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MINISTRY OF HEALTH - ETHIOPIA

Annual Perfromance Report 2015 EFY

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The 25th Annual Review Meeting of the Health Sector

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Strong Health Financing for Sustainable Health Development!

STRATEGIC AFFAIRS EXECUTIVE OFFICE
MOH - Ethiopia

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Foreword

Lia Tadesse, MD, MHA

Minister, Ministry of Health,

Federal Democratic Republic of Ethiopia

I am pleased to share with you the 2015 EFY performance report of the health sector of Ethiopia. The 2015 EFY marks the end of the second health sector transformation plan (HSTP-II) and the sector prepares a three years medium term health sector development and investment plan (HSDIP) for the period 2016 EFY to 2018 EFY. This annual performance report indicates the progress made during the three years of the HSTP-II period and the report mainly presents the performance of the health sector in 2015 EFY, the major initiatives, major activities implemented and achievements during the fiscal year. In addition, the major challenges and the next focus areas for each program area are outlined in the report.

The health sector has registered remarkable results during the fiscal year despite the presence of challenges such as conflicts and other emergencies that affected the health system. We were able to improve access to and utilization of health services by enhancing the implementation of essential health interventions at all levels of the health system, with due emphasis to primary health care. The report shows that utilization of maternal and child health interventions and services have improved; and registered encouraging results in the prevention and control of major communicable diseases such as HIV and tuberculosis. However, incidence of malaria has increased this year due to climate change and other related factors. The sector strengthened NCD prevention and control interventions that resulted in improved screening, service integration, treatment and management of major NCDs such as hypertension, diabetes mellitus and cancer. Promising progress was also registered in the expansion of specialty and sub-specialty services. In addition, we have been successful in improving health system investments such as improving the number and mix of health workforce, strengthening health information system, improving the supply of pharmaceuticals, regulation and health financing.

We have strengthened our public health emergency management through which occurrence of disease outbreaks were prevented and the reported outbreaks were effectively controlled without causing significant harm to the population. The MOH in coordination with partners have developed a resilient recovery and reconstruction plan for conflict affected areas based on which health service restoration and recovery activities have been conducted. Through our emergency management efforts, we have learned lessons to ensure that our health system is resilient and accelerate progress towards universal health coverage.

These results were registered through the determination and hard work of our health workers and health leaders at all levels, and through a strong partnership and collaboration with all our stakeholders. I would like to express my sincere appreciation and gratitude to all health workers, donors and development partners, civil society organizations, academic and research institutions, the private sector, professional associations and all other stakeholders for the continued partnership and collaboration. Thanks for being part of the effort towards improving the health of our population.

The sector has developed a three years strategic plan, the HSDIP, which identifies the major priorities, initiatives and activities for the next three years. The year 2016 EFY will be the first implementation year of the HSDIP, during which we will build up on our strengths, overcome challenges to achieve the targets we set. We will continue to strengthen our health system towards universal health coverage and improve the health of our population. I call upon all stakeholders to strengthen our partnership and collaboration to a greater level, work together towards achieving the objectives and targets of the HSDIP. **“Alone we can do so little; together we can do so much.”**

Lia Tadesse, MD, MHA

Minister, Ministry of Health

Acknowledgements

The Annual Performance Report for 2015 EFY is prepared by a technical team composed of senior experts from the strategic affairs executive office (the former policy, Planning, monitoring and Evaluation Directorate). The team acknowledges and appreciates the support and continuous commitment of directors and experts from all the executive offices of the Ministry of health, and all agencies. We appreciate and thank all regional health bureaus and all levels of administrative health units of the health sector for collecting and submitting performance data on a regular basis. MOH would also extend its gratitude to development partners and others who have been supporting for the preparation of the performance report.

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Acronyms

AA	Addis Ababa
AA	Addis Ababa
AARHB	Addis Ababa Regional Health Bureau
AIDS	Acquired Immunodeficiency Syndrome
ALOS	Average Length of Stay
ANC	Antenatal Care
ANC 8	Antenatal Care eight visits
ANC 4+	Antenatal Care Four or more visits
APR	Annual Performance Report
APTS	Auditable Pharmaceutical Transaction and Service
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Ciommunication
BEmOC	Basic Emergency Obstetric Care
BFHI	Baby Friendly Hospital Initiative
BG	Benishangul Gumuz
BMI	Body Mass Index
BOR	Bed Occupancy Rate
BP	Blood Pressure
CAR	Contraceptive Acceptance rate
C/S	Caesarean Section
CAG	Community ART Group
CAR	Contraceptive Acceptance Rate
CASH	Clean and Safe Health Facility
CBHI	Community Based Health Insurance
CBMP	Capacity Building and Mentorship Program
CBN	Community Based Nutrition
CBNC	Community Based New Born Care
CBT	Competency based training
CEmOC	Comprehensive Emergency Obstetric Care
CFR	Case Fatality Rate
CHD	Community Health Day
CHIS	Community Health Information Center
CHP	Comprehensive Health Posts
CLIP	Clinical leadership improvement program
COPD	Chronic Obstructive Pulmonary Diseases
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
CRD	Chronic Renal Disease
CRVS	Civil registration and vital statistic
CSC	Community Score Card
CTC	Case Treatment Centers
CVD	Cardio Vascular Disease

DALYS	Disability Adjusted Life Years
DBS	Dry Blood Sample
DD	Dire Dawa
DHIS2	District Health Information System
DM	Diabetes Mellitus
DP's	Development Partners
DR TB	Drug resistance Tuberculosis
DSD	Differentiated Service Delivery
DST	Drug sensitivity test
EBTBS	Ethiopian Blood and Tissue Bank Service
EBTS	Ethiopian Blood and Tissue Servie
ECD	Early Childhood Development
eCHIS	Electronic Community Health Information System
ECSAT	eye care service assessment tool
EDHS	Ethiopia Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHAQ	Ethiopian Health Alliance for Quality
EHAQ	Ethiopian Hospitals Alliance for Quality
EHCRIG	Ethiopian Health Center Reform Implementation Guideline
EHIS	Ethiopian Health Insurance Service
EHRIG	Ethiopian Hospital Reform Implementation Guideline
EHSTG	Ethiopian Hospital Services Transformation Guideline
EID	Early Infant Diagnosis
ENAP	Every newborn action plan
ENBC	Essential New-born Care
EOS	Enhanced Outreach Strategy
EPHCG	Ethiopian Primary health care clinical guideline
EPI	Expanded Program on Immunization
EPMM	Ending preventable maternal mortality
EPSA	Ethiopia Pharmaceutical Supply Agency
EPSS	Ethiopian Pharmaceutical Supply Service
EPTB	Extra pulmonary Tuberculosis
ESS	Ethiopian Statistics Service
ESV-ICD11)	Ethiopian simplified version of ICD11
ETB	Ethiopian Birr
EU	European Union
FHT	Family Health team
FMHACA	Food, Medicine and Healthcare Administration and Control Authority
FNS	Food and Nutrition Strategy
FP	Family Planning
FTAR	Fast Track ART Refill
GGI	Good Governance Index
GMP	Growth Monitoring and Promotion
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HCs	Health Centers

HCT	HIV Counselling and Testing
HDA	Health Development Army
HEP	Health Extension Program
HEPO	Health Extension program optimization
HEW	Health Extension Workers
HIT	Health Information Technician
HIV	Human Immunodeficiency Virus
HIVST	HIV self test
HMIS	Health Management Information System
HP	Health Post
HPV	Human Papilloma Virus
HRH	Human Resource for Health
HSTP	Health Sector Transformation System
HSTQ	Health Service Transformation in Quality
ICCM	Integrated Community Case Management
ICD	International Classification of Disease
ICMNCI	Integrated Community Case Management of New-born & Childhood Illness
ICS	Immigration and Citizenship Servie
ICU	Intensive Care Unit
IDP	Internally Displaced People
IEC	Information, Education & Communication
IEQAS	International External quality assessment
IESO	Integrated Emergency Surgery &Obstetrics
IGA	Income generating activity
IMNCI	Integrated Management of Neonatal and Child Illness
IMR	Infant Mortality Rate
IPEC	Integrated people centered eye care
IPPCAR	Immediate Post-Partum Contraceptive Acceptance Rate
IQMS	Internal Quality management system
IR	Information Revolution
IRS	Insecticide Residual Spray
IRT	Integrated refresher Training
ISS	Integrated Supportive Supervision
IUCD	Intrauterine Contraceptive Device
JCCC	Joint Core Corrdinating Committee
JCF	Joint Consultative Forum
JSC	Joint Steering Committee
KPI	Key Performance Indicators
LEEP	Loop Electro Excision Procedure
LIP-H	Leadership Incubation Program for Health
LLINs	Long-Lasting Insecticidal Net
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MARPs	Most-At-Risk Population
MASReP	Multi-sectoral approach for stunting reduction project

MCC	Motivated, Competent and Compassionate
MCH	Maternal and Child Health
MCP	Model Community Pharmacy
MDA	Mass Drug Administration
MDSR	Maternal Death Surveillance and Response
MECIP	Major Cities Emergency and Critical Care Improvement Program
MFR	Master Facility Registry
MHM	Menstrual Hygiene Management
MMD	Multi-month dispensing
MMR	Maternal Mortality Ratio
MNH	Maternal & Newborn Health
MNHQoC	Maternal Newborn and child health Quality of Care
MOE	Ministry of education
MoF	Ministry of Finance and Economic Commission
MOH	Ministry Of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
MPH	Master of Public Health
MTCT	Maternal To Child Transmission
NBC	New Born Care
NCDI	Non-Communicable Diseases and Injuries
NEQAS	National External Quality Assessment Scheme
NEQAS	National External quality assessment
NICU	Neonatal Intensive Care Unit
NIEM	National Incident Emergency Management
NMEP	National Malaria Elimination Program
NMHSP	National Mental Health Strategic Plan
NNMR	Neonatal Mortality Rate
NNP	National Nutrition Programme
NTD	Neglected Tropical Diseases
ODF	Open Defecation Free
OPD	Out Patient Department
ORS	Oral Rehydration Salt
PBF	Performance Based Financing
PCR	Polymerase Chain reaction
PEP	Post Exposure Prophylaxis
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PHPAI	Pediatric HIV Program Accelerated Initiative
PIRI	Periodic Intensified Routine Immunization
PLHIV	People Living with HIV
PMED	Pharmaceuticals and Medical Equipments Directorate
PMS	PostMarket Surveillance
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Postnatal Care
PPM	Public Private Mix
PPMED	Poliy, Plan, Monitoring and Evaluation Directorate

PPP	Public-Private Partnership
PrEP	Pre-exposure Prophylaxis
PTB	Pulmonary Tuberculosis
QI	Quality Improvement
RCCE	Risk communication and community engagement
RDQA	Routine Data Quality Assessment
RDT	Rapid Diagnostic Test
REQAS	Regional External quality assessment
RHBs	Regional Health Bureau
RHD	Rheumatic Heart Disease
RMNCAYH	Reproductive, Maternal, Neonatal, Child, Adolescents and Youth Health
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SALTS	Saving Life through Safe Surgery
SAM	Severe Acute Malnutrition
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavior Change Communication
SD	Seqota Declaration
SDGs	Sustainable Development Goals
SLD	Second Line Drug
SLIPTA	Stepwise Laboratory Improvement towards Accreditation
SNNPR	Southern Nations, Nationalities and Peoples' Region
SNS	Social network strategy
STH	Soil Transmitted Helminthiasis
SWE	South West Ethiopia
TB	Tuberculosis
TFC	Treatment Follow up centers
TICs	Treatment Initiating Centers
TOT	Training of Trainers
TPT	Tuberculosis Preventive Treatment
TVET	Technical Vocational Educational Training
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UHC	Universal Health Covergae
UN	United Nation
UNFPA	United Nations Population Fund
USD	United States Dollar
VAS	Vitamin A Supplementation
VHL	Village health leaders
VIA	Visual Inspection with Acetic Acid
VL	Viral load
VMMC	Voluntary Medical Male Circumcision
VPN	Virtual Private Network
WASH	Water, Sanitation and Hygiene
WDA	Women Development Army
WDG	Women Development Group
WHO	World Health Organization
WoHO	Woreda Health Office

Executive Summary

This annual performance report (APR) is the health sector's comprehensive report that indicates the performance and progress of the sector in 2015 EFY and also highlights progress over the past three to five years. It mainly describes performance against the targets in 2015 EFY and includes description of the major achievements, initiatives, activities, challenges and way forwards of all programs and health system investments or inputs.

Ethiopia prioritizes primary health care (PHC) as one of the service delivery platforms to improve access and utilization of essential health services to the population. In the fiscal year, various initiatives that strengthen PHC and the health extension program (HEP) were implemented and encouraging results were documented. Based on the HEP optimization roadmap, re-categorization of health posts was done, that resulted in the categorization of 16,898 health posts throughout the country (all health posts except Tigray). According to the categorization, 12,470 (74%), 1,873 (11%) and 2,555 (15%) are basic, comprehensive health posts (CHPs) and to be merged health posts respectively. In the fiscal year, 49 CHPs (2.6% of the 1873 CHPs) started comprehensive services. The new Village Health Leaders community engagement strategy, which was piloted in 2013 EFY, has been expanded to 80 Woredas. To strengthen the implementation of PHC and realize a PHC oriented strong health system, a national PHC strategic framework is developed. Ethiopian health center reform implementation guideline (EHCRIG) was revised and 70% of health centers have implemented the revised EHCRIG, with an average overall score of 79% on the fourth quarter of 2015 EFY. The number of health centers with an OR block has reached 430 but only 106 of them are providing OR service. Regarding sanitation and hygiene, 36% of Kebeles in the country are verified as open defecation free, 52% of households have access to basic sanitation; 44% and 31% of households have access to solid and liquid waste management respectively. The proportion of health facilities with basic water supply, basic sanitation and basic waste management was 76%, 62% and 63% respectively.

The performance of key reproductive, maternal, child and adolescent health indicators has shown improvement in 2015 EFY compared to the previous year. In the fiscal year, 76% of non-pregnant women in the reproductive age received modern contraceptive methods, 79% of pregnant women received four or more antenatal care visits, 15% of pregnant women received eight or more antenatal care visits, 75% pregnant women attended their deliveries at health facilities and 92% women received postnatal care service within seven days after delivery. All these indicators have improved from the previous year. Syphilis screening service and iron supplementation was provided to 74% and 67% of pregnant women, respectively. Still birth rate has decreased from 11.4 per 1,000 births in 2014 EFY to 10.8 in 2015 EFY.

Immunization program was strengthened in the fiscal year, mainly enhancing efforts towards identifying and reaching zero dose and under vaccinated children. During the fiscal year, more than 3.3 million children under one year of age received three doses of pentavalent vaccine. The coverage of measles second dose and full immunization was 89% and 97% respectively. To improve access to quality immunization service, different strategies such as periodic intensification of routine immunization (PIRI) among low performing areas, supplemental immunization activities (SIA), strengthening the capacity of the cold chain system and demand creation activities were done. Identification and vaccination of zero dose children were among the key activities and a total of more than 200,000 children were reached through integration of routine immunization with other campaigns. Regarding treatment of childhood illnesses, treatment was provided to 78% and 22% of children with pneumonia and diarrhea

respectively. In the fiscal year, 93.2% of health centers had IMNCI service, 90.4% of health posts provide integrated community-based management of newborn and childhood illnesses (ICMNCI) service and 222 hospitals had Neonatal Intensive Care Unit (NICU).

Nutrition program has been coordinated through the newly established nutrition coordination office in 2015 EFY. More than 3.2 million (63%) of children under 2 years of age participated in a growth monitoring and promotion service; deworming service was provided to more than 10.6 million children aged 24-59 months and biannual vitamin A supplementation was provided to more than 15.9 million children aged 6-23 months of age. The fiscal year was the second year of Seqota Declaration expansion phase, during which the government of Ethiopia has sustained its commitment by allocating about 12 million USD for costed Woreda based implementation in the 240 expansion phase Woredas. Multi-sectoral coordination and governance mechanisms were strengthened to address the multi-sectoral determinants of malnutrition.

Prevention and control of major communicable diseases such as HIV, tuberculosis and malaria resulted in remarkable progress during the fiscal year. In the fiscal year, more than 6.6 million individuals were tested for HIV, among which 36,182 (0.55%) were tested positive and linked to care and treatment. At the end of the fiscal year, there were a total of 473,625PLHIVs who were receiving ART. The performance of the three 95-95-95 targets of HIV shows that the second and third 95 targets are achieved but not the first 95-target. At the end of 2015 EFY, the first 95 performance was at 85.5%, the second 95 performance was at 98% and the third 95 performance was at 96.4%. Remarkable results were registered on prevention and control of tuberculosis, with a tuberculosis treatment coverage of 95%, a coverage higher than any previous year. Regarding tuberculosis treatment outcome, among new bacteriologically confirmed pulmonary tuberculosis cases, 84% were cured and 96% successfully completed treatment. In the fiscal year, 882 drug resistant TB cases were detected and put on DR TB treatment, which is 73 % of the estimated 1,139 DR TB cases in Ethiopia and DR TB treatment initiation has been provided in 57 treatment-initiating centers. Malaria cases has increased in 2015 EFY, with more than 3.3 million malaria cases treated in the year, which is more than double compared to the number of cases in 2014 EFY. Malaria incidence was 48.2 per 1000 population at risk and death rate was 0.42 per 100,000 population at risk, showing that both incidence and death has increased in 2015 EFY compared to the previous year. This indicates that more strengthened interventions are required to curve the increasing trend of malaria in the country.

To address the growing incidence of non-communicable diseases and mental illnesses, various interventions were implemented and encouraging results documented. According to the findings of the 2021/202 service provision assessment, about 8 of 10 health facilities diagnose, prescribe treatment, or manage patients with diabetes, cardiovascular disease, and chronic respiratory disease. During 2015 EFY, a total of 14,382,120 individuals were screened for hypertension, out of which 11,459,493 of them were people above 30 years of age. Screening for diabetes mellitus was done for 2,667,724 individuals, out of which 1,509,843 were over the age of 40 years. The number of individuals screened over the past few years have shown a significant increment. A total of 529,507 women have received cervical cancer screening service, which has increased by more than 50% compared to last year's performance. Since the initiation of cervical cancer screening in 2001 EFY, the number of VIA and Cryotherapy services providing health facilities have tremendously increased and reached 1330.

The prevention and control of neglected tropical diseases were strengthened through interventions such as preventive chemotherapy, innovative and intensified case management, transmission vector control, WASH, innovative case management, prevention of zoonotic diseases, and vector ecology

management. In 2015 EFY, more than 17.7 million Zithromax treatment was provided in 136 trachoma endemic districts; more than 19.3 million people were treated with ivermectin for the prevention of onchocerciasis and more than 2.3 million people were treated with ivermectin for lymphtic filiariasis. In addition, 46.4 million school-age children, adolescents, and Women of reproductive age group were treated for STH and more than 5.1 million school-age children were treated for Schistosomiasis.

The OPD attendance per capita in 2015 EFY was 1.50, which is higher than the 1.44 in the previous year. The national average bed density was 3.1 per 10,000 population, admission rate was 15.4 per 1,000 population, hospital bed occupancy rate was 68% and the average length of stay at hospitals was 4.1 days. In the fiscal year, 352,962 units of whole blood were collected, from which 50,372 (8.5%) of whole blood units were separated into blood components. System Bottleneck focused reform (SBFR), a project that aims to address major system bottlenecks at hospitals, has been implemented in 38 public hospitals with encouraging positive results.

To expand health infrastructure and improve access to health services, the sector has been engaged in construction of new health infrastructure and rehabilitation of the existing ones. At the end of 2015 EFY, functional 379 public hospitals, 3,826 health centers and 17,569 health posts were providing health services. In addition, 52 hospitals, 91 health centers and 116 health posts were under construction. Upgrading of second generation health posts to comprehensive health post was completed for 52 projects and additional upgrading construction is progressing for additional 52 comprehensive health posts.

The total health workforce in 2015 EFY was 462,820, which is increased by 35% compared to the previous year. From the total health workforce, 67% are health professionals (310,591) and 373 are administrative staff (152,229). The health professional density (for physicians, health officers, nurses, midwives) is 1.4 per 1,000 population, which shows nearly halfway remaining to attain the HSTP II target of 2.3 per 1000 population.

Regulation activities were strengthened in the fiscal year to ensure the safety and quality of food, medicines, medical devices, and other regulated products. During the fiscal year, 94 dietary supplements, 15 baby foods and other different types of food were registered and 586 market authorization and 2,230 notifications were given. A total of 25.23 billion birr worth of medicine and 382.08 million birr worth of medicine raw materials were given import permits. Intelligence-led surveillance was conducted through which substandard and counterfeit medicines were found in 71 pharmacies, 89 importers and distributors, and one illegal medicine store and the necessary legal measures were done.

Improving pharmaceutical chain management, supplies and services has been one of the major programs of the health sector. During the fiscal year pharmaceuticals, supplies and medical equipment worth of more than 41.65 Billion Birr were procured and pharmaceuticals worth of 37.2 Billion birr were distributed to health facilities. The number of health facilities implementing Auditable Pharmaceutical and Transaction Service (APTS) implementation has reached to 408 at the end of the fiscal year.

Health information systems and use of digital health technologies were strengthened to improve evidence based decision making in the health sector. As part of Civil registration and Vital Statistics (CRVS) initiative, birth notification rate has increased significantly from 15% in 2011 EFY to 75% in 2015 EFY. However, death notification was only 4% and does not show improvement over the last five years. The overall average report completeness and timeliness reporting rate for all service report data sets in 2015 EFY was 85% and 41% respectively, which is lower than the previous year mainly because of

the delay in implementation of customized DHIS2 version in the first quarter of 2015 EFY. DHIS2 is being used for aggregate data compilation and reporting since 2010 EFY and upgrading of the DHIS2 from v2.36 to version 40 is currently on progress. Electronic Community Health Information System (eCHIS) implementation is currently scale up to 7,806 health posts in 366 Woredas. As of July 2023, a total of 6,913 HPs registered more than 85% of their catchment population and more than 4.67million households and 20 million individuals have been registered.

Health financing improvement initiatives have been strengthened in the fiscal year. Active resource mobilization from domestic and foreign sources was conducted, development partners disbursed 555.1 million USD to the health sector in the fiscal year. Implementation of the different components of health care financing reform was strengthened, through which 90% of public health facilities were managed by functional facility governing board, 140 hospitals outsourced at least one clinical services and 32 hospitals established private wing. Implementation of three public private partnership projects, which were registered in the previous year, was progressing during the fiscal year. As part of the foreign direct investment, seven projects were registered in 2015 EFY, with a total capital of about 10 billion birr. Implementation of Community Based Health Insurance (CBHI) has been expanded to about 1,011 Woredas (87%), and more than 12 million households (78% of the eligible households in the CBHI implementing Woredas) has been enrolled to the insurance scheme. More than 4.4 billion birr was collected from CBHI member in the fiscal year.

Though encouraging results were documented during the fiscal year, the health system was not without challenges. The sector has been challenged by natural disasters such as flood and drought, and conflicts in different parts of the country that affected service access and provision. Inadequate health inputs such as shortage of pharmaceuticals and medical supplies, inadequate health workforce, shortage of basic amenities at health facilities, inadequate finance and low quality of data were also the challenges of the health sector. In addition, there was inadequate inter-sectoral collaboration, weak coordination and referral system with in the sector. A huge disparity in health access, utilization and health outcomes among regions was reported informing the design and implementation of tailored intervention to close the geographic equity gap.

CHAPTER

1

Introduction

CHAPTER 1: Introduction

The second health sector transformation plan (HSTP-II), initially developed for the period 2013 EFY-2017 EFY, which is then revised to be for three years (2013 to 2015 EFY) is the sector's strategic plan which aims to improve the health of the population by accelerating progress towards Universal Health Coverage (UHC). The 2015 EFY was the last year of HSTP-II, based on which the sector has developed a health sector development and investment plan for the next three years (2016 EFY to 2018 EFY). During the 2015 EFY, the health sector of Ethiopia has been implementing various programs and initiatives towards the objective and targets of HSTP-II. During the fiscal year, the sector has registered encouraging results despite many challenges such as manmade and natural emergencies including conflicts in different parts of the country.

This annual performance report (APR) is a comprehensive report that indicates the performance and progress of the health sector during 2015 EFY (2022/23), mainly comparing the annual performance against the annual target of core indicators of the sector. The report includes all the major health programs of Ethiopia. The progress and status of the priorities or transformation-agendas of the health sector are also highlighted. The transformation agendas identified in HSTP-II includes 1) quality and equity; 2) Motivated, Competent and Compassionate Health workforce (MCC); 3) information revolution; 4) health financing and 5) leadership.

The contents of the report includes the performance of selected core indicators for each program against baseline and the target for the year, trend of performance over the past five years, description of major initiatives and activities performed during the fiscal year, the major challenges for each specific program area and the recommendations/way forward for the next fiscal year. The detail contents of the APR includes the following:

- The status of the transformation agendas of HSTP-II
- Utilization of services (Coverage), using selected core indicators for each program area
- Trend of service utilization/coverage over the past five years
- Comparison of performance in 2015 EFY against the baseline and the target for the year
- Comparison of performance of service utilization by selected equity parameters such as geography (region), age, sex and others
- Performance and status of health system investments such as infrastructure, pharmaceuticals, information, health financing, leadership and governance
- Emergency response, mainly on epidemic prevention and control, COVID-19 prevention and control, emergency response and rehabilitation efforts for conflict-affected areas
- Major initiatives, interventions and activities accomplished during the fiscal year
- Major challenges and way forward for each program area

Different data sources were used to prepare this APR. The major source of data was the routine health management information system (HMIS), which is available in the DHIS2 platform from all levels of the health system (from health posts up to the MOH level). The other data sources include the Public Health Emergency Management (PHEM) reports, regulatory information system, reports from health insurance reporting system, human resource information system, health commodity management information system and administrative program reports. In addition, for some program areas, global reports and estimates are also used. Population data is from the population projection by the Ethiopian statistical services for the year 2015 EFY.

For the preparation of this APR, different data sources were used. The main quantitative data source was the routine health management information system (HMIS). The HMIS captures and transmits routine service report from all levels of the health system, from health post level up to the MOH. Other data sources such as PHEM (Public Health Emergency Management) reports, health-commodity information system, regulatory information system, human resource information system, global reports and estimates and others are also used. Population data is based on population projection by the Central statistics Agency (the current "Central Statistics Service). The 2015 EFY year is a period from Hamle 2014 to Sene 2015 EFY. Unless mentioned, most of the years are described in Ethiopian fiscal year (EFY). There was no data reported via the DHIS2 system from Tigray region since October 2020, as a result of which the national performance doesn't include the performance of Tigray region.

The preparation of this APR is coordinated by a technical team represented from the strategic affairs executive office (SAEO) of MOH and in close consultation with directors and program experts from each department of MOH.

This Annual Performance Report (APR) is organized into nine chapters, which describes the performance of all the program areas of the health sector, including emergency preparedness, prevention and control.

Chapter 1 [**Introduction**] - is an introduction that covers the background, data sources, data analysis, the contents and process of the preparation of the APR

Chapter 2 [**Progress of transformation agendas of HSTP-II**] – Provides a summary of the progress and current status of the five priorities or transformation agendas of HSTP-II

Chapter 3 [**Health Service Delivery**] – This chapter covers the performance of health service delivery of the health sector. It includes the performance of the various health programs of the health sector, including, Primary health care/health extension program; hygiene and environmental health; reproductive, maternal, neonatal, child, adolescent and youth health (RMNAYH), nutrition, disease prevention and control programs, clinical services and others

Chapter 4 [**Leadership and governance**] – This chapters includes the major governance and leadership programs such as regulation, health infrastructure, health reform and governance, women and youth mainstreaming and related programs and initiatives

Chapter 5 [**Human Resource development and management**] – describes about human resource development and management programs, and includes report on the distribution and mix of health workforce in the Ethiopian health system

Chapter 6 [**Health Information System, digital health and evidence based decision making**] – covers about evidence based decision making in the health sector, digital health initiatives, use of technology and innovations and basic and operational researches

Chapter 7 [**Pharmaceuticals, medical supplies and pharmacy service**] – covers about pharmaceutical supply chain management, management of medical devices and pharmacy services

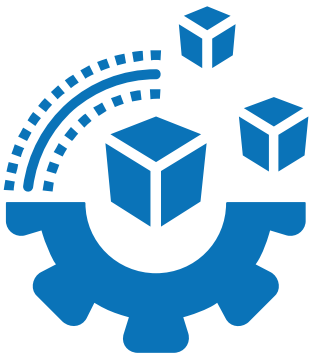
Chapter 8 [**Health Financing**] – Covers about resource mobilization, implementation of health care financing reforms, public health budget allocation and implementation status of health insurance in Ethiopia

Chapter 9 [**Public Health Emergency preparedness and response**] – deals about public health emergencies such as disease epidemics and response, COVID-19 prevention and control and emergency and recovery responses in conflict-affected areas

CHAPTER

2

Progress of transformation agendas of HSTP-II



CHAPTER 2: Progress of transformation agendas of HSTP-II

2.1. Transformation Agenda: Quality and Equity

The Health Sector Transformation Plan II aims to address equity and improve quality of care by ensuring delivery of health care that is dependable, patient-centered, and efficient to all in need in an equitable and timely manner. The overall goal of this transformation agenda is to build a high-performing health system through primary health care and improving clinical care at secondary and tertiary levels of care too. Ethiopia aims to improve the provision of quality and equitable services to the population by developing and implementing a national health care quality and patient safety strategies, institutionalizing a concept of health care quality and practice at all levels, establishing a national health care quality council, and standardizing and strengthening health care quality structures and their functions.

To operationalize the quality agenda in the health sector, a National Quality and Safety Strategy-II (NQSS-II, 2020/21-2024/25) was developed and launched in 2020/21. The goal of the NQSS-II is to continually improve health outcomes and confidence in the system through the realization of improvement in evidence-based essential health care provision, people-centeredness of care, healthcare safety, efficiency in the health care delivery, and creating a quality culture through continuous learning and improvement. The NQSS-II has been implemented for the last three consecutive years. Respective measures have been put in place to achieve this goal, including the development and implementation of a health center clinical audit tool, the completion of an accreditation roadmap, and the creation of guidance for the National Healthcare Safety High-risk Clinical Conditions and Incident Reporting System. Additionally, a guide for the workflow of surgical service provision was developed and implemented in twelve hospitals that have high surgical patient loads, a guideline for surgical safety improvement was developed, and a memorandum of understanding was signed to strengthen the National HealthCare Quality & Safety Hubs established in six University Hospitals. System Bottleneck Focused Reform (SBFR) is being implemented in thirty-eight public hospitals in Ethiopia which aims to identify and address bottlenecks in the health system, improve the quality of care, and increase access to health services by implementing evidence-based interventions.

The National Health Equity Strategy (NHES- 2020/21-2024/25) has set ambitious goals to narrow the health equity gaps and improve the quality of healthcare services, emergency management, and the implementation capacity of the health sector at all levels of the health systems to attain the theme of UHC ‘no one should be left behind’ by 2030. Several initiatives have been implemented to achieve these goals, including supporting the implementation of NHES through customization of the strategy into regional contexts, designing and implementing a mobile health service approach aimed to address the inclusion of vulnerable groups in targeted population groups, conducting a national health equity survey to enhance evidence-based informed policy decisions, designing and implementing different projects in addressing social determinants of health (SDH) aimed to reduce geographic inequities in the four selected Regional States, increasing access to health services by health facility expansion & construction, equipping facilities with basic amenities such as solar power, building residential houses for health workers deployed in hard to reach health facilities, expansion of EPSS hubs, blood banks, operation rooms, and ambulances.

2.2. Transformation Agenda: Leadership

Leadership and Governance is a crucial component of health system building blocks. Recognizing its significance, the Ministry of Health (MOH) has prioritized leadership and governance as a transformation agenda in both HSTP I and II. Over the past 3 years, the health sector has implemented various interventions to enhance leadership and governance, including institutional restructuring, capacity building, setting strategic direction, cultivates accountability, stakeholder involvement, and inter-sectoral collaboration.

Institutional Restructuring: The MOH has successfully undertaken organizational restructuring, aiming to strengthen the coordination between the MOH and Regional Health Bureaus (RHBs), facilitate prompt decision-making, and enhance the implementation of health policies and initiatives. As part of this restructuring 1 Chief executive office, 13 Lead executive offices, and 12 executive offices were established. Implementation of the new restructured system was started early in 2015 EFY.

Leadership Capacity building: Over the past three years, the Ethiopian Ministry of Health has focused on strengthening leadership and governance across the health system. Various leadership capacity building development initiatives like the Leadership Incubation Program for Health (LIP-H), in which 175 trainees with 47% women have participated, and the Clinical Leadership Improvement Program (CLIP) to build skills of junior professionals and improve clinical leadership. However, evaluations revealed opportunities for improvement, leading to the new High Impact Leadership Program for Health (HIL-PH) which aims to harmonize and enhance leadership competencies at all levels to promote excellence.

Cultivate Accountability: The MOH places great emphasis on promoting social and managerial accountability at all levels, with a specific focus on service-based community engagement and grievance handling to ensure good governance and equitable healthcare. To achieve this, various mechanisms have been implemented, such as the Community Score Card (CSC) and the Managerial Accountability Program in the Health Care System (MAPS). The CSC has been implemented in more than 760 Woredas, and 2,760 health centers across all regions. Each Woreda has established a community council comprising seven members from different sectors, which meets quarterly. This initiative has strengthened community ownership, leading to increased community contributions for constructing health facilities, purchasing ambulances, and supporting staff salaries. The CSC has received national and international recognition, including the African Leadership in Malaria award for best community engagement program. Service improvement councils have also been established in hospitals and MOH agencies to promote managerial accountability, while the Good Governance Index is being implemented in 64 hospitals nationwide.

Stakeholder engagement and collaboration: The MOH has successfully conducted a diagnostic exercise to assess the country's status in relation to the domains of One Plan, One Budget, and One Report. Alignment Action Plans were developed and approved by all stakeholders, providing a solid foundation for implementation. The commitment of the MOH's top management has been instrumental in achieving this exemplary success in alignment. The MOH has actively engaged in rehabilitating and resuming services in conflict-affected areas, mobilizing resources from all stakeholders, including the diaspora community. The twinning of some hospitals with hospitals affected by the conflict is a model innovative services provision with significant positive impact. Furthermore, the health sector has been collaborating with other sectors in different programs such as Nutrition program, Seqota Declaration, WASH and other endeavors.

2.3. Information Revolution

Information revolution (IR) continues to be a transformation agenda, with the objective of enhancing the health system's capacity to produce and use high-quality data for evidence-based decision-making and progress towards better health systems performance. Transforming a culture of high-quality data use; digitization of the health information system (HIS); and improving HIS governance are the three pillars of IR. The detail of this year accomplishment is stated in the health information system, digital health and evidence-based decision-making section of this report. Below are highlights of major accomplishments.

Transforming a Culture of High-Quality Data use: Inadequate implementation research and low utilization of available evidence for decision-making is one of the major gaps in Ethiopian health sector. To address these gaps, MOH has established a Policy, Strategy and Research Lead Executive Office. Additionally, a number of policy briefs were prepared to convey summary of evidence that can help decision maker in making evidence-based decision making.

Implementing data quality review mechanisms have improved significantly. In 2015 EFY, 97% of hospitals and 87% of health centers conducted data quality consistency checks for monthly service reports using LQAS before reporting their performance. Likewise, 93% of hospitals and 82% of health centers conducted data quality check for their OPD report. Routine data quality assessment (RDQA), one of the tools that help in understanding the strength and weakness in data quality system and process for routine health information, was conducted for two consecutive years at national level. Similarly, most regional health bureau are also conducting it consistently. Birth and death notification plays a vital role in availing data that can be used for individuals and administrative purposes. The birth notification rates have increased significantly from 15% in 2011 EFY to 75% in 2015 EFY. However, the death notification does not show improvement over the last five years.

A capacity building and mentorship program (CBMP) was launched with six selected universities to enhance the implementation of this agenda. Number of Woreda supported by this project has increased from 36 to 79. Standardized checklist that measure the performance of IR agenda at facility and Woreda level was developed and implemented over the last couple of years. Initially this checklist was implemented in Woreda and facilities that have intensive support either by CBMP or implementing partner. However; during the fourth quarter of 2015 EFY, its implementation is scaled up and 36% of all Woreda health offices and 48% of health facilities (HCs and hospitals) have conducted their self-assessment. Of all institutions that conducted the IR self-assessment, 948 (39%) reported reaching model status while 13 Woredas reported to be model by IR composite measure.

Digitization of health information system: The ministry has been using DHIS2 for aggregate data compilation and reporting purpose since 2010 EFY. This platform is customized and used for different purpose in addition to routine HMIS report. It is in use for multi-sectoral nutrition, COVID 19 tracker, COVAX tracker, Woreda based plan, TB tracker etc. To make maximum benefits out of the timely release of the DHIS2 core system, and addressing current challenges in data quality, the Ministry is undergoing an upgrading of the DHIS2 from v2.36 to version 40 (latest stable version).

The development of all four modules of Electronic Community Health Information System (eCHIS) are completed and implementation is scaled up to 366 Woredas. As of July 2023, 7806 health posts have started implementing eCHIS, among which 6,913 of them registered more than 85% of their catchment population and more than 4.7 million households and more than 20 million individuals have been registered. The ministry has acknowledged PulseCare and BahmniEMR as national EMR systems for

scale up. To date, the systems are being implemented at 38 health facilities selected from all regions and city administrations. Other digitals tools such as Integrated Human Resource Information System (iHRIS) and three digital commodity management tools (Dagu, mBrana, Vitas and Fanos) are being implemented as part of realization of digital pillar of IR agenda.

The currently available digital health tools are not exchanging health data with one another which can lead to duplication of effort and inefficient resource use. To address this issue MOH has created a centralized and authoritative health facilities database known as the Master Facility Registry (MFR) and working on interoperability. By the end of 2015 EFY more than 47,000 health facilities (all types, including pharmacies, labs…) from both public and private owned are registered in the MFR and more than 36,637 have received approval. Furthermore, the data hosting capacity was improved by investing on the digital infrastructure. Currently DHIS2 is hosted in local cloud owned by Ethio-telecom while all other digitals tools such as eCHIS, MFR, and iHRIS are hosted in the Ministry's local data center.

Health Information System (HIS) Governance: HIS governance plays pivotal role in aligning the HIS strategies with broad health sector objectives and in coordination of stakeholder's efforts. A number of governance document such as HIS governance framework, eHealth architecture, MFR protocol, data access and sharing guidelines, HIS strategic planning document, digital health blue prints were developed prior to this reporting period. Furthermore, the national Health Data week was celebrated at national and regional levels under the theme of "Enhancing the engagement, capacity and accountability of the private health sector: An action to improve the Health Information System".

2.4. Transformation Agenda: Health Financing

During the last three years of the HSTP-II implementation period, the health sector has prioritized health financing as one of the top health agendas towards ensuring adequate and sustainable financing to health and accelerating progress towards universal health coverage without financial hardship for the population. To improve health financing in Ethiopia, various interventions and innovative financing mechanisms have been implemented over the last three years.

Active resource mobilization from domestic and foreign sources was conducted, including resources for emergency responses. The amount of resource disbursed from development partners for the health sector has increased from 388.12 million USD in 2012 EFY to 555.01 million USD in 2015 EFY. However, the amount disbursed through SDG pool fund has decreased from 219.1 million USD in 2012 EFY to 87.6 million USD in 2015 EFY. In the fiscal year, 12.3% of the total government budget was allocated to health, which is a little lower than the previous years.

The health sector has strengthened implementation of the different components of the health financing reform to raise additional resource, enhance efficient allocation and utilization of resources, improve quality and coverage of health service delivery and ensure the sustainability of the health financing system. By the end of 2015 EFY, 90% of public health facilities are managed by functional facility governing board, 140 hospitals outsourced at least one clinical services and 32 hospitals established private wing. By implementing the health financing reform, the amount of internal revenue collected by health facilities has consistently increased over the past five years, increasing from 3.1 Billion ETB in 2011 EFY to 8.8 Billion ETB in 2015 EFY.

Performance based financing initiative is initiated, passed all the preliminary steps and piloting is started in Addis Ababa, SNNP and Somali regions. Based on the findings of the pilot study in these regions,

decision will be made on its scale up. In order to foster financial resilience, establishment of a dedicated health fund is initiated.

To improve the engagement of the private sector in health, three public private partnership projects (for diagnostic service, oncology service and medical gas plant) were registered in the previous year by the Ministry of finance and implementation is progressing. As part of the foreign direct investment, seven projects were registered in 2015 EFY, with a total capital of about 10 billion birr. In addition, 130 domestic private investments in health were registered in 2015 EFY, and are expected to create a job opportunity of more than 10,000 people once the projects become functional.

Strengthening health insurance system has been one of the areas the health sector has been focusing over the past few years. Implementation of Community Based Health Insurance (CBHI) has been expanded to about 1,011 Woredas (87%), and more than 12 million households (78% of the eligible households in the CBHI implementing Woredas) has been enrolled to the insurance scheme. The amount of resource pooled from CBHI has been increasing over the years. In 2015 EFY, more than 4.4 billion birr was collected from CBHI member, which is a four times increment from 1.23 billion birr in 2012 EFY in three years. In addition to the CBHI scheme, the health sector has conducted preparatory activities to implement social health insurance system for the formal sector employees.

2.5. Motivated, Competent and Compassionate Health Workforce

The HSTP aims to improve the health status of the population by ensuring the availability of an adequate number and mix of health workers who are motivated, competent, and compassionate. Creating a motivated, competent, and compassionate health workforce depends on several factors, including: Well-regulated, high-quality pre-service education, in-service training, and continuing professional development (CPD) to build the required number of well-qualified professionals and managers and proper human resource management practices, such as fair recruitment, selection, orientation, and placement, as well as the creation of an enabling work environment with clear roles and responsibilities, equitable remuneration packages, and performance support through supportive supervision and timely feedback. Different interventions have been executed to translate the national motivated, competent, and compassionate health service implementation strategy (2020/2021-2024/25) to attain the objectives of this strategy. Some of the accomplished activities related to the transformation agenda of MCC are described below:

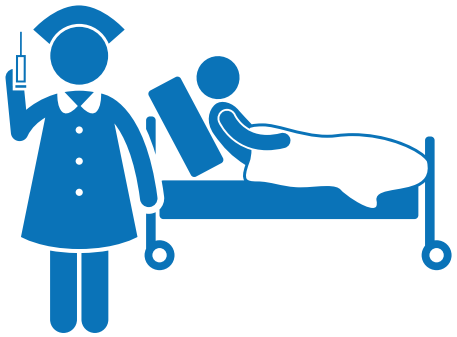
Capacity building on motivated, competent and Compassionate health service: To build the capacity of motivated, competent, and compassionate health workers, MCC training was provided to coordinators and facilitators to enable them to effectively manage the MCC implementation process and facilitate cascading trainings. Accordingly, TOT training on MCC was provided for a total of 50 MCC focal persons (25 from Tigray region and 35 from Addis Ababa RHB and Federal hospitals).

Strengthening the implementation of a motivated, competent and compassionate health system (MCC) in selected health institutions: As part of the support given to the MCC institutions, implementation of system bottle neck focused reform (SBFR) was initiated. From 38 hospital selected for SBFR implementation, baseline assessment was conducted in selected 22 hospitals Gambella, Somali, Amhara and Addis Ababa city administration. Based on the results from the SBFR baseline assessment, renovation of duty rooms and refreshment corner will commence in 2016 EFY. During the baseline assessment the health facilities were supported to ensure the implementation of those activities ensuring MCC.

CHAPTER

3

Health service delivery



CHAPTER 3: Health service delivery

3.1. Primary Health Care and Health Extension Program

Building on its success and lessons learned, Ethiopia has continued to implement the Health Extension Program (HEP) for community engagement and as an effective service delivery platform to reach individuals, families, and communities with a comprehensive package. This section of the report discusses the achievements in the implementation of the health extension program Optimization Road map and the implementation of various reforms to strengthen the provision of primary health care services at health centers.

The Health Extension Program Optimization (HEPO): The implementation of the 15 years HEPO roadmap was initiated in 2013 EFY. Following its launching, regional level advocacy and initial categorization of the health posts was conducted in 2014 EFY. Several activities were planned and implemented in 2015 EFY to operationalize the roadmap and change packages. Capacity building training was conducted on the HEPO implementation manual, health post reform implementation guideline, and other standards for RHBs and implementing partners. Below are details of implementation.

Health Post categorization: The quality of the previous categorization of health posts was assessed and re-categorization was carried out by all regions. Accordingly, 16,898 (99% of all health post except Tigray) are categorized and, of which 12,470 (74%), 1,873 (11%) and 2,555 (15%) are basic, comprehensive and to be merged health posts respectively. Among those categorized to be merged with the supervising health facility, 1,572 (61.5%) of them are merged and started provision of services as per the revised standard. To facilitate a supportive environment and functional linkage between facilities, 1,455 (37.4%) health centers have established community health units.

Furthermore, 49 (the plan was 39) comprehensive health posts (CHP), which is 2.7% of expected CHP, have started providing comprehensive health extension program services. Onsite technical support was provided to 11 (22.4%) of them to strengthen the implementation. Similarly, 3,213 basic health posts are staffed with a nurse and two HEWs and started to render basic HEP services.

Health Post Construction: Based on the new standard, the regional governments are working to improve the health post infrastructure. Accordingly, in 2015 EFY construction of 91 comprehensive and 32 basic health posts was started by respective regions. From this, Oromia region has mobilized over 800 million birr from government, community and partners and started construction of 81 and 28 comprehensive and basic health posts respectively. The Amhara region has also mobilized over 135 million birr and started construction of 5 comprehensive health posts. Similarly, construction of comprehensive health posts was initiated in other regions like 2 in Sidama, 1 in SNNP, Harari and Dire Dawa each. The ministry of health is also in a process to construct 12 comprehensive health posts.

Table 1: Health Post Service Delivery Status as per HEPO roadmap by regions, Aug. 2023

Region	Total Health Posts	To be merged HP			Basic Health Post			Comprehensive Health Post		
		Number	Merged with HFs	%	Number	Service started	%	Number	Service started	%
Tigray		NA	NA	NA	NA	NA	NA	NA	NA	NA
Afar	399	11	1	9%	327	327	100%	38	2	5%
Amhara	3,596	782	0	0%	2,457	0	0%	355	0	0%
Oromia	6,857	1,053	1,053	100%	4,922	2,651	54%	797	25	3%
Somali	1,532	58	20	34%	1316	20	2%	158	10	6%
BG	410	61	48	79%	275	115	42%	74	1	1%
SNNP	2,623	345	264	77%	2011	5	0%	267	5	2%
Sidama	551	97	97	100%	388	20	5%	66	2	3%
SWE	826	120	70	58%	613	23	4%	93	1	2%
Gambella	152	25	20	80%	109	0	0%	18	1	6%
Harari	26	2	0	0%	21	21	100%	3	1	33%
Dire Dawa	36	1	1	100%	31	31	100%	4	1	25%
Total	**17,008**	**2,555**	**1,574**	**61.6%**	**12,470**	**3,213**	**25.8%**	**1,873**	**49**	**2.6%**

Community Engagement Strategy: Different studies including the 2019 National Assessment of the HEP revealed the declining performance of the HEP in the area of community-based activities. Cognizant of these gaps, developing alternative community engagement aimed at the identified gaps and ensuring an all-society engagement through optimizing the women development group (WDG), men and youth social structure was considered as one initiative in HEPO road map. A brand-new strategy-the village health leaders (VHLs)-was piloted in four Woredas in 2013 EFY and scaled up to 24 more Woredas in 2014. In 2015 EFY this strategy was further scaled up to 50 Woredas which increases the number of implementing Woredas to 80. To date, a total of 8,197 VHLs were recruited, 7,188 trained and 5,454 of them became functional. The strategy is also customized to fit the context of the pastoralist settings and is under pilot implementation in four Woredas in Somali and three Woredas in Afar regions.

Voluntary community health workers like WDGs should have the required competency to communicate health messages and contribute toward bringing the desired health behavior. Competency based training (CBT) was designed and has been implemented since 2008 EFY. To improve the knowledge and skills of the WDG members. Over the last three years the number of WDGs that have received the CBT fluctuated with the lowest number reported in 2014 EFY. Percent of trainees that were assessed for competency among those who completed training are 91%, 93%, and 81% in 2013, 2014 and 2015 EFY respectively. Lowest proportion of competent (81%) among assessed was reported in 2015 EFY while more than 90% was reported for the rest two years. This might be because of low quality training and support for the WDG trainees from woreda and PHCU level.

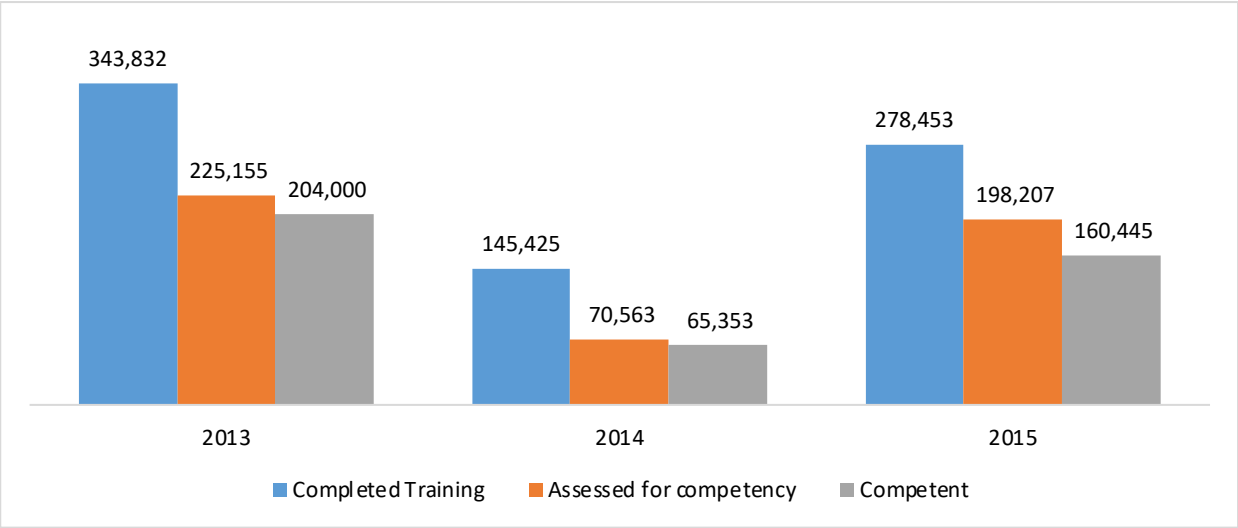


Figure 1: Number of WDGs that completed CBT, assessed for competency and found to be competent, 2013-2015 EFY

Urban PHC Reform Implementation: Contextualizing service delivery modality is one strategy proposed in HEPO road map to ensure equitable access to essential health service. Despite geographical proximity of urban population to both public and private health facilities, multiple social determinant related barriers remain a major challenge to bring about the desired health behavior and service utilization.

To augment the urban HEP and address the challenges and reach the marginalized community groups in urban settings, the urban PHC reform was initiated in 2007 EFY. The service delivery points of the reform are households, communities, schools, youth centers, homeless sites, and workplaces. Before the service provision, the catchment population was categorized into three groups based on epidemiological/demography and economical status of the population. Since then, the reform has been scaled up to 152 cities and towns. In these cities and towns, the number of urban health centers implementing the reform has reached 328. Through the team-based service delivery approach of the reform, in 2015 EFY over 1.26 million households have been visited and about 3 million people have received services. In the 2015 EFY, the initiative was scaled up to 13 additional health centers.

Development of Primary Health Care Strategic Framework: Since the declaration of Alma Ata in 1978, Ethiopia has been expanding the PHC services by designing and implementing different strategies like expansion of health facilities, training and deployment of midlevel health care workers, and availing essential supplies. The PHC services accessibility has been significantly improved since the introduction of the HEP in 2003. To further strengthen the implementation and realize a PHC oriented strong health system, a national strategic framework is developed.

Health Center Service Delivery: To strengthen health service delivery at the primary health care level, MOH has been designing and implementing several initiatives such as Ethiopian health center reform implementation guideline (EHCRIG), Ethiopian primary health care clinical guideline (EPHCG), emergency surgery services and others.

Ethiopian health center reform implementation guideline (EHCRIG): This guideline, having 10 chapters and 81 standards, has been implemented since 2009 EFY and achieved tremendous results which includes, improvement in the health centers leadership and governance (65% to 80%), establishment of triage services (45% to 58%), strengthening of the existing drug and therapeutic committee (DTC) works

(58% to 73%) and others. The existing guideline was revised in 2014 EFY considering lessons learned from prior implementation and accommodating newly introduced protocol and guideline during HSTP II period. The revised EHCRIG have 12 chapters and 131 standards. In 2015 EFY training was provided to more than 9,000 health workers and its implementation was started. Additionally, a dashboard for monitoring its implementation was prepared. The quarterly report completeness (Miazia to Sene) on EHCRIG varies from 75%-79% during 2012-2014 EFY. Since only 70% of the HCs received training and implemented the new EHCRIG this year, the completeness has dropped to 64% in fourth quarter of 2015 EFY. The overall chapter average performance on the fourth quarter of each year has increased from 73% in 2011 EFY to 79% in 2015 EFY.

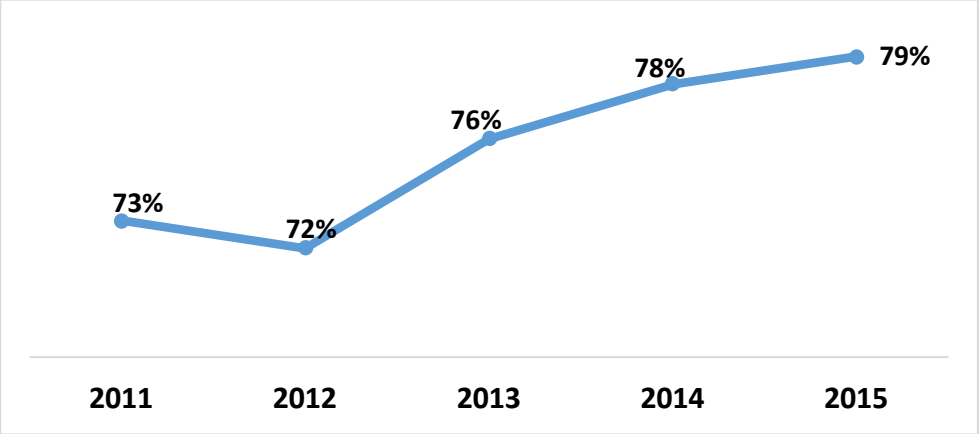


Figure 2: The overall chapter average performance of EHCRIG in Ethiopia on the 4th quarter of the fiscal year, 2011-2015 EFY

Ethiopian primary Health Care Clinical Guidelines (EPHCG): it is an integrated symptom-based algorithmic approach to address the common presenting symptoms and priority chronic conditions in the country and consider as a standard tool to be utilized at the health center level. Its implementation was started in 2011 at 572 health centers; only 83 new HCs were added in 2012. The number of HCs implementing this guideline were increased to 2,054 and 3,392 in 2013 and 2014 EFY respectively. In 2015 EFY, 98 HCs newly started implementation making the cumulative number of HCs to date at 3,490. Updating the Ethiopian PHCG regularly is inevitable due to ever-changing medical science. Updating it in hardcopy is resource intensive and takes a long printing time. To facilitate easy implementation and accommodate the changes, a mobile/desktop app was developed. Online web-based e-learning platform has also been developed to capacitate the health care providers and Master TOT was provided for all regions. Currently 3,664 health care workers are enrolled and 2,583 started learning.

Health Centers Emergency Surgery Service (OR-Block health centers): Ethiopia has adopted WHO's initiative of integrating surgery as universal health coverage. The second phase of saving life through safe surgery strategy (SaITs II) primarily focused on accessing surgical service by expanding the surgical care in primary hospitals and health centers. In 2015 EFY, it was planned to increase the number of health centers providing surgery from 74 to 100. A total of 32 HCs newly started providing service which made the cumulative number of health centers providing surgical service to 106 (>100% of annual target). On the other hand, a total of 430 health centers across the country have OR blocks. However only 106 of them are providing the service. During 2015 EFY, assessment was conducted to all HCs with OR blocks. The major findings were shortage of human power, especially anesthesiologists (available at 26% of HCs with OR) and emergency surgeons or IESO (available at 23% of HCs with OR), shortage

of surgical equipment (only 39% of OR block HCs have an OR table and OR light, whereas 49% have an anesthesia machine and 50% have a suction machine). Water and electricity as well as OR block construction quality were other problems identified by the assessment.

Integrating COVID-19 service in PHCU: To strengthen the COVID 19 response and sustain the essential health services in primary health care units, ministry of health selected 1,000 health centers from 1,000 woredas of each region and distributed and installed medical oxygen devices, provide capacity building training on medical devices installation and maintenance for biomedical engineers and end users.

Challenges

- Competing priorities (conflict, climate change, outbreaks) hamper the implementation of the HEPO roadmap
- Shortage and stock-out of essential drugs and supply for health centers and health posts
- Weak inter-sectoral collaboration
- Frequent leadership change at lower level of the health system
- EHCRIG DHIS2 report timeliness problem from regions
- Perception of some health care providers to see EPHCG as reference rather than care providing tool
- Shortage of medical equipment (OR table and light), water, electricity and human resource to start the surgical service in health centers with OR services
- Protracted medical equipment procurement process

Ways Forward

- Continue conducting advocacy on HEP Optimization roadmap at all levels
- Design and implement innovative financing mechanisms for HEPO roadmap implementation
- Follow and support the availability of essential supplies for health center and health posts
- Revitalize multisectoral collaboration for PHC in general and HEP in particular
- Avail medical equipment and basic amenities to health centers with OR services to start surgical services
- Foster the procurement process of medical equipment

3.2. Hygiene and environmental Health

Water, sanitation, Hygiene and Environmental Health (WASH and Environmental health) is one of the programs under the Ethiopian heath sector, which focuses on the management of the environmental determinants of health, prevention of disease and promotion of health. Major achievements in 2015 EFY are described below.

Sanitation

A number of initiatives such as strengthening of market-based sanitation system, scaling Open Defecation Free (ODF) and development of different supportive documents were planned for 2015 EFY. Market based sanitation (MBS), a demand driven approach in which the user makes a full or partial monetary contribution for products and services from the private sector, has been implemented in Ethiopia since 2005 EFY. The aim of MBS is to increase sustained access to and use of basic sanitation service with a focus to low-income households. In 2015 EFY it was planned to increase the number of MBS center from 430 to 500. A total of 121 new center was established making total number of centers to 551(>100%)

ODF, an initiative aimed at breaking the disease transmission chain through eliminating visible open defecation practices, are created through community lead total sanitation and hygiene (CLTSH) approach. In 2015 EFY, it was planned to increase the proportion of Kebele declared ODF to 40%. However; even if a total of 921 new kebeles are declared and verified as ODF in this year, currently only 36% of all kebeles found in the country are ODF. Likewise, the house hold basic sanitation coverage of 2015 EFY is 52% (one percent increase from 2014 baseline). Furthermore, TSEDU Ethiopia 2030 program preparatory phase was completed in this fiscal year. To operationalize the program, implementation manual, SBCC strategy, advocacy strategy, sanitation infrastructure catalog and seven-year action plan were developed.

In 2015 EFY, it was planned to increase proportion of HHs with safe solid and liquid wastes management from 35% to 44% and 27% to 36% respectively. The data obtained from administrative report, indicate that, currently the proportion of households that practice safe solid and liquid disposal are 44% and 31% respectively at national level with wide regional variation as depicted in table below.

Table 2: Proportion of households with access to basic sanitation and waste management, 2015 EFY

Region	Households access to basic sanitation (%)	Households with solid waste management coverage (%)	Households with Liquid waste management coverage (%)
Tigray	NA	NA	NA
Afar	35%	23%	21%
Amhara	60%	50%	46%
Oromia	69%	50%	26%
Somali	27%	9%	4%
BG	50%	14%	16%
SNNP	72%	20%	26%
Sidama	51%	48%	25%
South west	80%	38%	31%
Gambela	5%	14%	14%
Harari	79%	75%	35%
Dire Dawa	91%	54%	20%
Addis Ababa	92%	71%	62%
National	**52%**	**44%**	**31%**

Hygiene

Hand Hygiene: It is believed to be the major solution towards reducing morbidity and mortality from communicable diseases. In 2015 EFY, it was planned to increase proportion of households with basic hand washing facility from 8% to 31% while the achievement is 25%. MoH in collaboration with MOE has developed and launched a ten years Hand Hygiene for all (HH4A) road map. The road map envisions a future where all communities have the resources and can practice proper hand hygiene and every one does so habitually. HH4A road map implementation draft manual was developed and is at its second draft stage. Community mobilization activities were conducted in schools and at community level for one month to increase the awareness of the community on the importance of practicing hand hygiene; in addition, SBCC materials were developed and distributed to all regions on hand hygiene procedures, practices and its significance.

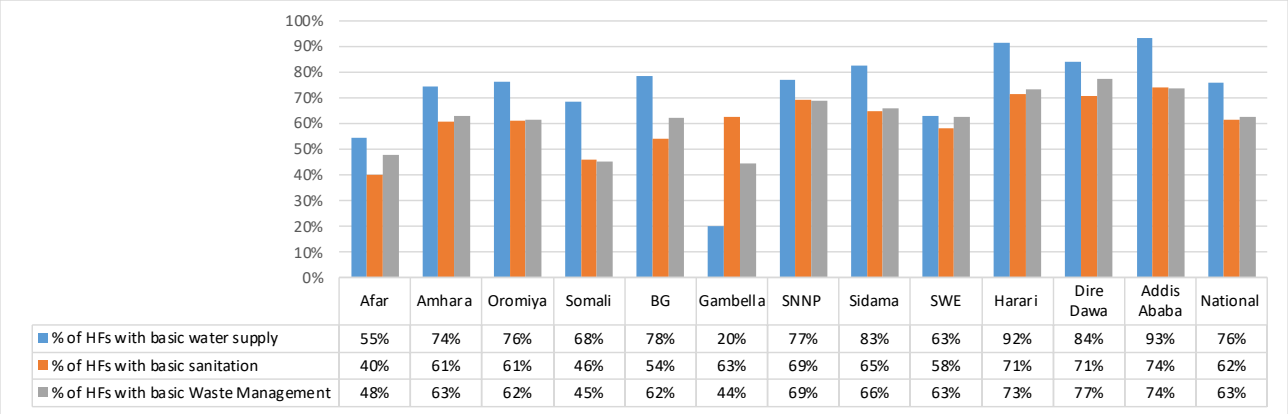
Menstrual Hygiene and Health (MHH): Menstrual Hygiene management is useful in protecting the health of girls and women. MOH in collaboration with MOE has constructed and equipped MHM blocks in 1080 schools through different projects. Menstrual Hygiene Day was observed in Addis Ababa in the presence of senior officials from the MOH, MOE, Ministry of Women and Social Affairs, WASH sectors, and development partners. MOH and other stakeholder's high level advocacy has convinced the decision maker to reduce the tax on menstrual hygiene products from 30% to 10%.

Water Safety and Food Hygiene: It is among the initiatives of WASH and Environmental health which helps to prevent water and food borne diseases. In 2015 EFY, facilitators and participant manuals on water quality testing and surveillance were developed and a training of trainers were provided to 32 participants drawn from regional and federal level. Furthermore, a teaching aid were developed on household water treatment and safe storage and were distributed to all regions.

Institutional WASH and Environmental Health

Availability of water supply, sanitation and waste management service are highly required at all health institutions. During 2015 EFY, it was planned to increase the proportion of all health facilities with basic water supply from 57% to 70%. Similarly, it was planned to increase proportion of health facilities with basic sanitation and waste management to 85% and 70% respectively. However, the achievement for basic water service supply, basic sanitation and basic waste management are 76%, 62% 63% respectively. The low achievements in two areas are basically attributed to damage to infrastructure due to conflict and price escalation of construction materials

There is wide regional variation in terms of institutional WASH status. Better basic water service availability was reported from Addis Ababa (93%), Harari (92%) and Dire Dawa (84%) while Gambella reported very low (20%) basic water supply availability. Similarly, health facilities at those three urban populations dominated region have better availability of basic sanitation and basic waste management service. Afar reported lowest (40%) basic sanitation service while Gambella again reported lowest basic waste management service.



	Afar	Amhara	Oromiya	Somali	BG	Gambella	SNNP	Sidama	SWE	Harari	Dire Dawa	Addis Ababa	National
% of HFs with basic water supply	55%	74%	76%	68%	78%	20%	77%	83%	63%	92%	84%	93%	76%
% of HFs with basic sanitation	40%	61%	61%	46%	54%	63%	69%	65%	58%	71%	71%	74%	62%
% of HFs with basic Waste Management	48%	63%	62%	45%	62%	44%	69%	66%	63%	73%	77%	74%	63%

Figure 3: Percentage of hospitals and health centers with basic water supply, sanitation and basic waste management service by region, 2015 EFY

Furthermore, it was planned to construct and rehabilitate 367 basic water supplies, 354 basic sanitations, 242 incinerators, and 108 placenta pits through one national WASH program in this reporting period. However, 246 (67%) basic water supplies, 356 (>100%) basic sanitations, 271 (>100%) incinerators, and 118 (>100%) placenta pits were constructed and rehabilitated.

National water and sanitation for health facility improvement tool (WASH FIT) implementation Guideline was develop to improve WASH and waste management in health care facility. Training of trainers were provided for 39 experts from federal, region and partners. Cascading of this training was given to 65 health care workers in Amhara and Somali regions. Additionally, Religion institution WASH toolkit, aimed at preventing epidemic prone diseases, was prepared in collaboration with Ethiopian inter-religious counsel.

Climate Change and Health

TOT training was provided to 30 regional experts on Emergency WASH. Additionally, advocacy workshop was conducted on air pollution and its consequence in the presence of 40 relevant sectors, regional officials and partners. Likewise, Chemical and hazardous waste management guideline was developed in collaboration with universities, regions and partners

Challenges

- Adequate resource was not allocated for WASH and Environmental Health activities
- Price escalation of construction materials which were a challenge in building WASH facilities in Health care facilities
- Shortage of test kits to perform water quality test and lack of water treatment chemicals for cholera affected areas.
- Inadequate interventions in institutional WASH and limited partner's engagement

Way forward

- Establish different financing mechanism for sanitation and hygiene to ensure the services to all
- Ensure procurement of water quality monitoring test kits and water treatment chemical
- Launching TSEDU Ethiopia in the presence of higher official and conduct advocacy work
- Improving the capacity and leadership of one WASH national program
- Strengthen regulation of WASH services in institutions as part of licensing and re-licensing process.

3.3. Family Planning and Maternal Health

Enhancing the provision of equitable and quality comprehensive health services to the population is one of the strategic directions of the second health sector transformation plan (HSTP-II). Family planning, reproductive and maternal health services and programs is given a due emphasis in the strategic plan. In this section, the 2015 EFY performance on reproductive and maternal health services is presented by comparing with the baseline and targets set for the fiscal year. Performance is disaggregated by region and other parameters as appropriate. In addition to the quantitative performance report, the report includes the major initiatives, major activities and achievements and challenges in the fiscal year are described for each specific program area.

Summary of selected key reproductive and maternal health indicators is presented in the table below, which is then followed by detail report for each program area.

Table 3: Summary of performance of selected reproductive and maternal health indicators, 2015 EFY

Indicator	Baseline (2014 EFY)	Target (2015 EFY)	Performance (2015 EFY)	Change from baseline
Contraceptive Acceptance Rate (CAR)	68%	72%	76%	Improved
Proportion of pregnant women that initiated ANC before 12 weeks of gestational age (Early initiation of ANC)	NA		22%	
Antenatal Care 4+ coverage	69%	78%	79%	Improved
Antenatal Care 8 coverage	NA	15%	15%	
Proportion of pregnant women tested for syphilis	71%	81%	74%	Improved
Percentage of deliveries attended by a skilled health personnel	68%	73%	75%	Improved
Caesarean Section rate	5.0%	10%	5.4%	Improved
Early Postnatal care coverage (within 7 days)	86%	90%	92%	improved
Early Postnatal care coverage (within 2 days)	65%	75%	72%	improved
Still birth rate (per 1000 births)	11.4		10.8	Improved

3.3.1. Family Planning Service

Family planning services has been provided in Ethiopia since the 1960s and the health sector has been consistently working towards improving access to and utilization of quality family planning services to the population. The major indicators to measure family planning program through the routine health management information system includes contraceptive acceptance rate (CAR), contraceptive method mix, immediate postpartum contraceptive acceptance rate and removal of long acting family planning methods. The performance of these indicators and the major activities conducted in the fiscal year are presented in this sub-section.

Contraceptive Acceptance Rate

Trend of contraceptive acceptance rate shows that it has been consistently increasing over the past five years, increasing from 68% in 2011 EFY to 76% in 2015 EFY.

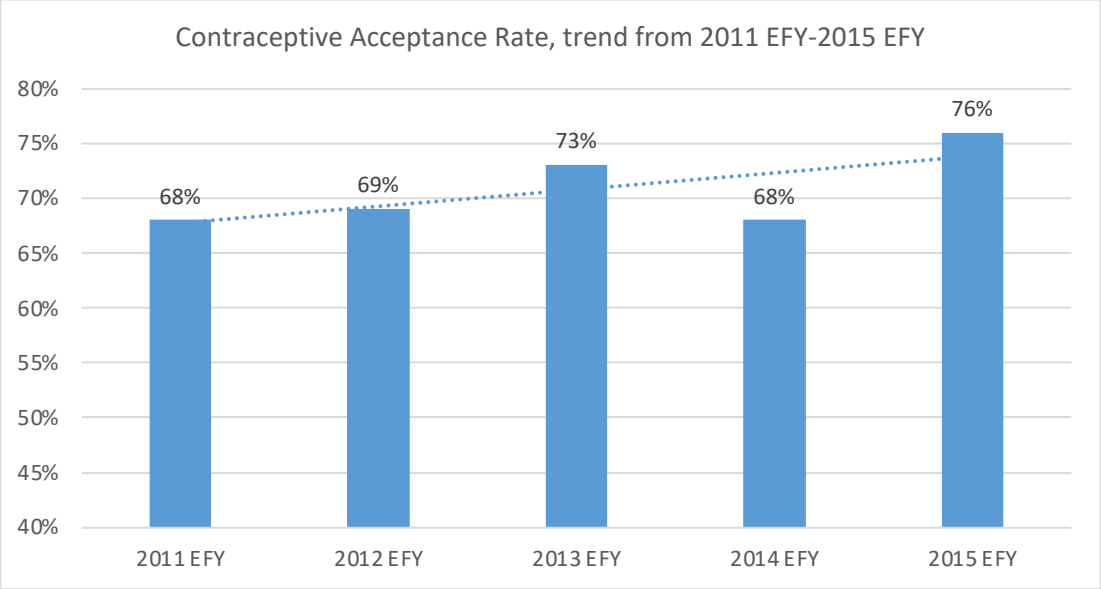


Figure 4: Trend of contraceptive acceptance rate, 2011 EFY to 2015 EFY

In 2015 EFY, more than 15.38 million women in the reproductive age group have received a modern contraceptive method. This year's performance (76%) is higher than the baseline (68%) and also more than the 72% target for the fiscal year. However, the performance of CAR has a huge disparity among regions. The performance of the regions, compared with the baseline, showed that all regions except Somali had a performance higher than the baseline. However, there is a huge disparity among regions. CAR performance in the fiscal year ranged from 10% in Somali region to 95% in Oromia region.

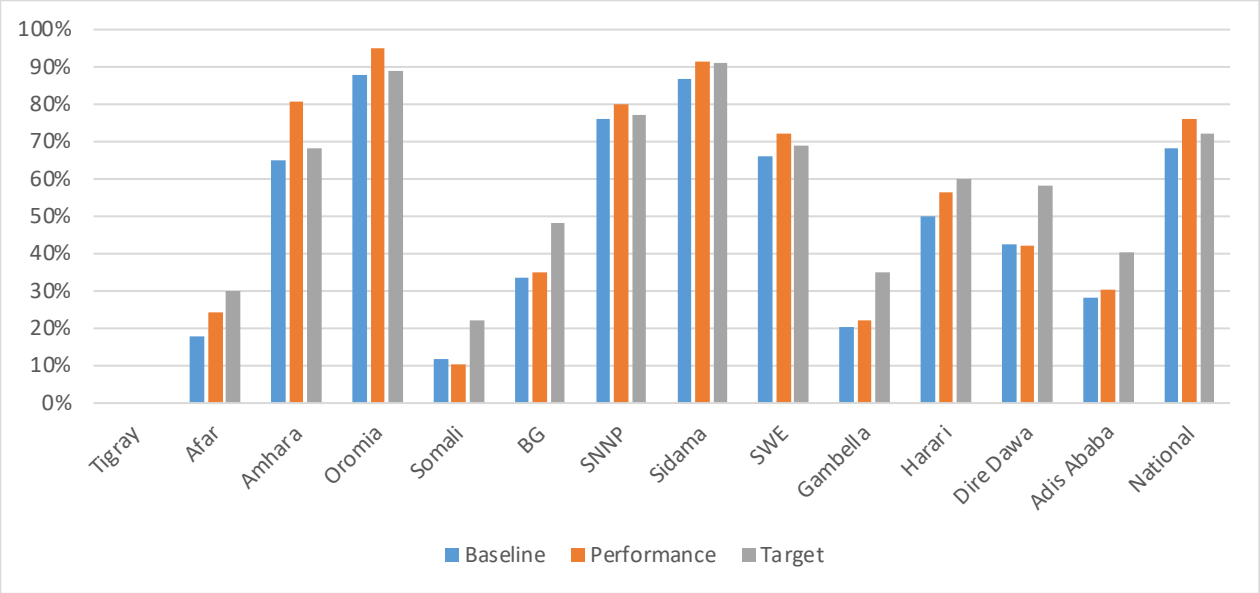


Figure 5: Contraceptive Acceptance Rate: Comparison of baseline, 2015 EFY performance and target

Modern Contraceptive Method mix

Improving availability and access to different modern contraceptive methods has been one of the major initiatives of the national family planning program. In 2015 EFY, the majority of contraceptives were using injectable (51.7%), followed by implants (28.7%) and Oral Contraceptive pills (15.8%). The trend of contraceptive method mix is similar to the previous year's method mix. There is no significant difference from last year.

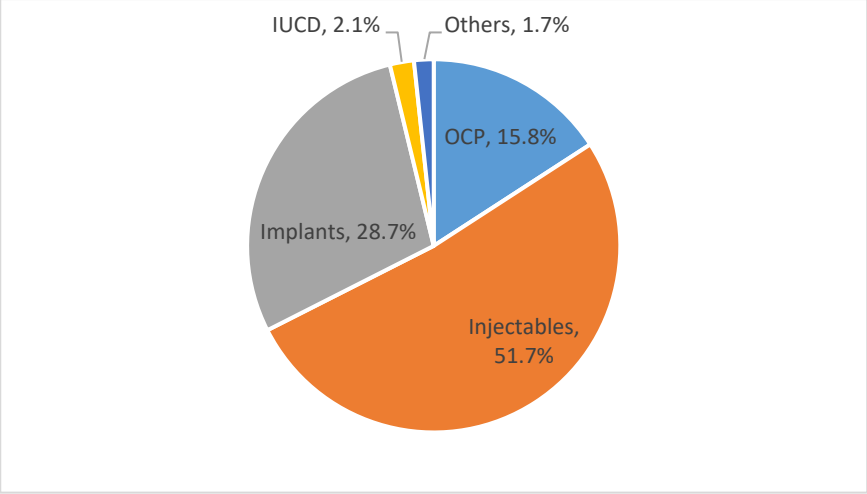
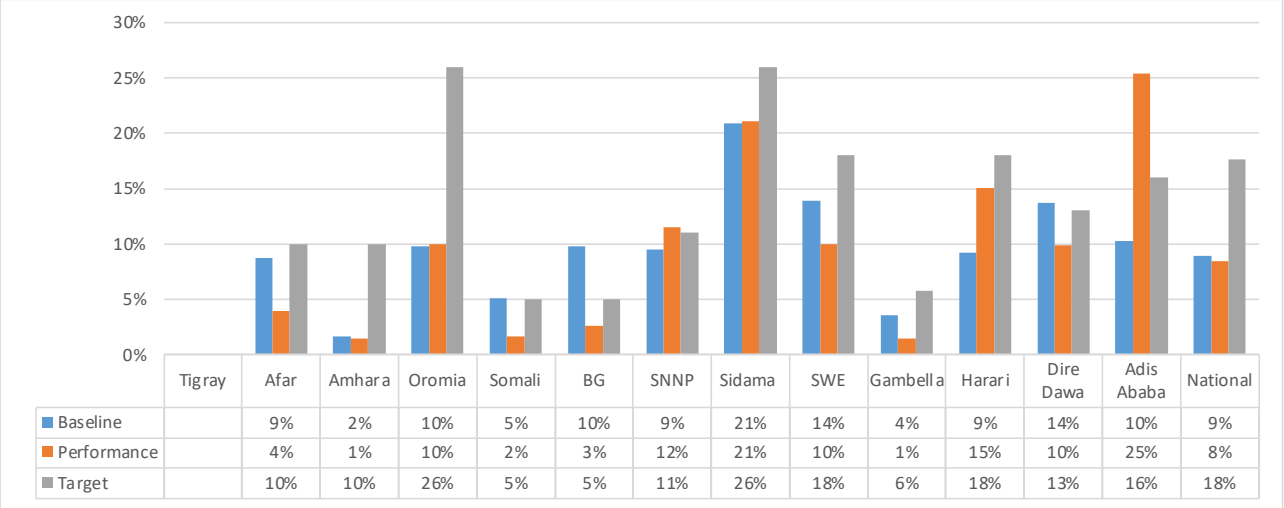


Figure 6: Contraceptive Method mix, 2015 EFY

Immediate Post-Partum Contraceptive Acceptance Rate (IPPCAR)

Postpartum family planning was a flagship initiative of the health sector. Strengthening the provision of PPFP especially in facilities where facility delivery is high was one of the major initiatives. In the fiscal year, more than 288,100 (8%) women have received modern contraceptives during the immediate postpartum period. This performance is lower than the baseline by 1 percent point and only half of the

target set for the year. Except Addis Ababa, no region has achieved the target for the fiscal year. Only four regions (SNNP, Sidama, Harari and Addis Ababa have a performance more than 10%. The lowest performance was in Amhara (1%) and Gambella (1%); while Addis Ababa (25%) and Harari (21%) had a better performance compared to other regions.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	Dire Dawa	Adis Ababa	National
Baseline		9%	2%	10%	5%	10%	9%	21%	14%	4%	9%	14%	10%	9%
Performance		4%	1%	10%	2%	3%	12%	21%	10%	1%	15%	10%	25%	8%
Target		10%	10%	26%	5%	5%	11%	26%	18%	6%	18%	13%	16%	18%

Figure 7: IPPCAR: comparison of baseline with performance and target in 2015 EFY

Premature removal of long acting family planning Methods

During the fiscal year, insertion of 268, 679 long acting family planning (LAFP) methods was performed, among which 48,675 (18%) of the LAFP methods were removed prematurely within six months of insertion. The proportion was premature removal of LAFP methods has decreased from 30% in 2013EFY to 23% in 2014 EFY and 18% in 2015 EFY.

Other major FP and reproductive health related activities and achievements in 2015 EFY

In addition to the above mentioned results, the other major FP, reproductive health and adolescent and youth health related activities and achievements in 2015 EFY are described below.

Private Sector Engagement: In Ethiopia, the public sector is the primary source of contraception nevertheless the GOE policies and strategies recognize the value of the private sector as well. The Ministry of Finance approved the Public-Private Partnership (PPP) Policy in 2013, which outlined the need for private sector involvement in all sectors for economic growth, increased innovation, improved quality, and reduction in delays in service delivery. In the fiscal year, the MOH finalized the public-private-mix (PPM) implementation guidelines for RMNCAH (including FP) services to enhance private sector contribution to RMNCAH services including FP in Ethiopia. To enhance its implementation, successive advocacy workshops were conducted in all regions in partnership with implementing partners and regional health counterparts.

Contraceptive demand: In the fiscal year, evidence was generated on contraceptive demand. By undertaking desk reviews on available literatures, the program has identified the maximum mCPR that could be reached given the level of demand. Based on this, there was a modest potential use gap, i.e, there was some potential for additional mCPR growth without changes in demand. However, the 'potential use gap' varies by region, ranging from a large 'potential use gap' to no potential use gap. Evidences also showed presence of substantial barriers such as traditional, cultural and religious beliefs. Advocacy workshops on gender inequalities was conducted as it usually affect women's ability to make decisions in the household. This power dynamic often limits a woman's ability to choose to use contraceptives, leading to lower FP uptake in households.

Commodity security: FP commodities should be accessible to both men and women of reproductive age (15-49), including youth. Access to quality FP counselling is also a critical element of a successful FP program. Considering this, procurement of FP commodities and supplies as per the annual quantification was done and mobilization of adequate resource necessary to ensure the procurement of FP commodities was performed. As part of strengthening the commodity security and its supply chain system, MOH has developed and launched a reproductive health commodity security strategy in the presence of key government officials and stakeholders

Financing for FP: Over the past three years, the government has increased budget allocation from

treasury for FP, increasing government budget allocation to 19 million USD in 2022/2023. This government budget increment is following a decline of funding for FP from external donors that affected the procurement of adequate contraceptive commodities and other FP supplies. In order to fill this gap, the MOH has signed two big agreements to improve adequate resource for FP. These agreements are: Compact Memorandum of Understanding (MOU) worth 36 million USD for a 3 years interim joint financing of FP commodities between the GoE and development partners; and Compact on co-financing procurement of reproductive health commodities partnership with UNFPA

Others: In addition to the above major activities and activities, the following major ones were implemented in the fiscal year

- Considering counseling as one approach of improving FP service uptake, MOH has developed and endorsed family planning pocket sized counseling toolkit to promote effective family planning use
- Implemented national FP quality standards in 221 health centers that met the minimum criteria
- Ensured provision of a full range of family planning service delivery for women and girls affected by crises in different parts of the country
- Capacity building trainings were provided for more than 1,000 health care providers on post-partum FP, comprehensive FP and on willow box in particular to bring behavioral change toward family planning among rural communities.
- Advocacy workshops with a special emphasis to Reproductive Health, Teenage Pregnancy, FP misconception, gender inequalities and male involvement were conducted in all regions
- Family planning service integration orientation was provided to RHB Bureau heads and MCH directors to ensure the implementation of service integration and reduce unmet need for modern family planning and unplanned pregnancies
- The Costed Implementation Plan (CIP) for the national Family Planning Program for the period 2023–2030 was developed and made ready for endorsement
- Family planning counseling pocket guide produced and ready for printing as well as digitalizing using mobile application

Challenge

- Shortage of level 4 HEW to improve the contraceptive method mix closer to the community
- High turnover of staff, inappropriate trainee selection and assignment in non-FP units after training
- Shortage and interruption of family planning commodity and supplies
- Lack of comprehensive youth-friendly service for adolescent and youth health
- Sub-optimal partnership and coordination between the different stakeholders
- Misconceptions and rumors on Family Planning and unfavorable value and attitude towards Family planning
- Emergencies and conflicts that result in disruption of health services

Way forward for next year

Strengthen Private sector engagement

- Strengthen the existing Public-Private Partnership and draw evidence and lessons for scale up; scale up planned partnership model in selected regions where high private sector penetration exists
- Support access to a more balanced method mix and quality service delivery through the private sector; and maximize the implementation of strategies, protocols and guides for maximum benefit through right based informed choice

Strengthen FP services at public facilities

- Ensure access to FP method mix in all regions, with special emphasis to Somali and Afar
- Address access to short-term methods at health posts in Gambella, BG and Somali regions
- Align FP service provision with HEP roadmap

Strengthen adolescent and youth health services

- Strengthen collaboration among stakeholders to reduce teenage pregnancy in all regions
- Scale up RISE within RISE implementation regions and non-RISE implementing regions
- Enhance conducive environment for adolescent and youth to access quality health-education and information through implementation of the AYH quality standards in youth friendly services
- Increase the number of facilities providing youth friendly health service
- Strengthening and supporting youth and adolescent health services in industrial parks and development corridors
- Conduct the national AYH annual forum by ensuring meaningful youth engagement at all levels

Strengthen services in emergency situations and remote areas

- Strengthen collaboration with development partners to improve access to FP services in humanitarian settings
- Strengthen provision of targeted FP service through mobile and outreach modalities in remote areas

3.3.2. Maternal Health Services

Antenatal Care (ANC) coverage – First visit and Early Initiation

Early initiation of ANC service, i.e., ANC contact before 12 weeks of pregnancy, plays a crucial role in early detection of complications that may affect the outcome of the pregnancy. Besides, early antenatal care first contact increases the likelihood of a pregnant woman receiving continued care throughout her pregnancy by having eight or more ANC contact for effective maternal health interventions and outcomes.

In 2015 EFY, almost all expected pregnant women have attended ANC at least once during their pregnancy. However, only 22% of them have started the first ANC within 12 weeks of gestation, which shows that only very small proportion of women have initiated ANC early during pregnancy. The majority of them have started ANC later than 12 weeks of gestation. Early initiation of ANC within 12 weeks of gestation ranges between 8% in Benishangul Gumuz to 49% in Addis Ababa. The majority of pregnant women (59%) have started ANC after 12 weeks of gestation.

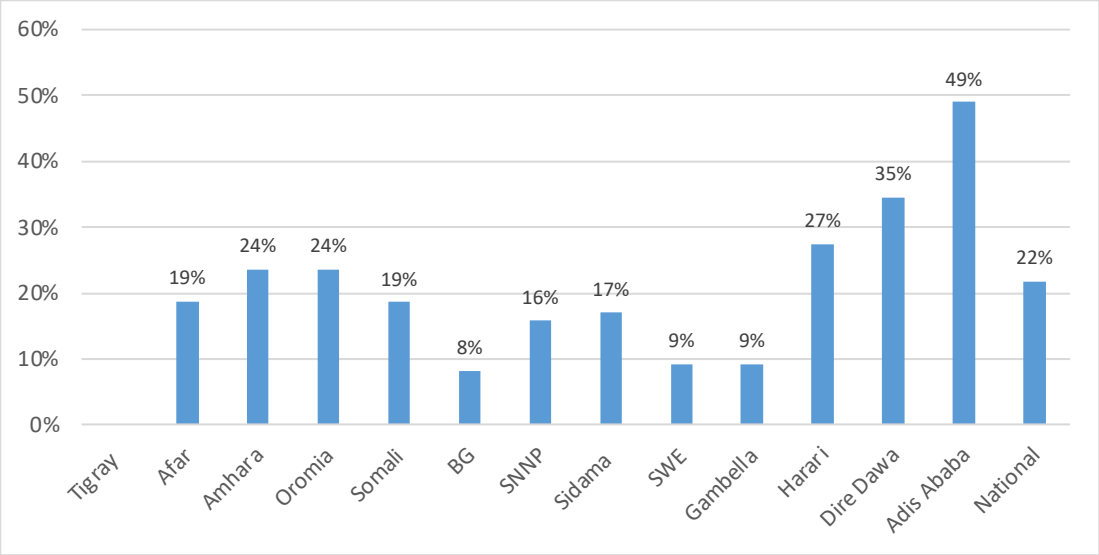


Figure 8: Proportion of pregnant women that initiated ANC within 12 weeks of gestation, 2015 EFY

ANC 4+ Coverage

The fourth antenatal care contact is an indicator of quality and continued use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and to their infants. Receiving four or more antenatal care contact increases the likelihood of receiving effective maternal health interventions during antenatal contact.

Over the past five years, ANC 4+ coverage has been consistently above 68%, ranging from 68% to 79%.

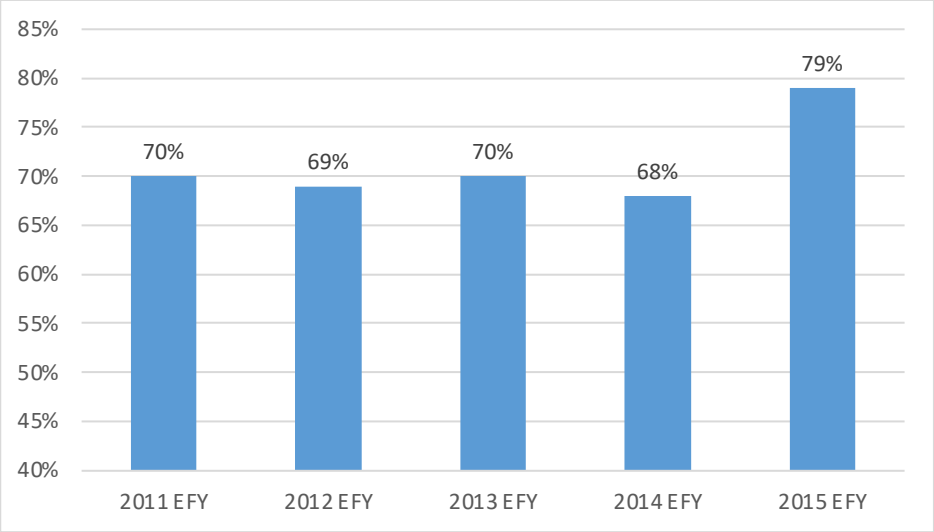
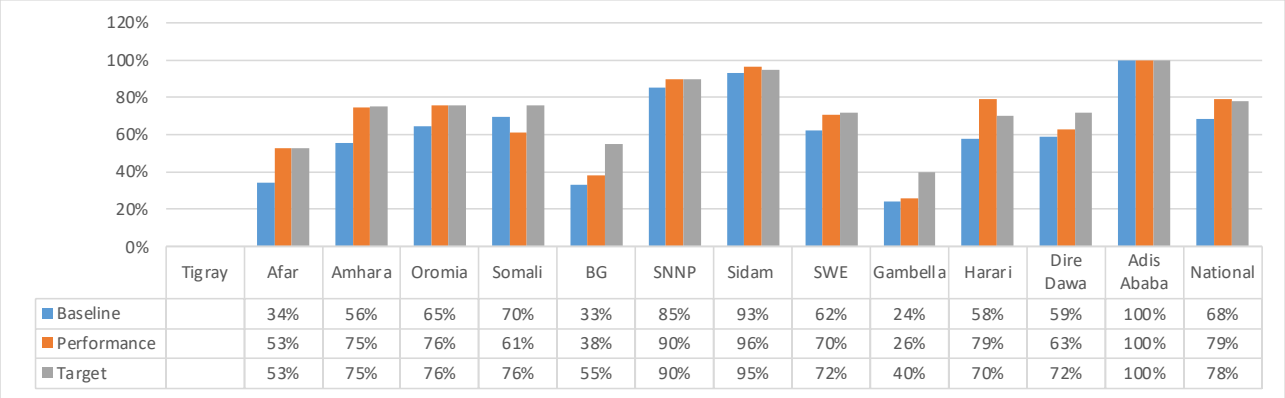


Figure 9: Trend of national ANC 4+ coverage, 2011 EFY to 2015 EFY

In 2015 EFY, more than 2.69 million (79%) pregnant women attended four or more antenatal care visits. This performance is higher than the baseline by 11 percentage points and also higher than the planned 78%. Five regions (Somali, BG, SWE, Gambella and Dire Dawa) did not achieve the target set for the year. The performance of ANC 4+ coverage ranges between 26% in Gambella to 100% in Addis Ababa, showing a huge disparity among regions.

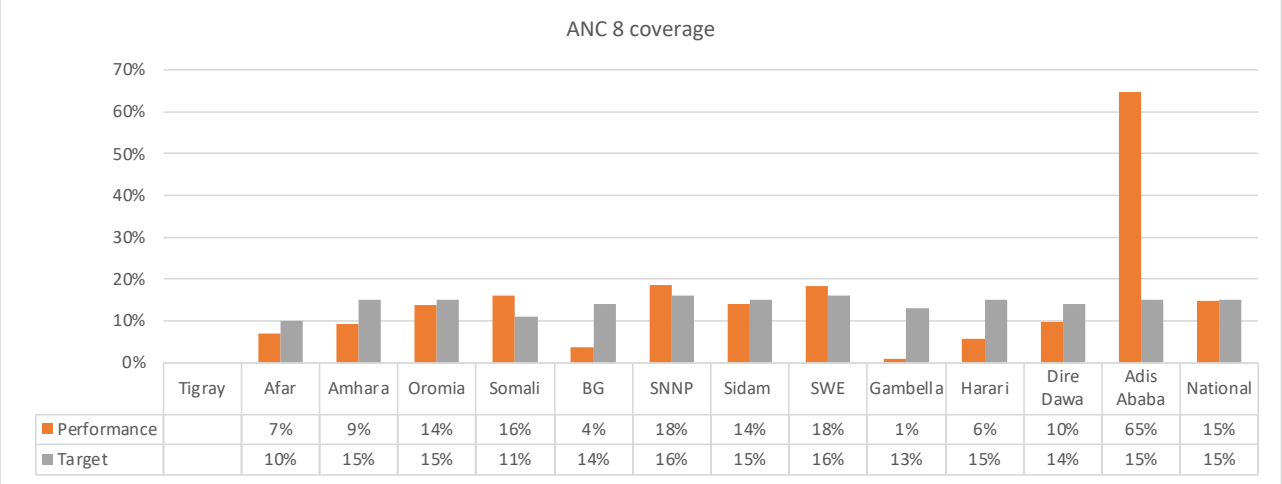


	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidam	SWE	Gambella	Harari	Dire Dawa	Adis Ababa	National
Baseline		34%	56%	65%	70%	33%	85%	93%	62%	24%	58%	59%	100%	68%
Performance		53%	75%	76%	61%	38%	90%	96%	70%	26%	79%	63%	100%	79%
Target		53%	75%	76%	76%	55%	90%	95%	72%	40%	70%	72%	100%	78%

Figure 10: Antenatal care 4+ coverage by region: comparison of baseline, 2015 performance and target

ANC 8 coverage

In the fiscal year, 502,878 pregnant women have received eight or more ANC contacts during their pregnancy period. This is 15% of the total expected pregnancies. This performance is exactly the same as the target for the year. The performance is only 15% as the country has revised the ANC service provision to be eight or more contacts very recently. The lowest ANC 8 or more coverage was recorded in Gambella (1%) and BG (4%), while the highest was in Addis Ababa (65%)

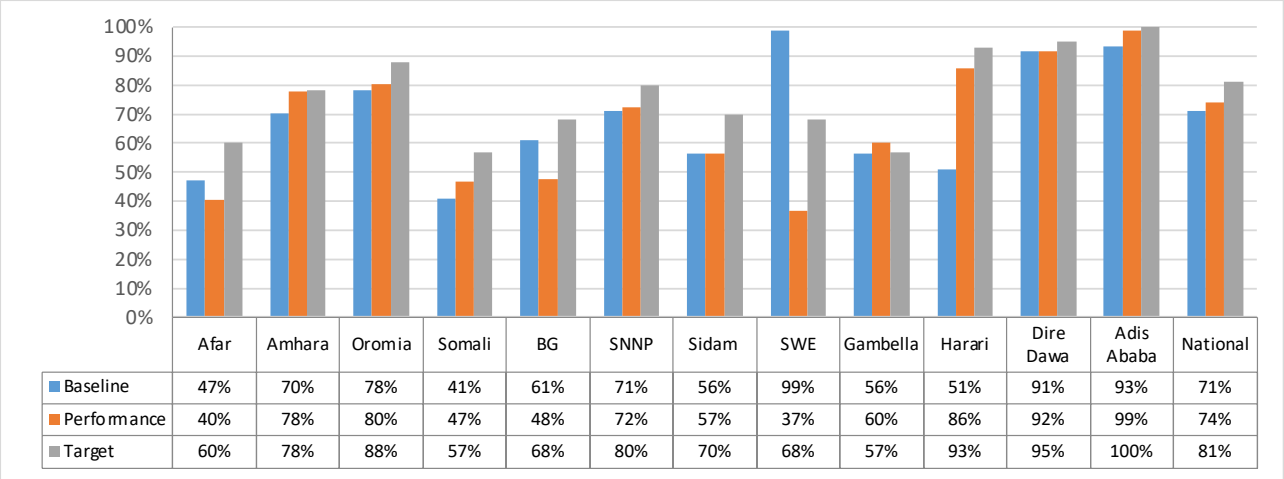


	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidam	SWE	Gambella	Harari	Dire Dawa	Adis Ababa	National
Performance		7%	9%	14%	16%	4%	18%	14%	18%	1%	6%	10%	65%	15%
Target		10%	15%	15%	11%	14%	16%	15%	16%	13%	15%	14%	15%	15%

Figure 11: Antenatal care 8 coverage by region: comparison of baseline, 2015 performance and target

Syphilis Screening

In the fiscal year, more than 2.69 million (74%) pregnant women were tested for syphilis. This performance is higher than the baseline by 3 percentage points but lower than the 81% target for the year. Among those who were tested for syphilis, 0.8% of them were reactive for syphilis and treated accordingly. Syphilis screening performance ranged from 37% in SWE to 99% in Addis Ababa.

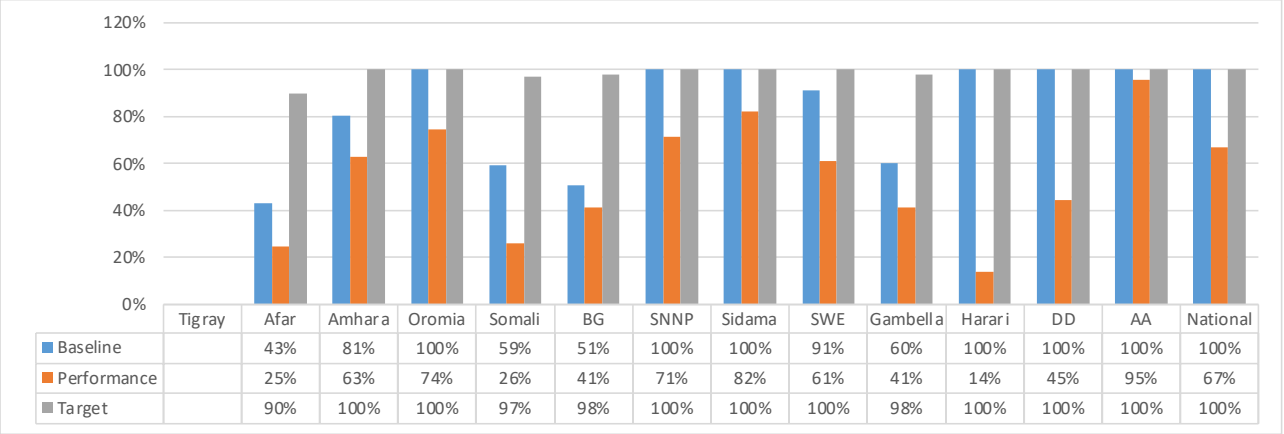


	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidam	SWE	Gambella	Harari	Dire Dawa	Adis Ababa	National
Baseline	47%	70%	78%	41%	61%	71%	56%	99%	56%	51%	91%	93%	71%
Performance	40%	78%	80%	47%	48%	72%	57%	37%	60%	86%	92%	99%	74%
Target	60%	78%	88%	57%	68%	80%	70%	68%	57%	93%	95%	100%	81%

Figure 12: Proportion of pregnant women tested for syphilis, 2015 EFY

Iron folate supplementation during pregnancy

Supplementation of pregnant women with iron and folic acid for at least 90 days (90+) is one of the ANC service packages, to reduce the risk of iron deficiency and anemia in pregnant women and to prevent newborns from congenital anomalies. In 2015 EFY, more than 2.28 million (67%) pregnant women received iron folate supplementation during their pregnancy. This performance is lower than the baseline and target for the fiscal year. There was also a big regional gap in the performance of iron folate supplementation, with the lowest coverage in Harari (14%), Afar (25%) and Somali (26%); it was high in Addis Ababa (95%), Sidama (82%) and Oromia (63%).



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	DD	AA	National
Baseline		43%	81%	100%	59%	51%	100%	100%	91%	60%	100%	100%	100%	100%
Performance		25%	63%	74%	26%	41%	71%	82%	61%	41%	14%	45%	95%	67%
Target		90%	100%	100%	97%	98%	100%	100%	100%	98%	100%	100%	100%	100%

Figure 13: Proportion of pregnant women received iron and folic acid supplements at least 90 plus, 2015 EFY

Skilled Birth Attendance

Over the past five years, coverage of skilled birth attendance has been consistently increasing from 62% in 2011 EFY to 75% in 2015 EFY.

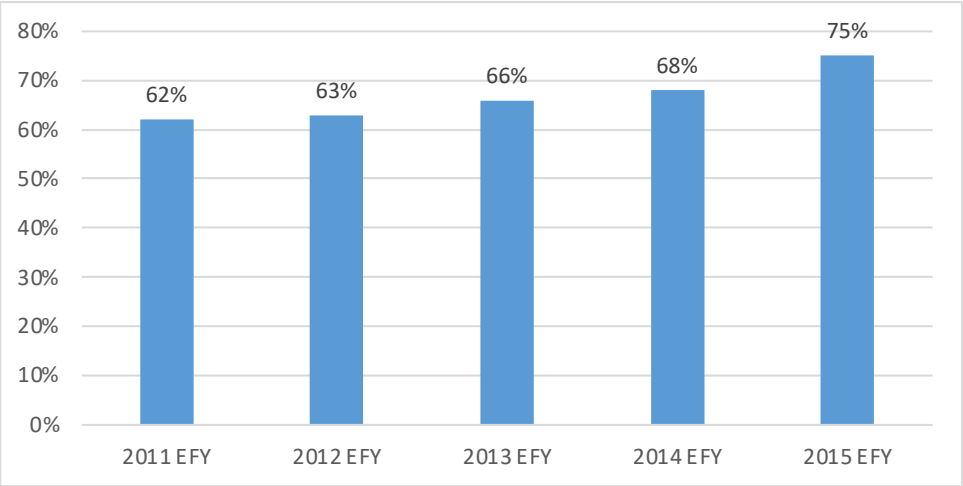
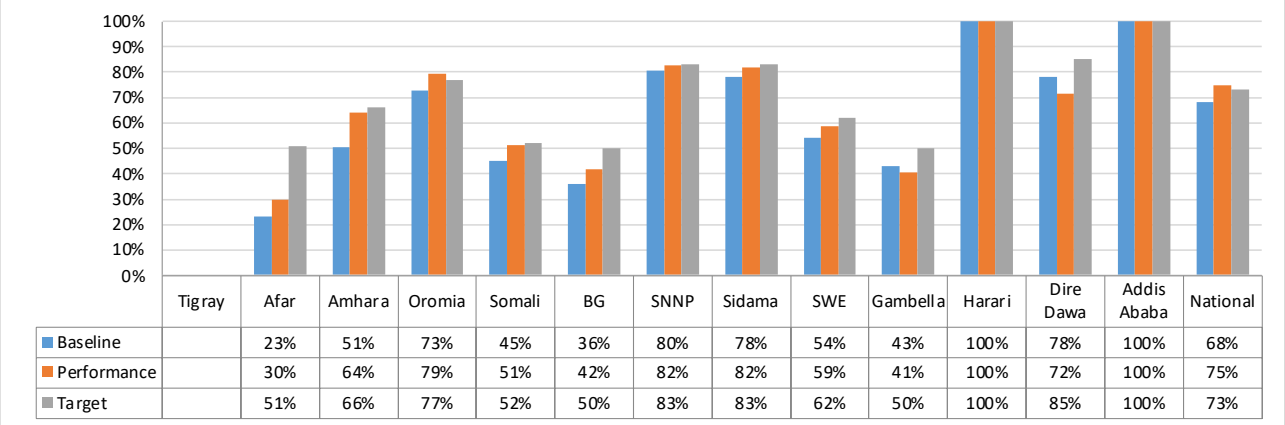


Figure 14: Trend of national skilled birth attendance coverage, 2011 EFY to 2015 EFY

In the fiscal year, more than 2.55 million (75%) women attended delivery services at health facilities. This performance is higher than the baseline by 2 percent points and also higher than the 73% target for the fiscal year. The performance ranges from 30% in Afar to 100% in Addis Ababa and Harari regions. All regions had a skilled birth attendance higher than the baseline except for Gambella and Dire Dawa. In addition, 36,336 births were attended by level IV HEW and nurses at Health posts.

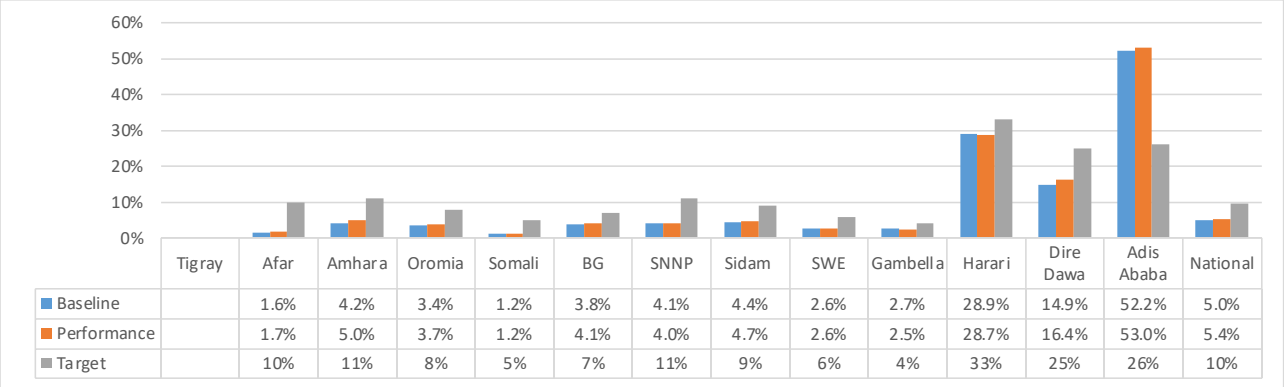


	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline		23%	51%	73%	45%	36%	80%	78%	54%	43%	100%	78%	100%	68%
Performance		30%	64%	79%	51%	42%	82%	82%	59%	41%	100%	72%	100%	75%
Target		51%	66%	77%	52%	50%	83%	83%	62%	50%	100%	85%	100%	73%

Figure 15: Proportion of births attended by skilled health personnel, EFY 2015

Caesarean Section Rate

Caesarean sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. It is expected that 5%-15% of women may develop severe complications that requires caesarean section. However, every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate. In 2015 EFY, the caesarean section rate was 5.4%, which is similar to the previous year's performance (5%) but lower than the targeted 10% for the fiscal year. The C/S rate of Addis Ababa (53%), Harari (28.7%) and Dire Dawa (16.4%) is much higher than the expected C/S rate in the population. However, the C/S rate in other regions is much lower than the expectation. The lowest rate was reported in Somali (1.2%), Afar (1.7%), Gambella (2.5%) and SWE (2.6%) regions.



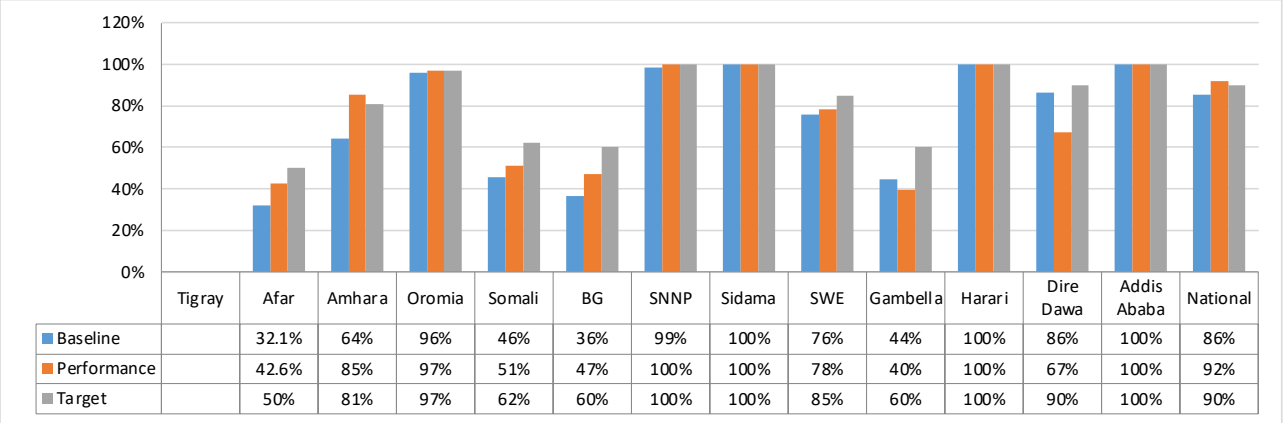
	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidam	SWE	Gambella	Harari	Dire Dawa	Adis Ababa	National
Baseline		1.6%	4.2%	3.4%	1.2%	3.8%	4.1%	4.4%	2.6%	2.7%	28.9%	14.9%	52.2%	5.0%
Performance		1.7%	5.0%	3.7%	1.2%	4.1%	4.0%	4.7%	2.6%	2.5%	28.7%	16.4%	53.0%	5.4%
Target		10%	11%	8%	5%	7%	11%	9%	6%	4%	33%	25%	26%	10%

Figure 16: Caesarean section rate by region, 2015 EFY

EARLY Postnatal Care (PNC)

Early Postnatal care (PNC) coverage is the proportion of women and newborns that get care, at least once during the first 7 days after delivery for reasons relating to post-partum services. It is a critical period when the majority of maternal deaths occur and early intervention is critical to prevent maternal and neonatal deaths.

In 2015 EFY, more than 3.12 million (92%) women received PNC service within the first seven days after delivery. This is higher than the baseline by 6 percentage points and also higher than the targeted 90%. Though early PNC performance at national level was good, there was a huge gap in performance among the regions. The lowest early PNC performance was in Afar (42.6%), Benishangul Gumuz (47%) and Somali (51%) regions. The other regions have a good performance. Moreover, 72% of women received postnatal care service within 2 days after delivery.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline		32.1%	64%	96%	46%	36%	99%	100%	76%	44%	100%	86%	100%	86%
Performance		42.6%	85%	97%	51%	47%	100%	100%	78%	40%	100%	67%	100%	92%
Target		50%	81%	97%	62%	60%	100%	100%	85%	60%	100%	90%	100%	90%

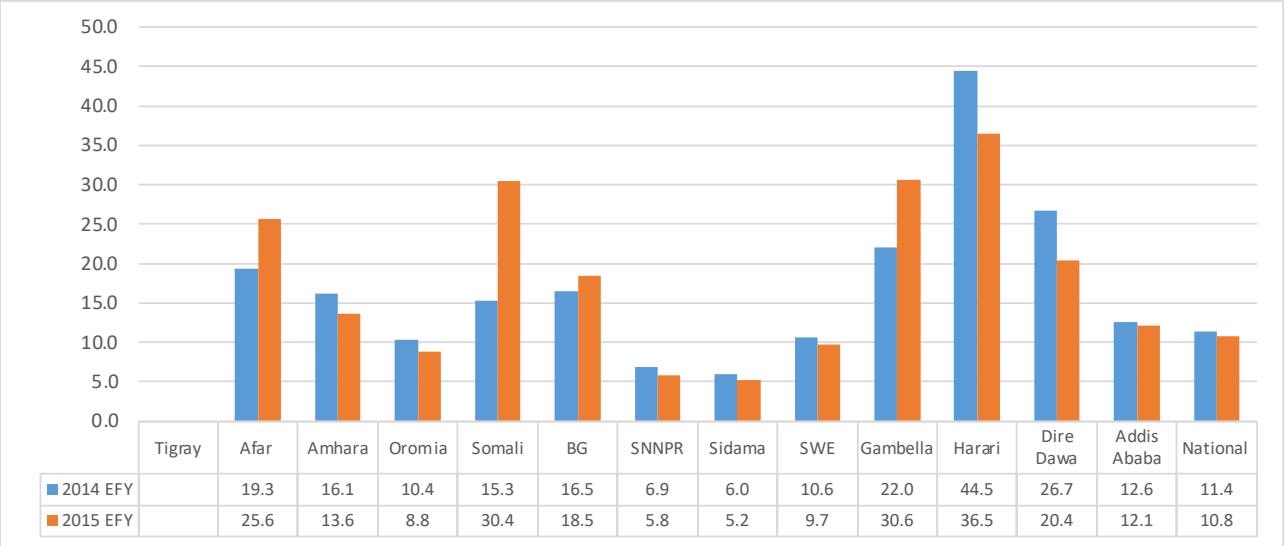
Figure 17: Early Postnatal care coverage, 2015 EFY

Abortion Care

Safe abortion and post-abortion services have been provided to prevent abortion related complications and deaths. In 2015 EFY, 261,724 women received comprehensive abortion care service. Among the total women with comprehensive abortion care, 138,185 (53%) women received safe abortion service and 123,539 (47%) received post-abortion service. From the total women that received comprehensive abortion service, 15% were teenagers aged 10-19 years. With regard to the timing of the abortion service, the majority (78%) women received comprehensive abortion service in the first trimester (before 12 weeks of gestation) but still 22% of the abortion service received the service during the second trimester.

Still birth Rate

Still birth rate is the proportion of stillbirths from the total number of births attended (still and live births attended). It is a proxy for the accessibility, availability and quality of obstetric care and the result of neglected obstructed labor, but could also be due to major congenital malformation, RH incompatibility, or many other causes. In 2015 EFY, the national stillbirth rate was 10.8 deaths per 1000 total births attended. It is similar to the previous year. The highest stillbirth rate was in Harari (36.5) and Somali (30.4) regions. The lowest stillbirth rate was in Sidama and SNNP region, with a rate of 5 and 6 per 1000 births respectively. Compared to the previous year, still birth rate has increased in Afar, Somali, BG, and Gambella regions but decreased in all the other regions compared to the previous year.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNPR	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
2014 EFY		19.3	16.1	10.4	15.3	16.5	6.9	6.0	10.6	22.0	44.5	26.7	12.6	11.4
2015 EFY		25.6	13.6	8.8	30.4	18.5	5.8	5.2	9.7	30.6	36.5	20.4	12.1	10.8

Figure 18: Still birth rate per 1000 births, 2015 EFY

Maternal and Perinatal death surveillance and response (MPDSR)

Maternal death surveillance – Maternal death notification

According to estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division, Ethiopia's maternal mortality ratio in 2020 is 267 maternal deaths per 100,000 live births. This means that about 9,626 estimated maternal deaths are expected annually (9.099 in all regions without Tigray). In the fiscal year, a total of 929 maternal deaths were notified through the MPDSR system. This is only 10% of the total estimated deaths in Ethiopia (excluding Tigray, as there is no information about the region). This performance is a little lower than last year's performance (which was 11%). Maternal death notification ranged from 4% in Afar region to 60% in Harari region. The regional performance of maternal death notification is show in the table below.

From the total notified maternal deaths, the majority (57%) were deaths in hospitals, followed by health centers (42%) and home (<1%) respectively. Analysis of the causes of notified maternal deaths showed that the major cause of death was hemorrhage followed by hypertensive disorders of pregnancy.

Table 4: Number and proportion of maternal deaths notified through MPDSR in 2015 EFY

Region	Estimated no. of maternal deaths (2015 EFY)*	No. of maternal deaths notified in 2015 EFY	% of notified maternal deaths in 2015 EFY
Tigray	-	-	-
Afar	159	6	4%
Amhara	2,090	250	12%
Oromia	3,788	403	11%
Somali	562	49	9%
BG	113	5	4%
SNNP	1,289	65	5%
Sidama	429	38	9%
SWE	311	23	7%
Gambella	43	5	12%
Harari	23	14	60%
Dire Dawa	47	4	8%
Addis Ababa	245	67	27%
National	9,099	929	10%

*MMR of 267 per 100,000 live births (World Health Statistics, 2021) used to proportionate to the regions (Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division)

Perinatal death surveillance: Perinatal mortality is the total of still births (pregnancy loss that occurs after 7 months of gestation) and early neonatal deaths (deaths of live births within the first 7 days of life). In 2015 EFY, a total of 2,875 perinatal deaths were notified through the weekly maternal and perinatal death surveillance and response (MPDSR) system. Prematurity, birth Asphyxia and sepsis contributed to 80% of the perinatal death.

Other maternal health related activities and achievements

In addition to the above achievements on maternal health services, the following major activities and achievements were registered during the fiscal year

Preconception care: As part of the continuum of health care, preconception care is as important as other maternal health care in improving the health outcome of both the mother and infant. MOH has developed a preconception care guideline and preconception Job aid in order to enable health care provides to provide quality preconception care

Improve access and quality ANC, skilled delivery and PNC services: Along the continuum of care, ANC is an important platform in the health care functions of health promotion, disease prevention and treatment through implementing high impact evidence-based practices. As per the WHO 2016's recommendations for positive pregnancy outcomes, Ethiopia developed a new ANC guideline where the following major activities were done to strengthen access to quality antenatal care with due attention to early initiation of ANC <=12 weeks of gestation, skilled delivery and PNC care. Some of the major activities were the following:

- Capacity building training was given to health workers on the new ANC guideline and on the revised maternal health policy documents such as Obstetrics Management Protocols, Obstetrics Fistula Elimination and Reproductive Health Strategic Plans. In addition, a self-care training was provided to 50 health care professionals from four pilot implementing regions and pilot self- care intervention implementation follow up was done in selected health facilities from Oromia, A.A, Somali and Amhara regions

- Assessment was conducted on catchment based clinical mentorship in Gambella, SNNPR, Dire Dawa and Harari regions to understand how it improved quality maternal health service delivery, to identify the challenges as well as the best practices

- The national Safe Motherhood initiative was commemorated with a theme "Lets end preventable maternal death together" with the focus of supporting conflict affected regions through various activities including resource mobilization. An estimated 70 million birr worth medical equipment & supplies was mobilized and supported to regions. The event was commemorated at BG and SWE regions

- A consultative workshop conducted to strengthen pregnant women conference and early initiation of ANC in the presence of national and regional community engagement & primary health care higher officials and experts

- A radio message was transmitted on ANC, childbirth and maternal health services

- National level Preeclampsia and Obstetric fistula days were celebrated with the presence of high government officials, development partners and other stakeholders including the media. Preeclampsia day was celebrated at Saint Paul Millennium Medical college hospital and Obstetric Fistula day was celebrated at Hamlin Fistula Treatment center in Addis Ababa

- Program specific and integrated supportive supervision conducted to strengthen maternal health programs. In addition, experience sharing program was conducted for experts from Afar, BG and Gambella regions in one of the health center in Oromia region to enhance proper maternity waiting home utilization

- High level discussion forum was held to strengthen MPDSR system. Based on this, recommendations were set to revitalize the MPDSR system and to provide timely response based on the findings

- Guidelines: RMNCAY-H self -care, CE-MPMM Guide, Integrated catchment based clinical mentorship guideline, Emergency Preparedness and Response Guide for SRH were developed and submitted for endorsement

Strengthening services for Obstetric fistula and uterine prolapse: During the fiscal year, various activities for the prevention, identification, diagnosis, Treatment, Rehabilitation & reintegration of Obstetric fistula and uterine prolapse were conducted. Accordingly, by integrating fistula identification with measles SIA campaign, a total of 1,331 suspected fistula cases were identified, among which 996 were examined, 335 cases were confirmed and 300 received treatment.

Improving comprehensive abortion care (CAC) service: Even though the access to quality CAC service is improving over time, only 63% of health centers are currently providing CAC services. During the reporting period, the following activities have been done

- CAC specific supportive supervision was conducted in selected health facilities of some regions

- CAC TOT training was provided for 39 experts and basic CAC for 190 experts from conflict affected regions. In addition, capacity building training was given to 24 experts from Sidama and 32 experts from Amhara region by identifying health institutions with low performance in safe abortion services

- The national technical and procedural guide for safe abortion care is revised and validation workshop conducted

Improving medical supplies for maternal health services

- 67 (out of 80) Freezers have been installed for the Mini Blood Bank establishment in 68 hospitals; 30 Thawing are installed; 64 refrigerators have been installed

- 125 Ultrasound, 8515 MVA kit, 210 Rh kit, three ambulances and 2,800 BP apparatus procured for conflict and non-conflict affected regions

Challenges

- Budget shortage and delay in fund release
- Conflict and draught
- Shortage and interruptions of maternal health commodities and supplies
- Lack of timely maintenance of medical equipment
- Low utilization of Magnesium sulfate, misoprostol 25 mcg and TXA

Focus areas for the next fiscal year

- Strengthen provision of quality and equitable services along the continuum of care
- Hasten endorsement of reimbursement protocol and initiate its implementation
- Strengthen the early initiation of ANC and ANC eight or more contact model, institutional delivery and expansion of ultrasound services
- Revision of PNC 24 hours care and stay implementation guide
- Expansion of CEmONC facilities and CAC service providing health centers
- Strengthen the RMNCH catchment based clinical mentorship
- Strengthen obstetrics fistula and UVP identification, and management
- Health facility restoration in conflict affected regions
- Mini blood bank installation and follow up of its utilization
- Follow up the implementation of prepared maternal health policy documents
- Integrating oxytocin in to the immunization cold chain system and introduce heat stable Carbitocin as an option.

3.4. Newborn, Child, Adolescent and Youth Health

Ethiopia has made a remarkable progress in improving neonatal, child, adolescent, and youth health with declining mortality rates, but challenges persist. The country has a high neonatal mortality rate of 33 per 1,000 live births, and the Ministry of Health aims to reduce it to 21 by 2025/26. Efforts outlined in MOH strategic documents involve improving quality of care, strengthening neonatal and child health interventions like immunization and Kangaroo Mother Care, strengthening and strengthening referral systems. For adolescents and youth, the focus is on expanding youth-friendly sexual and reproductive health services to address various issues. This section summarizes achievements, major initiatives, and challenges on neonatal, child, adolescent, and youth health during 2015 EFY.

3.4.1. Immunization Program

The Ethiopian Expanded Program on Immunization (EPI) is a vital public health program that reduces vaccine-preventable infections. Progress has been made through strong collaborations with many stakeholders. The following section summarizes the performance of the national immunization program in 2015 EFY.

Pentavalent-3 Vaccination Coverage

More than 3.3 million children under one years of age received third dose of pentavalent vaccine in 2015 EFY. This is 100% of the eligible surviving infants in the year. Some regions have a performance of more than 100% (Amhara, Oromia, SNNP, Sidama, Harari, and Addis Ababa). Two regions, namely Benishangul Gumz (68%) and Dire Dawa (84%) are the only regions with a performance of less than 90%. A coverage of more than 100% may be due to various factors, one of which is due to denominator issue (which we are using a population projection based on a census data that was done more than 15 years ago). Pentavalent 3 coverage from the routine HMIS report has a big deviation from the WUENIC (WHO/UNICEF Estimates of National Immunization Coverage) estimated coverage of 65% for the year 2022.

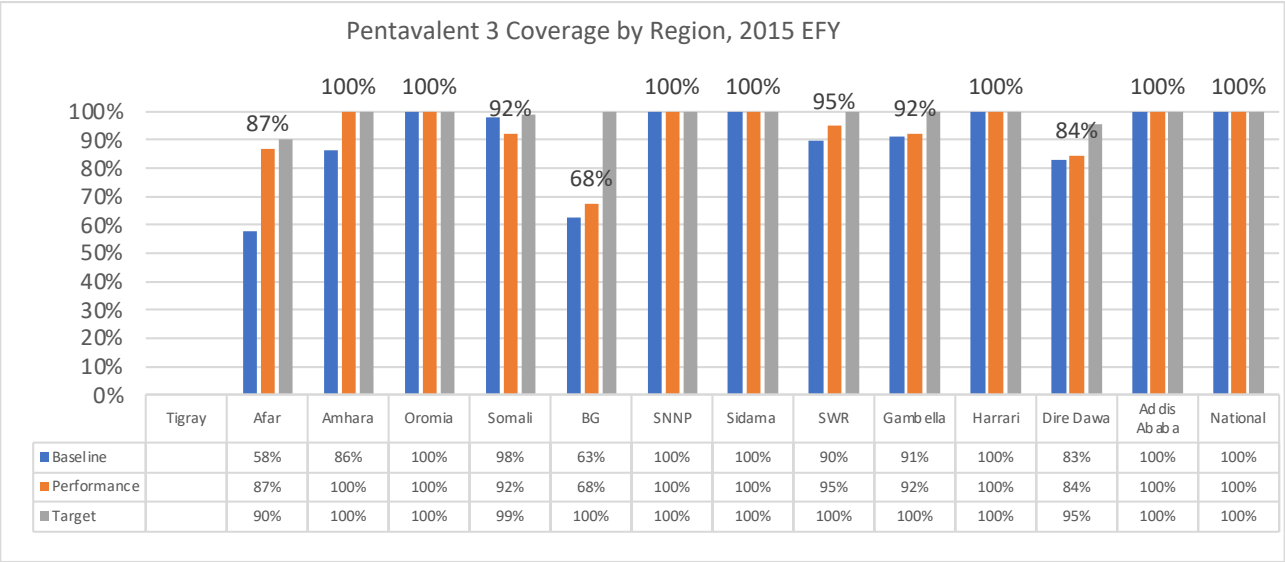
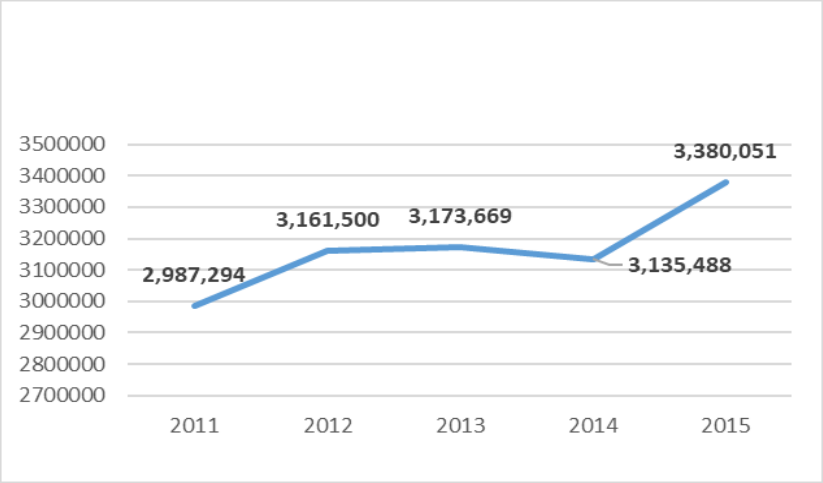


Figure 19: DPT3-HepB3-Hib3 (Pentavalent third dose) vaccination coverage (<1 year) by region, 2015 EFY

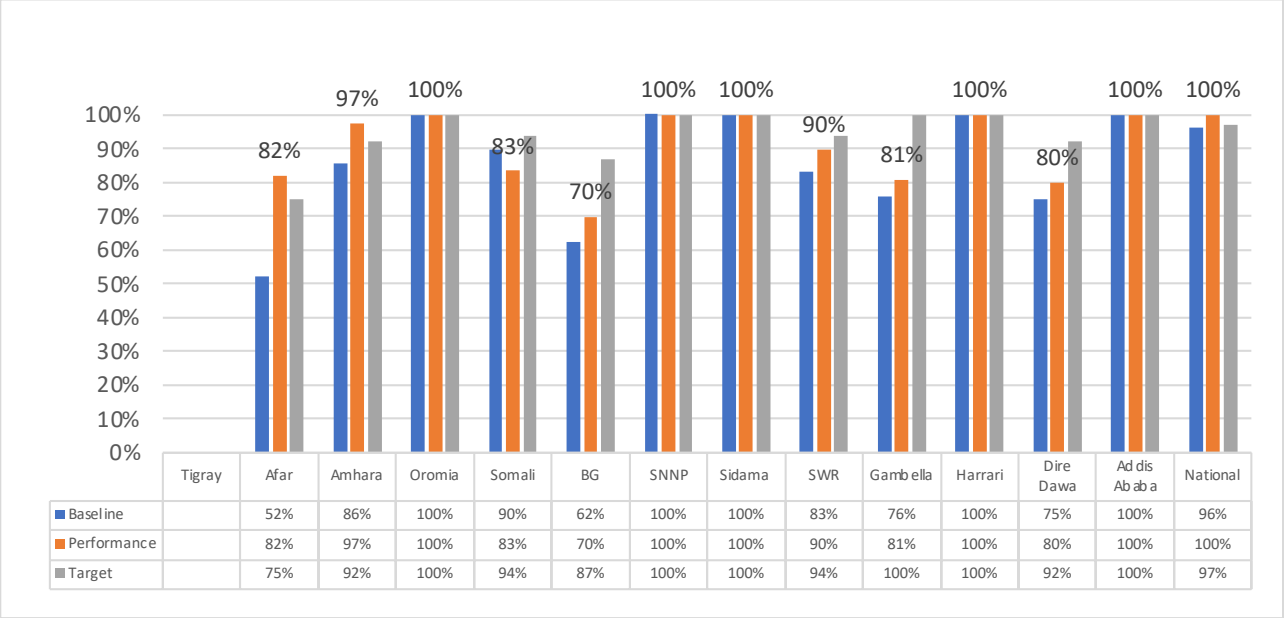


As depicted in the figure, there has been a notable increase in the number of children under one year of age who received third dose of pentavalent vaccine, apart from 2014 when a slight decrease was observed compared to previous years.

Figure 20: Number of children under 1 year of age that received the third dose of pentavalent vaccine, 2011 EFY to 2015 EFY

Measles-1 Vaccination (MCV1) Coverage

The nationwide measles 1st dose coverage among estimated 1-year-old surviving infants was 100%, which is greater than the baseline (96%) and target (97%) for 2015 EFY. Five regions had coverage below 90%, while the others were above 90%. The year's target was not achieved in Somali, Benishangul Gumz, Southwest, and Dire Dawa regions. Eventhough MCV1 coverage is high based on the routine HMIS report, it differs significantly from the 2022 WUENIC (WHO/UNICEF Estimates of National Immunization Coverage) estimate of 56%.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWR	Gambella	Harrari	Dire Dawa	Addis Ababa	National
Baseline		52%	86%	100%	90%	62%	100%	100%	83%	76%	100%	75%	100%	96%
Performance		82%	97%	100%	83%	70%	100%	100%	90%	81%	100%	80%	100%	100%
Target		75%	92%	100%	94%	87%	100%	100%	94%	100%	100%	92%	100%	97%

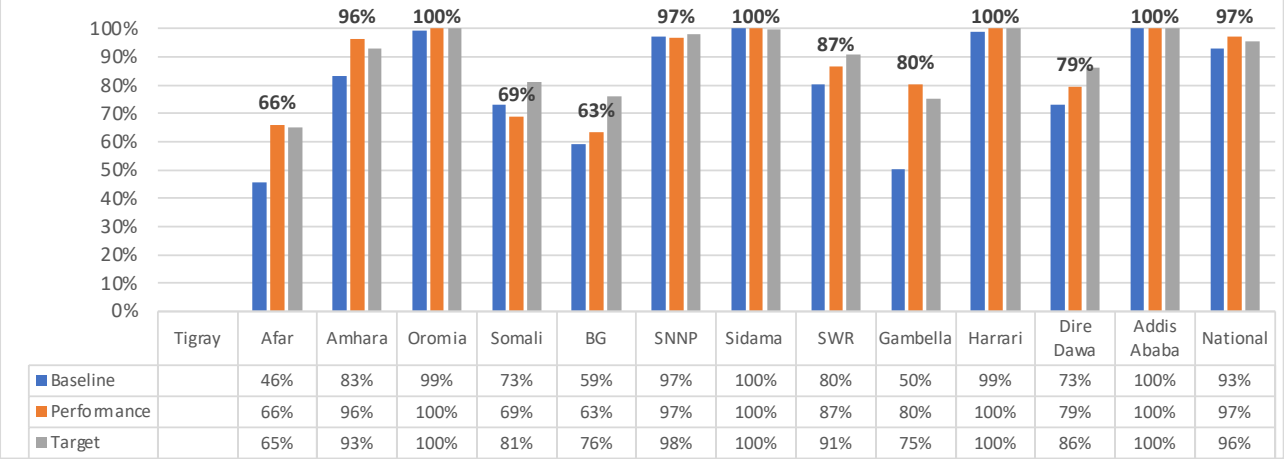
Figure 21: Measles 1st dose (MCV-1) Vaccination Coverage (< 1 Years) by region, 2015 EFY

Measles-2 vaccination (MCV 2) coverage

In 2015 EFY, the coverage of second measles dose (MCV 2) for children aged 15 to 23 months was 89%, a four percentage point increase from the previous year. However, there was a high regional disparity, with Benishangul Gumz (55%), Dire Dawa (60%), Afar (61%), Somali (65%), and Gambella (65%) having the lowest rates, while other regions exceeded 80%. This coverage differs significantly from the 2022 WUENIC estimate of 48%.

Full vaccination coverage

In 2015 EFY, more than 3 million (97%) children under the age of one have received all the basic vaccinations before their first birthday. This performance is higher than the year's target of 96% and the baseline (93%). The coverage in four regions, namely Sidama, Addis Ababa, Oromia and Harari, was more than 100%. Afar, Benishangul Gumz, and Somali performed at a level below 70%, with a coverages of 66%, 63%, and 69% respectively. This coverage is notably different from the WUENIC estimation of 48% for 2022.

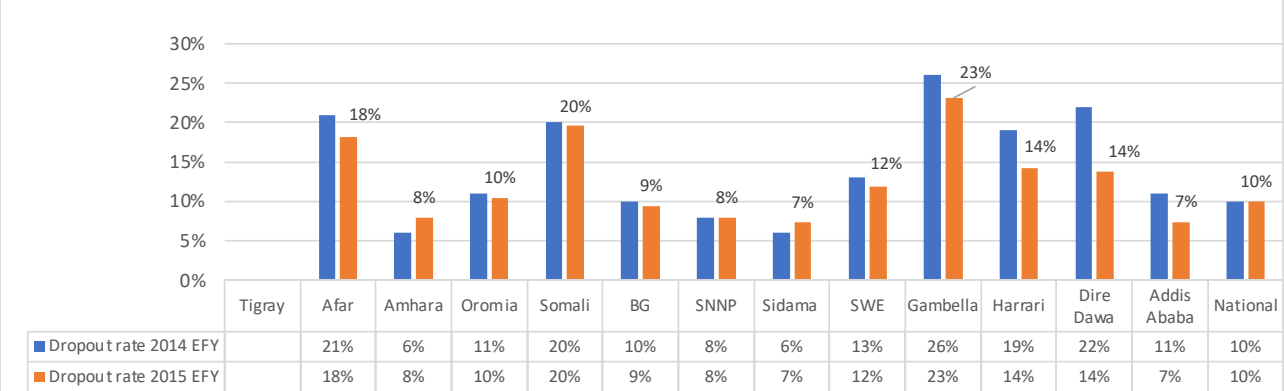


	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWR	Gambella	Harrari	Dire Dawa	Addis Ababa	National
Baseline		46%	83%	99%	73%	59%	97%	100%	80%	50%	99%	73%	100%	93%
Performance		66%	96%	100%	69%	63%	97%	100%	87%	80%	100%	79%	100%	97%
Target		65%	93%	100%	81%	76%	98%	100%	91%	75%	100%	86%	100%	96%

Figure 22: Full vaccination coverage (<1 year) by region, 2015 EFY

Dropout Rate (Pentavalent-1 to Measles Vaccination)

The national dropout rate from pentavalent 3 to measles 1 in 2015 EFY was 10%, which is comparable to the previous year. Six regions, namely Gambella (23%), Somali (20%), Afar (18%), Harari (14%) Dire Dawa (14%) and Southwest (12%) have disproportionately high drop-out rates. A dropout rate less than or equal to the national average was reported by the remaining regions. Except for Amhara, SNNP and Sidama, all the other regions have shown a reduction in dropout rates.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harrari	Dire Dawa	Addis Ababa	National
Dropout rate 2014 EFY		21%	6%	11%	20%	10%	8%	6%	13%	26%	19%	22%	11%	10%
Dropout rate 2015 EFY		18%	8%	10%	20%	9%	8%	7%	12%	23%	14%	14%	7%	10%

Figure 23: Pentavalent-1 to MCV-1 Vaccination dropout rate, 2014 EFY Versus 2015 EFY

Other Major Activities and Achievements on immunization program in 2015 EFY

- **Ensuring access to quality immunization service through routine immunization and supplemental immunization activities:** In the fiscal year, implementation of effective strategies such as Periodic intensification of routine immunization (PIRI) among low performing areas, supplemental immunization activities (SIA), strengthening the capacity of cold chain system and demand creation activities were done with due emphasis. Identification and vaccination of zero dose children were among the key activities and a total of more than 200,000 children were reached through integration of routine immunization with other campaigns. A national integrated measles SIA was conducted reaching a total of 15,070,279 (98%) children of age 9-59 month and more than 109,084 zero dose children vaccinated, 95.2% and 92.4% children received deworming and Vitamin A respectively. In addition, screening for fistula, clubfoot and malnutrition was performed during the implementation of measles SIA.

- In an integrated HPV and 4th-round COVID-19 campaign, more than 14.5 million people were vaccinated for COVID-19. Since the introduction of COVID-19 vaccination in the country, a total of 54.2 million (80%) eligible individuals received at least one dose of COVID 19 vaccination, and 44 million (65.5) of them completed the primary series of COVID 19 Vaccination.

- During the integrated vaccination campaign, a total of 1,435,711 (99%) and 1,044,867 (96%) adolescent girls received their first and second doses of HPV vaccinations respectively. Since the launch of HPV vaccination program in 2018 in Ethiopia a total of 7.9 and 5.2 Million adolescent girls vaccinated for HPV1 & HPV2 respectively. In the fiscal year, about 3.3 million (100%) children under 1 year of age have received the second dose of Rota virus vaccine in the routine immunization program. In addition, more than 54,998 zero dose children vaccinated, more than 7 million children screened for malnutrition, 28158 sick children identified and managed and Obstetric fistula screening performed.

- **Introduction of new vaccine in to the routine immunization system**: During the fiscal year, preparatory activities to introduce new vaccines were conducted. Some of the activities include: Application documents were prepared and submitted to Gavi to introduce Second dose of Inactivated Polio Vaccine (IPV2) and received approval from GAVI. In addition, preparations are ongoing for the introduction of HeB birth dose, malaria vaccine, yellow fever vaccine and switching of 10 dose measles vial to 5 dose vial. GAVI approved a total of 190 million USD to strengthen the immunization program in the country for 2023-2025 under the full portfolio planning

- **Improve community demand towards immunization by engaging community:** Different activities were conducted to improve demand for immunization. The Africa Vaccination Week and World Polio Weeks were celebrated to promote immunizations and increase demand. TV and radio outlets were used to spread information on COVID-19, HPV, measles, and routine immunization. Regional advocacy workshops have engaged different stakeholders during integrated measles, COVID-19, and HPV vaccination campaigns.

- **Improve Immunization supply chain management system:** In the fiscal year, procurement and distribution of 31,811 cold chain spare parts and 4,113 SDD refrigerators was done to improve vaccination supply chain management system. Ledger books, temperature monitoring pads, VRFs, and immunization cards were also printed and distributed to regions

- **Improve evidence-based planning, and M&E on immunization program:** Data verification and CCEI using Measles SIA 2022 were done. National and regional EPI specialists received EVM (Effective Vaccine management) 2.0 training of Trainers and hubs cold room temperatures mapping was also conducted. Three-year GAVI FPP, CDS, and WB grant budget plan was prepared.

- **Guidelines and manuals:** The COVID 19 national deployment and vaccination plan (NDVP), vaccination training guidelines and IPV training guidelines were revised. The catch-up vaccinations guideline has also been finalized and endorsed. Drafts are prepared for “Accelerated plan to address zero-dose children” and “COVID-19 vaccination integration guide”.

Challenges of immunization program

- Conflict-related disruption of immunization service in different parts of the country
- Huge data discrepancy between the administrative report and other surveys and estimations. Different surveys shows the presence of a high number of zero-dose children that need basic vaccines
- Vaccine and supply distribution delays and shortages in some areas
- Frequent Measles outbreaks
- Delay in financial liquidation

Way forward for next year

- Address zero-dose and under-vaccinated children through implementation of an accelerated catch-up vaccination program, restore essential services, and strengthen the routine immunization system

- Integrate COVID-19 vaccination into routine immunization and other primary healthcare services, ensuring comprehensive coverage

- Introduce the second dose of inactivated polio vaccine (IPV2) to the routine immunization program
- Rota vaccine switch(ROTARIX to Rotalsil)
- Conduct Multi Age Cohort (MAC) HPV vaccination for 9-14 years of adolescent girls.
- Continuously evaluate the immunization program for ongoing improvement and prioritize a data validation and quality improvement initiatives to rectify substantial data discrepancies
- Enhance leadership, management, and coordination for immunization at the sub-national levels to ensure timely budget Liquidation and effective implementation of the program

3.4.2. Newborn and child health services

Ethiopia's newborn and child health initiatives include a comprehensive array of programs designed to enhance the health and well-being of its youngest citizens. These initiatives include newborn health packages, which prioritize critical interventions for newborn survival, Newborn Care Corners addressing key causes of neonatal mortality, and Neonatal Intensive Care Units (NICUs) at various healthcare levels. Additionally, Integrated Management of Newborn Child Illnesses (IMNCI) offers integrated care, while Integrated Community Case Management of newborn and childhood illness (ICMNCI) extends treatment to children by community health workers. The country also emphasizes Early Childhood Development (ECD) to ensure children grow in nurturing environments, integrating nurturing care interventions across health programs and other sectors. These initiatives collectively promote child survival, maternal health, and early childhood development throughout Ethiopia.

This section outlines the performances of various essential newborn and child health related interventions.

Treatment of newborn and childhood illnesses

Treating newborn and childhood illnesses is crucial for several reasons: it saves lives, reduces child mortality, prevents disease transmission, fosters healthy growth, and supports families. Timely treatment speeds up recovery, minimizes discomfort, and prevents complications. Major newborn and childhood illnesses include Pneumonia, Diarrhea, prematurity, and birth asphyxia. In the past year, over 3.1 million under-5 children were treated for pneumonia, covering 78% of expected cases. Over the last five years, there has been a consistent annual increase in pneumonia treatment, indicating positive progress. In contrast, diarrhea treatment with zinc and ORS has shown a notable increase in cases treated in 2015 EFY, diverging from the previous four years.

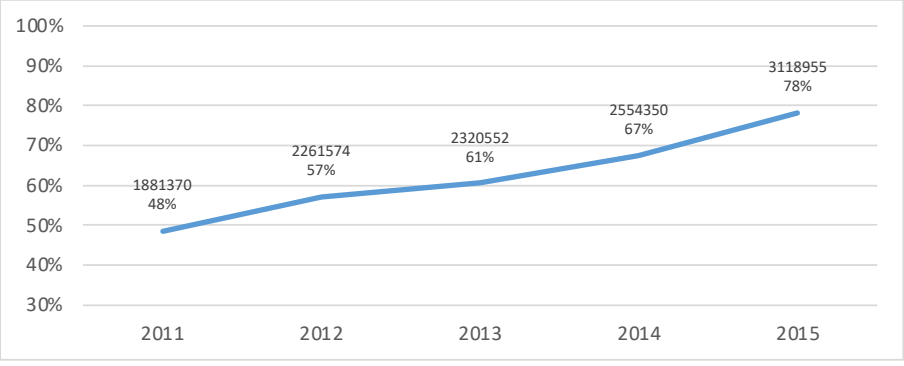


Figure 24: Number and proportion of under 5 years children treated for pneumonia, 2011 EFY to 2015 EFY

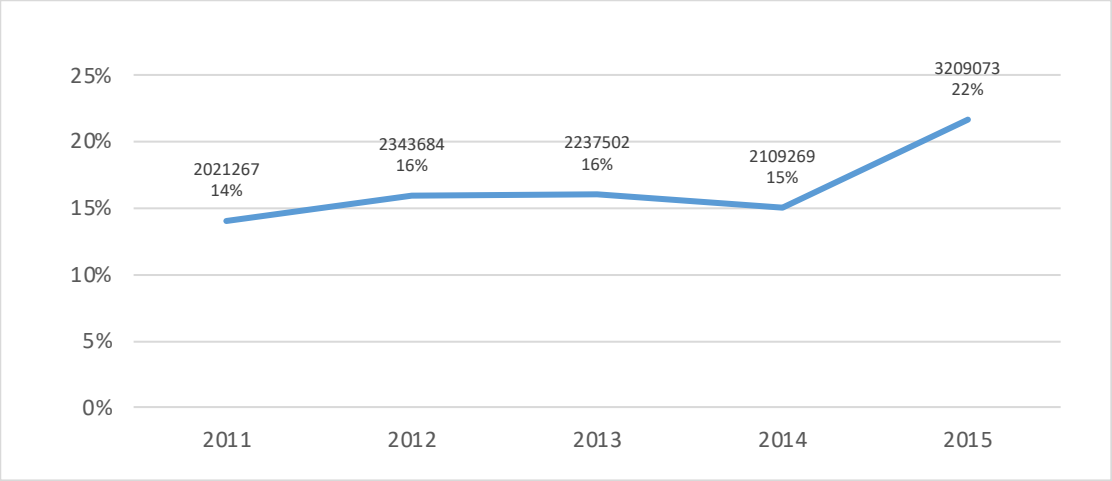


Figure 25: Number and proportion of under 5 years children treated for diarrhea, 2011 EFY to 2015 EFY

Out of 57,331 neonates who experienced asphyxia and received resuscitation, 47,561 of them survived, which accounts for 83%. This marks a one percent-point improvement compared to the previous fiscal year. However, it's worth noting that despite this positive performance, it falls short of the annual target of 90%. Among the 39,763 reported cases of underweight (< 2000 grams) or premature infants, 70% received Kangaroo Mother Care (KMC). A KMC technical and implementation guideline was developed and launched; and orientation was provided to 25 experts and instructors from health science colleges.

Integrated community-based management of newborn and childhood illnesses (ICMNCI): In the fiscal year, more than 90% of health posts offer ICMNCI services. ICMNCI service at health posts was strengthened through various important efforts in the fiscal year. The following are the major efforts exerted:

- Conducted a two-day workshop addressing utilization gaps for commodities like Amoxicillin DT, chlorohexidine, Zink-ORS co-pack, and IPLS.
- Provided performance reviews, mentorship, and open house training to 57 health workers from low-performing districts.
- Provided training on the revised ICMNCI to 47 health workers in the Somali region.
- Printed and distributed 1,180 ICMNCI chart booklets and 3,820 INMNCI Registration booklets.
- During the measles vaccination campaign, identified and connected 342 clubfoot cases in children under five (302 below 2 years old and 30 above 2 years old) to medical care centers.

Table 5: Percentage of health posts providing ICMNCI service in 2015 EFY

Region	Proportion of health posts providing ICMNCI service
Tigray	
Afar	57.8%
Amhara	90.0%
Oromia	83.4%
Somali	74.3%
BG	100 %
SNNP	96.5%
Sidama	98.3%
SWE	100 %
Gambella	94.4%
Harari	100 %
Dire Dawa	100 %
Addis Ababa	NA
National	90.4%

Integrated Management of Newborn and Childhood Illness (IMNCI): Integrated Management of Newborn and Childhood Illness (IMNCI) is a comprehensive child health approach that manages common childhood illnesses, especially in newborns and young children. It provides a holistic framework for recognizing, classifying, and managing illnesses to minimize child mortality and enhance child health. Nationally, 93.2% of health centers offer IMNCI in 2015 EFY. All regions except Somali (58.06%) and Afar (70.3%) have good IMNCI service coverage. In the fiscal year, the following important actions were taken to strengthen IMNCI service.

- IMNCI pre-service post-training follow-up and integrated supportive supervision were conducted in 24 health science colleges
- Distributed 1429 IMNCI chart booklets and 1585 registration books
- Developed and launched KMC Technical and Implementation Guideline
- Provided orientation for 25 health sciences college teachers and Regional Neonatal and Child Health specialists on KMC Technical and Implementation Guideline.

Table 6: Percentage (%) of health centers providing IMNCI service in 2015 EFY

Region	Proportion of HCs providing IMNCI service
Tigray	
Afar	70.3%
Amhara	97.9%
Oromia	100%
Somali	58.1%
Benishangul Gumz	100%
SNNP	100%
Sidama	97.8%
Southwest Ethiopia	100%
Gambella	100%
Harari	100%
Dire Dawa	93.8%
Addis Ababa	100%
National	93.2%

Neonatal Intensive Care Unit (NICU) and Essential Newborn care (ENBC) service

In the fiscal year a total of 146,256 neonates were reported as discharged from NICU, among which 80% of them were recovered and 9% were died. A total of 222 hospitals provides NICU services as depicted in the table below across different regions of the country. To strengthen the NICU and ENBC services in the hospitals, different activities were performed in the fiscal year.

- Integrated NICU mentorship, including ENC, was provided to 19 hospitals with a high rate of neonatal mortality.
- Provided basic NICU training to 12 health care professionals operating in 12 hospitals located in pastoralist regions.
- Integrated clinical mentoring was conducted on NICU, KMC, ENC, and labor and Delivery facilities in 127 Hospitals identified as saving little lives project (SLL) implementation sites.
- Distributed 80 oxygen concentrators, 100 radiant warmers, and 30 phototherapy devices to health facilities in need.
- Different consultative workshops were held on Building consensus and advocating at a high level for the 80 Hospital NICU investment, Caffeine citrate use for apnea of prematurity, and local availability of NICU medical equipment spare parts.
- Developed a three-year plan for every newborn action plan (ENAP) and ending preventable maternal mortality (EPMM) and shared it with global communities

Table 7: Number of Hospital providing NICU services in 2015 EFY

Region	Number of hospitals with NICU service
Tigray	
Afar	6
Amhara	55
Oromia	60
Somali	9
BG	5
SNNP	45
Sidama	19
SWE	9
Gambella	4
Harari	2
Dire Dawa	2
Addis Ababa	6
National	222

Early Childhood Development (ECD) Intervention

The Ministry of Health (MOH) initiated child development assessment and monitoring based on the five years strategic plan (2020/21 – 2024/25) of early childhood development. The health sector has been implementing various activities on ECD in 2015 EFY. The following are the main activities accomplished.

- Delivered Training of Trainer (TOT) sessions on ECD to 105 healthcare professionals and regional experts
- Revised the ECD policy framework, in collaboration with the Ministry of Labor and Skills (MoLS), Ministry of Women and Social Affairs (MoWSA), and Ministry of Education (MoE), receiving official endorsement
- Conducted Joint and Program- focused supportive supervision visits to ECD-implementation health facilities in Addis Ababa, conflicts-affected areas of the Amhara and Oromia regions

Challenges (newborn and child health program)

- Delayed healthcare seeking behavior and delayed presentation to services
- Insufficient budget allocation for Newborn and Child health programs, coupled with delays in releasing SDG budget.
- Shortage of medical supplies, medications, and essential consumables
- Lack of NICU medical equipment spare parts within the country
- Limited number of trained healthcare personnel capable of providing quality NICU and ENC (Essential Newborn Care) services
- Shortage of updated IMNCI/ICMNCI printed materials, including registers and chart booklets

Way forward for next year

- Conduct refresher training on ICMNCI for HEWs and other health workers
- Enhance integrated clinical mentorship for NICU and ENC
- Provide need-based training for NICU, ENC, and IMNCI
- Develop a national integrated training manual for Kangaroo Mother Care (KMC)
- Expand access to ICMNCI services in the Somali region
- Strengthen the implementation of Performance Review and Clinical Mentorship Meetings (PRCMM) and Health Post (HP) open house sessions at primary healthcare units
- Ensure the availability of necessary medical equipment, medicines, and consumables
- Promote the generation of new evidence for informed health decision-making
- Support regions in conducting cascading training on ECD and conduct ToT sessions
- Guarantee the availability of essential drugs at all levels

3.4.3. Adolescent and youth health services

Adolescent and Youth Health Services are primarily designed to serve individuals aged 10 to 24, covering both adolescents (10-19) and young adults (20-24). This period is pivotal for establishing the groundwork for a thriving and robust adulthood, underscoring the importance of furnishing suitable assistance and resources to ensure the well-being of individuals and society at large. The health sector of Ethiopia has recognized the importance of addressing the specific needs of the youth and has initiated youth-friendly services, albeit with notable challenges. The number of facilities providing youth friendly services (YFS) has been increasing over the past few years, but coverage of youth friendly services varies across regions. Regions such as Oromia, Amhara, SNNP and Addis Ababa have higher coverage of facilities with YFS having youth friendly services. The following major activities were done in the fiscal year.

- A Five-year Adolescent & Youth Health Standards, Implementation Guidelines & Minimum Service Delivery Package (2021-2025) has been finalized and launched
- **Document preparation**: The adolescent and youth training material was revised, and the Ethiopian Adolescent and Youth Health Council document was developed
- **Capacity building**: Adolescent and youth health related TOT, basic and refresher training were given to new health facilities and started to provide YFS service. Training was provided for 56 hotline counselors of MOH, for 98 healthcare providers working at delivery units, 20 health workers working in humanitarian setting, refresher training to more than 200 health workers and health providers working at industrial parks were trained
- RISE program acceleration plan was implemented in RISE implementation Woredas to reach clients who were deprived due to COVID-19 pandemic and conflict and more than 100 thousand married adolescents reached with smart start counseling approach and adopted FP method. The service uptake at RISE implementing sites is maintained with a steady increment after the acceleration plan. As of June 2023, more than half a million married adolescents were identified

and reached for the counselling approach and more than a quarter of a million (253490) of them used modern FP option.

- The Smart Start Counselling approach of married adolescents is integrated into the routine health service delivery system by including into national strategic documents and training materials.
- The Pastoralist version of 'Smart Start' i.e. Family Circle approach which gives due emphasis for health during counselling the married couples is being implemented in Afar and Somali regions
- The third Annual National Adolescent and Youth Forum was conducted under the theme "Bridging the Gap: integrating adolescents and youth health issues in emergency settings". It was conducted in the presence of Ministers, UN agency higher officials and relevant stakeholders, and a significant number of adolescents and youths were represented both in person and virtually
- Advocacy events on child marriage, teenage pregnancy and adolescent and youth health service access and utilization were conducted for school community members, parliamentarians, political, community, religious leaders and different community members at national and regional level.
- A review meeting and integrated supportive supervision on the implementation of the Youth and Adolescent Health Program was held
- An experience sharing event on youth friendly health service provision and nutrition interventions has been conducted at Wolayta region in the presence of regional AYH, FP and nutrition focal points

Challenges (adolescent and youth health program)

- Lack of comprehensive youth-friendly service for AYH
- Conflict, drought, and the pandemic challenged service provision

Way Forward

- Working towards HEP optimization to benefiting the AYH program at the PHCUs
- Strengthen collaboration among stakeholders to reduce teenage pregnancy in all regions
- Scaling up RISE within RISE implementation regions and non-RISE implementing regions
- Enhance conducive environment for adolescent and youth to access quality health-education and information through implementation of the AYH quality standards
- Increase the number of facilities providing youth friendly health service
- Strengthening and supporting youth and adolescent health services in industrial parks and development corridors
- Conduct the national AYH annual forum in collaboration with sectors, partners, youth led organization and young people themselves ensuring meaningful youth engagement

3.5. Nutrition Program

The government of Ethiopia recognizes attaining food and nutrition security is a constitutional and human right of Ethiopians and is working towards ensuring its citizens to be food and nutrition secure. Despite the socio-economic progresses over the past decades, Ethiopia is still facing a triple burden of malnutrition: under nutrition, micro-nutrient deficiencies and rapid rise in overweight, obesity and non-communicable diseases. Malnutrition is the underlying cause of 51% of child mortality.

In order to speed up the overall economic development, the government has approved Food and Nutrition Policy in 2018 and endorsed the 10 years Food and Nutrition Strategy and the Seqota Declaration Expansion Phase Road Map in 2021 to deliver high impact, cost-effective and sustainable nutrition specific, nutrition sensitive and nutrition smart and climate proof infrastructure interventions.

In the past two decades the prevalence of stunting has decreased from 58% to 39% between 2000 and 2023, which is high compared to the HSTP and GHA target. In the same period, the proportion of underweight children declined from 41% to 22% and wasting decreased only from 12% to 11% (EPHI 2023). The current 39% prevalence of stunting shows that there are over 6 million stunted children and over a million cases of acutely malnourished children in Ethiopia. Even though malnutrition has decreased over time in Ethiopia, the problem is still high calling for a strengthened food and nutrition actions. The national food and nutrition strategy outlines the importance of multi-sectoral response and multi-sectoral approach to implement nutrition specific and sensitive interventions to improve nutrition status.

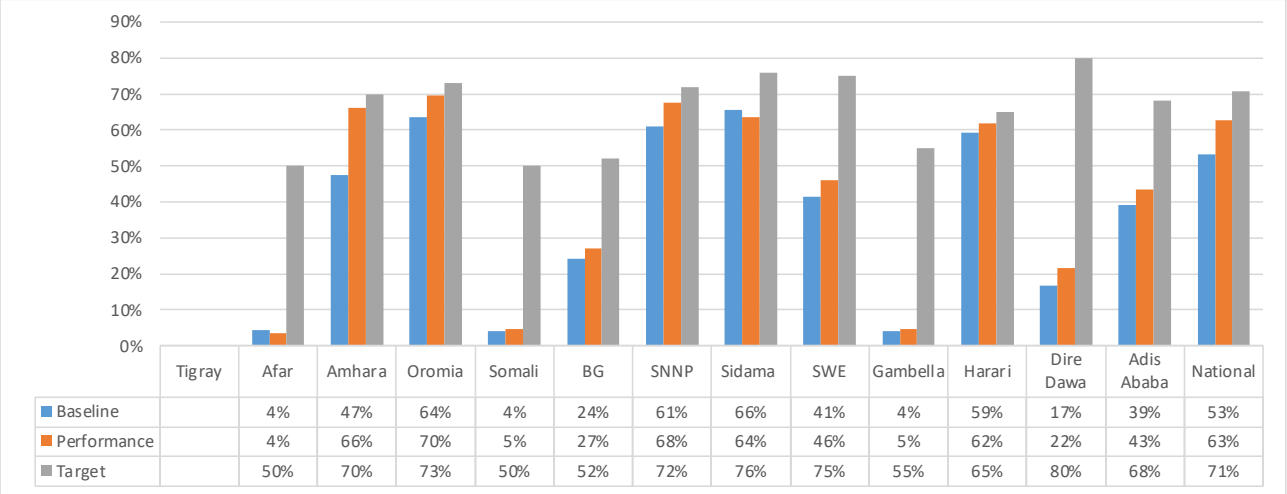
In 2015 EFY, to better address nutrition problem in the country, the ministry of health has established a nutrition coordination office restructured into three desk offices: Developmental Nutrition, Management of Acute Malnutrition, and Multi-sectoral and Seqota Declaration.

In this section, nutrition-specific, multi-sectoral and Seqota declaration related interventions and activities are discussed. In addition, major challenges during the fiscal year and priorities for the next fiscal year are outlines.

3.5.1. Growth Monitoring and Promotion

Evidences showed that Growth monitoring and promotion (GMP), as part of a package of nutrition and health programs, brought positive impacts on child growth outcomes. GMP is a prevention activity and is based on growth monitoring of children, especially children under 2 years of age. It primary focuses on monthly measurement of weight on children under 2 because early identification of malnutrition in children under 2 years of age can be reversible with appropriate nutritional interventions. GMP deals with the total environment of the growing child, encompassing not only food but health, physical environment, psychosocial development, and intellectual stimulation. GMP uses regular community dialogue to engage community members to assess the overall nutritional status of children in their community, to understand the barriers and potential supports for improved nutrition, and to develop consensus on plans of action to make a difference. It is one of the nutritional interventions implemented in Ethiopia, mainly at community level by health Extension Workers, and at facility level as well. GMP revitalization is being undertaken to increase the quality-of-service delivery and promote use of GMP as a multi-sectoral performance scorecard.

In 2015 EFY, more than 3.2 million (63%) of children under 2 years of age have received growth monitoring and promotion service. This performance is higher than the baseline (53%) but lower than the target (the plan was 71%) for the year. The performance was too low in Afar (4%), Somali (5%), Gambella (5%) and Dire Dawa (22%).

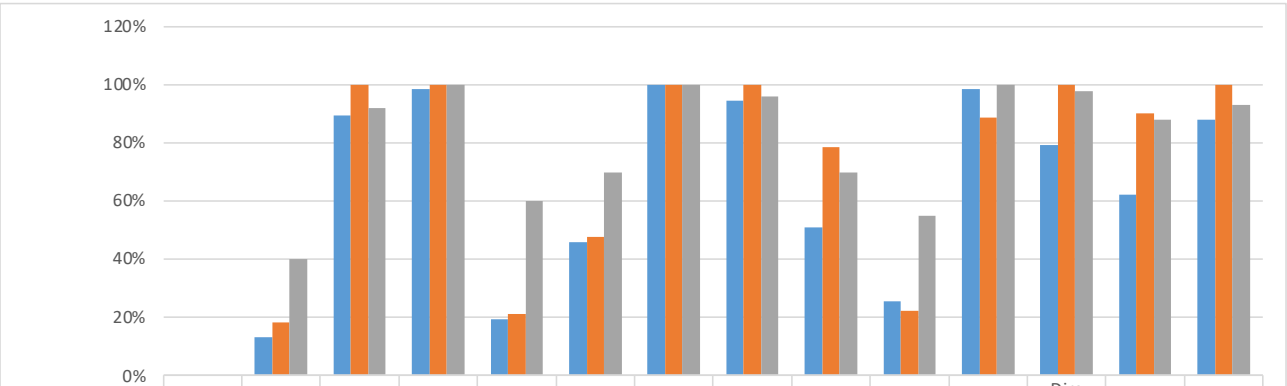


	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	Dire Dawa	Adis Ababa	National
Baseline		4%	47%	64%	4%	24%	61%	66%	41%	4%	59%	17%	39%	53%
Performance		4%	66%	70%	5%	27%	68%	64%	46%	5%	62%	22%	43%	63%
Target		50%	70%	73%	50%	52%	72%	76%	75%	55%	65%	80%	68%	71%

Figure 26: Proportion of children under 2 years of age that received GMP service, 2015 EFY

3.5.2. Deworming service

Deworming service is provided for children aged 24-59 months, twice a year for the prevention and control of intestinal parasites. In 2015 EFY, more than 10.6 million (more than 100%) children aged 24-59 months received deworming twice a year. The performance is more gthan the baseline and the target for the year. Most regions have a coverage more than 100% (Oromia, SNNP, Sidama, and Dire Dawa) but deworming service is low in Afar (18%), Somali (21%), Gambella (22%) and BG (48%).



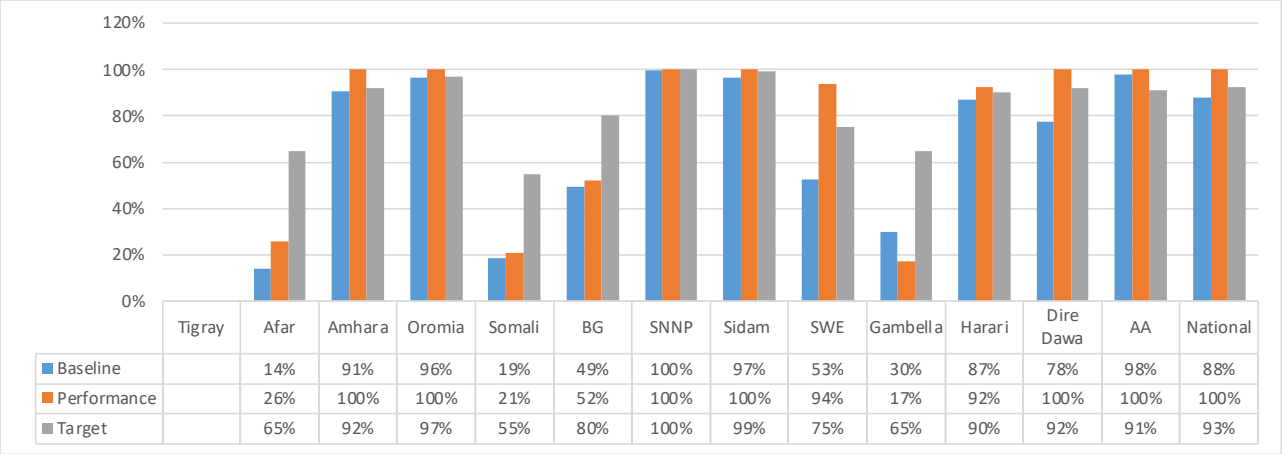
	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline		13%	89%	99%	19%	46%	100%	95%	51%	25%	99%	79%	62%	88%
Performance		18%	100%	100%	21%	48%	100%	100%	78%	22%	89%	100%	90%	100%
Target		40%	92%	100%	60%	70%	100%	96%	70%	55%	100%	98%	88%	93%

Figure 27: Proportion of Children aged 24 - 59 months de-wormed twice a year, 2015 EFY

3.5.3. Vitamin A Supplementation

Biannual supplementation of Vitamin A to children aged 6-23 months of age is a key nutrition intervention to eliminate Vitamin A deficiency and its consequences in children. In 2015 EFY, more than 15.9 million children aged 6-59 months have received two doses of vitamin A supplementation. The performance is higher than the baseline and the target for the fiscal year.

Vitamin A supplementation is high in all regions except for Afar (26$), Somali (21%), BG (52%) and Gambella (17%).



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidam	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline		14%	91%	96%	19%	49%	100%	97%	53%	30%	87%	78%	98%	88%
Performance		26%	100%	100%	21%	52%	100%	100%	94%	17%	92%	100%	100%	100%
Target		65%	92%	97%	55%	80%	100%	99%	75%	65%	90%	92%	91%	93%

Figure 28: Proportion of children aged 6-59 months of age who received two doses of Vitamin A supplementation, 2015 EFY

3.5.4. Screening for nutritional status

Screening of pregnant and lactating women (PLWs); and screening of under 5 children for nutritional status and providing the appropriate nutrition counseling and services reduces adverse malnutrition related health effects on the mother, infants and children. Accordingly, screening of PLWs and under 5 children was conducted and interventions provided accordingly.

In the fiscal year, more than 1.8 million PLW (54%) were screened for malnutrition. The lowest proportion of PLWs screened was in Dire dawa (8%) and Gambella &10%), Addis Ababa (15%) and Afar (20%). The performance in other regions wass: SWE (23%), Somali (24%), BG (26%), Harari (29%), Amhara (45%), Amhara (45%), Sidama (57%), SNNP (58%), and Oromia (69%).

More than 8.45 million under 5 children were screened for malnutrition. Among those who were screened for malnutrition, 6% had moderate malnutrition and 0.7% had severe acute malnutrition (SAM). The highest SAM was recorded in Somali region (11.6%), followed by Afar (8.7%), Gambella (2.8%), Dire Dawa (2.6%) and Harari (1.4%). The proportion of SAM among screened in other regions was lower than 1%. It was 0.7% in Amhara and Sidama, 0.6% in BG, Oromia SWE and SNNP, and 0.5% in Addis Ababa.

3.5.5. Developmental Nutrition

- **Guidelines Development**: operational and implementation guidelines are developed to support frontline workers to operationalize adolescent, maternal, infant, young child nutrition and disseminated to Oromia, Amhara, SNNPR, Somali, Afar regions
- **Strengthened integration of nutrition services with MCH services**: IFA supplementation, and under five & PLW Screening was integrated with measles campaign to improve the uptake of these services, addressing over 15 million children
- **World breastfeeding week**: World Breastfeeding Week was celebrated through various activities at national and regional levels, at which time SBCC materials were prepared and distributed; media orientation was held and different awareness creation activities were performed

3.5.6. Management of Acute Malnutrition

- **Family MUAC**: Implementation research on family MUAC is being piloted in the Amhara and Somali regions, for which technical support was provided
- **Nutrition Centric Humanitarian Development and Peace Nexus**: To create resilience among households and sustainably prevent acute prevention, avoid relapse and leverage resources among the emergency and development stakeholders, the government of Ethiopia has started new initiatives such as the "Global action plan on the child wasting initiative" and development of roadmap and operational guideline for Nutrition Centric Humanitarian Development and Peace Nexus
- **SC Opening Kit**: Identified 1819 SC and 2323 OTP service providing health facilities from 11 regions and 200 SC opening kit distributed for facilities not providing SC service
- **Food for Caretakers**: Food for caretaker guideline is finalized to facilitate provision of food for mother or caretakers of children during their stay in health facilities at stabilization centers
- **Capacity-building**: Capacity building trainings including TOT on guidelines of acute malnutrition management for 60 health workers, TOT on guidelines of outpatient therapeutic program (OTP) for 30 health workers

3.5.7. Seqota Declaration (SD) expansion phase

This fiscal year (2015 EFY) was the second year of Seqota Declaration expansion phase, during which the government of Ethiopia has sustained its commitment by allocating about 12 million USD for costed Woreda based implementation in the 240 expansion phase woredas and this treasury budget transferred for the regions.

Technical and financial support was provided to effectively implement the expansion phase of Seqota Declaration in 240 Woredas. Initially, at the beginning of the fiscal year, 214 woredas participated in the costed woreda based planning and the budget allocated from the federal government was transferred to implement the costed woreda based plans in these Woredas. Later after peace prevailed in Tigray region, additional 26 Woredas in Tigray developed a costed plan where emergency and recovery activities were implemented. Therefore, at the end of 2015 EFY, 240 Woredas have prepared costed Woreda based plan and implementation of SD activities was started. The following major activities were implemented in the fiscal year.

- **Advancing the African Year of Food and Nutrition Security Agenda:** to reaffirm the stakeholder's commitment and show case Seqota Declaration, the government of Ethiopia has conducted the AUC Year of Nutrition national launching. A virtual and face to face event was held where Seqota Declaration was presented as a show case. The Government of Ethiopia (GoE) and development partners demonstrated their commitment for food and nutrition, Seqota Declaration and the Ethiopian Food system. In addition, the GoE has taken part in the technical meetings Africa Year of Nutrition and Food Security and the Africa Day of Food and Nutrition Security. The GoE has also conducted a high-level side event at the Africa Union Commission with the theme of South-to-South Dialogue to exchange learning among five exemplar Africa Union Member countries namely Nigeria, Malawi, and Senegal.

- **Scaling up nutrition**: Sustaining the government and development partners' commitment to Scaling up Nutrition (SUN) Movement was one of the focus areas during the fiscal year. The government of Ethiopia has six active scaling up nutrition networks namely government, Ethiopian Civil Society, donors, academia, business and UN nutrition. The networks, under the leadership of SUN-Multi-Stakeholder Platform (SUN-MSP) with the leadership of Ministry of Health, has conducted the 2022 Joint Annual Assessment and submitted to the SUN secretariat at the United Nations.

- **Sensitization and advocacy to member of Parliamentarians**: - to create awareness on micro-nutrient deficiency and secure support, MOH has conducted sensitization and advocacy event to the Members of Parliaments in Addis Ababa.

- **Multi-sectoral approach for stunting reduction project (MASReP)**: This is a four-year project with a total cost of USD 48.17 million, financed by African development Bank, and was designed to contribute to the realization of the Seqota Declaration (SD) commitment. It is implementing a package of nutrition specific and nutrition sensitive, climate smart infrastructures (health, agriculture, water supply and education) projects in 27 SD woredas in Amhara and Tigray regions. In 2015 fiscal year the following major intervention coordinated and supported through MASReP:

    - Contract agreements are signed for nine community water supply subprojects, 19 small scale irrigation subprojects, 7 health posts, 4 model school feeding structures, and 5 farmer training centers (nutrition demonstration corners).

    - As part of livelihood support and promotion of nutritious food, a total of 28,656 chicken was purchased and distributed to 2,388 vulnerable pregnant and lactating women (PLW), and 9,392 dairy goats purchased and distributed to 1,563 vulnerable PLW

    - 48 fish faring ponds excavated and 32 of them lined with geo membrane and water filling conducted and 100 small water filtration bottles distributed to 100 PLWs.

    - Various items of 1,502 farm tools and 181 kg vegetable seed distributed to 54 schools, and nutrition training was provided to 334 school health and nutrition club members from 54 schools

    - Small farm tools and seeds /seedlings of nutritious dense crops distributed to 2013 and 6034 PLWs respectively.

- **Capacity building to advance use of proven Seqota Declaration Innovations**: as part of the expansion phase of SD implementation, scale up of proven innovations is being undertaken. These includes the costed Woreda based planning, Unified Nutrition Information System for Ethiopia (UNISE), Community Lab, Resource Tracking and Partnership Management, and Triangle of Knowledge Partnership.

    - Implementation of UNISE was expanded to 67 Woredas (Oromia (23), Amhara (21), SNNP (5), Sidama (10), Afar (4), and Somali (4)

    - National community lab TOT training was provided for participants from 9 regions and One City administrations and roll-out community lab training was conducted in 7 regions

    - The first 1000 days plus public movement for SBC guideline prepared, endorsed and shared to all federal and regional FNS implementing sectors. Different advocacy packages prepared and disseminated for different target audience with different platforms (annual FNS & SD review meeting, global hunger index Ethiopian report launching, SUN general assembly, health exhibition with booze, Nutrition service delivery TV spots, parliamentarian's advocacy tools etc.)

    - A program - University knowledge sharing linkage was established; Evidence based nutrition financing and partnership planning workshops were conducted with participation of nearby universities in SNNP, Amhara, DD, Harari and Oromia regions.

3.5.8. Multi-sectoral Food and Nutrition Strategy (FNS) implementation

- **Multi-sectoral Coordination and Governance**

Malnutrition is caused by a variety of factors, necessitating a variety of solutions and actors. As a result, multisectoral coordination and linkages are being tested and are a globally accepted solution to the problem. This coordination platform has been established, and actors are attempting to collaborate on a global scale.

Following the development and implementation of the National Nutrition Strategy and Program in 2008, structured and formal coordination platforms were established and implemented in Ethiopia. The recently endorsed food and nutrition policy strategy, Seqota declaration road map and SD expansion phase plan, and other national food and nutrition related documents are developed and implemented using multi-sectoral coordination and linkages concepts.

Food and nutrition coordination body was established in 81% of regions, 100% of Zones, and 77% of Woredas, In addition, food and nutrition technical team is established in all region, zone, 77% Woredas and 64% kebeles.

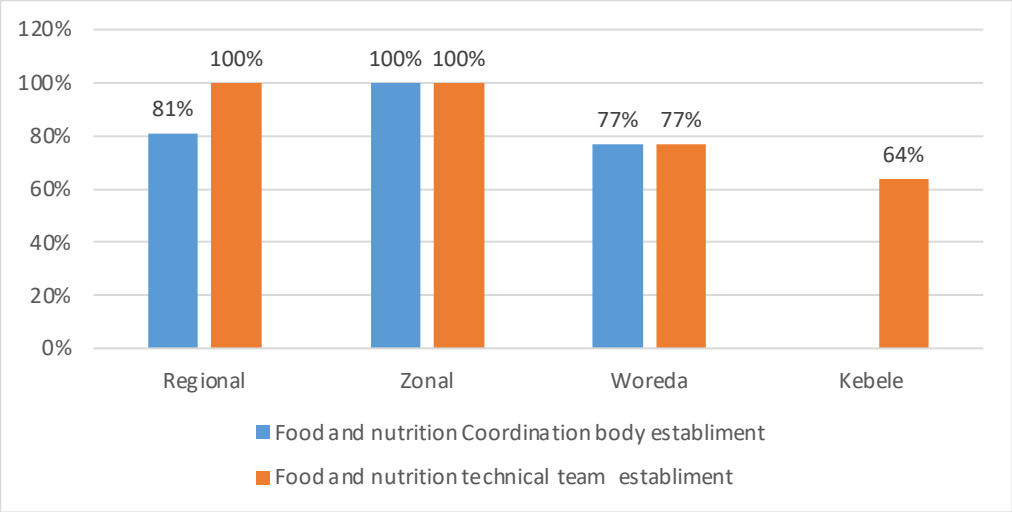


Figure 29: Proportion of administrative units that established food and nutrition coordination body and technical team

In 2015 EFY, the 14 food and nutrition implementing sectors have undertaken various activities including production, consumption and promotion of diversified nutrient dense foods, school feeding, water supply, women empowerment, income generation, food safety and quality and food fortification. In the fiscal year, Food System and Nutrition coordination platforms were established in 8 regions and 2 city administrations. In addition, the regional food and nutrition strategy launching was undertaken at regional level; and the food and nutrition strategy baseline survey has been finalized and disseminated.

- **Endorsement of the Food System and Nutrition governance**: to strengthen the multi-sectoral coordination at national level, an inter-ministerial food system and nutrition steering committee was established. The committee, co-chaired by Ministry of Health (MOH) and Ministry of Agriculture (MOA), is composed of members of the 14 food and nutrition, Seqota Declaration and Food system transformation implementing sectors. The food system and nutrition inter-ministerial steering committee is established to provide high level leadership and guidance for implementation of the food and nutrition strategy, the Seqota Declaration and food system transformation roadmap

- **Operationalizing Food System Transformation roadmap**: among the 22 game changing solutions, advancing the implementation of food consumption, promote nutrition literacy, facilitate the implementation of the food based dietary guideline as well as sustain the implementation of the Seqota Declaration are being implemented

- **Climate Change Actions for Nutrition:** MOH has prepared a position paper on climate action for nutrition. This document has been submitted as part of the country preparation for the COP27 where MOH has taken part during COP27. In addition, the ministry is actively taking part in the second phase of tree planting where nutrient dense trees were planted

- **Participation in experience learning and show casing of food and nutrition programs at various platforms**: the ministry has been actively taking part to show case the Ethiopian food and nutrition work using national and global platforms. This includes the food security exhibition which ATI has organized, the national Health Exhibition, the Africa High Level Dialogue on Year of Nutrition and Food Security held in Abidjan, Africa Dialogue Webinar, the high-level AUC side event which was held on the side of the 36th Heads of States Summit.

- **Procured and distributed KIO3 for salt manufacturers**:- 13 iodized salt manufacturers received 532 Quintals of KOI3 worth of over 64 Million Birr
- **Multi-sectoral Guideline development**: Finalized the revision of the multi-sectoral coordination and linkages guideline and Nutrition Leadership manual. The guideline and manuals are currently at the final stage for approval
- **Monitoring and Evaluation**: Multi-sectoral coordination and linkages Monitoring and Evaluation framework (M&E SOP) is developed for FNS and SD implementation. A joint supportive supervision on implementation of FNS was conducted by food and nutrition implementing sectors and partners. In addition, an annual review meeting on implementation of FNS was conducted.

Challenges

- Delayed FSNC Establishment, and unclear role and structure of Technical committee engagement
- Sub-optimal inter-sectoral and multi-sectoral collaboration among the different food and nutrition implementing sectors
- High disparity in the performance of nutrition interventions among regions, with a very low performance in pastoralist areas
- Shortage of nutrition supplies, interruptions and misuse of supplies
- Inadequate regional commitment and support for FNS and SD implementation
- Inadequate budget allocation for FNS and SD implementations from the government treasury at national and regional
- Delayed request, utilization and liquidation of the SD budget from regions and sectors
- Low awareness on healthy diet, poor implementation of adolescent's nutrition program
- Inadequate FN structure at national and regional levels

Way forward for next year

- Strengthening governance platforms for FNC, SD implementation and strengthening multi-sectoral coordination and linkages among actors
- Dissemination and advocacy of FNS and SD implementation guidelines
- Provide capacity building to the leadership and health workers at all levels of the health system
- Conduct advocacy and sensitization on linkage between nutrition and communicable/non-communicable diseases
- Improve access to and utilization of nutrition sensitive and nutrition sensitive interventions at health facility and community levels
- Conduct timely forecasting, procurement and distribution of nutrition supplies
- Mobilize adequate resource, mainly from domestic financing sources
- Strengthen nutrition emergency preparedness and response; mobilize resources to support the government effort humanitarian response and building a resilient system that operationalize nutrition centric humanitarian and development nexus

- Mobilize resources to expand food-based approaches for micronutrient deficiency and to develop a framework for establishment of a resilient food and nutrition service delivery

3.6. HIV prevention and Control

In Ethiopia, according to the National HIV Related Estimates and Projections (2022-2023), the national adult (age 15+) HIV prevalence in 2022 is estimated to be 0.91%, with a regional variation in prevalence ranging from 0.18% in Somali region to 3.69% in Gambella region. The national HIV estimate shows that there are estimated 610, 350 PLHIVs, among which 573,538 (94%) are adults >=15 years and 36,812 (6%) are children less than 15 years of age. The estimation also shows that there were about 8,257 new infections and 11,322 estimated deaths in 2022.

The health sector has restructured the organizational structure of MOH in 2015 EFY. Following this restructuring, HIV/AIDS Prevention and Control Lead Executive Office (HAPC LEO) was established to lead initiatives related to HIV prevention and control activities at national level. The HAPC LEO coordinates three major components, namely; 1) HIV prevention, STI and PMTCT programs; 2) HIV/AIDS and viral hepatitis care and treatment programs; and 3) HIV/AIDS Multi-sectoral response coordination interventions.

In 2015 EFY, the health sector has been implementing various HIV prevention and control interventions through the coordination and leadership of HAPC LEO at national level. The major interventions include HIV testing and counselling services, PMTCT service, STI prevention and treatment, HIV/AIDS care and treatment interventions, TB/HIV collaborative interventions, pre-exposure and post-exposure prophylaxis services, multi-sectoral HIV/AIDS response interventions, hepatitis prevention and control, and other interventions. In this section, the major HIV prevention and control program activities, achievements and challenges in 2105 EFY (2022/2023) are described.

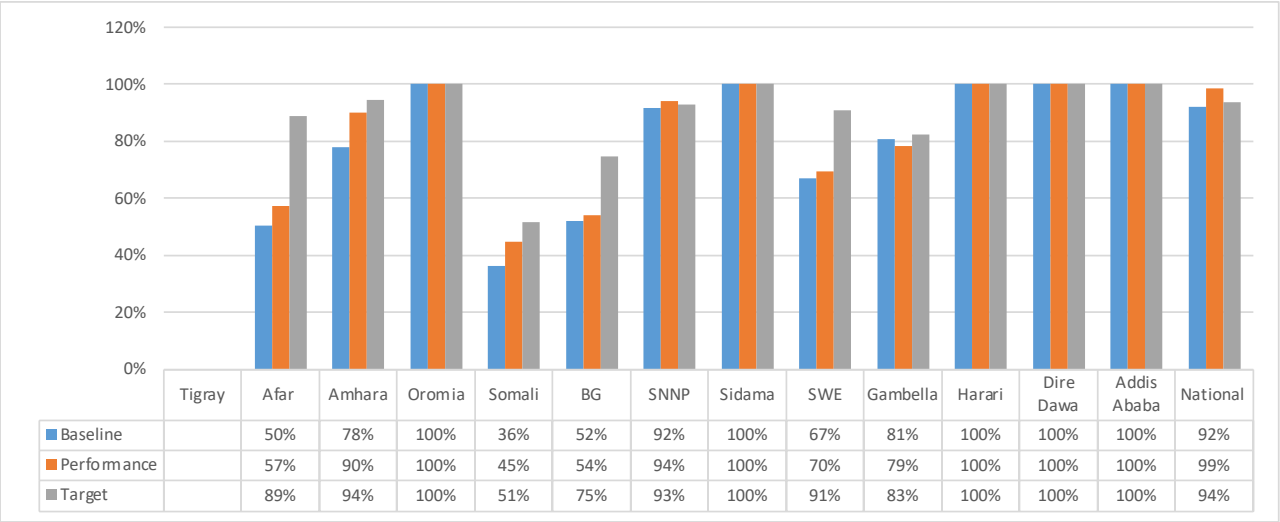
Note: Since there were no reports from Tigray region, the national performance report does not include Tigray

3.6.1. Prevention of mother to child transmission of HIV (PMTCT)

Testing for PMTCT

The health sector has endorsed and committed to achieving the Triple elimination of mother to child transmission of HIV, syphilis and hepatitis virus (HBV) by 2025 by implementing proactive measures including primary preventions, prevention of unintended pregnancies, and practicing safe pregnancy and delivery interventions, and administering prophylactic and/or therapeutic medications.

Testing pregnant and lactating women for HIV is the key entry point to PMTCT and other HIV care and treatment services. In 2015 EFY, more than 3.35 million (99%) pregnant and lactating women were tested for HIV and know their status. The majority of tests (76.2%) were done during pregnancy. This year's performance was higher than the baseline and the target for the fiscal year. PMTCT testing rate ranged from 45% in Somali, 54% in BG and 57% in Afar to 100% in Sidama, DD, Harari, Oromia and Addis Ababa.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline		50%	78%	100%	36%	52%	92%	100%	67%	81%	100%	100%	100%	92%
Performance		57%	90%	100%	45%	54%	94%	100%	70%	79%	100%	100%	100%	99%
Target		89%	94%	100%	51%	75%	93%	100%	91%	83%	100%	100%	100%	94%

Figure 30: Percentage of pregnant, laboring and lactating women who were tested for HIV and know their status, 2015 EFY

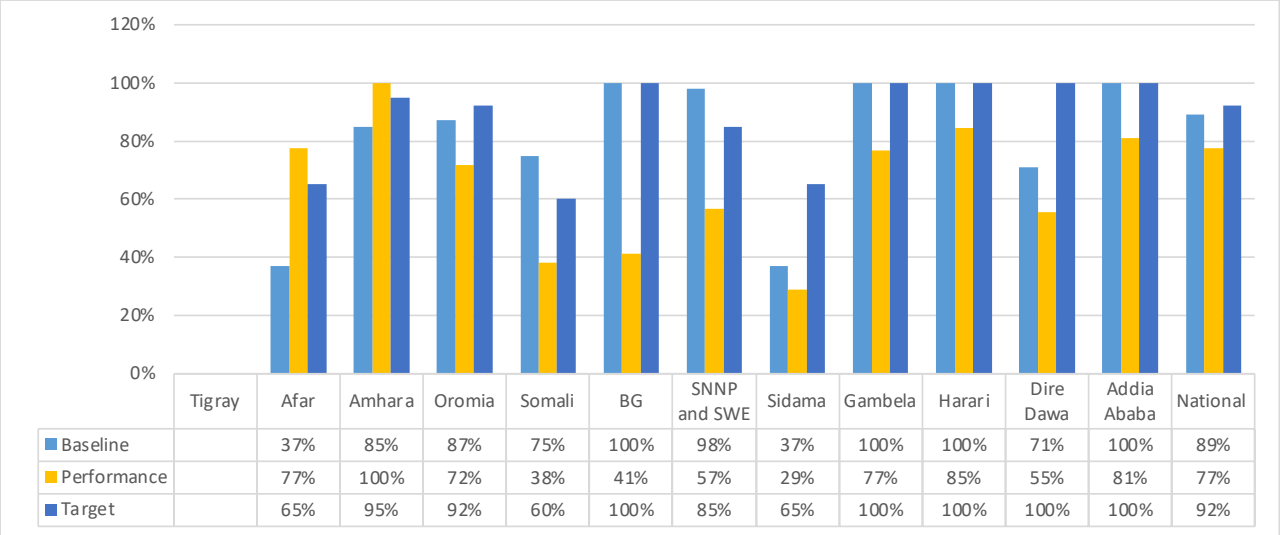
Regarding testing for HBV, more than 2.27 million (67%) pregnant women were tested for HBV. Among those tested for HBV, 20,868 (0.9%) were tested reactive for HBV

Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to child Transmission

According to the 2022-2023 HIV and related projections and estimates in Ethiopia, there are about 16,486 estimated number of HIV positive pregnant and lactating women who are in need of PMTCT service in 2022. The expected number of estimated PLHIVs needing PMTCT excluding Tigray region is 14,678. The performance is computed from the total estimates excluding Tigray region since there is no report from Tigray. Hence the analysis excludes expected positive pregnant from Tigray region.

In 2015 EFY, 11,359 (77%) HIV positive pregnant and lactating women were receiving ART. From the total positives, 7,376 (65%) were known HIV positives who were linked from ART to PMTCT, while 3,983 (35%) were newly identified positives during ANC, labor and Delivery and during the early PNC period. The performance in 2015 EFY is lower than the baseline by 12 percentage points and also lower than the target by 23 percentage points. There was a huge regional disparity in performance, ranging from 29% in Sidama to 100% in Amhara.

Note: SNNP and SWE regions are analyzed together since there is no estimation of PLHIVs separately for SWE in the 2022/23 HIV estimation and projection in Ethiopia



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP and SWE	Sidama	Gambela	Harari	Dire Dawa	Addia Ababa	National
Baseline		37%	85%	87%	75%	100%	98%	37%	100%	100%	71%	100%	89%
Performance		77%	100%	72%	38%	41%	57%	29%	77%	85%	55%	81%	77%
Target		65%	95%	92%	60%	100%	85%	65%	100%	100%	100%	100%	92%

Figure 31: Percentage of HIV positive pregnant and lactating women who received ART, 2015 EFY

Care for HIV exposed infants

ARV prophylaxis for HIV-exposed infants plays a critical role in efforts to eliminate new pediatric HIV infections and maximize HIV-free survival. All newborns who were exposed to HIV perinatally should receive postpartum antiretroviral (ARV) prophylaxis to reduce the risk of perinatal transmission of HIV.

In the fiscal year, a total of 7,969 (54%) of HIV exposed infants received ARV prophylaxis for 12 weeks. This year performance is higher than the base line by 7 percentage points (it was 47% in 2014 EFY) but lower than the 70% target for the year. The lowest performing regions are Somali (14%), Sidama (25%) and Afar (42%)> Amhara region has the highest performance (76%) followed by Addis Ababa (61%) and Dire Dawa (57%).

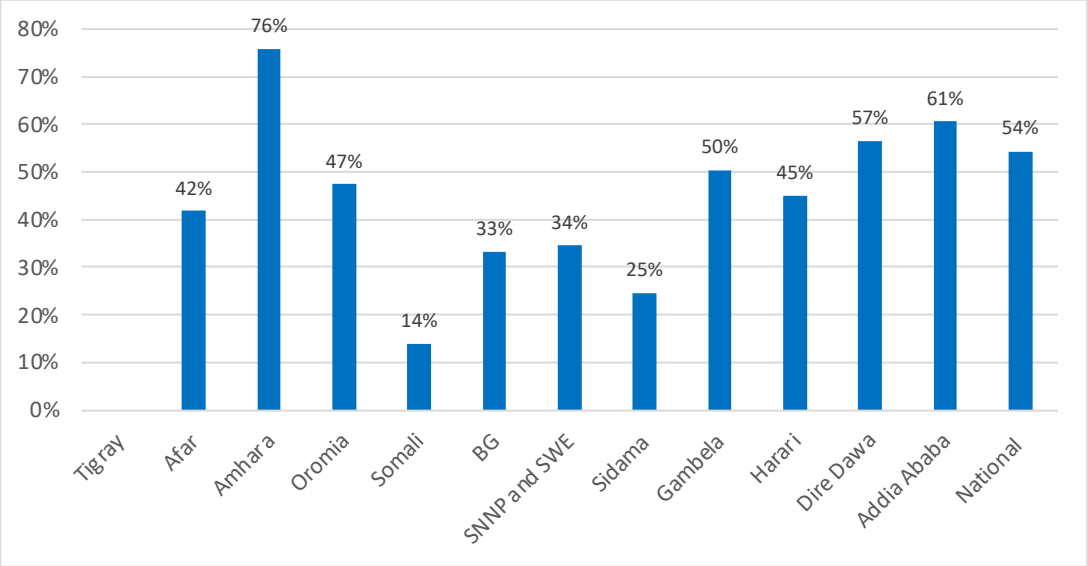


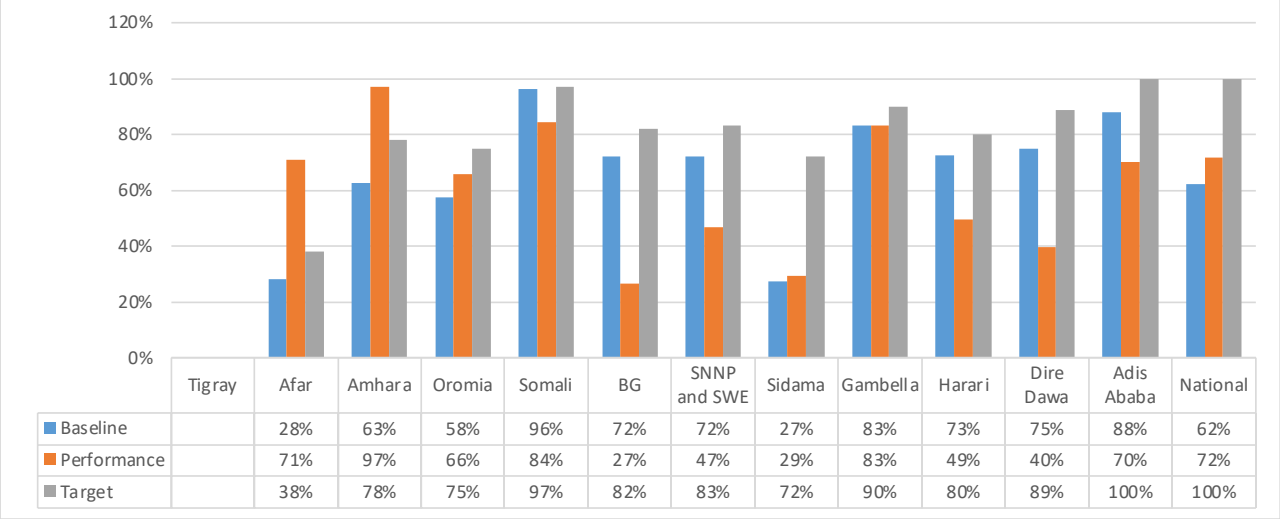
Figure 32: Percentage of HIV exposed infants who received ARV prophylaxis, 2015 EFY

Cotrimoxazole prophylaxis is recommended for HIV exposed infants at 6weeks of age and should be continued until HIV infection has been excluded and prevent a variety of bacterial, fungal and protozoan infection. During this fiscal year, a total of 8,293 (56%) infants born to HIV positive mother (HEI) started cotrimoxazole prophylaxis within two months of birth. This year performance is lower than last year's performance by 2 percentage points.

Early infant diagnosis

Early infant diagnosis (EID) of HIV infection and subsequent initiation of anti-retroviral therapy (ART) significantly helps in the reduction of HIV related morbidity and mortality among children born to HIV positive mothers. Point-of-care early infant diagnosis (POC EID) is an innovative technology that allows for the rapid return of HIV test results to caregivers and timely initiation of ART and care. Using this technology, the number of POC EID testing sites has been expanded to 180 sites at the end of 2015 EFY.

In 2015EFY, a total of 10,511 (72%) of HIV exposed infants received virological test within 12 months. This year's performance has increased by 10 percentage points compared to last year, but much lower than the target for the year. From those exposed infants tested in 12 months, around 70% of HIV exposed infants tested with in 2month of age and 30% of HIV exposed infants received a virological HIV test between 2-12 Months of birth. Out of the total tests, 215 (2.1%) infants were tested positive by virological test. Confirmatory test (Antibody test) for HIV exposed infants by 18month was done to a total of 7,565 HIV exposed infants, out of which 0.6% had a positive test result.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP and SWE	Sidama	Gambella	Harari	Dire Dawa	Adis Ababa	National
Baseline		28%	63%	58%	96%	72%	72%	27%	83%	73%	75%	88%	62%
Performance		71%	97%	66%	84%	27%	47%	29%	83%	49%	40%	70%	72%
Target		38%	78%	75%	97%	82%	83%	72%	90%	80%	89%	100%	100%

Figure 33: Percentage of HIV exposed infants who received virological test with in 12month of birth, 2015 EFY

Other major activities related to PMTCT

- High level advocacy visits on Triple EMTCT strategy were conducted in 5 selected regions (Benshangul Gumuz, Oromia, SNNP, Diredawa and Harari)
- The revised PMTCT guideline was distributed to health facilities, PMTCT refresher training manual was developed
- Comprehensive PMTCT TOT and refresher training was provided for health care professionals by the revised training manual

- Using Gene xpert machine, 31 new POC EID sites were added to the existing 149 POC EID sites making the total 180; and the number of POC Viral load sites was increased from 37 to 52 viral load sites (15 new sites this year)
- PMTCT Supportive supervision was conducted, including in conflict affected regions
- PMTCT Data quality improvement workshop was conducted for participants from all regions, and refresher training on PMTCT indicators was provided
- Radio spot messages on PMTCT services has been broadcasted to the public

Challenges of PMTCT program

- Interrupted supply of CPT and Cartridge for EID
- Conflicts and security problems in different parts of the country affected service provision
- Budget shortage

Way forward (PMTCT program)

- Enhance implementation of continuous quality improvement, PMTCT cohort monitoring and mentorship
- Scale up of Dual and Syphilis testing for pregnant and lactating women
- Improve Syphilis and HBV testing and start-up of treatment for HBV positive among eligible pregnant women
- Close monitoring to make PMTCT supplies available timely
- Strengthen and scale-up POC EID and Viral load sites
- Sustain the experience of Mothers Support Groups (MSG) to support the adherence and retention and also bringing MSGs in the government system or mobilizing resource for them to maintain the service they are providing.
- Strengthen family planning service among HIV positive women in reproductive age group

3.6.2. Prevention of HIV and STIs

Social behavioral change communication (SBCC)

Social Behavior Change Communication (SBCC) is one of the combination prevention components of HIV prevention, which encompass targeted peer to peer and one-on-one education for KPPs. In the fiscal year, public meetings, community dialogues/conversation, print and electronic SBCC materials development and distribution, documentaries, and TV/Radio spot messages were conducted. The list of key and priority populations (KPPs) identified by the HIV/AIDS Strategic Plan 2021-2025 and National Roadmap for HIV Prevention includes: Female sex workers, prisoners, widowed, separated and divorced men and women, long distance drivers, PLHIV and their partners, mobile and resident workers in hotspot areas, adolescent girls and young women and HIV negative partners of sero-discordant couples have been addressed with different type of SBCC approaches to bring intended behaviors that have crucial contribution in reduction of high risky behavior to HIV.

In the fiscal year, intensive social behavioral change communication intervention (ISBCC) has been implemented targeting KPPs in the identified 265 priority woredas. This was done mostly peer based facilitated small group learnings with at least 85% of the intended sessions implemented over two to three months by community level implementers to bring an intended positive behavior. A total of 1,300,523 KPPs were reached with ISBCC, which is 83% of the planned 1,567,205 KPPs.

In the fiscal year, a national HIV prevention roadmap (2023-2025) and different training materials, including "prisoners peer learning manual" and KPP friendly services training manual were developed. Trainings were provided for health professionals providing service for KPPs, and for adolescent and young peoples with disability. Messages targeting different KPPs were transmitted through radio and television spot messages. World AIDS Day was commemorated on December 1, 2023 under a theme "Achieving Equity towards access for HIV/AIDS services", which was attended by higher officials from federal and regional governmental offices, delegates from UN, Civic Societies, local and international partners . In addition, a consultative workshop was conducted with stakeholders to strengthen HIV/AIDS prevention program in humanitarian settings and reduce vulnerability of the displaced people.

Condom distribution

Condom promotion, distribution and use is one of the important biomedical interventions for the prevention of HIV and sexually transmitted infections, as well as for family planning. The national condom program uses the total market approach as the business model which encompasses free supply of condom, condom distributed through social marketing and through commercial approaches. The free condom distribution is mainly for key and priority populations (KPPs), which can be distributed through DICs, KPP clinics and peer service providers. The distribution for the general population was through the public sector, via social marketing channels and private outlets.

In 2015 EFY, more than 71.2 million condoms were distributed, among which more than 41.1 million (58%) were distributed to KPPs. However, the performance in condom distribution for KPPs is very low (39% from a target of 105,720,441). A refresher training was provided to HIV program coordinators on condom programming for female sex workers and workers in hot spot areas. Rapid assessment was conducted on current condom implementation practice to find out the real causes for the occurrence of condom deficit across the country.

In and out of school youth reached by HIV prevention SBCC intervention (Peer to peer education and Life skill)

The school-based HIV prevention program is implemented to address specifically the needs of students at high school and college and university level. The interventions for these groups include promotion and distribution of condoms at university and college levels, and strengthening mini-media and AIDS clubs. Curriculum integration and prevention of a risky environment around schools has variable performance across regions and universities. In 2015 EFY, a total of 5,700,300 in school and out of school adolescent and youth were reached with SBCC, which is 74.9% of the planned 7,605,696 adolescents and youth. MOH in collaboration with Ministry of Education have developed tailored HIV prevention message to school adolescent and youth students for dissemination through school mini media. In addition, HIV prevention message was developed for out of school adolescent and youth to be transmitted through youth development centers.

Prevention and treatment of Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections (STIs) diagnosis, treatment and testing of STI cases for HIV is one of the strategies of HIV prevention and control program. In 2015 EFY, 202,074 STI cases were diagnosed and treated. From the total 202,205 STI cases, 197,425 (98%) were tested for HIV. From the total HIV tested STI cases, 5,647 of them were HIV positive, with a 2.9% HIV positivity rate among STI cases. In the fiscal year, a national level TOT training on STIs was provided for 54 health workers. Moreover, in collaboration with the Ethiopian Public Health Institute (EPHI), preparatory activities are finalized to conduct STI treatment validation study.

Other HIV prevention interventions: In addition to the above mentioned HIV prevention activities, other initiatives such as pre-exposure prophylaxis, post-exposure prophylaxis and voluntary medical male circumcision services were strengthened during the fiscal year. The performance of these initiatives is as follows.

- **Pre-Exposure Prophylaxis of HIV (PrEP):** Pre-Exposure Prophylaxis (PrEP) to population groups with substantial HIV risk is one of the biomedical HIV prevention methods that can have a significant impact to further decrease the transmission of HIV. In 2015 EFY, PrEP service has been provided in all ART providing health facilities. A total of 15,482 individuals at high risk of HIV (13,273 female sex workers and 2,209 sero-discordant couples) were newly enrolled to PrEP in the fiscal year. TOT and basic trainings were provided to health workers on PrEP.

- **Post-Exposure Prophylaxis of HIV (PEP):** Post exposure prophylaxis (PEP) service is one of the HIV prevention strategies for individuals that are exposed to the virus due to occupational and non-occupational risks. PEP is the use of antiretroviral drugs by HIV-negative people, after potential exposure to prevent the acquisition of HIV to an exposed individuals. In the fiscal year, a total 5,770 individuals has received PEP service. Among them, 2,328 (40%) were due to occupational risk, 1,670 (29%) were due to sexual violence and 1,772 (31%) were due to other non-occupational risks.

- **Voluntary Medical Male Circumcision (VMMC):** As one of the public health prevention interventions to reduce incidence of HIV, VMMC is implemented in Gambella region, where male circumcision is low. In 2015 EFY, 23,809 individuals received VMMC service in Gambella region. Among those who have had VMMC, 5,212 individuals were tested for HIV and six of them were tested positive and linked to HIV care and treatment service. Training was provided to 16 health professionals on VMMC and SBCC materials were distributed.

3.6.3. HIV testing and counselling services and the first 95 performance

Targeted HIV testing is a key strategy to identify new HIV positives and progress towards the first 95 HIV target. Targeted HIV testing is offered through high yield case finding modalities such as index case testing and partner notification services (ICT/PNS), social network strategy (SNS), voluntary counseling and testing (VCT) and optimized Provider Initiated Testing and Counseling (PITC). It is performed using HIV risk screening tool in outpatient departments, family planning, maternal and child health clinics (ANC, delivery, and postnatal services), inpatient departments, specialty clinics, KPPs/youth friendly clinics, and other health service delivery points. In addition, testing is done using HIV self-testing (HIVST) for adults and care giver assisted HIVST for children aged 2 – 15 years old to create demand for conventional testing.

In 2015 EFY, more than 6.6 million individuals were tested for HIV, out of which 36,132 were tested positive for HIV (yield of 0.55%). HIV test yield ranged from 0.62% in Sidama to 2.69% in Gambella. To enhance demand for conventional testing, a total of 140,353 HIVST kits were distributed through directly assisted (67%) and unassisted (33%) approach.

The national HIV Testing algorism was changed in the fiscal year, based on which TOT and cascaded were provided and test kits were distributed to health facilities. More than 8.3 million HIV test kits was procured and distributed to all EPSS hubs.

Table 8: Number of individuals tested for HIV and positive result by region, 2015 EFY

Region	Total tested	Total positives	Yield
Tigray			
Afar	101,278	799	0.79%
Amhara	1,495,118	9,440	0.63%
Oromia	2,962,247	10,066	0.34%
Somali	149,417	555	0.37%
BG	46,404	249	0.54%
SNNP	666,963	2,760	0.41%
Sidama	338,775	877	0.26%
SWE	168,707	823	0.49%
Gambella	41,556	1,118	2.69%
Harari	36,235	215	0.59%
Dire Dawa	67,865	500	0.74%
Adis Ababa	554,622	8,780	1.58%
National	6,629,187	36,182	0.55%

Replicate Operation Triple A (RoTA): In order to improve HIV case identification and link the identified positives to HIV care and treatment services, Ministry of Health have started an initiative called Replicate Operation Triple A (RoTA) initiative in 2013 EFY. It is an initiative to enhance HIV case finding through enhanced implementation focusing on high risk individuals. In the fiscal year, RoTA implementation continued and support was provided through regional support team.

Pediatric HIV Program Accelerated Initiative (PHPAI): This is an initiative which aims to address the gaps in pediatrics HIV prevention, care and treatment services, with a primary objective of accelerating pediatrics case finding using an HIV risk screening tool and improve the yield by targeted testing, clearing untested ICT backlog ,reducing the missed opportunities seen in different service delivery points (like Tb clinic malnutrition clinic and inpatient with universal testing) and scaling up of care taker assisted HIVST for children. A task force was established and PHPAI implementation manual was prepared. The initiative was launched in November 2022 and cascaded to regions. This initiative is implemented in all pediatric ART providing health facilities, among which 103 are selected as level-1 PHPAI facilities. Since the implementation was initiated in November 2022, various activities were done. These include: A mobile based reporting tool was prepared, orientation on use of mobile data collection and reporting platform to regional focal and M&E personnel was provided, performance monitoring has been conducted on a monthly basis, review meeting was conducted twice and Joint

supportive supervision(JSS) was done. In the reporting period, a total of 1,430 children were tested positive (Yield=0.4%), with increasing trend in number of children tested for HIV as well as improvement in reducing missed opportunity in HIV testing

HIV Case Based Surveillance (CBS) and Recency Testing: CBS was started in 2019 to improve target prevention services and identify hotspots of new infections and to accelerate epidemic control. HIV case reporting with recency testing for recent infection (RTRI) is currently integrated with the existing public health emergency management (PHEM) system. CBS and recency testing report in 2022 showed that 8.6% tests were recent infections.

First 95 performance: The first 95 target of HIV aims that 95% of all people living with HIV will know their HIV status (diagnose 95% of HIV positives). A community based survey is a standard to estimate the first 95 performance but the last community based survey to determine the first 95 performance was done in the 2016 Ethiopia demographic and health survey. Since the survey is done more than six years ago, estimating the first 95 from the routine data system is essential. Accordingly, the performance of the first 95 HIV target is computed from the routine health information system considering the following data elements, based on indicator reference guide of the Ethiopian health sector. The denominator for the first 95 is the estimated number of PLHIVs in 2022, which is 610,352 in all regions and 562,636 (not including Tigray), according to the 2022-2023 HIV estimation and Projections report. The numerator will be the sum of the following: 1) "PLHIVs who were currently on ART at the end of 2015 EFY", 2) "The number of PLHIVs who were lost to follow up and 3) "The number of new HIV positives identified in the last month of 2015 EFY, who may not immediately started ART and hence may not be included as Rx-Current". From this sum, the number of PLHIVs who restart treatment after lost to follow up is subtracted. Accordingly, the numerator for the first 95 target will be the sum of treatment current (473,625) + number who were lost from treatment (57,068) + new positives in Sene 2015 (3,574) and subtracting number of PLHIVs who restart treatment (52874). This sum up to 481,393, which is the number of people who know their status. This means that 481,393 people (85.5%) from the estimated 562,636 PLHIVs know their status (not including Tigray). Therefore, the first 95 performance is estimated to be 85.5% in 2015 EFY.

3.6.4. HIV care and treatment service and the second 95 performance

According to the 2022-2023 national HIV and related estimates and projections, the estimated number of People living with HIV (PLHIVs) in Ethiopia in 2022 was 610,352. From the total estimated PLHIVs, 573, 539 (94%) are adults aged 15+ and 36,813 (6.0%) are children aged 0-14 years; 61% are females and 39% are males.

At the end of 2015 EFY (Sene 2015 EFY), a total of 473,625 PLHIVs have been receiving anti-retroviral therapy (ART) in all the regions, except Tigray region. Tigray region is not included in this report as there was no report from Tigray. Therefore, the estimated versus performance on ART is done excluding data from Tigray region. The estimated number of PLHIVs used for ART coverage and second 95 performance is therefore data from all regions except Tigray. Accordingly, the total estimated PLHIVs used is therefore 562,636 (The estimated 47,716 PLHIVs in Tigray is deducted from the total national estimate. From the total estimated 562,636 PLHIVs in Ethiopia (excluding Tigray), 473,625 PLHVs were receiving ART at the end of 2015 EFY. This shows that 84% of the total estimated PLHIVs were on ART in Ethiopia at the end of 2015 EFY. However, there is a huge ATRT coverage gap between children and adults. ART coverage for children under 15 years was only 35% of the estimated under 15 children while ART coverage for adults aged 15 and above was 87%. This calls for strengthened program for pediatric age groups.

Table 9: Number and percentage of PLHIV currently on ART in Ethiopia, 2015 EFY

Region	Estimated PLHIV in 2014 EFY (Disaggregated by Age)			No. of PLHIVs currently on ART in 2015 EFY			ART coverage from the total estimated PLHIV		
	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total
Tigray									
Afar	833	10,086	10,919	101	4,685	4,786	12%	46%	44%
Amhara	8,855	157,100	165,955	3,536	150,220	153,756	40%	96%	93%
Oromia	10,743	147,410	158,153	4,220	120,963	125,183	39%	82%	79%
Somali	1,041	6,039	7,080	74	2,141	2,215	7%	35%	31%
B/Gumuz	709	5,540	6,249	94	3,941	4,035	13%	71%	65%
SNNP*	3,664	44,053	47,717	1,262	35,864	37,126	34%	81%	78%
Sidama	2,484	21,822	24,306	292	10,539	10,831	12%	48%	45%
Gambela	1,297	12,098	13,395	336	7,809	8,145	26%	65%	61%
Harari	243	5,337	5,580	62	3,943	4,005	26%	74%	72%
Dire Dawa	414	10,683	11,097	118	7,044	7,162	29%	66%	65%
Addis Ababa	3,206	108,979	112,185	1,406	107,201	108,607	44%	98%	97%
OGAs				182	7,592	7,774			
National	33,489	529,147	562,636	11,683	461,942	473,625	35%	87%	84%

**Note: The estimated number of PLHIVs for SNNP includes SW Ethiopia. A separate estimation for SWE was not done in 2022-2023 due to the fact that it is only one year since SWE is established and adequate input was not available for SWE. By the end of 2015 EFY, the total number of PLHIVs receiving ART in SNNP = 28,823 and total currently on ART in SWE= 8,303*

Second 95 performance

The second 95 HIV target aims that 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (95% PLHIVs who know their status will be on HIV treatment). As discussed above, the first 95 performance in 2015 EFY was 85.5% and this is used as a denominator to compute the performance of the second 95. Accordingly, the performance of the second 95 HIV target in 2015 EFY was 98%. However, there is a big discrepancy between children and adults. The second 95 performance among children 0-14 years of age was only 41% while all adults who know their status were on ART.

Although the national performance of the second 95 was higher than the target, there was a regional disparity in performance. The performance in Addis Ababa and Amhara regions was more than 100%, which may be due to immigration of PLHIVs from neighboring regions to take ART in the capital city for different reasons or other factors. However, all the other regions have a performance less than the targeted 95% performance. The lowest performance was in Somali (37%), Afar (51%) and Sidama (52%) regions, as shown in the table below.

Table 10: The performance of the 2nd 95 HIV target, 2015 EFY

Region	Estimated PLHIV in 2015 EFY			No. of PLHIVs currently on ART in 2015 EFY			No. of PLHIVs who know their status (i.e. the 1st 95 result)			2nd 95 performance		
	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total
Tigray												
Afar	833	10,086	10,919	101	4,685	4,786	712	8630	9,342	14%	54%	51%
Amhara	8,855	157,100	165,955	3,536	150,220	153,756	7,571	134415	141,986	47%	112%	108%
Oromia	10,743	147,410	158,153	4,220	120,963	125,183	9,185	126124	135,309	46%	96%	93%
Somali	1,041	6,039	7,080	74	2,141	2,215	890	5167	6,057	8%	41%	37%
BG	709	5,540	6,249	94	3,941	4,035	606	4740	5,346	16%	83%	75%
SNNP	3,664	44,053	47,717	1,262	35,864	37,126	3,133	37692	40,824	40%	95%	91%
Sidama	2,484	21,822	24,306	292	10,539	10,831	2,124	18671	20,795	14%	56%	52%
Gambela	1,297	12,098	13,395	336	7,809	8,145	1,109	10351	11,460	30%	75%	71%
Harari	243	5,337	5,580	62	3,943	4,005	208	4566	4,774	30%	86%	84%
DD	414	10,683	11,097	118	7,044	7,162	354	9140	9,494	33%	77%	75%
AA	3,206	108,979	112,185	1,406	107,201	108,607	2,741	93242	95,984	51%	115%	113%
OGAs				182	7,592	7,774	-	0	-			
National	33,489	529,147	562,636	11,683	461,942	473,625	28,633	452738	481,371	41%	102%	98%

To improve the performance of the second 95 target and improve care of PLHIVs, the following major activities were performed in 2015 EFY.

- The number of health facilities that provide second line ART drugs is increased to more than 600 facilities, which is increased from only 69 in the previous year
- The revised national guidelines for comprehensive HIV prevention, care and treatment was launched at a national workshop where relevant stakeholders attended the program
- **Adherence to care, retention and Pediatric ARV Optimization**: - ARVs are optimized for almost all children on ART (DTG based), psychosocial support and adherence support was provided (Enhanced adherence counseling and High Viral load management i.e early notification), strengthened interventions to address lost to follow ups via –home-to-home visit and through a "Bring back to care" campaigns
- Capacity building trainings on ART were organized to health workers: TOT for 78 health workers, basic ART training for 22 and refresher ART training for 104 health professionals was provided
- **Differentiated Service Delivery (DSD) models for PLHVs receiving ART**
  - Differentiated service delivery (DSD) is a person-centered approach to HIV prevention, testing, and treatment. Moving away from a one-size-fits-all model, DSD tailors HIV services to diverse groups of people living with HIV while maintaining the principles of the public health approach to enable high-quality service delivery at scale. Differentiated antiretroviral therapy (DART) includes both innovative less-intensive service delivery models for people doing well on ART as well as more-intensive service delivery models for people newly starting HIV treatment, those with opportunistic infections and/or co-morbidities, people with unsuppressed viral load, groups who typically need close follow-up such as children, adolescents, and pregnant people, and those with psychosocial barriers to adherence and retention.

- Ethiopia adopted DSD since 2017. Since then scale up to different models are implemented at community and facility level. DSD reduces the burden for patients (reduced time and cost of travel to clinic and less income loss) and the health system (reduced clinic attendance), while maintaining high retention in care

- More than 98% ART providing health facilities are currently implementing DART. At the end of 2015 EFY, among a total of 473,625 PLHIVs on ART, about 444, 817 (94%) of them were using one of the DSD models. From the total PLHIVs on DSD model, 60% were on Appointment Spacing Model(ASM/6MMD), 33% were on three multi-month dispensing model (3MMD), 2.5% were on Fast track ART Refill (FTAR), and 2% were on Peer lead community based ART distribution (PCAD). Advanced HIV Disease Care Model was used by 7,354 PLHIVs.

- To strengthen DSD model implementation, DSD tools such as client screening tool, classification tool, patient follow up tool were printed and distributed to health facilities

3.6.5. Viral load testing and the third 95 performance

During the fiscal year, a total of 366,164 PLHIVs who were on ART received viral load testing. This shows that the viral testing coverage was 77% (From the total 473,625 PLHIVs who were on ART). From the total PLHIVs tested for viral load, 96.4% of them had a viral suppression (a viral load of less than 1000 copies per ml). This is a high viral load suppression performance, which has significant positive individual and public health impacts. High viral load reduction is also an indication that there is high retention and adherence to ART treatment. Viral load suppression performance has been consistently improving over the years, increasing from 89% in 2011 EFY to 91.4% in 2012 EFY, to 95% in 2013 EFY and to 96% in 2014 EFY and 2015 EFY.

Table 11: Viral load testing and suppression rate by region, 2015 EFY

Region	VL Copies/ml		Total	Suppression rate
	< 1000	>=1000		
Tigray				
Afar	3,986	193	4,179	95.4%
Amhara	132,096	5,139	137,235	96.3%
Oromia	76,877	2,879	79,756	96.4%
Somali	1,568	56	1,624	96.6%
BG	1,848	77	1,925	96.0%
SNNPR	22,881	1,172	24,053	95.1%
Sidama	8,933	271	9,204	97.1%
Gambella	6,280	286	6,566	95.6%
Harari	3,788	141	3,929	96.4%
Dire Dawa	6,249	293	6,542	95.5%
Addis Ababa	85,502	2,712	88,214	96.9%
OGA	2,287	84	2,371	96.5%
	352,833	**13,331**	**366,164**	96.4%

Third 95 performance: The third 95 target aims that 95% of all people receiving antiretroviral therapy (ART) to have a viral suppression. In 2015 EFY, as discussed above, the viral load testing coverage was 77% of PLHIVs on ART, among which 96.4% had viral suppression. According to UNAIDS, if the viral load testing coverage is between 50% and 90%, the numerator for the third 95 target can be estimated from the routine viral load test report. Hence, using this approach, the numerator for the third 95 target will be estimated as (Viral load-suppression rate from routine test)*(PLHIVs who are currently on ART), which is 96.4%*473,625= 456,382. This means that the estimated number of PLHIVs who have suppressed viral load is 456,382. Therefore, the numerator for the third 95 is 456,382 and the denominator is the number of people who are currently on ART (473,625). This gives the performance of the third 95 target to be 96.4%.

3.6.6. Integration of HIV with other programs

TB Preventive Therapy (TPT): TB preventive therapy (TPT) have been provided to PLHIVs on ART who were screened negative for TB. Three types of TPT courses have been provided, including 6H, 3HP and 3HR. During the reporting period, a total of 212,856 PLHVs were screened for TB and 90% of them were screened negative for TB. Among cohort of ART patients who were initiated on any course of TPT 12 months before the reporting period, 73% of them have completed a full course of TPT (6H, 3HP and 3HR). TPT backlog clearance campaign was conducted to enhance TPT coverage especially among pediatric age groups and preliminary results from the catch up campaign shows improvement both in the initiation and completion of TPT. LF-LAM is utilized as a better diagnostic tool to enhance the early diagnosis of active TB among PLHIV in advanced stage.

HIV integration with cervical cancer screening: During the fiscal year, 78,070 HIV positive women aged 15 and above were screened for cervical cancer. From the total screened women, 93.5% had a normal cervix, 5.6% had precancerous lesion and 0.8% had suspicious cancerous lesion. Those with precancerous cervical lesion were treated with cryotherapy, LEEP or thermal Ablation.

HIV integration with NCDs and mental health: To strengthen integration of HIV services with NCD and mental health services, basic training was provided to health workers, advocacy workshops were conducted and supportive supervision was done in SWE region.

Hepatitis prevention and control: To strengthen viral hepatitis prevention and control, implementation manual was revised and distributed to facilities, drugs and laboratory reagents were procured and distributed to facilities, and demand creation activities were done through radio and television spot messages. World hepatitis day was commemorated during which panel discussions and awareness creation was done. Training on viral hepatitis was provided for 37 health care workers. A total of 297,492 individuals were tested for viral hepatitis in the fiscal year (198,355 for hepatitis B and 99,137 for hepatitis C). Among those tested, 3.5% of them were tested positive for hepatitis B and C. Treatment was provided to 3,533 hepatitis B patients and 895 hepatitis C patients.

3.6.7. Multi-sectoral response and coordination

As part of the response to the HIV epidemic, in addition to the above interventions, various multi-sectoral response interventions were provided in the fiscal year. Some of these major activities and interventions include strengthening multi-sectoral response coordination and governance, care and support to orphans and vulnerable children (OVCs), care and support to PLHIVs, support to vulnerable women, people with disabilities and IDPs. Summary of the major multi-sectoral response interventions performed in 2014 EFY is as follows.

Multi-sectoral response coordinating and governance

- A consultative workshop with House of People Representatives (Health, Social, and Culture Affairs standing committee) has been conducted to enhance their roles and strengthen their involvement in the multi-sectoral HIV/AIDS response. In addition, a consultative workshop was conducted with selected federal strategic sectors to strengthen HIV/AIDS mainstreaming implementation at different sectors.

- Assessment of HIV/AIDS mainstreaming implementation was conducted, which helped to identify current practices, and challenges and the findings of the assessment have been used for high level advocacy.

- To increase the engagement of the media on HIV prevention response Media forum capacity building workshop conducted for a total of 40 media professionals drawn from different private and public medias

- Mapping of non-governmental organizations working on HIV/AIDS prevention and Control program was done

- The revised National Strategic Plan (2023 to 2027) document is prepared and ready for printing and distribution

Reducing stigma and discrimination

- To strengthen and enhance involvement of HIV positive adolescent, young and youth in the HIV/AIDS prevention response, capacity building training on leadership skills for leaders of their association was conducted. In collaboration with Ministry of Women and Social Affairs, training on community based care coalition (3Cs) implementation manual was provided for program officers.

Care and support to Orphan and Vulnerable Children (OVC) and PLHIVs

- Orphan and Vulnerable Children and their caretakers were supported with food, education, training and start-up capital support. In 2015 EFY, Income generating activity (IGA) training was provided to 47,408 OVCs and/or their caregivers.

Support to vulnerable women, people with disabilities and IDPs

- Support was provided to vulnerable women including commercial sex workers, out of school youth women who are at high risk to HIV and other vulnerable women. In the fiscal year, 60,102 vulnerable women were provided with a start-up capital for IGA.

- Peer–to-peer training was provided for 47 facilitators from national and regional associations of persons with disabilities. In addition, training provided for program coordinators on Peer-to-peer training manual.

Challenges

- A gap in implementation of targeted testing for HIV, with an undertesting of pediatrics age group, low yield, and missed opportunities in implementation of index case testing across the cascade
- Low accessibility of viral load testing in Gambella, BG and SWE regions
- Delay in procurement and distribution of HIV/AIDS, STI and hepatitis commodities
- Shortage of supplies such as HIV test kits, ARVs, OI drugs, DBS etc..
- Lack of viral hepatitis diagnostics reagents and treatment drugs
- Interruption of viral load sample transportation due to security issues
- Conflicts resulting in disruption of HIV prevention, care and treatment services
- Shortage of budget and delayed global fund budget release
- Lack of ownership and commitment by the leadership for HIV prevention activities
- Absence of policies and regulations on PWID, disclosure of HIV status
- Variation in regional HIV/AIDS programs coordination structures

Way forward

- Enhance high-yield HIV testing services and improve case finding through RoTA and Pediatric HIV Program Accelerated Initiative (PHPAI)
- Strengthen initiatives that improve and sustain the performance of the three 95 targets of HIV
- Improve availability of commodities for HIV prevention and control program
- Provide intensive service recovery support to areas that are affected by conflict
- Provide capacity building to health workers and managers at different levels of the health system
- Strengthen regular monitoring and evaluation of HIV prevention and control interventions
- Conduct high level advocacy and develop a mainstreaming legal framework to ensure commitment and accountability on HIV prevention and control
- Enhance the engagement of leadership and parliamentarians; revitalize National Aids Committee (NAC) and HIV board at all level
- Follow-up of sectors to establish a structure to implement HIV mainstreaming

3.7. Tuberculosis and Leprosy prevention and Control

Tuberculosis (TB) is a major global public health problem globally and in Ethiopia as well. Ethiopia is one of the 30 high TB burden countries with an annual estimated incidence of 119 cases per 100,000 population (WHO Global TB Report 2022). Ethiopia has recognized TB as a major public health problem nearly six decades ago. Cognizant of the burden of TB in Ethiopia, the Ministry of Health has given priority to the prevention and control of TB and implementing high-impact interventions in line with global strategies. As a result of our past investments and successful implementation of the strategies, substantial gains were made in reducing the disease burden. The TB incidence has declined dramatically and TB mortality rate has also declined substantially to reach 16 per 100,000 populations in 2021. Ethiopia has been transitioned out from the list MDR-TB high burden countries, which is great success

for the country. Ethiopia has expressed commitments to end TB epidemic by 2035 by endorsing the END TB strategy and new global targets set in the political declaration at the first UN high-level meeting on TB, in September 2018. Ethiopia has also adopted the global strategy to eliminate leprosy by 2030. The country has revised its National TBL Strategic Plan in line with the global targets. The National End TB strategy aims to end the TB epidemic by reducing TB related deaths by 95% and incident TB cases by 90% between 2015 and 2035; and to ensure that no family is burdened with catastrophic expenses due to TB. The strategy calls for use of robust TB case finding strategies and use of rapid diagnostic technologies to address the gaps in treatment coverage for both Drug Susceptible TB and RR/MDR-TB. The National TBL Control program is committed to improve access to equitable TBL services to all vulnerable population groups where TBL burden concentrates. The program also recognizes the need for intensified research and innovations to sharply bend the TB epidemic curve to meet the ambitious targets for 2035.

In this section, the performance of key tuberculosis and leprosy indicators, major national and sub-national level activities performed and challenges are discussed.

TB incidence rate: The annual incidence of TB in Ethiopia has decreased over time. The incidence has decreased by 38 % from 192 cases per 100,000 populations in 2015 to 119 in 2021 (World TB report, 2022) which Ethiopia already achieved the end TB targeted for 2020. Incidence has declined by 38% from 2015 to 2021, with an annual average reduction of 6%.

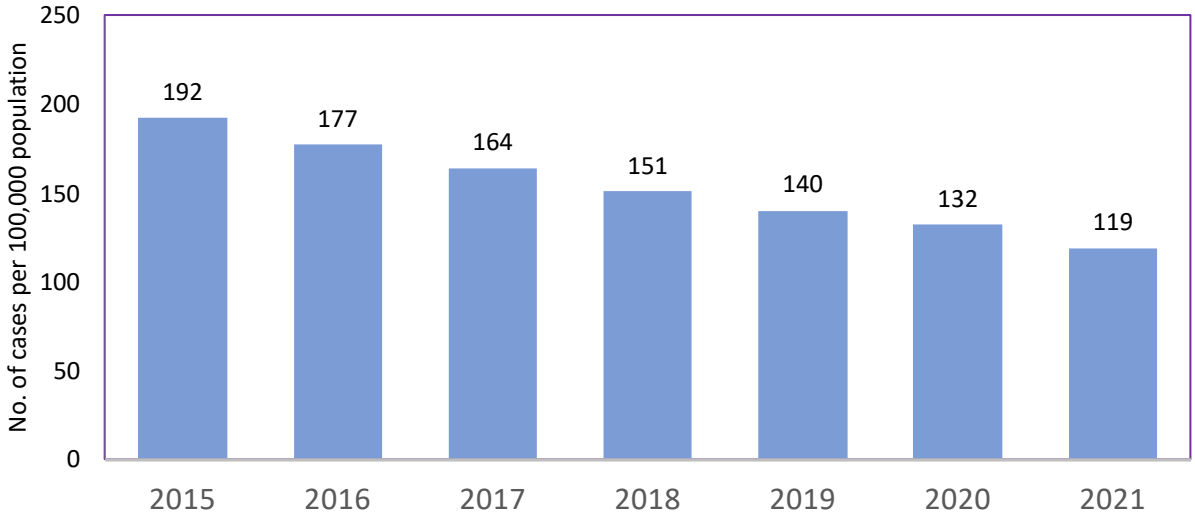


Figure 34: TB incidence rate in Ethiopia (number of cases per 100,000 population), 2015 to 2021

3.7.1. Tuberculosis treatment Coverage

TB treatment coverage is one of the key indicators in evaluating the effectiveness of TB Prevention and control program. It helps to measure and monitor status of TB identification and treatment. It is the number of notified and treated all forms of TB cases from the total number of TB cases estimated to occur in the area during a given time period. In 2015 EFY, a total of 134,616 all forms of TB cases were notified and treated based on the national tuberculosis treatment protocol. This shows that 95% of the total estimated TB cases were treated in the fiscal year. Most regions have a treatment coverage more than 100%, which may be due to low incidence estimation or other factors that requires investigation. Regions that have more than 100% TB treatment coverage are: Afar, Oromia, Sidama, Gambella, Harari, DD and AA. Treatment coverage was low in BG (58%) and Amhara regions (76%). This performance

is higher than the performance in the previous years, and also higher than the plan for the fiscal year (90%). As shown in the figure below, TB treatment coverage has consistently increased in the last five years. It has increased from 65% in 2010 EFY to 95% in 2015 EFY.

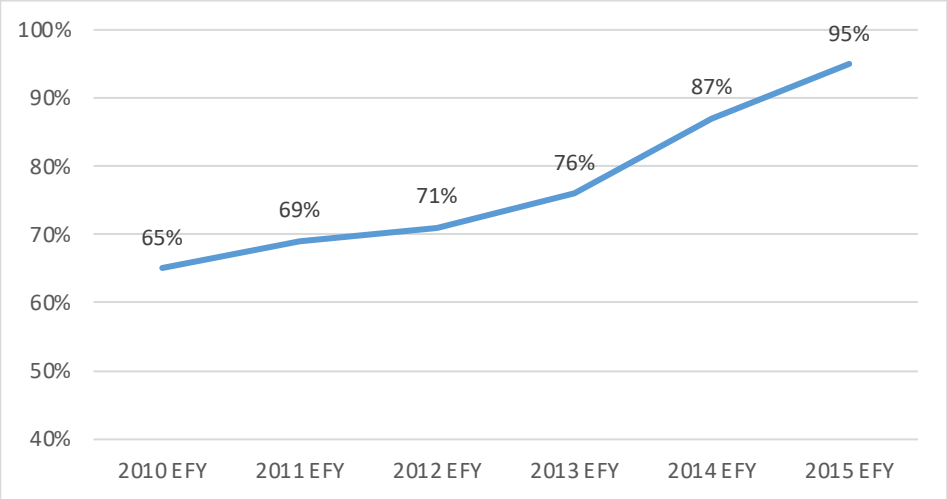


Figure 35: Trend of TB treatment coverage in Ethiopia, 2010-2015 EFY

Some of the major effective strategies for reducing the transmission of TB are engaging the community in TB case detection, public private mix (PPM), enhanced interventions on TB among key and priority population groups, childhood TB interventions and periodical outreach campaigns for TB detection activities. In 2015 EFY, from the total all forms of TB cases detected in the fiscal year, 18.3% of them were contributed through community TB contribution. Community contribution to TB case detection in 2015 EFY is almost similar compared to the previous year (which was 18.5%). Community contribution for TB detection was the lowest in Somali (1.3%), Gambella (3.1%) and BG (6.7%) regions; while the highest was in Sidama (34.3%) and SNNP (26.7%). Regarding private contribution to TB case detection, 17% of all TB cases were notified in public health facilities with initial referral by Public Private Mix (PPM) sites for TB diagnosis or for initiation of TB treatment. Contribution of PPM for TB detection ranged from 2.5% in Somali region to 26.2% in Benishangul Gumuz region.

3.7.2. Tuberculosis Treatment Outcomes

Tuberculosis cure rate and treatment success rate

TB treatment cure rate and treatment success rate are key indicators to monitor the effectiveness of TB treatment program. It measures the program's capacity to retain patients through a complete course of chemotherapy with a favorable clinical result. In 2015 EFY, cure rate and treatment success rate for bacteriologically confirmed new pulmonary TB cases was 84% and 96% respectively. Treatment success rate for new clinically confirmed PTB and extra pulmonary TB cases was 95% and 96% respectively.

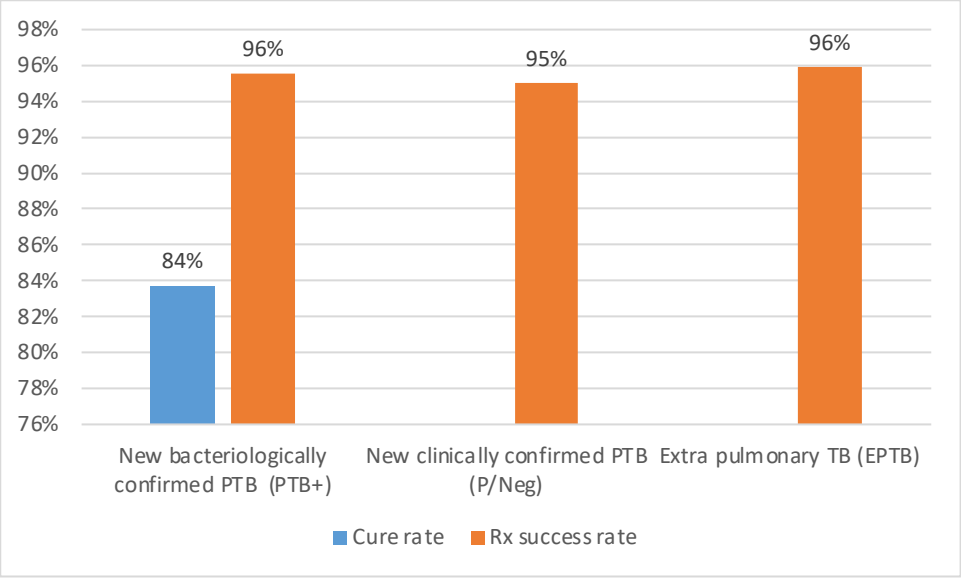
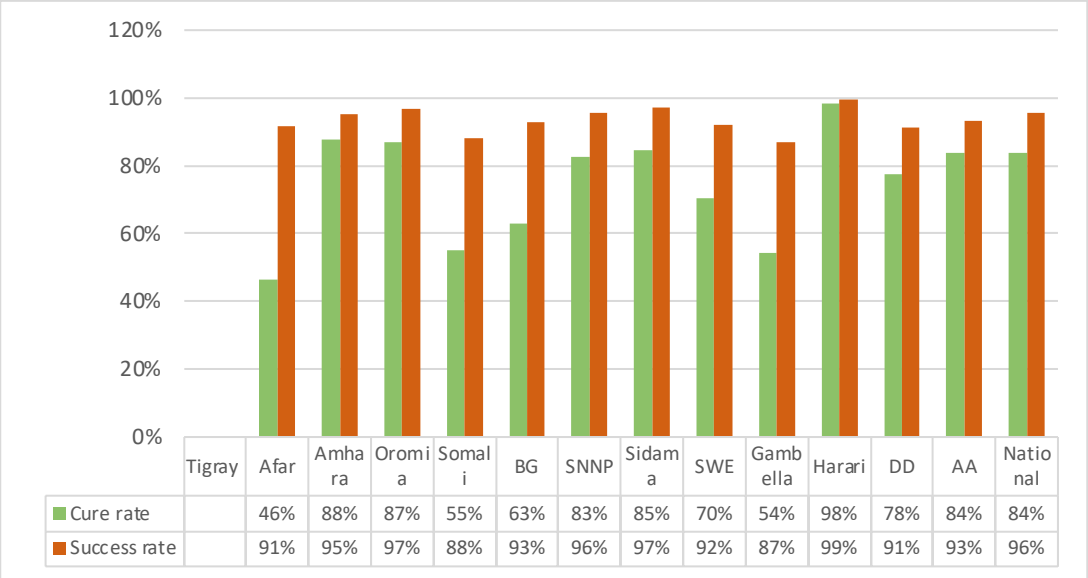


Figure 36: Treatment outcome among cohort of all forms of TB cases, 2015 EFY

Tuberculosis treatment outcome cohort of new PTB+ bacteriologically confirmed TB cases by region shows that the lowest TB cure rate was documented in Afar (34%), Gambella (54%) and Somali (55%) regions. These regions require close follow up towards increasing treatment cure rate. TB treatment success rate among PTB+ bacteriologically confirmed TB cases was higher than 90% in all regions except Gambella (87%) and Somali (88%) regions.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harari	DD	AA	National
Cure rate		46%	88%	87%	55%	63%	83%	85%	70%	54%	98%	78%	84%	84%
Success rate		91%	95%	97%	88%	93%	96%	97%	92%	87%	99%	91%	93%	96%

Figure 37: TB treatment cure rate and success rate among cohort of bacteriologically confirmed TB cases by region, 2015 EFY

Unsuccessful TB treatment outcome

Unsuccessful TB treatment outcome is the percentage of cohort of all forms of TB (new and relapse) cases (Bacteriologically confirmed, clinically diagnosed) registered in a specified period that failed, died or lost to follow up during treatment.

Unsuccessful treatment outcome was high among clinically diagnosed PTB cases, with 4.1% of cohort of clinically diagnosed PTB cases having unsuccessful treatment outcome and 0.7% of them were not evaluated. 3.6% of bacteriologically confirmed PTB cases and 3.2% of extra pulmonary TB cases have had unsuccessful treatment outcomes (lost to follow up or died or lost). The percentage of each group who were died, lost to follow up and failed treatment are displayed in the figure below. In addition, the percentage who were not evaluated is also displayed.

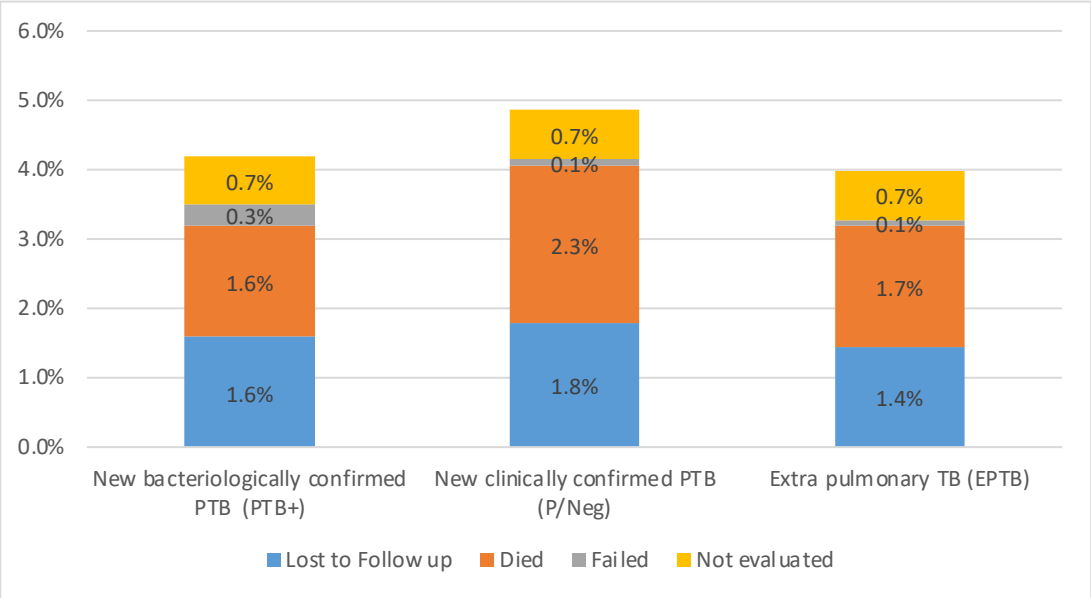


Figure 38: Proportion of all forms of TB cases with unsuccessful treatment outcome, 2015 EFY

3.7.3. TB Contact tracing and screening

Contact tracing and screening is one of the key components of TB prevention, especially in children. It is one of the major initiatives in the national TB prevention and control program. People who are exposed to active TB are at increased risk for TB infection and disease. Tuberculosis may be as high as 5% or more among household contacts, particularly children. Contact investigation aims to identify people at high risk and evaluate if they need treatment for TB prevention (TB preventive treatment).

In 2015 EFY, a total of 193,363 contacts with index of TB cases were traced/identified, among which all (100%) were screened for tuberculosis. Regarding contact tracing and screening of children under 15 years old, 60,517 children that had contacts with index of drug susceptible pulmonary TB and DR-TB cases were traced/identified and all of them were screened for tuberculosis. A total of 54,490 individuals who were screened negative for TB were put on TB Preventive Therapy (TPT) in the reporting period (7495 were on 3HP, 43619 were on 3HR and 3376 on 6H).

3.7.4. Drug Resistance Tuberculosis (DR TB)

Drug resistant TB continues to a major threat in the national response to TB in Ethiopia. To identify DR TB cases, notified TB cases eligible for drug susceptibility testing were provided with drug sensitivity test (DST) according to the national policy. In the fiscal year, 38,528 notified TB cases were evaluated for drug susceptibility testing. Among the 38,528 notified TB cases who were eligible for drug susceptibility testing in the fiscal year, evaluation for drug susceptibility testing result for at least rifampicin was done for 32,684 (85%) of them.

In 2015 EFY, 882 drug resistant TB (DR TB) cases were detected and put on DR TB treatment. This is 73 % of the estimated 1,139 DR TB cases in Ethiopia. DR TB treatment initiation has been provided in 57 treatment-initiating centers (TICs) in all regions except Tigray and treatment follow up was provided in treatment follow up centers (TFCs).

Regarding treatment outcome among DR TB cases, from the total number of cohort DR-TB cases that started short-term second-line anti-TB treatment regimen 24 months earlier, 86% have successfully completed treatment and among cohort of DR-TB cases that started long- regimen second-line anti-TB treatment 36 months earlier, 71% have successfully completed treatment.

3.7.5. Leprosy Prevention and Control Program

Leprosy Case Detection Rate: In 2015 EFY, a total of 2,531 New leprosy cases were detected and started treatment. Among the new cases, 1657 (66%) were multi-baciliary and 872 (34%) were pauci-baciliary new leprosy cases. This shows that the incidence of leprosy cases at national level was0.25 per 10,000 population. Leprosy case detection was high in Gambella (1.34 per 10,000 population) followed by Harari region (0.60 per 10000). The lowest case detection of leprosy was in Somali region, with an incidence of 0.02 new case per 10,000 population. In addition to the new cases, 421 retreatment and 1,221 relapse leprosy cases were detected and treated in the fiscal year.

Table 12: Number of leprosy cases detected and incidence per 10,000 population, 2015 EFY

Region	Population	Total leprosy cases (All cases)	Total New leprosy cases	Incidence per 10,000 population
Tigray				
Afar	2,076,408	30	23	0.11
Amhara	23,215,330	910	737	0.32
Oromia	40,884,249	1656	1400	0.34
Somali	6,657,345	15	12	0.02
BG	1,237,366	47	34	0.27
SNNP	13,950,342	120	91	0.07
Sidama	4,647,672	47	33	0.07
SWE	3,368,384	48	32	0.10
Gambella	530,893	85	71	1.34
Harari	282,848	18	17	0.60
DD	550,642	31	22	0.40
AA	3,938,772	66	59	0.15
National	101,340,251	3073	2531	0.25

Grade II disability rate among new cases of leprosy

In 2015 EFY, from the total 2,531 new leprosy cases, 305 of them had grade 2 disability (93% were adults >=15 years of age and 7% were children <15 years). This shows that the grade II disability rate among new cases of leprosy cases was 12%, which is higher than last year's rate (which was 9.9%). The highest disability rate was reported in SWE (38%), SNNP (37%), BG (26%) and Addis Ababa (20%) regions. There was no reported grade II disability in Dire Dawa and Harari regions.

Table 13: Grade II disability rate among new cases of leprosy cases, 2015 EFY

Activity	Total number of new leprosy cases	Total new cases with grade 2 disability	Grade II disability rate
Tigray			
Afar	23	5	22%
Amhara	737	84	11%
Oromia	1400	135	10%
Somali	12	2	17%
BG	34	9	26%
SNNP	91	34	37%
Sidama	33	9	27%
SWE	32	12	38%
Gambella	71	3	4%
Harari	17		0%
DD	22		0%
AA	59	12	20%
National	2531	305	12%

Contact screening of leprosy cases: During the reporting period, a total of 10,451 household contacts of leprosy cases were registered in the reporting period. Among these contacts, 10,138 (97%) of them were screened for leprosy and 1,091 of these contacts were diagnosed with leprosy.

Leprosy treatment outcome: in 2015 EFY, leprosy treatment-completion rate for Pauci-Bacillary (PB) leprosy cases was 91% and for multi bacillary (MB) leprosy cases was 89%.

Other major activities performed

- **National TB, leprosy and other lung disease strategic plan developed:** This plan articulates Ethiopia's milestones and provides the technical and strategic priorities to End the TB epidemic and eliminate leprosy as public health problems and mitigate the burden of priority lung diseases in the country. It highlights the aspirations of the country, within the context of national progress to achieve the goals of UHC and SDGs. It is evidence informed and enriched through extensive and inclusive consultations at all stages of the planning process.

- **Multi sectorial response and accountability framework developed and launched:** Addressing the challenges to halting the spread of TB and mitigate its impact on the family and national economy requires a collaborative and multi-sectoral response and a clear national investment plan to address the social determinants and consequences of TB. Tuberculosis is a disease of poverty and most of the contributing factors are beyond the scope of the health sector. Hence, this Multisectoral response and Accountability Framework (MAF) for TB is prepared to guide the multi stakeholder response in Ethiopian in the effort to achieve the global plan and UN Political Declaration to End TB by the year 2030.

- **TB screening service:** A TBL catch up screening campaign was conducted in all regions during which TB screening and testing was conducted in 8 regions except Somali, BG, Gambella and Afar. During the catchup campaign, a total of 1,420,440 people were screened for TB among which 3,403 people were diagnosed with all types of TB. IN addition, 7507 students were sensitized on TB and leprosy in 46 schools; 2560 students were screened for TB and 16 cases were detected.

- **External Mid Term review:** Ethiopia has been implementing the National Tuberculosis and Leprosy Program Strategic Plan (TBL NSP 2021 -2026). To assess the progress made in its mid-way implementation, the Government of Ethiopia has requested WHO AFRO to lead the external mid-term review, which was done in February 2023. The purpose was to assess the implementation status, the progress made after the kick-off the TBL NSP 2021-2026 and to identify strategies and make recommendations to address the new set of complex challenges the TBL response has faced in the country after the kick-off the TBL NSP 2021-2026 and to help design an adaptive TB, Leprosy and Lung diseases programming strategy

Challenges

- Low universal drug sensitivity testing (DST) coverage
- Suboptimal community and public-private mix (PPM) contribution in case notification
- Conflicts in different parts of Ethiopia, which result in health service disruption and high number of number of internally displaced people (IDPs)including HCWs
- Weak domestic resource mobilization and allocation for Tb and leprosy prevention and control program
- Insufficient supply of second line anti-Tb drugs
- Low DR-TB Case detection rate
- High attrition and turnover of trained man-power

3.8. Malaria and Other Vector-borne Disease Prevention and Control Program (MOVBD)

Malaria is a preventable and treatable disease, but it remains a major public health problem. Globally the progress in malaria control and elimination stalled in recent years. In 2021, there were an estimated 241 million cases of malaria and 627,000 deaths from malaria globally. This represents a 12% decrease in cases and a 14% decrease in deaths from 2020. The African region accounted for 95% of all malaria cases and 94% of all malaria deaths in 2021.

Ethiopia is one of the countries that had significant malaria case and death reduction. Ethiopia is among the few countries with unstable and seasonal malaria transmission. With the recent malaria stratification in the country made, 69.1% of the population is at risk for malaria. The government of Ethiopia is committed and is working with partners to scale up malaria prevention and control interventions. With continued effort, Ethiopia has a plan to eliminate malaria by 2030. Currently, malaria elimination activities are being implemented in 565 Woredas in seven regions of the country. However, due to natural and manmade factors, malaria surge is reported in recent years. The major activities, achievements, and challenges in EFY 2015 are described as follows.

Malaria Cases and Deaths

The number of malaria cases in Ethiopia has been on a decreasing trend since 2009 EFY. However, in 2012 EFY, the number of cases increased, followed by a slight decline in 2013 EFY. The number of cases then continued to increase in 2014 EFY and 2015 EFY. In 2015 EFY, the number of cases was more than double compared to the 2014 EFY, and 89% higher than the number of cases in 2009 EFY.

In 2015, a total of 3,303,469 malaria cases were treated. From the total malaria cases, 3,214,864 (97.3%) were laboratory confirmed cases (either by microscopy or RDT) and 77 percent were due to plasmodium falciparum. Children under five accounts for 15.6 percent and 1.7 percent were admission cases. No data from Tigray region Since 2013 EFY.

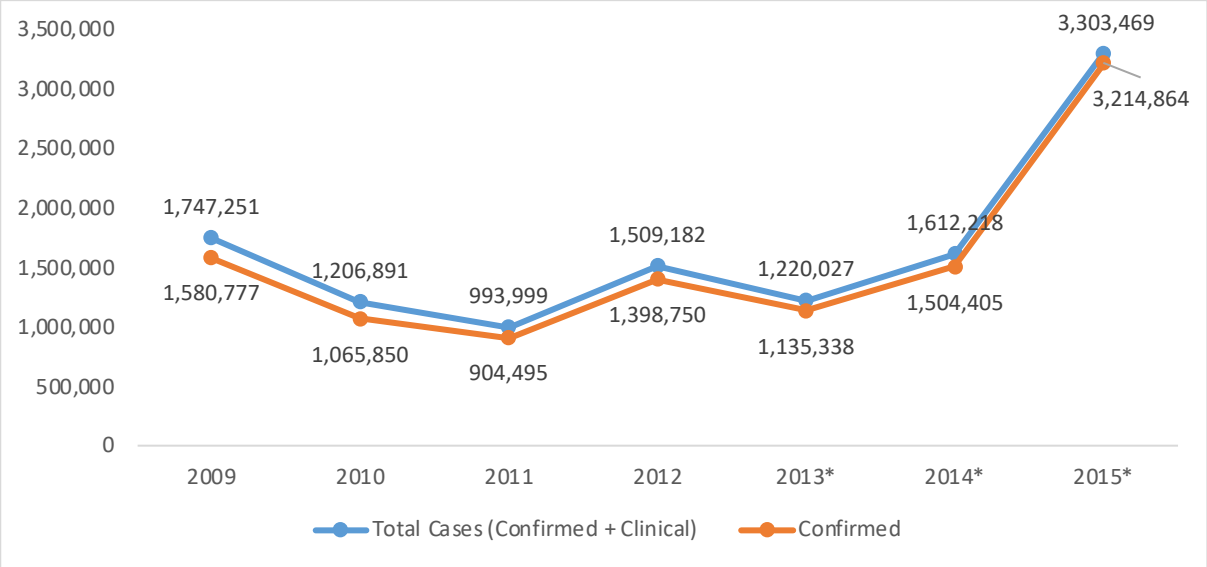


Figure 39: Trend for total malaria and confirmed cases, 2009 to 2015 EFY

Note: *Tigray data is not included from 2013 EFY to 2015 EFY analysis as there was no report from the region.

Nationally, in 2015 EFY around 69.1% of the total population (more than 70 million people) is at risk of malaria. The proportion of population who are at risk of malaria differs among regions, where more than 80% of the population in Afar, Somali, Benishangul Gumuz, Gambella, SWE and Dire Dawa are at risk of malaria.

The national malaria annual incidence per 1,000 population at risk in 2015 EFY was 47.2, which is an increase by 62.7% from the 2014 EFY. The regional distribution of malaria shows that malaria incidence rate per 1000 population at risk was the highest in Benshangul Gumuz region (169 cases per 1,000 population at risk) and the lowest in Harari (2.4 cases per 1000 population at risk).

In the fiscal year, there were 296 deaths due to malaria in Ethiopia. This represents an increase by 27% from the previous year. The malaria death rate per 100,000 populations at risk was 0.41, which is still below the World Health Organization's target of 1 death per 100,000 populations at risk. The highest number of malaria deaths was reported in the Oromia region, which contributed 43% of national malaria deaths. Gambella had the highest malaria death rate per 100,000 population at risk. Of the total inpatient malaria deaths, 41 (14%) were under five years old.

Table 14: Malaria Incidence rate per 1,000 populations at risk and Malaria Deaths per 100,000 populations at risk, 2015 EFY

Region	Total population	Population at risk	Cases				Deaths			
			< 5 years	>= 5 years	Total case	Incidence per 1000 pop at risk	< 5 years	>= 5 years	Total Death	Malaria Death per 100,000 pop at risk
Tigray										
Afar	2,076,408	2,076,408	34,986	112,778	147,764	71.2	1	6	7	0.34
Amhara	23,215,330	13,882,767	76,794	911,173	987,967	71.2	3	16	19	0.14
Oromia	40,884,249	26,942,720	105,386	539,732	645,118	23.9	12	115	127	0.47
Somali	6,657,345	6,657,345	17,987	52,042	70,029	10.5	1	2	3	0.05
BG	1,237,366	1,237,366	41,896	167,127	209,023	168.9	2	17	19	1.54
SNNP	13,950,342	10,909,167	102,276	365,206	467,482	42.9	8	16	24	0.22
Sidama	4,647,672	3,016,339	23,402	131,356	154,758	51.3	0	1	1	0.03
SWE	3,368,384	2,755,338	76,002	363,921	439,923	159.7	7	59	66	2.40
Gambella	530,893	530,893	37,116	125,972	163,088	307.2	4	13	17	3.20
Harari	282,848	219,773	74	460	534	2.4	0	0-	0	0
DD	550,642	550,642	738	12,216	12,954	23.5	3	6	9	1.63
AA	3,938,772	649,897	123	4,706	4,829	7.4	0	4	4	0.62
Total	101,340,251*	70,026,113	516,780	2,786,689	3,303,469	47.2	41	255	296	0.42

Note: *The total population is not including Tigray region population

Long-lasting Insecticidal Nets (LLINs) Distribution

The Ministry of Health-Ethiopia in collaboration with partners is working to ensure that all eligible households in malaria risk areas have access to LLINs. MoH with its partners are also working to improve the use of LLINs and to ensure that they are distributed effectively.

In the fiscal year, 19.7 million LLINs were purchased with Global fund and PMI|USAID support for distribution to households in 537 Woredas that were eligible for LLINs replacement. Of these, 16,991,437(90%) were distributed to households; additional 89,000 LLINs was distributed for emergency response in Afar, Somali and Gambella regions. This is a significant increase from the previous year, when 2.9 million LLINs were distributed. The increase in LLINs distribution is a positive development, as it will help to protect people from malaria. LLINs are one of the most effective ways to prevent malaria, and they are especially important for children under five years old, who are at a higher risk of developing severe malaria.

Table 15: LLIN distribution status by region, 2015 EFY

LLINs Targeted Region	# of LLINs Planned	# of LLINs received from EPSS	Hubs to Woreda distribution coverage (%)	# of LLINs distributed to HHs	HH level distribution coverage
Tigray	1,479,150	1,247,818	84%	1,174,673	94%
Afar	914,850	914,850	100%	780,004	85%
Amhara	3,949,928	3,947,328	100%	3,820,038	97%
Oromia	7,186,474	6,558,935	91%	5,368,492	82%
BG	678,645	595,600	88%	466,719	78%
SNNP	3,168,600	3,168,600	100%	3,147,130	99%
Sidama	915,950	911,650	100%	835,605	92%
SWE	1,247,548	1,236,286	99%	1,144,762	93%
Gambella	258,382	254,014	98%	254,014	100%
Total	19,799,527	18,835,081	95%	16,991,437	90%

Indoor Residual Spraying (IRS) of Unit Structures

In Ethiopia, IRS has been conducted in targeted malaria risk areas since the 1950s. It is an important part of Ethiopia's malaria control and elimination strategy in reducing malaria transmission. In the fiscal year, 1.2 million (96.9% of planned) houses were sprayed with IRS insecticide.

The National Malaria Elimination Program (NMEP) is supporting different studies to enhance the strategies for malaria prevention, control, and elimination. Currently, NMEP is collaborating with EPHI on a study of the insecticide efficacy and mosquito biting behavior of existing and newly identified mosquitoes. NMEP is also collaborating with PMI/Vector Link on a study of the distribution of An. Stephensi and the effectiveness of larvicide.

Table 16: Indoor residuals spraying (IRS) coverage by regions, 2015 EFY

Region	# of Woreda	# of Kebele	# of unit structures	Performance	Coverage (%)	Estimated people protected
Afar	7	24	14,524	12,990	89.4	79,895
Amhara	19	130	318,994	304,757	95.5	855,648
Oromia	31	234	256,208	262,488	102.5	879,569
Somali	40	249	122,605	115,765	94.4	516,571
BG	20	313	208,809	204,856	98.1	466,586
SNNP	45	181	142,515	130,176	91.3	420,339
Sidama	4	4	9,686	9,380	96.8	30,270
SWE	20	74	48,334	46,606	96.4	151,915
Gambella	14	247	131,594	127,269	96.7	502,377
Total	200	1,456	1,253,269	1,214,287	96.9	3,903,170

Malaria Elimination Activities

Malaria elimination activities being implemented in 565 districts enrolled in two rounds. In the fiscal year from the identified 138,042 malaria cases, 93,031 index cases were eligible for case investigation and managed to investigate 56,423 (61%) index cases. Based on the malaria elimination guideline to instigate household within 70-meter radius of index case, 197,084 households were eligible for investigation, this account 3.5 household per the index case and managed to investigate 187,658 (95.2%) households. In the 70-meter radius of index cases able to elicit 583,576 individuals for malaria test, which account 10.3 people per the index case and identified 14,079 secondary cases (2.4% positivity rate). In the fiscal year, foci investigation and response being conducted in 21,966 breeding sites (active foci).

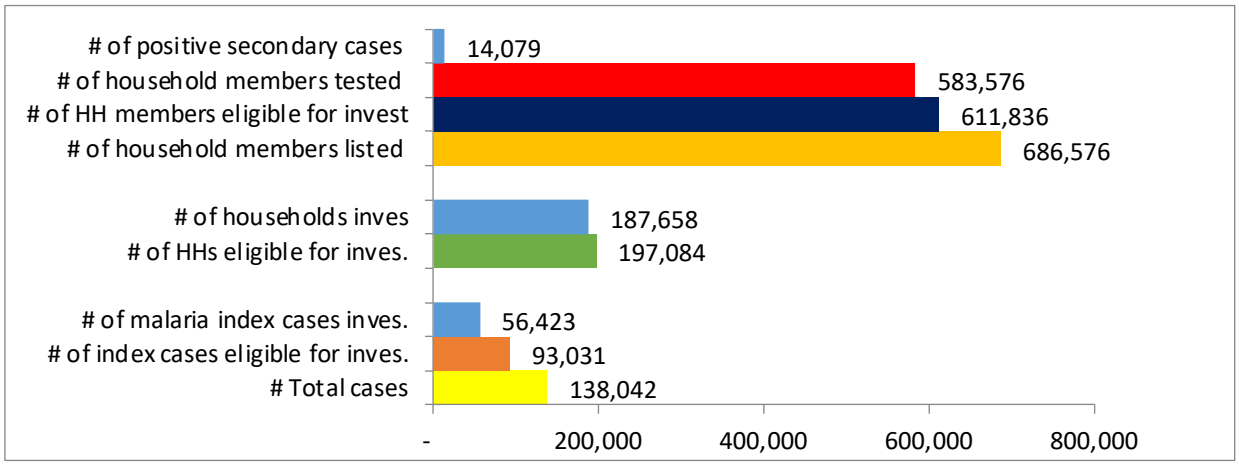


Figure 40: Malaria elimination on index case investigation and test 2015 EFY

Other major achievements and activities performed on malaria prevention and control

- **Malaria Epidemiology:** Morbidity attributed to malaria had been declined significantly from 2008 EFY – 2011 EFY, though morbidity increased in 2012 EFY, 2014 EFY and 2015 EFY is a concern in the disease prevention, control and elimination. Death due to malaria has declined by 41% from 0 .71/100,000 population to 0.42/100,000 population at risk between 2009 and 2015 EFY.

- **Entomology**: Monitoring of insecticides susceptibility, survey on geographical distribution of An. Stephensi and other entomological works have been carried out in collaboration with partners.

- **Vector Control**: Various activities have been performed to control malaria vectors such as distribution of LLINs, IRS spraying and evidence generation with studies to support the vector control interventions.

- **Malaria case management**: National malaria diagnosis and treatment guideline, which is in line with the WHO guideline is developed, revised and whenever there is a new development/ updates the technical working group discuss and being shared to facilities accordingly.

- **SBCC**: Different SBCC activities have been implemented in the physical year including broadcasting five spot messages in television and radio programs using national as well as regional media platforms to reach the community. World Malaria Day 2023 was celebrated with the theme “Time to deliver zero malaria: invest, innovate, implement” involving relevant stakeholders at Hawassa town.

- Weekly data analysis and feedback sharing using the weekly PHEM data, and case and foci investigation reports to regional malaria focals. The information is used to bring the attention of the management body to an appropriate decision.
- The National Malaria Strategic plan is being revised with reiterative process from planning, desk review and field validation by national and international consultative and will be shared once the document is approved by the ministry.
- Global fund grant application for 2024/25 – 2026/27 grant is being done and the funding request is submitted.

Challenges

- Delays in the timely procurement of Long-Lasting Insecticidal Nets (LLINs) and Indoor Residual Spraying (IRS) chemical by EPSS and the Global Fund Wambo have affected the timely implementation of malaria prevention and control interventions.
- Interruptions of anti-malaria drugs and diagnosis kit supplies at health facilities could have a negative impact on the current upsurge.
- The lack of strong joint coordination with stakeholders at development corridors in addressing seasonal migrant workers in malaria prevention and control activities.

Way forward

- EPSS should give priority for malaria treatment, diagnosis and prevention supplies on timely procurement and provide uninterrupted supplies for health facilities.
- Stakeholders working on development corridors should invest on malaria prevention and control interventions in consultation with MoH and RHBs.
- Researchers and universities should come up applied research on malaria vectors and effective interventions to halt the case build up in the country.

3.9. Prevention and control of non-communicable diseases and mental health illnesses

Major NCD prevention and control program, cancer control program and prevention of blindness (eye health) programs are currently the three major areas that MOH is implementing under the prevention and control of non-communicable diseases unit. In 2015EFY At MOH level, Diabetes mellitus training manual for health care providers was finalized and endorsed, final breast cancer screening and treatment guideline was prepared and a five-year eye health care draft strategic plan was also prepared. Below is detail of performed activities on NCD and mental health programs

Awareness Creation on NCDs and their risk factors

The MOH has been using the global public health days as an opportunity to raise awareness of and understanding about health issues. During 2015 EFY, World heart, diabetes, hypertension and tobacco days were commemorated with panel discussions, press release and different awareness creation and screening activities. During commemoration of world hypertension day, on top of the aforementioned activities, spot message was transmitted through mass media.

Moreover, media spot transmission on cervical cancer was transmitted for 2 months in this year to increase the public awareness on cervical cancer. An awareness creation and sensitization training were given to mainstream media professionals and they have managed to prepare TV programs on the benefits of cervical cancer screening. These programs were aired through major media channels that have larger coverage (EBC, Fana BC, Walta TV.).

Integration of NCDs services within health system

To strengthen integrated diagnosis and treatment of major NCDs into the health system, supportive supervision and mentorship visits were undertaken in more than 56 health facilities. The service provision assessment conducted in 2021/2022 and disseminated in 2023 showed that overall, about 8 of 10 health facilities diagnose, prescribe treatment, or manage patients with diabetes, cardiovascular disease, and chronic respiratory disease.

In this reporting period, Integration of major NCDs with HIV program is being piloted at 10 hospitals. In this regard, training manuals and implementation guideline were developed and training provided on hypertension and diabetes for 40 ART service providers. Furthermore, blended Integrated Refresher Training Module on Non-Communicable Diseases Prevention and Control for Health Extension Program has been developed.

Hypertension, Diabetes Miletus and cardiovascular disease prevention and control Service

Screening for hypertension and diabetes have paramount importance for early detection of the disease and reduce the chance of poor health outcome. During 2015 EFY, it was planned to screen 8,177,712 individuals of over 30 years for hypertension. However, a total of 14,382,120 individuals were screened for hypertension, out of which 11,459,493 (>100% of plan) of them are people above 30 years of age. Of all screened, 52% of them are female while 48% are male.

Likewise, during 2015 EFY, it was planned to screen 2,950,086 individuals of over 40 years for diabetes mellitus (DM). The performance shows that 2,667,724 individuals were screened for DM, out of which 1,509,843 (51% of plan) are those over the age of 40 years. Sex disaggregation shows proportion of female among screened are 50%. The overall screening performance over the last four years shows sharp increasing trends. The 2015 EFY screening performance for hypertension increased by nearly six time compared to 2012 EFY while DM screening increased four times during same period.

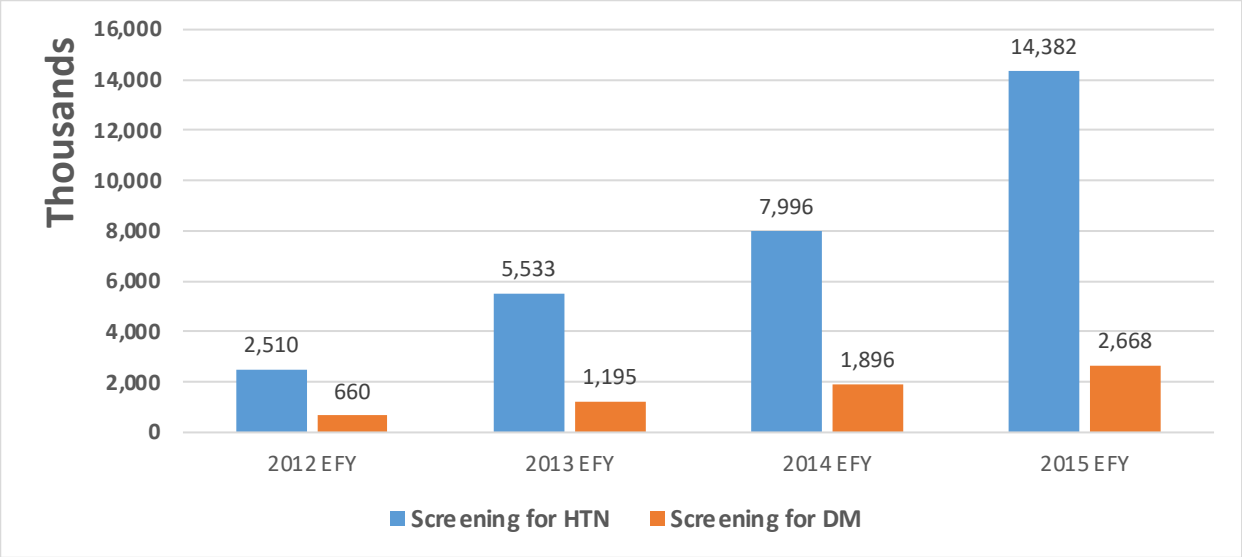


Figure 41: Hypertension and Diabetes Screening Performance at national level, in thousands, 2012-2015 EFY

The number of individuals with confirmed hypertension newly enrolled to care in 2015 EFY are 190,439 (43.7% against the plan). Similarly, the number of individuals newly enrolled to diabetic care are 49,030 (53% of planned target 91,403). The trends of enrollment to hypertensive and diabetic care increased from 2012-2014 EFY, however it declines in 2015 EFY, which might be due to change in NCD data reporting format during recent indicator revision and weak linkage to care and treatment.

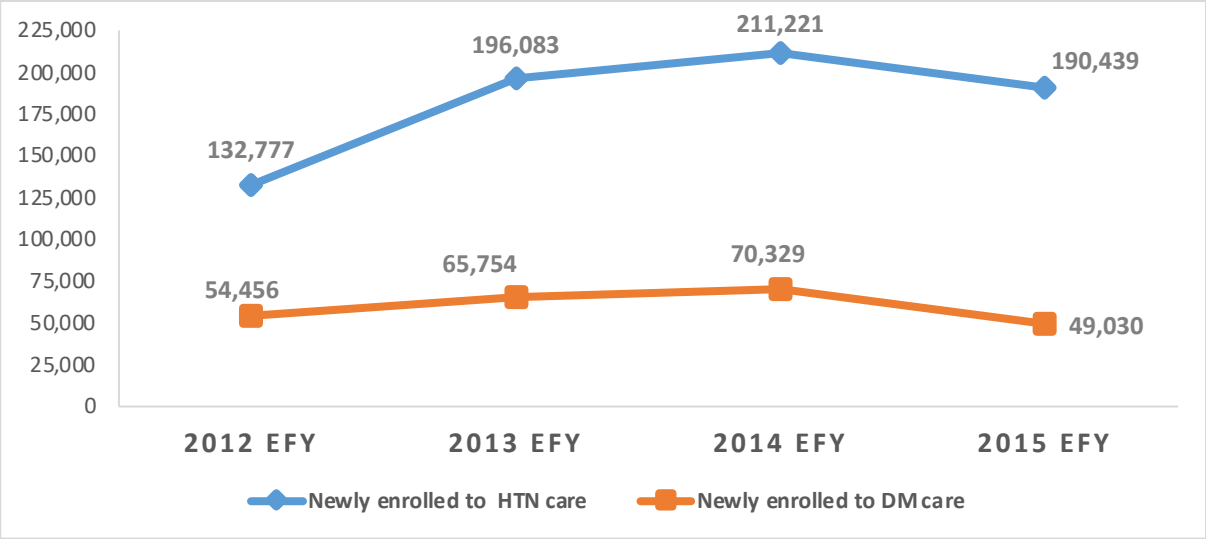


Figure 42: Trend of number of individual enrolled to hypertensive care and diabetic care at national level, 2012-2015 EFY

Cancer Screening and Treatment Program

The public health importance of cancer in Ethiopia is increasing in recent decades. According to EPHI's 2021 national burden of disease report, the cancer mortality rate per 100,000 population is 36.7. On the other hand, the cervical cancer incidence rate per 100,000 population is around 26. Cognizant of the problem, Ethiopia has taken significant strides to address cancer care gap. A national cancer control strategy has been developed, focusing on a continuum of care approach: Primary Prevention;

Early Detection; Diagnosis and Treatment; and Palliative Care. Currently there are a total of three (Black Lion Specialized hospital, Jimma university referral Hospital and Haromaya university hospital) centers providing radio-therapy services with 3D-LINAC Machine. In the reporting period pre-requisite to start radio therapy at Hawassa University and Gondar university hospitals were finalized. The start of service at these two hospitals will contribute toward ensuring equitable geographic distribution of the cancer treatment service.

In Ethiopia, cervical cancer is the second most frequent form of cancer and leading cause of cancer deaths among women. A large majority of cervical cancer (>95%) is due to the human papillomavirus (HPV). In line with the WHO global strategy (90-70-90 i.e., reaching the target of 90% HPV vaccination, 70% cervical screening and 90% cervical cancer treatment by 2030), the Ministry is following the strategy of strengthening the existing services including scale-up of secondary cervical cancer screening & treatment to ensure service is accessible in the country.

Ethiopia introduced HPV vaccination in December 2018 for a single age cohort of 14-year-old girls, with a one-week school-based campaign design strategy providing as the key platform. Currently the country is going to introduce the HPV vaccine through the routine immunization program. (See immunization section of this report for detail of HPV vaccination performance).

The cervical cancer screening service was started in 2001 EFY at five health facilities. Since then, the number of VIA and Cryotherapy service providing health facilities are tremendously increased and reached 1330 during this reporting period; however LEEP providing site shows marginal increase.

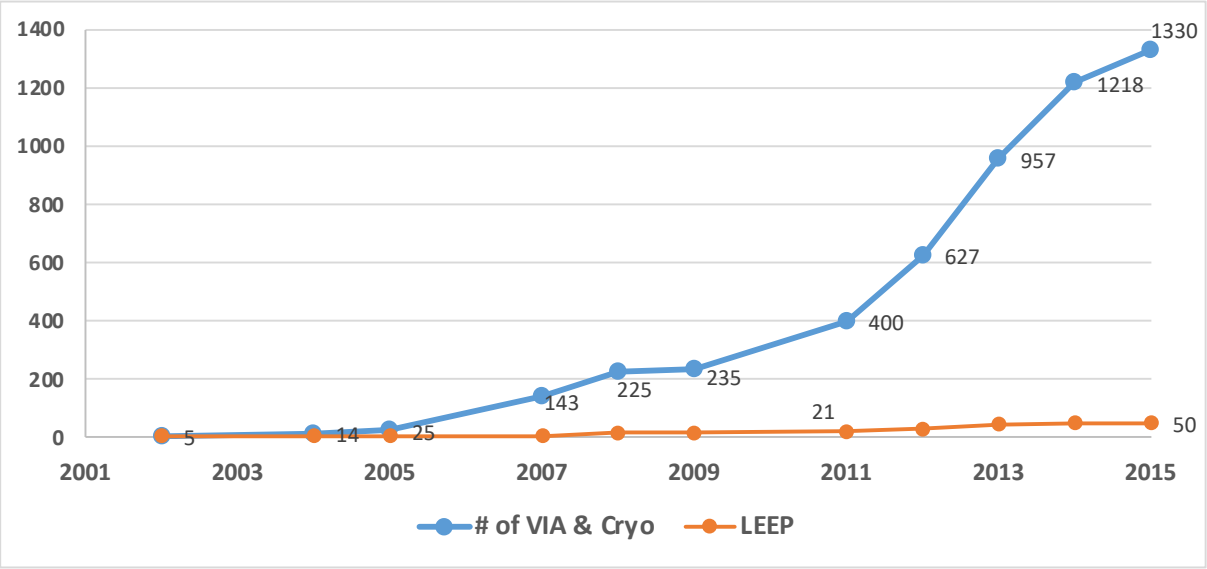


Figure 43: Number of cervical cancer screening and treatment sites, trend from 2002-2015 EFY

In addition to service expansion, quality improvement is one component that is given due attention by the Ministry on cervical cancer program. In this regard two rounds of mentorship were conducted in this fiscal year and a total of 262 HFs were supported by clinical mentors.

During the reporting period, a total of 529,507 women have received cervical cancer screening service which is nearly 53% against the annual plan. However, the current year performance is improved by 50% compared with last year performance. Of all screened women in 2015 EFY, 492,195 (93%) are

screened by VIA while the rest are by HPV/DNA test. There is wide regional variation of screening performance against plan, Addis Ababa and Harari reported more than 100% while Sidama, Oromia, and SNNP reported 92%, 60% and 53% respectively. Somali reported the lowest (3%) followed by South west (9%), Benishangul Gumuz (10%) and Gambella (12%). The remaining three regions performance fall between 20-50%. Overall, cervical cancer screening service has improved significantly since 2011 EFY.

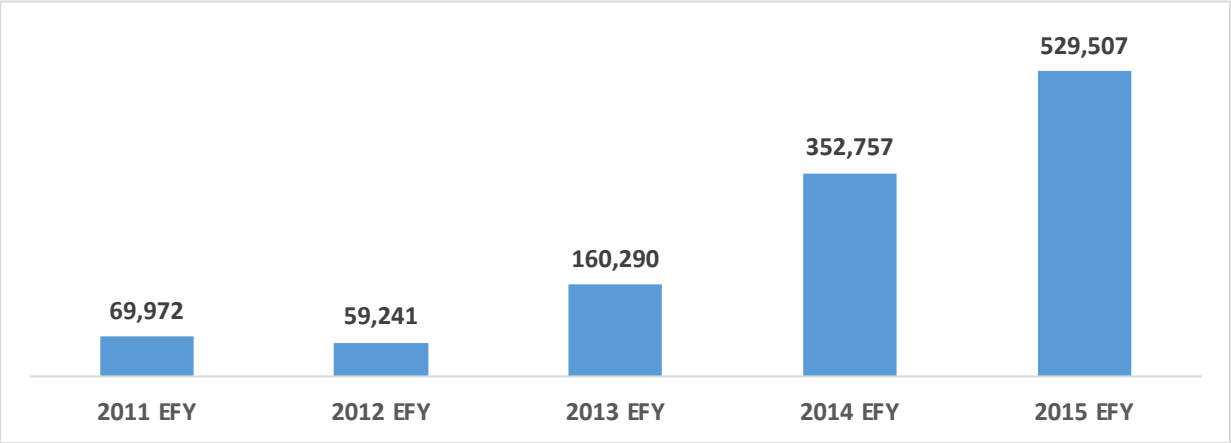
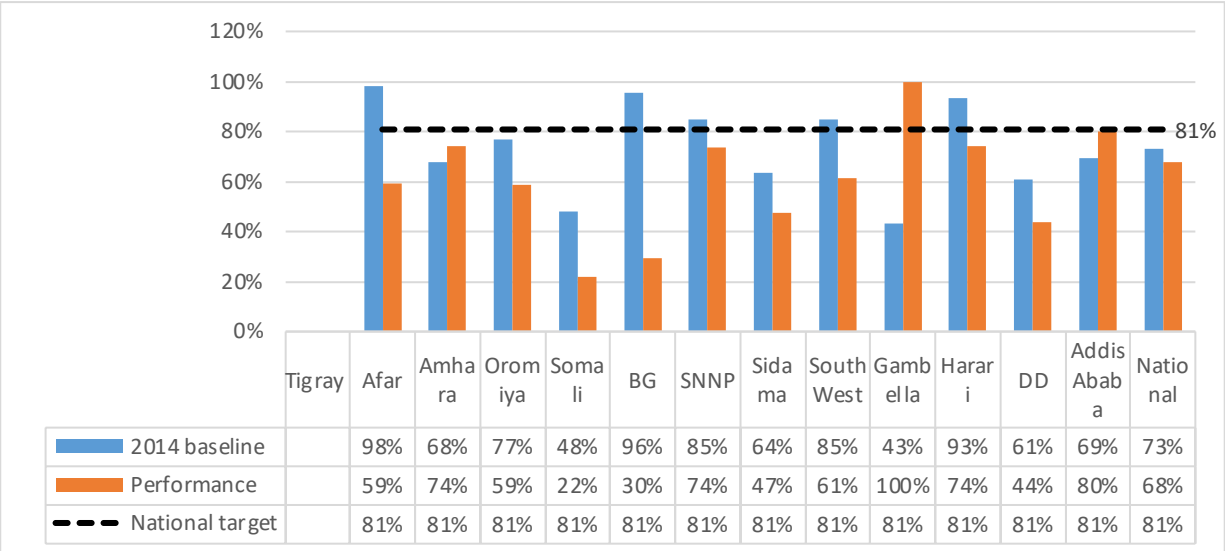


Figure 44: Number of women screened for cervical cancer, trend from 2011-2015EFY

Of all screened women for cervical cancer by VIA (492,195) in 2015 EFY, 20,800 of them are eligible to receive the treatment for lesion. At national level 14,037(67.5%) have received cervical cancer lesion treatment which is below 73% of 2014 baseline and 81% of 2015 national target. At regional level, none of the region achieved the target except Gambella & Addis Ababa and similarly all regional performance except Gambella, Addis Ababa and Amhara are below their respective region 2014 baseline.



	Tigray	Afar	Amhara	Oromiya	Somali	BG	SNNP	Sidama	South West	Gambella	Harari	DD	Addis Ababa	National
2014 baseline		98%	68%	77%	48%	96%	85%	64%	85%	43%	93%	61%	69%	73%
Performance		59%	74%	59%	22%	30%	74%	47%	61%	100%	74%	44%	80%	68%
National target		81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%

Figure 45: Proportion of Eligible women that received treatment for cervical lesion by region, against baseline and Target, EFY 2015

Eye health national program

Eye health conditions such as cataract, glaucoma and refractive errors are among the common eye problem in Ethiopia. Based on the gaps identified by the Eye Care Situation Analysis Tool (ECSAT) in 2014 EFY, integrating eye health into the broader health system, and strengthening primary eye care are major focus area during this reporting period.

To enhance the capacity of health worker, in service training on screening of common eye problems was given to 56 health workers from primary health care facilities. Similarly, a total 223 health workers have received training on integrated people centered eye care (IPEC), and measuring biometry. Ophthalmic nursing curriculum was revised, to re-start the ophthalmic nursing training which was interrupted in the last three years. Furthermore, two Primary eye care units (Assosa and Dubti hospitals) have been upgraded to Secondary eye care units

Awareness creation and advocacy was conducted during World Sight Day Celebration Day. At national level the commemoration was held at Harar town in the presence of higher officials from MOH and Parliament members from Federal and the hosting region. Eye screening was conducted during the world sight day celebration at regional and national level. A total of 285,146 individuals are screened and people with eye health problem are identified. Of all screened, 4.4% (12,492) had cataract, 3% (8,831) had refractive error, 1.8% (5,021) had glaucoma and 2.9% (8,304) were diagnosed with other eye health problems.

In 2015 EFY, a total of 83,792 cataract surgery was performed from the existing backlog. The cataract surgical rate (CSR) per 1,000,000 population in 2015 EFY was 826 which is higher than that of 2014 baseline (555). The CSR in 2011 and 2012 EFY was 304 and 294 respectively. It is increased to 329 in 2013 EFY. Furthermore, 69,136 (60% are male) patients were treated for glaucoma and a total of 107,118 (53.5 % are male) were treated for refractive related problem.

Mental Health Program

Mental illness comprised 11% of the total burden of disease, with schizophrenia and depression included in the top ten most burdensome conditions. A systematic review and meta-analysis also indicated the prevalence of common mental illness to be 21.58% and 36.43% in the general population and among patients with co-morbid conditions respectively. Considering the burden of disease, MOH made mental health as one of focus area during the coming three years health sector development and investment plan.

Integration of mental health service with the health system: To build the capacity of health workers, mhGAP-IG, a clinical guide for general health-care providers who work in non-specialized health-care settings, training was given for 120 health workers while mhGAP-HIG training was given for 1083 health workers to address mental health in crises and drought affected area. At national level, of all hospital and health center, 728 (17%) have started providing integrated mental health service. There is very wide regional variation: all public health facilities of Addis Ababa and Dire Dawa provide integrated mental health service followed by Harari (93%). The proportion of public health facilities that provide integrated mental health service in Oromia, Somali, SWE, Afar and SNNP are 8%, 9%, 12% and 13% respectively. The rest of the region status is above national average.

Mental Health Service: According to 2021 SPA finding, 22% of health facilities have trained staff for provision of mental, neurological and substance abuse service while 26% percent of facilities provide

services for mental illness. Mental health service provision is routinely monitored by DHIS2 through monthly disease report. During 2015 EFY, a total of 173, 018 individuals have received treatment for priority mental health disorder which comprise psychosis 115,505 (57% are male), depression 39,895(53% are female) and bipolar disorder 17,618 (51% are male). Likewise, 183,782 (56% male) and 8,291 (81% male) individuals have received treatment service for epilepsy and substance use disorder.

The 2011-2015 EFY trends of individuals treated with priority mental health disorder (MHD) and epilepsy shows declining from 2013 EFY onward. This may be attributed to absence of Tigray report.

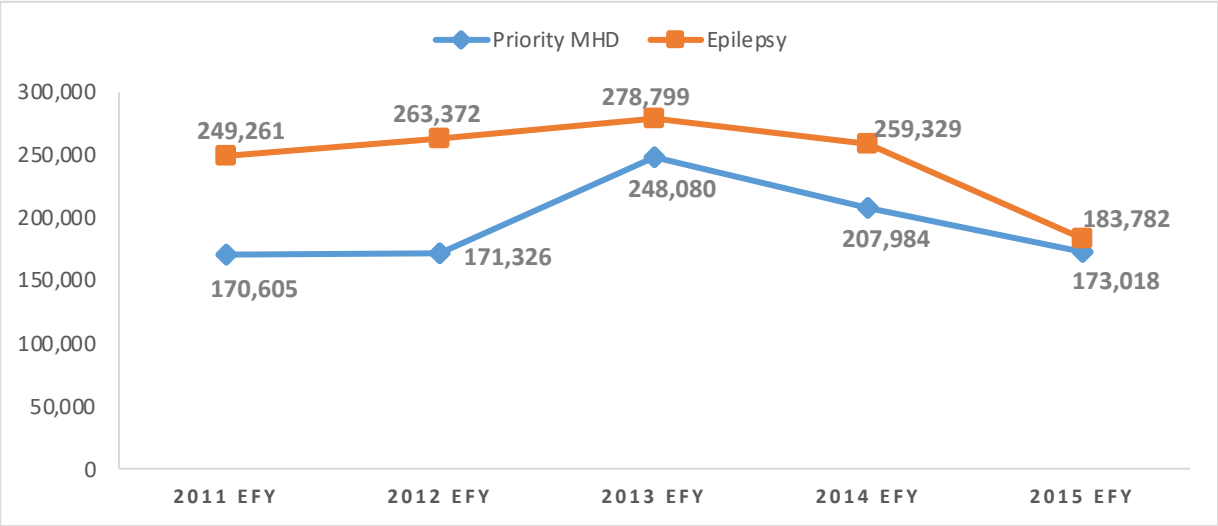


Figure 46: Number of individuals that received treatment service for priority mental health disorder (MHD) and Epilepsy at National Level, 2011-2015 EFY

Additionally mental health service was given to the area affected by crisis and drought. In this regard, mental health awareness creation was given to a total of 245,633 individuals while psychological support was given to 39,172 individuals. Mental health screening service and pharmacotherapy was also given to 10, 704 and 8,899 people respectively.

Challenges:

- Shortage of budget and human resource for NCDs and mental health program
- Lack of ownership of major NCDs and mental health program at regional, zonal, woreda and HF level
- Absence of functional structure for mental health in the region
- There is limited implementing partner that support the program
- Treatment outcome of mental health and eye health treatment service could not be monitored through current HMIS indicators
- Lack of communication and integration between cervical cancer program and other health programs at all level

Way forwards

- High level advocacy at national and regional level for bringing the required commitment and ownership on the program
- Conducting capacity building for Mental Neurological and Substance use disorder program managers at national and regional level
- Expand the center of excellent to increase the diagnosis and treatment capacity to meet the high demand of referral and confirmatory diagnosis of cervical cancer.
- Heath Extension Workers Engagement to increase the demand creation, and improve the screening uptake of hypertension, diabetes and cervical cancer.

3.10. Prevention and control of Neglected Tropical Diseases

The neglected tropical diseases (NTDs) that are identified for control and elimination in Ethiopia include: Schistosomiasis, Soil-transmitted helminthiasis, Onchocerciasis, Podoconosis, Lymphatic Filariasis, Leishmaniasis, Trachoma, Scabies, dracunculiasis (targeted for eradication), Dengue and Chikungunya, Human African Trypanosomiasis, and Snakebite envenoming. A variety of interventions have been developed and put into place to help control and eliminate neglected tropical diseases (NTDs), including preventive chemotherapy, innovative and intensified case management, transmission vector control, WASH, innovative case management, prevention of zoonotic diseases, and vector ecology management. Moreover, service integration and multi-sectoral collaboration approaches are key emphasis areas. The major achievements in 2015 EFY are described below.

Preventive Chemotherapy of Neglected tropical diseases (PC-NTDs)

Trachoma: In 2015 EFY, more than 17,789,461 Zithromax treatment was administered in 136 endemic districts out of 520 endemic districts. As part of the SAFE (Surgery, Antibiotics, Facial cleanliness, and Environmental improvement) strategy, surgery was done for 134,939 people with Trachomatous Trichiasis (TT). According to the trachoma impact surveys, so far 295 districts with a population of more than 32 million stopped MDA by achieving the WHO TF elimination threshold, which is below 5%. To accelerate TT surgery, 280 integrated eye care workers (IECW), and 1,813 TT case finders were trained and deployed for Woredas with a high TT backlog. Since the introduction of the SAFE strategy, 115 districts achieved the TT elimination threshold (a prevalence of TT < 1 case per 1000 total population) and over 1,737,566 individuals get TT surgery services.

Onchocerciasis and Lymphatic Filariasis: In 2015 EFY, over 19,340,445 (96% of the target) people were treated with Ivermectin drug for the prevention of onchocerciasis in 232 districts, and 2,325,241 (89% of the target) people were treated for lymphatic filariasis. In addition, over 700 individuals received hydrocele surgery and 53,768 received Lymphedema morbidity management for Lymphatic filariasis and Podoconiosis. According to the impact survey conducted in the previous years, more than 3.08 million people in 30 districts and 3.06 million people in 47 districts no longer required MDA for onchocerciasis and lymphatic filariasis respectively.

Schistosomiasis (SCH) and Soil-transmitted helminthiasis (STH): In 2015 EFY, a total of 46,428,824 School-age children, adolescents, and Women of reproductive age group were treated for STH in 595 districts. In addition, 5,176,867 school-age children were treated for Schistosomiasis (SCH) in 177 districts.

Leishmaniasis: A total of 1,902 Visceral and 2,143 cutaneous leishmaniasis patients received treatment in more than 30 treatment centers.

Dracunculiasis eradication program: The Guinea Worm Disease (GWD) eradication program, which began in 1986, has reduced the number of woredas (districts) in Ethiopia that are endemic to the disease from 7 to 2. Currently, the only case identified from Gambela region only. In 2015 EFY, only one human case and three animal infections were reported in August and September. In the physical year, the disease burden dropped by 91% compared to 1986.

Other NTD-related activities

- In 2015 EFY, nine confirmed cases of Human African trypanosomiasis, eight from SNNP and one case from SWE were reported and four deaths were also reported as of 13 June 2015 EFY.
- Capacity building was provided for HMIS focal persons in more than 191 health centers and zonal NTD program personnel on NTD-related indicators, data recording tools, DHIS2, and data use.
- In collaboration with African Leaders Malaria Alliance developed an NTD scorecard for accountability and transparency and gave training for more than 60 program and M&E managers.
- In 2015 EFY, WASH-NTD coordination toolkit training was conducted in four regions Afar, BG, Gambella, and Somali regions in 51 Woredas
- Review the performance of WASH for the NTD elimination program in three zones (Hadiya, East Harerge, and North Wollo).

Challenges

- Limited capacity of the health system to fully integrate/mainstream NTDs interventions.
- Limited support for NTD interventions from donors and the government.
- Fragile security affected the logistic supply system for timely drugs distribution.
- Limited WASH intervention and vector control activities.

Way forward

- Health system strengthening to integrate NTD interventions into the primary health care system
- Work with international agencies to find a support for logistic supply in those security threat areas.
- Advocacy to increase commitment to NTD program implementations and local resource mobilization.

3.11. Clinical Services

Access to Specialty and Sub-specialty Service: During the fiscal year, various actions were taken to implement the specialty and subspecialty roadmap and expand tertiary medical care. Senior Specialists mentored and conducted gap analysis at 18 hospitals establishing primary ophthalmology, dermatology, and mental health services. These 18 hospitals also received training from Alert, St. Peter, and Amanuel

Hospitals' specialists to improve their medical capabilities, ensuring the quality and efficacy of their newly established services. Five forensic psychiatry-focused hospitals received onsite supportive monitoring as part of this program. Federal court officials, regional police, justice offices, and other stakeholders attended a ceremony to recognize these hospitals' progress and performance. The signing of a memorandum of understanding between JDC-Ethiopia and the Israeli government was another milestone, in neurosurgery.

For the national implementation of medical tourism, a comprehensive draft Medical Tourism Roadmap was drafted, a baseline assessment was conducted in selected university hospitals, and a panel discussion with relevant stakeholders was also held.

Evaluation of Medical Oxygen Roadmap was conducted. Comprehensive training on the proper use of medical oxygen was provided to 180 healthcare professionals across different regions. Furthermore, sustainable financing guidelines for oxygen plants were crafted, and training materials were fine-tuned to promote the rational use of medical oxygen.

In the endeavor to strengthen and standardize national clubfoot treatment, different activities were conducted. These include the development of a comprehensive treatment guide, affiliation with four clubfoot service-providing institutions, and the development of detailed training manuals for Ponseti-based clubfoot treatment services. Technical and material support was provided to regions. In 56 hospitals across the nation, a total of 2550 children received clubfoot treatment in the fiscal year.

Access to Rehabilitation Service: To strengthen rehabilitation services, preparations for the 2016 launch of a bachelor's degree program in Prosthesis & Orthosis have been concluded, and rehabilitation center leaders and specialists have received training. In the revised EHSTG, a chapter was included for palliative care and rehabilitation services. At a national review meeting, the efficacy of rehabilitation and assistive technology service delivery was evaluated. Rehabilitation personnel from various institutions have also received resource mobilization training. Integration of rehabilitation services into primary health services was preceded by a landscape analysis. A comprehensive rehabilitation information system has been implemented in ten rehabilitation centers and two hospitals to facilitate the reporting of rehabilitation service delivery.

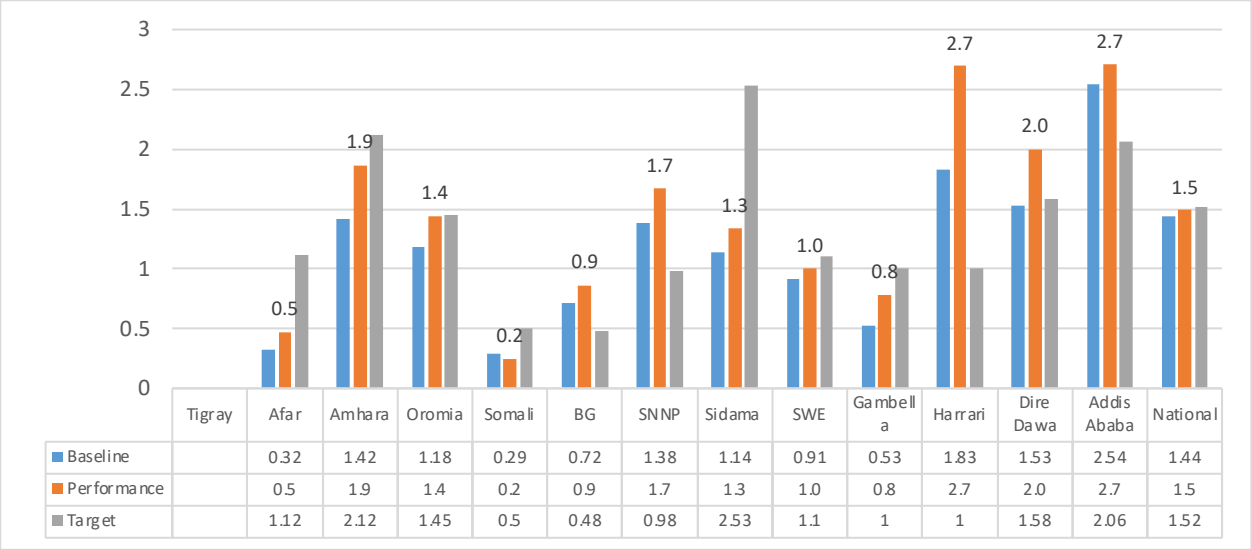
Diagnostic Service Improvement Initiative: To enhance diagnostic service accessibility and quality, various activities were conducted. A national diagnostic advisory team was established, a standardized audit tool was developed and a comprehensive national survey was conducted with a focus on enhancing diagnostic services.

Hospital Service Improvement initiatives: The Ethiopian Hospitals Alliance for Quality (EHAQ) is actively working to improve the quality of healthcare in Ethiopia. Supportive supervision and monitoring efforts were conducted to ensure that healthcare facilities across the country adhere to evidence-based practices. As a response to the COVID-19 pandemic, EHAQ initiative has provided financial support to all regions. In addition, evaluations were done to assess the impact of programs and continually enhance the quality and efficacy of healthcare services. The revision of the Ethiopian hospital reform implementation guidelines (EHRIG), which now include 23 essential chapters and provide comprehensive guidance to healthcare institutions and professionals, is another accomplishment during the fiscal year. These initiatives illustrate Ethiopia's dedication to improving the quality of medical services, promoting

evidence-based practices, and conforming to national guidelines and international standards. To standardize and enhance the quality of nursing practices, a comprehensive nursing procedure guideline was developed and distributed to all regions and select institutions.

OPD Attendance Per Capita

The monitoring of per capita attendance at outpatient departments (OPDs) is of paramount importance as it aids in the optimization of healthcare resource distribution, comprehension of disease prevalence and trends, formulation of strategies for preventive care, assessment of healthcare policies, and the facilitation of healthcare infrastructure growth. In the fiscal year, more than 151 million OPD visits were reported, which shows that the average national OPD attendance per capita was 1.5. This achievement surpassed the previous year's figures and almost similar to the targeted value of 1.52. There exists a notable regional disparity in performance, with regions like Harari (2.7), Addis Ababa (2.7), Dire Dawa (2.0), Amhara (1.9), and SNNP (1.7) surpassing the national average. Conversely, the remaining regions exhibited performance levels either below or on par with the national average, with Somali (0.2) and Afar (0.5) being the least performing regions.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harrari	Dire Dawa	Addis Ababa	National
Baseline		0.32	1.42	1.18	0.29	0.72	1.38	1.14	0.91	0.53	1.83	1.53	2.54	1.44
Performance		0.5	1.9	1.4	0.2	0.9	1.7	1.3	1.0	0.8	2.7	2.0	2.7	1.5
Target		1.12	2.12	1.45	0.5	0.48	0.98	2.53	1.1	1	1	1.58	2.06	1.52

Figure 47: OPD attendance per capita by region, 2015EFY

The findings reveal that 46% of the reported OPD visits were by males, while the remaining 52% were by females. About 80% of OPD attendees receive care in Primary Health Care Units (Health Centers and Health Posts), which serve as the primary point of contact for healthcare. Hospitals account for 17% of attendances, often handling more specialized or complex cases, while clinics attend to 3% of clients. This distribution underscores the essential role of Primary Health Care Units in delivering widespread care, with hospitals and clinics playing supplementary roles for specific and advanced healthcare needs. The last five years trend seems consistent except for some changes in 2014 EFY.

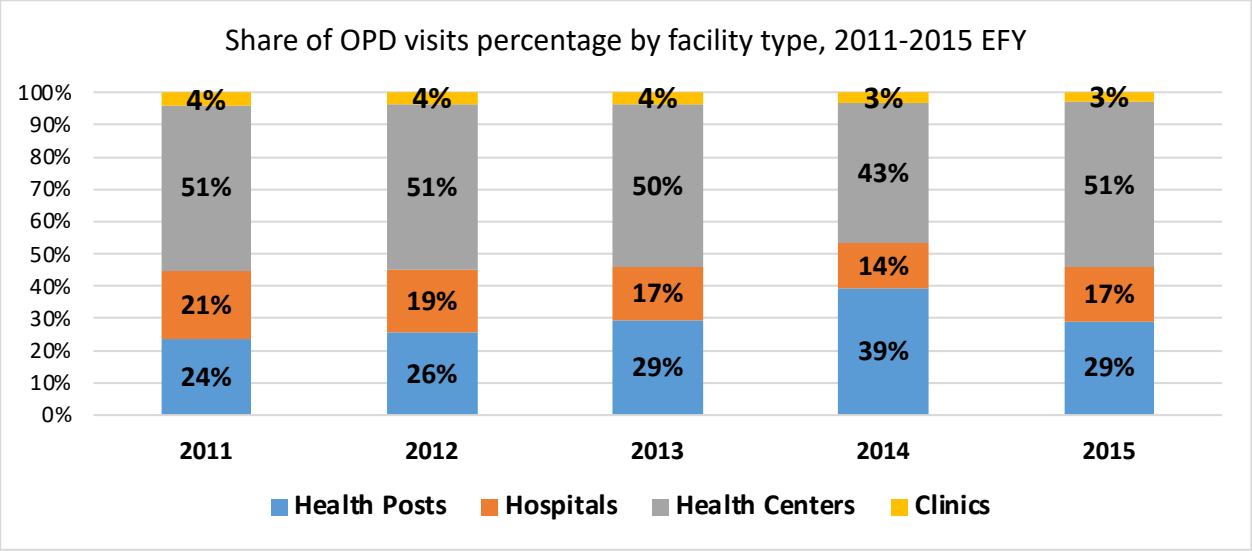
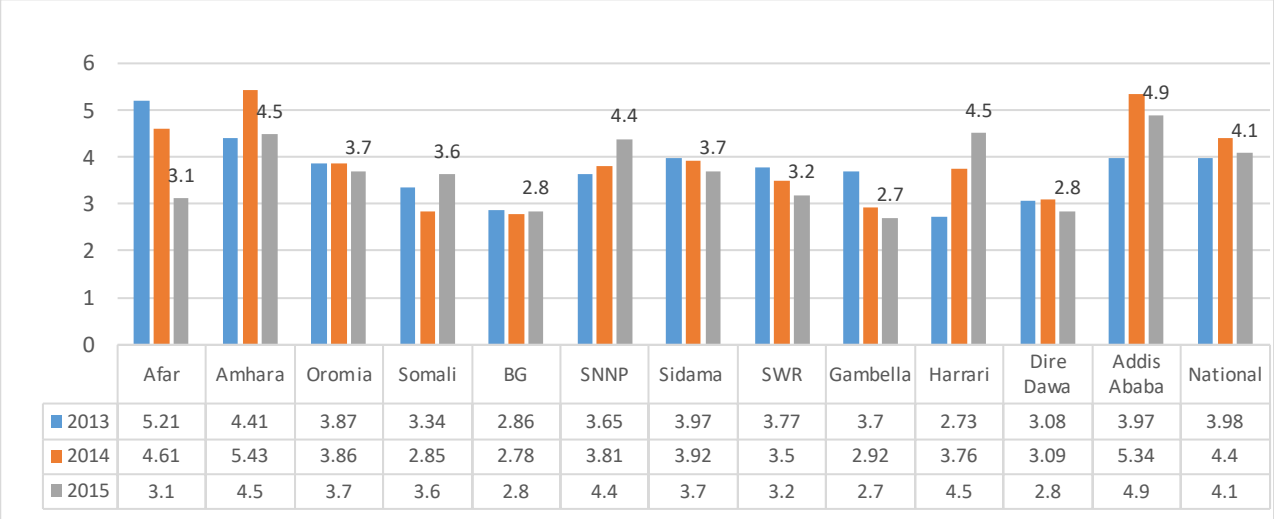


Figure 48: Distribution of OPD attendees by Facility Type and Year

Average Length of Stay (ALOS)

Monitoring Average Length of Stay (ALOS) in hospitals is important as it provides a key metric to evaluate hospital efficiency, quality of care, and patient outcomes over time. Tracking ALOS enables hospitals to identify trends, benchmark against targets, optimize care delivery, and implement focused improvements, ultimately benefiting both the hospital and patients through shorter stays, reduced costs, and better health outcomes. During the fiscal year, there was a plan to reduce the average patient's length of stay from 4.4 days to 3.19 days. The actual performance showed an average length of stay of 4.1 days, which is lower than the baseline. The data indicates variability among different regions - with Addis Ababa having the highest average length of stay at 4.9 days, while Dire Dawa and Benishangul Gumz had the lowest at 2.8 days. Though we did not achieve the target, here was still progress in decreasing average length of stays.



	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWR	Gambella	Harrari	Dire Dawa	Addis Ababa	National
2013	5.21	4.41	3.87	3.34	2.86	3.65	3.97	3.77	3.7	2.73	3.08	3.97	3.98
2014	4.61	5.43	3.86	2.85	2.78	3.81	3.92	3.5	2.92	3.76	3.09	5.34	4.4
2015	3.1	4.5	3.7	3.6	2.8	4.4	3.7	3.2	2.7	4.5	2.8	4.9	4.1

Figure 49: Average length of stay: Comparison of baseline with performance, 2015 EFY

Breakdown of the average length of stay over the past four years by hospital type shows that referral hospitals have the highest average length of stay, and this has been increasing year-over-year. Primary and General hospitals have also seen their average length of stay rise in most years, except for a slight decrease in 2015 for Primary hospitals. This increasing trend need to be evaluated to identify the driving longer hospital stays and develop initiatives to begin reducing average lengths of stay across all hospital types going forward.

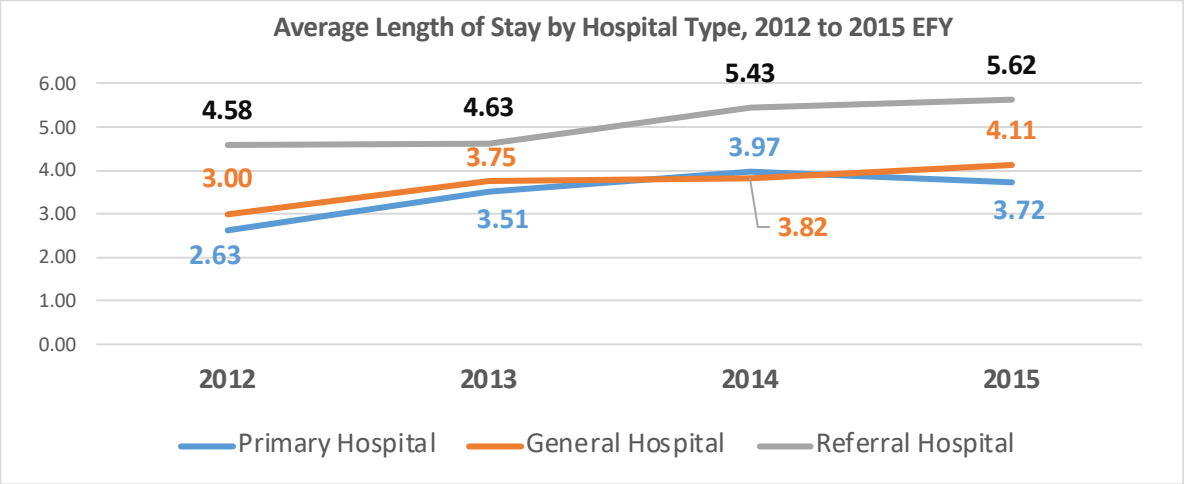


Figure 50: Average length of stay: comparison over the years and by facility type

Bed Occupancy Rate (BOR)

Bed occupancy rates, indicating the percentage of occupied hospital beds annually, play a vital role in optimizing limited healthcare resources. This metric reflects hospital capacity and utilization of resources efficiency. An optimal rate of approximately 85% balances resource efficiency and prevents overcrowding, staff burnout, and shortages during emergencies. Monitoring bed occupancy aids developing countries in assessing needs, guiding investments, managing diseases, preparing for surges, and enhancing care access and quality through data-driven planning and management of under-resourced health systems.

In the fiscal year, the national bed occupancy rate exceeded the set target by reaching 68%, compared to the 65% goal. Some regions consistently reported above-average rates, such as Amhara (86%), Harari (81%), and Addis Ababa (69%). In contrast, some regions such as Gambella (35%), Afar (38%), Benishangul Gumz (44%), and SWE (47%), had BOR below the national average. These figures highlight varying usage levels, showing some regions experiencing overcrowding while others having excess capacity. To enhance bed occupancy rates and ensure sufficient capacity nationwide, it is essential to investigate the factors influencing these regional disparities, necessitating targeted resource allocation and infrastructure improvements.

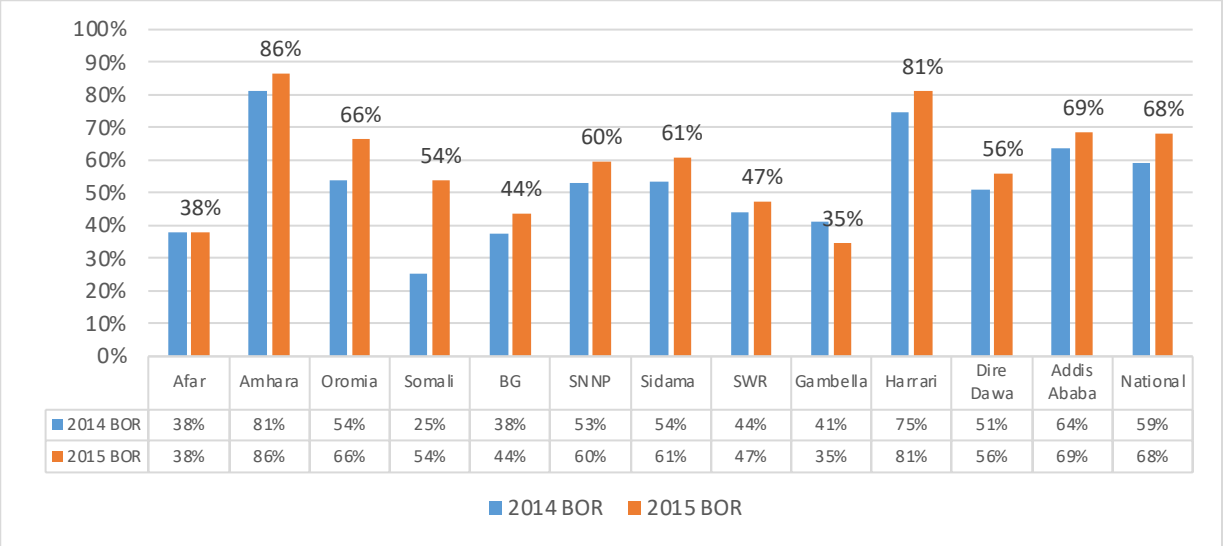


Figure 51: Hospital bed occupancy Rate: Comparison of baseline and Performance, 2015 EFY

Bed Density per 10,000 Population

Assessing the adequacy of healthcare infrastructure relies on gauging the number of inpatient beds available per 10,000 people. The World Health Organization (WHO) advises a minimum bed density of 5 per 10,000 people, as lower densities often point to insufficient capacity and challenges in accessing services. The 2015 report shows that the national average bed density was 3.1 per 10,000 population, below WHO's minimum. Disparities existed between regions, with Harari, Addis Ababa, Dire Dawa and Gambella exceeding the standard while remaining regions were below average. This indicates inadequate and inequitable bed capacity across the country. Targeted infrastructure expansion is required to increase bed availability and access to hospital services.

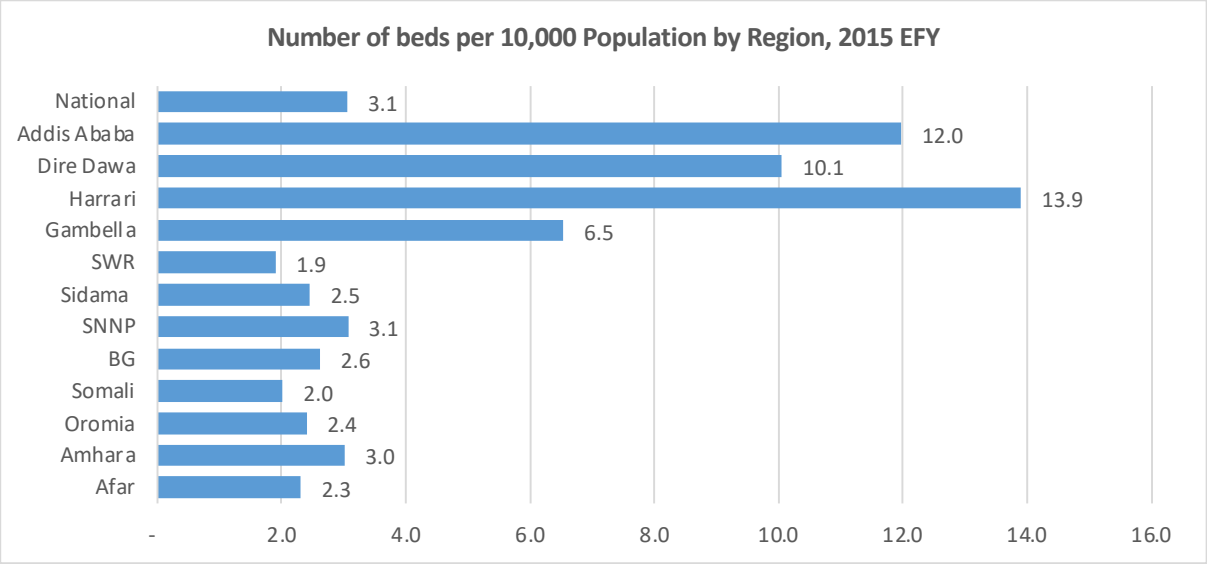


Figure 52: Hospital Bed Density per 10,000 Population by Region, 2015 EFY

Admission and Inpatient Mortality Rate

The 2015 report shows that the national inpatient admission rate was 15.4 per 1,000 population. However, there was significant regional variation, ranging from 8.6 to 84.4 admissions per 1,000 between regions. Harari had the highest admission rate at 84.4 per 1,000 population, followed by Addis Ababa at 50.1. The differing regional rates point to unequal access and utilization of hospital care across the country. Additionally, the national inpatient mortality rate was 1.04%. Moving forward, efforts should focus on increasing access and admission to underserved areas, while continuing to monitor mortality rates and quality of care as admission numbers rise.

Challenge

The challenges faced during the execution of clinical service initiatives include:

- Lack of sufficient funds.
- Security concerns hindering support for RHBs and health facilities.
- Insufficient coordination in leading and implementing MOH initiatives and programs
- Lack of commitment and support from leadership to implement initiatives and programs

Way forward

- Strengthen the implementation of the Clinical Leadership Improvement project and implement the Succession-Focused Leadership Incubation Program (SF-LIP).
- Enhance leadership and social accountability activities, including the implementation of the High Impact Leadership Program
- Strengthen Rehabilitation service and Assistive device production
- Expansion of Specialty and subspecialty services
- Strengthening EHAQ hospitals networking

3.12. Emergency and critical care services

Emergency and critical care services provide immediate and specialized medical care for individuals facing life-threatening situations or severe injuries. These services encompass emergency departments, trauma care, critical care units, and pre-hospital emergency medical services. Effective triage, rapid response, and coordinated communication are essential for delivering timely and lifesaving care in emergency situations, including disasters and mass casualty incidents. This section summarizes emergency and critical care related achievements in 2015 EFY.

The Major Cities Emergency and Critical Care Improvement Program: The Major Cities Emergency and Critical Care Improvement Program (MECIP) was implemented to enhance emergency and critical care services in major cities. MECIP is being implemented in 12 cities in the country and four of the cities started implementation in the 1st phase and eight additional cities in the 2nd phase. Hospitals found in the selected cities are part of the program. Seven out of eight cities' hospitals have prepared and submitted their quality improvement project proposals. In addition, supportive supervision and monitoring activities was done to four hospitals. These efforts were aimed at improving the quality of care in intensive care units and ultimately reducing elevated mortality rates.

Pre-facility and Emergency Referral Services: Efforts to enhance pre-hospital emergency services included the repair of 22 ambulances and procurement and delivery of essential office supplies for the ambulance dispatch and call center in Addis Ababa. Out of 3673 ambulances found in different regions of the country excluding Tigray, 2843 (77.4%) are functional based on the assessment conducted in the fiscal year. In terms of strengthening the patient referral system, a comprehensive national service directory was developed. The formulation of the National Inter-Regional Referral Catchment guideline was a pivotal step in improving the effectiveness of the patient referral system. Furthermore, integrated supportive supervision was conducted with a focus on implementing a web-based referral system, facilitating valuable feedback, and addressing identified gaps through productive discussions with key stakeholders.

Facility Based Emergency Services: To enhance facility-based emergency care services different activities were conducted. This include the provision of Basic Emergency Care (BEC) Training of Trainers (TOT) for 46 regional experts. Additionally, the development of the WHO-ECS Toolkit Scale-up guideline has been instrumental in standardizing and facilitating the expansion of emergency medical services. The introduction and implementation of a clinical audit tool in selected hospitals have further promoted ongoing quality improvement in emergency care.

Mortality within the first 24 hours of emergency department arrival serves as an indicator of care quality, with elevated rates suggesting suboptimal emergency care, ideally below 0.6%. For the fiscal year, the national performance was 0.2%. This figure demonstrates a consistent decline in emergency room mortality, given that the prior year's performance was 0.36%, and it was 0.45% in the 2013 fiscal year. Nonetheless, despite this overall positive trend, regional disparities persist. From the total 14,000 reported deaths in the emergency unit in the fiscal year, 62% occurred within 24 hours of admission, while the remaining 38% occurred after 24 hours. A total of 3,678,471 emergency room attendances were reported in the fiscal year.

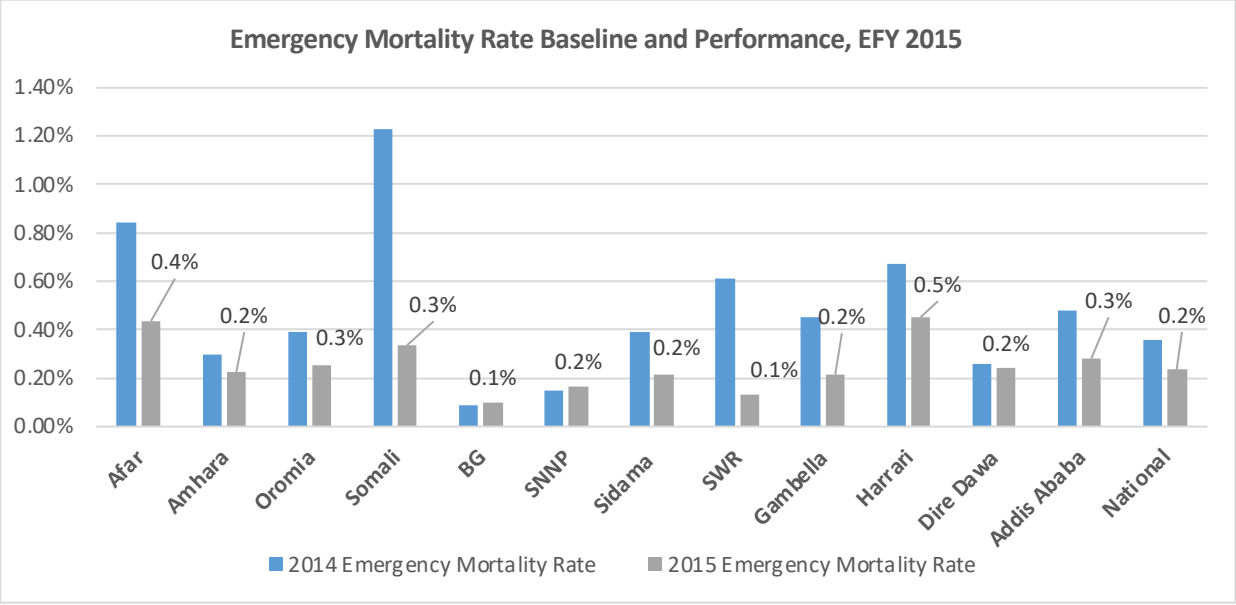
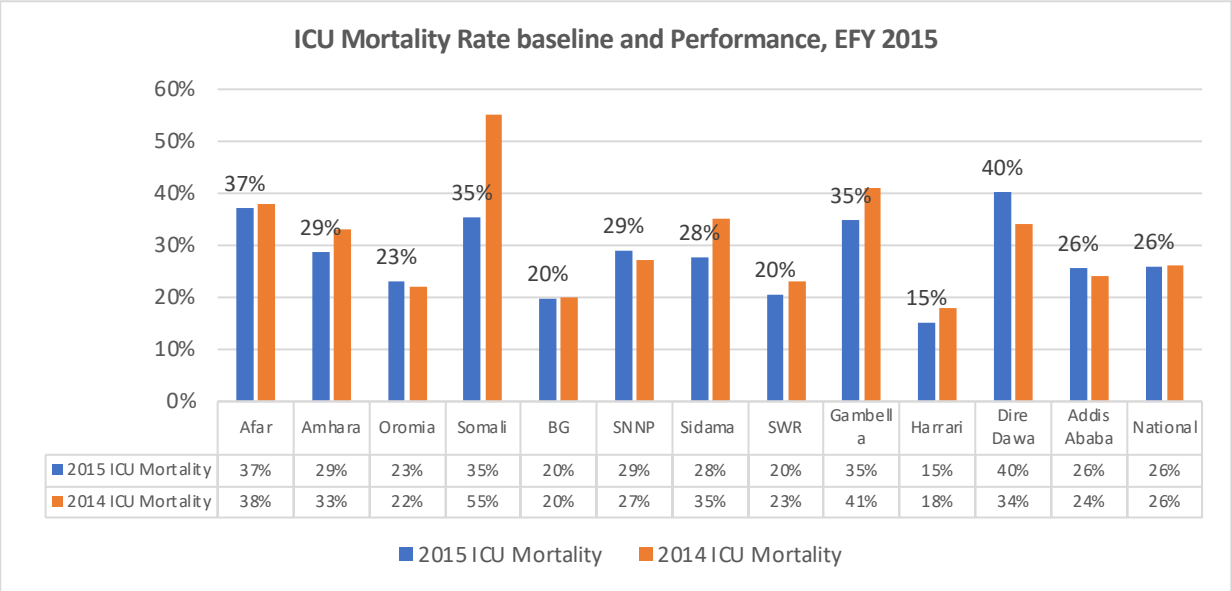


Figure 53: Emergency Mortality Rate by Region, 2015 EFY

Emergency room beds are meant for short-term emergency treatment, and patients should ideally stay for less than 24 hours. If treatment extends beyond this, patients should be moved to a ward to prevent congestion and ensure space for new emergencies. Due to different reasons patients are staying for more than 24 hours in health facilities and in the fiscal year 9% of patients stayed more than 24 hours.

Critical Care Services: In the fiscal year, ICU skill-based critical care attachment training guide was revised to improve and expand intensive care services. This program trained 66 practitioners from 12 regions on advanced critical care. Regions received financial and technical assistance to build 40 new intensive care centers, expanding critical care accessibility. Additionally, over 438 health professionals received basic ICU training from over 40 hospitals, improving their ability to offer intensive care. National level mechanical ventilators functionality assessment was conducted and according to the findings in a total of 102 health facilities providing ICU services (excluding Tigray), a total of 506 mechanical ventilators were found and only 66% of the mechanical ventilators were functional.

The national mortality rate within intensive care units (ICUs) was 26%, which is similar to the previous year. However, notable regional variations have emerged. Among all the ICU fatalities recorded during this reporting period, a significant majority (55%) involved individuals who were receiving mechanical ventilation. The most elevated ICU mortality rate was observed in Dire Dawa (40%), closely followed by Afar at 37%, Gambella (35%), and Somali (35%).



	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWR	Gambella	Harrari	Dire Dawa	Addis Ababa	National
2015 ICU Mortality	37%	29%	23%	35%	20%	29%	28%	20%	35%	15%	40%	26%	26%
2014 ICU Mortality	38%	33%	22%	55%	20%	27%	35%	23%	41%	18%	34%	24%	26%

Figure 54: Intensive care unit (ICU) mortality rate by region, 2015 EFY

Road Traffic Injury and Third-Party Insurance: Nationally, a total of 306,390 road traffic injuries were reported in the fiscal year, marking an increase of over ten thousand compared to the previous year. This trend of rising reported injuries has been consistent year after year. As in the prior reporting period, Oromia accounted for the highest number of cases (49.1%), followed by SNNP with 18.3%, and Sidama with 11.2%.

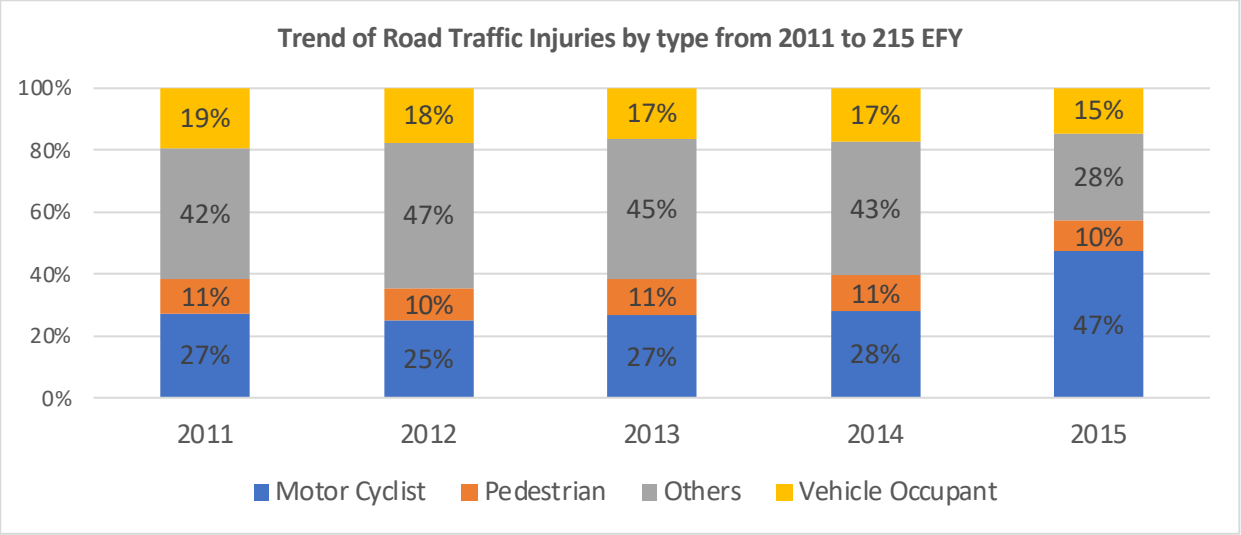


Figure 55: Road Traffic Injuries by Type and Year, 2011 to 2015 EFY

To strengthen the trauma care service in the country capacity-building training for 25 emergency medical professionals in Addis Ababa was provided. Basic and Advanced Trauma Life Support training was also provided for 35 professionals. Additionally, a review meeting was held to improve post-crash care third party road traffic accident reimbursement processes, and a Poisoning call center at St. Peter Hospital was functionalized.

Challenges

Some of the major challenges faced during the implementation of *Emergency and Critical Care Services includes* budget shortage and Security issues in different parts of the country.

Way Forward

- Service initiation in Ambulance dispatch and call centers
- Expansion of Poison Center and burn units
- Mechanical Ventilators Repair and Replacement
- Strengthen Ambulances availability through maintenance of existing ones and through other modalities

3.13. Blood and tissue bank services

The Ethiopian Blood and Tissue Bank Service (EBTBS) has continued to enhance the provision of safe and adequate blood, blood products and tissue services. Various activities have been carried out in line with the institution's five-year transformation plan and annual plan for 2015 EFY. The EBTBS major activities and achievements during 2015 EFY are as summarized below.

Blood Donation

During the fiscal year, a total of 352,962 units of whole blood were collected, which is 72% of the planned 490,699 units for the year. The total amount collected during this fiscal year has shown a 5% increment (15,189 units) from the previous year. From the total collected blood, 99.9% was collected

from voluntary blood donors. The reason for not achieving the target include: gaps in full functionality of various blood bank in regions such as Tigray, Amhara, SNNP, Sidama, Southwest Ethiopia and Gambela due to security issue, budget shortage and the prevailing limitations on awareness of the community in voluntary blood donation especially in rural areas. Repeat blood donors contributed 39.3% from the total donors which is encouraging as it showcases the results of the services' various efforts to enhance the culture of blood donation from regular blood donors. Female donors constituted 38.7% while male donors were 61.3%. Blood collection activities through mobile blood drives are significantly increasing with 86.9 % of the unit's collection through mobile blood drives, while the remaining 13.4% were collected from blood bank, blood collection and distribution centers.

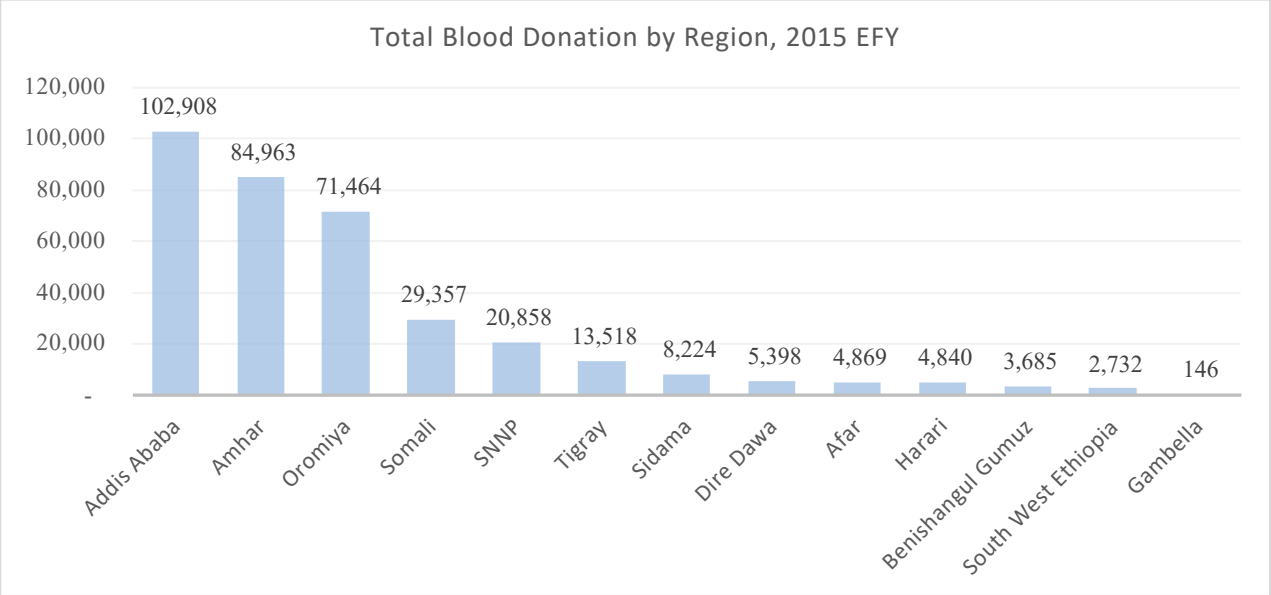


Figure 56: Number of units of blood collected by region in 2015 EFY

Most of the blood donations were collected at the EBTBS national center in Addis Ababa, accounting for 29.1% of the total nationwide collection. Amhara and Oromia region followed with 24.07% (84,963 units) and 20.2% (71,464 units) of the whole blood collection, respectively. In terms of plan versus achievement in the regions, the top performers were the Southwest, Somali, and Oromia regions, which exceeded 100% of their planned collections, surpassing the national average. On the other hand, the lowest performers were Gambela, Southwest, and Benishangul Gumuz regions.

Table 17: Number of units of blood collected in 2015 EFY, by blood bank

S.No	Region	Blood Bank name	Annual Plan	Annual performance	
				Units of blood collected	%
1	Addis Ababa	EBTBS head office	148,800	102,908	69%
2	Tigray	Mekelle	20,234	8,230	41%
3		Axum	9,834	5,288	54%
4		Humera	3,000	-	0%
		Tigray Total	**33,068**	**13,518**	**41%**
5	Amhara	Bahir Dar	22,000	27,407	125%
6		Gonder	14,000	15,557	111%
7		Dessie	14,000	10,257	73%
8		Debre Markos	9,510	9,829	103%
9		Debre Birhan	8,507	6,511	77%
10		Debre Tabor	8,000	6,167	77%
11		Woldiya	5,060	4,421	87%
12		Sekota	4,000	1,307	33%
13		Metema	5,000	2,483	50%
14		Kemise	3,705	1,024	28%
		Amhara Total	**93,782**	**84,963**	**91%**
15	Oromia	Adama	22,000	20,462	93%
16		Jimma	14,000	11,260	80%
17		Nekemte	9,000	4,122	46%
18		Woliso	10,000	7,747	77%
19		Bale Goba	7,000	6,168	88%
20		Chiro	5,100	3,965	78%
21		Metu	5,200	4,928	95%
22		Shashemene	5,750	6,024	105%
23		Bule Hora	5,000	5,417	108%
24		Negele	4200	1371	33%
		Oromia Total	**87,250**	**71,464**	**82%**
25	SNNP	Hossana	14000	8927	64%
26		Arba Minch	7411	4935	67%
27		Wolaita Sodo	6793	3042	45%
28		Dilla	3705	1523	41%
29		Jinka	3705	2431	66%
30		Bonga	5705	2215	39%
31		Tercha	-	517	
32		Hawassa	14000	6685	48%
33		Yirgalem	3705	1539	42%
		SNNP total	**59024**	**31814**	**54%**
34	BG	Assosa	5000	3034	61%
35		Gilgel Beles	3705	651	18%
		BG total	**8705**	**3685**	**42%**

S.No	Region	Blood Bank name	Annual Plan	Annual performance	
				Units of blood collected	%
36	Afar	Semera	4000	3194	80%
37		Awash	3705	1675	45%
		Afar Total	**7705**	**4869**	**63%**
38	Somali	Jigjiga	20000	22698	113%
39		Gode	7000	3624	52%
40		Hargele	3705	1001	27%
41		Fik	3705	1068	29%
42		Wardher	-	462	
43		Biki	-	504	
		Somali Total	**34410**	**29357**	**85%**
44	Gambella	Gambella	3705	146	4%
45	Harari	Harar	7125	4840	68%
46	Dire Dawa	Dire Dawa	7125	5398	76%
		NATIONAL TOTAL	**490,699**	**352,962**	**72%**

Post Donation Counseling Service

Providing post blood donation counseling service (PDCS) for blood donors is of great value in terms of monitoring and following up on transfusion transmissible infectious diseases and supporting and encouraging blood donors to seek treatment or lead a healthy lifestyle after their blood donation results. In 2015 EFY, a total of 19,022 (5.4%) blood donors received post donation counseling service. This is a lower performance compared to the planned PDCS coverage of 17 % planned for the year. The majority (7,312) of post-blood donation services were provided in Addis Ababa. Some of the reasons for this low post-blood donation counseling service is lack of trained human resource in post donation counseling service in regional blood banks, unavailability of rapid testing kits for PDCS; inadequate budget to provide counseling services through mobile blood collection teams and poor coordination with other health bureau programs in the regions. The scale up and increased coverage of this service will be crucial to improve the health status of blood donors and contribute to public health interventions to identify and improve access to infectious disease control and treatment schemes, thus stakeholders in the health sector should collaborate to support the service work in this area.

Blood Component Production

From the total donated whole blood, 50,372 (8.5%) of whole blood units were separated into blood components in the fiscal year. From the total component production, 38,838 units (77%) were converted at the Ethiopian Blood and Tissue Bank Service in Addis Ababa. This is a low performance from the planned 40% component production from total donations and regional blood banks are not performing well in availing blood component therapy to health facilities in their catchment. Reluctance of blood banks in the regions to collect 450 ml blood, from which to prepare blood component and lack of blood component centrifuges due to budget shortages have been the main contributing factors for this performance. Fifteen Blood component centrifuge worth a total of 31 million ETB were procure and distributed to blood banks at the end of the fiscal year which is expected to support the scale of the performance of component production in 2016 EFY.

Table 18: Blood component production in 2015 EFY

Blood component	Units of blood
Total Whole Blood Separated to Blood Components	50,372
Concentrated Red Cells	50,164
Platelets	46,855
Fresh Frozen Plasma	46,766
Cryoprecipitate	30

Laboratory Testing

All the 352,962 blood units collected in blood banks were screened for the four transfusion-transmitted infectious diseases, namely HIV, Hepatitis B, Hepatitis C, and Syphilis based on the national standards. Out of the total screened blood, 3.65% donors tested positive for one of the TTIs. The most common infections were Hepatitis B (1.67%), Syphilis (0.89%), Hepatitis C (0.63%), and HIV (0.46%).

Table 19: Proportion of blood donors tested for TTIs and positives for TTIs, 2015 EFY

Name of Transfusion Transmissible infection (TTI)	Total Units of blood tested	Tested positive for TTI	
		Number	Percentage
HIV Positive	352,962	1,611	0.46%
Hepatitis B Positive	352,962	5,910	1.67%
Hepatitis C Positive	352,962	2,229	0.63%
Syphilis Positive	352,962	3,133	0.89%
Total TTIs Positive		12,883	3.65%

Blood quality assurance and safety service

Provision of safe and quality assured blood is one of the core elements of blood service. To ascertain this, daily quality control checks are performed across the blood banks. Internal audit of the transfusion chain from collection up to health facilities has been conducted four times in the year and corrective actions were taken as needed based on audit findings. In addition to this, Internal Quality control program implementation and mentorship support has been provided to twenty-eight blood banks in the year. Standard operating procedures (SOPs) play a crucial role in ensuring staff carry out function in the blood banks as per set quality management systems. Thus, a total of 57 SOPs for blood donor service, Laboratory, Medical Service, Quality assurance and safety were timely revised, training provided to staff and implemented in the fiscal year. EBTBS participated in three rounds of external Quality Assessment Schemes (EQA) in the fiscal year.

Equipment preventive and curative maintenance and installation of new equipment has been provided to Gambela, Jigjiga, Bahir Dar, Gondar, Adama, Chiro, Diredawa, Hawassa, Debrebirhan and Awash blood banks and Black Lion Specialized hospital.

Health and environmental safety assessment have been regularly carried out and vaccination against Hepatitis B is provided to staff at high risk of exposure by the service. Internal assessment based on African Society for Blood Transfusion standards have been carried out at EBTBS, Adama, Debre Birhan, Woliso, Bahir Dar, Dessie, Jigjiga, Hawassa and Shashemene blood banks and roadmaps have been prepared.

Medical service / appropriate clinical use of Blood

The EBTBS promotes and monitors the appropriate clinical use of blood in health institutions through the medical service department of EBTBS. In 2015 EFY, the total health facility satisfaction rate based on proportion of blood requested and received from blood banks by health institution was 85%. From 561 transfusing health facilities, 97.7 % of them have formed transfusion committees, performed and reported clinical audit. Based on the feedback reported back from health facilities, 42% of recipient of blood and blood products were male and the remaining 58 % were females. Most of the transfusions were provided for recipients in the age group 15 to 44, with an average of 1.16 units per recipient.

In Addis Ababa, feedback on the use of blood from health facilities was reported back to the blood bank for about 23% from total distribution. The percentage of health facilities which have attained minimum requirement for mini blood bank in their laboratory has also increased to 94%, which is an increment by 9% from the previous year. To further strengthen the mini blood banks, provision of medical equipment worth 86 million ETB was provided to health institutions.

Ensuring the appropriate use of blood in health facilities has been a main challenge due to structural and various issues. To strategically solve this, a national survey on blood usage and haemovigilance system has been conducted in selected 26 blood banks and 46 health institutions across the country.

Eye bank and cornea transplant service

In 2015 EFY, the Eye bank of Ethiopia has harvested a total of 277 cornea, which is more than 100% achievement from the planned 243 units for the year. A total of 191 individuals have pledge to donate their corneas upon their death and this has been documented properly. A documentary showcasing the 20 years journey of the eye bank has also been prepared. As the Eye Bank is the only institution that collects, processes and distributes corneal tissues in Ethiopia, it is necessary to maintain the quality of tissues to avoid any possible infections. Accordingly, the eye bank established a quality audit process. As a result, quality certification was received until September 2023.

Challenges

- Many blood banks have not provided services in the year due to security problems in different areas of our country
- Lack of budget for operations in regional blood banks (Blood Banks in SNNP, Sidama, SWE and Gambella blood Bank)
- Seasonal variation in blood donation campaigns, especially in wintertime when schools are closed leads to low collection
- Lack of transportation and vehicle to conduct mobile blood collection sessions
- Delay in the procurement of critical supplies on time

- Challenges in implementing automated testing platforms, gaps in cross regional collaboration between blood banks and occasional machine failures

Way forward

- Strengthen community mobilization and awareness activities to increase blood collection from volunteers
- Implement projects to enhance cornea collection and establishment of other tissue transplant related services
- Introduce advanced testing methods to enhance the quality of blood and blood products
- Collaborate with African institutions to convert surplus plasma into plasma derived medicinal products
- Start Apheresis collection and enhance blood component production
- Implement a consolidated automated testing in selected blood banks and introduce automated component production technologies
- Promote the appropriate use of blood in transfusing health facilities
- Expand the use of Blood Safety Information System (BSIS) in blood banks.
- Strengthen the quality management system towards accreditation of blood banks

3.14. Laboratory Services

Quality laboratory service is an essential component of healthcare delivery services for patient care and public health emergency management. As part of this, the MOH and Ethiopian Public Health Institute (EPHI) are working towards quality laboratory service through capacity buildings, quality assurance programs, and infrastructure development and maintenance towards laboratory quality assurance and accreditation programs.

Accreditation and star level: The laboratory accreditation program has been implemented in Ethiopia since 2008 G.C. Having customized international experience, EPHI support regional reference laboratory and selected facilities laboratory integrated into this program. In the reporting period 80% of facility laboratories (hospital, health centers) implement basic laboratory quality management system/ LQMS. In 2015 EFY a total of 130 health facilities laboratory supported and assessed for star level. Among the assessed laboratories, 01 reached full scope accreditation, 05 are limited scope accreditations with additional disciplines and 10 laboratories achieved limited scope.

External Quality Assessment Program: To ensure the quality of laboratory service, a number of external quality assessment program implemented by international institution, National External quality assessment (NEQAS) by EPHI and Regional External quality assessment (REQAS) by regional reference laboratory has been implemented. In In 2015 EFY a total of 195 laboratories under one world accuracy International External quality assessment (IEQAS) was planned and all the 195 laboratories participated according to their capacity, 265 laboratories under National External quality assessment (NEQAS) and 85 under Regional External quality assessment (REQAS) program had participated. Additionally, in 2015 EFY 36 Experts received international training on WHO-AFRO external competency assessment for malaria microscopy (ECAMM). This will help to expand EQA centers, to increase Laboratory Equipment testing capacity and to increase malaria rechecking and Proficiency testing EQA performance.

Evaluation & Introduction of test and Services expansion: One of the programs implemented in EPHI is the evaluation and introduction of new testing to the country and expand laboratory service to the regions. Consolidation and expansion of existing 70 priority laboratory diagnostic services like Xpert VL10-, EID Xpert-30, TB Xpert-30, Clinical microbiology culture-2 and Conventional HPV DNA-15 are conducted. Standard water physico-chemical testing services was provided to 3,150 customers. About 88,771 referral testing services (HIV, TB, Chemistry, PT and PTT) were provided. In Addition, three Arboviral laboratories were established and expanded in selected regions of Ethiopia. Drug resistance testing by Whole Genome Sequencing was conducted for 79 patients who are suspected to have been exposed to TB drugs according to the National TB algorithm.

Laboratory Information System/LIS: Currently different kinds of laboratory information system are being implemented in the country. Sysmex XN-550, Sysmex XP 300 and Kx21, DxH800, Abbott M2000, Mindray–BC 5800, Cobas 6000 and 311 laboratory instruments/equipment interfaced with existing LIS. 8 EID/VL database sites are updated, 431 GenXpert machines have been connected and started sending data. 97 institutions have started exchanging data using electronic test ordering and result reporting system (ETORRS), and 432 institutions have started new GenXpert connectivity software and currently sending data to EPHI server.

3.15. Health service quality and safety

Ethiopia's National Healthcare Quality and Safety Strategy (2021-2025) seeks to improve health outcomes and system confidence. The strategy focuses on enhancing evidence-based healthcare, patient-centered care, the reduction of preventable harm, the enhancement of efficiency, and the promotion of continuous learning. Key accomplishments in the establishment of Health system Innovation support mechanisms, platforms, system Bottleneck focused reform (SBFR) Implementation, Infection prevention and control-related activities, and other safety and equity-related activities carried out during the fiscal year are outlined below.

Strengthening Health System Innovations: The National Health System Innovation Guide has been prepared to guide the health system's innovation process, defining priority areas, roles, and coordination mechanisms. A National Innovation think tank group has been formed to provide technical support, and National Innovation Labs have been initiated to serve as innovation centers having necessary protocols.

System Bottleneck focused reform (SBFR) Implementation: Since May 2022, 38 public hospitals have progressively implemented the System Bottleneck Focused Reform (SBFR) Project. The project aims to address major system bottlenecks such as inefficiencies, system disintegration, poor evidence uses for decision making, and lack of proper accountability mechanisms, which resulted in high rates of institutional morbidity and mortality during clinical, diagnostic, and pharmaceutical services.

Several project-related initiatives and major activities were implemented during the 2015 fiscal year, including the development and introduction of project implementation technical guidance, staff orientation, nighttime supervision visits, establishment of collaborative learning sessions, regular implementation monitoring, and provision of financial support and equipment. Accomplishments include enhanced leadership and coordination, improved services such as emergency and critical care, outpatient and inpatient services, surgical and anesthesia care, diagnostic care, and pharmacy services. The quality of data and utilization of evidence were enhanced, and some medical schools-initiated client-centered and system-focused medical education. Patient satisfaction has increased, emergency room attendance decreased, and the bed occupancy rate increased compared to the previous year's performance.

Institutionalizing quality culture within the health care system: During the 2015 EFY, implemented the Healthcare quality agenda, guided by the 2nd National Quality and Safety Strategy (NQSS-II). The hospital clinical audit tool revision was concluded during the 2015 EFY period, including national launch, distribution, and orientation to Regional Health Bureaus, quality hubs, and Addis Ababa public hospitals. The National Quality and Safety Hubs were established in seven teaching institutions in 2013 EFY to establish centers of excellence in healthcare quality and safety. Technical and financial support has been provided to build capacity, and in 2015 the guiding document was revised to include health system innovation, 130 health care providers received training in capacity building, and 40 hospital administrators and quality unit coordinators received training in high impact leadership. The accreditation road map for health services and facilities has been finalized, and the development of accreditation standards has commenced. To support the implementation of these initiatives, the national steering committee and health services and facility accreditation task force were established. Six regions also implemented the Health Center Clinical Audit Tool, which provides technical and financial support for health center audits. The clinical audit instrument was introduced to 290 health professionals from 70 health centers in the regions.

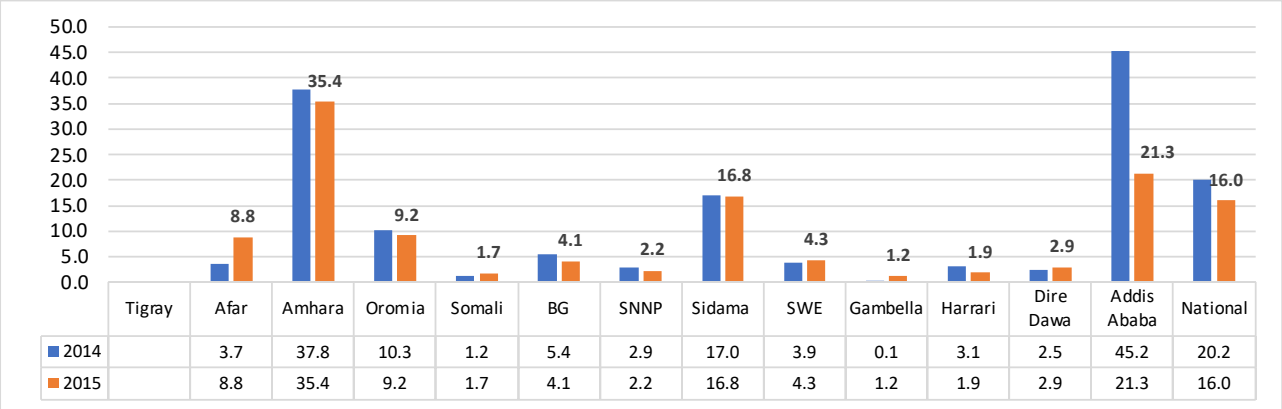
Improving healthcare safety: The National Healthcare Quality and Safety Strategy emphasizes enhancing healthcare safety practices in healthcare facilities to reduce preventable harm. World Patient Safety Day, the development of a national patient safety guideline for high-risk clinical services, the endorsement of the national healthcare safety training package, the conduct of a national healthcare safety assessment, and the monitoring of surgical site infection rates are among the key activities implemented during the 2015 EFY.

The Ministry of Health has been implementing the national infection prevention and control program (IPC) strategy to promote and guide high standards of IPC practice to prevent and reduce risks of Healthcare-Associated Infections (HAIs), Antimicrobial Resistance (AMR), and respond and manage outbreaks for the health and safety of patients, healthcare workers, and the community. Major activities during the fiscal year include the establishment of a Center of Excellence for Infection Prevention and Control, the development of an advanced IPC training program, and the creation of an IPC monitoring and evaluation plan and reporting tools. The national IPC program's budget line was approved for the first time, and surveillance guidelines for healthcare-associated infections were devised and disseminated. In addition, revision of the National IPC reference manual was also done.

Equity: Ethiopia has committed to advancing health equity to achieve national and global SDG targets. The National Health Equity Strategic Plan (NHESP) aims to narrow health equity gaps, improve coverage and utilization of essential health services, enhance healthcare quality, emergency management, and enhance the health sector's implementation capacity. Major initiatives include launching the NHESP, designing mobile health service approaches, conducting national health equity surveys, and designing and implementing projects to address social determinants of health and reduce geographic inequities in developing regional states. The ministry has also developed a mobile health service implementation guide and conducted a national health equity survey to generate evidence on health in-equality.

Elective Surgery: Through a number of programs, efforts have been undertaken to improve the quality and accessibility of surgical and anesthetic care. Training to develop the capability of surgical service leadership was provided. A pilot phase for a new application that would modernize the surgical service appointment system is now being conducted in five hospitals. In 14 selected hospitals with large surgical volume, mentoring programs were implemented to enhance surgical services.

In the fiscal year, 322,597 individuals had major surgery. The total number of persons who received surgical treatments has increased year over year, with 57% of the recorded surgeries being emergency procedures. According to reports, 242,464 and 289,125 individuals underwent surgery in 2013 and 2014, respectively. In 2015 EFY, the average number of days a patient who underwent elective surgery had to wait before being admitted has reduced from 32.7 days in 2013 EFY to 20.2 days in 2014 EFY and 16 days in 2015. Even if there has been a noticeable decrease, there are still regional differences, and certain regions, like Afar, have reported a higher number of days (8.8) than in the prior fiscal year.



	Tigray	Afar	Amhara	Oromia	Somali	BG	SNNP	Sidama	SWE	Gambella	Harrari	Dire Dawa	Addis Ababa	National
2014		3.7	37.8	10.3	1.2	5.4	2.9	17.0	3.9	0.1	3.1	2.5	45.2	20.2
2015		8.8	35.4	9.2	1.7	4.1	2.2	16.8	4.3	1.2	1.9	2.9	21.3	16.0

Figure 57: Number of days for elective surgical admission by region, 2015 EFY

Challenges

The challenges faced include financial shortages, insecurity issues in various parts of the country, inadequate coordination in leading and implementing MOH initiatives and programs.

Way Forward

Developing a national innovation guide, labs, scaling up Hospital-SBFR initiative, and PHCU-SBFR pilot projects are priorities for the coming year. Healthcare quality and safety will focus on national quality and safety strategy implementation, coaching and learning mechanisms for quality improvement, and a catalog of quality-adjusted measurements. Priorities include evidence-based healthcare, patient safety incident reporting and learning systems, and infection prevention and control. Health equity initiatives will include establishing and implementing standards and measurement systems, mobile health services, and socioeconomic determinants of health.

CHAPTER

4

Leadership and governance

CHAPTER 4: Leadership and governance

4.1. Regulation of Food, Medicine, Medical equipment and Other Health Products

The Ethiopian Food and Drug Authority (EFDA) was established by the Government of the Federal Democratic Republic of Ethiopia (FDRE) under Proclamation No.1112/2019 and responsible for ensuring the safety and quality of food, medicines, medical devices, and other regulated products in Ethiopia. The EFDA adopts a risk-based regulation approach and evidence-based regulatory decision-making. Based on the mandate given to the Authority, some of the key activities performed in the budget year are indicated as follows.

Quality and safety regulation of food

The regulatory functions focuses on improving the registration and licensing of organizations that can produce and import food items. During the reporting year 94 dietary supplements, 15 baby foods (including infants) and other different types of food were registered and 586 market authorization and 2,230 notifications was given. For those new food establishments (food manufacturers, food exporters, importers & distributors), 147 manufacturers and 813 (Importers and distributors) were issued certificate of competency. Similarly, post-licensing inspections were carried out on 678 food manufacturers, and 848 importers and distributors. Moreover, assurance was provided to 540 food facilities (food manufacturer, exporters, importers and distributors) implementing internal quality management system (IQMS).

To control illegal food trade and food adulteration in the market, two approaches were used: market assessment and surveillance, and intelligence-based operations in collaboration with key stakeholders. Based on the findings, operations were conducted, administrative measures were taken, risk communication has been done through social and mainstream Medias, and products were also recalled, and local industries were made to take corrective and preventive action. Accordingly, 12 market assessments has been done and 6 intelligence-led surveillance and operation has been conducted and measure has been taken on 48-facilities.

A consignment test was performed for 41 imported food items and 1,359 (97.6% from sample) were found to comply the national standard, while 8 failed and detained them from entering the country. Post market surveillance (PMS) was conducted for 9 food items including Water treatment chemicals, candy, packed water, packed juice, edible salt, peanut sample, pasteurized milk, yoghurt and milk. Of the 1033 PMS samples, 578 (56%) were found to comply the national standard, while 450 failed and collected from the market. A total of 13,319.445 tons and 4,605,335 Birr worth of food products that are not suitable for human use were seized for various reasons or prevented from being used for human use.

Regulation of medicine products

The Ethiopian Food and Drug Authority (EFDA) works to ensure the quality, safety, and efficacy of medicines in Ethiopia. In the past fiscal year, the EFDA issued new market authorizations for 867 medicines, conducted consignment tests on imported medicines, and provided certificates of competency to newly established medicine facilities. The EFDA also conducted post-license auditing inspections of medicine manufacturers, importers, distributors, and Pharmaceutical Small Scale manufacturing facilities.

In the fiscal year, a total of 25.23 billion birr worth of medicine and 382.08 million birr worth of medicine raw materials were given import permits after checking their quality and safety. A total of 42.5 million-birr worth of medicine and medical products, that are not suitable for human use were seized for various reasons or prevented from being used for human use.

The EFDA also worked to prevent the circulation of substandard and counterfeit medicines. In collaboration with stakeholders, the EFDA conducted intelligence-led surveillance and identified 71 pharmacies, 89 importers and distributors, and one illegal medicine store. The EFDA also seized medicine and medical products that were not suitable for human use. This included medicines that were expired, contaminated, or falsified. The EFDA also monitored adverse drug events and Adverse Event Following Immunization (AEFI) reports. This information is used to identify potential safety concerns with medicines and vaccines.

Regulation of medical device

Registration and licensing of medical devices are essential to ensure their quality. The EFDA planned to issue 860 new market authorizations for non-in-vitro diagnostic (NIVD) devices and 720 new market authorizations for in-vitro diagnostic (IVD) devices during the fiscal year. However, they were only able to issue 658 (76.5%) and 601 (83%) licenses, respectively. The authority's annual performance in issuing new market authorizations for medical devices was 76.5% for NIVDs and 83% for IVDs. The plan was to issue 860 and 720 licenses, respectively.

In the fiscal year, the authority conducted microbiological consignment tests for 10 types of medical equipment as planned. The authority also planned to test 150 condoms for quality, but only 123 (82%) were tested. Of the 123 samples tested, all of them (100%) complied with the national standard. The authority also planned to test 300 gloves, but only 281 (94%) were tested. Of the 281 samples tested, 197 (70.1%) complied with the national standard, while 84 (29.9%) failed and were detained from entering the country.

In addition to issuing certificates of competency to newly established medical device manufacturers, the authority also conducted post-license auditing inspections to ensure the provision and use of quality medical equipment. The authority issued new licenses to 2 medical device manufacturers (100%), 49 importers and distributors (73%), and 14 low-risk medical device manufacturers (58%). The authority planned to inspect 253 medical device manufacturers, importers and distributors, and low-risk medical device manufacturers, but only 180 (71.1%) were inspected. The authority also planned to inspect 12 foreign medical device manufacturers, and all 12 were inspected (100%).

At the entry checkpoints, medical devices worth 13.52 billion birr were inspected and allowed to enter the country after passing the necessary quality control. In contrast, medical devices worth 33.4 million birr were seized from being imported and distributed in the country because they did not meet the requirements set by the authority.

Regulation of Cosmetics

The Ethiopian Food and Drug Authority focused on improving the licensing of organizations that can import cosmetics to ensure the quality of cosmetics in the country. The EFDA issued 435 notifications for imported products to ensure that they do not contain prohibited ingredients and that restricted ingredients are present at the permitted level. The EFDA also issued certificates of competency to 119 newly established cosmetic manufacturers, importers, and distributors. The EFDA conducted pre-

licensing activities based on the needs of the applicants. There was a plan to conduct post-license inspections, but only 72 (24%) of the facilities were inspected. The low performance of the post-license inspections was due to a change in strategy to focus on intelligence and operations against illegal cosmetics trade rather than facility inspections. The EFDA also faced challenges with foreign currency and restrictions on foreign currency for cosmetics importation, which caused them to stop some work.

Control of tobacco and tobacco products

It is known that there are illegally imported cigarettes in different parts of Ethiopia. The EFDA has taken steps to prevent and control the problem, particularly in the areas of Dire Dawa and Jigjiga. The EFDA conducted surveillance in these areas and took appropriate action based on the findings. The EFDA also conducted inspections of public places to control tobacco smoking. There was a plan to inspect 36,518 public places, but 64,677 (more than 100%) public areas were inspected. All the inspected areas were smoke-free. To strengthen tobacco control activities, the EFDA committed to initiate the Addis Ababa Smoke Free Initiative. A technical working group was established to coordinate this initiative and engage all relevant stakeholders. The EFDA and the Addis Ababa food, medicine, and health care administration and control authority (AA FMHACA) held a movement in all sub-cities of Addis Ababa to raise awareness about tobacco control. To create a tobacco-free environment, illegal tobacco products seized during the inspections were displayed in public squares in all sub-cities. Teaching, public discussions, and awareness-raising activities were also conducted.

Quality management System

One of the strategic directions that focus on improving the quality management system is to prepare various documents and operating procedures (SOPs) required for the inspection procedure in accordance with ISO/IEC/17020/2017, and the inspection of medicine has maintained ISO/IEC/17020/2017 accreditation. On the other hand, food laboratory has obtained ISO/IEC/17025/2017 accreditation. In addition, the medicine and medical device laboratory maintained the ISO/IEC/17025/2017 international accreditation and obtained additional accreditation in 4 parameters glove test during the fiscal year.

Official benchmarking for maturity level 3 was conducted on June 12-16, 2023 and 75 recommendations were provided as non-compliance. Based on the recommendations from WHO, the Authority has developed CAPA and submitted it to WHO. Currently, The Authority started implementations of the non- compliances.

Challenges

- Inadequate skilled and experienced regulatory workforce
- Inadequate allocation of budget to regional regulatory bodies by regional governments
- Absence of automated performance management system
- Shortage of vehicles at region for inspection work
- Lack of availability of necessary laboratory supplies
- Peace and Security challenges in certain areas of the country for inspection

Focus areas for the next fiscal year

- Attaining WHO maturity level 3
- Strengthen regulation of quality and safety of food and health products
- Strengthen collaboration with region and other stakeholders
- Strengthen quality management system

4.2. Regulation of health and health related institutions

Regulation of health institutions helps to protect health and safety of the public by ensuring that health care providers and facilities meet certain standards of quality and safety. Moreover, it helps to ensure that patients receive high-quality care that is safe and effective. During the fiscal year, some of the activities conducted related to regulation of health and health related activities includes:

- **Inspection and licensing of health institutions**: inspection of 51 (88 % from the target) federal health institutions was done and issued certificate of competency for 5 health institutions and renewal of certificate of competency for 18 (90%) health institutions was done during the fiscal year

- **Clinical audit:** Conducted caesarian section (CS) clinical audit in 40 (100% of the plan) health institutions, conducted diagnostic investigations clinical audit in 50 (100% of plan) health institutions and sudden inspection in 42 (100%) health institutions from Addis Ababa city administration facilities

- **Establish self-regulation system**: Training was provided for 13 hospitals to establish self-regulation system

- **Registration of health institutions on Master Facility Registry (MFR)**: Nationally around 70 percent of health institutions service domain data were registered on MFR

- **Revision of the existing standards and develop new standards**: 12 health institutions standards were revised and 8 new were developed in collaboration with Ethiopian standards institute and 13 health institution standards were approved by the standards council

- **Inspection of health-related institutions:** Conducted inspection of 188 (92% of the plan) federal government institutions including universities, prisons, refugee camps, and food and drink establishments found in international airports.

- **Establish self-regulation system**: training and support was provided for 60 (100%) health related institutions (university and prison) to establish self-regulation system.

- Besides, six health related institutions, hygiene and environmental health standards were developed in collaboration with Ethiopian standards institute in the fiscal year, and 14 standards were approved by the standards council. National assessment was conducted on selected health related institutions regarding compliance to the national standards.

The major challenges during the fiscal year include lack of ownership to implement MFR at regional level and lack of commitment of government health institutions to implement the national standards.

4.3. Regulation of health professionals

During the fiscal year, to conduct health professional competency assessment, two blueprints were developed for nursing and pharmacy professions, 13 blueprints were revised for selected professions, two OSCE versions were developed for dental medicine and anesthesia professions, exam developed for seven professions, competency assessment exam was administered in four rounds and computer-based licensure exam was initiated. License was also issued for health professionals who came from abroad (foreigners and Ethiopians).

In the fiscal year, competency assessment was conducted among thirteen disciplines and 62,656 professionals took the exam and the overall pass rate was 47% (31.5% among the private and 67.2% among government institution). The highest pass rate was among Anesthesia professionals with 81.8% managed to score the passing rate while the lowest score was among nurse professional with only 40% managed to score the passing rate (See the table below).

Table 20: Health professional competence assessment pass rate by profession, 2015 EFY

S.No	Profession	Examined	Passed	Passed Rate
1	ANESTHESIA	687	562	81.8
2	DENTAL MEDICINE	204	117	57.4
3	Emergency and Critical Care Nursing	48	35	72.9
4	ENVIRONMENTAL HEALTH	411	219	53.3
5	MEDICINE	4,090	3,272	80.0
6	MIDWIFERY	4,226	2,031	48.1
7	MEDICAL LABORATORY SCIENCE	6,392	3,187	49.9
8	MEDICAL RADIOLOGY TECHNOLOGY	741	472	63.7
9	NURSING	26,151	10,462	40.0
10	PEDIATRIC AND CHILD HEALTH NURSING	218	171	78.4
11	PHARMACY	11,994	5,771	48.1
12	PSYCHIATRIC NURSING	277	236	85.2
13	PUBLIC HEALTH	7,217	2,908	40.3
	Total	62,656	29,443	47.0

Moreover, to strengthen the capacities of regions: supportive supervision was conducted in all regional health regulatory bodies, health and health related institutions regulation package training was provided for 176 regulatory experts, and health professionals E- Licensing training was provided for Addis Ababa and Oromia region regulatory experts. Moreover, the new and revised national health and health related institutions standards and checklists were introduced to regional health regulatory experts in two rounds. One round training was provided to regional health regulatory experts and leaders to start self-regulation of health and health related institutions at regional level and four regional health profession ethics committees were supervised and supported by the Federal Health Profession Ethics Committee. The major challenges include limitation in professional mix and number for regulation of health institutions and professionals, shortage of regulatory inputs and delayed SDG budget

4.4. Health Infrastructure

Health infrastructure is a key component of a health system, and the health sector has been working towards the expansion of health infrastructure over the past few decades and encouraging results were achieved. To expand health infrastructure, the sector has been engaged in construction of new health infrastructure and rehabilitation of the existing ones. The health infrastructure program mainly includes activities such as providing adequately equipped, staffed, and regulated health facilities, making the health facilities customer friendly and with standard layout, sustainable facility and equipment maintenance and IT supported health infrastructure. In this section, the number of health facilities that are functional and under construction are described and other accomplishments such as constructions, maintenance, renovation, and rehabilitation projects in 2015 EFY are described.

Number of functional and "on Construction" health facilities

Number of Health Posts

By the end of 2015 EFY, the cumulative number of functional health post in the country was 17,569. In addition, 116 health posts were under construction. As shown in the table below, the majority of health posts, 99 (85%) under construction are from Oromia and Amhara regions. The detail of health post distribution by region is displayed in the table below.

Table 21: Number of functional and under construction Health Posts by Region, 2015 EFY

Regions	Functional	Under construction	Total
Tigray	769	0	769
Afar	365	4	369
Amhara	3570	18	3747
Oromia	6747	81	6828
Somali	1496	0	1496
Benishangul Gumuz	424	2	426
SNNP	2599	6	2605
Sidama	549	0	549
Southwest Ethiopia	832	3	835
Gambella	150	2	152
Harari	32	0	32
Dire Dewa	36	0	36
Addis Ababa	NA	NA	0
Total	17,569	116	17,685

Number of Health Centers

The total number of functional health center by the end of 2015 EFY was 3,826. In addition to the functional health centers, 95 new health centers are currently under construction in the fiscal year.

Table 22: Number of functional and under construction Health Centers by Region, 2015 FY

Regions	Functional	Under construction	Total
Tigray	231	1	232
Afar	100	3	103
Amhara	874	11	885
Oromia	1425	2	1427
Somali	229	16	245
Benishangul Gumz	60	5	65
SNNP	490	25	515
Sidama	138	9	147
Southwest Ethiopia	125	9	134
Gambella	30	2	32
Harari	9	0	9
Dire Dewa	16	0	16
Addis Ababa	99	8	107
Total	3,826	91	3,917

Number of Public hospitals

In the Ethiopia health service delivery tier system, there are three types of hospitals, namely, primary, general, and comprehensive specialized hospitals. By the end of 2015 EFY, there were a total of 379 functional public hospital (254 primary hospitals, 98 general hospitals and 27 comprehensive specialized hospitals throughout the country. In addition to the functional hospitals, a total of 52 hospitals (41 primary, 9 general and 2 comprehensive specialized hospitals) are currently under construction. The two specialized comprehensive hospitals under construction are in Oromia region and Dire Dawa City Administration.

Table 23: Number of functional and under construction public hospitals by type and region, 2015 EFY

Regions	Number of Hospitals by type						Total
	Primary Hospital		General Hospital		Comprehensive Specialized Hospital		
	Functional	Under construction	Functional	Under construction	Functional	Under construction	
Tigray	24	5	14	1	2	0	46
Afar	9	0	1	0	0	0	10
Amhara	67	14	15	3	8	0	107
Oromia	73	8	33	1	4	1	120
Somali	11	0	6	0	1	0	18
B.Gumuz	4	1	2	0	0	0	7
SNNP	38	9	8	1	3	0	60
Sidama	15	1	5	0	1	0	22
SWE	9	3	4	0	0	0	16
Gambella	4	0	1	0	0	0	5
Harari	0	0	1	0	1	0	2
Dire Dewa	0	0	2	0	0	1	3
Addis Ababa	0	0	6	3	7	0	16
National	254	41	98	9	27	2	431

Infrastructure Projects

Different renovation and construction projects were performed in different regions, financed by World Bank. Some of these infrastructure projects are:

- Renovation of 13 medical workshops (Debre Birhan, Bahirdar, Jigjiga, Semera, Yirgalem, Adama, Nekemte, Harar, Gambella, Arbaminch, Asosa, Dire Dawa and EPHI) are completed and becomes functional in the fiscal year
- Renovation and Construction of 4 point of entries were completed (Afar - Beleho & Galafi, Amhara-Metema and Somalia-Moyale). On the other hand, 2 point of entry (Benishangul Gumuz –Kumruk , and Gambella-Lare) are under construction.
- Renovation and construction of Galafi Isolation Center physical progress has reached 60%
- The construction of 13 COVID-19 Projects (Point of Entry, Isolation center and Quarantine center) is completed in the fiscal year
- The Construction of twelve regional reference laboratories in regions are under construction and their average progress is 40% and three regional laboratories (Dembidolo, Mayichew, Humera are on bid process to start construction

Comprehensive health posts construction: Second generation health post upgrading to comprehensive health post was completed for 52 projects. In addition, upgrading construction progress of other 52 projects has reached to an average construction progress of 96%.

Restoration of health facilities: MoH in close coordination with RHB has identified health facilities that need minor and major restoration and construction; and conducted cost estimation. MoH will provide technical and financial support on phase-based approach for reconstructing of damaged health facilities in the next fiscal years.

Water supply and Solar Power supply: Safe water supply for 2,496 health centers was completed by the end of 2015 EFY and solar electric supply for 467 Health centers was completed by the end of 2015 EFY.

Regional Financial and Technical supports: The Ministry of Health has supported an estimated 46 Million birr for construction and renovation of health facilities for Amhara region, Somali region (three health center construction & one health post upgrading to comprehensive health post), Afar (one health post upgrading to comprehensive health past), Dire Dawa City Administration (one health post upgrading to comprehensive health post), Sidama region (Health center renovation), Oromia region (health post upgrading to comprehensive health post & seven health center renovation) and Gambela region (Korgang Health Center Renovation). In collaboration with government of Ethiopia and World Bank 1.1 billion Birr investment is allocated for different projects under and to be constructed in all regions. MOH has supported an estimated cost of 150 million birrs for safe water construction for Health Centers in the last three years. With regular plan and needs from the regional health bureaus engineering technical team did repeated on site supportive supervisions.

Federal Infrastructure Projects Financed by Government: To improve the specialty health and related advanced services, the construction of various mega projects financed by the Ethiopian government is underway. The progress is described as below:

1. **Specialty and Other Related Mega projects (Under construction)**

    - The construction of advanced research laboratory complex with nine floors (2B+G+6) for Armer Hansen Research Institute (AHRI)'s is currently at 99.5%
    - The 1st nationally advanced trauma center with inpatient capacity of 600 beds for ALERT (2B+G+7) is under construction with the progress of 46%
    - The construction of Apartment complex with fifteen floors for Ammanuel hospital medical staff (senior physicians) is under construction and its progress is 30%

2. **New Specialty Centers to be constructed in 2016 EFY Funded by Government**

In addition to improving access to advanced specialty health services, the following three mega projects are under international bid process to start their construction:

- Nationally the 1st and Advanced Dermatology and plastic reconstruction surgery complex/ center with 600 beds and 11 floors in ALERT
- Nationally the 1st and Advanced Emergency Comprehensive complex/center with 600 beds and 11 floors (2B+G+8) in Addis Ababa, Lebu Area
- Nationally the 1st and Advanced Diagnostic center with seven floors (3B+G+3) in St. Peter specialized compressive hospital.

3. **Laboratory Complex and Cold Room Projects Financed by World Bank**

The following Meg projects which are internationally advanced and financed by world bank are under construction and their progress is as follows:

- Advanced Vaccine Laboratory Center of Excellence dedicated for Food & Medicines supplies Quality Control Center owned by Ethiopian Food and Drug Authority (FDA) with ten floors (3B+G+6) is under construction and its progress is 12%
- The Construction of Advanced Vaccine Cold room and related services building complex renovation works with eleven floors for Ethiopia Supply Services (ESS) is under construction and its physical progress 60%
- The Construction of Advanced Bio bank, PT Panel Production and Central Warehouse building with eleven floors for Ethiopian Public Health Institute is under construction and its physical progress is 5%

Challenges

- Uncontrolled construction materials market inflation
- Shortage of foreign currency
- Cement Supply Shortage for the last two years
- Security problem and conflict in some regions

4.5. Gender, Youth and People with Disability Mainstreaming

The ministry of health women and social affairs inclusive implementation executive office has been working to mainstream and include the issues of women, social affairs, persons with disabilities, and young people in health programs and operations. Different documents were developed and provided capacity building trainings to ensure equal participation, strengthen women's capacity and engagement, increase the participation of persons with disabilities and young people in the health sector, and ensure the protection and safety of children.

To ensure gender mainstreaming and women empowerment in the health sector, training was provided on gender mainstreaming and workplace harassment for 216 leaders and officers in collaboration with WHO; leadership training has been given for 75 women in three rounds in collaboration with Marie stope international; TOT training for 40 participants given on gender-based violence and consultative workshops conducted at different conflict affected regions. In addition, during the fiscal year the executive office able to facilitate for 266 valuable children receive support by the ministry and health facilities, ensure day care service initiated in 31 facilities including in ministry compound, health and spot messages translated to sign language (70% from the target), sign language trainings provided for 110 female and 102 male health care workers, disability corners being establishment in the health facilities and with routine health service program the health facilities provides medical service for all survivors of gender based violence and in 70 health facilities coordinated one stop service is being provided.

Major Challenges: The main constrains during the fiscal year was lack of structures at lower levels to case cade the implementation of gender related activities and not having adequate budget to support the planned activities at different levels.

Way Forward: The major initiatives for the next fiscal year include strengthening gender mainstreaming, disability inclusion, and social inclusion in primary health care; assessing and supporting structures using gender responsive indicators; finalizing women empowerment training materials and providing capacity building trainings, facilitating experience sharing for women health work force, expanding day care centers, strengthening GBV prevention and response performances, providing trainings on disability and social issues, expanding corners, conducting accessibility audit, transmitting health messages and spots by sign language using different medias and channels, and strengthening multisectoral collaboration and coordination.

4.6. Reform and governance

Leadership, Management and Governance: As one of the health system's building blocks, the Ethiopian health sector has prioritized leadership and governance development as a means of achieving its objectives. Efforts have been made throughout the fiscal year to harmonize and standardize the various leadership initiatives that have been implemented across the various programs. The impact of health leadership and management programs, including Leadership Management and Governance, Clinical Leadership Improvement Program (CLIP), and Leadership Incubation Program, was evaluated through a series of assessments. National evaluations of the CLIP, leadership incubation program (LIP), and Leadership & Governance programs were conducted at midterm. To improve implementation, a National Health Leadership Program document was created, which includes training packages for various management levels. The fifth cohort of young professionals received LIP training, and support for the CLIP pilot hospitals was revived. Leadership, Management, and Governance scores increased as a result of implementation of the Ethiopian Health Sector Transformation Plan (EHSTG), resulting in enhanced healthcare services nationwide.

Effective leadership and governance entail strategic policy frameworks, oversight, resource allocation for healthcare access and well-being improvement, along with accountability. Ministry of Health emphasizes governance enhancement via initiatives such as the community scorecard, good governance index, and managerial accountability program. The major activities performed in 2015 EFY are described below.

Community Scorecard: Community Score Card (CSC) is a regular feedback process from citizens being enacted to foster community engagement, ownership, and social responsibility. CSC implementation could improve primary health care by enhancing quality, efficiency, accountability, transparency, and fostering community engagement and empowerment for the improvement of primary health care service. There was a plan to initiate implementation of CSC in 50 new Woredas during the fiscal year, but implementation was started in 46 health centers found in 36 new Woredas. This increases the cumulative number of health centers and Woredas implementing CSC to 2,760 HCs and 760 Woredas across the country. The highest number of health centers implementing CSC are in Oromia (1,087) followed by Amhara (799), SNNP (420), Sidama (112), SWE (101), Addis Ababa (88), and the number of HCs in the other remaining regions was 153 health centers. To strengthen implementation of CSC in new Woredas, training was provided for 1,500 health workers and managers from 24 Woredas. In addition, 108 managers from Afar, Gambella and SNNP regions received TOT on CSC. A survey was conducted in 52 health centers found in 40 Woredas to assess the progress of CSC implementation and identified gaps in the process. Based on the results of the survey, manual and guideline revision are being carried out. Preparations are underway to finalize the social responsibility strategic document of the health sector.

Good Governance Index (GGI): The implementation of the Good Governance Index in hospitals serves to detect and address governance-related issues, with the ultimate goal of delivering equitable and high-quality healthcare services to the population. In the fiscal year, a Good Governance Index survey was conducted in 15 hospitals, and plans are underway to address the identified areas for improvement.

Managerial accountability program: A training on managerial accountability program was provided to seven Woredas and implementation is inder way in these Woredas (Debre Elias and Tehuledere in the Amhara Region; Seka Chaqorsa and Negele Arsi in the Oromia Region; Wardijo in the SNNPR; Bensa in Sidama; and South Bench Woreda in the Southwest Ethiopia Region).

Kaizen and other reform tools: Technical support, and close monitoring on the implementation of Kaizen was done to three hospitals (Shashemane, Amanuel and Central Gondar Denbia Hospitals).

Way forward for next fiscal year

- Finalization, approval, dissemination and implementation of of the social accountability strategy
- Start implementation of CSC in 144 new health centers and strengthen CSC implementation in the existing ones
- Implement managerial accountability in 40 new Woredas
- Strengthen implementation of good governance index and initiate GGI implementation in 40 new hospitals

CHAPTER

5

Human resource development and management

CHAPTER 5: Human resource development and management

According to the World Health Organization (WHO), there has been some progress in recent years on health workforce development worldwide, but there are still many challenges to overcome. One of the key challenges is the shortage of health workers. The WHO estimates that there is a global shortage of 18 million health workers, with the highest shortages in low- and middle-income countries.

The ministry of health is working to improve the disparities on the number and mix of human resource and commenced different initiatives to fill the gaps. In the fiscal year, the human resource for health development and improvement lead executive office has carried out focusing on strengthen the qualification framework of health professions, establishing and implementing a training system for health sector workers, and strengthening an information-based planning, monitoring and evaluation system. Furthermore, the CEO managed to strengthen the relationship with the stakeholders of the health sector, coordinating the voluntary activities of health professionals, holding a consultation forum with stakeholders working on human resource development, and focusing on building their capacity by providing support and monitoring in regions, universities, public and private health science colleges, and health institutions.

During the reporting year, development of new health professions disciplines was initiated, revision of graduate public health programs was performed, sustained applied public health program and coordinated field epidemiology training program. To strengthen the continuous professional development system a draft guide has been prepared; the guide will help on coordinating the work of professional license renewal with the continuous professional development system.

In this chapter, the major initiatives and achievements on human resource development and management are discussed as follows.

Organizational restructuring

The FDRE government, in accordance with Proclamation No. 1263/2021, defines the powers and duties of the executive organs. Accordingly, the Ministry of Health has amended its previous structure and work divisions. A committee of senior experts was established under the executive coordination of the competency and human resource management department to develop a new structure that would improve efficiency and effectiveness. The committee submitted the new structure to the Civil Service Commission for approval. Once approved, the new structure was implemented, and employees were assigned to their new positions.

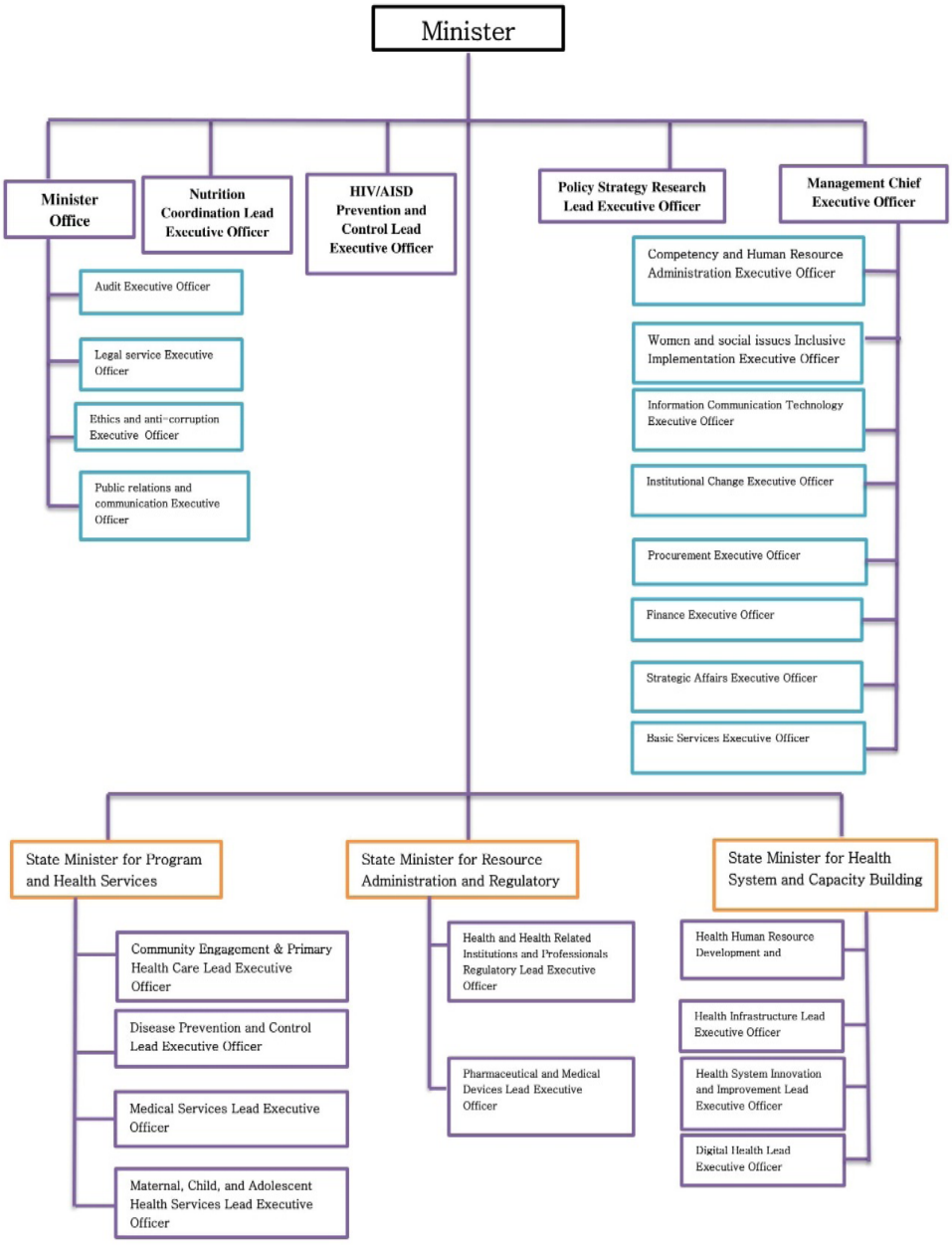


Figure 58: The new organizational structure of the Ministry of Health, 2015 EFY

After the approval of the new ministry's structure, an allocation committee was established. A total of 988 positions were filled, comprising 431 health management (technical experts) and 557 administrative staff. This represents 91% of the 1,090 approved positions and only 103 positions were open.

5.1. Health workforce deployment

Every year, health professionals graduate from different educational institutions with different professions. Federal and regional health institutions need many professionals to fulfill their responsibilities. The 2015 EFY plan was prepared and it was discussed with the federal responsible institutions and the regional states, and a mutual agreement was reached. The federal institutions employed experts who graduated from higher education institutions and provided quality services for the community with the federal budget subsidy and the regular budget allocated by the region.

In the fiscal year, the government planned to employ 8,224 professionals and managed to deploy 8,139 professionals, which is 98.9% of the target. Among the professionals who have been employed, the Executive office worked closely with various partner organizations to hire new graduate physicians. With the support and monitoring of the matching fund budget obtained from the Ministry of Finance and the Souza Buffett Foundation, regional and city administrations were able to employ 1,520 graduate physicians (52.4%).

Furthermore, to increase the access of healthcare professionals using the matching fund, 1,629 graduate doctors were deployed, which accounts for 56.2% of the target. The low performance was due to the graduate doctors' refusal to work in remote areas of Somalia, Gambella, Afar, Oromia, and Benishangul Gumuz regions.

Table 24: Number of Physicians deployed in 2015 EFY using Matching Fund by Region

No	Region	Plan	Physician recruitment	
			Employed	%
1	Tigray	158	0	0
2	Afar	56	8	14.3
3	Amhara	631	631	100
4	Oromia	1,102	470	42.6
5	Somali	179	0	0
6	Benishangul Gumuz	33	12	36.4
7	SNNP	379	181	47.8
8	Southwest Ethiopia	91	80	87.9
9	Sidama	126	126	100
10	Gambella	14	8	57.1
11	Harari	8	8	100
12	Dire Dawa	15	15	100
13	Addis Ababa	106	106	100
Total		**2,898**	**1,629**	**56.2**

5.2. Distribution of Health workforce

5.2.1. Stock of Health workforce

Human resources data collected in 2015 Ethiopian fiscal year from all regions except Tigray shows that the total health workforce has slightly increased from the preceding years. The total health workforce in the fiscal year was 462,820, including university hospitals and private health facilities. The workforce has increased by 35% compared to 2014 EFY and by 42% compared to 2013 EFY.

Of the total health workforce, 67% are health professionals (310,591) and 33% are administrative staff (152,229). Nurses, health extension workers, and health officer are the top three professional categories, with 33.2%, 13.8%, and 10.7% of the professional workforce, respectively. General practitioners and specialists make up 5.7% of the professional health workforce (see the figure below).

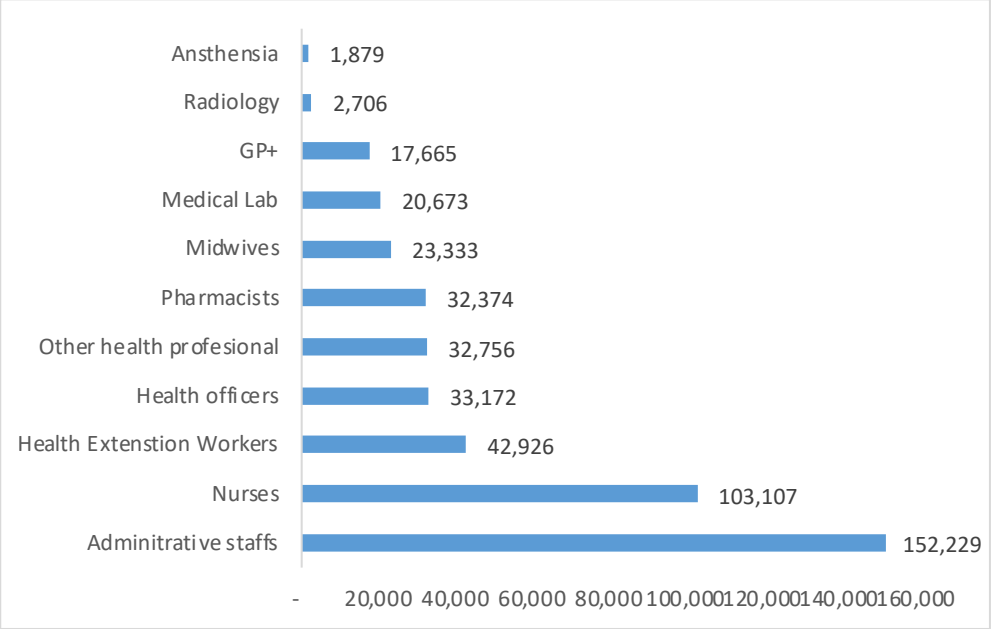


Figure 59: Summary of the national health workforce in 2015 EFY (2022/23)

5.2.2. Distribution of Health workforce by region

Over the past two decades, the Ethiopian Ministry of Health (MOH) has made significant efforts to ensure a fair distribution of health workers across the country. This is important because the distribution of health workers can have a major impact on the quality, coverage, and equity of health services. One way that the MOH measures the fairness of health worker distribution is by looking at the health workforce distribution and disparity between different regions. Regions with fewer health workers per capita are considered to have a disparity in staff distribution. This disparity can be used as an equity indicator to help health managers identify and address areas where there is a need for improvement.

In the fiscal year, the highest workforce to 1,000 population ratio was from Addis Ababa city administration followed by Harari region and Gambella region. The national work force per 1,000 population was 4.6 and seven regions Sidama, SNNP, Afar, Amhara, Somali, Oromia and SWE have below the national work force per 1,000 population (see the details in the figure below).

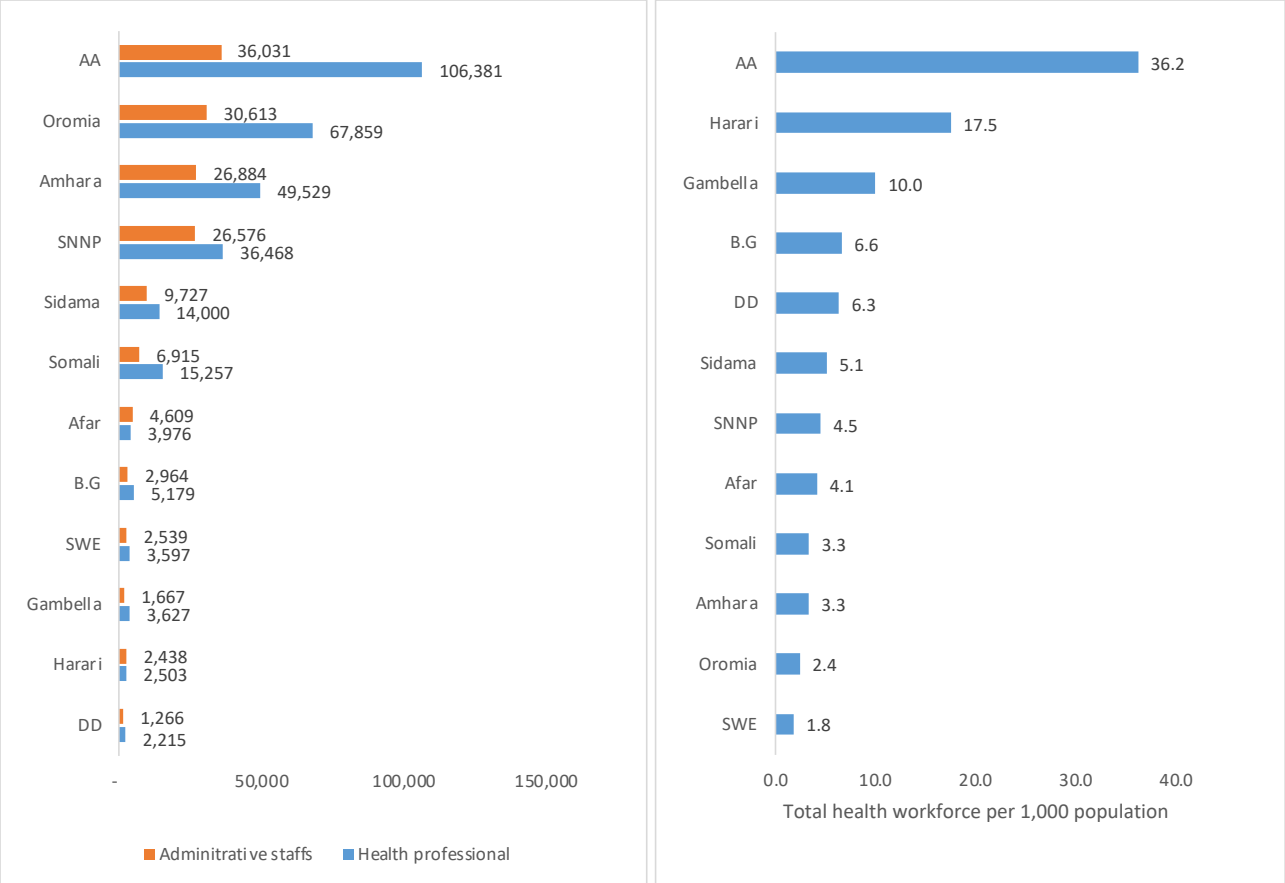


Figure 60: Number and proportion of health professionals and admin staff per 1000 population, 2015 EFY

5.2.3. Health professionals to population Ratio

According to the World Health Organization, the health professional density level is a key criterion to measure health sector staffing. The standard health professional density level for GPs, nurses, and midwives (for all three professionals together) is 4.45 per 1,000 population based on WHO set target, whereas HSTP II target is 2.3 per 1000 population by the end of 2025. This is the threshold identified by the World Health Organization (WHO) as an indicative minimum density representing the need for health workers to achieve universal health coverage (UHC) and the Sustainable Development Goals (SDGs). The health professional density (for core health professional categories) for Ethiopia is 1.4 doctors, Health Officers, nurses, and midwives per 1,000 population at the end of 2015 EC, which is far from both HSTP II target and the WHO target.

Regarding health professionals to population ratio by professional category, the national physicians (GPs, specialist, and subspecialist) to population ratio is 1: 5,737 (which is 1.7 physicians per 10,000 population). The highest physician to population is from Addis Ababa with is 1: 615 (or 16.3 physicians per 10,000 population) followed by Harari 1:664 (or 15.1 physicians per 10,000 population) and the lowest is 1:32,703 (which is 0.3 physicians per 10,000 population) from SWE. The nurse to population ratio at national level is 1: 983 (which is 10.2 nurses per 10,000 population). The nurse to population ratio data shows regional disparity and the highest is from Addis Ababa 1:104 (95.9 nurse per 10,000 population) and the lowest is from SWE with 1:12,249 (which is 0.8 nurse per 10,000 population). In SWE one physician is expected to serve 32,703 people and a nurse is expected to provide service for 12,249 people. See the details from the table below.

Table 25: Selected Health Professionals to Population Ratio by Region, 2015 EFY

Regions	Population	GP+		Nurses		Midwives		Pharmacists		Medical Lab		Health officers	
		Num.	**1GP+:Pop**	**Number**	**1Nurse:Pop**	**Num.**	**1Mid:Pop**	**Num.**	**1Pharm:Pop**	**Num.**	**1Med.L:Pop**	**Num.**	**1HO:Pop**
Tigray													
Afar	2,076,408	180	11,536	1,383	1,501	279	7,442	340	6,107	286	7,260	357	5,816
Amhara	23,215,330	3,100	7,489	14,542	1,596	5264	4,410	4570	5,080	3,602	6,445	3,556	6,528
Oromia	40,884,249	3,136	13,037	21,463	1,905	5233	7,813	5264	7,767	3,771	10,842	4,542	9,001
Somali	6,657,345	808	8,239	5,289	1,259	2141	3,109	925	7,197	980	6,793	970	6,863
BG	1,237,366	123	10,060	1,921	644	703	1,760	587	2,108	194	6,378	156	7,932
SNNP	13,950,342	2,074	6,726	11,828	1,179	3693	3,778	2176	6,411	3,004	4,644	3,463	4,028
Sidama	4,647,672	927	5,014	5,310	875	1013	4,588	1265	3,674	1,123	4,139	1,012	4,593
SWE	3,368,384	103	32,703	275	12,249	547	6,158	275	12,249	325	10,364	313	10,762
Gambella	530,893	77	6,895	1,694	313	134	3,962	143	3,713	287	1,850	181	2,933
Harari	282,848	426	664	830	341	197	1,436	242	1,169	219	1,292	91	3,108
Dire Dawa	550,642	308	1,788	782	704	160	3,442	181	3,042	172	3,201	77	7,151
AA	3,938,772	6,403	615	37,790	104	3969	992	16406	240	6,710	587	18,454	213
Total	101,340,251	17,665	5,737	103,107	983	23,333	4,343	32,374	3,130	20,673	4,902	33,172	3,055

5.3. Professional development

The Ministry of Health has sponsored and covered the cost of 809 resident doctors in 13 universities studying in different specialties. Among the sponsored practitioner, 345 resident doctors have completed their studies and returned to their sponsored institutions to perform their duties. While 42 doctors identified not returned to their prior assigned institutions after completed their studies and the ministry make the professionals to reimburse the cost spend to government. A lot of work has been done to find scholarship opportunities in international and national institutions and to use the opportunities found based on guidelines. In the fiscal year, 462 (87% from the target) management and technical employees received short- and long-term training and education opportunities in international and national institutions.

5.4. Continuing professional development

Continuing Professional Development (CPD) stands as a paramount national priority in the Health Sector Transformation Plan (HSTP II). It aims to optimize the competencies of the health workforce, thereby directly impacting the performance and productivity of the health system. Ensuring health workers have access to need-based CPD is crucial for maintaining and improving their competencies. The overarching goal of CPD is to elevate the quality of health services by enhancing the competencies of the health workforce and seamlessly integrating CPD with license renewal. A robust system of quality control has been established, accrediting accreditors, CPD providers, and courses.

Establishment of Governance: Strengthened the formation of a National CPD Committee that signifies a crucial step in providing oversight and strategic guidance at the national level. Simultaneously, regional CPD teams have been established to facilitate localized efforts, ensuring a comprehensive approach

Quality Assurance: Accreditation has been granted to 37 accreditors and 219 CPD providers, to maintaining high-quality CPD activities to ensure that the workforce is continually enhancing its competencies

Integration with Re-licensure: This year nine regions integrated CPD with the relicensing process. This integration is pivotal in reinforcing the importance of ongoing professional development as a prerequisite for license renewal.

Technological Advancements: The Ministry of Health has developed five new courses this year on its Online Training Platform. This platform hosts a diverse range of courses, a total of 24, 043 health professionals were enrolled in the platform which reflect a commitment to harnessing technology for accessible and flexible learning

Leadership Incubation Program for Health (LIP-H): The program aims to build leadership capacity among healthcare professionals to strengthen the healthcare system. The program selects participants from different health facilities, agencies, and regional health bureaus across Ethiopia. An intensive 6-month curriculum is delivered through in person trainings, workplace learning projects, shadowing, coaching, and mentoring support. Until now, 128 trainees successfully completed and graduated, marking a significant milestone for health professional development in Leadership. Program evaluations of the training program were conducted, and valuable lessons learned were flawlessly integrated. Subsequently, curriculum enhancements were done based on the insightful results derived from the evaluation process. Recently the fifth cohort, consisting of 40 trainees, successfully completed the

program component, with a balanced representation of 16 females and 24 males. Building on this success, the 6th cohort welcomed a larger cohort, enrolling 57 trainees in two groups, of which 28 were females and 29 were males they have taken the month 1 and 2 program components also. Excitingly, this cohort boasted diversity, with 32 trainees originating from different regions.

5.5. Human Resource Data Management

Integrated human resource information system (iHRIS) is under development by customizing it from an open source eHRIS system, which handles the functionalities HR administration, HR Development, and the HR Licensure services. Accordingly, all personal files of the permanent and contract employees of the MOH staffs were scanned and captured in the system. Moreover, 834 employees received digital identification (ID) card.

Under the strengthening of evidence-based planning, monitoring and evaluation system, a needs assessment was conducted to start the implementation of iHRIS in regional health Bureaus, and training and technical support were provided on IHRIS implementation methods. An iHRIS implementation plan has been prepared and training has been provided to 64 (59 government and 5 private hospital) human resource information professionals.

Capacity building support to regions

- Facilitation skill, IDS and CPD management trainings were given to 145 regional health office experts and coordinators of various professional development centers
- Awareness raising was done to Addis Ababa City Administration, Amhara RHB Health Bureau and Zonal level supervisors on professional license renewal
- Technical assistance was provided to regions to launch the Health Sector Human Resources Information System (HRHIS) and conducted a needs assessment to initiate iHRIS implementation
- Training on Motivated, Competent and Compassionate (MCC) health workforce was provided to health professionals working in hospitals in Tigray

Challenges

- Lack of willingness of graduate doctors to be deployed in remote area of the country while the over concentration of health professionals in major cities
- High turnover rates among graduate's medical doctors deployed by the matching fund project
- Some of sponsored specialist are not willing to return and serve institutions that sponsored them.
- Unable to carry out series of professional development awareness activities in all regions due to lack of budget
- Some of continuous professional development providers lack adherence to guidelines and has limited capacity

CHAPTER

6

Health information system, digital health and evidence based decision making

CHAPTER 6: Health information system, digital health and evidence based decision making

6.1. Birth and Death Notification

The primary purpose of civil registration is to establish legal documents for individual, administrative, and statistical use. MoH is mandated to notify births and deaths that happen both in the facility and outside of the health facility. To fulfill the mandate, It signed a memorandum of understanding with Immigration and citizenship service in July 2015G.C. A joint civil registration and vital statistics (CRVS) 5-year strategic plan was prepared and endorsed as of 2021 with a motto of "Ethiopia, where everyone is recognized". The strategic plan aimed at increasing birth registration to 80% and death registration with causes of death information to 50%.

In 2015 EFY, the birth notification rate from the expected live birth was increased from 52% to 75% while the notification rate from the total number of health facility births reached 90%. Afar, Somali, Gambela, Southwest, Sidama, and Benishangul Gumuz regions' birth-notification performance is below the national average while Harari, Addis Ababa and Dire Dawa show better performance. The death notification rate remains still very low (4%).

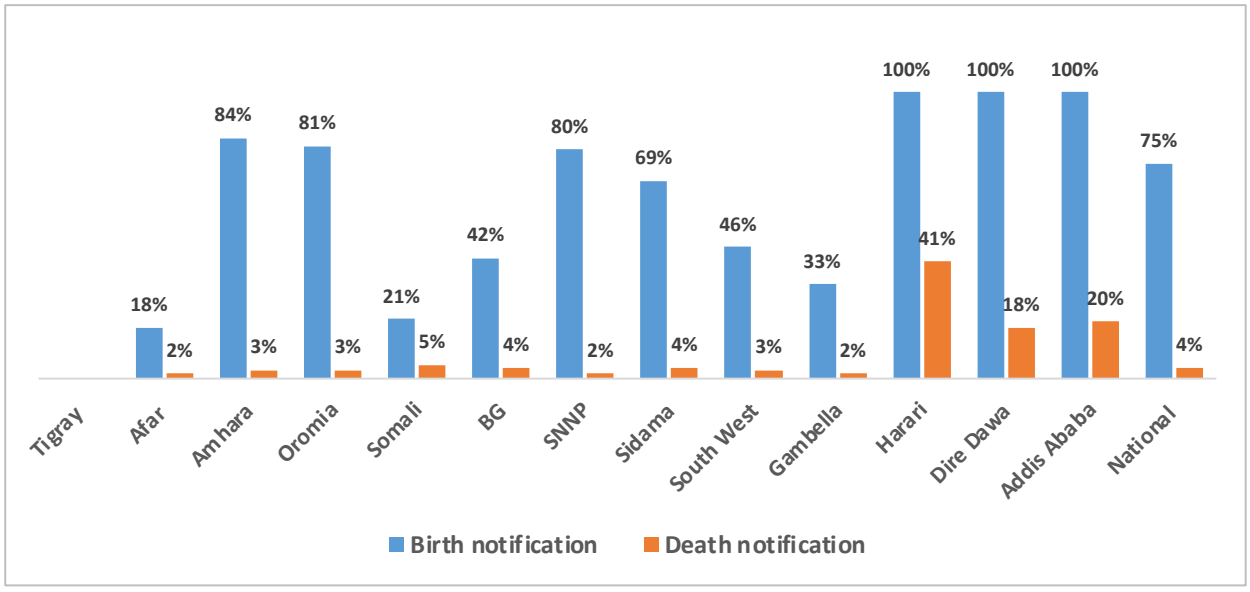


Figure 61: Birth and death notifications out of total birth and death by region, 2015 EFY

Currently, community birth and death notification are initiated in more than 2,000 health posts and community causes of death is captured using verbal autopsy in 47 woredas. As of now, more than 1,000 deaths have been collected so far. Different round of supportive supervision is provided to regions to improve notification and causes of death information. Over the last five years birth notification shows increasing trends while death notification does not show major improvement as described in below graph.

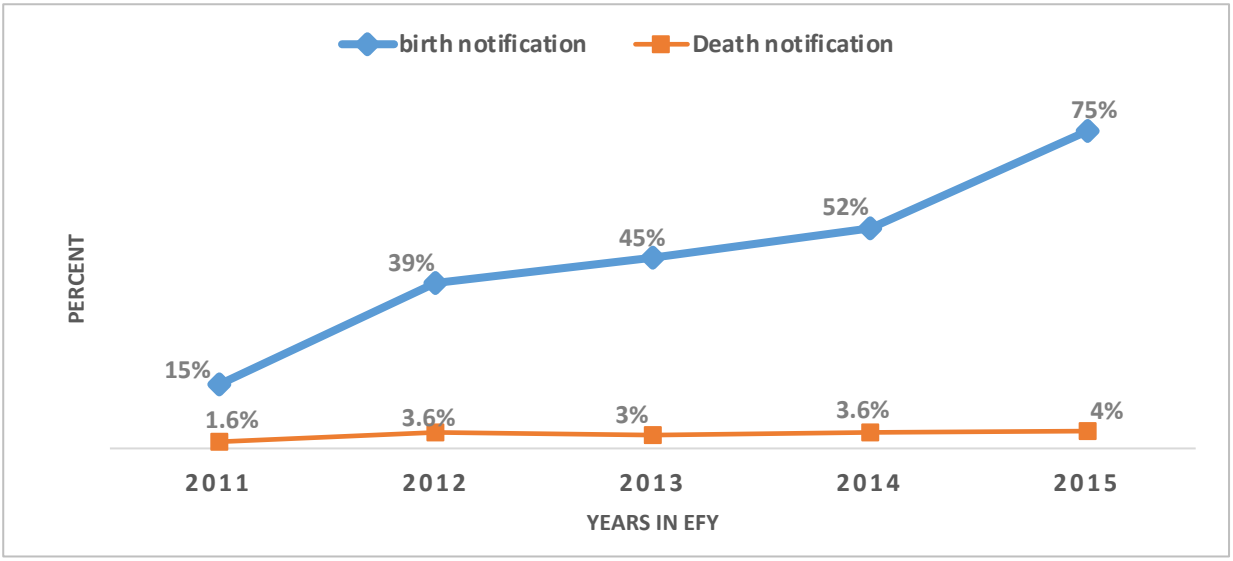


Figure 62: Trend of Birth and death notification from eligible number, 2011-2015 EFY

6.2. Health sector planning

The Health Sector Transformation Plan II has been implemented for the last three years. Midterm review was conducted using the independent international and local consultants. In additional to secondary document review, primary data was collected from RHB, WorHOs and Health facilities based on each thematic area. The consultants produced report indicating the major findings, challenges and recommendations on major issues and strategic directions.

A three-year strategic plan is produced based on the national need to link strategies with investments, address challenges encountered in the last three years, and synchronize all sectoral strategic plans to a similar period. The name of this strategic plan is health sector's medium-term development and investment plan (HSDIP), and it spans for the period 2016 – 2018 EFY (July 2023 – June 2026). The HSDIP development process followed a participatory approach with the engagement of various stakeholders. It was informed by an in-depth situational analysis of the performance of the health sector, findings from the HSTP II midterm review, the socio-economic situation of the country and aligned with continental and global situations and commitments. It builds on the previous successes and considers the current challenges and gaps.

The overall goal of the HSDIP is to improve the health status of the population through accelerating progress towards universal health coverage, protecting people from health emergencies, transforming Woredas and improving health system responsiveness. It has identified eight strategic objectives, which are the major expected results to be achieved during the strategic period. Accordingly, health sector 2016 EFY annual plan is based on the HSDIP.

6.3. CHIS implementation

Community Health Information System (CHIS), as part of the reformed health management information system, is designed to assist in the management functions of health extension programs through data collection on basic demographic data, health service delivery, and utilization based on the health extension package. Its implementation is contextualized in three settings: Agrarian, pastoralist and urban CHIS.

In this fiscal year, Agrarian CHIS customization was done based on an HEPO roadmap by establishing a technical team from all stakeholders. Supportive supervision visit on Pastoralist CHIS were also done in Somali, Gambella, Oromia and Afar regions. Additionally, urban CHIS manual was updated by aligning with the health extension reform packages and the family health team approach.

6.4. Data Quality, Data analysis and Dissemination

Data quality review at MOH and regional level now become a routine practice. The review mainly focuses on report timeliness, completeness, outlier and internal consistency. In this reporting period the service data reporting set is sub-categorized in to 9 for health center and hospital while it is 6 for the health post. The overall average report completeness and timeliness reporting rate for all service report data sets are 85% and 41% respectively. Compared to 2014 EFY, service report completeness is reduced by 3% while timeliness is reduced by 22% mainly because of the delay in implementation of customized DHIS2 version in the first quarter of 2015 EFY.

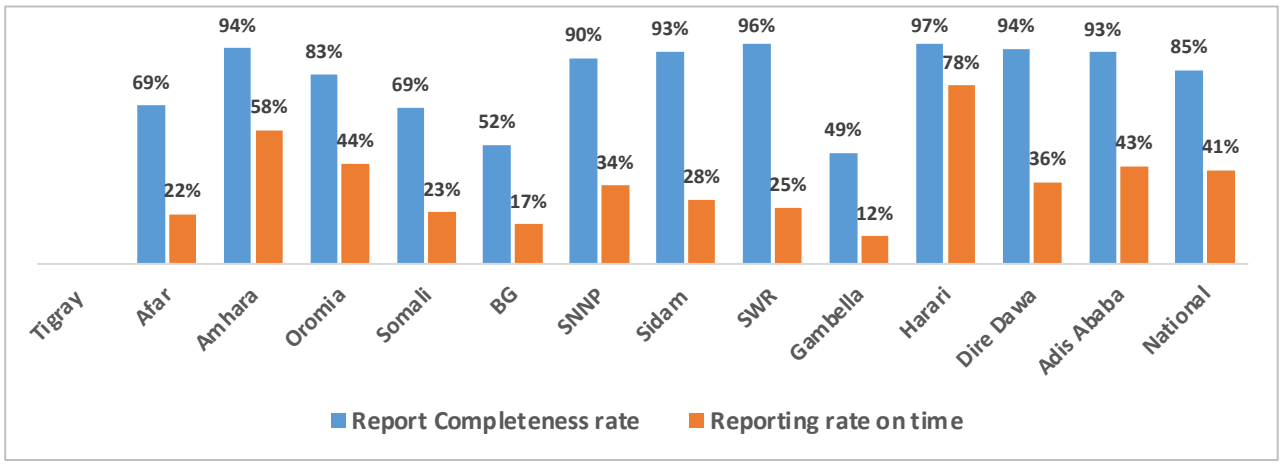


Figure 63: Service report data sets completeness and timeliness by region, 2015 EFY

The comprehensive 2014EFY health sector annual performance report, 2014 EFY health and health related indicators document, special bulletin and 2015 EFY annual woreda based plan documents are prepared and disseminated during the 24th annual health sector review meeting. This meeting was conducted from October 19-21, 2022 at Hawasa city with over 500 participants from all stakeholders under “equitable and quality health service for all “motto.

6.5. Information revolution (IR) Model health institutions creation

According to IR Implementation guideline, revised version of connected woreda, the health institution has to conduct self-assessment quarterly to determine the IR status of their respective institution. The IR status is categorized into five IR path way: emerging, candidate, model, digital model and demonstration site.

The number of facilities conducting IR self-assessment is increased remarkably in this fiscal year. In quarter 4 of 2013 and 2014 EFY 771 and 452 health institution reported conducting the self-assessment respectively. However, during fourth quarter of this reporting period, 375 (36%) of all woreda health office and 2085 (48%) of health facilities (hospitals and health centers) conducted the self-assessment using standardized IR checklist. Of all institutions (2460) that reported IR self-assessment through DHIS2, 948 (39%) reported greater than 90 IR scores. For the woreda to be model, the IR composite measures have to be greater than or equal to 90. Accordingly, 7 woreda supported by CBMP and 6

other woreda reported reaching the IR model status. In the coming year verification will be conducted for the woreda and selected model hospitals that reported reaching model status according to their self-assessment result.

6.6. HIS Governance

HIS national advisory group (NAG) meeting, attended by 24 participants from key stakeholders, was conducted. The participants have discussed on HIS related 2015 EFY, DHIS2 and eCHIS implementation challenges. The major key action items of the meeting are: more efforts are required from NAG member to mobilize additional resources for HIS activities and addressing eCHIS issue (particularly the issues related to scope, resources and maintenance).

A three-days training on the Data Access and Sharing Guideline and its SOP was provided for 30 participants from MOH departments, agencies, RHBs, universities and HIS partners. In addition, a TOR to establish Data Access and Sharing Task force has also been drafted. Furthermore, Ethiopia's experience on data access and sharing processes and practice has also been shared during the Second Inter- country partners Coordination Meeting of the WHO-AICS project whose aim is improving access to nutrition services among migratory cross-border communities of Ethiopia and Somalia using digital solutions.

The national Health Data week was celebrated at national and regional levels under the theme of "Enhancing the engagement, capacity and accountability of the private health sector: An action to improve the Health Information System". Various events including a panel discussion, exhibition, dissemination of messages via electronic and print medium was accomplished during the week.

6.7. Digital health/Technology and Innovations

6.7.1. DHIS2 Customization/development and Implementation

The Ministry has customized DHIS2 software for various purposes including electronic National Health Management Information System (eHMIS), multisectoral nutrition, COVID 19 tracker, COVAX tracker, woreda base plan, woreda transformation, activity budget tracking, stakeholder mapping etc.

To make maximum benefits out of the timely release of the DHIS2 core system, and addressing current challenges in data quality, the Ministry is undergoing an upgrading of the DHIS2 from v2.36 to version 40(latest stable version). To date, about 70% of the activities have already been accomplished. The interoperability between eHMIS/DHIS2 and MFR, eHMIS/DHIS2 and eCHIS were done and on the verge of the actual implementation. Despite the huge successes in capturing and reporting data, low DHIS2 utilization by private clinic, computers availability and its capacity, Local Area network (LAN) and connectivity to healthNET remain a bottleneck for the implementation of DHIS2/eHMIS to its optimum level.

6.7.2. Electronic Community Health Information System (eCHIS)

In this year the MoH has focused on strengthening the existing eCHIS implementation as opposed to expanding eCHIS to new sites. In this regard, new 2,700 high specification tablet computers were distributed to high performing health posts across the implementing regions. The tablet computers have been individually configured using a device management system, and labeled with barcodes before distribution.

The development of all programmatic modules of eCHIS are completed. The Child Health, Nutrition/ GMP, TB, Leprosy, Malaria, NTD, NCD, and HIV are now all in the process of scaleup in sites already implementing the RMNH modules. To start the additional modules in implementing sites a national level master TOT was provided to experts from 8 regions. Currently eCHIS is deployed in 7,806 health posts of all agrarian and pastoralist region except Tigray. A total of 6,913 health posts registered more than 85% of their catchment and 5,740 HPs have started capturing the services provided using eCHIS app. As of July 2023, more than 4.7 million households and more than 20 million individuals have been registered. Though the home profile aspect of the implementation was successful, using eCHIS for service delivery is not satisfactory yet. Additionally, paperless woreda initiatives is being tested in 12 selected agrarian woreda and the eCHIS maturity assessment result was finalized and shared with all stakeholders.

6.7.3. Electronic Medical Records (EMR)

The Ministry of Health has continued to expand the implementation of EMR system to more hospitals and health centers. Maintaining and upgrading of the local infrastructure and supplying the required hardware for selected facilities is ongoing parallel to the deployment and starting the implementation of the system to those health facilities whose infrastructure is ready. The Ministry has conducted a readiness assessment and accordingly has made distribution of ICT network equipment (Network Cable, switch and accessories) for 17 health facilities and medium end servers for 11 hospitals to strengthen the implementation of the System.

The ministry has acknowledged PulseCare and Bahmni EMR as national EMR systems for scale up. To date, the systems are being implemented at 38 health facilities selected from all regions and city administrations. The Bahmni EMR is implemented in 21 hospitals and 5 health centers across all regions. Similarly, the PulseCare system is also implemented in 6 hospitals and 6 health centers at Addis Ababa City Administration.

Various Trainings were provided on the BahmniEMR system for 135 experts selected from hospitals that had started implementing the system. Shortage of budget to fulfill the required hardware, the inflation on the local market to purchase ICT equipment, and the absence of ICT technical workforce at health facilities are major challenges on EMR implementation. Considering the challenges, MOH is cautiously expanding its implementations to more health facilities.

6.7.4. Digital Health Systems Quality Assurance

Guidelines are instrumental in upholding the safety, efficacy, and reliability of digital health technologies, while simultaneously fostering innovation and accessibility within the healthcare sector. In this reporting period, comprehensive Digital Health Quality Assurance Guidelines is developed.

The guiding principles of these guidelines encompass user-centered design, equity, accessibility, interoperability, and security. By adhering to these principles, digital health technologies can provide safer, more effective, and accessible solutions while maintaining the highest standards of security and equity. These guidelines not only promote innovation but also facilitate the widespread adoption of digital health technologies across healthcare providers and organizations, ultimately contributing to the advancement of healthcare outcomes.

6.7.5. Unified Nutrition Information System for Ethiopia (UNISE)

UNISE is a multi-sectoral nutrition score-card data management tool implemented using DHIS2 to capture, store and analyze multi-sectoral nutrition data at all administrative levels to enhance evidence-based decision making and contribute toward reduction in childhood stunting.

In the 2015 EFY the following major tasks are accomplished:

- UNISE list of indicators are revised by all Food and Nutrition Strategy (FNS) implementing sectors and second version of UNISE/DHIS2 developed
- National level master TOT was provided and User manual, Operating procedure guide documents are produced
- Currently 78 Sekota Declaration expansion phase woredas have implemented UNISE using online mode
- UNISE implementing Woreda sector office internet access is being upgraded to 8MB bandwidth
- Nutrition data are being captured and reports are generated for improved decision making at all levels (Kebele, Woreda, Zone, Region and Federal levels)

6.7.6. Integrated Human Resource Information System (iHRIS)

The Ministry of Health has invested in the iHRIS development and its implementation, ICT infrastructure and human resources capacity building activities. This system has three core components such as iHRIS-Licensure for health workforce registration and licensing, iHRIS-HRA for human resources for health management; and iHRIS-Development for managing pre-service and in-service training data.

Currently, iHRIS is officially launched, and implemented at more than 200 health institution. So far more than 23,000 HRH data points have been recorded. On the other hand, iHRIS-Licensure is implemented at the MOH level to manage the health professionals licensing and certification processes.

6.7.7. Implementation of Master Facility Registry (MFR)

The Ministry of Health has created a centralized and authoritative health facilities database known as the Master Facility Registry (MFR). This registry captures comprehensive information about all health facilities across the country, including essential details such as facility name, location, reporting structure, and contact information. More than 47,000 health facilities encompassing both private and government-owned facilities are registered in the MFR. Out of all registered facilities, more than 36,637 have received approval which signifies that they meet the SOP of the MFR governance documents. Furthermore, an initial pilot project focused on integrating and achieving interoperability between the MFR and the DHIS2 has displayed promising results.

The implementation of MFR has encountered several challenges that need to be addressed for its successful operation and sustainability. These challenges include: lack of basic infrastructure such as computers, internet connectivity, and GPS devices at majority of woreda regulatory offices; computer literacy and skill gaps among experts working at the lower levels of the healthcare system and overall budget shortage.

6.7.8. Strengthening Hosting Infrastructure

To ensure data security and align with the country's data hosting regulations, the Ministry has opted to host digital health systems locally rather than using external cloud platforms. Local hosting eliminates dependence on foreign cloud providers, give MOH more control over the data management and avoids ongoing costs in foreign currency.

The existing data center is expanded to accommodate the growing demand. For instance, the eCHIS servers are upgraded to 7 physical machines and more than 40 virtual machines. Two new air conditioning facilities were installed to enhance the cooling system. New servers were installed and configured at the ministry's data center. Converged servers (8 blade servers with more than 130 TB storage) are deployed. Furthermore, modern maintenance and system monitoring tools are deployed to live monitor the health of each digital health application.

Currently systems like eCHIS, MFR, and iHRIS are hosted in the Ministry's local data center, while systems like DHIS2 are hosted in local cloud owned by Ethiotelecom. After the expansion of the local data center, systems which were previously hosted on the amazon cloud are migrated to the local data center.

6.7.9. Collaborate and Prepare National Health Exhibition

The Digital Health area is one of the six thematic areas showcased at the National Health Exhibition, held from June 19 to July 28, 2023, with the theme "Next Generation Health." This area featured 32 booths exhibiting a wide range of innovations, technologies, and solutions related to digital health, from the national digital health architecture to cutting-edge Artificial Intelligence applications. The strategic significance of digital health becomes apparent as the country progresses towards realizing its vision of "Digital Ethiopia by 2025."

The Digital Health exhibition was thoughtfully organized into six thematic areas such as Digital Health Architecture, Governance, and Infrastructure, Supply Chain Ecosystem, eCHIS, eLearning Ecosystem, Institution based information Systems and Collaboration with Startups and Private Companies. This thematic area highlights how the health sector has been leveraging digital solutions to achieve the national vision. About 210,084 individuals have visited the national health exhibitions.

Digital technology played a vital role in enhancing the overall exhibition experience. Two applications were developed and deployed to facilitate the process. The Inventory Training System, utilizing QR codes, efficiently managed all materials in the science museum. The MoHExpo app, available on Google Play Store, provided visitors with easy registration, event information, feedback submission, thematic area and booth details, and networking opportunities.

Challenges

- Persistent low death notification due to low community awareness, sensitivity of the issue and fear of medicolegal consequence from health professional side
- Interruption of routine reporting from Tigray Region
- Low reporting rate from private health facilities
- Digital health tools including computers, tablets, connectivity and network related problems

- Digital health knowledge and skills gap among health work force
- Isolated digital health systems that are not exchanging health data with one another,

Way forward

- Strengthen implementation of IR guideline across all regions
- Realize interoperability among the priority digital health solutions tools
- Piloting paper less woreda initiatives on eCHIS and document lessons
- Strengthening community level death notification and verbal autopsy implementation.
- Incorporate ICD 11 and death notification in the pre-service curriculum to raise awareness of the health professional.
- Explore options on strengthening HMIS implementation in private health sector
- Provide capacity building and trainings for health workforce force to enhance digital literacy and on other HIS competency area

6.8. Operational, Basic Researches and Innovation

Inadequate implementation research and low utilization of available evidence for decision-making is one of the major gaps in Ethiopian health sector. To address this shortcoming the ministry has established Policy, Strategy and Research Lead Executive Office. Major accomplishment in this area is described below.

The national research road map was developed and research landscape analysis process was started. Concept note on the linkage of MOH with Universities was prepared and situational analysis was conducted at selected five universities (Bahr Dar, Jimma, Addis Ababa, Hawassa and Arbaminch) in collaboration with Ministry of Education and Ministry of Innovation and Technology. Furthermore research Strategic framework was developed and disseminated to key stakeholder. A total of 26 different researchable policy topics that require policy options to strengthen evidence generation on priority health programs was mapped out of which 9 topics, that touch more than one sector, were sent to Policy Study Institute to be studied.

The EPHI and AHRI has continued to be the back bone of health sector in generation of scientific evidence. In this reporting period a total of 161 (EPHI 87 and AHRI 74) scientific manuscripts was published on the peer reviewed journal. Additionally, EPHI has produced and disseminated 68 technical reports to key stakeholders.

The research projects conducted by EPHI were categorized under communicable and non-communicable diseases, nutrition, food system and food safety, health system and reproductive health research and technology evaluation. Likewise, the research project conducted by AHRI were basic biomedical, clinical, translational, clinical trial, traditional and modern medicine, vaccine and diagnostics, and operational studies for the control and prevention of infectious and non-infectious diseases as well as for developing technologies and/or technological solutions.

Policy briefs and issue brief are a knowledge transfer tools used to convey summaries of evidences to decision makers. AHRI has prepared two policy briefs and two Issue briefs for policy consideration. Title of issue brief are: Leprosy Patients Remind hidden and undiagnosed; Call for action and mHealth

intervention for better maternal & neonatal health in pastoralist communities; and issue briefs title are: Curb pneumonia deaths with low cost locally made oxygen device (BCPAP) and; Integrating physical and psychosocial care for people with Podoconiosis, lymphatic filariasis, and leprosy in Ethiopia. Additionally, Policy briefs on eCHIS was prepared and disseminated for key stakeholders by MOH. Likewise, a policy dialogue is a tool which promotes evidence-informed policy-making. Policy dialogue was conducted on title "Private Sector Engagement in Tertiary Health Care in Ethiopia" and "Optimizing the Ethiopian Health Extension Program: policy options to address workforce challenges".

Through the Grand Challenges Ethiopia Scheme which aims to promote local health innovations, support has been provided to 10 transitions to scale projects by AHRI. In addition, in the budget year, a guideline for the National Health Innovation Steering Committee (NHISC) was prepared and the committee was established. This committee will be involved in solving problems faced by innovators and facilitates the production and use of the innovations.

Challenges

- Security problem in some areas chosen for research create hurdle to conduct studies within a scheduled timeline
- Customs clearance has been a long-standing challenge for procurements of equipment and in-kind donations from abroad.

Way forward

- Conduct high level advocacy to solve custom clearance related challenges
- Strengthen multi-sector cooperation and coordination on survey, surveillance and research

CHAPTER

7

Pharmaceuticals and medical supplies and pharmacy services

CHAPTER 7: Pharmaceuticals and medical supplies and pharmacy services

In this Chapter, supply of pharmaceuticals and medical supplies, management of medical equipment and pharmacy service related major achievements, initiatives and activities are discussed.

7.1. Supply of pharmaceuticals and medical supplies

The Ethiopian Pharmaceuticals Supply Service (EPSS), one of the institutions/agencies under the MOH, is an institution responsible for the pharmaceutical supply management in Ethiopia. It provides pharmaceuticals, laboratory reagents, medical equipment and supplies to the Ethiopian people. It mainly focus on strengthening and improving the pharmaceutical chain management to provide basic medicines, medical supplies, medical devices, laboratory reagents and chemicals that are proven to be of approved high quality, efficacy and safety for the health services in Ethiopia. It procures and distributes the pharmaceuticals and medical supplies to health facilities throughout Ethiopia.

Procurement and distribution

Procurement: In 2015 EFY, EPSS has procured pharmaceuticals, supplies and medical equipment worth of more than 41.65 Billion Birr. From the total procured pharmaceuticals and supplies, 11.76 Billion Birr was from recurrent budget, 5.94 Billion birr was from health programs and 23.94 Billion Birr was from aid sources.

Distribution: In the fiscal year, pharmaceuticals and medical supplies worth of 37.2 Billion birr was distributed to health facilities. In addition, medicines and medical equipment were distributed to conflict affected areas. To strengthen last mile delivery of medicines and cold chain system, 16 vehicles and 19 motorbikes were donated from GAVI.

The amount of pharmaceuticals and medical supplies distributed over the past six years has consistently increased over time since 2010 EFY but with a slight reduction in 2015 EFY compared to the 2014 EFY procurement and distribution amount.

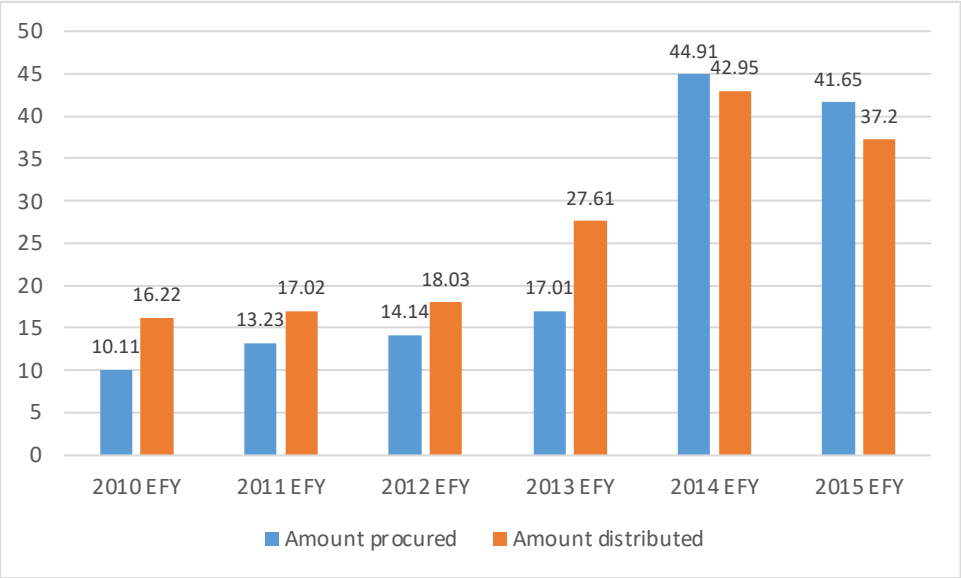


Figure 64: Amount of pharmaceuticals and medical supplies procured and distributed from 2010 EFY to 2015 EFY, in Billion Birr

Strengthening supply chain management

During the fiscal year, the availability of life saving and essential medicines at national pharmaceutical warehouse level was 83.4% for revolving drug fund (RDF) medicines and 94.3% for health program medicines. Compared to the previous fiscal year, availability has improved. Availability of essential medicines has increased from 81% in 2014 EFY to 83.4% for RDF medicines and a slight increase from 94% to 94.3% for program medicines.

To improve the supply chain management and supply of pharmaceuticals, various activities were performed. Some of them include using effective forecasting models, strengthening timely visibility of information to health facilities, conducting inventory on a monthly basis and using for decision making, establishing sales and operations team and conducting market studies. The forcast accuracy was 60%, which is lower than the target 70% set for the year. Stock according to plan was planned to be 80% but it was 60% during the fiscal year.

Improving procurement process

Framework procurement system: In the previous years, more than 400 types of medicines and medical supplies were procured from one vendor that win the tender process. This procurement strategy resulted in interruption of supplies. As a result, in the fiscal year, a framework procurement system was implemented through which many vendors were participated.

Domestic supply of pharmaceuticals: To strengthen the supply of medicines and supplies from domestic manufacturers, various activities have been conducted in the fiscal year. There was a plan to procure pharmaceuticals worth of more than 1.1 billion birr but only 60% of it was supplied from domestic manufacturers, which is a lower achievement.

Table 26: Key procurement performance indicators, 2015 EFY

S.No	Key procurement performance indicator	Target	Performance
1	Average procurement lead time	160 days	194 days
2	Average lead time from ocument received from TMD to Products cleared date	112 days	81 days
3	Performance Guarantee upto LC opening	25 days	16 days
4	Average tender evaluation lead time	75 days	78 days
5	lead time from port to EPSS warehouse	22 days	14 days
6	Supplier's fill rate	100%	99%

Warehouse management

To improve warehouse management, different activities have been conducted in the fiscal year. During the fiscal year, renovation of warehouses was done to meet their standard. In addition, procurement of different warehouse material handling equipment was done, such as procurement of 10 forklifts, 18 generators, shelves and rack. In addition, bar code scanner machines were procured and preparations are ongoing to start its implementation. Timely Perpetual Inventory (PI) was performed, and post inventory analysis was done and corrective actions were taken. The inventory accuracy rate was 98.6%, which is a little lower than the 100% target. The average time to make newly arrived medicines ready for distribution was only 12 hours, which is a good performance compared to a 3 days target.

Wastage Rate: In the fiscal year, wastage rate at central warehouse and regional hubs was 0.72%. This wastage rate is a little higher than the target (0.70) but lower than the previous year (it was 0.74% last year). Five hubs had a wastage rate higher than 1.0%, namely Semera hub (1.93%), Gambella (1.33%), Bahir Dar (1.26%), Addis Ababa-1 (1.09%) and Assosa hub (1.08%). The lowest wastage rate was at Jigjiga (0.10%), Gondar (0.21%) and Dire Dawa hub (0.24%). The wastage rate at the central (head office) of EPSS was 0.78%). To reduce wastage of medicines, regular inventory and analysis of available pharmaceuticals at the different hubs was done and re-distribution was done from overstock hubs to understock hubs.

Table 27: Performance of key warehouse management indicators, 2015 EFY

S. No	Indicator	Target	Performance
1	Availability of essential medicines at hubs	91.5%	84.3%
2	Inventory accuracy rate	100%	98.6%
3	Pharmaceuticals wastage rate	0.72%	0.72%
5	Average time to make medicines and supplies ready for distribution	3 days	12 hours
6	Average cost of distribution (%)	0.90%	0.77%

Challenges

The main challenges of pharmaceutical supply services during the fiscal year include:

- Global level shortage of pharmaceuticals and high inflation
- Inadequate performance of local pharmaceutical manufacturers and unable to supply timely
- Weak logistics management system of medicines and medical supplies at health facilities
- Conflicts in different parts of Ethiopia affected the distribution of medicines and supplies
- Due to price inflation and other forced conditions, suppliers are unwilling to provide at the contracted price, contract cancellation is a challenge for the supply of medicine

Way forward for next year

- Strengthen enterprise resource planning (ERP) project
- Reduce procurement lead time and improve availability and supply of medicines and medical supplies
- Strengthen supply and management of medical equipment
- Implement different reforms such as Kaizen, risk management, quality management system and others
- Implement supply-chain security procedures to reduce pharmaceuticals supply risks
- Strengthen implementation of e-procurement system
- Strengthen financial, performance, quality and compliance audits
- Develop, endorse and implement a guideline on outsourcing distribution vehicles to third party institutions

7.2. Pharmaceuticals and medical devices management and services

Strengthening Pharmacy services and ensure rational use of medicine

In the 2015 EFY, the program aimed to implement AMS programs in 130 hospitals and has successfully implemented them in 135 hospitals, providing training for health professionals. Quality improvement interventions have been initiated to address surgical site infections and surgical antimicrobial use prophylaxis, resulting in significant improvements. In the fiscal year, 22 drug use evaluation studies were conducted in prioritized areas, primarily focusing on antimalarial and other antimicrobial drugs. Based on the study findings hospitals took the commitment and developed intervention plan to improve the rational use of medicine.

In collaboration with regional health bureaus, hospitals that met the implementation criteria were selected to enhance the implementation of the Auditable Pharmaceutical Transaction System (APTS). In 2015 EFY, 47 new health facilities implemented APTS after undergoing a comprehensive training.

In the fiscal year, revision of the pharmaceuticals and medical devices policy was initiated, resulting in the development of the first draft document. The draft policy was subsequently presented to federal and regional stakeholders, and inputs were gathered.

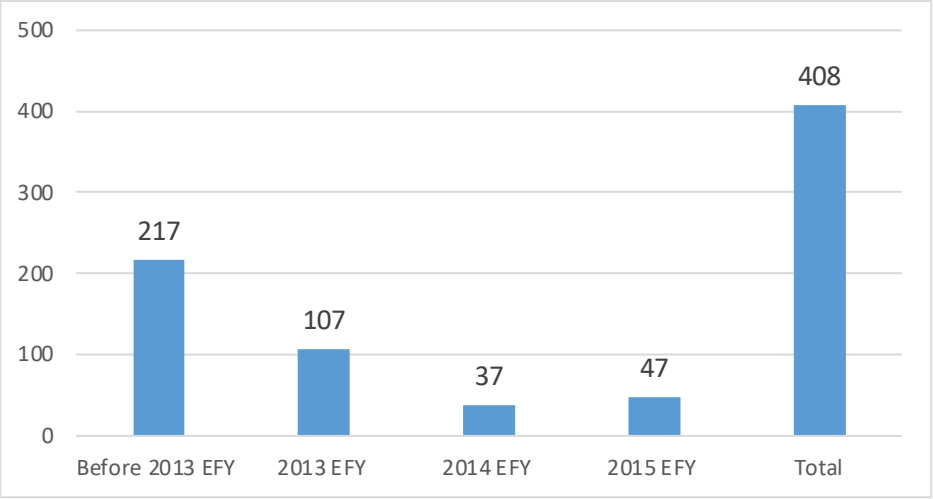
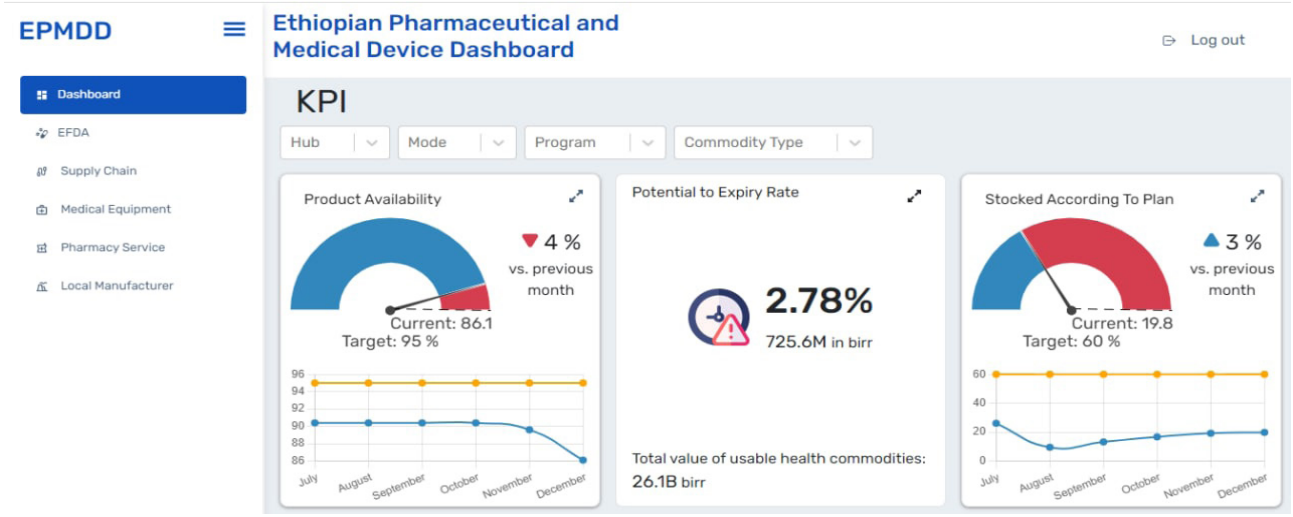


Figure 65: Number of health facilities implementing APTS, 2015 EFY

Digitalization of pharmaceutical and medical device management information systems

Through integration with the existing systems, a dashboard for pharmaceuticals and medical equipment was developed by identifying crucial sources of information for effective management of pharmaceutical and medical equipment sector through consultation with various stakeholders. User accounts and passwords were subsequently provided to senior officials of the relevant stakeholders.



Strengthening medical devices supply and management system

In 2015 EFY, a comprehensive list of required medical equipment was compiled from all executive offices, totaling approximately $93 million in cost. Following this compilation, an order was placed with EPSS for procurement, which was then reconciled with the purchase order from the previous fiscal year in 2014.

Efforts are underway to enhance access to healthcare services, rehabilitate damaged institutions by conflict, and prevent and treat COVID-19. To this end, a range of medical equipment has been procured and the total cost of $17.3 million medical equipment's have been stored in a warehouse before being distributed to regional health bureaus and health facilities.

Additionally, successfully installed three medical oxygen plants, and specifications have been developed for over 250 capital and routine medical equipment items. A campaign was also launched to maintain more than 408 medical equipment items in Amhara, Tigray, and Afar regions which have been affected by conflicts, Biomedical experts from RHBs and health facilities provided valuable assistance during this campaign, resulting in the installation of 206 medical equipment items, including 25 ultrasound machines and also identified accessories for over 250 medical equipment items. Overall, the campaign led to a cost savings of approximately $300,000 for maintenance. In EFY 2015, a total of 823 medical equipment's are maintained.

Improve emergency response and services for health related problems: Medical equipment valued at approximately $12.1 million with support from the World Bank and an additional $4.2 million from the government was purchased and distributed to conflict-affected areas for the restoration of health institutions.

Improve drug availability and reduce wastage: To effectively manage program pharmaceuticals supply chain management in an effective and integrated manner, a protocol was developed. Forecasting was done for TB, HIV and Malaria drugs. Based on the 2015 EFY forecasting result of program pharmaceuticals collected from all health programs, a total of $2.4million was placed to EPSS for procurement.

Improve traditional medicine: A draft monograph was created for 40 medicinal plants to facilitate the development of the Ethiopian herbal pharmacopeia. The first draft of the Ethiopian traditional medicine

strategy was developed by integrating with the health transformation plan and other stakeholders plan. Additionally, efforts were initiated to facilitate the inclusion of three medicinal plants in clinical trials.

Other achievement and major activities

- DAGU2 software has been successfully implemented across 368 healthcare facilities
- MEMIS software was successfully implemented in 45 health facilities, accompanied by comprehensive training for 90 bio-medical professionals
- The data from the Health Information System (DHIS2) showed that 68% of the patients received their prescribed medicine from the health facilities.
- The wastage rate has exhibited a positive trend, which can be attributed to the capacity building initiatives undertaken in the areas of inventory management, demand, demand forecasting and overall consumption data management and utilization.
- A protocol has been developed and finalized and a detailed standard operating procedure (SOP) has been drafted to enable effective and coordinated management of health program drugs (selection, forecasting and procurement process).
- Trainings were provided on integrated logistics system, APTS, emergency drug supply chain management, compounding service, oxygen, NICU, cold chain, COVID-19 equipment.

Challenges

- Delay on SDG budget release
- Data quality problem sent from health facilities
- Inadequate human resource

CHAPTER

8

Health financing

CHAPTER 8: Health financing

Ethiopia's commitment to achieving universal health coverage (UHC) underscores its emphasis on accessible, affordable, and high-quality healthcare for every citizen. Healthcare financing serves as the backbone of this ambitious goal, facilitating the necessary resources to build a resilient healthcare system. The Ministry of Health of Ethiopia has given attention to the importance of health financing in all strategies including the Health Sector Transformation and the current Health Sector Development and Investment plan. This has been manifested by continuous implementation of the health care reforms coupled with additional innovative financing approaches.

Ethiopia's healthcare financing landscape is a dynamic and evolving domain. The Ethiopian government, in alignment with its commitment to achieving UHC, has been working diligently to improve healthcare access and quality across the nation. The GoE allocating a considerable portion of its budget to the health sector, though it is still far below the Abuja declaration, reflects its dedication to prioritizing the well-being of its citizens. Furthermore, international collaborations and partnerships have played a pivotal role in bolstering healthcare financing in Ethiopia. These collaborations facilitate resource mobilization and the implementation of targeted health programs. The exploration of innovative financing models, including public-private partnerships, results-based financing and establishment of Equity and Resilient Fund, have the potential to optimize resource allocation and service delivery. While commendable progress has been made, challenges persist. Some of these include ensuring sustainable funding streams, enhancing cost-effectiveness, and financing exempted health services. However, these challenges also present opportunities for innovation and collaboration.

This section highlights key achievements in 2015 EFY on health financing, including resource mobilization, utilization and implementation of health financing reforms and strategies. It showcases the commitment to advancing healthcare access, financial protection, and sustainable development in Ethiopia.

Improving health financing

In response to the evolving landscape of healthcare needs and the aspiration for universal health coverage, the establishment of a dedicated Health Fund is important. This initiative aims to revolutionize healthcare financing, ensuring equitable access to quality services while fostering financial resilience. It recognizes that reliable and sustained financing is integral to the realization of robust healthcare systems, specially funding for exempted health services. A proposal that discussed the rational of health fund and source of finance as well as for what purpose the resource will be used and how the fund will be manage included. The proposal was reviewed by MoF and revised by incorporating the MoF feedback and this leads to preparation of legal documents.

A draft regulation was prepared to improve the efficiency of the Federal Hospital and University Teaching Hospital's medical services and health sector learning, teaching, and research activities. The regulation aims to collect additional government budget revenue and enhance health sector education and research quality.

In order to prepare individual and total costs for the selected free health services, various data have been collected and the resources and costs required under each program have been identified and the individual and package costs of each detailed service have been estimated. Regarding this, it has been discussed with the senior leaders of the MOH and the relevant program departments at different

times and directions have been given. The estimated cost for provision of exempted health service is included in the three years Health Sector Development and Investment Plan (2023/24-2025/2026).

8.1. Health financing reform implementation

The health sector has been implementing a Health Financing Reform that aimed to raise additional resource for the health sector, enhance efficient allocation and utilization of resources, improve quality and coverage of health service delivery and ensure the sustainability of the health financing system. The implementation of the reform has shown remarkable achievement in most of the regions with the exception of Afar, Benishangul, Gambella and Somali. An assessment to review challenges and opportunities of health financing reform in these regions were conducted and result discussed with regional health bureaus.

In order to strengthen the implementation of the health financing reform, 63 board members from various health institutions in the Somali region were given a three-day training. In addition, to strengthen the implementation of health financing for the health institutions that were damaged due to the war, a training involving 144 board members from various health facilities.

In 2015 EFY, 90% of public health facilities are managed by functional facility governing board, 140 hospitals outsourced at least one clinical services and 32 hospitals established private wing.

Revenue retention and utilization by health facilities is one of the health financing reform strategies in order to bring quality improvement at health facilities. Over the past five years, the amount of internal revenue collected by health facilities has consistently increased. It has increased from 3.1 Billion ETB in 2011 EFY to 8.8 Billion ETB in 2015 EFY.

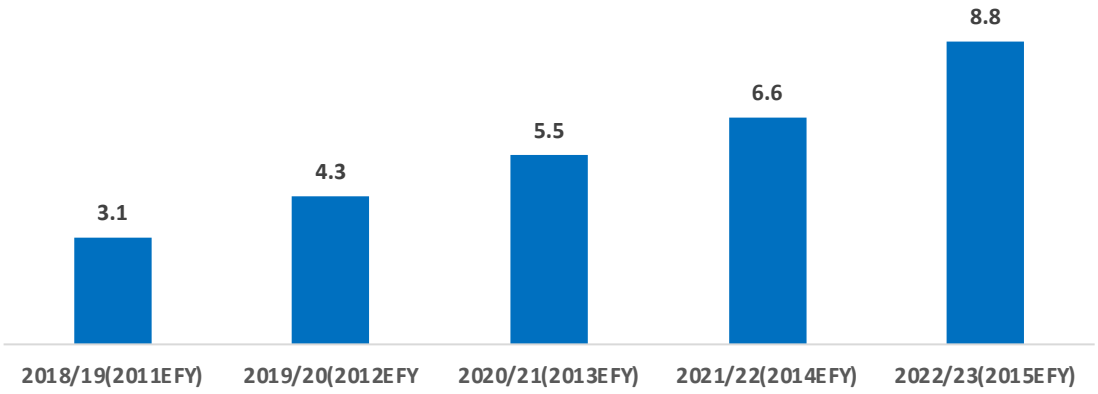


Figure 66: Amount of health facility budget from internal revenue in Billions ETB, 2011 EFY to 2015 EFY

8.2. Strengthening evidence based health care financing

Health financing and economic analysis are integral components of healthcare systems, contributing to effective resource allocation, policy formulation, and the attainment of public health goals. The convergence of these two domains facilitates evidence-based decision-making that optimizes healthcare delivery and ensures sustainable health systems. Accordingly, health technology assessment, health financing and economic analysis and policy dialogues were some of the activities conducted to strengthen evidence-based health financing decision making in the fiscal year.

8.2.1. Health Technology Assessment

Health Technology Assessment (HTA) plays a vital role in guiding healthcare decision-making by evaluating the clinical effectiveness, cost-effectiveness, and overall impact of medical interventions, technologies, and treatments. The establishment of Health Technology Assessment within Ethiopia's health sector is a strategic and progressive step. By integrating evidence-based decision-making into healthcare policies, Ethiopia can optimize its resources, improve patient outcomes, and enhance the overall quality and efficiency of its healthcare system.

A technical committee comprised of various institutions was organised to develop a roadmap for health technology assessment in Ethiopia, according to the TOR prepared in the previous fiscal year. The technical team then gathered important documents from each institution and looked through them to gain a general understanding of the HTA process and how different countries have institutionalized HTA. In addition, the HTA framework and political economy analysis were completed as input for the roadmap, and the technical team developed the initial roadmap design, which will be evaluated and commented on at various levels.

8.2.2. Health financing and economic analysis

In 2015 EFY, various assessment and analysis on health financing were completed such as emergency health financing operational research; efficiency analysis on drug procurement, distribution and utilization as well as the use of medical equipment; economic evaluation of adolescent health services/ interventions. In addition, two studies that measures the health finance equity (benefit incident analysis and financial incident analysis). Capacity building trainings on health financing and economic analysis various topics have been provided for national and subnational trainees including academia.

8.2.3. Policy dialogues

Policy dialogue in the health sector is essential for shaping effective, evidence-based, and inclusive policies. It promotes better health outcomes, resource allocation, and stakeholder engagement while ensuring accountability and adaptability in the ever-evolving field of healthcare. In 2015 EFY, three policy dialogues were conducted. All the three were timely and has got remarkable positive response from all stakeholders with regards to providing tangible solution with actionable recommendations. The policy dialogues were on Primary Healthcare at large and Strategic Purchasing for Health in particular. In addition, five selected policy briefs were prepared and published on ARM 2015 special bulletin with the intention of making the research results into various policy inputs. The policy briefs were on covid-19 financing, TB, Malaria, and reproductive and child health financing.

8.3. Performance based financing

Performance-based financing (PBF) in the health system are a strategy aimed at improving the quality and efficiency of healthcare services by linking financial rewards to specific performance targets. These incentives are designed to motivate healthcare providers and organizations to deliver higher-quality care, enhance patient outcomes, and meet predefined indicators. The Ministry of Health PBF initiative has passed all the preliminary steps that includes conducting scoping assessment on the possibility of PBF through government led aiming institutionalization and sustainability. Accordingly, the widely known PBF design customized and making the Ethiopia Health Insurance Service (EHIS) the purchaser. Currently, Addis Ababa, SNNPR and Somali are selected for PBF pilot representing urban, agrarian

and pastoralist context. Capacity building trainings including TOR was provided. The PBF project implementation manual is finalized but it is being revised to accommodate local context variations after conducting the baseline assessments on the PBF selected health facilities and facilities designated as control. Having the baseline data both in the treatment and intervention areas will help to attribute the changes to PBF and to decide if it will be good PBF scale up in Ethiopia.

8.4. Private sector engagement

Health as one of the sectors that benefits from private sector engagement, the Ministry of Health explored various options to ensure effective private sector engagement and manifest this by explicitly mentioning the importance of private sector in health in various strategic documents. As part of the foreign direct investment, in 2022/23 in Ethiopia seven projects were registered of which 6 of them are at the pre-implementation phase and on start operating. These projects are for health service provision at General and specialized private hospitals and also for establishment of a laboratory test center. The total capital investment for the seven projects is about 10 billion birr. Similarly, in 20222/23, there were 130 domestic private investments on health sector, of which 125 of them are in pre-implementation phase. These projects will create job opportunity for more than 10,000 individuals of which 80% will be permanent employment.

Private sector engagement strategy: A technical committee composed of relevant stakeholders has been formed and a draft strategy document to strengthen the participation of the private sector in the health sector is being prepared. Capacity building training on public-private partnership was provided for 44 participants. A Policy brief on Private Sector Role in Tertiary care has been prepared and consecutive dialogues will be initiated on key findings.

Public Private Partnership (PPP) for Diagnostics Service: A PPP for three diagnostic services (laboratory, pathology, and imaging) was initiated in Saint Peter Specialized Comprehensive Hospital. Following the approval of feasibility study by PPP board, the Project management team has done early market engagement and scoping review before launching of tender process to understand market appetite and enquire inputs for structuring the tender documents. For response to the Request for Expression, about 50 organizations have expressed their interest which is encouraging to go to the next bidding process. The Request for qualification was prepared and advertised for local and international bidders to apply. Following the application, committee was established to do evaluation of technical, financial and legal due diligence of six consortium applicants but only two qualified consortiums were shortlisted, which is below the minimum requirement to proceed to request for proposal stage. Currently, there is revision of feasibility demand and financial analysis with integration model and the tender document.

Public Private Partnership for Oncology service: Consultants were hired through Expertise France Financial support- and data for feasibility assessment of public-private partnership on cancer project was obtained from public and private hospitals. A feasibility study was conducted, and a final report was produced. Based on comments from Ministry of Health management, the project management team and St. Paul's Hospital are considering options for project and hospital staff allocation and organization, as well as determining the proportion of public and private patients.

8.5. Development Partners financial Contribution

Development partners has been supporting the health sector of Ethiopia through financial and technical contributions. In 2015 EFY, more than 590.6 million USD was committed from development partners (DPs), from which more than 555 million USD was disbursed using channel two modality to the health sector. The disbursed amount was 94% of the total commitment. From the total 555 million USD disbursed to the health sector in the fiscal year, the majority was from Global Fund (42%), followed by bilateral partners (35.1%) and SDG pool fund (15.8%). The other contributors include GAVI (2.5%), foundations (2.3%) and UN organizations (1.9%).

Table 28: Commitment and Disbursement of Funds by Development partners, 2015 EFY

S.N	Source of Fund	Commitment (USD) in 2015 EFY	Disbursement (USD) in 2015 EFY	Percentage of Disbursement
1	**SDG Performance Fund**			
	Italian Agency for Development Cooperation (AICS)	4,392,717.10	4,392,717.10	100%
	Korea International Cooperation Agency (KOICA)	250,000.00	250,000.00	100%
	Spanish Cooperation	734,230.00	710,640.00	97%
	FCDO(DFID)	11,325,600.00	11,344,381.06	100%
	UNFPA	50,000.00	50,000.00	100%
	World Bank	64,200,000.00	68,530,328.00	107%
	WHO		-	
	GAVI		-	
	Gates	1,000,000.00	1,000,000.00	100%
	DKT	1,370,630.00	1,370,630.00	100%
	EKN		-	
	Irish Aid		-	
	Total SDG fund	**83,323,177.10**	**87,648,696.16**	**105%**
2	**Bilateral Partners**			
	CDC-Atlanta US	5,010,000.00	4,904,998.00	98%
	AfCDC -WB	25,634,332.36	23,037,970.67	90%
	COVID-19 Emeregency Response_World Bank	161,883,222.33	159,804,990.02	99%
	EU	2,653,836.69	195,446.00	7%
	Italian Coopration (for developing regions)	1,000,000.00	1,000,000.00	100%
	Spanish Cooperation COVID 19	751,725.00	751,725.00	100%
	Sekota-AfDB	10,000,000.00	5,156,884.34	52%
	Total from bilateral partners	**206,933,116.38**	**194,852,014.03**	**94%**
3	**UN Organization**			
	UNICEF	674,944.00	620,910.00	92%
	UNFPA	4,408,105.19	4,408,105.19	100%
	WHO	5,784,149.89	5,784,149.89	100%
	Total from UN organizations	**10,867,199.08**	**10,813,165.08**	**100%**

S.N	Source of Fund	Commitment (USD) in 2015 EFY	Disbursement (USD) in 2015 EFY	Percentage of Disburse-ment
4	**Global Fund**			
	GF Malaria	58,104,183.33	58,104,183.33	100%
	GF TB	20,160,220.75	20,160,220.75	100%
	GF HSS	15,797,365.36	15,797,365.36	100%
	GF HIV	105,364,590.97	105,364,590.97	100%
	GF RSSH COVID-19	7,343,517.85	7,343,517.85	100%
	GF C19 RM HIV	28,217,610.12	28,217,610.12	100%
	Total from Global fund	**234,987,488.38**	**234,987,488.38**	**100%**
5	**GAVI**			
	GAVI-HSS	30,000,000.00	3,470,187.00	12%
	GAVI PIRI	2,477,791.70	2,477,791.70	100%
	GAVI-Measles Campaign	2,244,079.00	2,244,079.00	100%
	GAVI-COVID Delivery Support	5,485,070.00	5,485,070.00	100%
	Total from Gavi	**40,206,940.70**	**13,677,127.70**	**34%**
6	**Foundations**			
	CIFF GASHERO-MOH	423,488.00	666,183.00	157%
	CIFF GASHERO-EPHI	439,729.00	719,880.00	164%
	End Fund)	2,500,000.00	3,422,807.54	137%
	SCI (Imperial)	2,500,000.00	2,500,000.00	100%
	Sekota-Biwin	1,883,862.00	720,980.85	38%
	Buffet (HRH for UHC) Matching fund	1,554,338.00	0.00	0%
	Buffet (SRH) M	5,000,000.00	5,000,000.00	100%
	Total from Foundations	**14,301,417.00**	**13,029,851.39**	**91%**
	Grand Total	**590,619,338.65**	**555,008,342.74**	**94%**

SDG pool fund: In 2015 EFY, more than 87.6 million USD was disbursed via the SDG pool fund. The major contributor of the SDG pool fund was World Bank, contributing more than 68.5 million USD (78.2%), followed by FCDO (12.9%) and Italian Agency for Development Cooperation (5%). The other SDG pool fund contributors include DKT (1.6%), Gates foundation (1.1%), Spanish Cooperation (0.8%), Korea International Cooperation Agency (0.8%) and UNFPA (0.1%) The amount of disbursement from the SDG pool fund has significantly decreased over the past few years, with a slight increment this year compared to last year. Disbursement through SDG pool fund has decreased from 219.1 million USD in 2012 EFY to 87.6 million USD in 2015 EFY.

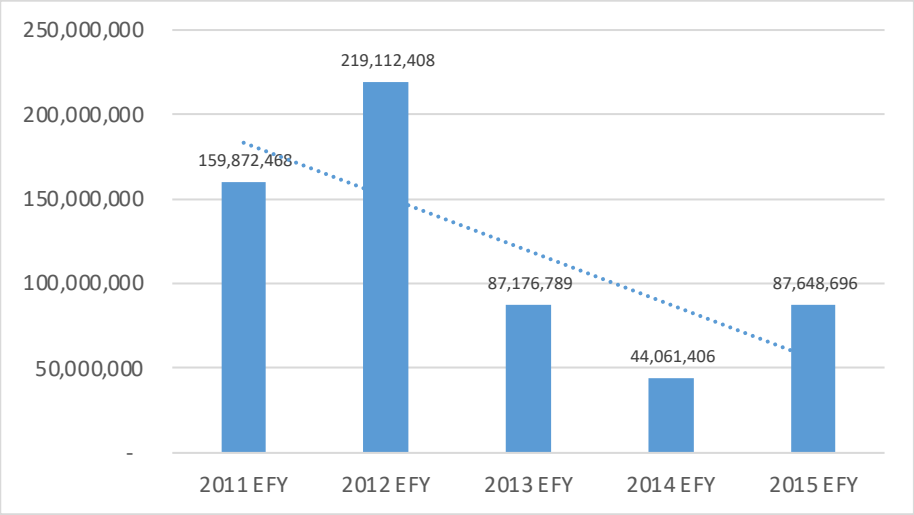


Figure 67: Amount disbursed to SDG pool fund to the health sector in USD, 2011 to 2015 EFY

8.6. Public budget allocation

Share of government health budget from the total government budget

The government of Ethiopia allocates annual budget to regions and city administrations for implementation of different development programs, from which the regional states allocate to the different sectors of the region. In 2015 EFY, 12.3% of the total government budget was allocated to health, which is a little lower than the previous two years. Three regions (Amhara, Sidama and Dire Dawa) have allocated at 15% or more of the total government budget to health, allocating 15.6%, 15% and 16.1% to health, respectively. Addis Ababa city administration has allocated the lowest proportion (8.5%).

Table 29: Share of Total health budget (%) from total government budget, 2013 EFY to 2015 EFY

Region	Share of Total health budget (%) from total government budget		
	2013 EFY	2014 EFY	2015 EFY
Tigray	10.40%	NA	NA
Afar	13.90%	14.40%	10.2%
Amhara	12.70%	15.30%	15.6%
Oromia	14.50%	12.40%	12.3%
Somali	14.40%	10.30%	11.4%
Benishangul Gumuz	14.30%	14.40%	13.7%
SNNP	14.80%	17.10%	13.6%
Sidama	15.40%	15.30%	15.0%
SWE			11.2%
Gambella	19.50%	13.20%	14.4%
Harari	16.00%	11.40%	12.1%
Dire Dawa	12.60%	12.30%	16.1%
Addis Ababa	7.00%	6.80%	8.5%
National	13.20%	13.80%	12.3%

8.7. Health Insurance

Ethiopia aims to accelerate progress towards universal health coverage (UHC), for which health insurance is one of the major health financing strategies to avoid financial risk to the population and progress towards UHC. In Ethiopia, implementation of Community Based Health Insurance (CBHI) for the informal sector was initiated in 2004 EFY as a pilot and currently it is expanded to cover more than 87% of the Woredas. As a strategy for the formal sector employees, social health insurance is planned to be implemented, but only preparatory activities are done and implementation not yet started. The CBHI program significantly expanded access to healthcare services, especially in rural and underserved areas. It allowed millions of Ethiopians who were previously excluded from formal healthcare systems to access essential health services.

The Ethiopian Health Insurance Service (EHIS) is responsible for the planning, implementation, monitoring and evaluation of health insurance programs in Ethiopia. In 2015 EFY, EHIS has conducted various initiatives focusing on four main objectives, including: Strengthening and expansion of CBHI coverage; ensuring sustainable financing for health insurance; improving utilization of equitable and quality health services and strengthening CBHI implementation capacity of insurance services. In this section, the implementation status of health insurance, mainly CBHI, and other major achievements in the fiscal year are discussed.

Expansion of Community Based Health Insurance Program

Number of Woredas implementing CBHI

By the end of 2015 EFY, the total number of Woredas implementing CBHI (started CBHI scheme and provide CBHI service) was increased to 1,011, which is 87% of the total Woredas in Ethiopia. This shows that additional 17 Woredas have newly started in the fiscal year (It was 894 Woredas in the previous year). All Woredas in Amhara, SNNP, Sidama, Harari, Dire Dawa and Addis Ababa have started CBHI scheme and service, while the proportion of Woredas implementing CBHI was low in Somali (4%), BG (33%) and Afar (34%).

CBHI membership status of households

From the total 15,425,427 eligible households in the 1011 Woredas, more than 12.1 million (78%) households were enrolled to CBHI. This shows that the proportion of households that are enrolled to CBHI has increased from 66% in 2014 EFY to 78%, which is a commendable improvement. However, there is a disparity between regions in the proportion of households enrolled to CBHI among Woredas implementing CBHI. In Somali region, among eligible woredas in 4 CBHI implementing Woredas, only 2.5% of Woredas were enrolled to CBHI. Enrollment rate was high in Harari (100%), Amhara (93.7%) and Addis Ababa (90.8%).

From the total HHs enrolled to CBHI, more than 2.08 million were indigents for which the government pays the CBHI premium. This shows that 58.7% of the total estimated indigents were enrolled to CBHI with the support of the government, which is higher coverage than the previous year by 6.7 percentage points (last year, only 52% of indigents were covered).

Table 30: Number and proportion of Woredas and households that started CBHI services by region, 2015 EFY

Region	Woredas/City admins implementing CBHI			HHs enrolled to CBHI		
	Total number of Woredas/ city admins	No. of Woreda that start CBHI service	Proportion of Woredas implementing CBHI	Total eligible HHs	Total no. of CBHI member HHS	Proportion of CBHI member HHs
Tigray						
Afar	44	15	34%	130,876	64,844	49.5%
Amhara	219	219	100%	4,163,924	3,901,006	93.7%
Oromia	358	354	99%	6,774,115	5,400,836	79.7%
Somali	95	4	4%	54,335	1,346	2.5%
BG	24	8	33%	97,427	49,171	50.5%
SNNP	173	173	100%	2,507,297	1,606,144	64.1%
Sidama	37	37	100%	667,464	406,275	60.9%
SWE	57	55	96%	588,585	280,094	47.6%
Gambella	14	10	71%	54,735	32,754	59.8%
Harari	9	9	100%	45,746	45,746	100.0%
Dire Dawa*	1	1	100%	64,905	47,662	73.4%
Addis Ababa	126	126	100%	298,488	270,945	90.8%
National	**1,157**	**1,011**	**87.4%**	**15,447,897**	**12,106,823**	**78.4%**

*Dire Dawa is considered as one considering the city administration and there is no Woreda structure in DD

CBHI Membership renewal

In the fiscal year, from the expected 9.8 million households to renew their membership, more than 8.88 million households (90.5%) have renewed their membership. This year's renewal rate (90.5%) is higher than the previous year renewal rates (renewal rate was 82% in 2013 EFY and 83% in 2014 EFY). This shows that the renewal rate is improving over the years.

CBHI premium collection and expenditure

Pooling: During the fiscal year, from the expected more than 4.6 billion birr that was expected to be collected from CBHI members, more than 4.4 billion birr (96%) was collected/pooled.

Expenditure to revenue ratio: Data collected from 675 Woredas for the period of January 2022 to December 2022 showed that expenditure to revenue ratio of 474 Woredas (70%) was less than 0.95, while the expenditure to revenue ratio of 201 Woredas (30%) was more than 0.95. This shows that expenditure in 201 Woredas (30%) is high and may be in a financial challenge unless appropriate intervention is done. The assessment in these 675 Woredas also showed that 35,546,728 CBHI members received service during the assessment period (81.9% received service from health centers and 18.1% from hospitals), for which more than 3.45 billion birr was reimbursed for the health facilities.

Social insurance related activities

In the fiscal year, preparatory activities to implement social insurance were conducted. Some of the activities include preparation of different guidelines and manuals, conducted advocacy meetings with different stakeholders, identification and documentation of data on employers, civil servants, employers and their salary scale.

Other activities and achievements

- In the fiscal year, the total number of health facilities that provide CBHI service has reached 3,809
- Clinical audit was conducted in 373 hospitals, 2,986 health centers and 128 drug stores
- Training was provided to 500 health professionals drawn from new CBHI affiliate health facilities
- To strengthen implementation of capitation payment mechanism, training was provided to about 2,122 participants
- Advocacy and social mobilization activities were conducted
- Public awareness was done through 29 FM radio and six television stations in 37 languages

Challenges

- Shortage of medicines, laboratory and diagnostic services at health facilities affected the quality of care provided to CBHI members
- Absence of timely payment claim, and delayed reimbursement process
- Conflicts in some parts of Ethiopia affected the implementation of planned activities
- Weak monitoring, evaluation and accountability mechanisms and responses to respond to audit findings
- Inadequate commitment from political leaders to support the implementation of CBHI
- High economic inflation is one of the causes for delayed implementation of social insurance

Way forward

- Increase the number of Woredas implementing CBHI
- Strengthen renewal of the existing members and enrollment of new members
- Ensure provision of quality health services to CBHI members
- Enforce implementation of CBHI legal framework
- Improve public awareness on CBHI and social insurance
- Conduct financial audits and take appropriate actions based on CBHI audit findings
- Conduct social mobilization and advocacy on health insurance systems
- Strengthen claim and audit systems
- Digitalization of insurance information system
- Strengthen monitoring and evaluation of health insurance activities

CHAPTER

9

Public health emergency preparedness and response

CHAPTER 9: Public health emergency preparedness and response

Response to public health emergencies, be it a disease outbreak or other resulting in a surge of demand for health care (eg, a natural disaster or a mass casualty event) needs both a vigorous public health response and a highly proactive and functioning health-care delivery system.

The Ethiopian Public Health Institute (EPHI) had been working to establish strong and effective public health emergency management system through instituting robust early warning, preparedness, prevention, response and recovery from various public health emergencies in the country. The institute's Public Health Emergency Management (PHEM)) aims to improve how the health system deal with existing and evolving disease epidemics, and natural disasters of national and international concern. This section of the report summarizes major activities related to public health emergency management in 2015 EFY, which include epidemic prevention and response and restoration responses to conflict affected areas.

9.1. Epidemic prevention and control

Disease Surveillance and Reporting

The EPHI's digital integrated call center continue playing its role in creating public awareness on emergency and receiving public health alerts or rumors. In 2015 EFY, the integrated call management system received 112,747 calls across all regions. All of these calls were 100% investigated and verified on-site within 48 hours with the collaboration of regional public health institutes/health bureaus. The most investigated were COVID 19, Monkey pox, cholera, measles, visceral leishmaniasis, dengue fever, Human Africa trypanosomiasis , Chinkungunya etc.

One of the key measurements for public health emergency management information system is the report timeliness and completeness. In 2015 EFY, the national surveillance data report completeness and timeliness are 91% and 90 % respectively, which is higher than the minimum requirement of 80%. All regions except Benishangul-Gumuz, SWE and Tigray regional states had achieved above the minimum requirement as depicted in below figure.

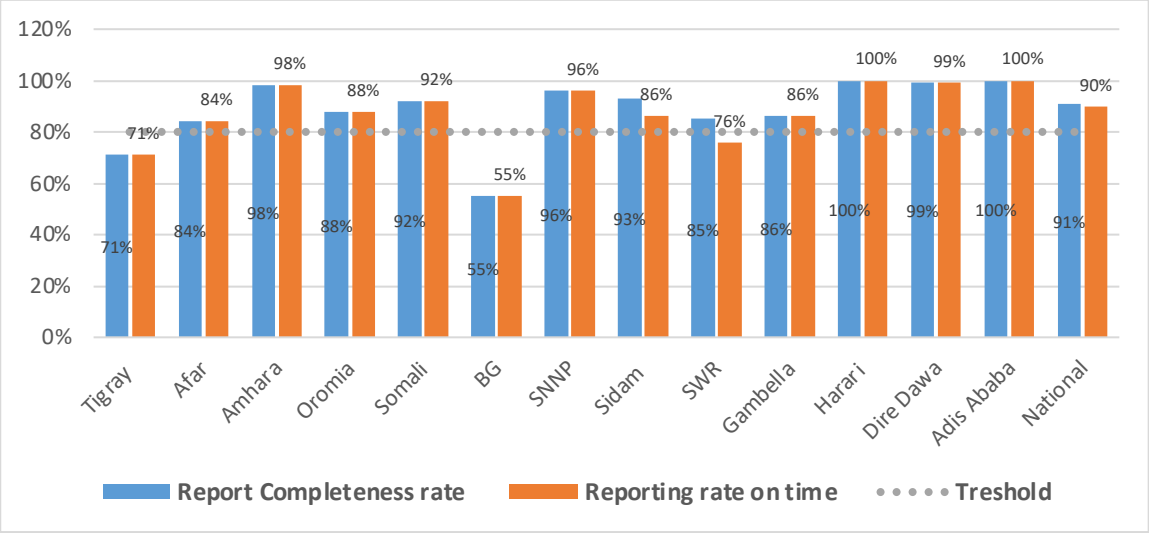


Figure 68: National PHEM weekly report completeness and Timeliness by region, 2015 EFY

The details of each disease of public health importance are described below

Measles

In 2015 EFY, measles outbreaks were reported from 219 Woreda and a total of 23,049 confirmed case and 228 deaths (0.99 % case fatality rate) were reported. The measles CFR is lower than 2.77% and 2.08% of sub-Saharan countries and global estimate respectively. Of the reported cases, more that 75% were from three regions (Somali 28.4%, Amhara 23.8% and Oromia 23.4%). There is wide regional variation regarding measles case fatality rate (CFR), the highest 9.89% from Addis Ababa followed by Somali 1.85% and Zero measles CFR from Dire Dawa.

To control the outbreak, 482,956 (100% coverage) and 229,949 (108% coverage) under 10 years age children in Amhara and Oromia respectively have received supplementary measles immunization. In Somali region, the campaign was completed in four Woredas and currently ongoing in Jigjiga City. Case management including Vitamin A supplementation and nutritional screening was also conducted. By the end of 2015 EFY measles outbreak was controlled in 187 Woredas while active outbreak exists in 32 Woreda.

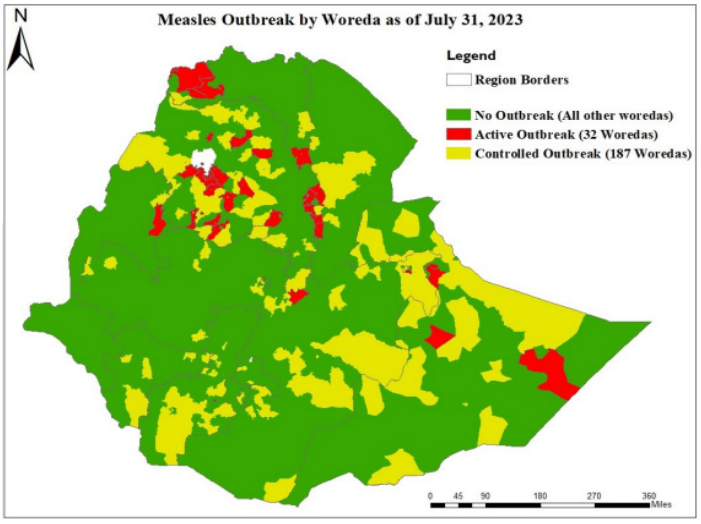


Figure 69: Measles outbreak by Woreda 2015 EFY (2022/23)

Emergency Nutrition

In 2015 EFY, emergency nutrition response was given in the four drought affected regions (Oromia, Somali, SNNP and SWE regions). A total of 6,065,809 under five children and 1,330,434 pregnant and lactating mothers were screened for their nutritional status. Out of those screened, 7% (518,755) cases were identified with SAM. More than three forth of SAM cases (77.2%) were reported from three regions (Oromia 216,526 cases, Somali 121,943, and SNNPR 62,113 cases). The total number of death due to SAM were 444. To address the emergency nutrition issue, surge team consisting of different expert was deployed three times in a year to Oromia, Somali, SNNP, SWE regions. Additionally, supplementary feeding program was implemented.

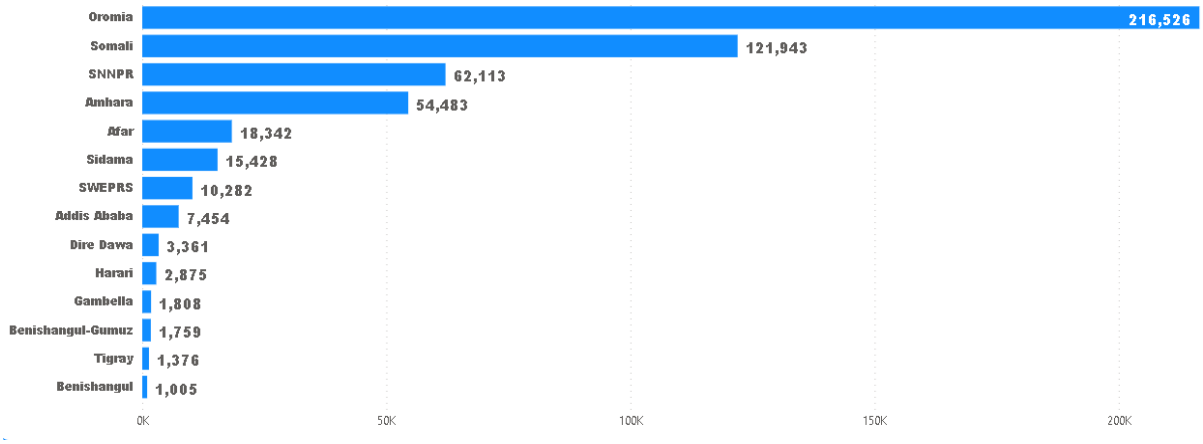


Figure 70: Number of reported SAM cases by region, 2015 EFY

Cholera

During this reporting period cholera outbreak was reported from a total of 140 woredas located in five regional states (Oromia 55, SNNP 41, Amhara 20, Sidama 18, and Somali 6). A total of 16,857 suspected Cholera cases and 229 deaths were reported across all regions making the cumulative CFR of 1.36%. Public awareness creation, nutritional screening and managing acute malnutrition, active house to house search, contact tracing, household disinfection, water scheme maintenance and distributing oral rehydration solution at all health facilities in the affected woreda are major implemented interventions to control the cholera outbreak. Furthermore, oral cholera vaccine (OCV) was given for at risk population living in Oromia and Somali as described in below table. By the end of fiscal year, the outbreak was controlled at 41 Woreda while there is active outbreak in the remaining 99 affected woreda.

Table 31: Oral Cholera vaccine (OCV) vaccination by region in two rounds, 2015 EFY

Region	Frist round December 2022 and January 2023			Second round May.2023		
	Target population	Vaccinated	Coverage	Target population	Vaccinated	Coverage
Oromia	76,400	76,226	99.77%	1,467,612	1466700	99.94%
Somali	24,487	24,487	100.00%	442,806	442707	99.98%
Total	100,887	100,713	99.83%	1,910,418	1,909,407	99.95%

Leishmaniasis

In 2015 EFY, Visceral Leishmaniasis cases were reported from nine woredas of Omo zone in SNNPR. A total of 199 case were reported out of which 10 of the cases are confirmed, 189 have epidemiological link and 22 deaths were recorded. More than 65 % of the cases were male. The public health responses include: Health facilities assessed for testing and diagnostics, social mobilization and sensitization activities were conducted.

Acute Flaccid Paralysis (AFP) /Polio

In this Fiscal year 1024 Suspected AFP/polio case were reported. The highest number of suspected AFP case was reported from Oromia (410 case), Amhara (237) and SNNPR (107).

Rabies exposure

In 2015 EFY, a total of 12,888 rabies exposer (dog bite) was reported with 50 deaths. The highest number of rabies exposure was reported from Amhara Region 11,057(85% followed by Oromia 602 (4.7%). Similarly, the highest rabies deaths were also reported from Amhara Region (36), followed by Oromia (6). Providing rabies vaccine to exposed individual serves as post exposure prophylaxis. To improve vaccine availability, Armer Hansen Research Institute has produced 22,704 (70% of planned target) doses of vaccine. Additionally, fermi vaccine distribution hubs are established in 5 regions (Amhara, Oromia, SNNPR, Sidama and SWE) of the country.

9.2. COVID-19 Response

COVID-19, a global pandemic, has precipitated significant adverse consequences in the realms of health, society, economy, and politics, spanning a period of approximately two years. The World Health Organization (WHO) had formally rescinded the declaration of COVID-19 as a Public Health Emergency of International Concern (PHEIC) in May 2023.

However, the COVID-19 pandemic persists, with 501,049 confirmed cases and 12 new cases reported in Epidemiological Week 36 (04-10 September 2023). The total number of tests conducted has reached 5,571,281. Additionally, five COVID-19 cases were detected from Severe Acute Respiratory Illness (SARI) and Influenza-Like Illness (ILI) sentinel sites, highlighting the need for continued surveillance.

It is worth noting that Ethiopia, with a tally of more than 501,049 COVID-19 cases recorded by the end of the reporting period, has emerged as the country with the highest number of cases in East Africa and ranks among the top nations in Africa with regard to COVID-19 prevalence. Since March 2020, Ethiopia has conducted a comprehensive testing campaign, analyzing a total of 5,561,223 samples for COVID-19. Among these tests, 501,049 confirmed COVID-19 cases were identified, reflecting a cumulative positivity rate of 9.01%. Encouragingly, 488,104 individuals have successfully recovered, resulting in a recovery rate of 95%. Unfortunately, the pandemic has claimed the lives of 7,574 individuals in Ethiopia, yielding a case fatality rate of 1.6% by the end of the reporting period.

In the fiscal year 2022/23 (2015 Ethiopian Fiscal Year), vigilant efforts were continued in combating the virus. During this fiscal period, a total of 486,689 samples were analyzed for COVID-19. Among these, 11,106 confirmed COVID-19 cases were identified, resulting in a cumulative positivity rate of 2.28%. Notably, 11,524 individuals have recovered from the virus, contributing to a low case fatality rate of 0.2% by the conclusion of the reporting period.

Other Major activities on COVID-19

- Spearheaded the funding request for the pandemic fund, collaborating closely with various executive offices and partners. This collaborative effort resulted in the development and successful submission of a funding request, securing a grant exceeding 50 million USD earmarked for bolstering pandemic preparedness and strengthening health system capabilities

- Orchestrated the additional C19-RM Wave 1 funding request, aligning it with prevailing trends, needs, and requisites. This endeavor yielded approximately 36 million USD in additional funding to address previously unmet demands. Areas of focus were HRH capacity building, surveillance, health product and waste management systems and mitigation of COVID-19 impact on programs.

- Strategically coordinated the funding request for portfolio optimization in Wave 2 of the C19-RM. This activity was tailored to enhance pandemic preparedness, specifically focusing on areas such as laboratory infrastructure, surveillance mechanisms, human resource for health, and the health product management system

- Represented Ethiopia and lead the African group for the Intergovernmental Negotiating Body (INB), dedicated to the formulation and negotiation of a WHO convention, agreement, or other international instrument pertaining to pandemic prevention, preparedness, and response

- Successfully initiated a training guideline for the use of the PAXLOVID drug under the "Test to Treat" framework. This guideline was produced and validated, with the drug being imported through the support of USAID. Concurrently, the distribution of the medication is commenced, accompanied by comprehensive training programs for healthcare professionals to ensure its proper administration.

- Genomic Surveillance project has been launched to generate real-time pathogen genomic data for public health action. EpiGen Ethiopia will meet this modern-day need for genomic surveillance of infectious diseases, to support evidence-based public health decision making process in the country

9.3. Restoration of war-affected health institutions

The health system of Ethiopia was challenged by the impact of conflict in different part of the country since 2020. The conflict worsened the disease burden, mental health issues, infectious disease outbreaks, and limited access to healthcare services mainly in Afar, Benishangul Gumuz, Amhara, Oromia and some part of SNNP region. A comprehensive damage assessment conducted by the coordination of MoF, MOH and RHB found that:

- More than 24 million people were impacted across the 5 regions
- 5.7 million people were internally displaced since the conflict started
- 3,217 health posts, 709 health centers, and 76 hospitals were partially or completely damaged during the same period

The MOH in coordination with partners developed Resilient Recovery and Reconstruction plan with an estimated budget of USD 1.42 billion over the next five years based on the assessment findings.

Furthermore. MOH has conducted Health Resources and Services Availability Monitoring System (HeRAMS) assessment in Tigray and Afar regions in 2023 and with a plan to conduct in other regions to unpack the level of damage and design interventions. These assessments revealed damage to medical equipment, infrastructure, and data systems, exacerbating the challenges faced by healthcare providers.

To address this, the following activities and initiatives were done

- The Ministry of Health established a coordination team, mobilized resources, and initiated partnerships to restore essential services
- Priorities included are training, capacity building, and mental health support, combatting gender-based violence, rehabilitating laboratories, vaccination campaigns, and procuring medical supplies.
- Infrastructure renovations, equipment procurement, improving supply chains, and accountability mechanisms were planned
- Assessments like HeRAMS informed response plans and coordination
- Funds were re-allocated and mobilized from development partners and diaspora
- Regional preparedness and emergency response capabilities were strengthened
- Primary healthcare was a focus of the response

By early 2023:

- 450 of 453 damaged facilities restored in Amhara region
- Almost all 43 damaged health centers restored in Afar region
- Almost all hospitals, health centers, and over 90% of health posts restored in Tigray region
- 16,000+ health workers trained in MHPSS and GBV

Key challenges remain:

- Active conflict in some parts of the country hindering recovery and restoration activities
- Critical infrastructure, commodities, drugs, and equipment shortage
- Significant funding gap – to build back the damaged health system
- Weak coordination of partners at subnational level to address the challenges

A holistic approach is essential, encompassing improved management and finance, government collaboration, local governance, human resource capacity building, communication, and preparedness. Strengthening the health system, emphasizing primary healthcare and universal health coverage, is pivotal for maintaining service continuity, protecting vulnerable populations, and contributing to the peace process.

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