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MINISTRY OF HEALTH - ETHIOPIA

Health Sector Medium-Term Development and Investment Plan (HSDIP)

2016-2018 EFY

(2023/24-2025/26)

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Foreword

Lia Tadesse, MD, MHA

Minister, Ministry of Health,
Federal Democratic Republic of Ethiopia

Reflecting on the past three years of tireless efforts in implementing the Second Health Sector Transformation Plan (HSTP-II), I am pleased to acknowledge the significant progress we have made in improving the health and well-being of our population. Increased access to healthcare services and commendable strides in combating major communicable diseases have led to improved life expectancy and reduced mortality rates. Notably, we have achieved noteworthy advancements in maternal and child health, resulting in the preservation of countless precious lives.

While we celebrate these achievements, it is important to recognize the ongoing challenges that Ethiopia faces. Internal conflicts have led to the displacement of communities, destruction of health facilities, disruption of supply chains, and the tragic loss of many lives. Furthermore, the nation has endured the most severe drought in three decades, affecting tens of millions of people. The COVID-19 pandemic and other disease outbreaks have posed significant threats to our health system, potentially reversing hard-earned gains of the past two decades. Addressing the remaining issues in communicable diseases, maternal and child health, and rising non-communicable diseases (NCD) and injuries requires a fresh approach. Moreover, the increasing burden of NCDs and injuries imposes a heavy strain on our healthcare system. Geographical and socio-economic disparities in service utilization and health outcomes further compound our challenges. To achieve our desired health objectives, it is imperative that we continually improve the quality of healthcare services provided.

Recognizing the dynamic landscape, we introduce the Health Sector Medium-Term Development and Investment Plan (HSDIP), a strategic three-year roadmap from 2023/24 to 2026/27. This plan aims to elevate the overall health status of our population by advancing progress towards universal health coverage, improving our response to health emergencies, transforming local healthcare systems, and increasing the responsiveness of our health system.

The HSDIP aligns with the government's national development and investment plan, marking a notable shift from our traditional five-year strategic planning approach. Embracing this change allows us to address the complex, unforeseen challenges we have encountered over the past three years. The plan outlines nine strategic objectives that define our focus areas for this transformative period. Key priorities include reproductive, maternal, newborn, child, adolescent, and youth health, with a continued emphasis on preventing and controlling major communicable diseases such as HIV, tuberculosis, and malaria. Additionally, we aim to address NCDs and mental health issues by integrating them into primary healthcare. A central aspect of our strategy involves revitalizing the health extension program (HEP), based on a newly revised roadmap, with the goal of expanding essential health services and ensuring accessibility for all.

Our commitment to ensuring public safety during emergencies remains steadfast. We will strengthen our public health emergency management system and build a resilient healthcare system that are capable of addressing any challenges that may arise. This entails improving health service delivery, leadership and governance, availability of pharmaceutical supplies, enhanced health information systems, empowering our healthcare professionals, upgrading healthcare facilities, leveraging digital health technologies, and promoting healthcare innovations. Recognizing the profound influence of social and economic factors on health outcomes, we will foster cross-sector collaboration to effectively address these determinants. Private sector involvement is critical to achieving our goals.

In conclusion, the core priorities of the health sector over the next three years will encompass restoring and establishing services in conflict-affected areas, enhancing the provision of medical supplies and equipment, increasing greater private sector engagement, and enhancing the quality and equity of health services by addressing challenges in health infrastructure, human resource development, and regulatory systems. With unwavering dedication and collaboration, I am confident that the Health Sector Medium-Term Development and Investment Plan (HSDIP) will lead to a healthier and more prosperous Ethiopia.

Lia Tadesse, M.D., MHA

Minister of Health, Ethiopia

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMR	Antimicrobial Resistance
ANC	Antenatal care
ANC4	Antenatal care fourth visit
ANC8	Antenatal care eighth visit
APR	Annual performance report
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARV	Antiretroviral
CASH	Clean and Safe Health Facilities
CBHI	Community Based Health Insurance
COVID-19	Coronavirus Disease 2019
CPD	Continued Professional Development
CSA	Central Statistical Agency
CSC	Community Scorecard
CSO	Civil Society Organization
DALYs	Disability Adjusted Life Years
DHIS2	District Health Information System
DR TB	Drug resistance Tuberculosis
ECD	Early Childhood Development
eCHIS	Electronic Community Health Information System
EDHS	Ethiopia Demographic and Health Survey
EFDA	Ethiopia Food and Drug Authority
EFY	Ethiopian Fiscal Year
EID	Early Infant Diagnosis
EHAQ	Ethiopian Hospitals Alliance for Quality
EHSTG	Ethiopian Hospital Services Transformation Guideline
EmONC	Emergency Obstetric and Neonatal Care
EPHI	Ethiopian Public Health Institute
EPI	Expanded Program on Immunization
ERP	Enterprise Resource Planning
ETB	Ethiopian Birr
MOH	Ministry of Health
FP	Family Planning
GBV	Gender-based violence
GGE	General Government Expenditure
GMP	Growth Monitoring and Promotion
HBV	Hepatitis B Virus
HCF	Healthcare Financing
HCI	Human Capital Index
HCs	Health Centers
HCV	Hepatitis C Virus

HEI	HIV Exposed Infant
HEP	Health Extension Program
HEW	Health Extension Workers
HF	Health Facility
HHM	Health Harmonization Manual
HIS	Health Information System
HIT	Health Information Technician
HIV	Human Immunodeficiency Virus
HSDIP	Health Sector Medium-Term Development and Investment Plan
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resource for Health
HRIS	Human Resources Information System
HSTP	Health Sector Transformation System
HSTQ	Health Service Transformation in Quality
ICMNCI	Integrated Community Case Management of Newborn & Childhood Illness
ICT	Information Communication Technology
ICU	Intensive Care Unit
IDP	Internally Displaced People
IHR	International Health Regulation
IPC	Infection Prevention and Control
IR	Information Revolution
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JRM	Joint Review Mission
JSC	Joint Steering Committee
KM	Knowledge Management
KMC	Kangaroo Mother Care
LAN	Local Area Network
LIP	Leadership Incubation Program
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MCC	Motivated, Competent and Compassionate
MCH	Maternal and Child Health
MCV	Measles Containing Vaccine
MEICIP	Major cities emergency, injury and critical care improvement program
MFR	Master Facility Registry
MHM	Menstrual Hygiene Management
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MTCT	Maternal to Child Transmission
NGO	Non-Governmental Organizations
NHA	National Health Account
NICU	Neonatal Intensive Care Unit

NNP	National Nutrition Program
NTD	Neglected Tropical Diseases
ODF	Open Defecation Free
OHT	OneHealth Tool
OOP	Out of Pocket
OPD	Outpatient Department
ORS	Oral Rehydration Salt
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PLHIV	People Living with HIV
PMT	Performance Monitoring Team
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public-Private Partnership
QI	Quality Improvement
RDT	Rapid Diagnostic Test
RED	Reach Every District
RHBs	Regional Health Bureau
RIS	Regulatory Information System
RMNCAYH	Reproductive, Maternal, Neonatal, Child, Adolescent, and Youth Health
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
SARA	Service Availability and Readiness Assessment
SBFR	System Bottleneck Focused Reform
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SPA	Service Provision Assessment
SRH	Sexual and Reproductive Health
STH	Soil Transmitted Helminthiasis
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TF	Total Fertility
THE	Total Health Expenditure
TICs	Treatment Initiating Centers
UHC	Universal Health Coverage
USD	United States Dollar
VPN	Virtual Private Network
VSD	Very Severe Disease
WASH	Water, Sanitation, and Hygiene
WDG	Women Development Group
WHO	World Health Organization
WoHo	Woreda Health Office
ZHD	Zonal Health Department

Executive Summary

The health sector has been implementing the Second Health Sector Transformation Plan (HSTP-II) for the past three years, from 2020/21 to 2022/23. To align all sectoral strategic plans to the similar period, address challenges encountered in the last three years, and connect strategies with investments, the Ethiopian Ministry of Health (MOH) developed a three-year strategic plan: the Health Sector's Medium -Term Development and Investment plan (HSDIP). It covers the period 2016– 2018 Ethiopian fiscal year (EFY) (July 2023 – June 2026) and was developed following a participatory approach that engaged various stakeholders. It is informed by an in-depth situational analysis of the performance of the health sector, findings from the midterm review of HSTP-II, the country's socio-economic situation, and aligns with continental and global contexts and commitments. This plan builds on past successes and considers the current gaps and challenges.

The situational analysis indicated significant improvements in health status, service utilization, and health investments over the past decades. Life expectancy at birth in Ethiopia has increased from 50.6 years in 2000 to 68.7 years in 2022. Maternal mortality rate has decreased from 399 per 100,000 live births in 2015 to 267 in 2020. Neonatal mortality and under- 5 mortality has declined to 26 and 47 per 1,000 live births, respectively. However, child malnutrition remains a major public health issue, with nearly 53% of under-five mortality linked to malnutrition. While there has been a significant decline in morbidity and mortality from major communicable diseases such as HIV, tuberculosis, and malaria over the past decade, there has been an increase in the prevalence of non-communicable diseases and injuries, resulting in a triple burden of diseases in Ethiopia.

Improvements in health status are a result of improved access to and utilization of health services. Utilization of essential health services has considerably improved over the past few years. In 2022, 39.5% of women of reproductive age (ages 15-49 years) received a modern contraceptive method; 70% of pregnant women attended at least four antenatal care visits, and 70.9% of women delivered in health facilities with assistance from skilled health personnel.

Disease prevention and control programs have registered notable results over the past decade. In 2022, Ethiopia made substantial progress toward achieving the three 95's targets of HIV—86% of people living with HIV know their HIV status, 98% of those aware their status were on ART, and 96% of those on ART had viral suppression. In the same year, TB treatment coverage reached 92%, the highest coverage to date. The government initiated a sub-national malaria elimination program with the aim of interrupting local transmission of the disease by 2030.

To improve access to health services, the government has made significant investments in expanding health infrastructure. In 2021/22, more than 18,200 health posts, over 3,800 health centers, and more than 380 public hospitals were providing health services to the population. Although there has been a substantial effort to augment the quantity and variety of healthcare professionals over the past decades, the health workforce density for essential categories (physicians, health officers, nurses, and midwives) was only 1.22 per 1,000 people in 2021/22, falling short of the required standard. Building a motivated, competent, and compassionate (MCC) health workforce is one of the transformation agendas, and various activities have been undertaken in this regard.

The government has launched various health financing initiatives to mobilize health resources and safeguard people from financial hardship. These measures include a fee waiver system for those in need and exemptions for essential high-impact interventions. The implementation of community-based

health insurance (CBHI) has expanded coverage to over 87% of woredas, with approximately 81% of households in these areas are enrolled.

However, despite improvements in health status and service utilization, the health sector grapples with significant challenges and gaps that affect service access, utilization, and health outcomes. Disparities persist in health status and service utilization among different groups, influenced by factors like education, geography, age, gender, and socio-economic status. The quality of care remains suboptimal, with low availability of medicines and medical supplies at health facilities, and a mere 8% of pharmaceuticals are sourced locally. The quantity and composition of the health workforce falls short of the required standard, and high out-of-pocket expenses pose financial risks for the population.

Over the last three years, the health sector has faced challenges posed by both natural and human-made disasters, leading to limited access to and interruption of services. Conflicts in different parts of the country have resulted in damage to numerous health facilities, affecting access to essential services. Additionally, disease outbreaks, drought, flood, and other emergency conditions have adversely impacted the health system.

The development of the HSDIP was informed by a comprehensive situational analysis that identified achievements and challenges within the health sector. The development process, from strategic objectives and initiatives to major activities and the monitoring and evaluation plan, involved extensive engagement with all relevant stakeholders and was subject to regular reviews by the senior management of the MOH.

The overall goal of the HSDIP is to improve the health status of the population by accelerating progress towards universal health coverage, protecting people from health emergencies, transforming woredas, and improving health system responsiveness. It includes nine strategic objectives to achieve during the strategic period:

- **Improve maternal, child, and adolescent health and nutrition status**: This focuses on improving the health of mothers, newborns, and children by implementing various programs and providing health services across the continuum of care through a life cycle approach.
- **Improve disease prevention and control**: This aims to reduce disease occurrence and minimize their effects through focusing on the prevention, control, and management of major communicable diseases, non-communicable diseases, neglected tropical diseases, and other diseases.
- **Improve community ownership and primary health care**: This strategic objective focuses on ensuring the active engagement of the community and creating ownership in the planning, execution, and monitoring and evaluation of health and health-related activities.
- **Improve access to quality and equitable medical health services**: This objective focuses on provision of comprehensive medical care services that are safe, effective, people- centered, efficient, equitably accessible, and affordable.
- **Enhance public health emergency and disaster risk management and post conflict recovery and rehabilitation**: This strategic objective focuses on effective and timely anticipation, prevention, early detection, rapid response, control, recovery, and mitigation of any public health emergency crisis with direct or indirect impacts on the health, social, economic, and political wellbeing of communities and society.

- **Improve health system capacity and regulation**: This strategic objective focuses on strengthening the capacity of the health system in delivering quality and equitable health services through transforming the national efforts toward building high-performing health system leadership, a competent and compassionate workforce, robust infrastructure, and strong regulatory capabilities.
- **Harnessing innovation for health system quality, equity and safety:** This strategic objective aims to provide high-quality, equitable, and safe health services that result in improved health outcomes through seeking, developing, and implementing innovative ideas and technologies, with a focus on problem-solving and improving health system performances.
- **Improve pharmaceuticals and medical devices management and production:** This objective aims to enhance the efficiency and effectiveness of the pharmaceutical supply chain, pharmacy services, and medical device management systems. It also focuses on promoting domestic manufacturing of medicines and medical devices, as well as improving the procurement and management procedures, and rational use of medicines.
- **Improve health financing and private engagement**: The objective aims to secure sufficient and sustainable funds to achieve the "Universal Health Coverage through strengthening Primary Health Care". It focuses on mobilizing enough financial resources and efficiently allocating them for health services and programs, while also improving accountability and transparency in managing and utilizing these funds. It also aims to improve the engagement of the private sector in a comprehensive range of health and health-related activities towards improving access to quality of health services.

Each of the nine strategic objectives includes identified initiatives and major activities to be implemented during the strategic period.

The plan has also set targets to measure and monitor the strategic objectives and programs. These targets encompass a range of health outcomes and service utilization indicators. For example, the plan aims to reduce maternal mortality from 267 to 199 per 100,000 live births, decrease under-five mortality from 47 to 44 per 1,000 live births, and lower neonatal mortality from 26 to 21 per 1,000 live births. Service utilization targets include increasing the proportion of pregnant women who receive eight or more antenatal care visits from 15% to 30%, increasing skilled birth attendance from 50% to 78%, raising early postnatal care coverage within two days of delivery from 67% to 78%, and increasing pentavalent 3 coverage from 61% to 80%. Disease prevention and control targets include increasing the proportion of people living with HIV who know their status from 85.5% to 95%, increasing TB treatment coverage from 95% to 96%, and reducing malaria incidence from 47.2 to 17.9 per 1,000 population at risk. Detailed indicators and targets can be found in the Indicators and Targets Section of this document.

The costing for the HSDIP is computed using OneHealth tool, which is a policy projection-modeling tool based on the World Health Organization's (WHO) six health system building blocks framework, which is designed for strategic planning in low- and middle-income countries. The costing is also based on projects with clearly set targets with budget breakdowns. The total budget required for the three-year period is estimated to be $16,333,449,328.05 USD. At the federal level (MOH and agencies), a total of $3,778,571,631.05 USD is required for three years, of which 19% is expected to come from the government treasury, 58% from development partners, and the remaining 11% from public-private partnerships.

The HSDIP will be translated to annual operational plans at all levels of the health system, following the Woreda-Based Health Sector Annual Planning approach. Implementation progress will be regularly monitored at all levels of the health system, using the monitoring and evaluation framework. At the end of the strategic period, a final evaluation will be conducted.

Chapter 1

Introduction

Chapter 1: Introduction

Ethiopia is located in the Northeastern part of Africa, sharing borders with Sudan to the northwest, South Sudan to the west, Eritrea to the north, Djibouti to the northeast, Somalia to the east and northeast, and Kenya to the south. It spans a total area of 1.1 million square kilometers and a population of approximately 107 million in 2023. Ethiopia is the second most populous country in Africa, with a rapid population growth rate (2.6%) and a predominantly young age structure. It has a high total fertility rate of 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and an estimated crude birth rate of 27 per 1,000. The population is projected to reach 113.8 million in 2026 and 122.3 million in 2030. Children under 15 years old and individuals aged 15-65 years account for 37.6% and 59.2% of the population, respectively. The gender distribution is nearly equal and women of reproductive age constitute about 23% of the population. About 77% of the population resides in rural areas, primarily reliant on agriculture (CSA, July 2013).

Ethiopia is administratively divided into 12 regional states and two city administrations. The regional states are Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Central Ethiopia, Sidama, South West Ethiopia, Southern Ethiopia, Gambella, and Harari. The two city administrations are Dire Dawa and Addis Ababa. In addition to regional administration, there are zonal and woreda (district) administrations. Woredas are further composed of kebeles, which are the lowest administration units in Ethiopia.

The country's healthcare system is structured into three tiers: primary, secondary, and tertiary levels of care. Primary health care units provide essential primary health care, general hospitals offer secondary care, and specialized hospitals provide tertiary care. By the end of 2021/22, 18,200 health posts, 3,579 health centers, and 353 hospitals were providing services to the population. The total health workforce was 342,899 by the end of 2022.

The Ethiopian health sector envisions a healthy, productive, and prosperous society. It strives to achieve this by promoting the health and wellbeing of the population through the provision and regulation of high-quality, comprehensive health services in an equitable manner. The health sector adheres to guiding principles of quality, equity, accountability, transparency, continuous learning, result orientation, and efficiency. Its core values include community-first, collaboration, compassion, professionalism, confidentiality, respect for law, and impartiality.

Ethiopia has previously implemented successive Health Sector Development Plans (HSDPs) in four phases since 1997. HSDP-IV, which concluded in June 2015, marked the final phase of HSDPs as part of the country's first Growth and Transformation Plan (GTP-I). After the completion of the four HSDPs, Ethiopia implemented the first health-sector transformation plan (HSTP I) from 2015/16–2019/20, followed by HSTP-II for the period 2020/21–2024/25. However, due to several emerging factors, including the need to align to the national development and investment plan (2023/24 to 2025/26) of the government, internal displacement, damage to health infrastructure, and challenges stemming from the COVID-19 pandemic, other disease outbreaks, and climate emergencies, it became necessary to revisit the HSTP-II.

The Health Sector Medium- Term Development and Investment Plan (HSDIP) represents the next three-year national health sector strategic plan, spanning from 2016–2018 Ethiopian fiscal year (EFY) (July 2023–June 2026). Its preparation was informed by an in-depth situational analysis of the performance of the health sector during the first three years of HSTP-II. The plan takes into consideration the nation's long-term socio-economic priorities, the ten-year health sector development plan, the global

context and commitments such as Sustainable Development Goals (SDGs). It was developed through a participatory process that engaged key stakeholders from all units of the MOH, agencies, regional health bureaus, development partners, the private sector, universities, professional associations, and other key stakeholders. The feedback obtained from consultative workshops was reviewed and incorporated to finalize the plan.

The plan's strategic objectives and directions were aligned and initiatives were updated based on the situational analysis. Baselines were developed using data from recent surveys, routine data, and other sources, while targets were set based on previous trends, availability of resources, and alignment with national and international commitments, ten-year health development plan, and the overall socio-economic situation of the country. Investment costing was prepared using the Ministry of Planning and Development's activity-based costing approach as well as the OneHealth tool.

This HSDIP is organized into seven chapters: which include an introduction; a situational analysis of health sector performance over the past few years; goals, strategic objectives, programs, and initiatives; performance measures; the investment plan with cost details and financial gap analysis; assumptions, risks, and mitigation strategies; and a monitoring and evaluation plan.

Chapter

2

Performance of Health Sector Transformation Plan II – Situational Analysis

Chapter 2: Performance of Health Sector Transformation Plan II – Situational Analysis

The situational analysis described in this section aimed to provide a comprehensive and detailed account of the overall performance of the Ethiopian health system over the last three years (2023/24 to 2025/26). The study primarily tried to provide descriptive and figurative performances of the sector, covering major achievements, challenges, and other factors that influenced the progress toward achieving the goals and objectives of HSTP-II. The Ethiopian health system framework (Figure 1), adapted from the WHO African Regional Framework, was used to effectively inform the analysis process and structure of the final write-up.

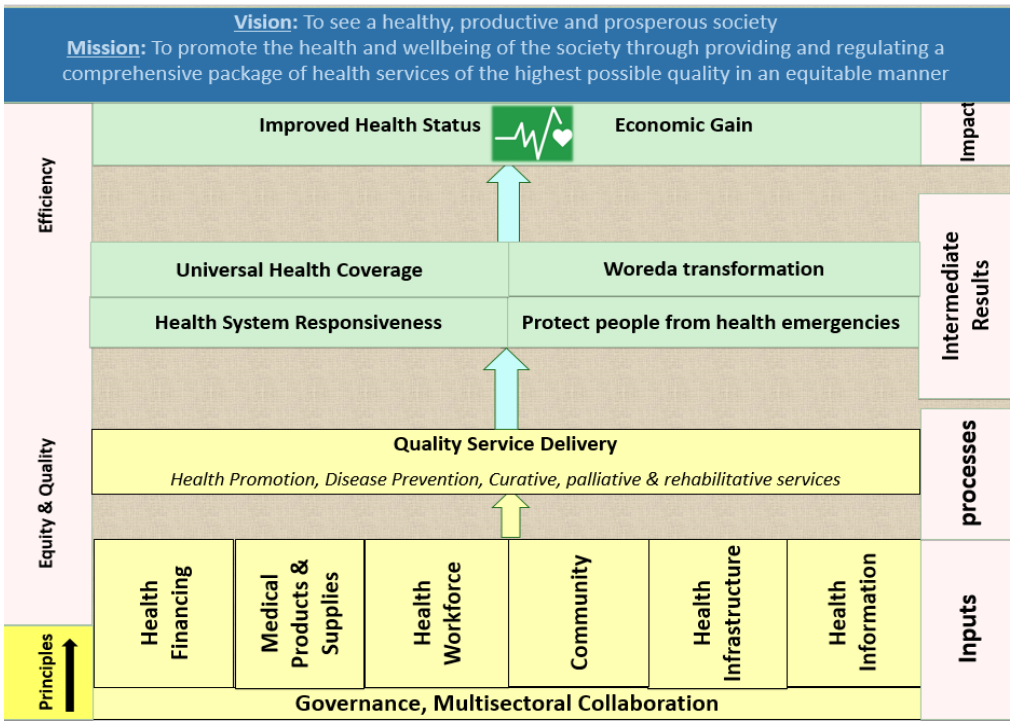

Figure 1: Ethiopia's health system framework (adapted from the WHO African Regional Framework)

The analysis used key performance indicators from its monitoring and evaluation (M&E) framework, drawing from different surveys and performance reports. The findings indicated that there was better performance in certain domains, while others fell short. . It is worth noting that some indicators are measured every five years and are awaiting from the Ethiopian Demographic and Health Survey (EDHS). Table 1 summarizes the baseline, targets, and achievements of the first three years of HSTP-II on key performance indicators. Details on specific topics are presented in subsequent sub-sections.

Table 1. Summary of performance for HSTP-II key performance indicators

HSTP II Mid-Term Performance (Indicators)					
No	**Indicator**	**Baseline (HSTP II)**	**Mid-term Target 2022**	**Target (2024/25)**	**Achievement (2022/23)**
General impact Indicators					
1	Life Expectancy at Birth (years)	65.5		68	68.7
2	UHC Index	0.43	0.5	0.58	0.38
3	Client satisfaction rate	46%	60%	80%	78%
Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health and Nutrition (RMNCAYH-N)					
4	Maternal Mortality Rate - Per 100,000 live birth	401		279	267
5	Under 5 Mortality Rate – per 1,000 LB	59	51	43	47
6	Infant mortality rate per - 1,000 LB	47	42	35	34
7	Neonatal mortality rate - per 1,000 LB	33	28	21	26
8	Contraceptive Prevalence Rate	41%	45%	50%	39.5
9	Proportion of pregnant women with four or more ANC visits	43%	60%	81%	79%
10	Early Postnatal Care coverage, within 2 days	34%	53%	76%	34%
11	Cesarean Section Rate	4%	6%	8%	5.4%
12	Still birth rate (Per 1000)	15	14.5	14	10.8
13	Proportion of asphyxiated newborns resuscitated and survived	11%	29%	50%	83%
14	Proportion of newborns with neonatal sepsis/Very Sever Disease (VSD) who received treatment	30%	37%	45%	72%
15	Proportion of under five children with Pneumonia who received antibiotics	48%	57%	69%	78%
16	Proportion of under five children with diarrhea who were treated with ORS and Zinc	44%	54%	67%	22%
17	Mother to Child Transmission Rate of HIV	13.40%		<5%	9.4%
18	Teenage pregnancy rate (%)	12.50%	10.00%	7%	13.6%
Disease Prevention and Control					
19	Proportion of people living with HIV who know their HIV status	79%	86%	95%	85.5%
20	PLHIVs who know their status and receives ART (ART coverage from those who know their status)	90%	92%	95%	98%
21	Percentage of people receiving antiretroviral therapy with viral suppression	91%	93%	95%	96%
22	TB case detection rate for all forms of TB	71%	76%	81%	95%
23	TB treatment success rate	95%	95%	96%	96%
24	Number of DR TB cases detected	642	967	1365	882
25	Grade II disability among new cases	13%	9%	5%	12%
26	Malaria mortality rate (Per 100,000 population at risk)	0.3	0.3	0.2	0.41
27	Malaria incidence rate (per 1000 Population at risk)	28	18	8	47.2
28	Proportion of Women age 30 - 49 years screened for cervical cancers	5%	21%	40%	11%
29	Cataract Surgical Rate (Per 1,000,000 population)	720	1071	1500	826
30	Proportion of hypertensive adults diagnosed for HPN and know their status	40%	50%	60%	59%
31	Proportion of hypertensive adults whose blood pressure is controlled	26%	41%	60%	80%

32	Proportion of DM patients whose blood sugar is controlled	24%	40%	60%	79%
33	Coverage of services for severe mental health disorders -	5%	16%	30%	26%
Hygiene and Environmental health					
34	Proportion of households having basic sanitation facilities	20%	38%	60%	52%
35	Proportion of kebeles declared ODF	40%	55%	80%	35%
36	Proportion of households having hand washing facilities at the premises with soap and water	8%	31%	58%	36.50%
HEP and Primary Health Care					
37	Proportion of Model households	18%	32%	50%	23.5%
38	Proportion of high performing Primary Health Care Units (PHCUs)	5%	19%	35%	26%
39	Proportion of health posts providing comprehensive health services	0%	5%	12%	49 Health posts
Medical Services					
40	Outpatient attendance per capita	1.02	1.35	1.75	1.5
41	Bed Occupancy Rate	41.90%	57%	75.00%	68%
42	Proportion of patients with positive experience of care	33%	42%	54%	79%
43	Institutional mortality rate	2.20%	1.90%	1.50%	1.04%
44	Percentage of component Production from total collection	23.30%	42.00%	65%	16.0%
45	Ambulance Response rate	NA	90%	90%	83%
Public Health Emergency Management (PHEM)					
46	Proportion of epidemics controlled within the standard of mortality	80%	90%	100%	80%
Health System Input Indicators					
47	Availability of essential medicines by level of health care	79.20%	84.00%	90%	83.4%
48	Prevalence of unsafe and illegal food products in the market	40%	36%	30%	37.2%
49	Percentage of substandard and falsified medicine in the market	8.60%	7.00%	6%	6.9%
50	Out of Pocket Expenditure as a share of total health expenditure (THE)	31%	28%	25%	30.5%
51	General government expenditure on health (GGHE) as a share of total general government expenditure (GGE)	8.10%	9.00%	10.00%	11.7%
52	Total health expenditure per-capita (USD)	33	37	42.2	36.3
53	proportion of eligible households enrolled in Community Based Health Insurance (CBHI)	49%	63%	80%	81%
54	Proportion of eligible civil servants covered by Social Health Insurance (SHI)	0	45%	100%	0
55	Proportion of Primary Health Care Facilities implemented Community Score Card	61%	74%	90%	58%
56	Information use index	52.50%	67.10%	85.00%	60%
57	Proportion of health facilities that met a data verification factor within 10% range for selected indicators	82%	86%	95%	89%
58	Proportion of births notified (from total births)	35%	55%	80%	75%
59	proportion of deaths notified (from total deaths)	3.40%	18.00%	35.00%	4%
60	Health workers density per 1,000 population	1	1.6	2.3	1.23
61	Improved water supply	76%	86%	100%	76%
	Electricity	61%	78%	86%	77%
	Improved latrine	16%	31%	50%	62%
62	Proportion of health facilities implementing compulsory Ethiopian health facility standard	53%	65%	80%	62%

NB. Indicators with no data are excluded

2.1. Health Status

2.1.1. The state of healthy life

Life expectancy at birth in Ethiopia has increased from 38 in the 1960s to 49, 65.5, and 68.7 in 1995, 2020, and 2021, respectively. This rise was achieved despite a low gross domestic product (GDP) per capita, indicating the country is punching above its economic weight by 3.03years (Freeman, T., Gesesew, H.A., Bambra, C. et al.).[1]

2.1.2. Major causes of mortality and morbidity

Ethiopia is currently facing a triple burden of diseases (communicable diseases and NCDs including mental health and injuries) that affects all age groups with a disproportionately higher burden among children and women of reproductive age. In 2019, 58% of disability-adjusted life years (DALYs) were due to maternal and neonatal conditions, communicable diseases, and malnutrition (Figure 2). The share of NCDs has increased from 17% to 35% over the last two decades. This trend is likely to continue as Ethiopia undergoes demographic and epidemiological transitions, and the population ages and experiences changes in lifestyle and diet.

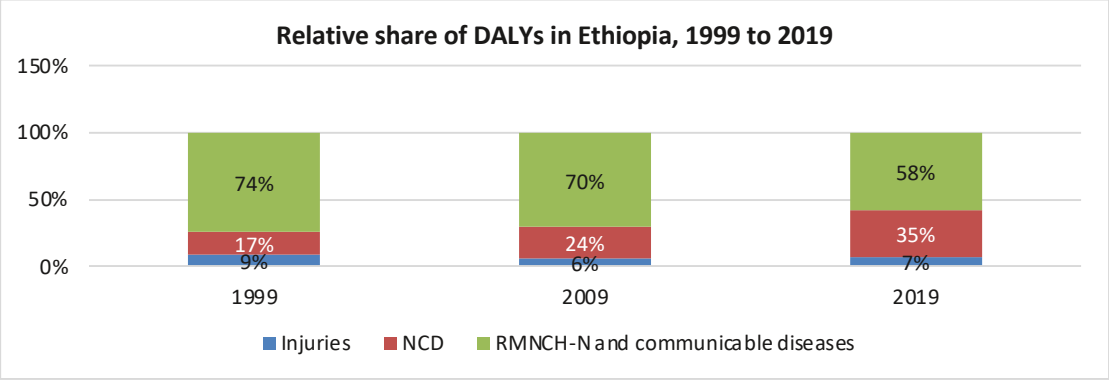

Figure 2: Relative share of categories of diseases for DALYs lost in Ethiopia, 1999-2019

Ethiopia has documented notable achievements in improving the health status of women and children in the last two decades. According to a joint United Nations (UN) report in 2023, the point estimate for maternal mortality in Ethiopia was 267 (189-427) per 100,000 live births in 2020 ,[2] which was 401 deaths per 100,000 live births, according to UN estimates done in 2017.

[1] *Why do some countries do better or worse in life expectancy relative to income? An analysis of Brazil, Ethiopia, and the United States of America. In. Equity Health* 19, *202 (2020*). https://doi.org/10.1186/s12939-020-01315-z

[2] *WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division'* https://www.who.int/publications/i/item/9789240068759

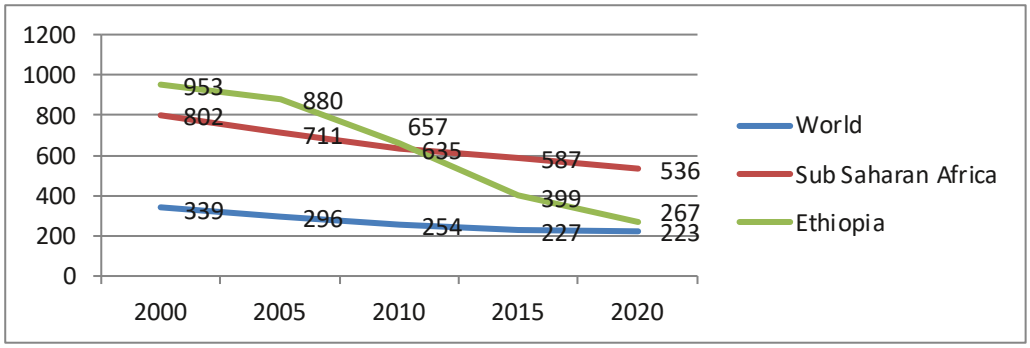

Figure 3: Estimate for Maternal Mortality rate in Ethiopia in 2020 by UN Agencies

2.2. The Status of Health System Performance

2.2.1. Progress towards universal health coverage (UHC)

Despite significant investments to expand health services, infrastructure, and the health workforce, the UHC index (0.38) does not show much progress. Similarly, out-of-pocket (OOP) health spending in Ethiopia remains high, accounting for 30.5% of total health expenditure (THE) in 2019/20, (NHA-8), with a slight reduction from the 31% of THE in 2016/2017. A significant proportion of households (4.2%) still face catastrophic health expenses, putting them at risk of financial hardship and poverty.

2.2.2. Public health emergency management

Since 2020, Ethiopia has faced a series of consecutive public health challenges that have imposed burdens on the emergency preparedness, operations, and financing systems in addition to the rise of new and emerging infectious diseases. The ongoing conflict has affected approximately 20% of districts, resulting in loss of life, widespread displacement, and damage to public health infrastructure, disruption of health service delivery, and the threat of public health emergencies. By September 2021, an estimated 5.698 million people had been forcibly displaced, including 477,048 pregnant and lactating women who were unable to access basic maternal health services. The conflict has inflicted significant damage with approximately 76 hospitals, 709 health centers, and 3,217 health posts damaged, looted, or destroyed across the country (MOH, 2022.). More than 268 ambulances, 68 woreda/zonal health offices, six EPSS stores, and five blood banks were also damaged. The total estimated cost in damages is approximately $1.42 billion USD, including $680.63 million USD for infrastructure damage and $739.38 million USD for destroyed infrastructure. Consequently, the health system remains fragile and underperforming, with ongoing outbreaks of infectious diseases such as cholera, measles, and meningitis, and a persistent risk of acute respiratory infections, including pneumonia, reaching epidemic proportions.

Impacts of public health emergencies on the health system

Apart from the direct damage to the primary health care system caused by the conflict, there is a heightened risk of outbreaks and epidemics of vaccine-preventable diseases and other infections. This includes an expected rise in the prevalence of vaccine-preventable diseases, diarrheal diseases (including cholera), influenza and malaria outbreaks, tuberculosis, and meningitis. Mental health issues stemming from the conflict, including conditions like depression, anxiety, and post-traumatic stress disorder, as well as psychological stress and substance abuse, are highly prevalent among conflict-affected and displaced populations (Panter-Brick 2009).

A rapid assessment conducted among internally displaced people in the Aura, Ewa, and Chifra woredas of the Afar Region shows critical levels of undernutrition among children aged 6–59 months. The proxy severe acute malnutrition rate is at 20% and the proxy global acute malnutrition rate at 49%—both of which exceed the emergency threshold level of 10%.

2.2.3. Health system responsiveness

Responsiveness refers to how individuals are treated and the environment in which they receive care, as well as how well the health system meets the legitimate expectations of the population. This includes confidence or trust in the system and a positive user experience. According to the Peoples' Voice Survey Report, 79.5% of respondents reported being somewhat or very confident that they could both get high-quality care when sick, but only 55% felt they could afford care. Approximately 50% of respondents believed they could access and afford quality care if they fell seriously ill tomorrow, with affordability rated worse than the availability of good care. This data could serve as a baseline for the country's progress towards UHC that aims to improve health and provide a financial safeguard. Similarly, 77.5% of the respondents reported that Ethiopia's health system had shown improvement in the past two years. However, nearly 70% of respondents expressed dissatisfaction with their current health systems, calling for major reforms or a complete overhaul. Only a minority of respondents (30%) endorsed the current health system as it is or with only minor changes needed.

The study also assessed various aspects of high-quality care, including competent care, system effectiveness, and overall user experience, which all contribute to building confidence in the system. About 45% of users rated the overall quality of their last visit to a health facility as excellent or very good. When assessing care competence, 47% of respondents rated provider skills, 42% of respondents rated the clarity of explanations given, and 30% of respondents rated the equipment and supplies as excellent or very good. For positive user experience, only 29% of respondents said their visit wait time as excellent or very good, while 39% said the same for their visit duration. Only 38% said that staff's courtesy was excellent or very good, and the same proportion said that they were involved in decision-making about their care. Overall, users rated their last visit 6.9 out of ten. In another assessment of responsiveness, according to a WHO-AFRO report, the health system in Ethiopia scored 0.52 for responsiveness and user satisfaction. Most aspects of responsiveness such as autonomy, prompt attention, and choice of care provider have lower scoring: 0.25, 0.27, and 0.31, (WHO Regional Office for Africa, 2018). However, access to social support received the highest score, at 1.0.

2.3. Service Delivery

Ethiopia has made significant efforts to make high-quality essential health services available, accessible, acceptable, affordable, and safe to the community. The essential health service package, which was first developed in 2005 and later revised in 2019, identified a list of essential health interventions on health promotion, disease prevention, curative, and rehabilitative services. It also identifies the list of health services to be provided at each level of service delivery. Access to secondary and tertiary care has also been expanded with the increasing number of hospitals.

2.3.1. Service delivery arrangement

Health services are provided by three major levels of service delivery platforms in a continuum of care starting from primary health care to advanced specialty, sub-specialty, and rehabilitation services.

2.3.1.1. Primary Health Care/ Health Extension Program

In Ethiopia, Primary Health care units (PHCUs) are the main source of primary care services, especially for rural communities. These units typically consist of one health center and about five health posts in agrarian and pastoral settings. In urban areas, health centers provide primary health care services and the Urban Health Extension program (HEP) is implemented using a family health team approach with urban health extension workers (HEWs) using the health center as a base station. HEP) provides a comprehensive range of basic health services, including health promotion, disease prevention, WASH and environmental health, as well as curative, palliative and rehabilitative care.

The first and second generations of the program were implemented between 2004 and 2020, leading to improvements in family health, the prevention and control of major communicable diseases, and WASH and environmental services. Notably, it contributed to reducing maternal and child mortality rates by increasing service utilization among mothers (MOH, 2020). In 2019, the government decided to optimize the program to better meet the expanding needs of the community. Optimization included addressing gaps in quality of care, revising the number and variety of health professionals, strengthening health post infrastructure, improving community structure functionality and engagement, strengthening HEP leadership, and revising information systems. It also included revisiting the current HEP service packages, delivery modalities, and service delivery points. Based on the 2020–2035 roadmap, the government has embarked upon revitalization of community engagement approaches by introducing a new health cadre known as village health leaders (VHL) and optimizing existing community structures. In addition, health posts were classified into three types (integrated HEP services/merged, basic and comprehensive health posts) based on the geographic proximity to their supervising health center. To strengthen health service delivery at the primary health care level, several initiatives and reforms have been implemented, including the Ethiopian Health Center Reform Implementation Guideline (EHCRIG), Primary Health Care Clinical Guideline (EPHCG), expansion of surgical services at health centers, and long-term PHC. Additionally, the government is expanding cesarean section services by expanding operating room blocks at health centers to increase access to comprehensive emergency obstetric and newborn care.

2.3.1.2. Medical Services

Pre-health facility and facility-based Emergency and critical care services: Pre-facility health interventions included expanding the ambulance dispatch system in different cities and creating public information access platforms. Currently, there are 2,843 functional and 802 non-functional ambulances available across the country, which fulfills only 48% of the current need.

To improve community engagement and awareness in the Emergency, Injury, and Critical Care System, a community squad approach was initiated and established in 53 woredas. A web-based referral system was implemented in all 12 major cities' emergency, injury, and critical care improvement programs (MEICIP). A shortage of basic amenities is a major challenge to sustain the services. Though a third-party insurance scheme is in place to alleviate the financial risk associated with road traffic accidents, only 35% of the government and private hospitals are implementing it thus far. Additionally, there is a challenge related to the reimbursement process for health facilities of the free-of-charge service expenses.

Currently, there are 53 ICUs in public facilities nationwide that are disproportionately distributed. The COVID-19 pandemic revealed that the number and distribution of ICUs are inadequate and require

additional attention and effort. The ICU mortality rate has decreased from 29.4% in 2020 to 26% in 2023.

Further challenges include the lack of a universal emergency access center, poor ambulance management system, and shortage of basic life support supplies in ambulances, low number of paramedics working in ambulances, poor infrastructure and design of emergency rooms and ICUs, and skill gaps among health professionals.

Clinical services: The health sector aspires to provide comprehensive, safe, effective, people-centered, efficient, and equitably accessible services. To realize this goal, strategic interventions have been implemented including the EHSTG initiative and Ethiopian Hospital Alliances for Quality (EHAQ). The EHSTG achieved an average performance score of 70.9% across all chapters in 2021/22 where it was 65.7% in 2020/21 with persisted disparity among regions. Hospital bed occupancy rate increased from 41.9% in 2020 to 59.3% in 2022, OPD attendance per capita increased from 1.02 in 2020 to 1.44 in 2022, and in-patient mortality reduced from 2.3% to 2% during the same period.

During the three cycles of EHAQ, focus was placed on enhancing clean and safe health facilities (CASH) and maternal, newborn, and child health (MNCH) services and implementing the national cleanliness and timeliness of health care for institutional transformation (CATCH-IT) program. EHAQ has achieved success in enhancing the quality of care, promoting collaboration, and fostering positive competition among hospitals and regions. Challenges such as resource constraints, performance disparities, sustainability, poor coordination and referral linkages, inefficient facility governance, weak accountability system, poor adherence to the clinical guidelines, low coverage of the implementation of electronic medical records, inaccessibility of essential services, and inadequate budget allocation at health facilities and regional health bureaus require ongoing efforts to address them effectively.

Specialty and rehabilitation service: Based on the specialty and sub-specialty roadmap developed three years ago, the government has implemented strategic interventions to strengthen specialty and sub-specialty services, which include establishing and maintaining essential specialty services, medical tourism, pain and palliative services, club foot, and other services. Specialty and rehabilitation services are provided in 35 public hospitals and specialty centers. Major challenges include the absence of a national coordination platform, lack of technology and a trained workforce, interruption of renal transplants during the COVID-19 pandemic, shortage and interruption of medical devices and supplies, and inadequate public-private partnerships for specialty, sub-specialty, and rehabilitative services.

Blood and tissue bank service: The national blood safety program has shown improvement in geographical coverage of hospitals accessing safe blood services, increasing from 90% to 100% in five years. Safe blood and blood products have been made available to 420 health facilities across the country. Total units of blood collected per annum increased from 288,966 units in 2019/20 to 337,774 in 2021/22, primarily provided by voluntary blood donors (99.5%). However, it still falls short of the country's demand, a minimum of 1.2 million units of whole blood donations per year, according to WHO estimates. Yet despite persistent challenges, screening donated blood for transfusion transmissible infections (TTIs) markers and processing blood units into components have shown an improvement over the years.

Nationally, blood component production was 18% and health facilities' blood satisfaction was 86% in 2022. The hemovigilance system has been reinforced to monitor and evaluate adverse events linked to blood supply and transfusion services. To increase blood donations and overall capacity of blood transfusion services as part of the health system development, a strong organization and coordination mechanism needs to be put in place. Additionally, ongoing efforts are underway to establish tissue testing and stem cell transplant services.

2.3.2. Reproductive, Maternal, Neonatal, Child, Adolescent, and Youth Health (RMNCAYH)

A. Family Planning

Family planning services are available in nearly all public health facilities in Ethiopia. Ninety percent of health facilities offered any family planning method, and 84% offered any modern family planning methods. The most widely available methods in health facilities were combined oral contraceptives and progestin-only injectable (77%), implants (67%), male condoms (63%), and progestin-only contraceptive pills (57%). However, IUCD (17%), female condoms (2%), tubal ligation (1%), and vasectomy (1%) were less common options (ESPA 2021/22).

The routine health management information system (HMIS) report shows that 68% of women aged 15–49 years (13,597,787) received a modern contraceptive in 2021/22 with a huge disparity between regions, ranging from 12% in Somali to 88% in Oromia. Approximately half of the acceptors (50.5%) received injectable, followed by implants (29.4%) and oral contraceptive pills (15.6%) (MOH, 2021/22). The proportion of women who chose to use long-term contraceptives has increased over time. Women in the postpartum period have the greatest unmet needs despite the existing opportunity to reach them within 48 hours after delivery. Only 11% of women who gave birth at health facilities received modern contraceptives in the immediate postpartum period in 2021/22. Primary challenges to the program include the interruption of supplies, conflicts, budget shortages, and donor dependency.

B. Maternal Health

Ethiopia has continuously improved maternal health conditions, demonstrated in a reduction of maternal deaths. A UN inter-agency report indicated, Ethiopia's maternal mortality ratio estimate is 267 per 100,000 live births in 2020,[3] compared to 399 per 100,000 live births in 2015. The routine HMIS report shows high first antenatal care contact whereas early antenatal care (ANC) (< 16 weeks) is as low as 34% in 2021/22. ANC four and more contact coverage and skilled delivery coverage reached 70% and 68% in 2022, respectively. The PMA report released in March 2023, shows skilled birth attendance is at 62%, equivalent with the midterm HSTP-II target, 62%. Only 14% of expected deliveries took place in functioning emergency obstetric and neonatal care (EMONC) facilities. The rate of cesarean delivery remains low at 4.7%, with high regional disparities ranging from 52% in Addis Ababa to 1.2% in Somali and 1.6% in Afar. Early postnatal care within seven days of delivery increased from 85% in 2020/21 to 88% in 2021/22 (ARM report, 2021/22).

Among the eligible women for abortion care, 95% of women received comprehensive abortion care in 2021/22 and 2022/23, of which 56% received safe abortion services and the remaining 44% received

[3] *WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division'* https://www.who.int/publications/i/item/9789240068759

post-abortion care services. Major challenges to the provision and utilization of maternal health services include a shortage of ambulances and low service utilization, budget deficits, road inaccessibility, and shortage and interruption of supplies and medical equipment.

C. Newborn and Child Health

Despite the promising progress in reducing under-five mortality in the last two decades, about 189,000 under-five Ethiopian children die from preventable childhood diseases every year, with more than half of the deaths happening during their neonatal period. Many more children suffer from illnesses and face long-term disabilities due to complications of neonatal and childhood diseases (IHME, 2019). The neonatal death rate has stalled for a few years and currently, 95,000 newborns die every year. The stillbirth rate was reduced from 15 per 1,000 attended deliveries in 2019/20 to 11.4 in 2021/22, surpassing the 2025/26 target of 14.

In 2019, 48% of children with pneumonia received antibiotic treatment (EDHS, 2019) whereas routine HMIS data shows 74% of children with pneumonia received antibiotics in 2022/23. The proportion of newborns admitted to the neonatal intensive care unit (NICU) who recovered and preterm neonates who received kangaroo mother care (KMC) increased from 76% and 63% to 80% and 67% in 2021/22, and 2022/23, respectively. The investment in early childhood development has been limited and threatens to affect children's ability to thrive and attain their potential to become productive citizens.

D. Immunization

Over the last four decades, child vaccination access, utilization, and equitable services have increased substantially. Routine immunization service is given in 75% of the facilities, where the majority of health centers (94%) and health posts (90%) offer the service, compared to 2% of higher clinics (SPA 2021/2022). Besides routine immunization, Ethiopia has conducted preventative and outbreak response vaccination campaigns for diseases such as Meningitis A, nOPV2, mOPV2, cholera, yellow fever, and COVID-19. Approximately 55% of the target population has received at least one dose of the vaccine for COVID-19. For childhood immunizations, 61% of children have received three doses of the pentavalent vaccine, while 43% are fully vaccinated with all basic vaccines (miniDHS, 2019). However, current immunization coverage rates remain below the thresholds required to control outbreaks, halt transmission, and achieve elimination of vaccine-preventable diseases.

The major challenges are inadequate supplies, high dropout rates, recurrent outbreaks, and data inconsistencies, limited availability of services in the private sector, lack of tailored and targeted behavior change communications, suboptimal program management, and difficult socio-political conditions. Overcoming these systemic issues through increased investments, engagement of the private sector, targeted interventions, and improving access will be critical to strengthening the program and progress toward coverage targets.

E. Adolescent and youth health

Adolescents and youth constitute 42% of the population in Ethiopia (CSA, 2013). Anemia, underweight, limited knowledge of sexual and reproductive health (SRH), urban-rural disparity in HIV knowledge and testing practices, an increasing trend in alcohol consumption, and Khat chewing are the major challenges related to adolescent and youth health. Only 51% of public health facilities provide youth-friendly services. Increasing access to and utilization of health services, health education, and life skills trainings for youth are needed to avert the adversities.

F. Nutrition

In Ethiopia, 53% of under-five mortality is associated with malnutrition. The FNS report shows, 39.3% and 11% of under-five children are still stunted and wasted respectively, with more burden in rural areas (FNS, 2023). In the drought-affected Borena zone of Oromia and Dolo zone of Somali, the Global Acute Malnutrition rate reached 14% and 16%, respectively, which is classified as “high” and “very high” that necessitated urgent response (Emergency Nutrition Coordination Unit, ENCU, 2023).

Recurrent drought, floods, locust invasions, conflicts, and climate vulnerability have been major factors for malnutrition, particularly affecting mothers and children. Weak nutritional surveillance and limited nutrition service coverage are the gaps from the program side. Over nutrition is on the rise and is leading to NCDs, especially overweight, obesity, hypertension, and type-2 diabetes. Micronutrient supplementation, deworming, screening, infant and young child feeding (IYCF) counseling and growth monitoring are limited. Vitamin A supplementation and deworming coverage among under-five children was 19% and 22%, respectively, and only 17% of pregnant women took iron/folic acid (IFA) tablets for 90+ days and 26% of mothers/caregivers received age appropriate IYCF counseling in 2022 (MOH, EPHI & UNICEF, (2023). Several steps in the delivery of GMP services are often missed, where only 41% of service delivery points saw measurements plotted on growth charts and only 45% used all essential GMP tools (UNICEF, 2021).

Strengthening multi-sectoral efforts, establishing a monitoring system, ensuring an accountability framework, and strengthening coordination platforms, especially at sub-regional and community levels, are critical areas for improvement.

2.3.3. Prevention and control of major diseases

A. HIV/AIDS

Ethiopia has made encouraging progress towards the 2025 targets of 95-95-95 for HIV. Currently, 91% of the people living with HIV (PLHIV) know their status, 92% of them were on ART, and 96% of them have achieved viral suppression (MOH, 2022). Nevertheless, ART coverage from total PLHIV is about 83% of which 81% have viral suppression (EPHI, 2022). Approximately 90% of the annual incident HIV infections in children under 15 are still due to mother-to-child transmission. Among the estimated HIV-positive mothers that need ART for prevention of mother-to-child transmission (PMTCT), 89% received ART, and 62% of HIV-exposed infants born to HIV-positive women received virological testing for HIV. Individuals who received antiretroviral prophylaxis is low (47%).

Key challenges in this area include suboptimal HIV case finding, especially in pediatric and adolescent age groups and in key and priority populations; low coverage of EID testing; and service disruption due to conflicts and a high number of internally displaced people.

B. Tuberculosis and Leprosy prevention and control services

Ethiopia, with an estimated TB incidence rate of 119 per 100,000 people, is among the 30 high TB burden countries where TB is among the top five causes of death. Notification and treatment coverage rate (previously known as case detection rate) have increased in recent years along with a rise in treatment success and cure rates. TB treatment coverage (all forms) and treatment success rates reached 92% and 96% in 2022/23, respectively (HMIS report, 2022/23).

The number of public health facilities providing TB services reached 80% in 2020, with 74% of facilities participating in EQA schemes and the concordance rate was 96%. Multi-drug-resistant (MDR) TB has remained a public health concern where a cumulative of 6,217 drug-resistant TB (DR TB) patients were detected and enrolled in second-line TB treatment channels in 67 DR TB treatment initiative centers, and more than 800 treatment follow-up centers. Despite a significant reduction in deaths due to TB, Ethiopia has a high TB-related mortality rate of 16 per 100, 000 population.

The prevalence of leprosy has sharply declined from 20 cases per 10,000 population in 1983 to 0.28 per 10,000 population in 2022. A total of 2,971 new leprosy cases were detected mainly from the Oromia and Amhara regions, which accounts for 84% of the total cases in 2022 (MOH, 2022).

C. Malaria Prevention and Control Services

Despite the significant reduction in the burden of malaria within the past two decades, malaria has continued to remerge and pose public health and socioeconomic problems. In 2022, the number of malaria cases doubled from the previous year and cases per 1,000 population increased from 28 in 2020 to 35 in 2022. The number of districts with high malaria risk has increased from 68 in 2020 to 89 in 2022. The spatial trends on malaria risk from 2020–2022 showed that a high malaria burden is being consistently reported from the western lowlands. The malaria surge in 2022 was mainly attributed to climate change, coverage gaps in WHO recommended tools, disruption of malaria interventions due to conflicts, and reduction of funding.

In 2017, the government of Ethiopia started a sub-national elimination program in 239 targeted woredas to comprehensively interrupt local transmission of the disease by 2030. In the second round, 326 elimination districts were selected in consultation with RHBs. Promising achievements were registered in terms of zero indigenous malaria in districts with an Annual Parasite Index (API) of less than ten and preventing the reintroduction of malaria into districts reporting zero indigenous malaria cases.

The geographical expansion of the new and potent vector, namely, an. Anopheles Stephensi and histidine-rich protein 2/3 (HRP-2/3) deletion are a concern for the malaria program. The high-level resistance of vectors to insecticides, sub-optimal usage of interventions by target communities, and shortage of complete and timely data for evidence-based decision-making are remaining challenges. In addition, natural and man-made factors including climate change, limited access to WHO-recommended tools, disruption of malaria interventions due to conflicts, COVID-19 pandemic, and contraction of funding are the main challenges to the program.

D. Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV)

In 2022, an estimated 7.8 million were HBV infected with less than 10% diagnosed and <1% of the eligible diagnosed population being treated. In addition, there were an estimated 690,000 viremic HCV infections in Ethiopia with less than 6% diagnosed and less than 1% treated (African Health Sciences, 2022). The hepatitis prevention and control program remains under-resourced, which affects access to diagnosis, treatment, and preventive measures. The low coverage of the hepatitis vaccine for newborn babies, the high cost of diagnostics and medications, stock outs of pharmaceuticals, and the slow scale-up of diagnosis and treatment services are among the major challenges for the program. In an attempt to eliminate HBV and HCV, the provision of a free birth dose vaccine for infants and massive scale-up of HBV and HCV screening and treatment were introduced in a phased approach.

E. Non-Communicable Diseases and Injuries

In Ethiopia, about 77,573 people develop cancer among which, less than 15% have access to the appropriate care and treatment from the three currently functional radiotherapy centers, providing therapy with LINAC and Cobalt machines, and 24 hospitals providing chemotherapy service for breast cancer. Breast cancer (32.3%) and cervical cancer (14.5%) are the most common types of cancer among adults and about two-thirds of reported annual cancer deaths occur among women. Limited awareness of signs and symptoms of cancer, inadequate screening, delayed detection and initiation of treatment, and inadequate diagnostic and treatment facilities are attributed to the high mortality rates.

The government plans to establish six additional comprehensive cancer care centers across the country. To align with the national initiative to realize the WHO cervical cancer elimination strategy of 90-70-90 (90% of girls vaccinated at the age of 15, 70% of women 30–49 years of age screened, and 90% of women treated for precancerous and invasive lesions), the MOH has engaged in scaling up the cervical cancer screening and treatment program to over 1,300 public health facilities. Additionally, since 2018, nearly 6.3 million girls in Ethiopia have received HPV vaccination, which is a critical intervention in the prevention and control of cervical cancer.

Despite the increasing trend of NCDs, only 78% of health facilities offer services for the diagnosis or management of diabetes and cardiovascular diseases, and 79% offer services for chronic respiratory diseases. Moreover, the availability of services for cancer and chronic kidney diseases is much lower, with only 28% and 48% of health facilities offering services for these conditions, respectively (EPHI, MOH & ICF, 2022). A quarter of facilities providing diabetic services offer oral and injectable anti-diabetics; while 41% of facilities that offer services for cardiovascular diseases had first-line antihypertensive. The availability of inhaled corticosteroids for asthma treatment is still very low (less than 10%). The cataract surgical rate (CSR) reached 1,000 per million people in 2022.

F. Mental Health

Nationally, 26% of facilities offer services for mental illness, neurological, and substance use disorders in 2021 (ESPA, 2022) with no improvement from 2019. Similarly, the availability of trained staff in health facilities that offer mental health services is 22%. At the national level, 12% of health facilities, excluding health posts, provide only diagnostic services for mental health issues (ESPA, 2022).

G. Neglected Tropical Diseases

Ethiopia has developed the third national neglected tropical diseas (NTD) strategic plans for the period of 2021–2025, prioritizing twelve diseases, which include Guinea-worm disease (GWD), onchocerciasis, lymphatic filariasis (LF), trachoma, schistosomiasis, soil-transmitted helminths, podoconiosis, leishmaniasis, and scabies. Rabies, leprosy, dengue fever, and chikungunya are additional NTDs. Regular mass drug administration and intensified disease management within the primary health care system led to remarkable progress towards the control and elimination of targeted NTDs during the HSTP-II period.

The number of woredas endemic to GWD reduced from seven to two woredas in the Gambela region (Gog and Abobo). Low levels of transmission continued with 29 human cases and 71 animal infections detected in the past five years (2016 -2020). In 2022, only one human case and three animal infections were reported.

The WHO elimination threshold was achieved in 289 woredas where more than 31 million people took trachoma MDA drugs. In addition, 50 and 29 woredas have stopped MDA for Lymphatic Filariasis and Onchocerciasis, respectively. As a result, 3.6 and 2.6 million people have stopped taking MDA drugs for lymphatic filariasis and Onchocerciasis, respectively. Similarly, over 858,025 individuals received surgical correction for trachomatous trichiasis, while 175,409 individuals sought the service in 2022/23.

Morbidity management and disability prevention services for LF and Podoconiais cases were expanded to 345 woredas. Currently, there are 30 functional intensified treatment centers for visceral leishmaniasis. Major challenges include inadequate WASH integration, high population movement in investment corridors, limited coordination on control and prevention of vector-borne NTDs, lack of prevalence or mapping data for some NTDs, and declines in both domestic and international funding, and interruption of MDAs.

H. Water, sanitation, and Hygiene and Environmental Health (WASH & EH)

The major strategic initiatives under the WASH and environmental health program are focusing on expanding open defecation-free kebeles; improving urban sanitation; strengthening market-based sanitation; strengthening water quality and safety practices; improving hygiene and safety; improving institutional WASH; strengthening emergency WASH and EH preparedness and response; and strengthening prevention and control of air pollution, chemicals, and hazardous waste management.

Sanitation: A total of 430 market-based sanitation (MBS) centers were established within the past three years. The coverage of improved sanitation facilities in Ethiopia is 18% (9% basic and 9% limited). Approximately 40% of schools have latrines which are unimproved. An estimated 15% of households (27.2% in urban and 3.4% rural) have proper gray water disposal practices and only 35.7% are practicing proper solid waste management. Moreover, access to basic sanitation services by the poorest and most vulnerable communities remains to be a challenge.

Hygiene and Safety: Hand Hygiene for All (HH4A) ten-year road map was developed and launched to improve hygiene and safety three years ago. Only 9.09% of households (15.7% in urban and 2.8% rural) have access to basic hygiene services (with water and soap). Only one in five schools had a basic hygiene service (JMP, 2022). Menstrual hygiene management (MHM) blocks have been constructed and equipped in only 151 schools at the end of the 2022/23 budget year.

Water Quality and Safety: Less than half of Ethiopian households (48.7%) have safe storage practices of water collection containers. Only 11.7% of Ethiopian households (18.8% in urban and 4.9% rural) have safe storage practices of bulk water storage containers (NHEHS, 2021). Only 14% of drinking water from point of collection was free from contamination (WHO and UNICEF, 2019).

Institutional WASH: Institutional WASH and environmental health are the key intervention areas for the prevention and control of disease and ensuring quality health care in safe facilities. Approximately 59% of facilities have elements of basic sanitation; 65% have hand hygiene facilities at the point of care. There is a high rate of occupational hazards among health workers in routine healthcare practice.

Emergency WASH: Emergencies that trigger emergency WASH & EH response are disease outbreaks, flood, drought, conflict, and landslides. WASH service delivery during emergencies is challenging due to many factors that require advocacy for enhanced and strong WASH mitigation, preparedness, and response mechanisms. Emergency, WASH, and environmental health guidelines were developed and capacity enhancement activities were conducted to improve the knowledge, skills, and attitudes of health professionals and health-determining sectors.

I. Climate Change and Health

The majority of the Ethiopian households (64.7%) utilize unimproved stoves that is the underlying factor for indoor air pollution-induced respiratory and cardiovascular diseases (NHEHS, 2021). Only 17% of households have an improved stove (both with and without chimneys combined) of which, only 7% of the improved stoves have chimneys.

In the last three years, the Health National Adaptation Plan (HNAP) was developed, and promotional and advocacy efforts were conducted to reduce the health impact of air-pollution. Moreover, air quality and health guidelines and training packages have also been developed and disseminated.

2.4. The State of Equity in the Ethiopian Health System

The MOH developed an Equity Plan of Action to address disparities in in health service access, utilization, and outcomes across regions, healthy system levels, settings, (rural/urban and agrarian/pastoralist), and demographic groups. The national health equity strategic plan was developed following the health quality and equity transformation agenda to address the disparities based on geography, socio-economic factors, gender, age, disability, and other variables.

Despite efforts to reduce regional disparities, significant variations in in health indicators persist among different segments of the population, including differences in health outcomes and service distribution by region, place of residence, gender, age, disability status, education, and socioeconomic status.

2.4.1. Geographic disparities in health

Regional variations in health indicators are visible due to low access to basic utilities, poor conditions of roads, long distances, communication networks, food insecurity, gender norms and harmful traditional practices, and low economic and educational status. According to the 2019 mini-DHS report, the coverage with RMNCH services is consistently lower in rural areas and in need of special support, compared to other regions. The widest urban-rural disparity in maternal health service utilization occurred in health facility delivery. The use of modern family planning methods varies significantly across regions. In 2019, the contraceptive prevalence rate (CPR) of modern methods ranged from 3.4% in the Somali region to 49.5% in Amhara. Vaccination with all basic vaccines varied from 18.2% in the Somali region to 73.0% in Tigray, and 83.3% in Addis Ababa.

In response, several efforts were made to improve rural health service access through health facility expansion and implementing a different service provision modality. Accordingly, several new health facilities, which include more than 500 health posts, 36 health centers, and 17 hospitals, began service provision in the first two years of the HSTP-II period. One of the modalities employed is a mobile team approach in pastoralist settings to reduce geographic disparities.

Geographic and regional disparities in health services access, utilization, and outcomes still require urgent attention. Major challenges include high turn-over of leadership at different health system levels, recurrent drought and conflict, limited contextualization of health service delivery systems, low community awareness and utilization of available services, mal-distribution and incorrect placement of health workers, and inadequate infrastructure.

2.4.2. Gender disparities in health

The MOH strives to mainstream gender, youth, and disability rights across the sector to expand access to services for women, children, youth, and persons with disability. Efforts to date include a gender inclusive audit, various capacity building trainings, gender analysis, promotion of women to leadership positions, gender mainstreaming in all programs, inclusion of gender in the health equity strategy. Moreover, the government created a one-stop center for gender-based violence (GBV) response at federal and regional levels and offered as a resource to GBV survivors.

Among the major challenges in this area are limited enforcement of existing laws and policies on the rights of women and girls, limited capacity among health care workers in designing and implementing gender-responsive health services, and limited capacity for providing comprehensive, multi-sectoral services to survivors of sexual GBV.

2.4.3. Socioeconomic disparities

An equity analysis for key MCH and nutrition indicators from the Mini EDHIS 2019 report showed that the wealthy and highly educated individuals consistently benefited from health interventions. Utilization of RMNCH services largely varied by educational status and wealth quintiles. Individuals and households with higher educational status and in the higher and highest wealth quintiles had consistently better health service utilization indicators compared to their less educated and poorer counterparts (Firew Tekle Bobo, 2017) (Figure 4). An individual with more than a secondary level of education are more likely to use health services than those with lower education levels. Households with the highest wealth quintiles are using health services of any kind compared to lowest quintiles. Moreover, rapid urbanization across the country with a mobile population is likely to pose new health sector challenges in equity.

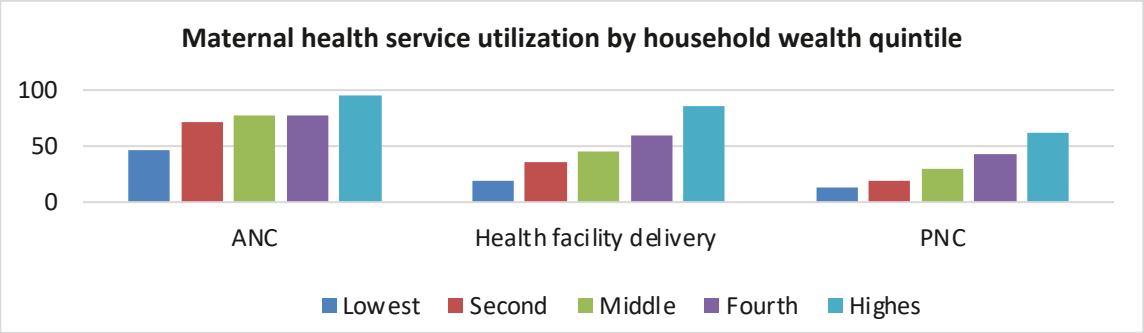

Figure 4: Maternal health service utilization by household wealth quintile

Though various national initiatives address financial barriers, the lack of social insurance, a weak fee waiver system for the poorest of the poor, a reimbursement gap for fee exemption for selected essential PHC services, and community-based health insurance are major gaps that contribute a significant amount of out-of-pocket expenditures.

2.4.4. Disparities in people with special needs

Individuals with disabilities face a range of barriers when they seek healthcare. The Disability Inclusiveness Guideline was developed to address these barriers in order to achieve UHC and the fulfillment of rights. People with disabilities represent a diverse group, and individuals with different types of impairment may be particularly vulnerable to specific barriers when accessing services. Global evidence indicates

that 1 in 6 people experience some form of disability, and they are twice as likely to develop conditions such as depression, asthma, diabetes, stroke, obesity, or poor oral health. Individuals with disabilities encounter obstacles across various aspects of the health system, including inadequate policy and standards, negative attitudes, problem with service delivery, and lack of service accessibility.

2.5. State of Health Innovation, Quality and Safety

Health innovation encompasses any development that leads to improved health outcomes and patient experiences, ranging from simple process change to the complex application of technology and data.[4] The National Quality and Safety Strategy was developed to operationalize the quality agenda, and its evaluation revealed several achievements in quality management systems. These accomplishments range from building technical capacities to establishing quality structures through leadership and provider trainings in quality, large scale QI implementation, strengthening learning platforms, introducing different standards and audit tools, and implementing initiatives in line with the strategy, such as development of materials like audit tools, patient safety training material, accreditation road map, the initiation of system thinking innovative quality initiative (System Bottleneck Focused Reform-Project), and the establishment of national quality hubs. Additionally, capacity-building efforts have been expanded and national/regional quality summits have been organized.

However, there are notable gaps, including disparities in quality structures at subnational and lower levels; , poor coordination, integration, linkage and interface and accountability mechanisms between the quality units and other program structures across the health system; high turnover and inefficiencies of leadership and health professionals; lack of quality-oriented and safety measures, including a poor data use culture and dashboard utilization; and limited responsiveness to client's need.

2.6. Health System Inputs

2.6.1. Health Workforce

The creation of motivated, competent, and compassionate (MCC) health workers is one of the priority agendas. In the past three year, the MCC strategy document was revised and implemented. The government has also aimed to increase the availability of health workers with an appropriate mix of professionals. In 2022, the density of health workers was estimated at 22.2 per 10,000 people, considerably lower than the WHO-recommended standard of 44.5 per 10,000 to achieve UHC. Another notable concern is the inadequate skill mix of health professionals, with a relatively high number of nurses but shortages of medical doctors, midwives, anesthetists, pharmacists, and medical laboratory technologists. The total health workforce comprises 342,899 individuals of which 177,709 are females (52%). Of this group, 221,046 (64%) are health professionals of various categories and the remaining 121,853 (36%) are admin and support staff. The three top health workforce categories that are female dominant includes HEWs, midwifery, and nursing, accounting for 96%, 64%, and 53%, respectively. In contrast, fewer females are represented among medical doctors (22.62%) and specialized doctors (22.83%).[5]

[4] WWW.ibm.Com /topics/healthcare- innovation

[5] MoH,2022, National Health Workforce Update pp5

During the past few years, key initiatives were implemented, including upgrading HEWs, the expansion of medical residency (specialization) programs, nursing specialty training, and the scale-up of midwifery, biomedical, and anesthesia professional training. The nursing specialty training program that was started encompasses categories for neonatal, emergency and critical care, operating room, pediatric and surgical nursing, oncology, nephrology, ophthalmic, and psychiatry. Harmonized curricula and minimum standards were developed for 22 medical specialty training programs, with 1,490 enrollees in 2023 through the Ethiopian Residency Matching Program (ERMP) across 20 higher learning institutions. Since the commencement of the ERMP, approximately 7,000 residents have been enrolled.

Efforts have also focused on strengthening the quality of clinical practices through the provision of skill lab equipment, training, and establishment of reading corners in hospitals. Various assessments, including Health Labor Market Analysis (HLMA), Workload Indicator Staffing Need Assessment (WISN), and a midterm review of the Human Resource for Health Strategic Plan (HRHSP) have informed strategies and initiatives. The HRHSP is currently under revision to align with Global Workforce Strategy 2030. Furthermore, the implementation of the National Health Workforce Accounts (NHWAs) aims to provide national health workforce data for the global community. A flagship Leadership Incubation Program for Health (LIP-H) has been launched, with a special focus on empowering women to strengthen leadership, management, and governance in the program. The accreditation of 37 continuing professional development (CPD) accreditors and 200 CPD providers has been carried out in accordance with the national CPD implementation guideline. An updated version of the Health Workforce Information System (iHRIS) has been developed to enhance administration, development, and license interface and its implementation is currently underway.

Primary challenges in this area include high staff turnover, inadequate skill mix, poor incentive mechanism, lack of uniformity on HR structures across the region, lack of attention for MCC agenda, limited motivation and commitment in CPD implementation, inadequate finance, limited regulation capacity of professional associations and failure to produce comprehensive national HR information.

2.6.2. Pharmaceuticals and Medical Devices

Several efforts have been made to strengthen pharmaceutical and medical device supplies and management. The primary areas of improvement include the integration of the Pharmaceuticals Logistics System, the reduction of pharmaceutical wastage, and the establishment of electronic supply management system.

According to a 2020 assessment of pharmaceutical supply chain management, pharmacy services, and medical equipment, the average wastage rate of health commodities at health facilities was 3.9%. While there was improvement in reducing wastage, it remained higher than the WHO-recommended level (less than 2%). The same assessment indicated variations in the availability of essential medicines among regions, ranging from 70.7% to 96%, with significant disparities. Lifesaving and essential medicines had an availability rate of 81% for revolving drug funds (RDF) and 94% for health programs (ARM 2022 report). Furthermore, the assessment also revealed that the average functionality of medical equipment in health facilities was 74%. The implementation of auditable pharmaceutical transactions and services (APTS) encompassed 388 health facilities, focusing on pharmaceutical compounding, clinical pharmacy, and antimicrobial stewardship programs to improve pharmacy services and ensure the rational use of medicine.

To ensure the proper implementation of traditional medicine practices, various efforts are underway, including strengthening research on traditional medicine for safety, efficacy, and product and service quality assurance. There is also a registration process for traditional medicine products and an initiative to integrate traditional medicine with modern health care services. The government has designed and implemented different incentive schemes for local pharmaceutical manufacturers, such as duty- and tax-free import of capital goods and spare parts, tax holidays for a period of approximately six years, (depending on investment location), duty- and tax-free import of raw materials, and income tax exemption for know-how transfers. An industrial zone for pharmaceuticals is being established, and the Ethiopian Pharmaceuticals Supply Service (EPSS) offers incentive packages for local pharmaceutical manufacturers, including 30% advance payment, 25% local preference margin, dedicated tenders for local manufacturers up to 1 billion ETB, and 70% loans through a tripartite agreement from Ethiopian Development Bank.

At the national level, 14 pharmaceutical manufacturing companies and 38 medical supply/device manufacturers and small manufacturing firms have obtained licenses from the Regional Regulatory Authorities, mainly producing antiseptic and disinfectant products. Similarly, 342 companies are also licensed by EFDA to import pharmaceutical products and medical devices into the country.

Key challenges in this regard include an inefficient supply chain management system, shortages of pharmaceutical and medical supplies, high wastage rates, unsafe disposal of non-use items, inadequate central warehousing, delays in stock pick-up from dry ports, inefficient procurement procedures for pharmaceutical products, limited local manufacturing capacity, weak medical equipment inventory management, and the absence of functional bioequivalence centers.

2.6.3. Health infrastructure

Health infrastructure is one of the critical components within the six building blocks of the health system. The health sector has been working on its expansion to improve service access with the development of a health infrastructure roadmap. As of the end of 2021/22, Ethiopia had a total of 18,200 health posts, 3,579 health centers, 252 primary hospitals, 100 general hospitals, and 33 specialized hospitals. Furthermore, there are ongoing construction at 77 health posts, 89 health centers, 52 primary hospitals, seven general hospitals, and two specialized hospitals. During implementation of HSTP-II, various special-purpose facilities like warehouses, trauma centers, mini blood banks, and laboratory infrastructures were also constructed.

Evidence indicates that only 1% of the 764 assessed health facilities meet the criteria for having the seven basic amenity tracer items. The mean availability of these tracer items across all assessed facilities was 39%, with referral hospitals scoring the highest and health posts the lowest (30%).[6] Current administrative reports show that water is available in 59% of health facilities, while electricity is accessible in 76% of them.

According to the post-conflict recovery plan, approximately 3,217 health posts, 709 health centers, and 76 hospitals were damaged and looted during the conflict period, rendering them unable to provide service for the community. These facilities require substantial attention within the investment plan. Moreover, challenges such as a rising inflation rate for construction materials, security issues in

[6] The SARA 2018 survey report.

certain regions, financial constraints and cash flow for capital projects, limited coordination in design, insufficient ICT infrastructure, contractor inefficiency, and capacity gaps at regional and lower levels continue to pose obstacles to the development of the health infrastructure.

2.6.4. Health financing

Health financing is a major part of the health system that can facilitate advancement toward UHC, enhancing service coverage and financial protection. The three primary functions of health financing are revenue generation, resource pooling, and purchasing. Over the past three years, the government's health financing initiative has sought to mobilize resources for health and protect people from financial hardship by implementing a number of interventions, which include providing a fee waiver for indigents and high-impact interventions, subsidizing over 80% of the cost of care in government health facilities, and implementing community-based health insurance (CBHI).

According to the HSTP-II fiscal space for heath estimate, the annual average funding gap was $0.64 billion USD. However, the financial deficit for HSTP-II has significantly increased due to the impact of the COVID-19 pandemic and the conflict. Several initiatives were implemented to minimize the finance gaps, which include the revision of the health care financing strategy and development of an implementation plan; the launch of a performance-based financing pilot project; the establishment of an equity and resilient trust fund that identifies potential innovative financing options and its governance; the launch of an exempted health services financing system; and development and implementation of the public-private partnership operational manual.

Ethiopia's total health expenditure was 127.47 billion ETB ($3.63 billion USD), accounting for 6.3% of the country's GDP. While total health expenditure has grown steadily since 1995/96, and grew by 77% in nominal terms from 72.05 billion ETB in 2016/17 to 127.4 billion ETB in 2019/20, the inflation-adjusted increase was only 16%. This share of GDP is lower than the expected average of 5% for low-income countries, and well below the global average of 9.2%. Government contribution for total health expenditure was the same at 32% between 2016/17 and 2019/20. Expenditure on health as a share of total government expenditure increased from 8.1% in 2016/17 to 8.5% in 2019/20. This figure is lower than the low-income country average government health expenditure (8.7%).[7] Average health expenditure per capita is $36.4, as compared to a regional average of $38 (World Bank, 2016). Although the government allocates 60–70% of total budget to pro-poor sectors, allocations to health fall well short of the Abuja Declaration target or WHO's recommended $86 per capita spent to deliver UHC.

During the implementation of HSTP-II, donors pledged an average of $150 million USD per year through the SDG Performance Fund. However, disbursements in 2020/21 and 2021/22 fell significantly short, experiencing a decline of 49% and 241% from the original pledges, respectively. Increasing enrollment and coverage under CBHI program has been major priorities. The CBHI woreda coverage grew from 834 to 921, which is 93% of the target, and the enrollment rate improved from 61% in 2020/21 to 75% in 2022/23. Corresponding to this, the average enrollment rate of eligible households in CBHI woredas rose from 55% to 75%. Over the last three years, the program has generated 7.3 billion ETB from paying members and 2.6 billion from targeted subsidies.

While there have been efforts to improve health financing in Ethiopia, persistent gaps remain. These

[7] National health account (2019/20) report, 8th round

gaps include low government spending on health, which falls below the Abuja Declaration target and the WHO's recommendation of at least $86 USD per capita. In addition, there is inefficient use of resources, significant reduction in pool funds, inefficient purchasing strategies, and performance-based financing mechanisms. Furthermore, there is an absence of social health insurance (SHI), and the pooling of CBHI is fragmented, with low coverage of indigents. Additionally, there is a lack of streamlined and automated mechanisms for collecting premiums and handling claims, which can lead to delays and inefficiencies in the health financing system.

2.6.5. Health Information system

There are notable improvements in the health information system (HIS) following the implementation of Information Revolution Roadmap and Strategy during the HSTP period. Over the last three years, the HIS governance has been endorsed and its coordination platform has been established. Several critical guidelines and standards have been developed and implemented, including the National Data Access and Sharing Guideline, Digital Health Blueprint, Standard for Electronic Health Records, MFR Management and Governance Protocol, and eHealth Architecture. Additionally, work is underway on the eHealth Interoperability and messaging standards. The HealthNet, an ICT network Infrastructure, has connected 3,760 facilities through copper-wired VPN, 3G wireless networks, and tailor-made options. The MOH's data center has also been upgraded to host digital health systems in-house, enhancing the institutionalization of the digital health system endeavors.

Key activities include HMIS indicators and tools revision, ESV-ICD 11 revision, revision of IR guideline, and the development of a HIS mentorship curriculum and guideline. The upgraded version of DHIS2 (Version 2.36) was rolled out to public health institutions, including a few private hospitals, and the automation of woreda-based planning using this platform has begun. An electronic community health information system (e-CHIS) has been implemented in 7,806 health posts. Furthermore, digital health tools and systems, such as electronic medical record (EMR), Smart-care ART, HRIS, MFI registry, supply chain management, regulatory information system, are in operation. Various platforms have been established to strengthen key decision-making, including performance monitoring teams (PMTs), review meetings, a joint steering committee (JSC), planning forums and capacity building and mentorship program (CBMP), involving local universities. Regarding vital events and civil registration, the birth notification rate is 52% and the death notification rate is 3.6%. [8]

Several research studies and surveys on various health and health-related topics have been conducted by research institutes, and CBMP universities, leading to the publication of various research manuscripts. The Ethiopian Journal of Public Health and Nutrition (EJPHN) has received accreditation from the Ethiopian Ministry of Education, positioning it as an essential platform for communicating high-quality empirical evidence to a broad spectrum of stakeholders. Additionally, a Policy, Strategy and Research Lead executive office has been established at MOH to coordinate and facilitate research, surveys, surveillance, and the application of their findings in policy development and other contexts. Regarding digitizing, efforts focused on data and information have been made, but less so on digitizing the other domains of health system functions for service improvements. The management of digital health tools and services has been inefficient, resulting in insufficient attention on digitizing health system services to benefit patients, care providers, and health care managers.

[8] ARM Report, 2022

Some of the major challenges encountered were inadequate competency and skill, low digital literacy among health workers, inconsistency of ICT structure at the lower levels, weak/poor digital health/ICT infrastructure, poor digital health governance structure, lack of standards for electronic multi-sectoral response information system, poor implementation of HMIS/DHIS2 in private health facilities, inadequate implementation of data quality assurance techniques, low birth death notification coverage, limited coverage of VPN-Health Net and LAN, and shortage of computers and networking materials.

2.6.6. Community Ownership

Community engagement is a primary principle and strategy of Ethiopia's health sector to achieve its goals. Initially, health extension workers utilized women development groups (WDG) to engage community members, but in recent years, the functionality of this platform has diminished. In response, in 2013 EFY, the MOH began optimizing the WDG platform and reimagining community engagement through the introduction of village health leaders (VHLs). These approaches were piloted in four woredas across Amhara, Oromia, and SNNP regions. Following a comprehensive process evaluation in the 2021/22, the redesigned community engagement approaches were scaled up to 26 more woredas. Furthermore, a tailored community engagement strategy has been designed for the pastoral communities in the Afar and Somali regions, with pilot implementation underway in selected woredas.

2.7. Leadership, Governance and Multi-sectoral Collaboration

2.7.1. Health System Leadership

The MOH has designed and implemented various leadership development programs, including the District Health Management training; the Leadership, Management, and Governance (LMG) for senior, mid-level, and facility-level managers; the Leadership Incubation Program (LIP-H) ; and the Clinical Leadership Improvement Program (CLIP) that focuses on improving senior clinician engagement to improve patient outcomes and social and managerial accountability interventions. The LIP-H initiative was designed to strengthen health leadership capacity by producing future health sector leaders. Accordingly, five rounds of training has been provided to the young health workforce from MOH, RHBs, and hospitals.

The national CLIP has been designed for putting the clinician at the heart of shaping and running clinical services. It is considered a core part of clinicians' professional identity and has been piloted in 11 selected public hospitals. According to the midterm evaluation, overall clinical leadership practice was improved from CLIP implementation. While there are promising achievements on leadership and governance, there remain fragmented implementations of the program, weak coordination and follow-up, limited competency in systems thinking and leadership, high turnover, and weak accountability in the health system.

2.7.2. Regulatory system

A strong regulatory system is paramount to ensure the safety and quality of health and health-related products and services. During HSTP-II, efforts were undertaken to strengthen the regulatory system for food, medicine, traditional medicines, equipment and supplies, health professionals, and health and health-related institutions.

A 2023 national survey showed that the percentage of substandard and falsified medicines decreased to 6.9% through proactive vigilance and robust surveillance systems. Approximately 9,356 medical devices were registered, inspected, and tested with 46 types of medical devices subjected to post-marketing surveillance using eRIS. This milestone was made possible by the introduction of new IVD laboratory infrastructures and machines in 2022. Moreover, 11,557 food types were registered, and market authorization was streamlined by extending notification activities to branch offices, improving the food registration process. Laboratory tests for quality assurance were conducted on foodstuffs, with seven food types undergoing post-marketing surveillance and 40 food types undergoing consignment tests.

To strengthen monitoring of medicine safety, electronic reporting and mobile applications were developed, and active surveillance was conducted on COVID-19 vaccines and ART medicines. Safety monitoring was extended to MDR-TB medicines and anthelmintic in mass drug administration (MDA) programs. Investigations on serious adverse drug events and causality assessment were also performed. The government's commitment to regulating tobacco products as a means to protect public health remained strong.

The proportion of health institutions that implemented national standards reached 62%. Notably, eight health institution standards were developed, and 42 were revised. An additional 31 hygiene and environmental health standards for health-related institutions were developed. The initiation of a self-regulation system for health institutions marked an important step. Further, 100% of health institutions completed domain registration, with70% of health institutions' service domain data registered on MFR. Efforts were made to establish a registration and licensing system for health and health-related institutions, as well as health professionals, on a centralized database. This led to the inclusion of 13 categories of health professionals for competency assessment examinations. Despite these achievements in the regulatory system, challenges persist, including of the need for an autonomous and harmonized structure, limitations in the number and professional diversity of inspectors, inadequate resources, and a lack of adequately secured infrastructure for the development and administration of competency assessment examinations for health professionals.

2.7.3. Multi-sectoral collaboration

Health is multifactorial and requires a strong multi-sectoral collaboration; however, by design, governments operate in sectoral silos. Despite national policy statements and coordination platforms, when it comes to delivering a truly prioritized set of interventions at the grassroots level, much remains to be done to translate policy into action. To effectively engage with other sectors, the MOH has initiated the concept of a multi-sectoral woreda transformation, comprising 11line ministries that was piloted in Gimbichu woreda. However, further action is needed.

2.8. SWOT Analysis

In the development of HSDIP (2023/24–2025/26), a SWOT analysis was conducted to identify the most prominent factors that were encountered during the implementation of HSTP-II. These are broadly divided into internal factors (strengths & weaknesses) and external factors (opportunities & threats). Based on an analysis of HSTP-II performance, the following list were identified as key factors that influenced implementation and the intended results.

Strengths	Weaknesses
○ Improved service availability and accessibility, particularly to PHC ○ Availability of community-based health extension program (HEP) ○ Availability of a mechanism to organize community engagement ○ Availability of a national learning collaborative platform ○ Availability of accredited lab and blood bank services ○ Presence of health facility management (governing board/management committee) ○ Good coordination and governance mechanisms ○ Increased number of new graduate health workers (availability) ○ Initiation and implementation of health care financing reforms ○ Implementation of Community Based Health Insurance ○ Engagement of development partners, IP, and CSOs ○ Increased community contributions ○ Regular and participatory review mechanisms in place ○ Initiation of HEI accreditation process ○ Sound distribution system in emergency supply chain management ○ Introduction of long-term framework procurement modality, cyclic procurement, and trans- docking of medical devices ○ Deployment of min-max inventory or supply-chain management systems in health facilities ○ Initiation of laboratory equipment placement (leasing)	○ Suboptimal quality of health services ○ High disparity in health care utilizations ○ Poor planning of human resource for health ○ Inadequate competency and skills of health workforce ○ Low motivation of the health workforce & high staff turnover ○ Inconsistencies in the implementation of gender mainstreaming ○ Inadequate budget allocation for pharmaceuticals and medical device procurement ○ Limited capacity in pharmaceuticals and medical device supply management ○ Long pharmaceutical and medical device procurement lead time ○ Absence of a robust SCM system at EPSS ○ Low market share of local pharmaceutical manufacturers ○ Poor medical equipment maintenance capacity ○ Sub-optimal public-private partnership and weak inter-sectoral collaboration ○ Lack of uniformity and double standards in regulatory practices at public and private health and health-related institutions ○ Inadequate implementation research and low utilization of evidence ○ Low digital literacy among health workers and poor ICT infrastructure ○ Poor management of clinical practice, academic integration and CPD regulation system ○ Donor dependency, weak domestic financing and resource mobilization, and poor implementation of CBHI packages ○ Delayed implementation of Social Health Insurance system ○ Inadequate reimbursement for exempted services ○ Lack of attention on health education and promotion at health facility level

Opportunities	Threats
○ Positive government attention to global commitments, such as SDGs ○ Donors' commitment to support health programs ○ Political will to advocate for women leadership ○ Global PHC/UHC movement ○ Presence of community and sector engagement mechanism in developmental activities ○ Global advocacy for resilient health systems and emergency responses ○ Increase in community demand for high-quality health care ○ Improved government commitment to PPP ○ Increased number of training institutions (public and private sectors) and programs for health professionals ○ Improved education enrollment, particularly girl's education ○ Improved access to various media outlets and social networks ○ National coordination and collaboration in emergency and disaster management response ○ Government priority intervention related to exit and qualification examination ○ Engagement of professional associations and stakeholders to improve the quality of education and CPD ○ Emerging food safety issues on the global agenda ○ Emergence of advanced digital health technologies ○ Government commitment in nurturing digitization in the country ○ Increasing number of local pharmaceutical manufacturing plants ○ Reestablishment of government communication Service Ministry, and merging of Health Education team to PRC ○ Increase in PRC and communication demands by different departments and organizations ○ Media commitment to report and educate on health as a social responsibility	○ High adult illiteracy rate, especially among women ○ High inflation rate ○ Uncontrolled population growth ○ Shift of donors' interest and a decline in levels of support ○ Low economic status of the population (poverty, high unemployment) ○ Poor health literacy and health system literacy ○ Increasing risk factors, unhealthy lifestyle, and harmful practices ○ Community fatigue in some activities such as HDA ○ Increasing manmade and natural disasters ○ Emergence and re-emergence of disease epidemics ○ Proliferation and/or poorly controlled promotion of processed foods ○ Unregulated global trade and its effect on importation of products and behaviors ○ Weak inter-sectoral collaboration ○ Poor infrastructure such as road, water supply, ICT, electricity ○ Inadequately managed urbanization and industrialization ○ Sub-optimal quality of education ○ Limited incentive mechanisms for private sector investment ○ Internal political instability and conflicts that hinder service provision ○ Low predictability of funding ○ Climate change and global warming ○ Weak border control of illegal food products and medicines ○ Data privacy and security risks, including cyber-attacks and data access vulnerabilities ○ Misinformation/ disinformation on different social media platforms ○ Low attention of the community to mainstream media because of social media influence

2.9. Stakeholder Analysis

Stakeholders are key players in the health sector and understanding their needs is crucial to the success of HSDIP. The table below shows the key stakeholders whose needs and interests should be taken into consideration during HSDIP implementation.

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
Community	○ Active participation and engagement ○ Ownership and literacy in health, Service utilization ○ Enrollment for health insurance and ○ Healthy lifestyles	○ Access for quality health services ○ Health information ○ Public accountability ○ Empowerment ○ Dignified and respectful care	○ Dissatisfaction and public grievances ○ Loss of trust in health system ○ Drop-out from health insurance ○ Underutilization	○ Regular community engagement ○ Public accountability and transparency ○ Implement public grievance tracking and response system ○ Ethics and governance
Parliaments, Prime Minister's Office, Council of Ministers, Regional Governments	○ Ratification of policies, proclamations, etc. ○ Enforce need-based financial resource allocation ○ Enforce implementation of health in all policies strategy	○ Implementation of proclamations, etc. ○ Public satisfaction and trust ○ Efficient and integrated care ○ Public accountability and transparency	○ Loss of trust and interest on timely approval of policies ○ Frequent leadership changes ○ Discourage incremental resource allocation	○ Strong performance monitoring and reporting mechanism ○ Strong accountability and transparency mechanisms ○ Enhance multi-sectoral engagement activities
Line Ministries (Finance, Labor, Women's Affairs, Agriculture, etc.)	○ Support and invest on implementation of Health in All Policies Strategy ○ Improve participation and contributions on multi-sectoral engagement programs	○ Improved efficiency and stewardship ○ Improved access for comprehensive, equitable, and quality health services Improved public trust and satisfactions	○ Loss of interest for active participation and contributions ○ Fragmentation on joint leadership and coordination practices	○ Collaboration ○ Transparency ○ Advocacy
Academic Health Institutions	○ Production of competent and versatile health professionals ○ Alignment in health system needs and training curriculums ○ Engage in evidence generation ○ Support innovation and technology for health	○ Platforms and attractive mechanisms for academic institutions' active and regular engagement ○ Clear accountability and transparency mechanisms	○ Weak training curriculum design and implementation ○ Production of incompetent health cadre ○ Lack of interest for collaboration	○ Create joint platforms for regular engagement and collaborative participation ○ Apply accountability and transparency mechanisms ○ Apply merit-based motivation and recognition programs

Development Partners	○ Harmonization and alignment ○ Support for plan and implementation ○ Provide material, financial and technical supports	○ Financial system accountable and transparent ○ Involved in planning, implementation and M&E	○ Fragmentation ○ High transaction cost ○ Inefficiencies ○ Duplication of efforts	○ Government leadership ○ Transparency ○ Efficient resource use ○ Build financial management capacity
CSOs, and professional associations	○ Harmonization & alignment ○ Participation, resource & TA ○ Participate in licensing and accreditation ○ Promote professional code of conduct	○ Involvement in planning, implementation, and M&E participation	○ Dissatisfaction ○ Fragmentation ○ Scale down ○ Withdrawal	○ Transparency, ○ Advocacy ○ Capacity building ○ Financial support
Diaspora and Private for-profit entities	○ Quality of care ○ Client oriented ○ Knowledge and technology transfer	○ Enabling environment for their engagement	○ Mistrust ○ Rent seeking	○ Transparency ○ Accountability ○ Dialogue
Civil servants	○ Commitment ○ Participation ○ Regular relicensing (CPD)	○ Conducive environment ○ Transparency ○ Incentives ○ Capacity building	○ Dissatisfaction ○ Unproductive ○ Attrition	○ Motivation ○ Involvement

2.10. Summary of Lessons from HSTP-II Implementation

Government Commitment

The government of Ethiopia has prioritized the health sector, making substantial investments to expand access to quality health services for all citizens, including increasing trained health personnel, health facilities, and essential medicines. Various health policies, strategies, and programs have strengthened the capacity of the country's health service delivery tiers to deliver comprehensive, high-quality, and equitable primary healthcare.

Despite these efforts, challenges persist in the health sector, stemming from socio-economic and political factors. Poor coordination among institutions and sectors often leads to duplication of efforts, budget inefficiencies, and misallocation of resources. Approximately one-third of the Ethiopian health expenditure comes from external assistance or foreign sources, with the government contributing a similar proportion. However, the government's contribution is still insufficient, representing only 11.7% of the total government expenditure, falling short of the Abuja Declaration's 15% target.

Further, regulatory constraints from a weak legal policy framework and lack of investment incentives have limited the involvement of the private sector in the country's healthcare.

Health services quality and equity

While access to essential health services has improved, the quality of healthcare is still a key concern. Availability of pharmaceuticals at the health facility level is suboptimal with less than 10% sourced from local manufacturing plants There are also persistent shortages in the health workforce with only 0.7 physicians per 10,000 inhabitants (global average is 1.3 per 10,000), over-extending existing staff who are unable to provide the necessary care to all patients. This scarcity is attributed to employment challenges despite improving the availability of human resources in the market.

Despite intensive efforts to address equity gaps, disparities remain in the delivery and coverage of high-quality health services across domains of geography, age, gender, and disability, which contribute to inequities in use of health services, health outcomes, and population-level impacts. Rural areas face challenges in access to services due to a scarcity of health workers and limited infrastructure such as roads and proper sanitation systems. Ethiopia has very limited modern or optimally acceptable public health facilities that render it difficult to provide efficient and effective health services.

Despite implementing financial hardship protection measures like fee waivers, exempted services (e.g. maternal and child health services), and community-based health insurance (CBHI), financial hardships related to health care persists. According to the eighth Ethiopian Health Account (EHA), out-of-pocket (OOP) health spending is alarmingly high, reaching 30.5% of total health expenditure, above the recommended global target of 20%. Shortages of medicines and medical devices in public health facilities, inadequate insurance coverage, and insufficient reimbursement for exempted services contribute to these hardships

Over the last three years, natural and man-made disasters, including the COVID-19 pandemic, market inflation, and internal conflicts, have limited access to and/or interrupted health service delivery. Further, more than 4,000 health facilities, including health posts, have been damaged and looted in the conflict affected areas of the country.

Public Health Emergencies Management

Ethiopia has built a public health management system at national and subnational levels to coordinate and strengthen preparedness for public health emergencies improving core capacities to prevent, detect, respond to, and mitigate emergencies such as the COVID-19 pandemic, epidemic diseases, concomitant effects of flooding, and internal displacement.

Despite these notable improvements, a number of challenges to health security persist, which include limited surveillance capacity at the lower levels, poor functionality of emergency operations centers (EOCs), suboptimal laboratory-based surveillance, and inadequate emergency funds.

In summary, the following key areas require attention in the coming plan period:

- Restoration and initiation of services in conflict-affected areas
- Improve the supply and quality of medical equipment, laboratory materials, and medicines
- Strengthen the engagement of private and other sectors in health
- Improve quality and equity of health services through alleviating the gaps in infrastructure, human resource development, and regulatory system

Chapter 3

HSDIP Goals, Strategic Objectives, Programs, and Initiatives

Chapter 3: Goals, Strategic Objectives, Programs, and Initiatives

3.1. Goal

The overall goal of the HSDIP is to improve the health status of the population through accelerating progress towards UHC, protecting people from health emergencies, transforming woredas, and improving health system responsiveness that will all further contribute to sustainable economic development.

This goal entails strengthening the health system to ensure that people live longer and healthier lives by reducing the causes of premature deaths, including maternal and childhood health conditions, unhealthy lifestyles, and accidents; expanding access to high-quality health care for all; and ameliorating the effects of social determinants of health. It embraces the inclusion of all segments of the population, irrespective of gender, age, places of residence, geographical areas, level of economic status, education, or other equity dimensions, and aspires to never leave anyone behind.

3.2. Strategic Objectives

The strategic objectives of this medium-term plan outline the key results that this plan intends to achieve. They serve as clear indicators of high -impact interventions and programs to advance the overall goal. HSDIP comprises nine strategic objectives that encompass various programs, services, initiatives, and main activities, all contributing to the realization of the intended goal (Annex 3).

3.2.1. Improve maternal, child, and adolescent health and nutrition status

This strategic objective focuses on the promotion of health and disease prevention among mothers, newborns, and children through the implementation of different programs that encompass health services along the continuum of care through the lifecycle course, including preconception and pregnancy care, labor and delivery, newborn care, child health, adolescent health, and nutrition services. The RMNCAYH-N package contains seven major program areas: 1) family planning and reproductive health, 2) maternal health, 3) neonatal and child health, 4) immunization, 5) adolescent and youth health, and 6) nutrition. Achieving this objective will improve health service coverage, and contribute to the reduction of maternal, neonatal, and child morbidity and mortality. The strategic initiatives and main activities are described in each of the program areas as follows.

3.2.1.1 Family Planning and Reproductive Health

Strategic initiatives and Main Activities

Strengthening access to equitable and quality family planning services

- Implement effective social and behavior change communication interventions
- Ensure access to method mix and enhance uptake of long-term contraceptives
- Strengthen the integration of family planning services with other key services, such as HIV, immunization, postpartum care, sick childcare, post abortion, AYFS, etc.
- Expand family planning service to workplaces, private health facilities, people with special needs, universities and colleges, and pastoralist communities

- Implement national family planning quality standards, capacity building, and catchment-based clinical mentorship
- Enhance public-private partnerships on family planning services
- Mobilize adequate and sustainable financial resources from various sources and improve family planning commodities at all levels
- Strengthen community and male engagement in family planning

3.2.1.2 Maternal Health

Strategic initiatives and Main Activities

Introduce preconception care (PCC)

- Integrate preconception care services to major service delivery areas such as schools, YFS, youth centers, and other RMNCAHN and OPD services

Strengthening access to quality and equitable antenatal, labor, delivery, postnatal care, and abortion care services

- Enhance early identification of pregnant women and linkage to ANC services
- Scale up ultrasound services for all pregnant women before 24 weeks of gestation
- Introduce and implement multidisciplinary mobile services to pastoralist communities
- Expand and strengthen maternity waiting room utilization
- Strengthen and scale up of BEmONC and CEmONC services
- Accelerate obstetric transition through significantly increasing the rate of appropriate cesarean delivery
- Strengthen maternal and perinatal death surveillance and response system
- Introduce reimbursement of exempted services for maternal, newborn, and child health services
- Expand access to comprehensive abortion care (CAC) services

Expand and strengthen emergency obstetric and surgical care services at selected health centers

- Equip health centers with medical devices and supplies for emergency obstetric and surgical care services
- Build the capacity of health professionals working at health center with surgical services on emergency obstetric and surgical care

Strengthen prevention and management of obstetric fistula and pelvic organ prolapse

- Improve screening, early identification, and prevention of obstetric fistulas
- Strengthen services provided by obstetrics fistula treatment centers

3.2.1.3 Newborn and Child health

Strengthen and expand quality, facility-based newborn and child health services

- Expand and strengthen services for low birth weight and preterm babies including kangaroo mother care (KMC)
- Improve access to and quality of essential and advanced neonatal and child health care services
- Improve access and uptake of essential medicines, supplies and equipment

Strengthen and expand quality community-based integrated management of newborn and childhood illnesses services

- Expand iCMNCI services for pastoralist communities
- Strengthen implementation of Performance Review Clinical Mentorship Meetings (PRCMM) at PHCU level
- Promote demand creation activities through existing community platforms (HP open house)

Introduce and scale up early childhood development (ECD) and prevention of injuries

- Strengthen and scale up ECD services through integration with RMNCAHN programs
- Strengthen multi-sectoral coordination and collaboration
- Expand early stimulation/play areas in health facilities
- Develop, integrate, and implement childhood injury prevention and management at community levels and across health facilities

3.2.1.4 Immunization Program

Strategic initiatives and Main Activities

Improve access to quality and equity for routine, catch up, and supplementary immunization campaigns

- Enhance demand creation, communication and political commitment on immunization
- Optimize Periodic Intensified Routine Immunization/PIRI/ activities
- Identify and address zero-dose and under-vaccinated children and missed communities
- Expand and strengthen urban and semi-urban immunization services at private health facilities
- Strengthen quality of Supplementary Immunization Activities (SIAs) and reactive vaccination

Introduce and scale up conventional and new vaccines and innovation

- Introduce and scale up existing and new vaccines in to the National Immunization Program/ Service (HepB birth dose, Yellow Fever, Meningitis A, IPV2 Vaccine, Malaria vaccine, Routinize Covid-19 Vaccines, Measles Five Dose vaccines, Measles and Rubella (MR) etc.)

Improve and strengthen immunization supply chain

- Strengthen vaccine and supply planning, micro-planning, forecasting, quantification, cold chain equipment (CCE), and Last Mile Delivery
- Strengthen financial sustainability for the procurement and distribution of vaccines and supplies

Enhance and strengthen surveillance of target diseases and vaccine safety

- Enhance surveillance, detection, investigation, and response for vaccine-preventable diseases and adverse events following immunization (AEFI)
- Strengthen vaccine safety and surveillance, detection, investigation, and response, including adverse events following immunization
- Strengthen AEFIs reporting system for routine and supplementary immunization activities

3.2.1.5 Adolescent and youth health

Strategic Initiatives and Main Activities

Strengthen reproductive health services

- Improve access to screening and management for SRH and medical problems
- Improve access to legal safe abortion services
- Implement interventions to prevent, detect, and manage sexual and other forms of gender-based violence and harmful practices such as child and forced marriage
- Enhance inclusion of sexual and reproductive health services in humanitarian settings

Expand and strengthen access to equitable and high-quality adolescent and youth health services

- Strengthen adolescent and youth-focused and youth-friendly health services
- Strengthen key interventions to reduce injuries, violence, and harmful practices among adolescent and young people
- Intensify and expand parenting and life skill enhancement school health program
- Strengthen and integrate AYH services into humanitarian emergency responses interventions
- Expand YFS services and minimum in service package (MISP) AYH services in workplaces, industrial parks, universities, colleges, and schools
- Strengthen reach of youth and adolescents through mHealth and other platforms

3.2.1.6. Nutrition services

The prevention of malnutrition across all stages of life demands multi-sectoral planning and collaborative execution of low-cost, high-impact nutrition-specific and sensitive interventions. This program focuses on ensuring optimal nutrition along all stages of life in order to improve the nutritional status of priority groups that include children, adolescents, pregnant women, and lactating mothers.

Strategic Initiatives and Main Activities

Improve infant & young child feeding (IYCF) and nutrition services

- Protect, enforce, promote, and support breastfeeding for children 0–24 months through implementing the Baby Friendly Hospital Initiative (BFHI) and advocacy
- Improve service demand, coverage, and quality through routine, integrated and catch-up nutrition activities
- Strengthen age appropriate IYCF counseling and demonstration, and ensure timely initiation of age-appropriate, optimal complementary feeding for children aged 6–24 months at facility and community levels
- Strengthen community-based participatory complementary feeding promotion, using local food items
- Strengthen Growth Monitoring and Promotion sessions (GMP) at health facilities

Improve nutritional status of adolescents

- Enhance nutritional assessments and counseling services for adolescents
- Scale up iron and folic acid supplementation for adolescent girls in schools and health facilities

Improve quality and coverage of nutrition services for pregnant, lactating, and women of reproductive age

- Introduce preconception folate supplementation for women at high risk of giving birth to babies with neural tube defects
- Improve uptake and coverage of IFA 90 plus tabs for pregnant women
- Strengthen uptake of deworming for pregnant women
- Introduce the calcium supplementation for pregnant women for prevention of pregnancy -induced hypertension

Strengthen nutrition service delivery for people with communicable and NCDs

- Provide nutrition screening, treatment, and counseling services for patients with HIV, TB, other infectious diseases, and NCDs
- Promote public awareness on healthy dietary behaviors and physical activities

Expand and strengthen quality and comprehensive outpatient and inpatient treatment services for acute malnutrition

- Strengthen regular screening and active case finding for acute malnutrition
- Enhance sustainable provision of essential supplies and commodities for acute malnutrition management
- Strength the integration and expansion of management of moderate acute malnutrition into the health extension platform (IMAM)

- Strengthen and expand outpatient therapeutics program (OTP) and stabilizing centers (SC)

Strengthen timely and coordinated nutrition emergency response

- Build national and subnational surge capacity to respond to rapid onset of nutrition emergencies (staff, commodities, etc.)
- Prevent and control micronutrient deficiencies for children in emergency and special situations
- Strengthen emergency nutrition services (simplified and combined) in humanitarian settings
- Support local production of therapeutic food items and specialized nutritious food products

Strengthen multi-sectoral coordination and linkages

- Optimize functionality of food system and nutrition council
- Establish and strengthen regional and sub-regional Food and Nutrition Coordination platform
- Enhance and enforce food fortification

Strengthen the implementation of Seqota Declaration Expansion Phase

- Mobilize resources for SD & FNS implementation
- Strengthen multi-sectoral coordination linkages across food and relevant sectors
- Expand evidence-based innovations (community lab, AITEC, UNISE, Triangle of Knowledge partnership, etc.)

Strengthen multi-sectoral Food and Nutrition Monitoring and Evaluation System

- Expand the Unified Nutrition Information System (UNIS)
- Roll out the food and nutrition multi-sectoral score card at all levels
- Strengthen innovation and knowledge management on FNS and SD

Social Behavioral Change Communication (SBCC) for FNS and SD

- Mainstream FNS SBCC into sectoral plan
- Conduct high level advocacy on food and nutrition at all levels
- Promote 1,000 days plus public movement

3.2.2. Improve disease prevention and control

This strategic objective aims to reduce disease occurrence and minimize its effects by focusing on the prevention, control, and management of major communicable diseases such as HIV, malaria, vector borne diseases, tuberculosis, leprosy, lung diseases, hepatitis, NTDs, NCDs, and mental health. High-impact interventions will be used to reduce the burden of these targeted diseases that include health promotion and disease prevention; and strengthen screening, diagnosis, and treatment of communicable diseases. It will be measured with the coverage of interventions and reduction of morbidity and mortality attributed to these diseases.

3.2.2.1 Prevention and control of HIV and viral hepatitis

Strategic Initiatives and Main Activities

Intensify and scale up HIV prevention interventions

- Strengthen advocacy activities on HIV/AIDS prevention and control
- Intensify and scale up HIV prevention interventions, targeting key and priority populations and high incidence geographic localities
- Strengthen HIV prevention and control mainstreaming and social enablers that includes gender -based violence prevention and mitigation, elimination of stigma and discrimination, and empowerment of communities to respond to the HIV program

Scale up and increase access to biomedical HIV prevention interventions

- Provide PrEP for individuals at substantial risk of contracting HIV (commercial sex workers and HIV negative partner of discordant couples)
- Provide voluntary medical male circumcision (VMMC) for eligible men
- Provide post-exposure prophylaxis for individuals at substantial risk of contracting HIV
- Provide harm reduction intervention for intravenous drug users
- Strengthen STI prevention and treatment services, including condom distribution

Scale up and strengthen implementation of HIV testing, care, and treatment

- Strengthen case finding through provision of high yield, targeted HIV testing, and self-testing services
- Strengthen follow-up and support mechanisms for implementing the Pediatrics HIV Program Acceleration Initiative (PHPAI)
- Strengthen linkage to treatment and provide ART to PLHIV
- Strengthen retention to treatment and adherence support
- Enhance provision of TB preventive therapy for eligible PLHIV
- Strengthen viral load testing service for eligible ART clients
- Strengthen HIV service integration with TB, NCD, mental health, and SRH

Improve the screening of HIV, syphilis, and HBV infections during pregnancy, delivery and lactation

- Strengthen universal and early HIV, syphilis, and HBV testing for pregnant, laboring, and breastfeeding women and sexual partners
- Implement HIV and syphilis testing (dual testing) and other new testing innovations
- Strengthen provision of HIV self-testing in case of opt out for HIV testing

Enhance the treatment uptake of HIV, syphilis, and HBV infections for pregnant and lactating women

- Strengthen provision of treatment and or prophylaxis to eligible women and their partner
- Instituting adherence and the lost to follow up tracing mechanism through mother support groups
- Expand point of care viral load testing for pregnant and lactating women on ART
- Strengthen PMTCT cohort monitoring and analysis

Intensify early infant diagnosis (EID), prophylaxis, and treatment uptake for HIV exposed infants

- Strengthen the provision of enhanced postnatal prophylaxis and cotrimoxazole for HEIs
- Strengthen the provision of early infant diagnosis (EID) and initiated ART
- Expand point of care testing for HIV exposed infants

Strengthen care and support for PLHIV and orphan children

- Strengthen care and support to PLHIVs in need
- Establish mechanisms to care and support AIDS orphans in need

Strengthen leadership and coordination of HIV programs

- Strengthen HIV program leadership capacity building endeavors
- Strengthen M&E and data quality for HIV and hepatitis prevention and control programs
- Revitalize the governance structure/AIDS Council of the HIV response at federal and regional levels

Enhance partnership and inter-sectoral collaboration with stakeholders

- Capacity building for federal and regional parliamentarians on HIV prevention
- Capacity building on HIV mainstreaming for sector offices
- Enhance engagement of civic society organizations in the HIV program
- Introducing community-led monitoring
- Implement the domestic resource mobilization strategy

Strengthen viral hepatitis prevention, testing, and treatment services to improve service accessibility

- Strengthen and scale up HBV and HCV testing services
- Strengthen and scale up treatment for eligible hepatitis b and hepatitis c patients

3.2.2.2 Prevention and control of tuberculosis, and leprosy

This program focuses on the prevention, screening, diagnosis, and treatment of TB, leprosy, and other lung diseases. Thus, strategic initiatives and main activities that enable the prevention and control of these are described as follows.

Strategic Initiatives and Main Activities

Strengthen comprehensive community-based TB prevention and care strategies

- Enhance implementation of community-based TB care activities
- Strengthen TB prevention and control activities in major urban areas, emerging mega-cities and development corridors
- Strengthen TB prevention, screening, and care strategies among key affected populations (KAPs)
- Identify and intervene TB burden pastoralist areas and developing regions
- Initiate national TB pre-elimination strategies in areas with declining burden and higher rates of extra-pulmonary TB

Strengthen health facility-based TB prevention and control

- Strengthen TB screening and testing in all service outlets
- Optimize TB and airborne infection prevention at health facilities
- Strengthen quality of TB/DR-TB care and transform patient referral management system
- Strengthen TB, DR-TB, and leprosy patient support systems
- Enhance diagnostic capacity of health facilities
- Strengthen childhood and adolescent TB prevention and control interventions

Strengthen TB diagnostics and lab system transformation

- Expand the use of chest x-rays and other highly sensitive tools for TB diagnosis
- Expand highly sensitive rapid molecular diagnostics for TB with universal on-site testing coverage
- Differentiate/implement courier services for efficient sample referral
- Transform the TB lab information system through a rollout of DHIS2-based TB laboratory tracker system and connectivity solutions for real-time monitoring
- Support the implementation of the revised policies on universal DST
- Strengthen childhood TB diagnostic capacity improvement
- Enhance DR TB and extra-pulmonary TB diagnostic capacity improvement

Strengthen national response to TB transmission hot-spot areas

- Strengthen national mapping of TB transmission hot-spot areas
- Implement simultaneous package of national response strategies in TB transmission hot-spot areas
- Enhance active community-based TB case finding strategies (ACT)
- Enhance universal coverage and access to same-day molecular rapid diagnostics (mWRDs)

- Strengthen TB preventive treatment (TPT) universal coverage and TB IPC strategies in affected hot-spot areas
- Institute an active surveillance and rapid response system in affected hot-spot areas
- Sustain high treatment success rate (TSR) and cure rates in TB transmission hot-spot areas

Initiate national drug resistant TB Elimination Program

- Introduce National DR-TB affected households and close contacts mapping and testing programs
- Introduce DR-TB Preventive Therapy initiation for DR-TB household and close contacts
- Implement active surveillance and a response system for DR-TB and community/household DR-TB outbreaks investigation and response
- Implement universal DST implementation strategy
- Rollout shorter, safer, and efficacious DR-TB regimens (BPaLM, and others)
- Initiate community-based DR-TB care services

Strengthen public-private Mix TB (PPM_TB) services at all levels

- Differentiated/strengthen PPM-TB care models scale up
- Develop national framework to engage private pharmacies and drug vendors through PPM
- Review sample-referral network to meet the needs of PPM-TB sites and introduce a new model of private-to-private sample referral for TB/DR-TB detection (private hospitals-to-private referral labs)
- Expansion of mWRDs for TB at PPM-TB sites/labs
- Develop a comprehensive incentive framework for PPM; non–financial incentives (awards/ accreditation)

Strengthen TB/HIV and other comorbidities collaborative activities

- Implement bi-directional screening and integrated management of TB and priority co-morbidities
- Strengthen integrated TB/HIV services delivery including ART services at TB/DR-TB clinics during TB treatment in non-ART sites
- Strengthen TB-NCDs screening and management through joint programming and capacity building of HCWs/HFs

Address TB in cross-border areas

- Develop a regional response plan/framework for TB in cross-border areas and strengthen the collaboration among the NTPs
- Focus on building the health systems in cross-border areas
- Harmonize guidelines and inter-country referrals
- Joint monitoring of the TB response in cross-border areas

Accelerate the implementation of TB prevention interventions

- Introduce and scale up TB infection testing services
- Expand implementation of TB Preventive Therapy for all eligible high-risk groups
- Conduct targeted mass TPT administration in selected areas
- Implement workplace TB infection prevention policies

Address TBLLD in humanitarian emergencies

- Develop and implement national framework, SOPs, and protocols to guide TBLLD response planning and implementation in complex humanitarian emergencies
- Provide capacity building to TBLLD program staff and HCWs in TBLLD services delivery during emergencies and post-emergency restorations

Strengthen the prevention and management of priority other lung disease (post-TB lung diseases, COVID-19 lung diseases, occupational lung diseases)

- Introduce Post TB Lung Disease Response
- Initiate occupational and environmental lung diseases response
- Strengthen post COVID-19 and other emerging pandemics lung diseases response
- Introduce asthma and COPD prevention and care- collaborative actions with NCD Desk and NCD partners

Implement leprosy elimination and post-elimination strategies

- Strengthen national mapping and determination of leprosy burden at sub-national level
- Strengthen community-based leprosy elimination active case finding strategies including sustained campaigns
- Conduct active surveillance and response – immediately notifiable disease with rapid response
- Expand engagement of CSOs and leprosy affected communities in case finding
- Enhance skill-based capacity development of health workforce -referral care centers based training programs expansion
- Implement leprosy clinical care mentorship programs
- Strengthen leprosy prevention through chemoprophylaxis (single-dose rifampicin or single-dose rifapentine)

3.2.2.3 Prevention and Control of Malaria

The prevention and elimination interventions in this program include interventions that address vulnerable populations, human rights, and gender-related barriers, as well as inequalities and vulnerabilities in accessing antimalarial services. Other vector borne diseases prevention and control strategies also included in the plan.

Strategic initiatives and Main activities

Enhancing community engagement, empowerment, and mobilization

- Implement advocacy and social mobilization activities on malaria prevention and control
- Strengthen the capacity of school communities to plan, coordinate, manage, implement, and evaluate malaria SBCC activities in schools and communities

Accelerate implementation of malaria elimination strategies

- Strengthen malaria surveillance and response system as a core intervention
- Strengthen surveillance, monitoring, and evaluation activities
- Conduct cases and foci investigation, classification, and response
- Assess risk of reintroduction and mitigate receptivity and vulnerability of areas

Strengthen early diagnosis and prompt treatment

- Improve access to appropriate and quality malaria parasitological diagnosis to all suspected malaria cases
- Sustain universal coverage of effective and efficacious treatment as per the national guidelines
- Improve a quality assurance system for malaria microscopy and RDTs

Strengthen malaria and arboviral disease vector control interventions

- Maintain universal coverage of ITNs among at-risk and targeted populations
- Implement digital tools for monitoring and tracking distribution of nets at lower/household level
- Deploy quality IRS in selected districts/villages where epidemiological and operational suitability ascertained and as per the national targeting criteria
- Implement targeted LSM (larval source management) where appropriate

Ensure human rights, gender equality, and special population groups in accessing malaria services

- Develop and implement a strategy to improve access to malaria prevention, diagnosis, and treatment services for refugees, IDPs, pastoralists, mobile, and migrant workers
- Introduce long-acting anti-malaria drugs to prevent transmission of malaria among seasonal migrant workers
- Strengthen engagement of all stakeholders, including CSOs and private sectors

Strengthen malaria program management, operational research, and M&E activities

- Monitor efficacy of antimalarial drugs and susceptibility of insecticides and assess dynamics and behavior of vectors through the established sentinel sites

- Evaluate new diagnostics, drugs, vector control tools, insecticides, and larvicides; and generate strategic information to update malaria epidemiological and entomological profile and facilitate appropriate decision-making
- Conduct health facility surveys to measure malaria test rate, and uncomplicated and severe malaria treatment according to the guidelines
- Promote the effectiveness, efficiency, and accountability of malaria elimination program at all levels by strengthening collaboration with all stakeholders (regions, partners, and other sectors)
- Improve the capacity of health workers to provide quality malaria case management, and planning, implementation, monitoring, and reporting of vector control activities

3.2.2.4 Prevention and Control of Neglected Tropical Diseases

The NTD program focuses on the implementation of appropriate interventions to prevent, control and eliminate many NTDs in Ethiopia that includes schistosomiasis, soil-transmitted helminthiasis, onchocerciasis, podoconiosis, lymphatic filariasis, leishmaniasis, trachoma, scabies, dengue/ chikungunya, and rabies.

Priority areas that require urgent attention include service integration, multi-sectoral approaches, and interventions like preventive chemotherapy treatment campaigns (mass drug administration) and intensive case management. Key interventions include WASH, prevention and control of zoonotic diseases, and vector ecology management.

Strategic Initiatives and Main Activities

Strengthen prevention, control, and elimination of trachoma

- Strengthen SAFE surgery to treat the advanced, blinding stage of the disease (trichiasis), antibiotics to treat active infections, facial cleanliness, and environmental improvements
- Strengthen TT surgery service provision, identify, and manage trachomatous trichiasis cases
- Strengthen surveillance systems for trachoma and provide TT corrective surgery services
- Initiate minimum packages of F and E activities in trachoma persistent, recrudescent, and slow progressing woredas

Eliminate guinea worm disease

- Improve access to safe water and treat unsafe water sources (Abating)
- Strengthen human and animal guinea worm disease surveillance and case containment
- Conduct awareness creation and social behavioral change

Strengthening the prevention and control of soil transmitted helminthiasis and schistosomiasis

- Conduct soil transmitted helminthiasis and schistosomiasis re-assessment mapping
- Strengthen MDA and conduct post-MDA validation of treatment

Prevention and control of leishmaniasis

- Strengthening the leishmaniasis disease surveillance and treatment
- Expand diagnosis and treatment facilities for leishmaniasis

Strengthen onchocerciasis elimination

- Strengthen onchocerciasis MDA and conduct impact/Stop/PTS/PES surveys
- Strengthen and expand molecular laboratories for epidemiological and entomological laboratory analysis

Enhance the prevention, control, and elimination of lymphatic filariasis, podoconiosis and scabies

- Strengthen MDA and conduct 63 Pre -TAS/TAS1/TAS2/TAS3 surveys for LF
- Provide MMDP services for LF/Podo
- Strengthen surveillance and case management of scabies disease

Enhancing multi-sectoral collaboration on WASH-NTD coordination activities

- Facilitate advocacy and collaboration with WASH sector to improve access to safe water supplies, sanitation, and basic hygiene services
- Strengthen multi-sectoral coordination and response with focus on WASH infrastructure and hygiene practices
- Initiate minimum packages of F&E activities in slow progressor persistence and recrudescent trachoma districts

3.2.2.5. Prevention and Control of Non-Communicable Diseases and Mental Health Services

The priority NCD prevention and control interventions are targeted to the reduction of risk factors for NCDs and the promotion of healthy lifestyles, resulting in the reduction premature mortality. Priority will be given to prevention of CVDs, diabetes, cervical cancer, and early detection and treatment of breast cancer, provision of cataract surgical services, screening for refractive error and correction with spectacles, treatment of childhood cancer, and implementation of high-priority multi-sectoral interventions. Mental health services are also among NCDs that is prioritized in this plan.

Non-Communicable Diseases

Strategic Initiatives and Main Activities

Facilitate and strengthen the development and enforcement of a strategic plan, guidelines, training manuals, legislations, and directives to address the rising burden of NCDs and their risk factors

- Establish a multi-sectoral coordination mechanism for prevention and control of NCDs and their risk factors
- Facilitate the development of proclamation and directives for regulation of unhealthy diet
- Develop and implement cancer control and eye health strategic plans

Intensify health promotion and awareness raising interventions on NCDs and risk factors

- Perform awareness raising activities on NCDs and risk factors
- Strengthen health extension program on NCDs and mental health programs
- Conduct advocacy and community mobilization activities on cervical cancer and other NCDs programs

Strengthen and expand implementation of cancer screening, diagnosis, treatment, and referral services

- Enhance demand creation activities for cervical cancer screening through massive community mobilization
- Expand implementation of services on screening, treatment, and referral of cervical cancer
- Strengthen quality assurance system for cancer care (both cervical and breast cancer)
- Strengthen cervical cancer screening service with ART service
- Strengthen and expand implementation of decentralized services for diagnosis and treatment of breast and other common cancers
- Expand childhood cancer care to health facilities
- Establish radiotherapy cancer care services in selected hospitals
- Expand institutional based cancer registry at three radiotherapy centers

Improve cataract surgery and eye health screening and treatment performance

- Expand and strengthen secondary eye care units with quality diagnosis and treatment
- Strengthen cataract surgery campaigns and outreaches
- Implement Integrated People-centered Eye Care (IPEC) by Integrating eye health screening and treatment (IPEC) within broader health care system and school health program
- Standardized and expand optical workshops within selected regions
- Expand and strengthen primary eye care units

Strengthen and expand prevention and control of CVD, diabetes and CRD diseases

- Expand and strengthen screening, diagnosis, and treatment of hypertension, risk-based management of CVDs and healthy lifestyle counseling
- Expand and strengthen implementation of services on screening, diagnosis, treatment, and referral of diabetes
- Expand and strengthen implementation of services on screening, diagnosis, treatment and referral of chronic respiratory diseases (asthma and COPD)

Mental Health

Strategic Initiatives and Main Activities

Intensify health promotion and raising community awareness on health service seeking behavior of mental, neurologic, and substance use (MNS) disorders.

- Conduct awareness creation activities on MNS disorders and their risk factors
- Strengthen the capacity of health extension workers on prevention and screening of MNS disorders
- Strengthen the health resource center (952-Hotline service) on MNS disorders
- Conduct advocacy and community mobilization activities against stigma on MNS patients
- Introduce promotion and preventive MNS health services in schools, work places, religious, and traditional treatment settings

Strengthen and Expand MNS health care services (screening, diagnosis, treatment, and referral services)

- Expand and strengthen screening, diagnosis, treatment, and referral of mental illnesses and neurological disorders, including child development and behavioral disorder interventions
- Integrate MNS health services with non-communicable (major NCD, eye health, cancer, and others) and communicable disease programs (TB/leprosy, HIV/ADS, maternal and child health)
- Develop nental, neurologic, and substance use disorder intervention guidelines and training manuals

Expand and strengthen prevention and rehabilitation interventions against substance use, suicide, and self-harm

- Intensify social mobilization and awareness creation activities for prevention of substance use, suicide, and self-harm
- Strengthen rehabilitation interventions of substance use disorder and integrate with mental health services
- Integrate suicide and self-harm interventions and referral services with mental health services
- Advocate for the replacement therapy for substance use disorders to be included in the essential drug lists

Ensure availability of mental health (MNS)services to vulnerable groups or special populations

- Conduct advocacy for the development of mental health services that ensure UHC for special populations
- Improve mental health psychosocial support or care in the existing supportive system of special populations (prisoners, homeless people, elders, people with chronic illness)
- Strengthen coordination with stakeholders and implementing partners working with special populations

Strengthen and ensure mental health psychosocial support services in humanitarian settings

- Enhance screening, early diagnosis, and intervention of MNS disorders in humanitarian settings
- Build the capacity of RHBs to provide mental health psychosocial support services for people in humanitarian settings
- Strengthen coordination with stakeholders and non-governmental organizations working on humanitarian responses
- Facilitate MNS disorder medications to be accessible in the humanitarian settings

Establish and strengthen disease registries, research, surveillance, and monitoring and evaluation on MNS and their risk factors

- Conduct research to strengthen expanded MNS services with data (research findings)
- Facilitate the nation-wide STEPS Survey to include selected MNS disorders
- Strengthen data recording, reporting, and use on mental health (MNS disorders)

3.2.3. Improve Community Ownership and Primary Health Care

This strategic objective will focus on ensuring the community's active engagement and ownership in the planning, execution, monitoring, and evaluation of health-related activities. It focuses on enabling communities to increase control over their lives through improving health literacy and decision-making power. Re-designing, testing, and implementing a package of alternative approaches tailored to address emerging challenges to existing community engagement strategies will be a key milestone to advance community engagement and ownership and accelerate progress towards UHC. Key programs to be implemented under this objective include health promotion, WASH and environmental health, Health Extension Program, and PHC. This strategic objective will be measured using the indicators of effective community engagement, and coverage of primary health services.

3.2.3.1 WASH and Environmental Health

This program focuses on addressing the environmental determinants of health and thereby promoting health, preventing diseases and other conditions, and improving the quality of health services. It encompasses implementation of multi-dimensional interventions to ensure adequate and safe sanitation; personal hygiene; water safety and quality; food hygiene and safety; indoor air quality; institutional WASH and IPC services, including HCFs; healthy living environment; occupational health and safety; and liquid and solid waste management. It also includes contributing to building a climate-resilient health system, chemical and hazardous waste management, and emergency WASH that all will require coordinated actions across sectors.

Strategic Initiatives and Main Activities

Enhance the progress towards ending open defecation practice

- Implement tailored social and behavior change communication strategies
- Strengthen the implementation of total sanitation to end open defecation and urination ('TSEDU')-Ethiopia Program

- Strengthen implementation of various approaches to realize ODF status

Improve access to quality and affordable sanitation and hygiene products and services

- Implement inclusive and contextually tailored WASH and EH technology options
- Establish woreda based market-based sanitation (MBS) centers
- Expand access to basic sanitation through strengthening sanitation financing schemes
- Implement SMART and TARGATED sanitation subsidy approach

Improve waste management and proper utilization of safely managed/basic sanitation services

- Increase demand for basic sanitation products and services
- Strengthen One Wash National Program woredas to strengthen construction and utilization of basic sanitation facilities
- Facilitate access to improved sanitation product and services in urban settings
- Enhance proper solid and liquid waste management
- Strengthen safe chemicals and hazardous waste management system

Ensure inclusive WASH facilities in institutions

- Implement WASH facility improvement tools (FIT) in Health Care Facilities (HCFs)
- Implement WASH in institutions other than health facilities

Strengthen sustainable personal and food hygiene and safety practices

- Strengthen equitable and sustainable access to basic hand hygiene products and practices
- Strengthen school feeding program
- Improve face and oral hygiene practices
- Improve access to safe and affordable Menstrual Hygiene Management (MHM) products
- Enforce the implementation of endorsed tax-free proclamation for MHH products
- Expand MHH program in schools and community

Improve drinking water quality and safety, and working environment

- Strengthen water source safety through strong monitoring and routine surveillance
- Conduct water quality monitoring through sampling and testing
- Promote and mobilize Household Water Treatment and Safe Storage (HHWTSS) Practices
- Improve the implementation of occupational health and safety

Strengthen system capacity to address the impacts of climate changes

- Increase the health system's resilience to climate change and reduce the system's role in climate change

- Introduce Health National Adaptation Plan (HNAP)
- Introduce Climate Resilience Health System (CRHS) & Health Care Facilities toolkit

3.2.3.2 Health Extension Program and Primary Health Care

This encompasses the utilization of the PHC service delivery platform, particularly the HEP, to accelerate progress towards UHC. The HEP, along with service delivery at health centers and health posts, continues to be an effective means for community engagement and providing a comprehensive package of PHC services to individuals, families, and communities. The implementation of the HEP optimization roadmap will address evolving community needs for quality health services and respond to emerging public health challenges. HEP enables the creation of model households, model kebeles, and high-functioning primary health care units and interventions will be contextualized to fit urban, agrarian, and pastoralist settings, while contributing to improving service quality at the PHCU level.

Strategic Initiatives and Main Activities

Redefine, standardize, and implement HEP service packages and restructure service delivery platforms

- Initiate comprehensive and basic health service provision based on the HP categorization
- Strengthen and expand mobile health team approach for pastoralist and semi-pastoralist settings
- Establish and expand HEP units in all health centers and primary hospitals
- Establish a clear framework of catchment support and supervision linkage within PHC unit

Strengthen woreda transformation coordination and monitoring mechanisms

- Identify interventions that required the involvement of other sectors, and create platforms of communication and monitoring system to ensure the execution of those interventions
- Implement woreda transformation performance monitoring system
- Revise and implement woreda management standards
- Implement contextualized Community Score Card for comprehensive health posts
- Implement collaborative mechanism through twinning partnerships between high and low performing woredas
- Accelerate creation of model kebeles and high-performing primary health care units
- Design and implement multi-sectoral coordination approaches at all levels

Enhance the capacity of health extension workers

- Introduce blended integrated refresher training (IRT) learning modality
- Strengthen the quality of pre-service training for HEWs in health science colleges

Strengthen and expand urban PHC reform

- Strengthen and expand family health team approach
- Equip FHT with adequate kit

Enhance the implementation of collaborative platforms

- Strengthen the Ethiopian Primary Health Care Alliance for Quality(EPAQ),
- Implement Good Governance Index (GGI),
- Build the capacity of lead health centers to strengthen catchment area mentorship

Enhance the implementation of primary health care strategic framework and facility-based reforms

- Introduce and implement the primary health care strategic framework (PHCSF)
- Strengthen Ethiopian Health Center Reform Implementation Guideline (EHCRIG)
- Design and implement quality Improvement (QI) projects and clinical communication skills at PHCU level
- Strengthen implementation of Ethiopian Primary Health care Clinical Guideline /EPHCG/

3.2.3.3 Strengthen Community Engagement and Ownership

Strategic Initiatives and Main Activities

Advance community engagement and ownership

- Strengthen the implementation of redesigned community engagement strategies at agrarian and pastoral settings
- Design and implement community engagement platforms for urban settings
- Enhance competency-based training for community engagement structures

Enhance the role of a community platform in improving the health system responsiveness to the community unity need

- Strengthening the implementation of community score card (CSC)
- Introduce contextualized CSC for comprehensive health posts
- Improve the engagement of community representatives in PHCU governance board

Strengthen school health program implementation

- Revise and implement the school health framework
- Revise and Implement school health service packages and implementation manual

3.2.4. Improve access to quality and equitable medical health services

This objective is addressed through the provision of comprehensive medical care services that are safe, effective, efficient, equitably accessible, and up to international standards of care. It requires designing and implementing a range of strategic interventions. The core programs or services under this objective are medical services, medical emergency and critical care services, laboratory and other diagnostic services, safe blood transfusion and tissue services, prevention and containment of anti-microbial resistance, health service quality, equity, and innovations.

Achieving this objective will improve the coverage of high-quality essential health service packages in pre-facility and facility-based settings.

3.2.4.1 Pre-Facility, Emergency, Trauma, and Critical Care Services

Strategic Initiatives and Main Activities

Expand and strengthen community first aid responses

- Strengthen community engagement and mobilization platforms
- Expand and strengthen community emergency squad at woreda level

Standardize and strengthen basic, advanced ambulance, and pre-hospital services

- Improve the availability of adequate, well-equipped basic and advanced ambulances
- Strengthen and expand mobile clinic services
- Expand ambulance dispatch centers and stations

Strengthen referral services across the continuum of care nationally and at local levels

- Conduct advocacy on pre facility, ambulance, and referral services
- Develop a comprehensive national health services map and real time referral systems

Strengthen the implementation of the major cities emergency, injury, and critical care (EICC) improvement program (MEICIP)

- Improve networks of major city hospitals with primary health care facilities
- Strengthen and expand web-based referral services at health facilities
- Establish overseas referral system

Upgrade facility based EICC service towards a standard

- Implementation basic emergency care course and toolkit at primary health care units
- Strengthen and expand ICUs including pediatric ICUs
- Strengthen and expand burn care services
- Establish trauma centers in selected trauma corridors
- Strengthening poisoning management service

3.2.4.2 Hospital and Diagnostic services

Strategic Initiatives and Main Activities

Improve and expand laboratory and diagnostic services

- Strengthen and establish diagnostic network optimization and digitization
- Establish Integrated Diagnostic Center with PPP arrangement
- Improve accessibility of essential diagnostic, specimen referral and back up service
- Improve and strengthen access and quality to pathology services
- Improve and strengthen Imaging services including nuclear medicine
- Introduce and expand auditable laboratory services

Strengthen and intensify the implementation of the hospital service reforms

- Improve implementation of Ethiopian Hospital Transformation Guidelines
- Intensify clinical auditing, HSTQ, and mentorship program
- Strengthen Teaching Hospital Improvement Program
- Strengthen the implementation of Hospital Alliance for Quality Assurance (EHAQ)

Expand and improve access to high-quality surgical and anesthesia care

- Strengthen PPP on specialty and subspecialty services including surgical care
- Strengthen implementation of saving lives through surgery initiative (SaLT)
- Strengthen interventions to reduce surgical backlog
- Strengthen specialty and subspecialty surgical services, including pediatric, obstetrics, and anesthesia units

Strengthen equitable access and quality of medical oxygen services

- Improve equitable national medical oxygen availability and production capacity
- Optimize standard and quality of medical oxygen production and delivery
- Improve rational use of medical oxygen

Improve nursing, midwifery, and geriatrics services

- Model major city hospitals on nursing and midwifery services
- Enhance partnership and resource mobilization for geriatrics services
- Mainstream the aging strategy at all levels

Strengthen national infection prevention control program

- Strengthen the multimodal approach for IPC
- Establish a strong healthcare associated infection (HAI) surveillance system at all levels.

3.2.4.3 Specialty and Rehabilitation Services

Strengthening specialty and subspecialty services per tire system

- Developing national guidelines and standards for the delivery of specialty and subspecialty services and ensure implementation
- Establishing accreditation systems for hospitals and healthcare facilities
- Establish specialized centers including diagnostic facilities by private investors and diaspora through Public-Private Partnership (PPP).
- Establish specialty and subspecialty service centers
- Establish a modern children's specialized hospital
- Improve access to quality essential specialty health services (mental health services, eye and skin, and children's neurosurgery treatment services)
- Establish research and development programs to advance the development of new specialty and subspecialty services

Strengthen the implementation of a medical tourism strategy

- Develop a national roadmap for medical tourism and promoting it to public and private health institutions
- Ensure that specialty and subspecialty services meet international standards to attract medical tourists seeking high-quality care
- Encourage private investors to participate in the medical tourism industry
- Promote medical tourism industry to relevant stakeholders

Strengthen and expand rehabilitation and palliative services

- Develop regulation that applies to rehabilitation and assistive technology and cascade to all necessary areas
- Enhance assistive technology for rehabilitative service
- Encourage local production, device assembly and maintenance
- Ensure sustainable AT supply chain and device management
- Introduce digital rehabilitation and use of new technology

Improve equitable access to quality comprehensive rehabilitation service

- Strengthen provision of physical rehabilitation, clubfoot and mental rehabilitation services
- Introduce sensory and communicative rehab services
- Introduce community-based rehabilitation and outreach services
- Ensure the availability of rehabilitation workforce
- Revitalize rehabilitation services information system

3.2.4.4 Blood and Tissue Services

Strategic Initiatives and Main Activities

Strengthen blood donation, proper use, and quality assurance services

- Strengthen advocacy on voluntary non-remunerated blood donation
- Strengthen quality-assured testing for transfusion-transmissible infections, blood grouping, compatibility testing, and component production and transport of blood
- Promote safe and appropriate use of blood and blood products at the clinical interface and strengthening hemo-vigilance program
- Introduce newer blood transfusion technologies and products

Strengthen tissue and stem cell transplant services

- Establish and strengthen tissue and stem cell transplant services
- Enhance the capacity of eye banking, cornea transplant services, organ transplantation, and central registry system
- Ensuring quality and safety of cornea products

3.2.5. Enhance public health emergency and disaster risk management, and post conflict recovery and rehabilitation

Description:

This strategic objective focuses on public health emergency and disaster management, which includes effective and timely anticipation, prevention, early detection, rapid response, control, recovery, and mitigation of any public health emergency crisis with direct or indirect impacts on the health, social, economic, and political well-being of communities and society. The range of public health threats experienced by countries worldwide is broad and highly diverse and includes infectious disease outbreaks, food and water contamination, chemical and radiation contamination, natural and technological hazards, war and other societal conflicts, and the health consequences of climate change.

The health sector requires solid capacity and strong coordination with other sectors to implement a spectrum of public health emergency risk management measures at the community, regional, national, and international levels.

The HSDIP period will focus on strengthening the capacity for preparedness, detection, prevention, response, and recovery to all public health emergencies and disasters supported by a robust and resilient laboratory system. An integrated approach to public health emergency management and clinical emergency care reduces the impact of public health emergencies. It also focuses on restoration of health services in the conflict affected areas and deals with recovery and rehabilitation.

3.2.5.1 Public health emergency and disaster risk management

Strategic Initiatives and Main activities

Strengthen leadership and governance (LMG) of PHEM

- Develop and implement public health emergency and disaster management strategy
- Revise the PHEM legal framework to empower PHEM officers in enforcing public health recommendations and reduce political interference
- Align, revise, and capacitate the governance structure of the national and sub-national PHEM
- Design a tailored PHEM system for predominantly pastoralist regions
- Provide PHEM leadership and IMS trainings to national and sub-national PHEM staffs and other relevant management from the health system
- Facilitate health sector and public health emergency multi-sectoral coordination and partnership
- Ensure the integration of PHEM in PHC

Strengthen human capacity and resources for public health emergency and disaster management

- Design a health emergency workforce/volunteer management program that includes training, recruitment/mobilization, roster, tracking, retention, protection, deployment, and compensation strategy/framework
- Improve the capacity to forecast, detection, prepared and respond to public health emergencies
- Mobilize the resources required to adequately fund emergency preparedness, emergency response operations, and recovery
- Conduct regular risk assessment, profiling (hazard, vulnerability, and capacity analysis), risk communication, and early warning system
- Ensure the availability of adequate and trained surge capacity for PHE response at all levels
- Strengthen implementation strategies to eliminate/eradicate for targeted diseases and health events
- Ensure continuity of essential health service during disasters
- Strengthen the capacities required to create a resilient health system to promptly respond, recovered and rehabilitate in the context of health emergencies
- Integrate PHEM into Higher Education Institutes curricula
- Establish and expand online PHEM training platform

Strengthen risk financing for PHEM

- Expedite the REF program to institute a domestic financing mechanism for PHEM
- Develop contingency funding by allocating a proportion of the national, regional, zonal, and woreda level health sector budgets to finance emergency preparedness and response
- Create a pool funding mechanism for PHEM similar to the SDG pool funding
- Develop an emergency trust fund where the community and the private sector (CSR) could contribute to finance emergency preparedness, response, and recovery including health emergency relief support
- Create a legal framework for emergency donations, funding allocation, access to the domestic financing platforms, and monitoring of utilization
- Adopt health financing by local philanthropies to improve recovery and reconstruction
- Facilitate financing (PPP, loan) of the private sector based on clearly identified gaps for priority PHE preparedness and response

Improve service deliveries during public health emergency and disasters

- Ensure availability and functionality of adequate isolation, quarantine, and treatment centers
- Conduct simulation exercises on facility readiness and makeshift center establishment based on VRAM
- Establish mass casualty management centers at region level

Strengthen logistics supply chain management

- Engage local and international private investors to produce emergency commodities
- Establish national and regional emergency LSCM institutes
- Develop emergency procurement and custom clearance framework for priority commodities during emergency preparedness and response
- Develop a strategy for emergency supply chain workforce development
- Conduct regular resource mapping exercise for emergency commodities

Strengthen and sustain the international health regulation capacity

- Implement and monitor multi-sectoral National Action Plan for Health Security
- Facilitate adequate regulatory measures in place at point of entries to prevent importation of communicable diseases

Strengthen PHEM information system and enhance informed decision-making

- Comprehensive digitalization of the PHEM system at all levels including multi-sectoral databases
- Map and integrate local risk communication for community engagement (RCCE) platforms, such as the Dagu system under the national and sub-national PHEM systems

3.2.5.2 Laboratory Services

Strategic Initiatives and Main Activities

Enhance building sustainable and resilient laboratory system for high-quality laboratory services

- Increase the laboratory scale formulation of scientifically validated traditional medicines and transfer the technology package
- Provide support to laboratories on the burden of disease-related issues
- Strengthen laboratory-based surveillance system
- Strengthen the implementation of laboratory quality management system for accreditation
- Strengthen the implementation of Laboratory Information Management System (LIMS)
- Strengthen national capacity for the evaluation and validation of laboratory technology methods and reagents

Enhance the standardization and expansion of laboratory services

- Standardize and harmonize laboratory testing services
- Introduce new laboratory methods and technologies
- Expand and strengthen laboratory testing capacities
- Strengthen national laboratory networks and specimen referral linkages
- Establish national genomics and bioinformatics center

Strengthen laboratory equipment management system

- Establish a system for laboratory equipment acquisition, inspection, installation, commissioning, decommissioning, and disposal
- Establish laboratory equipment calibration center
- Establish national laboratory equipment innovation/ refurbishment center

Enhance the Implementation of External Quality Assessment (EQA) Schemes

- Establish a national proficiency testing/EQA production center
- Establish and implement national electronic Proficiency Testing (ePT) data management program
- Establish Biobank centers
- Establish Quality Control and Reference material production center

3.2.5.3 Post-Conflict Recovery and Rehabilitation

Strategic Initiatives and Main activities

Strengthen leadership and governance of recovery and rehabilitation activities

- Establish emergency recovery coordination bodies at all levels
- Strengthen partnership and coordination platforms with different stakeholders
- Map partners working in the health, nutrition, and WASH clusters
- Organize capacity building training in leadership and management during crisis for SMT from hospital, ZHD, and woreda health offices
- Monitor and support the implementation of health emergency recovery plan by conducting forums with hospital board, zonal health department, and key actors in the implementation and key stakeholders

Restoration of service deliveries

- Re-initiate and strengthen reproductive maternal, neonatal, child adolescent and nutrition service in all health facilities
- Strengthen disease prevention and control programs
- Re-initiate and strengthen medical services provision
- Strengthen public health emergency management
- Ensure the availability of water, hygiene and sanitation health services
- Revitalize routine health information system

Strengthen rehabilitation of health infrastructures

- Devise a strategy for renovation of damaged infrastructure in the conflict-affected areas
- Renovate health facilities with physical damage
- Ensure the functionalities of water, electricity, and other sanitation facilities in the health institutions in close coordination with relevant stakeholders

Improve health workforce in the conflict-affected areas

- Identify human resource needs based on the inventory findings
- Mobilize additional critical health workforce to support the health service delivery at hospital level
- Organize capacity building training in leadership and management during crisis
- Provide mental health and psychosocial support (MHPSS) for HCWs in the war affected regions/zones/woredas

Strengthen the supply and replacement of pharmaceuticals and medical devices

- Identify unavailable drugs, medical supplies, and equipment and mobilize from different stakeholders and diaspora community
- Ensure the availability of RDF drugs, vaccine, and program drugs at hub level
- Prioritize and distribute medical supplies and equipment to initiate service in non-functional health facilities

Strengthen health financing and resource mobilization

- Support health facilities to reactivate their health care financing
- Provide capacity building on financial management during crisis
- Devise a mechanism to support communities in affected area to pay their CBHI premium
- Devise different strategies to mobilize resource from donors, philanthropies, and diaspora community

3.2.6. Improve Health System Capacity and Regulation

Description:

This strategic objective focuses on strengthening the capacity of the health system in delivering quality and equitable health services through building high-performing health system leadership, creating a competent and compassionate workforce, ensuring a robust infrastructure and regulatory capabilities.

It will be measured using key indicators that determine the changes in the capacity of leadership and governance, social accountability, availability of basic infrastructure and adequate workforce, adherence of health and health-related institutions to the standards and safety of food products and medicine.

3.2.6.1. Governance and leadership

This program works towards ensuring an accountable, transparent leadership and governance system for effective implementation of the strategies. It focuses on enhancing decentralization and local ownership as a means of creating a resilient health system. It addresses public accountability on resource management and optimal health service provision, while also designing and implementing sound regulation mechanisms, building effective teams, and institutionalizing appropriate implementation mechanisms and platforms.

Strategic initiatives and Main Activities

Design and implement high-impact health system leadership for program Improvement

- Harmonize and standardize national health leadership improvement programs
- Implement high-impact health system leadership competencies
- Establish and implement high-impact health system leadership program performance monitoring, evaluation, and learning mechanisms
- Mainstream gender in all health programs and operations, and empower women by ensuring their representation at all levels including leadership positions

- Strengthen partnership and coordination among various key stakeholders
- Strengthen monitoring and evaluation mechanisms of leadership development programs at the country and regional levels

Strengthen leadership capacity for senior, mid-level and operational/frontline leaders.

- Establish leadership incubation academy
- Build succession leadership capacities through introducing coach-based and innovative leadership incubation programs
- Strengthen clinical leadership improvement program
- Promote merit-based assignment of health facility leaders alongside gender equity
- Provide capacity building support for facility governing boards on LMG

Design and implement social accountability strategies

- Enhance good governance index and managerial accountability mechanisms
- Consolidate and scale up community scorecard (CSC) and managerial accountability
- Institutionalize grievance handling and monitoring mechanisms
- Design and implement transparent and equitable resource allocation mechanism
- Strengthen the implementation of civil service and health sector reform and change packages

Design and strengthen the implementation of legal frameworks, strategies, and guiding principles

- Design and implement legal frameworks (policy, proclamation, regulations, directives, and guidelines)
- Revitalize harmonization and alignment for health (one plan, one budget, and one report principles)
- Establish an accountability framework – all stakeholders from federal to community level

Strengthen multi-sectoral collaboration and integration of health and health-related interventions

- Advocate and ensure the inclusion of health and health-related issues in all relevant sectoral policies and regulation
- Expand the implementation of Multi-sectoral Woreda Transformation interventions to bring about four Ls (livelihood, lifestyle, literacy and longevity)
- Identify and expand lessons learnt/best practices from existing multi-sectoral initiatives
- Endorse the health in all policy (HIAP) strategy document and develop an implementation plan
- Develop and implement multi-sectoral data capture, reporting, and information use mechanisms

Strengthen partnership and coordination among various key stakeholders through the implementation of One Plan, One Budget, and One Report Principles

- Enhance sector's capacity for strategic and operational planning at all levels
- Enhance the engagement of the private sector and other stakeholder in the sector's strategic and operational planning and budgeting process at all levels
- Increase sector's capacity to improve ownership and quality of health sector woreda-based plan
- Ensure implementation of resource planning practice and one plan, one budget and one report principle system
- Ensure the alignment of program and health service strategies with the sector-wide strategies and policy, taking the crisis and social unrest into account

Strengthen regulatory structure and capacity

- Consolidate and establish independent regulatory body
- Expedite endorsement of HP Council Proclamation
- Standardize regulatory structures at regional, zonal, and woreda levels and capacity building

3.2.6.2. Health Workforce

This program focuses on human resources planning, development, and management (training, capacity building, recruitment, deployment, distribution, performance management, and motivation) to ensure the presence of a motivated, competent, and compassionate health workforce that is adequately staffed and possesses a mix of skills. It works on strengthening the quality of health science practical education, Continuous Professional Development (CPD) System, evidence-based human resource planning, monitoring and evaluation system, health workforce motivation and retention, and human resource distribution and management system**.**

Strategic Initiatives and Main Activities

Strengthen evidence use for demand-driven health workforce forecasting, planning, and development

- Facilitate the implementation of National Health Workforce Accounts (NHWAs)
- Facilitate HRH evidence generation and data use for decision-making
- Provide support on HRH planning, forecasting, and projection to RHBs
- Support the use of student profile data and research evidence to improve PSE quality
- Strengthen staffing of all health facilities to meet the standards
- Revise organizational and career structures in the health system and HRH standards for health facilities

Strengthen the access to and quality of health science education and training comprising pre- and in-service training

- Introduce health system oriented health science and medical education
- Expand specialties and sub-specialties programs to develop teams of health workers
- Facilitate the digital learning technologies for health professional education
- Support the reformation, appraisal, and implementation of competency-based curricula appropriate to the current health needs of the population
- Support Health Science Education Development Centers in all public and private higher education institutions
- Introduce national and international networking and collaboration among the pre-service education institutions
- Promote the increment of the number of schools programs and positions in medically underserved areas and potentially reducing the number of positions in communities where there are unemployed health workers
- Undertake HRH competency assessments and ratings to incentivize training institutions shift towards it

Ensure the availability of selected priority cadres including specialty and sub-specialty professional categories

- Ensure the equitable distribution and availability of a health workforce in health facilities with adequate numbers and appropriate professional and gender mix
- Facilitate an increase in the number of prosthetic, orthotic, speech therapy, surgical workforce, haemato-oncology, transplant surgeons, cardiac specialists
- Initiate passion-based student selection on medicine, nursing, midwifery, anesthesia, health officer, and medical laboratory
- Promote opportunities for local enrollment of students and deployment to address health professional distribution disparities of medicine, midwife, anesthesia, pharmacy, and radiography disciplines
- Coordinate to increase the proportion of women health workers in the field of medicine, medical specialty, and sub-specialty in the active health workforce

Strengthen health workforce motivation mechanism and ensure accountability

- Re-design and implement a transparent performance-based recognition system
- Facilitate the implementation of occupational health and safety preventive measures to enhance and promote the safety and protection of HWF
- Promote innovative non-financial motivation and incentive package
- Implement pilot delinking of remuneration at selected hospitals
- Implement career development opportunities and accommodate self-career developments
- Enhance the implementation of accountability framework

Improve the absorption of health professionals into the health sector

- Expand matching fund experience to enhance employments of critical health cadres
- Introduce medical plaza and office practice models
- Redesign evidence-based staffing norm standards
- Introduce overseas employment opportunities
- Customize and implement human resources for global health and care workers compact
- Contextualize and implement major HRH priorities stipulated in Working for Health 2022-2030 Action Plan
- Advocate and implement HRH national Investment charter to ensure job creation and employment
- Facilitate the identification and implementation of civil service reforms and structural improvement
- Strengthen private-public partnership on human resource development and practice of health workers

Ensure access and regulation of continuing professional development system

- Coordinate to increase the number of accreditors and providers
- Expand online and face-to-face trainings for health professionals
- Support CPD governance up to the lower level of implementation
- Create a platform for partnership and networking on CPD with national and global stakeholders
- Facilitate the integration of CPD with license renewal
- Integrate service provision with license renewal requirements
- Develop guideline to Integrate academic and health services
- Regulate the accreditation of health professional schools and the licensure of health workers
- Incentivize stakeholders to emphasize CPD as their own agenda (e.g., region-specific CPD priorities)

3.2.6.3. Health Infrastructure

This program aims to improve access and quality of essential health service packages to the community through the standardization, construction, expansion, and renovation of health and health-related facilities. It also includes equipping, furnishing, providing utilities (water, electricity, sanitation facilities), and ICT infrastructure, and enforcing construction quality standards.

Strategic Initiatives and Main Activities

Enhance the standardization of health facilities design that suits essential health service packages

- Design standard oncology, cardiac, ENT, cardiac specialty centers, health insurance office and mental health center for HC, PH, and GH
- Design standard waste management (solid and liquid) system for HC, PH, GH, and tertiary hospitals
- Modify the design of health centers, primary hospitals, general hospitals, and federal hospitals
- Develop and integrate standardized ICT infrastructure in all levels of health infrastructure
- Finalize the PHC infrastructure roadmap supported with geospatial mapping, and facilitate and monitor its implementation

Strengthen health infrastructure construction and its management

- Construct health institutions, including health research and laboratory centers, trauma centers, dermatology and plastic surgery, compressive emergency hospitals, diagnostic centers, rehabilitation centers (neuron and mental health), ENT specialty centers, cardiac hospitals, food and drug management excellence center, health centers, staff residences, and renovate pharmaceutical supply management system
- Upgrade and/or construct health posts to basic or comprehensive level for provision of comprehensive PHC services
- Coordinate community engagement in health infrastructure construction
- Build local capacity to construct, maintain, and renovate health facilities per infrastructure design standards

Enhances the expansion, maintenance, and renovation of health institutions

- Renovate and restore general hospitals used as COVID-19 treatment centers
- Restore health facilities in conflict-affected regions
- Renovate hospitals to be a one-stop shop for services

Strengthen the construction and maintenance of laboratories at health facilities

- Begin construction of national reference laboratory with BSL 3 containment
- Commence construction of BSL-2 RRL regional laboratories
- Start construction and installation of EQA PT panel production, bio-bank, central warehouse, and lab equipment maintenance complex
- Renovate and upgrade sub-national regional laboratory equipment maintenance workshop center

Improve the availability and functionality of basic amenities in health facilities

- Ensure the availability of safe water and electricity (PV Solar Power supply) to health facilities
- Support and facilitate environmental and social audits for federal tertiary hospitals
- Enhance health infrastructure database knowledge hub

3.2.6.4. Health Information and Research

This program aims to improve evidence generation and its use from numerous sources, including the census, civil registration, and vital statistics, as well as surveys, surveillance, routine information systems, research studies, and monitoring and evaluation systems. It also focuses on continuously improving the availability and quality of data, building capacity in core competencies of data use, bridging the gap between data users and data producers, strengthening organizational data demand and use platforms, documenting and communicating data demand and use successes, and enhancing data access and sharing, security, and warehousing.

The program further prioritizes national research agendas, setting standards, and maintaining health research quality. It also includes development and implementation of digital database systems for repositories of research outputs. Health innovation identifies new or improved health policies, systems, products, and technologies, and services and delivery methods that improve people's health and wellbeing.

Strategic Initiatives and Main Activities

Strengthen health information system governance

- Ensure functionality of the HIS governance structures
- Enhance implementation of HIS-related policies, legal frameworks, and directives
- Ensure gender mainstreaming in HIS

Strengthen capacity in routine health management information system and data quality practices

- Improve availability of adequate infrastructure, equipment, and recording and reporting tools
- Mainstream HIS training in all health professional training curricula
- Enhance capacity of health workforce on HIS
- Support the implementation of HMIS in private and other health facilities
- Facilitate the improvement of HIS infrastructure and logistics
- Strengthen the CHIS
- Enhance the implementation of birth and death notifications at facility level
- Support the implementation of community birth and death notification system
- Improve data quality assurance practices at all levels

Enhance data analytics and evidence-based decision-making

- Build a national health data warehouse that serves as a centralized repository for all the healthcare information that is retrieved from multiple sources
- Build local capacity in advanced data analytics, including machine learning, data mining, and artificial intelligence
- Implement a data analytics platform at national and regional levels
- Conduct advanced analytics, modeling, and forecasting in selected priority health areas by consolidating and triangulating data from multiple sources
- Ensure functionality of Performance Monitoring Teams (PMT) at all levels
- Enhance data access, sharing, and information use products

Strengthen surveillance, surveys, and research

- Establish and strengthen Research Council
- Enhance health research evidence generation for evidence-based decisions.
- Enhance biomedical, health biotechnology research to develop and test diagnostics, therapeutics, and use of biotechnology products
- Enhance and scale up national digital repository (database system) for research outputs
- Cultivate health policy culture and implement evidence to policy translation mechanisms
- Support the development and implementation of national health research roadmap development and national health research agenda setting
- Enhance health research quality standards and monitor implementation
- Embed research in health programs, with close involvement between research, policy makers, and program implementers
- Conduct community and health facility-based surveys to inform decision-making, including regular service availability and readiness assessment (SARA)

Strengthen the strategies for the creation of HIS model health institutions (administrative health units and health facilities)

- Support and scale up the implementation of Capacity Building and Mentorship Program (CBMP)
- Strengthen the implementation of IR Model Woreda Strategy
- Support establishment of Centers of Excellences in HIS

Strengthen evidence-based decision-making

- Build a national health data warehouse that serves as a centralized repository for all healthcare information that is retrieved from multiple sources
- Build local capacity in advanced data analytics, including machine learning, data mining, and artificial intelligence

- Implement a data analytics platform at national and regional levels
- Strengthen functionality of Performance Monitoring Teams (PMT) at all levels
- Enhance data access, sharing, and information use products
- Establish and enhance knowledge management system
- Improve capacity of HIS health workforce on advanced data analytics and modeling techniques
- Enhance data access and sharing practices
- Expand and improve documentation of HIS best practices, success stories, and lessons learnt

3.2.6.5. Digital Health

Digital health technologies provide concrete opportunities to tackle health system challenges, and thereby offer the potential to enhance the coverage and quality of health practices and services. The range of uses for digital technologies in supporting health systems is vast, and these technologies continue to evolve. Digital health technologies and interventions need to link to the broader digital health architecture. Thus, this program addresses the process of inception evaluation, selection, development, and implementation of new or improved products, services, or solutions to improve health outcomes.

Strategic initiatives and Main Activities

Strengthen the governance of digital health

- Develop and implement standards, guidelines, and a quality assurance framework for digital health solutions
- Strengthen the implementation of the Digital Health Governance and Framework
- Conduct maturity assessment for continuous improvement of digital health systems
- Enhance digital health literacy for successful uptake and implementation of digital health interventions
- Implement digitized knowledge management
- Strengthen digital health infrastructure and services /ICT infrastructure including computers, LAN, and connectivity
- Enhance resource mobilization for digital health activities
- Promote adoption and use of emerging healthcare technologies

Enhance the deployment of the national eHealth architecture and interoperability framework

- Build foundational shared services – leveraging the national ID program for MPI and implementing national health shared records
- Build and deploy systems that promote remote data access, findability, use and reuse, and interoperability
- Transition from electronic health information system to digital health era, improving health outcomes

- Implement interoperability of digital health systems based on priority public health use cases
- Harmonize different strategies and roadmaps to the national architecture

Deploy community and institution-based digital health solutions

- Enhance implementation of DHIS2 in public, private, and other facilities
- Expand and strengthen implementation of eCHIS
- Enhance the implementation of electronic Multi-Sectoral Response Information System (e-MRIS)
- Support information-based decision-making by implementing integrated ERP system (ICT-business automation)
- Implement client-based smart card solutions
- Adopt and implement innovative digital health technology solutions
- Expand the deployment of electronic medical record (EMR) and electronic health records
- Expand digital-based Community Based Health Insurance System
- Expand digital-based pharmaceutical and medical device supply chain management system
- Expand the implementation of Blood Safety Information Systems (BSIS)
- Strengthen digitization of the health regulatory system
- Leverage data science techniques and approaches, including machine learning, artificial intelligence, and disease prediction modeling
- Expand on the success of telemedicine

Scale up and strengthen shared digital health services

- Strengthen the development of Master Facility Registry (MFR)
- Establish a data warehouse to foster and support research, analytics, and more highly informed decision-making
- Expand and strengthen the implementation of integrated Human Resource Information System (iHRIS)

Strengthen and expand innovation lab and incubation centers

- Design and expand innovation labs
- Establish incubation centers for health innovations
- Develop and implement a strategy for introducing artificial intelligence enabled healthcare approaches

3.2.6.6. Strengthen Regulatory Systems

This program aims to protect the public from health risks that arise from poor and substandard products and services. It focuses on ensuring the safety, quality, efficacy, and proper use of medicines; performance of medical devices; safety of food; quality of health and health-related services against

standards; competence of health professionals; and regulation of tobacco and alcohol. It also includes the implementation of digital regulation systems to establish an effective, transparent, and accountable system that ensures adherence by all state and non-state actors to national health regulatory standards and legal frameworks.

Engagement of all stakeholders such as industry, academia, communities, and consumers will be a mainstay of this strategic direction. The MOH engages professional associations in the process of licensing health professionals (such as developing exams, participating in the examination process) and aims to eventually transfer this responsibility. The MOH will work towards establishing a semi-autonomous regulatory system for health facility regulation.

Regulation of Food, Medicines, Equipment, and Other Health Products

Strategic Initiatives and Main Activities

Strengthen the control of food adulteration

- Conduct risk-based intelligence-led food surveillance and operation
- Conduct risk-based inspection and market assessment
- Conduct laboratory testing using advanced and/or rapid test kits

Standardize, register and regulate the safety and efficacy of traditional medicine and practices

- Issue market authorization for traditional medicines
- Provide training for registration staff

Establish Regulatory Center of Excellence to provide service, training, and research

- Establish a Project Management Office and furnish HRCoE laboratories with equipment and supplies

Boost registration of medical products for better availability of sufficient options of quality assured medical products in the country

- Conduct assessment of the implementation of Market Authorization Strategy
- Organize international conferences with pharmaceutical manufacturers
- Provide market authorization for medicines and medical devices

Enhance regulatory functions for the promotion of proper use of antimicrobials and combat emergence and spread of AMR

- Conduct baseline assessment on drug retail outlets
- Conduct inspection on drug retail outlets on rational drug use in collaboration with RRBs and stakeholders
- Develop strategic roadmap/protocol for rational medicine use implementation

Strengthen risk -based product regulation by introducing product and risk-based auditing pre- and post-licensing inspection, improve post-shipment (consignment) and post-marketing surveillance

- Conduct risk-based inspection on local medicine and medical device manufacturers, importers, and wholesalers
- Conduct risk-based cGMP inspection on medicine and medical device manufacturers outside of Ethiopia

Strengthen laboratory testing through building and maintaining adequate quality control systems, infrastructures, and laboratories

- Conduct PMS testing on medicines and medical device products
- Conduct consignment testing on medicines and medical device products
- Conduct PMS and consignment testing on food products
- Furnish head and branch laboratories with advanced equipment

Strengthen the implementation of food safety regulation

- Conduct risk-based inspection on local food manufacturers, importers, and wholesalers
- Conduct risk-based cGMP inspection on foreign food manufacturers
- Conducting market survey on unregistered local and imported food products

Strengthen the implementation of Quality Management System

- Undergo certification of food inspection process by ISO17020
- Complete accreditation of glove hole test by ISO17025
- Maintain ISO17020 of medicine inspection process

Strengthening tobacco and nicotine products control

- Enforce ratified WHO's framework convention on tobacco control (FCTC) and national tobacco control directive
- Conduct national level awareness programs in all regions
- Conduct Global youth and adult tobacco survey
- Implement audit based nicotine products regulation at all levels of the supply chain

Strengthening the reduction of and the prevalence of substandard and falsified medical products

- Conduct market surveillance and operations at federal and regional levels
- Prepare community mobilization and media campaign programs
- Purchase and adopt anti-counterfeit technologies and technology transfer

Strengthen and extend the scope of pharmacovigilance system about the safety of all related health technologies, including medicines, vaccines, blood products, and traditional medicine

- Conducted active safety monitoring for newly introduced drugs/vaccines (e.g., antimalarial vaccines, new anti-TB drugs, anti-covid-19 drugs etc.)
- Conducting pharmacovigilance inspection
- Strengthening six sub-national pharmacovigilance accompanying centers at university hospitals

Regulation of health and health-related institutions and professionals

Introduce and scale up clinical audits

- Develop clinical audit tools and conduct clinical audits on selected health services
- Support regions to conduct clinical audits on selected health services

Improve the implementation of professionals, health and health-related institutions, laws, and standards

- Enhance the implementation of health and health-related institution standards
- Register and license health professionals
- Establish and maintain well-equipped and secured contemporary item bank
- Strengthen the online registration and result dissemination system/software

Strengthen the health professionals' competency assessment system

- Establish equipped exam development site
- Develop and review exam blueprint for all professions under the assessment
- Develop and review exam that assesses cognitive competency domains (MCQ) and administer using paper or computer-based exam
- Develop and review exam that assesses psychomotor and affective competency domains (OSCE) and administer it to selected professions
- Standardize the setting for the licensure exam
- Conduct research on the implementation of licensure exam every year

Strengthen medico-legal issue investigation and decision-making system

- Improve investigation and decision-making system of medico-legal issues
- Improve the capacity of health professional ethics committees
- Investigate and resolve medico-legal issues

Strengthening self-regulation of health and health-related institutions

- Provide capacity building and support for health institution on self-regulation
- Provide capacity building and support for health-related institutions on self-regulation

Strengthen Master Facility Registry (MFR)

- Ensure registration of health institutions signature domain data on MFR
- Ensure registration of health institutions service domain data on MFR
- Continuously update health institutions data on MFR

3.2.7. Harnessing Innovation for Health System Quality, Equity, and Safety

Description:

This strategic objective focuses on sourcing and implementing innovative ideas and technologies to ensure high-quality, equitable, and safe health services that result in improved health outcomes. It focuses on problem-solving and improving health system performance that enables sustainable improvements in service quality, equity, and safety.

3.2.7.1. Institutionalized Quality Culture

High-quality UHC can be ensured through the implementation of standards, assurance of evidence-based interventions, and access to health care for all people. Delivering the best performance from continuous learning and effective knowledge management and engaging the community will contribute to quality health services that improve citizens' quality of life and longevity.

This program focuses on interventions that ensure the provision of safe, evidence-based, timely, client-centered, efficient, and transparent health care services with integrity.

Strategic initiatives and Main Activities

Strengthen the implementation of national healthcare quality and safety strategy

- Develop and implement standards, manuals, procedures, and protocols
- Enhance the execution capacities of quality structures at all levels
- Expand and implement quality improvement projects
- Design and implement strategies that ensures people-centered care
- Implement public and private health facilities accreditation modality
- Establish quality and safety hubs
- Enhance regular institutional clinical auditing practices to inform evidence-based clinical decisions
- Design and implement accreditation support packages for private health facilities

Improve efficiency of health institutions

- Design and implement medical product and device wastage monitoring mechanisms
- Design and implement productivity measurement mechanisms
- Standardize common supplies for common procedures

Strengthen collaborative learning platforms

- Create and implement district-based learning and experience sharing platforms
- Award competitive-based grants for institutionalization of QI projects
- Enhance best practices identification, validation, and dissemination capabilities
- Integrate the concepts of quality into the existing programs and link with improvement and health extension package

Strengthen institutionalization of a safety culture

- Implement a national safety program that focuses on high-risk clinical conditions
- Implement infection prevention and control strategy roadmap
- Enhance surveillance system for healthcare acquired infections

Scale up health innovation practices

- Implement woreda-led health service delivery system improvement
- Strengthen the implementation of regular performance auditing, feedback provision, and shared learning practices
- Establish innovation hubs at national and regional levels

Strengthen health facility-led service efficiency, safety, and equity improvement

- Implement Primary Hospital -Led Service Efficiency, Safety, and Equity Improvement initiative
- Implement Health Center-Led Service Efficiency, Safety, and Equity Improvement initiative
- Implement Health Post-Led Service Efficiency, Safety, and Equity Improvement

Develop and implement system bottleneck focused reform (SBFR)

- Develop and implement leadership productivity and accountability protocol
- Conduct regular recognition scheme for high-performing program units
- Develop and implement generic technical documents related to the health facilities SBFR project
- Develop and implement national SBFR performance monitoring and accountability framework

3.2.7.2. Improve Health Equity and Social Determinants of Health

Equity reduces disparities in the provision of high- quality health services between geographic areas and disadvantaged groups (women, youth, children, uneducated, poor, and people with disabilities). Achieving UHC, access to essential health care services, and affordable essential medicines and vaccines for all assumes the achievement of universal equity. This principle focuses on ensuring that all Ethiopians, regardless of their geography, gender, age, wealth, education, or disability status, are able to access essential services and attain similar levels of health outcomes.

Strategic initiatives and Main Activities

Strengthen advocacy for the implementation of national and region- specific Health Equity Strategy

- Conduct high-level advocacy and trainings on region-specific health equity strategies to mainstream health equity in all policies, programs, and strategies
- Strengthen targeted technical, financial, and logistic support
- Enhance a health inequality monitoring system

Scale up the implementation of alternative and contextualized health service delivery modalities

- Test and expand mobile health team services in different settings
- Design and implement projects to address health equity of communities in industrial parks and development corridors, people with special needs and congregate settings (refugee, IDPs, geriatric centers, prisons) with tailored approaches and friendly health services

Strengthen the implementation and scale up of social determinants of health (SDH) for gender equality projects

- Mainstream and institutionalize gender equality in health equity concepts and practice through a multi-sectoral approach
- Implement SDH in selected woredas of the developing regional state
- Evaluate SDH pilot project and redesign for scale up in new woredas based on recommendations
- Promote and empower women in leadership positions in health sector

3.2.8. Improve Pharmaceutical and Medical device Management and Production

This objective aims to enhance the efficiency and effectiveness of the pharmaceutical supply chain, pharmacy services, and medical device management systems. It also focuses on promoting local manufacturing of medicines and medical devices, as well as traditional medicine, through the development and implementation of strategies. Additionally, the objective aims to improve the procurement and management procedures for medical devices, while ensuring the rational and proper use of drugs and reducing pharmaceutical wastage. Lastly, the objective aims to address the global health and development threat of Antimicrobial Resistance (AMR) by strengthening actions for prevention and containment.

3.2.8.1. Pharmaceuticals and Medical Devices

Strategic initiatives and Main Activities

Strengthen the leadership and governance of pharmaceutical and medical equipment management

- Assess EPSS and restructure to create better focus on pharmaceuticals, medical equipment and lab supplies, and cascade the new pharmacy structure down to the RHBs and lower-level structures as appropriate
- Restructure and revitalize the Regional Bioequivalence Center
- Integrate Pharmacy with PHPs -align and work in harmony at all levels
- Develop and implement Emergency SCM System
- Establish separate waste management system for pharmaceuticals and medical equipment
- Revise and implement standard national treatment guidelines for hospitals

Strengthen demand-based forecasting and supply planning for all health commodities

- Ensure the national essential medicine and medical device lists are updated
- Implement enterprise resource planning at EPSS central and hubs-warehouses
- Establish and implement track and trace system for medicines and medical devices across the supply chain
- Support a resilient emergency supply chain management system
- Optimize good warehousing, inventory, fleet, and distribution practices at all levels

Strengthen Strategic Procurement System

- Introduce e-procurement, establishment of international and regional pooled procurement, and long-term fixed price procurement mechanisms
- Develop medicine selection, pricing, and reimbursement strategy
- Establish Central Order Management System
- Ensure engagement of the private sector in the provision of medicines and medical devices
- Ensure affordability of medicines and medical devices
- Assess EPSS and restructure to create better focus on pharmaceuticals, MEs, and lab supplies

Strengthen scientifically sound and rational use of medicines and pharmacy practice

- Enhance clinical pharmacy and drug information services and pharmaco-vigilance system
- Facilitate the establishment of National Medicine and Poison Information Center
- Facilitate implementation of auditable pharmaceutical transactions and services
- Expand the implementation of model community pharmacy
- Introduce and implement selected public health services in community and hospital pharmacy

- Enhance access to medical oxygen
- Develop and implement strategies to reduce medical and pharmaceutical wastage

Strengthen medical device management system and maintenance

- Enhance standardization of medical device, maintenance workshops, refurbishment centers, and maintenance referral system
- Implement pharmaceutical and medical devices reverse logistic system
- Introduce and implement health technology assessment (HTA) system for selected medical devices
- Strengthen cold chain equipment maintenance and management system
- Ensure proper medical devices installation and safe handling

Strengthen prevention and containment of antimicrobial resistance (AMR)

- Improve awareness and understanding of antimicrobial resistance through effective communication, education, and training
- Strengthen knowledge and evidence through surveillance and research
- Improve access to quality antimicrobials and laboratory commodities and initiate DST in public and private hospitals
- Strengthen leadership, ownership, and commitment for implementation of AMR prevention and containment activities
- Improve infection prevention and contain the spread of resistant microorganisms through one health approach (human, animal, and environment)
- Optimize the use of antimicrobials through expanding antimicrobial stewardship program to health facilities

3.2.8.2. Domestic Pharmaceuticals and Medical Manufacturing

Strategic Initiatives and Main Activities

Strengthen the productivity and efficiency of existing local pharmaceutical and medical device manufacturers

- Identify potential support areas such as importing active pharmaceuticals ingredients (APIs) in bulk
- Collaborate with relevant stakeholders to strengthen local manufacturing capacity, efficiency, and continuously capacitate their workforce towards fulfilling international standards such as Good Manufacturing Practice (GMP) certification and WHO prequalification
- Establish sustainable financing underpinned by government involvement
- Create streamlined regulatory environment
- Create strong coordination across the manufacturing ecosystem

Enhance the production of more varieties of pharmaceutical products in the country

- Establish and strengthen axillary industries and exigent and other inputs manufacturers like pharma grade sugar, ethanol, vials, bottles, closures and containers, pharma grade packing materials, etc.
- Establish and expand the manufacturing of vaccines, diagnostics, and therapeutics to ensure access to life-saving medicines and equipment
- Collaborate with relevant stakeholders to support local manufacturing of APIs and packaging materials
- Establish system for aggregated demand for local products
- Design technology co-creation mechanisms to go beyond tech transfer
- Explore alternative financing mechanisms to solicit funding needed for investment in technology transfer, industry expansion, skill building, research, and development.
- Develop joint strategy to systematically categorize product portfolio and apportion amongst local manufacturers

3.2.8.3. Traditional Medicine

Strategic Initiatives and Main Activities

Strengthen the production and effectiveness of traditional medicine

- Enhance the support to traditional medicine through research, registration, and regulation
- Develop and implement strategies that safeguard society from harmful and risky traditional medicine practices
- Develop an ethical framework and code of conduct for traditional medicine practice
- Develop and implement standards of traditional medicine practice
- Promote registration of traditional medicine products, and market authorization of traditional remedies
- Establish incubation center for laboratory formulation of traditional medicines and increase laboratory scale formulation of scientifically validated traditional medicines
- Enable political, economic, and regulatory environment for the development of sustainable local manufacturing of traditional medicines in appropriate dosage forms
- Strengthen industry and research ties to facilitate the manufacturing of appropriate dosage forms of traditional medicines

Improve the contribution of traditional medicine in health services

- Revitalize the policy framework and strategies to enhance traditional medicine and practices for health
- Create an enabling environment for the traditional medicine and practice for health
- Strengthen the role of the traditional practice for the healthcare service

- Enhance support to the traditional medicine and practice to improve quality of care
- Improve conservation and documentation of medicinal plants, traditional medicine knowledge, and practices
- Promote intellectual property rights, registration of indigenous knowledge rights, and market authorization of traditional remedies
- Promote research and development of traditional medicines, including clinical trials, and engage academia and research institutions
- Establish incubation center for laboratory formulation of traditional medicines and increase laboratory scale formulation of scientifically validated traditional medicines
- Implement preparatory activities towards integration of traditional medicine into primary health care
- Establish traditional medicine registration system
- Strengthen integration of modern and traditional medicine

3.2.9. Improve Health Financing and Private Sector Engagement

This objective aims to secure sufficient and sustainable funds to achieve "Universal Health Coverage through strengthening Primary Health Care" in Ethiopia, without financially burdening its citizens. It focuses on mobilizing financial resources and efficiently allocating them for health services and programs, while also improving accountability and transparency in managing and utilizing these funds. The objective includes transitioning to more sustainable health financing by gradually shifting from external to domestic sources. Additionally, it emphasizes the collaboration between the government and the private sector to enhance national health priorities. This involves engaging private for-profit and non-profit institutions in various health-related activities, such as service delivery, supply forecasting, and strengthening health systems.

3.2.9.1. Capacity Improvement in Health Revenue Mobilizing

Strategic Initiatives and Main Activities

Design and implement innovative resource mobilization

- Revise user fees to reflect cost of care and advocacy
- Implement mandatory health insurance and social health insurance system
- Review premiums based on actual cost of care (not user fees), tailor benefit packages and premiums, and establish higher-level pooling
- Enhance health facility revenue generation and effective utilization
- Standardize exempted services and revisit the reimbursement mechanism (finalizing the resilient and equity fund)
- Implement the harmonization and alignment action plan to fit the support from development partners specially channel 3 to government priorities
- Scale up the domestic resource mobilization structures of Oromia, Amhara, and Addis Ababa to other regions

Improve resource allocation and efficiency

- Strengthen advocacy at all levels, particularly at the federal level, for increased allocation of resources to the sector
- Reform and implement the role of the MOH in health financing to improve resource mobilization and allocation
- Build consensus with Ministry of Finance on earmarking of tax (e.g. sin tax) for health
- Design and implement performance linked strategies to improve efficiency and effectiveness (performance-based financing and results-based financing)
- Design and implement strategies for appropriate allocation and efficient utilization of existing resources and capacity
- Revisiting the PBF approach to complement with other payment mechanisms, ensure sustainability and efficiency
- Enhance coordination and governance of health financing components and stakeholders
- Accelerate the shift to program-based budgeting and strengthen integrating resource tracking systems

Strengthen strategic purchasing

- Introduce a cost containment and risk mitigation strategy
- Introduce new payment mechanisms such as scaling up of the capitation pilot and exploring alternative payment for hospitals
- Support the nexus between provider payment mechanism and quality improvement
- Devise a mechanism to improve the frequency and quality of clinical and claim audits

3.2.9.2. Universal Health Insurance

Strategic Initiatives and Main Activities

Strengthen the health insurance governance system

- Enhance health insurance regulatory frameworks and functionality
- Design and implement strategies to increase insurance coverage for the poor and provide governmental subsidies for indigent
- Develop a tailored CBHI strategy for DRs that account for various contextual factors
- Standardize pooling arrangement and scaling up of pooling at zonal and regional levels
- Develop a tailored strategy to recover the CBHI coverage in conflict affected areas
- Revisit CBHI structure and staffing

Strengthen the deployment of health insurance

- Introduce social health Insurance
- Introduce CBHI re-insurer mechanism

- Introduce sliding scale CBHI contribution rate to ensure equity in health financing
- Integrate identification of the poor with social security programs such as PSNP in PSNP districts and standardized selection criteria

3.2.9.3. Private Engagement in Heath Service Provision

Strategic Initiatives and Main Activities

Improve the contribution of the private sector in health promotion, disease prevention, curative, rehabilitative, and palliative care services

- Review and revitalize the policy framework and strategies to enhance public-private engagement in health
- Create an enabling environment for public-private partnerships (PPP) for health
- Strengthen referral and continuum of care
- Strengthen the role of the private sector in the development of a competent health workforce, and distribution of medical products and supplies and healthcare financing (medical insurance)
- Enhance support to the private sector to expand quality specialty, tertiary, and quaternary care that paves the way for medical tourism

Ensure transparency, accountability, and responsiveness of private sector in health care service provision

- Engage private sector in planning, implementation, and monitoring and evaluation of the health services
- Set into place a quality control and regulation system
- Invest in bidirectional dialogue and capacity building with the private sector

3.3. Implementation Arrangement

The implementation arrangement of the strategic plan aims at facilitating the implementation of the medium-term plan at all levels of the system and by relevant stakeholders. This implementation arrangement includes eight focus areas, or initiatives, that enable the achievement of the stated objectives.

Integration of initiatives: The goal of this is to harmonize, align, and mainstream different programs and activities across the health sector. This will be materialized by incorporating crosscutting issues such as gender, equity, and quality into different programmatic interventions and by integrating interlinked service at service delivery units at health facilities. Furthermore, efforts will also be made to realize Health in All Policy by integrating and mainstreaming health in other sectors. This will foster inter-sectoral collaboration and help achieve UHC. All activities will focus on aligning with global initiatives and international declarations that the country endorses. This will help to create a more efficient, effective, and equitable health care system for all Ethiopians.

HSDIP governance: A strong governance system will help to ensure that all stakeholders are involved in the planning and implementation of strategic plan, and that resources are used in the most effective way. Thus, MOH will use internal (government only) and joint (MOH- DPs, private sector, and CSOs) coordination platforms to monitor the implementation of the strategic plan. The platforms are described below:

Joint MOH and health partners/donors' governance forums

Joint Consultative Forum (JCF)-the highest governance body, which decides, guides, oversees, and facilitates the implementation of the plan, and it is also a forum for dialogue and consultations on the overall policy direction, reform, and institutional concerns about the health sector between the government, development partners, and other stakeholders.

Joint Core Coordinating Committee (JCCC)- is the technical arm of the JCF and assists and works closely with the MOH in following up the implementation of the decisions of the JCF and the recommendations of the review missions (mid-term and annual review meetings and final evaluation). The JCCC is also responsible for assisting MOH in organizing the review, conducting M&E, and coordinating operational research and thematic studies.

MOH Internal Management and Coordination Forums- this is the government-only forum that plays a critical role in the implementation of the HSDIP. The platforms include MOH-RHBs Joint Steering Committee (JSC) which consists of MOH senior leadership, directors and RHB senior leadership, the Management Committee (MC), which consists of all chief executive office leads of the MOH, and the Executive Committee (EC), which convenes the MOH agency director generals and MOH senior leadership (Minister and State Minister).

Planning and budgeting: HSDIP will follow the "one plan, one report, and one budget" principles, where all initiatives, major activities, resources, and monitoring system is aligned and harmonized across the health system and with different stakeholders, including partners, private sector, and CSOs, for effective and efficient implementation. The MOH will have annual plans which emanate from the HSDIP to operationalize the high-level strategic initiatives and major activities across the health system. The annual plan developed following a top-down and bottom -up approach to ensure the alignment of the initiatives, activities, priorities, and targets at national and subnational levels (region, zone, and woreda). The cascade of the strategic plan and the annual plan development take into account the contexts at the lower levels of the health system. There will be a mutual accountability agreement to monitor the one plan, one budget, and one report, implemented by all stakeholders.

Health service delivery arrangements: The Ethiopian health service delivery system is structured into three tiers: primary, secondary, and tertiary. The primary level of care comprises a primary hospital (covering nearly 100,000 population), health centers (covering nearly 25,000 people), and satellite health posts (covering 3,000–5,000 people). The secondary level of care is a general hospital covering a population of 1– 1.5 million. This is the next referral center for the primary level of care. Tertiary level of care is a specialized hospital covering a population of 3.5–5 million. The HSDIP will continue to focus on strengthening and expanding health services and facilities within the framework of primary health care by improving governance and ensuring equitable access to and utilization of quality health services.

Multi-sectoral collaboration is essential for achieving the targets set in the HSDIP and health-related SDGs. The plan will be implemented using multi-sectoral collaboration to address all the determinants of health by closely working with different stakeholders within the public sector, private sector, non-government agencies, and CSOs. To ensure joint planning, implementation, review, and evaluation mechanisms will be implemented. In addition, coordination committees and forums will be established at national and subnational levels for areas that need continuous engagement of various actors.

Public-private partnership: The private sector has a strong presence in the health sector in Ethiopia. The Ethiopian government will leverage the private sector to provide and finance most curative services (and some preventive care) through public-private partnerships (PPPs). Additionally, the MOH will facilitate their engagement in the expansion of health infrastructure, local production of pharmaceuticals, and medical devices, as well as training and continuing development for health professionals.

Innovation: HSDIP will place innovation as a key focus area in the strategic plan implementation to improve health service quality and efficiency, ranging from new diagnostic technologies, pharmaceutical products, digital health solutions to processes to improve patient management. To realize this, MOH has designed several strategic mechanisms and worked with the private sector and academia. Innovation can help meet the HSDIP targets by minimizing costs, addressing disparities in access to care, and promoting the delivery of patient-centered, evidence-based care.

Health diplomacy, Communication, and visible leadership: Health diplomacy is becoming increasingly important as global health challenges become more interconnected. The MOH is committed to strengthening its health diplomacy capacity at all levels, both domestically and internationally. The MOH will align its policy and strategies with global health concerns and SDG targets and share success stories and lessons learned at the country level at global platforms to advocate for changes in global public health practices. The MOH will also build the capacity of Ethiopian diplomats across the globe to play their role in the health agenda and to advocate for the opportunities in health investment in the country.

Chapter

4

Medium- Term (2016-2018) Performance Measures and Targets

Chapter 4: Medium- Term (2016-2018) Performance Measures and Targets

This chapter covers the expected results under strategic objectives of the health sector with selected programs/initiatives and performance measures (targets) focusing on core indicators. The whole indicators that need to monitor and evaluate the performances of HSDIP are presented in the separate HSDIP Monitoring and Evaluation plan, whereas some of core indicators are presented with baseline and targets as follows. The indicator matrix is annexed for further information.

Table 2: Expected Outcomes/Impacts and targets of the HSDIP per the strategic objectives and programs

Expected Outcomes / Impacts	Programs/services	Targets per Strategic objectives and Programs
		General
Improved health status	**General**	Increase life expectancy at birth from 68.7 to 70
		Increase UHC index from 0.38 to 0.58
		Decrease the maternal mortality rate (MMR) from 267 per 100,000 live births to 199
		Decrease under-5 mortality from 47 per 1,000 live births to 44 per 1,000 live births
	1	**Reproductive, maternal, neonatal, child, adolescent and youth health and nutrition**
Improved reproductive and maternal health services	**Family Planning and Reproductive Health**	Decrease total Fertility rate (TFR) from 4.1 to 3.6 per household
		Increase CPR from 39.5% to 45%
	Maternal Health	Increase proportion of pregnant woman who received early antenatal first contact < 12 weeks from 22% to 40%
		Proportion of pregnant women who received antenatal care 8 contacts or more from 15% to 30%
		Increase deliveries attended by skilled health personnel from 71% to 78%
		Increase Cesarean Section Rate from 5% to 8%
		Increase coverage of early postnatal care (PNC) within 2 days from 67% to 78%
		Decrease stillbirth rate (per 1,000) from 10.8 to 9
Improved coverage of child health services	**Neonatal and Child Health**	Decrease infant mortality from 34 per 1,000 live births to 32 per 1,000 live births
		Decrease neonatal mortality from 26 per 1,000 live births to 21 per 1,000 live births
		Increase proportion of asphyxiated newborns resuscitated and surviving from 83% to 85%
		Increase Proportion of newborns with neonatal sepsis/Very Sever Disease (VSD) who received treatment from 72% to 80%
		Increase proportion of under five children with pneumonia who received antibiotics from 78% to 85%
		Increase proportion of under five children with diarrhea who were treated with ORS and Zinc from 22% to 60%
Increased coverage of immunization services	**Immunization**	Increase pentavalent 3 coverage from 61% to 80%
		Increase second dose of measles containing vaccine (MCV1) measles coverage from 59% to 69%
		Increase full vaccination coverage from 44% to 75%

Increased coverage of Adolescence health services	**Adolescent and Youth health**	Increase proportion of girls vaccinated for HPV from 97% to 98%
		Reduce teenage pregnancy rate from 13.6% to 9%
Increased coverage of nutrition services	**Nutrition Program**	Decrease stunting prevalence in children aged less than 5 years from 39% to 25%
		Decrease wasting prevalence in children aged less than 5 years from 11% to 7.8%
		Increase proportion of children participating in Growth Monitoring and Promotion(GMP) for 0-24 months from 63% to 75%
		Increase proportion of pregnant women who received iron & folic acid supplements at least 90 plus from 17% to 23%.
		Increase proportion of Exclusive Breastfeeding (EBF) for children under six months from 61% to 66%.
		Increase proportion of children 6-59 months who received vitamin A supplementation from 19% to 37%
2	**Disease prevention and control**	
Increased coverage of HIV interventions	**HIV/AIDS**	Increase proportion of HIV exposed infants that received ARV Prophylaxis from 54% to 95%
		Increase percentage of HIV positive pregnant, laboring, and lactating women who received ARV from 77% to 95%.
		Increase proportion of PLHIV who know their HIV status from 85.5% to 95%
		Maintain percentage of PLHIV who know their status and receives ART (ART coverage at 98%
		Increase percentage of people receiving antiretroviral therapy with viral suppression from 96% to 97%
Increased coverage of TB/ Leprosy interventions	**TB and Leprosy**	Increase TB detection rate from 95% to 96%
		Increase TB treatment success rate from 96% to 97%
		Increase number of DR TB cases detected from 882 to 1,301
		Increase RR/MDR-TB Treatment Success rate from 79% to 83%
		Reduce Grade II disability among new cases from 12% to 5%
Increased coverage of Malaria interventions	**Malaria**	Reduce incidence of malaria from 47 per 1,000 population at risk to 17.9 per 1,000
		Reduce malaria mortality rate from 0.41/100,000 population at risk to 0.21
Increased coverage of NCDs health services	**NCD**	Increase proportion of hypertensive adults whose blood pressure is controlled to 45%
		Increase proportion of DM patients whose blood sugar is controlled to 55%
		Proportion of individuals treated for priority mental health disorders 3.2% to 5.5%
		Increase the proportion of women 30-49 years screened for cervical cancer from 12.7% to 38%
		Increase cataract Surgical Rate (Per 1,000,000 population) from 826 to 1500

Increased coverage of NTD interventions	**NTD**	Increase proportion of trachomatous trichiasis cases who received corrective TT surgery from 67% to 100%
		Proportion of SCH endemic districts treated with minimum WHO threshold from 70% to 100%
	3	**Improve community engagement and Primary Health Care**
Effective community engagement	**WASH & EH, HEP and Community Engagement**	Increase proportion of households having basic sanitation facilities from 52% to 65%
		Increase proportion of health facilities having basic sanitation facilities from 62% to 80%
		Increase proportion of health care facilities having basic health care waste management from 63% to 75%
		Increase proportion of Model households from 23% to 35%
		Increase proportion of model kebele from 18% to 35%
Effective primary health service delivery	**Primary Health care (PHC)**	Increase proportion of high performing Primary Health Care Units (PHCUs) from 26% to 35%
		Increase the number of health centers providing major emergency and essential surgical care from 32 to 300.
		Increase the number of health posts providing comprehensive health extension services from 49 to 1159.
	4	**Improve access to quality medical health services**
Increased access and quality of medical health services	**Pre-Facility, Emergency, injury and Critical Care Services**	Increase ambulance response rate from 83% to 90%
		Decrease ICU mortality rate from 26% to 24%
		Reduce emergency mortality rate from 0.2% to 0.15%
	Hospital, Diagnostic , and Specialty and Rehabilitation Services	Increase outpatient attendance per capita from 1.5 to 1.68
		Decrease institutional mortality rate to less two (<2)
		Increase bed occupancy rate from 68% to 72%
	Blood and Tissue Services	Increase rate of blood donation per 1000 population from 3.5 to 5.42
		Increase percentage of component production per total population from 16% to 35%
	5	**Public health emergency management**
Sustainable, effective and efficient national epidemiological surveillance, response and recovery system	**Health emergency and disaster risk management**	Increase Health Security Index score (IHR SPAR) from 74% to 76%
		Increase proportion of epidemics controlled within the standard of mortality from 80% to 100%

	Laboratory Services	Increase proportion of health laboratories implementing Basic Laboratory Quality Management Systems (BLQMS) from 70% to 90%
		Increase proportion of laboratories providing standardized laboratory testing services as per national standard from 73% to 95%
	Post conflict Recovery and rehabilitation	Increase the proportion of health facilities in conflict affected areas that provide full packages of essential health services to 100%
	6	**Improve Health System Capacity and Regulation**
Improved institutional capacity in leadership and management	**Leadership and Governance**	Increase proportion of Primary Health Care Facilities implemented Community Score Card from 58% to 75%
Increased availability of a competent, motivated and equitably distributed health workforce	**Health Workforce**	Maintain the number of health professionals enrolled in specialty training per year and reach 1200
		Increase health workers density (Physician, Nurses, Midwives and Health Officer) per 1,000 population from 1.75 to 2.3
		Decrease Health care workers attrition rate from 3.3% to 3%
Improve availability of required amenities	**Health infrastructure**	Increase proportion of health facilities (health centers and hospitals) access to with basic amenities (water, electricity, basic sanitation) (water supply from 76% to 85%, electricity from 77% to 85%, and basic sanitation from 62% to 75%)
Improved evidence generation and use	**Health Information system**	Increase information use index from 60% to 85%
		Increase proportion of births notified (from total births) from 75% to 85%
		Increase proportion of deaths notified (from total deaths) from 4% to 35%
		Increase proportion of health facilities that meet data verification factor within 10% for selected indicators from 89% to 95%
		Increase report completeness from 85% to 95%
		Increase report Timeliness from 41% to 95%
		Increase number of researches conducted per year from 161 to 175
		Increase number of Policy briefs prepared per year from 3 to 12
Harnessed technologies for health	**Digital health**	83. Increase proportion of health posts implementing electronic CHIS from 45% to 70%
		Increase proportion of Hospitals Implementing EMR solution from 5.25% to 50%

Improved functional standards of health and health related institutions, professionals, and quality of health and health related products	**Strengthen Regulatory System**	Increase proportion of health institutions implementing compulsory Ethiopian health institutions standards from 62% to 80%
		Increase proportion of health institutions registered with service domain data on Master facility Registry (MFR) from 70% to 100%
		Increase proportion health professionals who have active license from 72% to 100%
		Increase proportion of ethical issues of the health professionals that have been resolved from 51% to 100%
		Increase proportion of health related institutions implementing compulsory Ethiopian hygiene and environmental health standards from 12% to 53%
		Increase number of health professional types (cadres) in which competency assessment exam was given before the graduates are joining heath workforce from 13 to 20
		Decrease prevalence of tobacco smoking and use from 5% to 3%.
		Decrease prevalence of unsafe and illegal food products in the market from 37.2% to 30%
		Decrease percentage of substandard and falsified medicine in the market from 6.9% to 5%
		Increase audit inspection coverage of medicine facilities (Importers and wholesalers) from 53% to 100%
		Increase the number of drugs issued market authorization from 867 to 1300.
7	**Harnessing Innovation for Health system quality, Equity and safety**	
Improve quality of health services	**Innovation for Health system quality, Equity and safety**	Increase proportion of clients satisfied during their last health care visit (Client satisfaction rate) from 78% to 85%
		Reduce surgical-site infection rate to below 5%
		Increase the ratio of deliveries assisted by Skilled Birth Attendants between pastoralist and non-pastoralist regions from to 0.61 to 0.70.

	8	**Improve Pharmaceuticals and Medical devices management and Production**
Improved sustainable access to good quality and efficacious medicines and medical products	**Pharmaceuticals and medical devices**	Increase availability of essential medicines at health facility level from 83.2% to 92%
		100. Increase proportion of clients received all prescribed drugs from respective health facilities from 68% to 90%
		Reduce drug wastage rate from 0.72% to 0.66.
		Reduce the number of days it takes to procure medicines from 194 days to 160 days
		Increase proportion of health facilities implementing auditable pharmaceutical transaction system from 10.4% to 33%
	Domestic Pharmaceuticals and Medical Manufacturing	Increase the contribution of local manufacturing out of the national pharmaceuticals supplies from 8% to 47%
		Increase the number of pharmaceutical factories initiated production from 2 to 8.
		Increase production capacity of domestic drug factories from 46 to 58
	Traditional Medicine	Scientifically validate one more traditional medicine product in the plan period
	9	**Improve Health Financing and private engagement**
Improved financial resources for health	**Health Revenue Mobilization Capacity Improvement**	Increase general government health expenditure (GGHE) as a share of general government expenditure (GGE) from 11.7% to 13.7%
		Increase total health expenditure per capita (US$) from 36 to 42
		Decrease out-of-pocket expenditure as a share of total health expenditure from 30.5% to 25%
		Increase the amount of money pledged from Development partners per from $590,619,338.65 to 595,775,614.72 USD
	Universal Health Insurance	Increase proportion of eligible households enrolled in Community Based Health Insurance (CBHI) from 81% to 90%
		Increase proportion of eligible civil servants covered by Social Health Insurance (SHI) from 0% to 100%
Effective private engagement in health services delivery and manufacturing of pharmaceutical and medical supplies	**Private sector engagement**	Increase number of private investment projects in health per year from 132 to 155
		Increase the amount of foreign direct investment capital in the health sector from 9,322,908,000 birr to 12,462,534,000birr
		Maintain the investment capital of local investors in the health sector per to reach 14,817,829.000birr
		Establish/implement at least one public-private partnership (PPP) per year.
		Increase proportion of private facilities reporting to DHIS2 from 36% to 50%

Chapter

5

Investment Plan

Chapter 5: Investment Plan

This chapter discusses the medium-term investment plan, priority programs, initiatives, corresponding targets, goals, implementation areas, and approaches. The HSTP II outlined ambitious targets, and implementation was commencing as local and global challenges began to impact the healthcare sector. This three-year plan for medium-term development and investment takes into account challenges and is designed to accommodate large projects as a mitigation strategy. Health facilities have experienced a lack of supplies, interruptions due to security issues, health professionals unable to provide the service, service seekers were unable to access health facility due to transportation and other security reasons, and all of these factors have had an impact on the delivery of health services and interrupted the progress made in the last decades. In addition to the internal conflict, the COVID 19 Pandemic's global effects have had a significant direct impact on fleet management, supply chains, and ongoing health services, posing a serious threat due to budget cuts and changes in program priorities. The financial and in-kind contributions from Development Partners has significantly declined and financing priorities mainly on emergency response has paid off the majority of the government treasury with significant reduction to the health expenditure.

This medium term strategic investment plan has taken into consideration projects for basic service delivery with due emphasis to capture what has not been done and interrupted due to the above caption justifiable reasons. So that comprehensively the compromised health service delivery will be reinstated to the normal position, and the target will be achieved through a well-organized and committed approach as well. The current peace agreement implementation strategy and recovered support strategy from development partners can serve as a springboard to mobilize and properly utilize resources for the implementation of listed out prioritized programs and projects in this plan. The projects are selected based on the available resources given limited fiscal space and prioritizing high impact projects.

The costing exercise and financing the Medium term development plan was done based on the One Health Tool (OHT). In addition, activity based costing by all MoH directorates and agencies was done. The OHT is an applicable instrument or model to low- and middle-income countries to develop their health strategic plan including strategic objectives and evaluate the performance based on inputs and associated costs. This tool is built on six health system building blocks, drawing upon the WHO framework on basic services to health systems that include health workforce, infrastructure, logistics and supply chain, health information system, health systems financing, leadership and governance. OHT is a policy projection-modeling tool that allows users to create short- and medium-term plans for scaling up health services. It is used for health planning, costing and budgeting with a focus on integrating planning and financial space analysis. The tool is also organized in three components namely: The health systems, the health services delivery and the impact module. The number of people seeking health services as well as the resources that are available to offer the necessary service are taken into account in the calculation of costing and financial viability. The results of this investment are related to system outputs, anticipated health outcomes, and implications.

The following factors are taken into account during the One Health Tool costing exercise:

- **Population size**: Official figures for base year population demographics
- **Targeted Population**: a mechanism to identify target population who seeks the health services

- **Number of Service seekers**: Those who seek the health service for the set targets and interventions

- **Coverage:** Expansion targets are set to meet the standards as based on population figures and other criteria

The budget for the entire health sector from 2016 to 2018 is about 898 billion birr (16.3 billion USD). Table 3, provide cost breakdowns by program and year. On average, about 300 billion birr (5.5 billion USD) is needed to implement all programs and projects in the health sector per year. This estimate includes all projects, regardless of their respective implementers.

Table 3: 2016-2018EFY Investment Needs & Targets (USD) by Program: Total Health sector

Programs	2016	2017	2018	Total (2016-2018)
PHEM, and post conflict Recovery and rehabilitation Program	119,476,585	129,430,299	138,300,214	387,207,098
Access to quality medical health services	911,111,624	987,017,247	1,054,657,964	2,952,786,835
Community Engagement and Primary Health Care Program	180,978,565	196,056,071	209,491,878	586,526,514
Disease prevention and control Program	688,223,135	745,559,694	796,653,222	2,230,436,051
Health Financing and private engagement improvement	437,437,515	473,880,872	506,356,133	1,417,674,520
Health System Capacity building and Regulatory Program	1,014,984,884	1,099,544,292	1,174,896,536	3,289,425,713
Innovation for Health system quality, Equity and safety	168,012,392	182,009,672	194,482,874	544,504,938
Maternal, child health and Nutrition Program	554,429,774	600,619,874	641,780,613	1,796,830,262
Pharmaceuticals and Medical Supplies	965,193,092	1,045,604,296	1,117,260,009	3,128,057,397
Total	**5,039,847,568**	**5,459,722,318**	**5,833,879,442**	**16,333,449,328**

According to the most recent evaluation, Ethiopia spends only $36 per person on health care, which is much less than the $86 per person recommended by the WHO or the Abuja Declaration target to deliver universal basic health services.

This is a strong case for why the government's efforts to achieve universal health coverage should give higher priority to projects in the health sector and other cross-sectoral initiatives. Lack of attention to allocate more resources to health sector projects will lead to more out of pocket health expenditure. This will have a great impact on top of the current economic challenge at the household and community level.

It is underlined that the projects specified in this medium term investment plan are to be implemented at the Federal Ministry and its agencies. The overall country wide health sector budget need is estimated to 898 billion birr and out of this the current budget proposal, the 207.8 billion birr (3.8 billion USD) is 23% of the whole health sector budget.

Table 4: 2016-2018 EFY Investment Needs & Targets (USD) by Program: MOH & Agencies level implemented programs

Programs	2016	2017	2018	Total (2016-2018)
PHEM, and post conflict Recovery and rehabilitation Program	28,156,265	31,456,132	29,963,890	8957628 7.76
Access to quality medical health services	214,715,718	239,880,037	228,500,409	683,096,163
Community Engagement and Primary Health Care Program	42,650,035	47,648,547	45,388,156	135,686,737
Disease prevention and control Program	162,189,045	181,197,327	172,601,538	515,987,910
Health Financing and private engagement improvement	103,088,038	115,169,782	109,706,262	327,964,082
Health System Capacity building and Regulatory Program	239,194,849	267,228,082	254,551,094	760,974,025
Innovation for Health system quality, Equity and safety	39,594,381	44,234,776	42,136,330	125,965,488
Maternal, child health and Nutrition Program	130,658,839	145,971,834	139,047,101	415,677,774
Pharmaceuticals and Medical Supplies	227,460,743	254,118,758	242,063,662	723,643,163
Total	**1,187,707,914**	**1,326,905,276**	**1,263,958,442**	**3,778,571,631**

This medium term development and investment plan has considered projects with clearly set targets with budget break down. Soliciting the required financial resources from government and development partners for the projects is the fundamental part of the plan. At the federal level, it is anticipated that the government from the treasury will fund about 19% of the three-year health investment needed. Even though there is a declining trend of development partner contributions, about 58% of the investment need will be covered by external assistance considering this period as transition, while the private sector (PPP) and others will cover 11% of what is needed. Following a comprehensive resource mapping of potential funding sources, 23.3 billion birr (423.8 million USD) or 11% of the investment need will remain unfunded. Table 4, provides an overview of the program by cost breakdown per year and Table 5 further illustrates programs by financing source and funding gap.

Table 5: Finance source for MOH & Agencies level implemented programs (in USD)

Programs	Investment required (2016-2018	Government Budget	AID/ Development partners budge	Private sector (PPP)	Total	GAP
PHEM, and post conflict Recovery and rehabilitation Program	89,576,288	21,927,273	57,278,132		79,205,405	10,370,883
Access to quality medical health services	683,096,163	146,181,818	328,247,756	95,087,426	569,517,000	113,579,163
Community Engagement and Primary Health Care Program	135,686,737	43,854,545	37,451,086		81,305,632	54,381,105
Disease prevention and control Program	515,987,910	73,090,909	440,601,015		513,691,925	2,295,986
Health Financing and private engagement improvement	327,964,082	73,091	220,301	326,458,867	326,752,258	1,211,824.1
Health System Capacity building and Regulatory Program	760,974,025	153,490,909	599,217,381		752,708,290	8,265,735
Innovation for Health system quality, Equity and safety	125,965,488	13,887,273	50,448,816		64,336,089	61,629,399
Maternal, child health and Nutrition Program	415,677,774	146,181,818	264,360,609		410,542,427	5,135,346
Pharmaceuticals and Medical Supplies	723,643,163	131,563,636	425,179,980		556,743,616	166,899,547
Total	**3,778,571,631**	**730,251,273**	**2,203,005,077**	**421,546,293**	**3,354,802,643**	**423,768,988**

Special emphasis will be placed on fostering an environment conducive to the implementation of this investment strategy. Conflict and natural disaster-affected regions are getting special attention. In addition, the recovery, reconstruction, and rehabilitation of service facilities and utilities will be the focus of major activities.

Chapter

6

Assumptions, Risks and Mitigation Strategies

Chapter 6: Assumptions, Risks and Mitigation Strategies

6.1. Assumptions and Enabling Factors

The effectiveness of this plan implementation in achieving the expected results is based on the following assumptions and enabling factors:

- **Adequate resource allocation**: There is an assumption that the economy of Ethiopia continues to grow with the current trend or more and the government of Ethiopia allocates adequate resources to the health and health related sectors. The resource allocation includes adequate financial resources, deployment of adequate numbers and mix of skilled human resources, and other required inputs.

- **Presence of government structure and political commitment**: The implementation of the plan can be translated into action through the strong commitment of political leaders and enabling government structure at different levels of the government system. There is an assumption that the political leaders' commitment continues to support the implementation of the strategic plan.

- **Effective multi-sectoral Collaboration**: A strong multi-sectoral collaboration is essential to address social determinants of health. A strong collaboration with all sectors and implementation of health in all policies will enable the effective implementation of the strategic plan

- **Peace and security**: There is an assumption that the internal conflict and high number of IDPs over the past two years gets resolved and the national stability continues

- **Strong restoration efforts**: There is an assumption that a strong multi-sectoral and multi-stakeholder engagement in restoring health and other social services in conflict affected areas that can restore health and other social services in these areas

- **Improved community participation and engagement**: This strategic plan assumes that there will be a strong participation of the community during planning, implementation, monitoring and evaluation stages. The community will engage in awareness creation, ensuring transparency and accountability through community representatives, and making decisions in the health system

- **Effective partnership and coordination:** Developing a collaborative partnership and engagement among relevant stakeholders, including donors, development partners (DPs), Civil Society Organizations (CSOs), professional associations, interest groups and other stakeholders is essential for the effective implementation of the strategic plan. The partnership and coordination includes in all stages of the strategic plan, extending from the planning phase to monitoring and evaluation of results.

- **Improved engagement of the private sector:** The private sector in Ethiopia has a great share and role in the health system and the engagement of the private sector in improving access to and quality of health services is essential to strengthen the health system. Their engagement will be strengthened and ensured in quality service delivery, pharmaceutical supply system, human resource development and other activities is key to the success of this strategic plan. In addition, the private sector will engage in public-private partnership (PPP) projects.

- **Environment for Learning & Adaptation:** The implementation process should create an environment where learning and adaptation are encouraged. This includes a culture of innovation where ideas can be tested and adjusted in order to adapt better to changing circumstances as they arise during the implementation process.

- **Advancements in technology**: The implementation of the strategic plan will be supported with the state of the art technology

- **Optimized monitoring and review system:** Presence of a well-established monitoring and evaluation structure and mechanism at different levels of the health system helps to identify gaps early so that the implementation of the strategic plan can be tracked as planned. Establishing strong accountable systems for regular monitoring and evaluation of the national health sector strategic plan's impact on national healthcare outcomes is critical for making sure improvements are taking place over time as well as identifying areas that need further work or greater attention.

- **Capacity building**: Strengthening the capacity of the health workforce, institutions and communities that are involved in the implementation process is essential for success. Capacity building measures should include enhancement of technical knowledge and skills along with strengthening organizational capacity, access to information and decision-making at different levels involved in the strategic plan's implementation.

6.2. Risks and mitigation strategies

During the implementation of the medium term strategic plan, the sector may encounter risks that impede achievement of results. Table below shows the risks identified through SWOT and stakeholder analysis, and the strategies identified to address or mitigate them.

Table 6: Risks and mitigation strategies

S.N	Risks	Mitigation Strategy
1	Occurrence of Health Emergencies	**Increase Surveillance and early Detection Capacity:** The MOH will strengthen the public health emergency management system by improving the capacity for emergency preparedness, prevention, early detection and response of emerging and re-emerging diseases and other emergencies. The MOH will also strengthen the intra-sectoral and multi-sectoral collaboration and coordination among different stakeholders, improve capacity as per the IHR recommendations and enhance regular risk assessment at all levels. Emergency preparedness will be strengthened for an effective emergency response to any emergency at all levels. Health screening at POAs will also be strengthened. **Strengthen Primary Health Care Systems:** The primary strategy for protecting populations from emerging epidemics and pandemics is to strengthen the primary health care systems in Ethiopia by investing in physical infrastructure, improving access for remote communities, training staff and implementing new management strategies. **Engage Communities:** It's important to involve local communities in strategizing how to respond to an outbreak of disease or a probable epidemic or pandemic. Public awareness campaigns should focus on preventive measures (such as vaccination and hand-washing) that individuals can take as well as understanding local attitudes towards treatment options like quarantine-based approaches. Local engagement is necessary to ensure successful implementation of any health sector strategic plan in Ethiopia
2	Financing and Budgetary Deficits Sudden reduction of donor funds (Low predictability of external funding due to world economic recession)	**Prioritize and budget projects:** It is critical that the health sector strategic plan in Ethiopia is financially supported by creating the right budget priorities to ensure proper implementation. This will involve analyzing the existing resources and setting appropriate spending plans to best support the plan. **Reduce costs where possible:** To mitigate the lack of adequate financial resources, MoH, RHBs and other key stakeholders should consider reallocating budgetary funds and reducing costs whenever possible. Cost reduction measures may include consolidating physical resources, shifting to digital tools and services, or engaging external stakeholders (e.g., donors) who have the capacity to provide additional financial support. **Collaborate with other actors:** One key way of mitigating inadequate financial resources is by partnering with other organizations whose objectives align with those of the health sector strategic plan in Ethiopia. Through collaboration, organizations can share expertise, resources and knowledge that can help inform better decision-making and resource management processes. **Domestic financing:** The health sector will focus more on domestic financing to fill the financial gap required during the HSDIP period. The following efforts will be done: - Implementation of innovative domestic financing strategies to mobilize adequate finance domestically will be implemented - Strengthen the implementation of CBHI and initiate implementation of Social Insurance as an internal mechanism to increase financing to the health sector - Strengthen public-private partnership

S.N	Risks	Mitigation Strategy
3	Socio-Political Challenges (Political unrest, violence and social tensions that may lead to displacements; in-migrations and instability of neighboring countries)	**Adopt a Tailored Approach:** It is important to recognize that socio-political challenges vary depending on location and time frame. Therefore, it is necessary for health sector strategic plans to fit specific contexts; one plan does not fit all communities or situations. Plans should incorporate different strategies such as community engagement projects involving citizens in decision processes and data collection to develop more effective approaches tailored for different locations over time, and for populations in need of more attention. **Ensure multi-sectoral engagement and partnership**: The MOH will work closely with other government ministries and agencies, civil society organizations, and neighboring countries in addressing emerging challenges as well as to prevent and control cross-border health and health-related health problems at centers for IDPs and refugees. Establishing service delivery points at IDP sites and refugee centers and strengthening health services in these sites.
4	Effects of climate changes	**Strengthen health system capacity:** The MOH will implement adaptation and mitigation measures by developing Health National Adaptation Plan to reduce the health impacts of climate change and strengthen adapting capacity with the goal of building climate resilient health system. Some of mitigation measures include decrease fossil fuel combustion/extraction and emissions from agriculture and food production, improve energy efficiency of health care facilities, homes and buildings; improve waste management systems, introducing solar/wind energy for health institutions; and promoting bicycle riding as means of transportation.

Chapter 7

Monitoring and Evaluation Plan

Chapter 7: Monitoring and Evaluation Plan

This Section includes the main M&E components of the strategic plan. Detailed descriptions, definitions, indicator matrix and other components are broadly described in a separate "Monitoring and Evaluation of HSDIP" document.

7.1. Monitoring and Evaluation Framework

Description of the M&E framework

This M&E framework is meant to guide the monitoring and evaluation of HSDIP implementation. The logic model is based on the Ethiopian health system framework and adopted from the recent WHO's Monitoring and Evaluation Framework. It includes the logical relationship from health system inputs to outputs to outcomes and then ultimately to impact (Figure 5). The framework includes domains at input, output, outcome, and impact levels. It also contains a summary of data sources, data management mechanisms (data analysis and synthesis), and communication and use; and identifies key principles that the sector should follow during M&E.

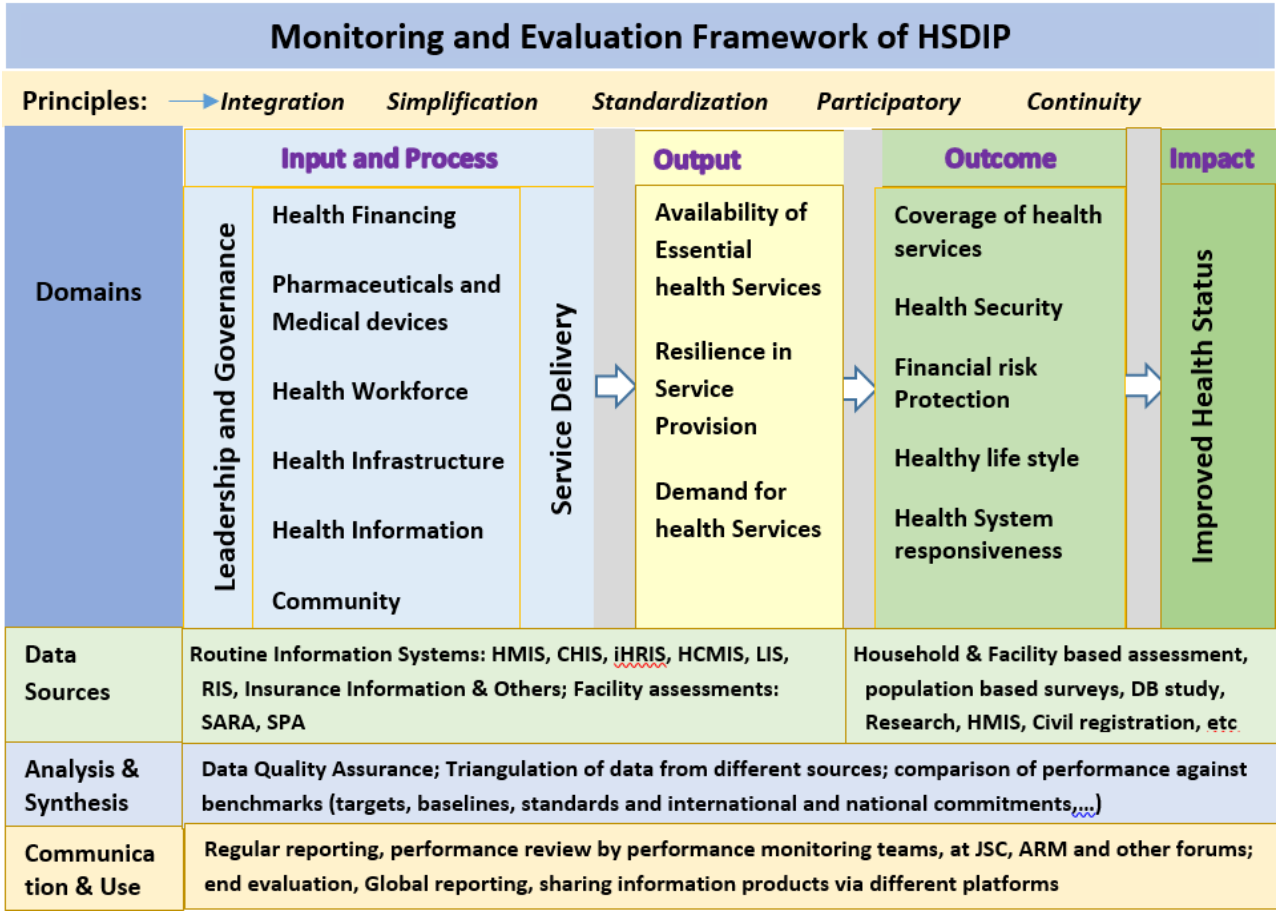

Figure 5: HSDIP Monitoring and Evaluation Framework adopted from HSTP II M&E framework

7.2. Indicators

M&E for HSDIP will use about 118 core indicators to monitor and evaluate the implementation of the strategic plan. The impact, outcome, output and input indicators were selected in a balanced way, using thoroughly defined selection criteria including relevance, availability of data sources, measurability, sensitivity, and alignment with the national and international priority health interventions and requirements. Besides the most commonly used types of indicators, indices/composite indicators are included. The period for data collection and analysis varies for each indicator. Some indicators are analyzed on a monthly basis, others quarterly, annually, at 2-3 years, and at 5 years' time.

Target setting was done using OneHealth tool with some adjustment considering criteria such as previous trend, baseline, capacity, and national and international commitments. The process was participatory, with iterative, consultative engagement of program experts and stakeholders. In addition to the listed indicators, agencies and programs in the health sector will have specific indicators related to their operational and program monitoring and evaluation. The indicator matrix for the selected indicators is detailed in Annex I.

7.3. Index measurement in HSDIP

In addition to the listed indicators in this document, composite (index) indicators will be used to measure the quality of care, equity, universal health coverage, health system responsiveness, demand index, health security, and health system resilience.

Monitoring Equity: the equity of health service use, health outcomes, and desirable healthy practices will be monitored using the commonest equity parameters including demographic (age and sex), geographical (urban/rural and regional differences) and socioeconomic characteristics (wealth and education). Indicators will be analyzed in sex disaggregation to monitor gender disparities in service provision and health outcomes. The plan is to regularly monitor and design interventions to reduce the inequality in selected parameters. The targets for the tracer equity indicators appear in Annex 2.

Monitoring Quality of Care: quality of services at health facility level will be measured based on the quality standards and measurement tools set for selected health services at hospitals and PHCU levels. The aim is to continuously measure and improve quality of health care at point of service delivery, based on various quality dimensions. Quality of services will be measured with quality of health care indicators such as reports of "positive user experience" during essential services, safety assurance during the care process, and effectiveness of the care process.

Monitoring Universal Health Coverage: Universal health coverage (UHC), which is about attaining effective coverage of essential health services and protecting people from financial hardship, will be measured using an index in this HSDIP period. The index is composed of 18 tracer indicators selected based on international recommendations, and adapted from WHO's tracking UHC. In 2019, the UHC index for Ethiopia was 0.43; the target in 2025/26 is 0.58.

Monitoring Health service responsiveness: The description and component of health service responsiveness is clearly stated in the separate "Monitoring and Evaluation Plan of HSDIP" document. The health service responsiveness index mainly measures the quality of the non-clinical aspect of health care provision. Health service-responsiveness assessment will be conducted every 2-3 years. Currently the baseline is 0.52, and the target at the end of the HSDIP period is 0.60.

Monitoring Demand Index: Effective demand for essential services reflects the potential for households and communities to utilize the essential preventive and curative services they need. Demand can be analyzed based on repeat services to identify how well the services provided are aligned to the needs of the people. The demand index will be measured using the following indicators: ANC1 _ ANC 4 dropout rate; Penta1 _ Penta3 dropout rate; BCG – MCV1 dropout rate and TB treatment dropout rate

Monitoring Health Security Index: The health security index is measured by IHR core competencies, which are organized under four major health security domains (prevention, detection, response, and others). The Ethiopian Public Health Institute will conduct a health security assessment on a yearly basis. HSDIP plans to increase the health security index from 0.63 to 0.79.

Resilience Index: The resilience index is derived from analysis of responses from key informants in relation to resilience attributes in their systems, which include awareness, diversity, versatility and self-regulation, and mobilization, adaptation and integration. The Ethiopian Public Health Institute will be responsible for conducting a survey every 5 years to determine the resilience of the health system. Based on the report from WHO for Africa region, the resilience score for Ethiopia in 2019 is 0.49, and the plan in the HSDIP period is to increase it to 0.50.

7.4. Transforming Data into Information and Action: The Data Cycle

HSDIP identified evidence-based decision-making as one of the strategic directions to transform use of information in decision-making in the sector, including the M&E system. The cycle includes how data is gathered, analyzed, interpreted, reported, shared, and used in decision-making. Hence, the components of the data cycle are described in separate “M&E of HSDIP”.

7.5. Evaluation

Evaluation of HSDIP activities will take place at end-term (2025) to assess the status of attainment of set objectives and targets. It will inform development of the subsequent strategic plan. In addition, the Joint MPH-HPN Review Mission (JRM), will be executed as scheduled in the HHM. Impact evaluation will also be conducted for selected interventions as deemed necessary.

7.6. Dissemination and communication

Monitoring and evaluation findings will be disseminated to stakeholders using different channels. Monthly, quarterly, Biannual and annual reports will be produced and submitted to the relevant government bodies; and M&E digests, health bulletins, newsletters, and fact sheets will be produced as per established schedules. Health and health-related indicators will be produced annually at RHBs and MOH level. MOH will strengthen electronic outlets, such as the website and social media, for dissemination of results. Documentation of best practices and dissemination of results will also be promoted at the international level through participation in international conferences, contribution to the debate on global health issues, and publication of scientific articles in international journals.

7.7. Coordination, Policy and Institutional Environment for Monitoring and Evaluation

The Ethiopian Public Health Institute and AHRI are mandated to conduct health related surveys and research, with the coordination of M&E, documentation and sharing of findings will be the responsibility of the Strategic Affairs Office of MOH. The newly established "Policy, Strategy and Research Lead executive Office" will map, coordinate, and lead the planning and execution of surveys, operational research, and translation of researches into action through policy dialogues, and by producing policy briefs and other evidence synthesis documents.

HSDIP promotes involvement of all stakeholders in the planning, implementation, review, and M&E process. The community will be involved in rating the health system; and the level of community involvement/ contribution in the health sector will be assessed. Community scorecards will be implemented to regularly measure the responsiveness of the health system and community satisfaction, and to identify priority areas within the health sector. Joint coordination platforms will be used for planning, monitoring and evaluation. The platforms include, Joint Steering Committee, Joint Consultative Forum, and Joint Core Coordinating Committee (described in the "Implementation Arrangement" chapter).

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Annexes

Annex 1: Indicators and Targets of HSDIP

The indicator matrix includes the list of the indicators, their category, type, data source, baseline and targets of HSDIP.

Table 7. HSDIP core indicator matrix

S.No	Strategic objectives, programs and indicators	Type of Indicator	Level of Data Collection	Data Source	Frequency of data collection / Analysis	Baseline 2022/23	HSDIP Yearly Target (EFY)		
							2023/24	2024/25	2025/26
	General								
1	Life Expectancy at Birth (years)	Impact	Population	WHS	5 years	68.7			70
2	UHC Index	Outcome	Facility	WHS	2-3 years	0.38			0.58
3	Maternal Mortality ratio - Per 100,000 live births	Impact	Population	EDHS	5 years	267			199
4	Under 5 Mortality Rate – per 1,000 LB (%)	Impact	Population	EDHS	5 yrs/2-3 yrs	47			44
1	**Improve Maternal and Child Health and Nutrition Program**								
1.1	**Family Planning and Reproductive**								
5	Total Fertility rate (TFR)	Impact	Population	EDHS	5 years	4.1			3.6
6	Contraceptive Prevalence Rate (%)	Outcome	Population	EDHS	5 years	39.5	41	43	45
1.2	**Maternal Health**								
7	Proportion of pregnant woman who received early antenatal first contact < 12 weeks (%)	Outcome	Facility	HMIS	Monthly	22	29	35	40
8	Proportion of pregnant women who received antenatal care 8 contacts or more (%)	Outcome	Facility	HMIS	Monthly	15	20	25	30
9	Proportion of deliveries attended by skilled health personnel (%)	Outcome	Population	HMIS	Monthly	70.9	73	76	78
10	Cesarean Section Rate (%)	Outcome	Facility	HMIS	Monthly	5.4	6	7	8
11	Early Postnatal Care coverage, within 2 days (%)	Outcome	Population	HMIS	Monthly	67	73	76	78
12	Stillbirth rate (Per 1000 births) (%)	Impact	Facility	HMIS	Monthly	10.8	10.4	10	9

1.3	**Neonatal and Child Health**								
13	Infant mortality rate per - 1,000 LB (%)	Impact	Population	EDHS	5 yrs/2-3 yrs	34			32
14	Neonatal mortality rate - per 1,000 LB (%)	Impact	Population	EDHS	5 yrs/2-3 yrs	26			21
15	proportion of asphyxiated newborns resuscitated and survived	Outcome	Facility	HMIS	Monthly	83	83	84	85
16	Proportion of newborns with neonatal sepsis/Very Sever Disease (VSD) who received treatment (%)	Outcome	Facility	HMIS	Monthly	72	75	77	80
17	Proportion of under-five children with Pneumonia who received antibiotics (%)	Outcome	Facility	HMIS	Monthly	78	80	83	85
18	Proportion of under-five children with diarrhea who were treated with ORS and Zinc (%)	Outcome	Facility	HMIS	Monthly	22	36	52	60
1.4	**Immunization**								
19	Pentavalent vaccine third dose coverage (%)	Outcome	Population	EDHS	5 years	61			80
20	Measles (MCV1) immunization coverage (%)	Outcome	Population	EDHS	5 years	59			69
21	Fully immunized children coverage (%)	Outcome	Population	EDHS	5 years	44			75
1.5	**Adolescent and Youth health**								
22	Proportion of girls vaccinated for HPV (%)	Outcome	Facility	HMIS	Monthly	97	98	98	98
23	Teenage pregnancy rate (%)	Impact	Population	EDHS	5 years	13.6			9
1.6	**Nutrition Program**								
24	Stunting prevalence in children aged less than 5 years (%)	Impact	Population	EDHS	5 yrs/2-3 yrs	39	36.9	34.5	25
25	Wasting prevalence in children aged less than 5 years (%)	Impact	Population	EDHS/	5 yrs/2-3 yrs	11	9.8	8.8	7.8
26	Proportion of children participating in Growth Monitoring and Promotion (GMP) for 0-24 months (%)	Outcome	Facility	HMIS	Monthly	63	65	70	75
27	Proportion of pregnant women who received iron & folic acid supplements at least 90 plus (%)	Outcome	Population	EDHS	5 yrs/2-3 yrs	17	19	21	23
28	Proportion of Exclusive Breastfeeding (EBF) for children under six months (%)	Outcome	Population	EDHS	5 yrs/2-3 yrs	61	62	64	66
29	Proportion of children 6-59 months who received vitamin A supplementation (%)	Outcome	Population	EDHS	5 yrs/2-3 yrs	19	24.7	30.4	37.1

2	**Improve Disease prevention and control**								
2.1	**HIV/AIDS Prevention and Control**								
30	Proportion of HIV exposed infants that received ARV Prophylaxis (%)	Outcome	Facility	HMIS	Monthly	54	70	75	95
31	Percentage of HIV positive pregnant, laboring, and lactating women who received ARV (%)	Outcome	Facility	HMIS	Monthly	77	93	94	95
32	Proportion of people living with HIV who know their HIV status (%)	Outcome	Population	EDHS	5 years	85.5	90	93	95
33	PLHIVs who know their status and receives ART (ART coverage from those who know their status) (%)	Outcome	Facility	HMIS	Monthly	98	98	98	98
34	Percentage of people receiving antiretroviral therapy with viral suppression (%)	Outcome	Facility	HMIS	Monthly	96	96	97	97
2.2	**TB, Leprosy and Other lung diseases Prevention and Control**								
35	TB case detection rate for all forms of TB (%)	Outcome	Facility	HMIS	Monthly	95	95	96	96
36	TB treatment success rate (%)	Outcome	Facility	HMIS	Monthly	96	96	97	97
37	Number of DR TB cases detected	Outcome	Facility	HMIS	Monthly	882	1244	1283	1301
38	RR/MDR-TB Treatment Success rate (%)	Outcome	Facility	HMIS	Monthly	79	80	81	83
39	Grade II disability among new cases (%)	Outcome	Facility	HMIS	Quarterly	12	9	7	5
2.3	**Malaria prevention and Control**								
40	Malaria incidence rate (per 1000 Population at risk)	Impact	Facility	HMIS	Monthly	47.2	37.8	27.6	17.9
41	Malaria death rate (per 100,000)	Impact	Facility	HMIS	Monthly	0.41	0.35	0.29	0.21
2.4	**Non-communicable diseases prevention and control, and Mental Health**								
42	Proportion of hypertensive adults whose blood pressure is controlled (%)	Outcome	Facility	HMIS/ STEPS	Monthly	NA	40	42.5	45
43	Proportion of DM patients whose blood sugar is controlled (%)	Outcome	Facility	HMIS/ STEPS	Monthly	NA	45	50	55
44	Proportion of individuals treated for priority mental health disorders (%)	Outcome	Facility	HMIS	Monthly	3.2	4.5	5	5.5
45	Proportion of Women age 30 - 49 years screened for cervical cancers (%)	Outcome	Facility	HMIS	Monthly	12.7	18	28	38
46	Cataract Surgical Rate (per year Per 1,000,000 population)	Outcome	Facility	HMIS	Monthly	826	850	1000	1500

2.5	**Prevention and control of Neglected Tropical diseases**								
47	Proportion of trachomatous trichiasis cases who received corrective TT surgery (%)	Outcome	Facility	HMIS	Monthly	67	75	90	100
48	Proportion of SCH endemic districts treated with minimum WHO threshold	outcome	HP	HMIS	Monthly	70	100	100	100
3	**Improve community engagement and Primary Health Care**								
3.1	**WASH, Environmental Health and Community Engagement**								
49	Proportion of households having basic sanitation facilities (%)	Outcome	Facility	HMIS	Quarter	52	55	60	65
50	Proportion of health facilities having basic sanitation facilities (%)	Outcome	Facility	HMIS	Quarterly	62	68	75	80
51	Proportion of health care facilities having basic health care waste management (%)	Outcome	Facility	HMIS	Quarterly	63	68	72	75
52	Proportion of Model households (%)	Outcome	Facility	HMIS	Quarterly	23	25	30	35
53	Proportion of model kebele (%)	Outcome	Kebele	HMIS	Quarterly	18	25	30	35
3.2	**Strengthen Health Extension Program and PHC**								
54	Proportion of high performing Primary Health Care Units (PHCUs) (%)	Output	Facility	Admin Report	Quarterly	26	27	31	35
55	Number of health centers providing major emergency and essential surgical care	Output	Facility	Admin Report	Annually	32	174	250	300
56	Number of health posts providing comprehensive health extension services	Output	Facility	HMIS	Quarterly	49	100	600	1159
4	**Improve access to quality medical health services**								
4.1	**Pre-Facility, Emergency, injury and Critical Care Services**								
57	Ambulance Response rate (%)	Output	Woreda	HMIS	Monthly	83	85	88	90
58	ICU mortality rate (%)	Outcome	Facility	HMIS	Monthly	26	25	24	24
59	Emergency mortality rate (%)	Outcome	Facility	HMIS	Monthly	0.2	0.18	0.16	0.15
4.2	**Hospital and Diagnostic services, and Specialty and Rehabilitation Services**								
60	Outpatient attendance per capita	Outcome	Facility	HMIS	Annually	1.5	1.56	1.62	1.68
61	Inpatient mortality rate (%)	Impact	Facility	HMIS	Monthly	1.04	<2	<2	<2
62	Bed Occupancy Rate (%)	Output	Facility	HMIS	Monthly	68	69	70	72

4.3	**Blood and Tissue Services**								
63	Rate of donation per 1000 population	Input	Blood Banks	Admin Report	Quarterly	3.5	4.2	5.1	5.42
64	Percentage of component production per total population (%)	Output	Blood Banks	Admin Report	Annual	16	25	30	35
5	**Improve PHEM and post conflict Recovery and rehabilitation Program**								
5.1	**Health emergency and disaster risk management**								
65	Health Security Index	Outcome	Facility	IHR SPAR	2-3 years	74	75	75.5	76
66	Proportion of epidemics controlled within the standard of mortality (%)	Outcome	Facility	PHEM Report	Monthly	80	90	95	100
5.2	**Laboratory Services**								
67	The proportion of health laboratories implementing Basic Laboratory Quality Management Systems (BLQMS)	Input	Facility	Admin report	Annual	70	80	85	90
68	Proportion of laboratories providing standardized laboratory testing services as per national standard (%)	Outcome	Facility	spot check	Annual	73	81	87	95
5.3	**Post conflict Recovery and rehabilitation**								
69	Restoration of Essential health service in all health facilities	Input	Facility	Admin Report	Annual	0	75	90	100
6	**Improve Health System Capacity and Regulation**								
6.1	**Leadership and Governance**								
70	Proportion of Primary Health Care Facilities implemented Community Score Card (%)	Input	facility	Admin Report	Annual	58	65	70	75
6.2	**Health Workforce**								
71	Number of health professionals enrolled in specialty training	Input	Facility	Admin Report	Annual	1389	1509	1300	1200
72	Health workers density (Physician, Nurses, Midwives and Health Officer) per 1,000 population	Input	Facility	HMIS	Annual	1.75	1.8	2	2.3
73	Health care workers' attrition rate (%)	Outcome	Facility	HMIS	Annual	3.3	3.2	3.1	3
6.3	**Health infrastructure**								
74	Proportion of health facilities (health centers and hospitals) with basic amenities (water, electricity, and basic sanitation)								

	Improved water supply	Input	Facility	HMIS	Annual	76	80	83	85
	Electricity	Input	Facility	HMIS	Annual	77	80	82	85
	Improved basic sanitation/latrine	Input	Facility	HMIS	Annual	62	65	70	75
6.4	**Health Information and Research**								
75	Information use index	Outcome	Facility	Survey	Annual	60	65	70	85
76	Proportion of births notified (from total births)	Input	Facility	HMIS	Monthly	75	78	80	85
77	proportion of deaths notified (from total deaths)	Input	Facility	HMIS	Monthly	4	10	25	35
78	Proportion of health facilities that met a data verification factor within 10% range for Skilled birth attendance	Input	Facility	Survey	Annual	89	90	93	95
79	Report completeness (%)	Input	Facility	HMIS	Monthly	85	92	93	95
80	Report Timeliness (%)	Input	Facility	HMIS	Monthly	41	85	90	95
81	Number of researches conducted	Input	MOH	Admin Report	Annual	161	165	170	175
82	Number of Policy briefs prepared	Input	MOH	Admin Report	Annual	3	4	8	12
6.5	**Digital health**								
83	Proportion of health posts implementing electronic CHIS	Input	Facility	Admin Report	Annual	45	55	65	70
84	Proportion of Hospitals Implementing EMR solution	Input	Facility	Admin Report	Annual	5.25	15	25	50
6.6	**Strengthen the Regulatory System**								
85	Proportion of health institutions implementing compulsory Ethiopian health institutions standards	Input	Facility	Survey	Annual	62	65	70	80
86	Proportion of health institutions registered with service domain data on Master facility Registry (MFR)	Input	Facility	MFR	Annual	70	90	100	100
87	Proportion health professionals who have active license	Input	Facility	Survey	Annual	72	90	95	100
88	Proportion of ethical issues of the health professionals that have been resolved (%)	Outcome	MOH	Admin Report	Annual	51	75	85	100
89	Proportion of health related institutions implementing compulsory Ethiopian hygiene and environmental health standards	Input	Facility	Survey	Annual	12	25	43	53

90	Number of health professional types (cadres) in which competency assessment exam was given before the graduates are joining heath workforce	Input	MoH	Admin Report	Annual	13	18	20	20
91	Prevalence of tobacco smoking and use	Outcome	EFDA	survey	2-3 years	5			3
92	Prevalence of unsafe and illegal food products in the market (%)	Outcome	EFDA	survey	2-3 years	37.2			30
93	Percentage of substandard and falsified medicine in the market	outcome	EFDA	survey	2-3 years	6.9			5
94	Audit inspection coverage of medicine facilities (Importers and wholesales) (%)	Input	EFDA	Admin Report	Annual	52.9	75	90	100
95	Number of drugs issued market authorization	Input	EFDA	Admin Report	Annual	867	1200	1300	1300
7	**Improve Innovation for Health system quality, Equity and safety**								
96	Client satisfaction rate (%)	Outcome	Facility	KPI Report	Quarterly	78	77	80	85
97	Reduce surgical-site infection rate.	Outcome	Facility	KPI	Monthly	1.7	<5%	<5%	<5%
98	Ratio of deliveries assisted by Skilled Birth Attendants between pastoralist and non-pastoralist regions	Outcome	Facility	Monthly	HMIS	0.61	0.64	0.68	0.70
8	**Improve Pharmaceuticals and Medical devices management and Production**								
8.1	**Pharmaceuticals and medical devices**								
99	Availability of essential medicines by level of health care (%)	Input	Facility	HMIS	Monthly	83	87	89	92
100	Proportion of clients received all prescribed drugs from respective health facilities (%)	Input	Facility	HMIS	Annual	68	86	88	90
101	Drug wastage rate (%)	Input	Facility	HMIS	Annual	0.72	0.70	0.68	0.66
102	Number of days it takes to procure medicines (in days)	Input	MOH	Admin Report	Annual	194	180	170	160
103	Proportion of health facilities implementing auditable pharmaceutical transaction system (%)	Input	Facility	Admin Report	Annual	10.4	21	27	33
8.2	**Domestic Pharmaceuticals and Medical Manufacturing**								
104	Contribution of local manufacturing out of the national pharmaceuticals supplies (%)	Input	MOH	Admin report	Annual	8	35	42	47

105	Number of pharmaceutical factories initiated production	Input	MOH	Admin report	Annual	2	6	7	8
106	Production capacity of domestic drug factories (%)	Input	MOH	Admin report	Annual	46	49	52	58
8.3	**Traditional Medicine**								
107	Number of scientifically validated traditional medicine products	Input	MOH	Admin Report	Annual	3	1		
9	**Improve Health Financing and private engagement**								
9.1	**Health Revenue Mobilizing Capacity Improvement**								
108	General government expenditure on health (GGHE) as a share of total general government expenditure (GGE) (%)	Outcome	MOH	Finance report	2-3 years/	11.7	12.33	13.01	13.72
109	Total health expenditure per-capita (USD)	Input	Population	NHA	2-3 years	36	38	40	42
110	Out of Pocket Expenditure as a share of total health expenditure (THE) (%)	Outcome	Population	NHA	2-3 years	30.5	28	26	25
111	Amount of money pledged from Development partners ($USD)	Input	MOH	Admin Report	Annual	590,619,339	541,614,195	568,694,905	595,775,615
9.2	**Universal Health Insurance**								
112	Proportion of eligible households enrolled in Community Based Health Insurance (CBHI)	Outcome	WoHO	HIIS	Annual	81	85	88	90
113	Proportion of eligible civil servants covered by Social Health Insurance (SHI)	Input	Population		Quarterly	0	50	75	100
9.3	**Private sector engagement**								
114	Number of private investment projects in health	Input	MOH	Admin report	Annual	132	115	140	155
115	Amount of foreign direct investment capital in in health sector (in birr)	Input	MOH	Admin report	Annual	9,322,908,000	9,304,784,000	10,931,996,000	12,462,534,000
116	Amount of investment capital of local investors in health sector	Input	MOH	Admin report	Annual	35,197,531,000	3,305,306,000	16,287,514,000	14,817,829,000
117	Number of projects implemented/established by public-private partnership	Input	MOH	Admin report	Annual	0	0	1	1
118	Proportion of private facilities reporting to DHIS2 (%)	Output	Facility	HMIS	Monthly	36	40	45	50

Annex 2: Equity indicators and targets

No	Equity Indicators	Data Source	Baseline	Target
1	Ratio of deliveries assisted by Skilled Birth Attendants between pastoralist and non-pastoralist regions	HMIS/survey		0.70
2	Ratio of deliveries assisted by Skilled Birth Attendants between Rural and Urban	HMIS/Survey		0.50
3	Ratio of SBA between lowest and highest wealth quintiles	Survey		0.50
4	Ratio of pentavalent 3 coverage between the lowest quartile and highest wealth quintile	EDHS		0.75
5	Ratio of average Pentavalent 3 coverage between woredas below and above the national median	HMIS		
6	Ratio of OPD attendance between Males and Females	HMIS		0.92
7	Ratio of OPD attendance between Rural and Urban	HMIS		0.90
8	Ratio of OPD attendance Between Pastoralist and Non pastoralist regions	HMIS		0.90
9	Ratio of Stunting between urban to rural	EDHS		0.75
10	Ratio of “Coverage of currently on ART” between pediatrics (<15) and Adults (>15)	HMIS		0.80
11	Ratio of facilities with basic amenities (water, electricity, sanitation facilities and ICT network) between rural and urban	SARA		0.90
12	Availability of essential drugs by Rural and Urban facilities	LMIS		0.90

Annex 3. Strategic objectives and programs/service in HSDIP

S.N	Programs/Services	Sub-Programs/Services
1	Maternal, child health and Nutrition Program	Family Planning and Reproductive
		Maternal Health
		Newborn and Child Health
		Immunization Program
		Adolescent and Youth health
		Nutrition Program
2	Disease prevention and control Programs	HIV/AIDS and Viral Hepatitis Prevention and Control
		TB and Leprosy prevention and Control
		Malaria prevention, Control and elimination
		Non-communicable diseases prevention and control, and Mental Health
		Prevention and control of Neglected Tropical diseases
3	Community Engagement and Primary Health Care Program	WASH and Environmental Health
		Health Extension Program and Primary Health Care
		Community Engagement and Ownership
4	Access to quality medical health services	Pre-Facility, Emergency, injury and Critical Care Services
		Hospital and Diagnostic services
		Specialty and Rehabilitation Services
		Blood and Tissue Services
5	Public Health Emergency Management, and post conflict Recovery and rehabilitation Program	Health emergency and disaster risk management
		Laboratory Services
		Post conflict Recovery and rehabilitation
6	Health System Capacity building and Regulatory Program	Leadership and Governance
		Health Workforce Improvement
		Health infrastructure
		Health Information and Research
		Digital health and ICT Infrastructure
		Strengthen Regulatory System
7	Innovation for Health system quality, Equity and safety	Institutionalized Quality Culture
		Health Equity and Social Determinants of Health
8	Pharmaceuticals and Medical devices management and Production	Pharmaceuticals and Medical devices
		Domestic Pharmaceuticals and Medical Manufacturing
		Traditional Medicine
9	Health Financing and private engagement improvement	Capacity Improvement of Health Revenue Mobilizing
		Universal Health Insurance
		Private engagement in heath service provision

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