

WHO in the African Region
Making People Healthier

Ethiopia





The WHO Regional Office for Africa (AFRO), based in Brazzaville, Republic of Congo is responsible for 47 of the 54 countries in Africa.



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Making People Healthier

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Introduction

Working towards the betterment of the health of the Ethiopian people is in many ways both rewarding and challenging. The huge burden of communicable diseases and the increasing burden of non-communicable diseases indicate that many health challenges still remain to be tackled. Nevertheless, Ethiopia has made remarkable progress towards the achievement of the health-related Millennium Development Goals (MDGs). The commitment, hard work and joint efforts of all health development partners under the leadership of the Government of Ethiopia have been at the centre of the country's rapid progress on its health agenda.

Achievements so far are the result of collective and individual dedication, commitment and tenacity in our quest to contribute to addressing the health challenges in Ethiopia.

The WHO Country Office's support to the Government of Ethiopia is based on the WHO Country Cooperation Strategy (CCS 2012-2015), which is aligned with the Ethiopian Health Sector Development Plan 2012-2015.

WHO's strategic agenda emphasizes six priority areas to achieve sustainable health development: 1) a continued focus on WHO's leadership role in the provision of normative and policy guidance, as well as strengthening partnerships and harmonization; 2) supporting the strengthening of health systems based on the primary health approach; 3) putting the health of children and mothers first; 4) accelerated actions on HIV and AIDS, malaria and tuberculosis; 5) intensifying the prevention and control of communicable and non-communicable diseases; and 6) accelerating the response to the determinants of health.



The implications of the Multilateral Organization Performance Assessment Network (MOPAN) and the WHO Reform have been a very important benchmark to improve our performance for the benefit of the Government and the people of Ethiopia. As WHO Director-General Dr Margaret Chan said, “We are at country level the ultimate ambassadors of what WHO stands for and what we do.”

In 2013 and in line with the CCS and WHO Reform at country level, the WHO Country Office in Ethiopia initiated the provision of Direct Technical Assistance (DTA) to the Ministry of Health and established WHO Regional Technical Support Teams to provide technical assistance to the Regional Health Bureaus.

The DTA is seen by both WHO and the Ministry of Health as good practice in facilitating a closer working relationship. In the words of Minister for Health Dr Kesetebirhan Admasu, as he welcomed the WHO DTA team to the Ministry, it is “a trail blazer for WHO technical assistance in Africa.”

I would like to acknowledge the excellent collaboration between the WHO Country Office and the Federal Ministry of Health as well as all health development partners. Together, we have made great progress and can achieve even more for the people of Ethiopia.

This brochure outlines WHO Ethiopia’s contributions under the guidance of Dr Luis G. Sambo, WHO Regional Director for Africa, and with the excellent collaboration of health development partners in Ethiopia.

Dr Pierre M’Pele-Kilebou
WHO Representative in Ethiopia







WHO in Ethiopia

Ethiopia is a federal republic, with nine regional states and two city administrations. It is the second most populous country in Africa with an estimated population of 86.6 million (CSA website, 2013), 84% of whom live in rural areas (CSA, 2007). The population is predominantly young, with a high rate of natural increase (4.8 children per woman).

Ethiopia is a low-income country, ranking 173th out of 187 on the 2013 Human Development Index. The economy is highly dependent on agriculture, and has seen double-digit growth over the past decade.

Total population 
86 million
(UNDP)

Population distribution
- urban (HSDP IV)

16%

The country ranks
173rd
out of 187 countries
on the Human
Development Index
(UNDP)

Maternal mortality ratio
per 100,000 live births

676 
(DHS 2011)

Infant mortality rate
per 1,000 live births
(DHS 2011)

59 

General government
expenditure on health


11.5%
(Fourth NHA)

GDP per capita

US\$ 235
(HSDP IV)

Population with
access to improved
sanitation

86% 
(GTP)

Population
with access to
improved drinking
water source 

73.3%
(GTP)



National commitment to improving the health of the population

Ethiopia's comprehensive five-year Growth and Transformation Plan (GTP) (2010/11-2014/15) aims to achieve and maintain double-digit average annual economic growth, address emerging development bottlenecks and help the country meet the Millennium Development Goals (MDG).

Since the beginning of major health sector reforms in 1993, the Government of Ethiopia's efforts have been directed towards improving standards of living, particularly the health of the population. This is being done through a combination of strategies and approaches, including integration with initiatives on education, poverty reduction and access to good sanitation and safe water.

The Health Sector Development Plan (HSDP) has been in place since 1997/98. The priorities of HSDP IV (2012-2015) are maternal and new-born health, child health, HIV and AIDS, tuberculosis, malaria and nutrition.





achievements



Major achievements

- Ethiopia is registering real GDP growth of around 11% annually.
- Ethiopia achieved MDG 6 and MDG 4 three years ahead of the 2015 target by reducing new HIV infections by 90% and under-five mortality rates by two-thirds, respectively.
- 78% of people needing ART are on treatment (FMHO/HAPCO Annual Report 2012/13).
- The proportion of stunted children declined from 58% to 44% between 2000 and 2011. The proportion of underweight children declined from 41% to 29% in the same period (DHS 2011).
- Per capita health expenditure increased from US\$7.14 in 2005 to US\$16.1 in 2007/08. Overall, government expenditure on health has increased by 71% (Fourth NHA 2010).
- In 2009, malaria deaths in all age groups fell by 55%, malaria in-patient cases by 44% and malaria outpatient cases by 28%.
- Availability of primary health care units increased from 20% to 100% for health posts and from 18% to 100% for health centres between 2005 and 2011 (FMoH 2013).
- A stronger health system with a focus on primary health care has been built, with implementation of the health extension programme, use of the Health/Women Development Armies and an increased number of health facilities at all levels, including hospitals.



Key challenges and opportunities



Challenges:

- Geographic diversity
- Disparities between urban and rural/ agrarian and pastoralist areas, rich and poor, males and females
- High burden of communicable diseases
- Increasing burden of non-communicable diseases and conditions
- Shortage and low density of health workforce, and disparity in distribution and skills mix

Opportunities:

- High political commitment and strong enabling environment for health development
- Availability of the country's comprehensive HSDP as a chapter of the GTP 2010/11-2014/15
- Focus on primary health care and health systems strengthening
- Encouraging developments in terms of addressing priority communicable diseases and outbreaks
- Prioritization of maternal and newborn health at national level
- Growing attention to the prevention and control of neglected tropical diseases and non-communicable diseases
- Better harmonization and alignment





“Critically positioned in Ethiopia to support the Government in its heightened efforts to increase primary health coverage by enhancing equitable access to quality health care for its people, WHO plays a leadership role in the provision of normative and policy guidance and capacity-building through technical support to the Federal Ministry of Health and its regional bodies”

Dr Pierre M’pele-Kilebou, WHO Representative in Ethiopia, Address to Staff at WHO Ethiopia Annual Staff Retreat, April 2013.



WHO Programme

“We will be doing our best to support efforts to achieve the health MDGs. We are conscious of the current state of progress in the African region but we are hopeful because some countries are making significant progress and we should build on these positive developments”

Dr Luis G. Sambo, WHO Regional Director for Africa, Acceptance Speech at the 126th Session of the WHO Executive Board, Geneva, Switzerland, 19 January 2010.

The mission of the WHO Ethiopia Country Office is to provide support to promote the attainment of the highest sustainable level of health by all people living in Ethiopia, through collaboration with the Government and all health development partners.

WHO delivers technical support in various health programmes to national counterparts – who value the Organization as a credible partner – in the review and development of national policies, strategies, guidelines, manuals and service delivery reforms, as well as in strengthening the health system, coordinating and facilitating resource mobilization and fostering partnerships among various health stakeholders.





Alignment of the WHO CCS 2012-2015 with the HSDP IV

WHO CCS 2012-2015 strategic agenda

HSDP IV strategic objectives

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 the regulatory system
- Improve evidence-based decision-making through harmonization and alignment
- Improve the health infrastructure
- Improve human capital and leadership

Contribute to the reduction of the burden of communicable diseases and non-communicable diseases and conditions/injuries

- Improve public 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 non-communicable diseases

Contribute to the reduction of maternal, new-born and child mortality and improved sexual and reproductive health

- Improve access to health services, particularly maternal, neonatal, child and adolescent health

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



leadership



WHO's strategic agenda for 2010-2015 in the Africa Region emphasizes six priority areas to achieve sustainable health development:

1. A continued focus on WHO's leadership role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization
2. Supporting the strengthening of health systems based on the primary health care approach
3. Putting the health of children and mothers first
4. Accelerating actions on HIV and AIDS, malaria and tuberculosis
5. Intensifying the prevention and control of communicable and non-communicable diseases
6. Accelerating the response to the determinants of health



equity





WHO's priority categories in Ethiopia

1. Communicable diseases
2. Non-communicable diseases
3. Promoting health through the life course
4. Health systems
5. Preparedness, surveillance and response

WHO is working in two technical clusters in Ethiopia:

1. Policy and Systems (PoS)

- a. Health Promotion – maternal and child health, ageing and health, gender equity and human rights, social determinants of health, protection of the human environment, health promotion
- b. Health Systems – integrated health services, essential drugs and medicines, blood safety, laboratory and health technology, health information system
- c. Polio – routine immunization, surveillance, monitoring and evaluation

2. Programme Support (PS)

- a. Communicable Diseases – tuberculosis, HIV, malaria, neglected tropical diseases, vaccine-preventable diseases
- b. Non-communicable Diseases – mental health and substance abuse, violence and injuries, disability and rehabilitation, nutrition, non-communicable diseases (such as hypertension, diabetes, cancer)
- c. Preparedness, Surveillance and Response – alert and response, epidemic and pandemic diseases, risk and crisis management, outbreak and crisis response, food safety, polio







Maternal and Child Health Cluster

Key indicators

DPT 3/Penta 3 vaccine coverage: 83% (FMoH unpublished report 2013)

Measles vaccine coverage: 76% (FMoH unpublished report 2013)

Under-five underweight: 29% (DHS 2011)

Under-five stunting: 44% (DHS 2011)

Under-five wasting: 10% (DHS 2011)

Adolescent pregnancy rate: 12% (DHS 2011)

Contraceptive prevalence rate (CPR): 12% (DHS 2011)

Geographical coverage of primary health care: 96% (Health and Health-related Indicators 2012/13)

Physician to population ratio 1:32,258 (FMoH unpublished data)

Per capita health expenditure: US\$16.1 in 2007/08 (Fourth NHA)

Out-of-pocket spending on health services: 37% (Fourth NHA)

Government contribution to health sector: 21% (Fourth NHA)

Maternal, New-born and Child Health

Maternal, new-born and child health (MNCH) is one of Ethiopia's priority health programmes. Thanks to great efforts by the Government of Ethiopia, in partnership with WHO and others, coverage of health services for most MNCH areas, including immunization, integrated management of new-born and childhood illnesses (IMNCI), antenatal care and family planning, has consistently increased over the years. As a result, there has been a remarkable drop in infant mortality, with the country achieving MDG 4 three years ahead of target, as well as making significant progress on maternal health, reducing the maternal mortality rate by more than 60% from the 1990 level. However, disparities exist in service coverage among regions, for reasons related to access, security, human resource capacity, health infrastructure and lifestyle, among other factors.



Challenges include insufficient and delayed utilization of skilled care, limited availability of quality emergency obstetric and newborn care owing to infrastructure problems, supply or human resource issues, a low rate of postpartum visits and inadequate infant and young child feeding practices.

Furthermore, adolescents in Ethiopia face many sexual and reproductive health problems related to limited access to information as well as quality adolescent- and youth-friendly reproductive health services, coupled with the widespread culture of early marriage.

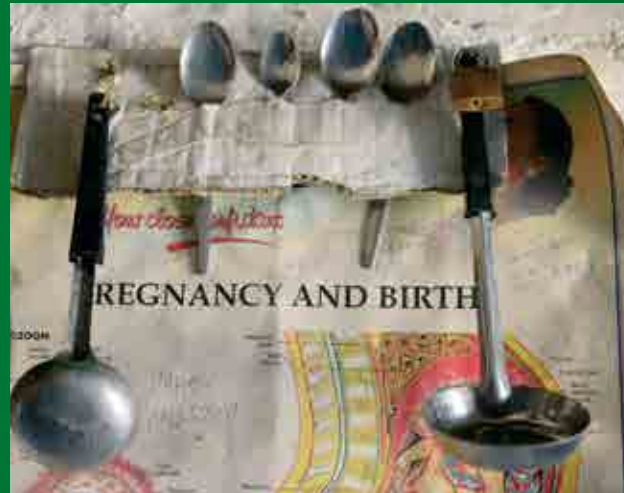
WHO supports the Federal Ministry of Health (FMoH) to improve the quality of life of children and adolescents. It does this through assistance in the development of policy and strategy, as well as capacity-building and technical support, monitoring and evaluation and advocacy and partnerships.

- The IMNCI approach helps ensure the effective prevention and treatment of childhood diseases, reducing death, illness and disability among children under five. It promotes accurate identification of childhood illnesses in outpatient settings, ensures appropriate combined treatment, strengthens the counselling of caretakers and speeds up referral of severely ill children.
- At community level, integrated community-based case management of childhood illness (ICCM) is implemented, delivered at health posts as well as at home. This promotes appropriate care-seeking, improved nutrition and preventative care and correct implementation of prescribed care.
- Community structures and resources are strengthened to maximize family and community participation in maternal, newborn and child health interventions.





coordination



Making Pregnancy Safer

The four pillars of safe motherhood, namely, Family Planning; Antenatal Care; Clean and Safe Delivery; and Essential Obstetric Care, were endorsed in the national Safe Motherhood Initiative and are implemented as major strategic directions under the leadership of the FMoH. WHO helps strengthen the capacity of the health system to provide adequate care and to accelerate reduction of maternal and neonatal mortality. The work

encompasses supporting the Government in setting norms and standards and in adoption of evidence-based strategies, including for community engagement; enhancing capacities through supporting in- and pre-service trainings; and providing technical support in monitoring and evaluation of programmes, including capacity-building for health programme managers at different levels of the health sector.



Reproductive Health

WHO assists the FMoH to put in place effective policies and strategies related to sexual and reproductive health, leading to improved outcomes throughout the life cycle, and also capacity-building and development of tools to enhance service provision.

Expanded Programme of Immunization (EPI), Including Polio Eradication

WHO provides technical support to the FMoH to reduce morbidity, disability and mortality from vaccine-preventable diseases.

Through technical support and assistance in policy development, planning, resource mobilization and monitoring and evaluation to the FMoH on EPI, WHO supports the implementation of appropriate approaches to increase vaccine coverage. Over 30 WHO staff are deployed at regional and zonal levels and provide support in capacity-building and supervision, among other aspects, towards the achievement of polio eradication, measles elimination, sustaining maternal and neonatal tetanus elimination and introduction of new vaccines.

Best practice in improving the health of the mother, the new-born and the child

Two years ago, Agula Health Centre in Wukro of Tigray region saw 92 deliveries per year. Now, 856 women are giving birth there. This has been achieved by:

- Assigning nurses to work together with health extension workers to register all pregnant mothers
- Using mobile technology (m-health) in information-relaying and online registration of pregnant mothers across the health system (through text messages and phone calls)
- Implementation of the Enat Messenger System to monitor pregnancy, which ensures no mother is missed from antenatal care or health facility-assisted delivery
- Assessing the delivery week and holding monthly conferences for pregnant mothers to discuss safe delivery and child care
- Availing traditional ambulances in villages (stretchers carried across villages by two to four people to bring mothers to health services) organized by the Women Development Army (WDA)
- Improving the environment of the health centre to make it mother-friendly through the mobilizing efforts of WDAs

Health Systems Strengthening

Although significant improvement has been noted in Ethiopian health systems, addressing the overall health needs of the country's population remains a challenge. The major response has been mainly in terms of policy reforms; management of health service delivery through the provision of people-centred, integrated approaches along a networking of service providers at decentralized levels; human resource development; health financing; medicine and health technology supply systems; and strengthening of partnerships for health and information for health planning and management.

Health care delivery is organized in a three-tier system that puts the Health Extension Programme, an innovative community-based service delivery approach, as a corner piece. The growing countrywide network of health care facilities has enhanced physical access to health services, particularly with respect to primary health care.

The decentralization of health services, including organization, planning, management and referral systems, is in progress.

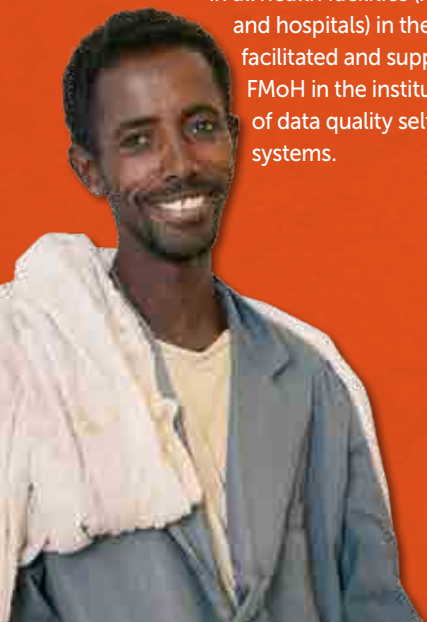
To strengthen service delivery and deal with the challenge of human resource shortages, WHO has supported the creation of a cadre of health extension workers (HEWs) at the community level. The Health Extension Programme entails health workers going door-to-door at community level to explain about health, monitor the



health of the population and engage in community-level health service provision, including implanon insertion, ICCM and immunization/vaccination. Initially set up in rural areas only, HEWs (all female) referred patients to health posts, to health centres/clinics and then to hospitals. Today, there is an urban health extension programme too. HEWs are given training on the health packages they supervise and carry pills, condoms, oral rehydration solution etc. with them.



WHO has also helped the country undertake extensive reform of its Health Management and Information System (HMIS). This has 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 has been developed and is being operationalized to ensure standardized data collection and management that guarantee better health information for decision-making, improved health system performance and better health status of the population. Currently, the HMIS is being implemented in all health facilities (health centres and hospitals) in the country. WHO facilitated and supported the FMOH in the institutionalization of data quality self-assessment systems.



Health Financing and Social Protection

WHO provides evidence-based policy and technical support to improve health financing systems, through policy development on allocation and tracking of funds and monitoring and measuring of social and financial risk protection, equity in financing and efficiency in resource use:

- Supporting countries to develop, implement, monitor and evaluate comprehensive health financing policies and strategies based on the best available evidence
- Advocating for health care fees to be replaced with pooled, pre-payment financing systems such as health insurance and/or taxation
- Reinforcing countries' capacities to undertake and institutionalize National Health Accounts
- Facilitating and supporting the generation of evidence through measuring and monitoring over time the extent of financial risk protection in health



social protection



The Health Development Army

The Health Development Army (HDA) (also known as the Women Development Army (WDA) in some regions) is a group of women volunteers with 30 women working under them who ensure women attend medical check-ups, including antenatal care, and deliver in health facilities. HDA members also help each other when, for example, a child is sick and the mother has no time to do other chores. They also regularly report to HEWs about the health situation in their community and set examples, for example by taking family planning pills. In some areas, no women now deliver at home.



ደም በመስጠት ሕይወት ያደኑ
Donate Blood to save Life



Policy for Health in Development

WHO provides technical support to improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research using the primary health care (PHC) approach:

- Helping expand access across the range of services needed to improve health outcomes and respond to legitimate demand for care using the primary health care approach in districts
- Facilitating exchange and learning between countries on innovative models to expand access and improve quality of health services
- Providing progressive information and evidence for timely decision-making and policy formulation through updating statistics on disease burden, cost-effectiveness analysis and National Health Accounts

Blood Safety

WHO has been providing technical assistance and support to expand and consolidate the blood safety programme so as to establish efficient and sustainable national blood transfusion services that can assure the quality, safety and adequacy of blood and blood products to meet the needs of deserving patients since 2004. A comprehensive situation analysis has been done, and WHO alone has provided standards, guidelines, a blood policy and plan and technical support to its implementation over the years. Since 2010, WHO has supported the restructuring of the national blood transfusion service under the FMOH as well as transitioning of services from the Ethiopian Red Cross Society to the FMOH. A total of 25 blood banks have been established to cover the transfusion needs of hospitals within a 100km radius and thus improved access to the service.



Essential Medicines

WHO aims to help save lives and improve health by closing the huge gap between the potential essential drugs have to offer and the reality that, for millions of people, particularly the poor and disadvantaged, medicines are unavailable, unaffordable and unsafely used. WHO works in close collaboration with the FMOH and other partners to identify needs and priorities; and plan, implement and monitor action in the pharmaceutical sector, including on traditional medicines.



Major achievements

- A significant expansion of health services and implementation of evidence-based cost-effective interventions, including at household and community level
- Enhanced local ownership of health services, including utilization
- A significant decrease in under-five and infant mortality rates between 2005 and 2010
- MDG 4 achieved three years ahead of target by reducing under-five mortality rates by two-thirds
- Maternal and neonatal tetanus elimination (excluding in Somali region, where validation is pending)
- New vaccines, such as pneumococcal and rotavirus vaccines, introduced into the routine immunization programme
- Availability of comprehensive health sector development programme with clear priorities and directions
- Laying of the groundwork for standardized and comprehensive health information
- Increase in per capita health expenditure from US\$7.14 in 2005 to US\$16.1 in 2007/08; increase in overall government expenditure on health by 71%
- Increase in the availability of primary health care units from 20% to 100% for health posts and from 18% to 100% for health centres through the expansion by 15,000 health posts and 3,200 health centres, respectively
- Increase in the number of hospitals (all types) from a total of 79 to 116 by the end of 2009/10
- A total of 31,831 HEWs trained in agrarian communities, representing a density of 1:2,437 (target: 1:2,500), plus more than 4,000 urban health extension workers (UHEWs) trained and deployed
- More than 8 million women all over the country participating in the Health Extension Programme alongside HEWs for community mobilization and follow-up, and contributing to the health system to ensure the health of the people
- Support to local pharmaceutical production in line with the country's GTP
- Restructuring of the national blood transfusion service by establishing it under the FMoH
- Development of a strategy and strategic plan in line with WHO Regional Strategy for Blood Safety
- Improvement of access by supporting the establishment of 25 blood banks to cover the blood requirements of health units/hospitals within a 100km radius
- Increased capacity for blood collection, testing, processing and clinical use





Disease Prevention and Control Cluster

Key indicators

Contribution of non-communicable diseases to deaths: 34% (WHO Global Status Report on NCD 2010)

Tobacco consumption (both sexes): 2.4% (WHO Global Status Report on NCD 2010)

Physical inactivity rate: 17.9% (WHO Global Status Report on NCD 2010)

Raised blood pressure rate: 35.2% (WHO Global Status Report on NCD 2010)

Overweight/obesity: 7.4% (WHO Global Status Report on NCD 2010)

Prevalence of mental health issues: 17% (WHO Global Status Report on NCD 2010)

Adult HIV prevalence: 1.5% (4.2% urban; 0.6% rural/1.9% females; 1% males) (DHS 2011)

HIV prevalence among young people aged 15-24 years: 0.6% (DHS 2011)

Mothers receiving complete anti-retroviral prophylaxis: 41.5% (Global AIDS Progress Report 2013)

Incidence of tuberculosis: 247 per 100,000 population (WHO Global TB Report 2013)

Prevalence of tuberculosis: 224 per 100,000 population (WHO Global TB Report 2013)

Proportion of the country that is malarious: 75% (FMoH unpublished)

Population at risk of malaria infection: 68% (FMoH unpublished)



challenges



Malnutrition, poor access to health services and inadequate safe water supply and sanitation services are a challenge for the Ethiopian population, leading to high prevalence of communicable diseases. Natural disasters have led to widespread health vulnerabilities, and various segments of the population are vulnerable to communicable diseases, including a number of neglected tropical diseases. Limited access to timely and adequate information has affected the design and implementation of effective intervention strategies.

Non-communicable diseases such as cardiovascular diseases, diabetes and cancer, along with injuries, are major contributors to high levels of mortality in Ethiopia. Tobacco consumption is increasing, as is the prevalence of other behavioural and metabolic risk factors, including physical inactivity, high blood pressure and overweight. Mental health issues are also on the rise. Road traffic injuries account for around a third of all injuries and affect all age groups across both sexes.

AGULA		
NO	NAME OF HR	Disto HP
1	MESANU	5
2	TSABAT	18
3	FUDUS	18
4	KIHEN	6
5	GUAHTERAT	13
6	D/BREHAN	13
AGULAE		

LAE PHCU CATHMENT

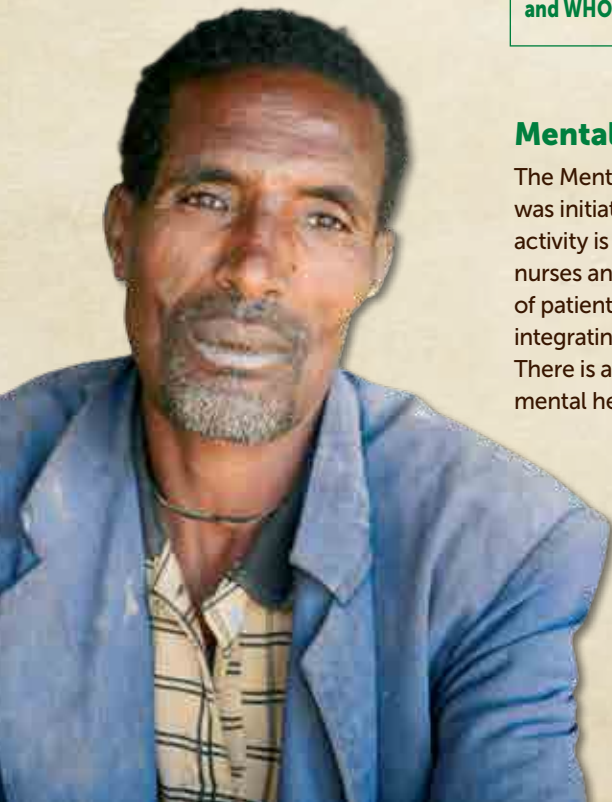
Distance of HP to HC	Distance of HP to WestHO	# HEWs	# HEW Super
5km	17 km	2	
18km	30km	2	1
8km	30km	2	1
5km	8km	2	1
3km	7km	2	1
3km	2km	2	1
TOTAL		12	2

The HIV and AIDS pandemic remains a major public health problem in Ethiopia, and is being addressed as a top priority in the health sector agenda. Trends of adult HIV prevalence over the past decade have been declining, particularly in urban settings. HIV prevalence among young people aged 15-24 years has also dropped, indicating a decline in new infections.

However, there is a need to address critical challenges such as patient retention, monitoring of HIV drug resistance and limited laboratory capacity while accelerating HIV prevention. Prevention of mother-to-child transmission (PMTCT) remains a national key challenge. The FMoH has recently adopted the 2010 WHO PMTCT guidelines and is moving towards an accelerated approach to PMTCT scale-up. Interventions targeting at-risk populations also need greater attention.

Tuberculosis (TB) was the third leading cause of hospital admissions and a leading cause of inpatient deaths in 2008/09. These high mortalities are associated with a high TB/HIV co-infection rate (15%) and the emergence of multidrug-resistant TB. Case detection of all forms of TB has improved, but only very few cases of smear-positive TB cases in communities are detected by routine health service delivery mechanisms, especially in pastoralist areas. The Stop TB Strategy is a key approach, but the pace of expansion of community TB care remains a challenge.

There has been a reduction in the burden of malaria by, on average, about 50%. However, malaria remains a major public health problem and one of the top causes of outpatient visits. Challenges include the development of vector resistance to multiple recommended insecticides for indoor residual spraying (IRS) and low utilization of long-lasting insecticide-treated nets (LLINs).



Nationwide step-wise survey on NCDs

A nationwide step-wise survey on Ethiopia's non-communicable disease burden is vital, including physical examinations, biochemical tests and data collection at community level, to understand the risk factors, inform decision-makers and mobilize interventions. The FMoH is preparing to conduct such a survey in 2014, and WHO will provide technical support.

Mental Health

The Mental Health Action Programme was initiated three years ago. The main activity is capacity-building of psychiatric nurses and physicians in the management of patients with mental health issues and integrating services into primary care units. There is a plan with the FMoH to scale up mental health services to other areas.



Non-communicable Diseases

WHO supports the Government of Ethiopia in developing and implementing policies and strategies for the management of the main chronic non-communicable diseases: cardiovascular diseases, diabetes, cancer, oral health problems and chronic respiratory diseases.

A number of these diseases are easy to prevent through vaccines and screening. WHO is providing technical assistance to integrate cancer treatment in primary health care units: there is currently only one location in the whole country (in Addis Ababa) for the treatment of cancer. The FMoH has also established a cancer registry at Black Lion Hospital to generate evidence and data on cancers and their distribution.

Neglected Tropical Diseases Prevention and Control

In Ethiopia, communicable diseases account for more than 85% of the diseases seen in health institutions. Diseases or infections for intensified control include intestinal parasitoses, leishmaniasis, schistosomiasis, trachoma and trypanosomiasis. Dracunculiasis is targeted for eradication, and leprosy, lymphatic filariasis and onchocerciasis are targeted for elimination at global or regional levels. However, national control or eradication strategies exist for only a few of these.

WHO is assisting with creating an environment in which countries and their international and national partners are better equipped, both technically and institutionally, to reduce morbidity, death and disability through the control, eradication or elimination of these diseases. Work includes formulation of evidence-based strategies, provision of technical support and advocacy and involvement of relevant partners for implementation.

WHO provided technical and financial support for the development of the National Master Plan for the Prevention, Control, Elimination and Eradication of NTDS, officially launched by the FMOH in June 2013.

Injury

WHO provides capacity-building to first responders and police to assist with bringing down the rate of road traffic accidents in Ethiopia. There is a vital need to work also on pre-hospital and hospital care, training paramedics, providing ambulances and enabling the provision of emergency trauma care, as well as expanding the exchange of information between the accident site and the hospital, using e-mobile technology.

WHO also helps prevent violence through addressing individual factors, monitoring public spaces, addressing gender inequalities and larger cultural, social and economic factors that contribute to violence, as well as caring for victims. In addition, WHO promotes the implementation of community-based rehabilitation for persons affected by disability.



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 has completed IHR core capacity assessments and, based on the results, a plan of action has been developed within the framework of IDSR.



Emergency and Crisis Management

The goal of emergency preparedness and response is to reduce suffering and immediate and long-term mortality, morbidity and disability related to emergencies, and to contribute to development. WHO provides mostly technical assistance, but also a significant amount of emergency drugs and funds, to the FMOH and Regional Health Bureaus in terms of assessing the health status of affected populations, identifying and prioritizing health problems, epidemic prevention and control activities, training of health workers on emergency-related health issues and supervision and monitoring.

Tuberculosis

WHO produces normative guidance in the area of tuberculosis management, such as developing draft frameworks to ensure the continuous availability of key national guidelines at service delivery points. With the support of WHO, the National TB Programme review was conducted and findings were disseminated. WHO has also supported the national TB Research Advisory Committee in the identification of research priorities on TB and TB/HIV and organized a national TB and TB/HIV research conference for the dissemination of the research findings.

Capacity-building support has been provided in the development of comprehensive TB, leprosy and TB/HIV training modules for health workers; training materials on programmatic and clinical management of multidrug-resistant TB and TB/HIV; and pocket reference and integrated refresher training materials for HEWs.



Much more work needs to go into drug resistance in the area of TB: multidrug-resistant TB requires very intensive treatment and very close follow-up. There are only 21 treatment and 8 diagnostic facilities for such a large country. In Oromia region, for example, there is a population of 30 million and less than 2 laboratories that can diagnose drug resistance.

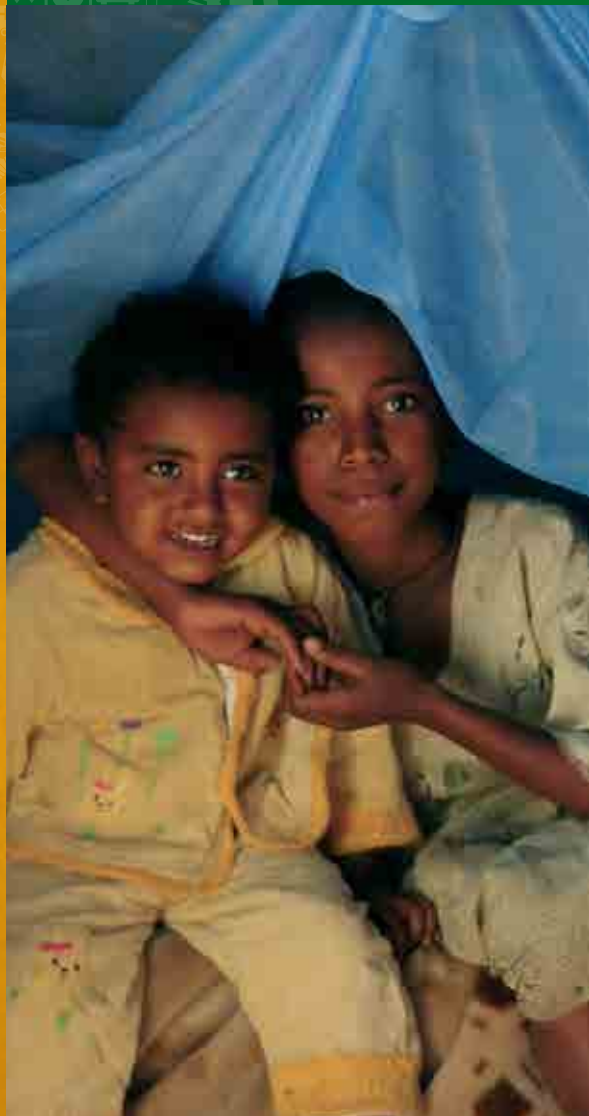
Malaria

Malaria prevention and control interventions, including mass distribution of LLINs, IRS, introduction of rapid diagnostics tests (RDTs) at community level and adoption of artemisinin-based combination therapies (ACTs), have been scaled up since 2005, leading to reduction in the burden of the disease by on average 50%.

WHO has also worked with the Government of Ethiopia in malaria prevention and control, including providing assistance in strategic information generation, documentation production and dissemination, situation analyses and

assessments of health facilities. Training of 691 mid-level health workers on comprehensive malariology courses has been held, as well as an international training course on Planning and Management of Malaria Control Programmes for WHO Anglophone African Countries, which took place in Addis Ababa.

More efforts need to go into ensuring a strong surveillance system is in place to early detect epidemic cases, especially between August and December, during and immediately after Ethiopia's main rainy season. WHO is trying to support those regions where there is a risk of malaria epidemics by putting in place a strong surveillance system.



interventions



HIV and AIDS

Notable efforts have been made by the FMoH, along with WHO, in response to the HIV and AIDS pandemic, with very significant progress in areas such as community mobilization, HIV testing and counselling (HTC) and HIV care/antiretroviral therapy (ART) scale-up.

In particular, WHO has helped in terms of adoption of normative guidance on areas such as care and treatment, PMTCT, prevention and HTC. WHO has also helped produce strategic information, such as best practices on

HIV prevention, care and support in Amhara region and draft national guidelines for documentation and dissemination of best practices. Capacity-building of stakeholders is also key.

Prevention is a key priority, especially in high-prevalence regions, to ensure the best use of resources. Meanwhile, Ethiopia is doing well at scaling up treatment; WHO is working on keeping people on treatment as long as possible and empowering health facilities to provide quality services.

achievements



Major achievements

- Encouraging developments in tackling priority communicable and non-communicable diseases, resulting in a reduction in morbidity and mortality
- Decentralization and integration of visceral leishmaniasis treatment centres, with an increase in the number of such centres from three to sixteen in endemic regions
- Community IDSR scaled up in the Southern Nations, Nationalities and Peoples (SNNP) region from two pilot districts to sixty-seven districts
- More than 150 non-specialized health workers in Tigray, Amhara, Oromia and SNNP regions trained in delivering the Mental Health Gap Analysis Programme (mhGAP) package along with close to 100 mental health professionals who will serve as mhGAP trainers and supervisors
- Ethiopian House of Peoples' Representatives ratifying the WHO Framework Convention on Tobacco Control, which aims to decrease demand for and supply of tobacco and tobacco products. This is the first international treaty negotiated in response to the globalization of the tobacco epidemic
- Technical support in the investigation of meningitis, yellow fever, measles and dengue fever outbreaks
- Technical support and resource mobilization through procurement and distribution of vaccines and medical and lab supplies in the FMOH's emergency response efforts



- Country adoption of the 2010 WHO recommendations for clinical care and treatment of HIV in adults, adolescents and children
- Adoption of the B+ option of the WHO PMTCT guideline
- Technical assistance in the development of the Global AIDS Progress Report
- Creation of an integrated HTC training package for health workers
- Development and dissemination of the HIV Related Estimates and Projections in Ethiopia 2012
- A considerable decline in HIV prevalence at national level, from 5.5% in 2003 to 2.2% in 2009, including in 15-24 year olds, in both rural and urban areas
- Considerable expansion of the free ART programme, from only 3 health facilities in 2005 to 550 by 2009; increase in the number of people started on ART from 900 in 2005 to more than 250,000 by 2010
- Finalization of the consolidated National TB, Leprosy and TB/HIV Guidelines
 - ✓ Development of Integrated Refresher Training Manual for HEWs
 - ✓ Development of the Guideline for the Programmatic Management of Multidrug-resistant TB
- ✓ Dissemination of National TB Prevalence Survey findings
- ✓ Introduction of new diagnostic technologies- gene-expert to improve TB case finding
- ✓ Rapid expansion of TB/HIV services providing health facilities
- Support in preparation, editing and dissemination of the Ethiopian Malaria Programme Review 2011 and Malaria Indicator Survey 2011 reports and updated National Malaria Control Guidelines (2012)
- Production of a malaria risk mapping using facility-based surveillance data collected from 2,092 health centres across the country
- Fall in malaria deaths by 2009 (compared with pre-2004/05) in all age groups by 55%, in malaria inpatient cases by 44% and in malaria outpatient cases by 28% (in health facility-based survey). Otherwise, there is no community-level reduction of malaria cases







Partnerships and Resource Mobilization

WHO's Strategic Agenda for Partnership

The main objective of the WHO Country Office is to support the strengthening of partnerships in the health sector for better coordination and resource mobilization for the implementation of Ethiopia's HSDP. WHO aims to enhance existing partnerships in and outside the UN system, including bilateral and multilateral partners, civil society organizations, training and research institutions and the private sector.

WHO contributes to the UN Delivering as One in Ethiopia and as UNH4+ coordinator, leading the UN flagship joint programme on Improving Maternal and Newborn Health and Survival. WHO also leads the UN Development Assistance Framework (UNDAF) 2012-2015

Pillar II, which focuses on improving access to and delivery of quality basic social services, particularly in education, health, HIV/AIDS, WASH and nutrition for the most vulnerable populations.

WHO Ethiopia continues to support harmonization and alignment efforts for health, as a member of the Health, Population and Nutrition (HPN) group to strengthen coordination, information-sharing and policy and technical advice for the implementation of the national NSDP. The HPN group has also asked WHO to facilitate the establishment and operation of the HPN at regional level to enable health development partners to provide better support to Regional Health Bureaus.



partnership



Facilitating the effective participation of civil society organizations, training and research institutions and the private sector in different partners' fora is a key element of WHO's work with its partners. The Country Office promotes public-private partnerships (PPPs) and is supporting the development of the national PPP Guidelines in Ethiopia.





Improving the WHO Partnership Role in Ethiopia

In 2013, WCO Ethiopia participated in the Multilateral Organization Performance Assessment Network (MOPAN) Survey. The overall findings demonstrate progress towards WHO's country-level goals and priorities, which were rated as 'strong' for strategic objective 2 (HIV, TB and Malaria) and as 'adequate' for all other strategic objectives. The findings acknowledged improvements in WHO's organizational effectiveness, especially in the areas of financial management and accountability, oversight and audit, humanitarian response and human resource management. The implementation of this exercise will help further improve WHO's role in strengthening partnership, coordination and resource mobilization.

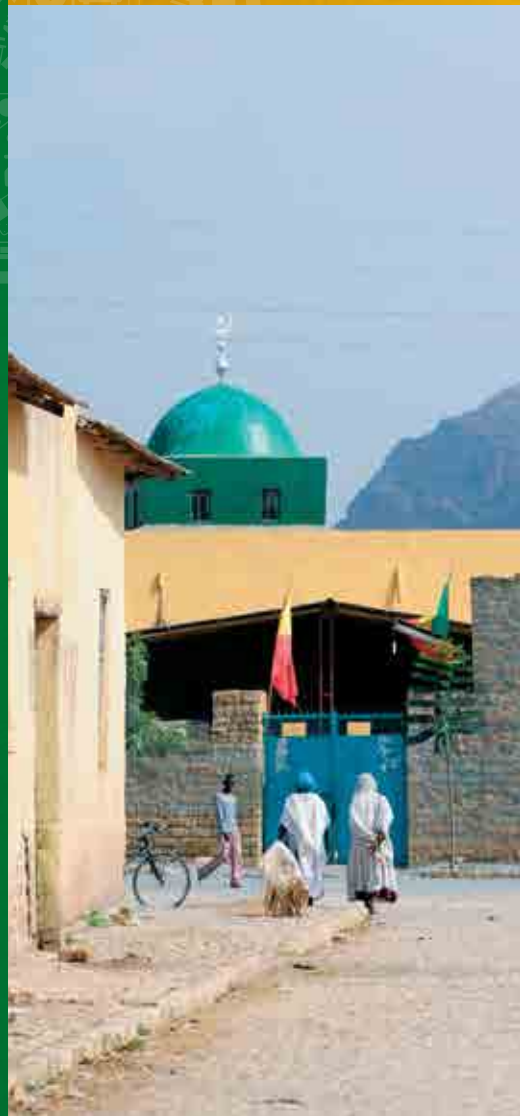
WHO within National Coordination Mechanisms

Health development partners in Ethiopia support the implementation of the national Health Development Plan under the leadership of the Government of Ethiopia through three structures: 1) the Joint Consultative Forum (JCF) at the policy level; 2) the Joint Core Coordination Committee (JCCC) at the technical level; and 3) the Country Coordination Mechanism for Resource Mobilization for HIV/AIDS, TB and Malaria. WHO participates in these three structures by providing evidence-based policy and technical advice in line with global norms, standards, regulations and tools. The WHO Country Office is also a member of the development partners' forum on HIV, which brings together multilateral and bilateral partners.

Resource Mobilization and Funding Needs/Gaps

WHO Country Office operates with a lack of budget predictability and flexibility. The Country Office's regular budget represents less than 10% of the total budget needed to implement the biannual work-plan. Over 90% of the budget is dependent on voluntary

contributions, which need to be mobilized during the two-year period of the programme work-plan. In 2013, the Country Office developed an Action Plan for Resource Mobilization to address funding gaps and plan for strategic engagement with partners.



partnership



The WHO Country Office in Ethiopia also benefits from the lessons learned and recommendations of the 2013 internal audit and the WHO Managerial Reform to improve transparency, accountability and management in a more structured manner. The Country Office's organizational structure, which was recently revised, facilitates a results-based management approach, which is more strategic and focused on the country's priorities

Thanks and acknowledgments

The WHO Ethiopia Country Office is grateful to the Ministry of Health at both federal and regional levels for creating a conducive environment where the Country Office can operate and provide technical support in the achievement of the global and national health agenda.

The WHO Ethiopia Country Office also acknowledges the UN Country Team in Ethiopia, which is working towards Delivering as One and contributing to the successful implementation of WHO's programmes in Ethiopia.

The contributions of all bilateral and multilateral health partners are also gratefully acknowledged.

We also thank universities, civil society organizations and professional associations for their collaboration and support. Last but not least, WHO thanks the Government and people of Ethiopia, who are the most important stakeholders of WHO's programmes in the country.

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