files/publication/120228_Morrison_RightingGlobalFund_Web.pdf.

the number of sites that provide preventing mother-to-child transmission (PMTCT) services. Currently, only 28 percent of women receive HIV counseling, HIV testing, and the results of those tests during antenatal care—a key step for reducing mother-to-child transmission of HIV. The strategy includes expanding the number of PMTCT sites in areas where there are large numbers of HIV-positive women, ensuring that HIV-positive women stay connected to a clinic so they can maintain an effective antiretroviral drug regimen, and addressing the cultural and transportation barriers that often make women reluctant to seek antenatal care in the first place. Since 2009, PEPFAR has also strategically focused prevention programs based on emerging evidence of the drivers of the epidemic so they better target the most at-risk populations (commercial sex workers, migrant workers, and men who have sex with men).

PEPFAR cannot succeed unless the Global Fund succeeds. If Ethiopia is to achieve universal access for persons living with HIV by 2015, the United States will need to do a better job of systematically leveraging the Global Fund, as the Fund itself deals with its own declining resource base and greater external scrutiny of its programs and managerial competence.⁸ There have always been routine working-level dialogues between PEPFAR and the Global Fund program manager for HIV/AIDS. That dialogue has grown more frequent and robust in the past few months, in the face of tougher fiscal and political realities. Intensified consultation and aggressive hands-on coordination will be essential to ensuring the success of both entities.

In the next few years, we can expect to see Ethiopia’s impressive treatment results expand (although the targets for 2012 and 2013 have not yet been finalized), combined with intensified efforts to use new evidence and epidemiological data to improve HIV prevention. Progress is also expected in further reducing malaria-related illness and death, the biggest communicable disease threat in the country, through continued cooperation with the Global Fund.

Health Investments in Ethiopia, 2007–2012 (millions of U.S. dollars)

Fiscal Year	2007	2008	2009	2010	2011	2012
U.S. Total	264.6	395.2	401.9	390.6	401.7	457.6 (req.)
World Bank	n/a	76.1	106	446.4	63	
DFID*	36.5	28.5	38.2	54.6	119.1	
Global Fund	161.7	144.3	130.4	256.7	194.6	
TOTAL	462.8	644.1	676.5	1148.3	778.4	

* UK Department for International Development.

⁸ Ibid.

2. Through more strategic use of USAID and PEPFAR resources and expertise, the United States can best support maternal and child health in Ethiopia. The United States should also press the World Bank to become more engaged.

A quandary for the United States, vis-à-vis aligning its HIV/AIDS work with the additional U.S. ambition to support maternal, neonatal, and child health (MNCH), is that PEPFAR's work, operationally and legislatively, must hue to where the epidemic is concentrated: namely, Ethiopia's urban and peri-urban centers and its heavy truck routes. That is a finite geographic and demographic portion of Ethiopia, whereas the government of Ethiopia's top health priority is to expand MNCH primary care services across the entire country.

The innovative U.S. team in Ethiopia has demonstrated that PEPFAR's service delivery platforms can be stretched to bring broadened benefits to women and children in urban and peri-urban settings, where it predominantly operates. It has successfully used its funds to strengthen essential health systems, which includes training key new health workers (e.g., midwives and emergency surgical officers); strengthening supply chains, laboratories, blood supply, health care finance, management, and health information; improving the infrastructure of maternity wards and neonatal intensive care units; and increasing demand and capacity for antenatal care and facility-based delivery. However, as PEPFAR strives to put new patients on ARV treatment as quickly as possible, in the absence of new funding resources, continued contributions in this area may be constrained.

The second channel of U.S. support to the government of Ethiopia's MNCH priority is through USAID's investment, \$67 million in this current year, which primarily supports training and pilot service programs at the district and village levels. USAID has been investing in reproductive health, family planning, and maternal and child health since the early 1990s, when the current ruling party came to power and the U.S.-Ethiopia relationship normalized. Over two decades, USAID has built strong technical relationships with implementing partners, developed close ties to the regional health bureaus, and made meaningful contributions to the training and equipping of community health workers through the Ethiopian government-led Health Extension Worker program.

It is our opinion that the United States should give serious consideration to an alternative USAID approach: instead of training and pilot service programs, USAID should concentrate its investments in assisting the Ethiopian Ministry of Health in creating a strategic MNCH planning unit that would build capacities at the national level in those areas where needs are most acute, if the government of Ethiopia is truly to realize its MNCH goals: financial, data and supply chain management; strategic and operational planning; and human resource development. The need for this kind of unit is especially acute following the government-wide adoption of Business Process Reengineering (BPR), an effort to reduce inefficiencies in the public sector. The BPR reorganized the Federal Ministry of Health into teams based on geographic area rather than subject matter expertise. As a result, the Ministry of Health does not have a core unit devoted to its number one health priority of improving maternal and child health.

A third option is for the United States to press the World Bank to finance the expansion of maternal and child services. In July 2011, the World Bank signed a three-year, \$3.5 billion program to support the Ethiopian government's Growth and Transformation Plan. Maternal and child health do not figure significantly in that strategy, but they could. The United States should also encourage the Bank to conduct a public expenditure review of the Ethiopian health sector.

3. GHI in Ethiopia has proven greater integration is possible. But it has also proven that much more concerted action is needed to better define interagency roles and responsibilities and thereby reduce costly rivalries, better define GHI processes and goals, and alter congressional authorities, including spending flexibilities and planning and reporting requirements.

When the Obama administration's signature Global Health Initiative was launched in April 2009, it raised hopes of bringing about a more efficient and streamlined U.S. global health effort, with an intensified focus on improving the health of women, girls, and newborns. Ethiopia was selected as one of eight initial "GHI-plus" countries to pioneer this approach. The successes and struggles of the embassy team in Addis Ababa as they worked to develop and operationalize GHI offer important lessons that should guide future endeavors.

The team began intense internal deliberations over a GHI strategy in mid-2010, shortly after the GHI-plus countries were announced. By early 2011, it produced a thoughtful strategy statement that prioritized Ethiopia's dual threats of communicable diseases and maternal and child mortality. The strategy embraced the Ethiopian government's MNCH priority and proposed reducing maternal and neonatal deaths by primarily better coordinating the health system strengthening components of PEPFAR with other U.S. government contributions to MNCH.

The development of the strategy, the primary deliverable under the GHI process, was followed by intensified dialogue with Health Minister Tedros Adhanom Ghebreyesus on a GHI implementation plan. The development of a concrete implementation plan was an additional step taken by the U.S. team in Addis Ababa under the direction of Ambassador Donald Booth, who dramatically increased his direct personal engagement on health issues. The ambassador attempted to consolidate negotiations with the Federal Ministry of Health into a singular process focused on the overarching GHI strategy—as opposed to multiple negotiations focused on singular disease programs.

This process did bring about some improved cooperation across U.S. agencies—including the Defense Department and Peace Corps, in addition to USAID, the Centers for Disease Control (CDC), and the Office of the Global AIDS Coordinator (OGAC)—to work more closely on a day-to-day basis in preparing their country plans and budgets. Including MNCH as a top priority within the GHI strategy in the absence of additional funding also promoted greater innovation. Embassy officials thought deeply about how the PEPFAR platform could be stretched to bring benefits to laboring women and newborns, a particularly challenging question in Ethiopia given the geographical misalignment between HIV/AIDS and MNCH challenges and other restrictions mentioned above.

The process also revealed serious challenges.

GHI was developed with the overt goal of fostering greater interagency cooperation. In reality, competition among agencies, particularly USAID and CDC, intensified on the ground in 2010–2011. While some of this competition stems from a long history of U.S. interagency tensions in the U.S. mission in Addis Ababa, prolonged indecision and tension in Washington over the direction and oversight of GHI exacerbated the problem. During a CSIS visit to Addis Ababa in November 2011, a large and diverse group of nongovernmental organizations (NGOs) and Ethiopian agencies lamented, with considerable vehemence and detail, that U.S. interagency antagonisms had spilled into the public domain and complicated dialogues with both NGO implementers and Ethiopian agencies. Many embassy officials felt Washington’s expectations were unclear, particularly because GHI guidance was delivered on an ad hoc basis. The excitement and legitimacy surrounding GHI in the early days began to wane as it became clear that the process would be lengthy, and amorphous. As this paper is being completed, GHI has passed its third anniversary, yet there is still no publicly available operational plan for GHI in Ethiopia. And indeed debate continues whether such a plan was ever formally mandated. It is also unclear precisely what portion of existing PEPFAR resources is being repurposed to support the new MNCH priority.

Further, the embassy has been unable to move to a more unitary budgeting and planning process for U.S. government health activities, which would have been a significant improvement in its business approach, because it had to follow Washington directives that require siloed budgetary and planning documents. In addition to these documents, the embassy team has had to plan and report on the GHI process, rather than submit those materials as a unified plan for PEPFAR, PMI, and USAID. Already facing multiple complex reporting processes, many embassy officials have found the additional level of planning for GHI an extra burden. This has further damaged internal excitement for GHI.

It is unclear what the future holds for GHI. Some argue, as President Obama’s first term nears an end, that GHI has not produced many valuable, durable outcomes and that, given the current budgetary situation and the increasingly concentrated focus on meeting ambitious new HIV/AIDS treatment goals, GHI should be allowed to expire. If this path is chosen, it will still be essential to ensure that GHI’s principles and the lessons learned are still relevant: future U.S. global health efforts, regardless of the rubric under which they are organized, will only be sustainable if there is closer integration of services, a special focus on gender, better data and accountability, and a determination to build partner country capacities and long-term ownership by these countries of their health agenda. Alternatively, if GHI does remain the lead organizing concept for U.S. global health engagement, its future success will depend on far greater clarity in defining procedures, goals, and concrete milestones, and winning from Congress and U.S. agency heads a true commitment to equip the U.S. ambassador and his/her in-country missions with greater budgetary, planning, and reporting flexibility.

4. As the United States presses ahead in its partnership with Ethiopia’s exceptional health leadership, it will need to better protect its investments against the risks that emerge from Ethiopia’s rigid, autocratic governance.

Progress across HIV/AIDS, malaria, and family planning has been possible because of sustained U.S. investments over the past decade and the emergence of the Ethiopian government as a strong partner in the health field. In particular, the Ethiopian government has prioritized improving the health of its citizens as part of its long-term political strategy, selected strong top-level leadership for its Ministry of Health, and doubled its health budget over the last five years. Improving the health of Ethiopians, particularly the rural peasant base, is one of four macro-objectives of the Ethiopian government’s five-year Growth and Transformation Plan, developed in 2010 as a means to achieving the Millennium Development Goals (MDG) by 2015. Ethiopia’s Health Sector Development Program IV (HSDP IV) provides the overarching operational plan for improving health in the country and puts a special focus on dramatically improving maternal and child health during the 2011 to 2015 period.

Ethiopia’s ambitious health plan is driven by its minister of health, Dr. Tedros Adhanom Ghebreyesus, who has led the country’s health transformation since 2005. In this role, and during his two-year term as chair of the Global Fund board (2009–2011), the minister has emphasized the need to use single disease investments—such as HIV/AIDS funding from PEPFAR and the Global Fund—for broader health system advancements. He has been a lead advocate for expanding the Global Fund’s mandate to include maternal and child health and for focusing health resources at the community level.

Under his tenure, the Ethiopian government has doubled its domestic resources for health, from 7 percent of the total budget in 2006 to 15 percent in 2011. Over this same period, international donor assistance for health skyrocketed. Among the largest donors—the United States, United Kingdom, World Bank, and Global Fund—total commitments grew from \$462.8 million in 2007 to \$778.4 million in 2011. Ethiopia quickly rose to become the single largest recipient of Global Fund monies, having won over \$1.3 billion in grants since 2003.

Progress also stems from the close, long-term collaborations that have developed between Ethiopian institutions and U.S. agencies. The U.S. Centers for Disease Control and Prevention has a direct funding relationship with the Federal Ministry of Health and other Ethiopian government agencies and is increasing its direct relationship with regional health bureaus. CDC is also colocated with the Ethiopian Health and Nutrition Research Institute to improve the Institute’s data collection and analysis capabilities so it can perform a similar public health role as that of CDC in the United States.

Through the National Institutes of Health (NIH) Medical Education Partnership Initiative (MEPI), several Ethiopian universities, led by Addis Ababa, and including Hawassa, Haremaya, and the Defense Universities, are now linked to prominent U.S. universities, including Emory University, Johns Hopkins University, University of California at San Diego, and University of Wisconsin, with a focus on improving the quality of medical education in Ethiopia. In addition, CDC has direct

cooperative agreements with six Ethiopian universities. USAID has also established close working and mentoring relationships with local communities, including local (*kebele*) and district (*woreda*) governments.

The recently completed 2011 *Ethiopian Demographic and Health Survey* (DHS) offers dramatic proof that progress has been achieved in the past decade and has raised confidence among partners that a concerted effort over the next five years—until the next DHS—will continue to improve the health of Ethiopians. There is much progress in the areas of family planning and child health in particular: Infant and under-five mortality decreased 39 percent and 47 percent, respectively, between the 2000 and 2011 surveys⁹; and the use of modern family planning methods in Ethiopia has risen dramatically from 3 percent in 2000 to 29 percent in 2011.¹⁰ Most observers attribute these gains to general improvements across multiple sectors in Ethiopian society, including roads, electricity, water and sanitation, education, and health.

The DHS also reveals areas where the greatest work remains. Serious gaps remain in terms of basic education and literacy, particularly among rural women and girls, despite recent gains. Mortality among mothers and newborns remains unconscionably high and has been persistently resistant to improvement. Despite a doubling of the number of deliveries occurring in health facilities, only 10 percent of women gave birth with a skilled provider in attendance,¹¹ meaning the vast majority of laboring women are out of reach of essential supplies and professional help when an emergency occurs. Even if a woman does reach a health facility, a difficult process given the country's harsh and remote terrain, she is unlikely to encounter one that has an obstetrician or emergency obstetric services. Despite the government of Ethiopia's determined efforts to reduce maternal mortality, the rate remains alarmingly high at 676 deaths per 100,000 live births¹² (the U.S. rate is 12.7 per 100,000). For newborns, the mortality rate is 37 per 1,000.¹³

There are also several inherent vulnerabilities in Ethiopia's governance. Sudden shifts in Ethiopia's economic or social stability, if not anticipated, could endanger U.S. investments, erode the health gains of the last five years, and diminish the feasibility of expanding health platforms to make progress in maternal and neonatal health.

The Ethiopian government's determined use of the state to achieve accelerated investment across virtually all sectors—agriculture, education, power, health, and transport through a unified Growth and Transformation Plan (GTP)—has achieved high economic growth in recent years but also carries considerable risks.¹⁴ In 2011, that strategy of a “development state” pushed the country's

⁹ DHS 2011, p. 109.

¹⁰ DHS 2011, p. 97.

¹¹ DHS 2011, p. 119.

¹² DHS 2011, p. 267.

¹³ DHS 2011, p. 111.

¹⁴ “Ethiopia: Development over democracy,” allAfrica.com, May 11, 2012, <http://allafrica.com/stories/201205110313.html>.

inflation rate to 40 percent, eroding economic gains, imposing costs on the poor and middle class, and raising the risk of macroeconomic and social instability. Under international pressure, the government eased back on the printing of new money in late 2011, and inflation subsided but still remains problematic.

There is a conspicuous gap between the GTP's urgent, huge ambitions and the Ethiopian government's capacity and finances.

Within the GTP, health competes with other high-priority sectors. Power generation, including a \$10 billion commitment to fund hydroelectric projects; expansion of the road network; increased access to electricity; and major improvements in the quality of education and agriculture all remain vitally important to the success of Ethiopia's development project. The Ethiopian leadership wishes to achieve accelerated transformation across all of these sectors simultaneously. That is simply not possible. It is too high a bar, in too little time.

The Ethiopian government has few strong societal partners. The government's apparent hegemony and strength are a tacit vulnerability. It is a "stable but brittle" state¹⁵ that has successfully consolidated its power since the violent contested elections of 2005, extending the party apparatus' reach into every corner of the country and putting into force draconian legislative controls over nongovernmental organizations and media. But in doing so, it has weakened and marginalized organized opposition parties, an independent civil sector, and an independent media. The private sector remains small and highly dependent. The government's achievements in economic growth and social services have earned it broad popular support, but the depth of that support is uncertain. If it stumbles in the delivery of continued economic growth and expanded social services, and the GTP vision begins to crack, there could be a sudden reversal of fortune.

While the government's ambitious health plan as outlined by the HSDP IV is admirable, it lacks a realistic or phased implementation strategy, a set of core priorities, and a defined package of minimum health service capacities required to reach its goals. Moreover, due to restructuring at the federal level, there is no longer a strong unit in the Ministry of Health empowered to direct implementation of the plan. With the exception of a top cohort of emerging leaders, ministry staff—particularly junior and mid-level staff—often lack the financial and data management skills to drive forward operations. Strong technical program leadership was also lost following the BPR process. There is no longer an HIV/AIDS, TB, or malaria "program" in the Federal Ministry of Health. Instead, there are now geographic case teams that are expected to cover all topics. Much of the staff is junior and lacks technical expertise and experience. At the ground level, there are glaring gaps in procurement, supply chains, and data systems.

The HSDP IV has a large finance gap, with no clear strategy for covering it. There also has not been a health sector expenditure review to help clarify how and where money is being spent. Currently

¹⁵ Terrence Lyons, *Ethiopia: Assessing Risks to Stability* (Washington, DC: CSIS, June 2011), p. 1, http://csis.org/files/publication/110623_Lyons_Ethiopia_Web.pdf.

the Ethiopian government's health budget is 40 percent dependent on external sources. For HIV/AIDS programming, it is 90 percent dependent on the United States and Global Fund. While MNCH may attract some additional resources from the United Kingdom, World Bank, and United States, the new funding will likely be limited in scope and not come near the major new external infusions needed to move the plan forward. Lastly, the Ethiopian government's drive to deliver health improvements to all parts of the country in order to satisfy political goals and remain popular with the rural peasant base also holds inherent risks. The government's strict adherence to universal policies makes it averse to trying pilots or regionally focused experiments, which in a resource constrained environment is often the best approach for testing new programs. There is also a risk that the accelerated transformation plan, focused so strongly on positioning Ethiopia to show dramatic MDG gains by 2015, will create strong incentives at the local (*kebele*) and district (*woreda*) levels to fudge numbers in order to meet excessively ambitious targets. Disputes over data are a recurring problem in the U.S.-Ethiopia relationship, as is transparency over funding.

Above all, there is a risk that, as members of the party become involved at the community level in stimulating demand for services, the push to drive individuals to facilities may take on a coercive quality. If people arrive at facilities that are not yet ready to meet demand, particularly if they feel forced to do so, the resulting feelings of disappointment and skepticism will hinder future efforts to mobilize communities around facility-based services.

Realistically, there are no easy or simple options to protect U.S. investments from these risks. However, some measures can be taken to minimize vulnerabilities.

First, the United States can more vigilantly monitor whether maternal, newborn, and child health programs are becoming tools to meet the Ethiopian government's political objectives and consolidate its support among the rural peasantry. Special attention should be given to ensuring that women are not coerced into visiting health centers and that local health officials are not pressured to exaggerate accomplishments in order to reach performance benchmarks. The United States can collect independent data on the political conditions in sample communities and use that information to engage in an open, candid dialogue with the Ethiopian government about reaching health milestones while respecting individual human rights.

Second, the United States can spur the World Bank to explore a results-based financing initiative in the health sector. Carefully monitored results-based financing efforts can encourage the government of Ethiopia to tie cash inputs to proven concrete performance, spend down existing pipelines, and improve the overall management of the health sector.

Third, the United States can accelerate the transition to greater ownership of health programs by the Ethiopian government. That will build self-interest in ensuring the success and longevity of the health sector.

Closing Thoughts

The U.S. health partnership with Ethiopia has been a relative success, a function of strong Ethiopian leadership and commitment and a continuous, serious U.S. engagement stretching out over several years. The health impacts for Ethiopian citizens have been impressive, as revealed by the recently completed DHS survey. Serious challenges do remain, however. Ethiopia's health sector has, to a significant degree, been oversubscribed by donors in recent years, and an abrupt downward adjustment is now under way that will need to be managed carefully so that critical gaps do not open in areas such as mentoring of health center staff now charged with ART delivery; prevention programs to reach commercial sex workers and men who have sex with men; and programs to benefit orphans and other vulnerable children on a mass scale.

Ethiopia's autocratic governance, and the excessive ambitions of its "development state," create vulnerabilities that could potentially derail health investments. These require special vigilance and a more strategic U.S. approach. It will be important that the United States be more multilateral, with a special focus on the Global Fund and the World Bank. It will be important that the United States make increased direct U.S. investments in Ethiopian capacities, leverage greater Ethiopian ownership of its health sector, and accelerate Ethiopian self-reliance in the coming years. And it will be important to digest and act realistically upon the very mixed results seen in Ethiopia in the past three years of the U.S. Global Health Initiative.



1800 K Street, NW | Washington, DC 20006
Tel: (202) 887-0200 | Fax: (202) 775-3199
E-mail: books@csis.org | Web: www.csis.org