HEALTH CLUSTER ETHIOPIA

# Strategy 2024-2025

## Introduction

Ethiopia has been repeatedly affected by conflict, flooding, drought, and disease outbreaks in the past years. As of January 2024, the country is actively responding to the longest recorded cholera outbreak which started in August 2022, recurrent measles outbreaks which started in August 2021, and the highest number of malaria cases reported since 2017. The El Niño phenomenon is expected to cause further havoc up to July 2024, by causing drought in some parts of the country, and flooding in others. Food insecurity due to lost harvest and livestock is aggravating already high malnutrition rates, negatively impacting morbidity and mortality.

The Health Cluster is closely collaborating with the Ministry of Health (MOH) to prepare for, prevent, and respond to public health emergencies by mobilizing resources to enable health partners to provide life-saving health services to vulnerable populations.

In an environment with ever-increasing needs and decreased funding, the below priorities for 2024 and 2025 have been identified:

1 Strengthen advocacy for longer-term, development funding to address root causes of recurrent disease outbreaks, including through the Humanitarian-Development-Peace Nexus
2 Advocate for increased access to quality health services, with a strong focus on:
   - sexual and reproductive health services (including for survivors of sexual and gender-based violence)
   - inclusion of people with disabilities, older people, and people living with HIV
   - remote populations through inclusion of Mobile Health Teams (MHT) as part of the health system
3 Standardize health services provided by Health Cluster partners through the implementation of Essential Health Care packages, aligned with existing MOH guidance, aimed at ensuring quality service delivery for affected populations, especially at community level
4 Strengthen quality of, and access to data for needs analysis and informed decision-making
5 Strengthen subnational coordination, with increased focus on zones and local health partners

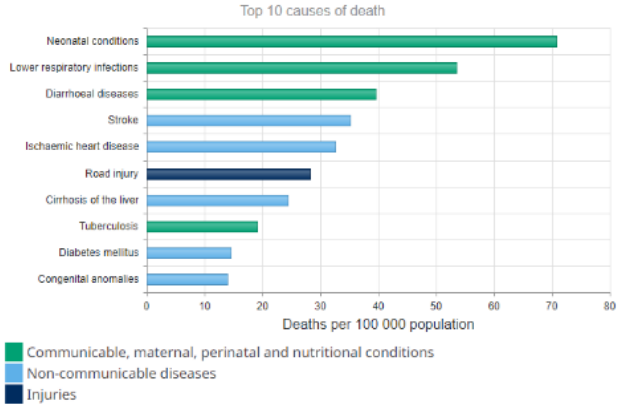
## Background

### Health status

When comparing Ethiopia with neighbouring countries, the high maternal and neonatal mortality rates stand out, as well as the low share of births attended by skilled health workers and low coverage of essential health services (*see table*).

| | Ethiopia | Kenya | Sudan |
|---|---|---|---|
| **Life expectancy** *(WHO, 2020)* | 68.7 | 66.1 | 69.1 |
| **Adult literacy rate** *(UNESCO, 2017)* | 51.8 | 82.6 | 60.7 |
| **Coverage of essential health services** *(WHO, 2019)* | 38 | 56 | 44 |
| **Maternal mortality ratio per 100,000 live births** *(WHO, 2017)* | 401 | 342 | 295 |
| **Malaria mortality in children U5 per 100,000** *(IHME, 2019)* | 68 | 72 | 18 |
| **Neonatal mortality rate per 1,000 live births** *(WHO, 2021)* | 26.2 | 18.4 | 26.7 |
| **Share of births attended by skilled health staff** *(UNICEF, 2019)* | 49.8 | 70.2 | 77.7 |

The main causes of death in Ethiopia are neonatal conditions followed by lower respiratory infection and diarrhoeal diseases (*see graph*)[1].




### Public health emergencies

Damage to health facilities and water supply systems due to flooding and conflict is increasing the risk of spread of disease and limiting access to health care. Drought is negatively impacting malnutrition and forcing people to use untreated water, while ongoing fighting is impeding access to communities and health facilities for vector control interventions, transport of samples for laboratory confirmation, distribution of supplies like diagnostics tests, drugs, vaccines, and bed nets, and training of health workers.

As a result of conflict, flooding, and drought, 3.5M people are internally displaced in Ethiopia[2]. Ongoing conflict in Sudan and Somalia in 2023 increased the refugee population to almost 1M people across the country, with over 1,200 people still arriving each week from Sudan, mostly arriving through Points of Entry in Amhara and Benishangul Gumuz[3].

[1] https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death
[2] https://dtm.iom.int/ethiopia September 2023
[3] https://reporting.unhcr.org/operational/operations/ethiopia

Ethiopia is affected by multiple disease outbreaks, including water-borne diseases like cholera, vaccine-preventable diseases like measles, and vector-borne diseases like malaria, dengue, and leishmaniasis.

Conflict and natural disasters have directly resulted in a surge in malaria cases, interrupting effective vector control interventions to minimise the mosquito or sandfly population, distribution of supplies including bed nets, testing kits, and medicines, as well as adequate surveillance and training of health workers in diagnosis and treatment.

Lack of availability of safe drinking water and open defecation are root causes of cholera outbreaks, which have been recurring in 118 cholera hotspot woredas since 2017. Over 60% of cholera patients report using untreated water from rivers or ponds. A high Case Fatality Rate of 1.47% as of 1 January 2024 is evidence of late health seeking behaviour, because of weak community-based surveillance, low awareness of cholera presence among the population and health care workers, and lack of access to treatment.

Data indicate a 157% increase in laboratory confirmed measles cases in 2023 when compared to 2022 with 56% of children under 5 never receiving any vaccination against measles.

Only by investing in durable solutions for sustainable access to safe water, sanitation, and routine immunization can cholera and measles outbreaks be addressed. Similarly, integrated vector control strategies are the only means to tackle diseases like malaria and dengue.

### Health system

Ethiopia's health system is structured in line with the federal government system, whereby the Federal Ministry of Health (FMOH) at national level plays a regulatory role, providing technical assistance and guidance to sub-national health authorities, like Regional Health Bureaus (RHB), Zonal and Woreda Health Offices. In addition to its normative and regulatory role, FMOH also runs several referral hospitals in Addis Ababa. The head of a RHB is a member of the regional cabinet chaired by the regional president. Similarly, a Woreda Health Office (WoHo) is accountable to the elected members of a Woreda Cabinet. RHBs and WoHo's have their own budgets, which provides them with the autonomy to implement health programs, in line with national guidance.

The Ethiopian Public Health Institute (EPHI) was established separately to focus on public health emergencies, including surveillance, laboratory services, response, and research. EPHI is an autonomous federal government office with its own legal personality and budget, accountable to the FMOH. The EPHI board of directors is chaired by the Minister of Health. Some regions, like Amhara and Afar, have their own Public Health Institute.

Unfortunately, government funding for preparedness, prevention and response to public health emergencies is limited and FMOH and EPHI remain reliant on foreign aid for response. Emergency funding is mostly short-term and discontinues once the emergency is considered over. There is an increased need of Mobile Health Teams (MHT) as the only means to access health care for displaced populations, as well in pastoralist areas with low primary health care coverage. Funding for MHT could be integrated within existing community-based health insurance schemes, to make it more sustainable.

The health system has been negatively impacted by ongoing conflict, damaging health facilities, diverting scarce resources, and reducing the availability of skilled health workers and other human resources.

It is key to advocate for longer-term funding for MHT to ensure pastoralist as well as conflict-affected populations will have uninterrupted, free access to health care and supplies.

### Health infrastructure

WHO implemented the Health Resources and Services Availability Monitoring System (HeRAMS) in Tigray[4] in May-June 2023, and in Afar in August 2023, collecting detailed information on the availability of essential health resources and services. Assessments conducted by ICRC and Zonal Health Offices in Western Oromia during 2023, show a significant number of health facilities as only partially functional due to looting, damage, and some health centres fully destroyed.

Thanks to available data, the extent of damage to health facilities' buildings and equipment due to conflict is clearly established: out of the 853 health facilities assessed in Tigray alone, 28 were fully destroyed and 736 partially damaged. Equipment was looted or destroyed in 232 health facilities, while partially damaged in 612 health facilities. 68 health facilities remain non-functioning, with 757 only partially functioning due to lack of staff, equipment, and funding. RHBs in regions like Amhara and Benishangul Gumuz keep detailed records on damaged health facilities, which will be incorporated in future HeRAMS exercises.

[4] https://www.who.int/publications/m/item/herams-tigray-baseline-report-2023-operational-status-of-the-health-system

## Health Cluster

The cluster system in Ethiopia has been active since 2007, after which the Health Cluster followed shortly. Under the auspices of the World Health Organization as the Health Cluster Lead Agency, and co-chaired by the Ministry of Health, the Ethiopia Health Cluster currently has 57 operational partners including national and international NGOs, the Red Cross Movement, UN agencies, MOH, and EPHI.

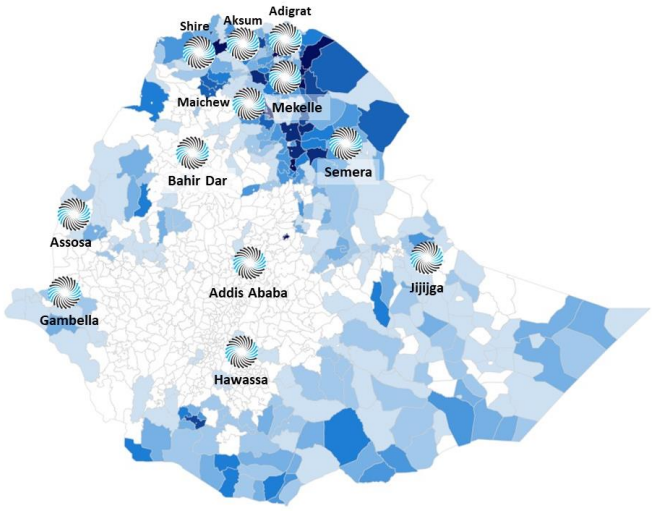
As of 1 January 2024, the Ethiopia Health Cluster team consists of 24 individuals, out of which 16 are full-time, 6 are double-hatting, and 2 are co-coordinators from NGO partners (Action Against Hunger in Gambella and Mothers and Children Multisectoral Development Organization (MCMDO) in Benishangul Gumuz). The team comprises 13 Health Cluster coordinators, 1 at national, and 12 at sub-national level, 2 public health officers, and 9 information management officers.

The Health Cluster is represented in each of the regions (*see map*) and at zonal level as well in Tigray. In other regions, coordination at woreda and zonal level remains a challenge. The Health Cluster does not have dedicated funding, which is limiting its ability to conduct regular assessments and monitoring visits.

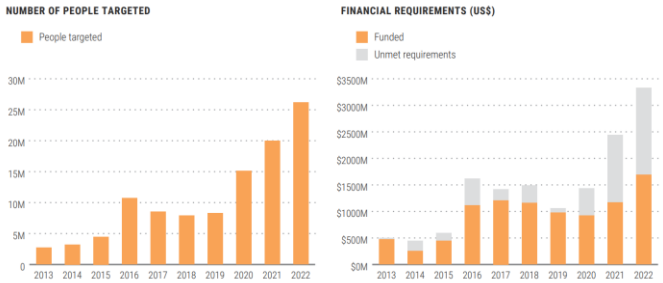
The Ethiopia Health Cluster is supported by a Strategic Advisory Group (SAG), consisting of UN, international and national NGOs, donors, and observers. SAG members are actively involved in any strategic decision that the Health Cluster needs to make.

The Health Cluster is planning to expand the system of co-coordinators at zonal level through its partners, to ensure a better overview of health needs and gaps at sub-national level. This will be done in close collaboration with the Public Health Emergency Management (PHEM) departments of local health authorities, who by default have a mandate for partner coordination.

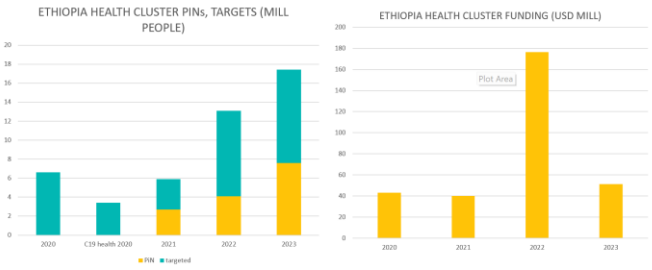
*Map of Ethiopia with health cluster presence as of January 2024*




*Number of People Targeted, and Financial Requirements for Ethiopia **Humanitarian Response Plans** 2013-2022*




*Number of People in Need, People Targeted, and Funding for **Health Cluster** in Ethiopia Humanitarian Response Plans 2020-2023*




## Humanitarian Response Plan

The OCHA-led Humanitarian Response Plan (HRP) is a key resource mobilization tool for all clusters. Since 2021, the number of People in Need in Ethiopia as identified in the yearly HRP have fluctuated around 20 million people, with a sharp increase in 2023 to 28.6 million[5]. This is substantial, seen the total population of Ethiopia estimated at 126.5 million[6].

For the health cluster, the number of People in Need significantly increased from 6 million in 2021 to 17.4 million in 2023.

After Syria and Yemen, the Ethiopia HRP was the third largest globally in terms of funding requirements for 2023. Only 33.6% of the total amount was funded, showing a serious decline in funding availability. For the health cluster, the funding coverage was 25%.

For this reason, the 2024 HRP is seeing a lower target population and financial requirement, in line with more realistic funding expectations.

There is an urgent need to diversify funding sources for all clusters, including with development donors.

[5] https://humanitarianaction.info/plan/1128

[6] Figure is based on extrapolation of data from the last population census conducted in Ethiopia in 2017.

# Strategic objectives and priorities

The Ethiopia Health Cluster works in line with the six core functions of the cluster system:

1. Support service delivery
2. Inform strategic decision making through the Humanitarian Coordinator/Humanitarian Country Team
3. Develop sectoral strategies
4. Monitor and evaluate performance
5. Build national capacity in preparedness/contingency planning
6. Support advocacy

In addition, the Health Cluster adheres to the key principles of Accountability to Affected Populations, Do No Harm, Prevention of Sexual Abuse and Exploitation, as well as supporting the Cluster Lead Agency as the Provider of Last Resort.

The Health Cluster aims to collectively prepare for and respond to humanitarian and public health emergencies to improve health outcomes of crisis affected populations through timely, predictable, appropriate, and effective coordinated health action.

The Ethiopia Health Cluster has identified 3 strategic objectives, in line with the 2024 Humanitarian Response Plan, and 5 strategic priorities:

## Strategic objectives

### *1 Ensure access to safe, effective, equitable and inclusive humanitarian lifesaving and life sustaining health services to crisis affected populations.*

Health partners are playing a crucial role in health service delivery at health facility level and through MHT, the latter mostly for displaced and difficult-to-reach populations.

Partners face severe challenges with the procurement of medical supplies. Donors often do not allow local procurement, while international procurement can take up to 6 months. In addition, the governmental Ethiopian Pharmaceutical Supply Services (EPSS) has been reluctant to sell or distribute medical supplies to NGO partners, which often are the only ones with access in conflict-affected areas.

Partners therefore depend on provision of emergency kits by the 3 core pipeline suppliers (UNFPA, UNICEF, and WHO). Global shortages of items like Rapid Diagnostic Tests (RDTs) for cholera and malaria, condoms, and others, as well as bureaucratic approval processes have been causing serious delays with delivery of supplies during 2023, often impeding partners to implement their health programs before funding expires.

Partners have also been supporting with assessments, training of health workers, health promotion activities, transport of government staff, delivery of supplies, and surveillance.

As partners rely on short-term emergency funding, life-saving interventions are often interrupted when funding runs out, leaving vulnerable people without access to health care. WHO as the Cluster Lead Agency of the Health Cluster is then expected to act as the Provider of Last Resort, depending on available funding.

The Health Cluster will:

- continue to map partners' operational presence and operational capacity to prioritise gaps in coverage and quality
- advocate for speedy processing of emergency supplies to partners
- conduct assessments and monitoring to identify and address gaps in health needs, where financially feasible
- step up advocacy for gap-filling interventions, in close collaboration with WHO as the Provider of Last Resort
- advocate with MOH and EPSS for dispatch of government supplies to partners for last mile delivery.

#### Mental Health and Psychosocial Support (MHPSS)

MOH and WHO are jointly chairing the MHPSS Technical Working Group, where partners are actively engaged in discussing technical and strategic matters on health and medical components of MHPSS. MHPSS is an integral part of the health service package for populations affected by emergencies. Partners are supporting with provision of specialised psychiatric care, including psychotropic drugs, diagnosis, and referral of severe cases.

MHPSS has an important non-medical component, aimed at preventing mild cases from becoming severe through psychological first aid and other activities that do not require a medical specialisation. These activities are supported by the Protection Cluster.

The Health Cluster will:

- continue to promote MHPSS as a mandatory component in any health emergency proposal
- work closely with the Protection Cluster to ensure smooth coordination between non-health partners working in MHPSS under the Protection Cluster and the medical side of MHPSS in relation to referrals to specialised psychiatric care
- mobilize expertise from WHO and specific partners to build capacity of local NGOs in MHPSS service provision.

## *2 Reduce excess morbidity and mortality; prepare, prevent, detect and timely respond to epidemic-prone and endemic diseases, driven by climatic shocks and conflict among crisis affected populations.*

Health partners have been actively engaged in response to the various disease outbreaks in the country. Partners are supporting with case management, such as the running of Cholera Treatment Centres, training of health workers, risk communication and community engagement, transport of government staff and health workers for outbreak investigation, sample collection, delivery of supplies, and surveillance.

Partners have also been supporting with last-mile delivery of government malaria supplies through the EPSS in areas with difficult access to the government.

WHO and UNICEF have been providing life-saving emergency supplies for diagnosis and treatment of cholera, malaria, measles, and other conditions.

OCHA is coordinating several rapid response mechanisms (RRM), which can also be used by disease outbreaks. The Health Cluster facilitates proposals from partners for RRM funding, to ensure interventions are in line with current needs.

The Health Cluster will continue to:

- facilitate partners with emergency kits through WHO, UNFPA, and UNICEF, funding for provision of health services and last-mile delivery of supplies, as well as technical expertise through training, guidelines, and epidemiological updates
- map partners' interventions in disease outbreak response to identify gaps and avoid duplication
- strengthen preparedness through joint contingency and response planning, in close collaboration with other clusters, like with WASH for cholera
- step up monitoring to ensure all emergency response activities are conducted in accordance with national guidelines.

## *3 Support recovery and restoration of essential health services disrupted or damaged by natural or human induced disasters including minor rehabilitation of health infrastructure.*

Data collected as part of the Health Resources and Services Availability Monitoring System (HeRAMS) is used for mobilizing resources for both large-scale rehabilitation and small-scale repair of health facilities. Depending on funding, MOH and WHO are planning to implement HeRAMS in Oromia and Amhara during 2024, to be extended to other regions afterwards. The Health Cluster regularly produces maps with partners' ongoing rehabilitation interventions, to avoid duplication of efforts and to advocate for additional resources, particularly with development donors.

The Surveillance System for Attacks on Health Care (SSA)[7] is an online database managed by WHO, collecting data on attacks on patients, health workers, and health facilities, as an important advocacy tool for the protection of people and structures. ICRC maintains a similar database, as part of its *Health Care In Danger*[8] campaign. The Health Cluster, in close collaboration with ICRC and MOH, aims to enhance the collection and verification of data on attacks on health care in Ethiopia.

The Health Cluster will:

- actively support the implementation of HeRAMS
- continue to map health partners' interventions on rehabilitation and repair of health facilities
- strengthen resource mobilization for rehabilitation and maintenance of health facilities
- step up efforts to collect and verify data on attacks on health care to be uploaded in the SSA database.

[7] https://extranet.who.int/ssa/Index.aspx
[8] https://healthcareindanger.org/

## Strategic priorities

### 1 *Strengthen advocacy for development funding to address root causes of recurrent disease outbreaks*

#### Humanitarian-Development-Peace Nexus

Prevention of recurrent disease outbreaks include immunization, provision of safe drinking water, handwashing, and sanitation facilities, as well as vector-control interventions including the distribution of bed nets. All these activities are considered developmental interventions, and not supported with emergency funding. They are however crucial in minimizing morbidity and mortality of recurrent disease outbreaks. 75% of Health Cluster partners implement both development and emergency programs, which will allow a cost-effective way to synergize disease outbreak prevention and preparedness interventions.

The Health Cluster will continue to:

- map both developmental and emergency interventions from partners
- foster collaboration with development partners to build resilient health systems
- strengthen advocacy for longer-term, development funding to address root causes of disease outbreaks.

#### Intercluster sectoral collaboration (ICSC)

Initiated by the Nutrition Cluster, ICSC has been established between the Agriculture, Food, Health, Nutrition and WASH Clusters in Ethiopia, aimed at reducing the burden of child wasting and mortality among drought-affected populations.

About 75% of health partners also implement nutrition, WASH, or protection interventions. To a lesser extent, health partners engage in food security and agriculture activities. ICSC aims to take advantage of existing multi-sectoral capacities of NGO partners, further promoting inter-sectoral working.

The Health Cluster will:

- work with other clusters to continue and further expand inter-cluster initiatives
- actively promote and support joint assessments, planning, programming, monitoring and evaluation activities.

### 2 *Advocate for increased access to quality health services*

#### 2.1 *SRH services (including for survivors of SGBV)*

Despite improvements in maternal and neonatal mortality in the past decades, lack of access to quality sexual and reproductive health (SRH) services and lack of skilled health workers in remote areas remain problematic in Ethiopia. UNFPA has been working hard to increase access to the Minimum Initial Service Package (MISP) for lifesaving SRH services, providing training, guidance, and emergency SRH kits to health partners. Strategic and operational matters are discussed in the Sexual and Reproductive Health Technical Working Group (SRH TWG), chaired by EPHI and co-chaired by UNFPA.

Although official data is not made public at national level, cases of sexual and gender-based violence (SGBV) are widely reported from conflict-affected areas through RHBs. Besides medical treatment, health partners engage in the provision of PEP kits, HIV testing and treatment, and MHPSS services for SGBV survivors.

To better measure gaps and impact of SRH services, additional indicators were added to the monthly data collected from partners by the Health Cluster.

The Health Cluster will continue to:

- collect, analyse, and disseminate data on health partners' SRH interventions
- advocate for increased access to, and resources for, SRH services, including for treatment of SGBV cases.

#### 2.2 *People with disabilities, older people, and people living with HIV*

In situations of sudden displacement, people with disabilities and older people are often left behind. In addition, those suffering from non-communicable diseases such as hypertension and diabetes are at increased risk of death due to difficult access to adequate medication. Associations of people with disabilities and older people can facilitate with the identification of these vulnerable groups in times of need.

Similarly, for enhanced inclusion of people with disabilities and older people in health programs, the Health Cluster will partner with relevant stakeholders to increase awareness for health partners to recognize the special needs of people with disabilities and the elderly, as well as innovative ways to improve their access to health care.

Unofficial data of over 20,000 people living with HIV who were lost to follow up for HIV treatment in Tigray region during the 2-year conflict are staggering and show the urgent need for uninterrupted access to essential supplies for the diagnosis and treatment of HIV as well as related conditions such as Sexually Transmitted Infections and TB.

Health partners have been supporting MOH with delivery of HIV testing kits and drugs to health facilities in conflict and post-conflict settings.

In close collaboration with UNAIDS and WHO, the Health Cluster has been advocating for increased access to HIV testing and treatment supplies for conflict-affected populations, through health partners' last-mile delivery at health facility level.

The Health Cluster will:

- advocate for uninterrupted access to diagnosis and treatment of HIV, Sexually Transmitted Infections, and TB
- advocate for better access to health care for people with disability and the elderly in humanitarian settings
- ensure the inclusion of people with disabilities and older people in any public health emergency preparedness and response intervention, through meaningful participation (*Nothing about them, without them*).

### *2.3 Hard-to-Reach populations*

Access to health care is limited, and in many rural areas absent. Availability of health services greatly depends on external donor funding and support from health partners providing life-saving health services through MHT. MHT are costly, because of increasing expenses for fuel and rental of vehicles. Short-term funding regularly disrupts the continuation of MHT, and this access to health care for large parts of the population, particularly among displaced and pastoralist groups.

MHT are considered an emergency health intervention, whereas they are often the only means to access health care for remote populations, particularly in regions with over 80% of pastoralist population, like Afar and Somali.

The Health Cluster will:

- step up resource mobilization for longer-term funding for MHT as part of routine health programs
- disseminate relevant information on MHT, like maps with partners' MHT interventions, MHT guidelines, etc.
- conduct supportive supervision of partners' MHT intervention to ensure compliance with government standards.

## *3 Essential Health Care packages*

WHO with support from the Global Health Cluster developed the High Priority Health Services for Humanitarian Response (H3 Package), aimed at promoting universal health coverage (UHC) in humanitarian settings. The H3 Package increases accountability to affected populations and identifies opportunities for the humanitarian-development nexus. The H3 Package defines which core services are feasible to deliver at community level or in health care facilities[9], in line with existing government guidance, such as the MHT guidance.

In close collaboration with MOH and WHO Health Systems Strengthening colleagues, the Health Cluster plans to introduce the H3 Package in Ethiopia and adapt it to the Ethiopian context. The Health Cluster SAG members will play a key role in this interactive exercise, aimed at enforcing health partners to provide standardized health services in line with existing MOH guidance. This will also include working with health extension workers.

Conflict has negatively impacted well-working community-based health programs like the Health Extension Program in many parts of the country. While health partners are encouraged to work through existing systems, and actively coordinate with available Health Extension Workers, this is not always the case. By agreeing on types of services provided at community level through the H3 Package, health partners will commit to working with Health Extension Workers.

To reinforce the above, it is required to develop a community-based health services delivery policy guidance, aimed at standardizing, and enhancing the quality of normal deliveries, community-based new-born care, and Integrated Community Case Management (iCCM) in the context of conflict and pastoralist populations.

[9] https://uhcc.who.int/uhcpackages/

The Health Cluster plans to:

- introduce and adapt the H3 Package to the Ethiopian context through the Health Cluster SAG
- strengthen advocacy to encourage partners to employ health extension workers in their programming
- capacity building of partners on the H3 Package
- advocate for the development of policy level guidance for community-based health services delivery.

## 4 *Strengthen quality of, and access to data for needs analysis and informed decision-making*

Analysis on impact on health services in Ethiopia is hampered by the absence of reliable disease data, particularly at woreda level, impaired by outdated population figures from the latest census conducted in 2007. Several data systems work in parallel, with EPHI's PHEM data being the key source of information for infectious diseases throughout the country.

Health partners actively support PHEM structures to collect surveillance data at health facility level. Disease data shared at regional level should be aligned with data published at national level, for informed decision making for timely disease outbreak preparedness and response interventions.


Health partners also submit monthly data through OCHA's ActivityInfo, providing a good overview of their interventions, including last-mile delivery of emergency kits. Thanks to a network of dedicated and double-hatting information management officers, the Health Cluster regularly updates the Health Cluster Dashboard, as well as the necessary maps and graphs representing partners' presence and their contributions to various ongoing emergencies in the country.

Health partners also submit financial information on resources allocated and utilized for emergency response through OCHA's Financial Tracking System. The Health Cluster will continue to advocate with MOH and EPHI to share rounded figures on financial contributions from the government, which are significant.

The Health Cluster works in close collaboration with OCHA's Information Management team, as well as the Assessment and Analysis Working Group (A&AWG) to ensure smooth coordination and joint analysis with other clusters on data-related issues, and to avoid duplication of efforts. One of the A&AWG efforts has been the establishment of the online Assessment Registry, which currently contains 72 health-related assessment reports.

The Health Cluster will continue to:

- collect disaggregate data based on sex, age, and disability
- regularly update and share the Health Cluster dashboard, maps, graphs, and other useful information products
- advocate for improved data quality and information sharing with MOH and EPHI
- collect assessment reports which include a health component for broad sharing.

## 5 *Strengthen subnational coordination, with increased focus on zones and local health partners*

Currently, the Health Cluster is mostly represented at national and regional level, except for Tigray, where 6 Health Cluster coordinators are active at zonal level in support of the regional Health Cluster coordinator. Zonal coordination enables a much better overview of health needs and gaps, and better engagement with health partners, including local health authorities.

The Ethiopia Health Cluster has initiated the system of Health Cluster co-coordination in Gambella and Benishangul Gumuz, where no dedicated Health Cluster coordinator is present. Thanks to trusted health partners like Action Against Hunger (ACF) and Mothers and Children Multisectoral Development Organization (MCMDO), the first 2 Health Cluster co-coordinators were officially introduced in the 2 regions. Taking advantage of partners' presence at zonal and woreda level and their good knowledge of the situation on the ground as well as their ability to engage local partners in health interventions, the Health Cluster is hoping to expand the system of co-coordinators at zonal level. This will be done in close collaboration with the PHEM departments, who by default have a mandate for partner coordination.

Local health partners have a unique role to play in health service provision, last-mile delivery of supplies, and disease outbreak response in areas with difficult access to government, international NGOs, and UN agencies. They are often part of the community they serve and have better understanding of the local context and better connections with local authorities. One key health partner with a strong local agenda is the Ethiopian Red Cross, which is also a member of the Health Cluster SAG.

The Health Cluster will:

- promote local and national health partners for potential funding opportunities to implement health programs
- support capacity building of local and national health partners with relevant training activities
- facilitate zonal Health Cluster co-coordination through health partners.

*Health cluster monitoring visit of health facility run by IRC in Taba Weyane IDP site, Tigray*