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MINISTRY OF HEALTH - ETHIOPIA

ANNUAL PERFORMANCE REPORT OF 2017 EFY

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Driving Health Gains Through Sustainable Investments and Innovations

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The 27th Annual Review Meeting of the Health Sector

October, 2025

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Driving Health Gains Through Sustainable Investments and Innovations

October, 2025

Contents

Foreword

Mekdes Daba (MD, MPH)

Minister, Ministry of Health,
Federal Democratic Republic of Ethiopia

It is with great honor that I present this Annual Health Sector Performance Report, which reflects the collective efforts and dedication of our health workforce, partners, stakeholders and communities. During the 2017 fiscal year, we have recorded notable achievements in expanding access to essential health services, improving maternal and child health outcomes, enhancing disease prevention and control interventions, enhancing health system capacity and advancing digital health innovations. These accomplishments demonstrate the resilience of our health system and the commitment of all stakeholders to advancing the health of our people.

Despite this progress, we continue to face challenges, including resource constraints, inequities in access, the double burden of communicable and non-communicable diseases, and the occurrence of emergencies and conflicts in some parts of the country. Addressing these challenges requires sustained investment, innovation, and strengthened partnerships and this reminds us of the importance of intensifying our efforts to accelerate progress toward universal health coverage.

Looking ahead, our priorities for the coming year will focus on building a more sustainable and resilient health system. Key areas of focus include advancing sustainable health financing, strengthening primary health care as the cornerstone of quality and equitable service delivery, promoting local pharmaceutical manufacturing to enhance self-reliance and supply chain security, investing in human resources for health and fostering innovation and technology to improve efficiency and impact.

On behalf of the Ministry of Health, I extend my sincere appreciation to our health workers, development partners, civil society organizations, academic institutions, the private sector and the community for dedication, commitment and collaboration. Together, we will continue to transform our health system and ensure better health for all the people of Ethiopia.

Acknowledgments

The Ministry of Health extends its sincere appreciation to all who contributed to the preparation of this Annual Health Sector Performance Report. The report was developed through the dedicated efforts of the Technical Working Group from the Strategic Affairs Executive Office, whose leadership and coordination were critical in bringing together inputs from across the health system. We acknowledge the valuable contributions of Regional Health Bureaus, Zonal Health Departments, Woreda Health Offices, health facilities, and other stakeholders at all levels, whose timely provision of data and insights formed the foundation of this report.

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Acronyms

AA	Addis Ababa
ALOS	Average Length of Stay
ANC	Antenatal Care
ANC 4+	Antenatal Care Four or more contacts
ANC 8	Antenatal Care eight contacts
APR	Annual Performance Report
APTS	Auditable Pharmaceutical Transaction and Service
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARV	Antiretroviral
BG	Benishangul Gumuz
BOR	Bed Occupancy Rate
C/S	Caesarean Section
CAG	Community ART Group
CAR	Contraceptive Acceptance rate
CBHI	Community Based Health Insurance
CBMP	Capacity Building and Mentorship Program
CBNC	Community Based Newborn Care
CBS	Case Based Surveillance
Central Eth	Central Ethiopia Region
CFR	Case Fatality Rate
CHIS	Community Health Information System
CHP	Comprehensive Health Post
CHX	Chlorhexidine
CLM	Community led Monitoring
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
CRVS	Civil registration and vital statistic
CSC	Community Score Card
CSO	Civil Society Organization
DD	Dire Dawa
DHIS2	District Health Information System
DM	Diabetes Mellitus
DP's	Development Partners
DR TB	Drug resistance Tuberculosis
DSD	Differentiated Service Delivery
EBTBS	Ethiopian Blood and Tissue Bank Service
ECD	Early Childhood Development
eCHIS	Electronic Community Health Information System
EDHS	Ethiopia Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHAQ	Ethiopian Health Alliance for Quality
EHCRIG	Ethiopian Health Center Reform Implementation Guideline
EHIS	Ethiopian Health Insurance Service
EHSTG	Ethiopian Hospital Services Transformation Guideline
EID	Early Infant Diagnosis
ENBC	Essential New-born Care
EPHCG	Ethiopian Primary health care clinical guideline
EPI	Expanded Program on Immunization
EPSS	Ethiopian Pharmaceutical Supply Service
ESS	Ethiopian Statistics Service
ETB	Ethiopian Birr
FHT	Family Health team
FNS	Food and Nutrition Strategy
FP	Family Planning
FTAR	Fast Track ART Refill
GC	Gregorian Calendar
GGI	Good Governance Index
GMP	Growth Monitoring and Promotion
GoE	Government of Ethiopia
HCs	Health Centers
HEP	Health Extension Program
HepB-BD	Hepatitis B birth dose
HEPO	Health Extension program optimization
HEW	Health Extension Workers
HIT	Health Information Technician
HIV	Human Immunodeficiency Virus
HIVST	HIV self-test
HMIS	Health Management Information System
HP	Health Post
HPV	Human Papilloma Virus
HRH	Human Resource for Health
HSDIP	Health Sector Development and Investment Plan
HSS	Health System Strengrhening
HSTP	Health Sector Transformation Plan
HSTQ	Health Service Transformation in Quality
HSWBP	Health Sector Woreda-Based Plan
ICMNCI	Integrated Community Case Management of New-born & Childhood Illness
ICS	Immigration and Citizenship Service
ICU	Intensive Care Unit
IDP	Internally Displaced People

iKMC	Immediate Kangaroo Mother Care
IMNCI	Integrated Management of Neonatal and Child Illness
IPC	Infection Prevention and Control
IPEC	Integrated people centered eye care
IPPCAR	Immediate Post-Partum Contraceptive Acceptance Rate
IPPFP	Immediate Post-Partum Family Planning
IRS	Insecticide Residual Spray
ISS	Integrated Supportive Supervision
IUCD	Intrauterine Contraceptive Device
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
KPI	Key Performance Indicators
LLINs	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MAC	Multi-Age Cohort
MAM	Moderate Acute Malnutrition
MASReP	Multi-sectoral approach for stunting reduction project
MCH	Maternal and Child Health
MCV	Measles Containing Vaccine
MDA	Mass Drug Administration
MFR	Master Facility Registry
MMD	Multi-month dispensing
MMR	Maternal Mortality Ratio
MNH	Maternal & Newborn Health
MOE	Ministry of education
MoF	Ministry of Finance
MOH	Ministry Of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
MTCT	Maternal To Child Transmission
NBC	Newborn Care
NCDs	Non-Communicable Diseases
NICU	Neonatal Intensive Care Unit
NTD	Neglected Tropical Diseases
ODF	Open Defecation Free
OPD	Outpatient Department
OVC	Orphans and Vulnerable Children
PBF	Performance Based Financing
PCC	Pre-conception Care
PEP	Post Exposure Prophylaxis
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PHPAI	Pediatric HIV Program Accelerated Initiative
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Postnatal Care
POC	Point of care
PPP	Public-Private Partnership
PrEP	Pre-exposure Prophylaxis
PTB	Pulmonary Tuberculosis
QI	Quality Improvement
RDQA	Routine Data Quality Assessment
RDT	Rapid Diagnostic Test
RHBs	Regional Health Bureau
RMNCAYH-N	Reproductive, Maternal, Neonatal, Child, Adolescents and Youth Health and Nutrition
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SAEO	Strategic Affairs Executive Office
SAM	Severe Acute Malnutrition
SBA	Skilld Birth Attendance
SBCC	Social and Behavior Change Communication
SD	Seqota Declaration
SDGs	Sustainable Development Goals
South Eth	South Ethiopia Region
SRA	Stringent Regulatory Authority
STH	Soil Transmitted Helminthiasis
SWE	Southwest Ethiopia
TB	Tuberculosis
TICs	Treatment Initiating Centers
TOT	Training of Trainers
TPT	Tuberculosis Preventive Treatment
TSR	Treatment success rate
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
USD	United States Dollar
VAS	Vitamin A Supplementation
VCT	Voluntary Counselling and Testing
VHL	Village health leaders
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
WDG	Women Development Group
WHO	World Health Organization
WoHO	Woreda Health Office

Executive Summary

This Annual Performance Report (APR) provides a comprehensive, evidence-based review of Ethiopia's health sector performance and challenges during the 2017 Ethiopian Fiscal Year (EFY). The report aims to transparently inform policymakers, development partners, and stakeholders to assist in future planning, resource allocation, and decision-making. Primarily using data from the Health Management Information System and other key sources. The report highlights achievements in reproductive, maternal, child and adolescent health (RMNCAH), nutrition, disease prevention and control, primary health care, medical services, emergency preparedness, health system capacity, innovation, pharmaceuticals, health financing and private engagement.

In 2017 EFY, Ethiopia achieved steady progress in RMNCAH, with contraceptive acceptance at 79%, antenatal care (4+ contacts) at 86%, skilled birth attendance at 80% and early postnatal care coverage within 2 days at 78%. Yet immediate postpartum family planning remained low (18%), cesarean section access was limited (6%), and regional disparities in service coverage persisted. To address the major causes of neonatal and child mortality, MOH has expanded newborn and child health interventions through facility based and community-based services. More than 4.0 million (92%) children were treated for pneumonia, >4.3 million (26%) treated for diarrhea, Kangaroo mother care was initiated for 80% of low birthweight/ premature babies, while 52% of newborns received chlorhexidine cord care. Neonatal Intensive Care Units (NICUs) treated over 168,000 neonates with an 83% recovery rate.

CAR
79%

ANC 4+
86%

Skilled birth attendance
80%

PNC within 2 days
78%

The national immunization program delivered vaccines to children, adolescents, and adults through routine services, outreach, and nationwide campaigns. Pentavalent-3, measles-1, and full immunization coverage exceeded 100% nationally, though there was a 9% dropout from pentavalent-1 to measles-1. Catch-up vaccination efforts reached over 1.4 million zero-dose and under-vaccinated children, yet an estimated 1.1 million remain unreached, mainly in conflict-affected and remote areas. The HPV multi-age cohort campaign vaccinated more than 7 million girls, while integrated measles campaigns reached 18.5 million under-five children with measles vaccine and delivered additional services. Preparations were also made for introducing malaria, Hepatitis B birth dose, Yellow Fever vaccines and transitioning to a five-dose measles schedule.

Penta 3
>3.8 million (>100%) infants

MCV 1
>3.6 million (>100%) infants

MCV 2
97% of children aged 15-23 months of age

Zero dose children
1,413,793 zero-dose children identified and vaccinated

The national nutrition program focused on implementing interventions that are nutrition-specific, nutrition-sensitive, and multi-sectoral. The major achievements in the fiscal year included growth monitoring and promotion for >3.8 million (67%) children under two, Vitamin A supplementation for over 20 million children aged 6-59 months, deworming of over 14.5 million children aged 24-59 months, screening of 58% of pregnant and lactating women, and treatment of acute malnutrition with a 90% recovery rate. Seqota declaration expansion phase has been implemented in 334 Woredas and preparations are completed to expand the number of woredas to 520 Woredas in the next fiscal year.

Growth monitoring and promotion

>3.8 million (67%) children

Vitamin A Supplementation

>20.5 million (>100%) children aged 6-59 months

Deworming Service

>14.49 million (>100%) children aged 24-59 months

The prevention and control of communicable diseases resulted in significant progress during the fiscal year. The PMTCT program achieved high coverage, testing over 4.1 million pregnant and lactating women (100%), with 87% of HIV-positive women receiving ART, and 72% of HIV exposed infants received ARV prophylaxis. More than 7.7 million people were tested for HIV, identifying 36,216 new HIV-positive cases. A total of 536,067 PLHIV were on ART, representing 89% of estimated PLHIV. The performance of the three 95-95-95 HIV targets was 94%, 97% and 97% respectively. TB case notification reached 134 per 100,000 population, with 150,654 cases treated, achieving 92% TB treatment coverage. TB treatment outcomes improved, with cure rates reaching 87% and treatment success above 94% across all forms of TB. A total of 652 drug-resistant TB cases were detected and treated. A total of 2,787 new leprosy cases were detected, with a national notification rate of 0.25 per 10,000 population. In the fiscal year, Ethiopia experienced a significant malaria resurgence, reporting 10.9 million cases and 754 deaths, corresponding to an incidence of 141 per 1,000 population at risk. Key malaria prevention interventions included distribution of 2.2 million long-lasting insecticidal nets (LLINs), indoor residual spraying covering 1.94 million households, larval source management targeting 22 billion m² of breeding sites, and malaria elimination activities in 565 districts.

HIV/AIDS

1st 95 performance = 94%
2nd 95 = 97%
3rd 95= 97%

TB incidence

146 new TB cases per 100,000 population;
150,654 TB cases detected and treated;
TB Cure rate: 89%

Malaria

10.9 million malaria cases treated

LLTIN

>2.2 million

IRS

1.9-million-unit structures

To strengthen the prevention and control of non-communicable diseases various interventions were implemented. More than 25.9 million individuals were Screened for hypertension, with 384,726 newly enrolled in care. Diabetes screening covered 6.1 million individuals, enrolling 92,252 new patients. Over 1.1 million women aged 30–49 were screened and 77% of those with precancerous lesions received treatment. More than 105,073 cataract surgeries were done, which is 934 surgeries per million population. Mental health services is expanded to 1,600 facilities, with integration into primary care. A total of 498,836 MNS cases were reported, a 22% increase from the previous year, with epilepsy accounting for the highest burden, followed by psychosis, depression, bipolar disorder, and substance use disorders.

Hypertension Screening

>25.9 million individuals

Diabetes Mellitus screening

>6.1 million individuals

Cervical Cancer screening

>1.1 million women aged 30-49

Community engagement (CE) is central to Ethiopia's PHC, enabling communities to actively participate in planning, delivering, and evaluating services. By 2017 EFY, the redesigned CE strategy reached 330 woredas, with Village Health Leaders and Women Development Unions supporting community health services. As per the HEP optimization roadmap, 2,419 health posts were merged with nearby

facilities (92% of the target) and 3,133 health centers established Community Health Program units (82% of the target). The number of Comprehensive Health Posts grew from 107 to 260. Health Center reforms and quality improvement initiatives were implemented through key reforms such as EHCRIG, EPAQ, and EPHCG—to enhanced governance, clinical standards, and quality improvement. EHCRIG average score was 79%, EPAQ covered 52% of clusters and EPHCG has been expanded to 3,606 centers (92%). To improve emergency surgery and C-Section services at health centers, the number of health centers with OR blocks and CS service has increased from 125 to 185, enabling 14,777 C-section deliveries at health centers. Household access to basic sanitation reached 38%, while 43% had safe solid waste disposal systems and 33% had adequate liquid waste management. At the institutional level, 54% of health facilities had basic sanitation, 74% had healthcare waste management systems, and 52% had water sources.

80%
Health centers with community health program units

185
Health centers with OR block and surgical service

14,777
Caesarean sections done at health centers

Medical and emergency services have been strengthened through pre-facility and facility-based initiatives. In the fiscal year, more than 6.6 million emergency cases were treated, and the emergency department mortality rate has decreased to 0.16% and the ICU mortality rate has declined to 23%. Surgical services were expanded, with 451,427 major procedures (44% elective, 56% emergency) and "Day Care Surgery" launched in 10 hospitals. Medical oxygen capacity increased to 58 plants nationwide. The OPD visits per capita was 2.08, but with notable regional disparities ranging from 0.38 (Somali) to 4.14 (Addis Ababa). Hospital efficiency indicators showed mixed trends: average length of stay slightly declined to 4.44 days, bed occupancy rate averaged 67%, and bed density improved to 3.2 per 10,000 population. Rehabilitation services were scaled up through local production and distribution of assistive technologies, reaching over 56,000 individuals. Physiotherapy is available in 41% of general hospitals and 85% of tertiary hospitals. About 423,295 units of whole blood was collected by 56 blood banks across the country. From the total blood collected, 14% was separated into blood components.

OPD attendance:
>233.8 OPD visits; OPD attendance per capita = 2.08

Inpatient admission rate
17.7 per 1,000 population

Hospital Bed Occupancy Rate
67%

Average Length of Stay (ALOS)
4.4 days

Health system inputs are the essential resources required to deliver effective, equitable, and quality health services. A total of 15,407 functional health posts, 3,932 health centers, and 275 primary hospitals were delivering primary health services. Secondary and tertiary care services were provided by 108 general hospitals and 32 comprehensive specialized hospitals. The total health workforce in 2017 EFY was 492,181, of which 66% were health professionals and 34% were administrative/supportive staff. The core health professional density, including physicians, health officers, nurses, and midwives, was 1.62 per 1,000 population, below the HSDIP target of 2.3. Regarding health information systems, health facility service report completeness and timeliness was 92% and 49% respectively. Civil registration and Vital Statistics implementation was strengthened, with a birth notification rate of 70% but death notification remained low at 5%. Electronic Community Health Information System (eCHIS) implementation was scaled up to more than 9,000 health posts, through which over 6.8 million households and 28.5 million individuals are registered in the system. Electronic Medical Record is implemented in 120 public health facilities.

HWF density of core health professionals
1.62 per 1000 population

Regulation is central to Ethiopia's health sector, ensuring the safety, quality, and efficacy of food, medicines, medical devices, health services, and professionals. In 2017 EFY, the Ethiopian Food and

Drug Authority licensed over 4,186 food items, 746 new medicines, and numerous medical devices, cosmetics, and tobacco products, while conducting extensive inspections, audits, and post-market surveillance. Health and health-related institutions were inspected nationwide, with thousands of facilities newly licensed, non-compliant establishments sanctioned, and self-regulation systems expanded. Competency assessments were provided to 19,653 health professionals, with a pass rate of 61%. Achievements such as WHO Maturity Level 3 certification in pharmaceuticals and ISO-accredited quality assurance reflect strengthened regulatory capacity, while ongoing challenges in human resources, infrastructure, and compliance highlight priority areas for future improvement.

Significant progress was recorded in pharmaceutical, medical supplies, and traditional medicine. Pharmaceuticals and medical supplies worth 52.3 billion birr were procured, and medicines worth of 64.54 billion birr was distributed to health facilities, supported by improved supply chain management, digital tracking systems, and enhanced vaccine distribution, including pilot drone deliveries. Medical device management and maintenance services were strengthened, achieving cost savings of ETB 161.1 million. Availability of essential medicines at health facilities was 84%, though antibiotic overuse was high, with 51% of clients receiving antibiotics (higher than the expected 20-30%). Antimicrobial resistance programs were expanded across 328 facilities.

Procurement

> 52.3 Billion ETB worth of pharmaceuticals and medical supplies

Distribution

Pharmaceuticals and medical supplies worth of ETB 64.5 Billion

Availability of tracer essential medicines at health facilities

84%

Health financing has been strengthened to improve mobilization of adequate resources and efficiency. Performance based financing (PBF) piloting continued in three regions and documented improvements in data quality, data use, resource mobilization and service quality. PBF was granted a unique revenue code 1484 by the Ministry of Finance. Development partners contributed over USD 334.8 million, from which 63.1 million USD was disbursed through the SDG performance fund. At the national level, public budget allocation to health was 12.1% of the total government budget, but with regional variations from 8.0% in Harari to 14.7% in Amhara and Benishangul-Gumuz. Public Private Partnership projects on diagnostics and oncology service were initiated. Implementation of Community Based Health Insurance (CBHI) was expanded to 1,183 woredas (91% coverage), enrolling 13.6 million households (84% of eligible), including 9.2 million paying members and 4.2 million indigent households. A total of 15.2 billion birr was pooled from CBHI. Capitation payment mechanism was expanded to 406 Woredas and 1,048 facilities, and piloting of case-based hospital (DRG) payments began in six hospitals.

CBHI

1,304 (91%)

Woredas

Membership

>13.67 million Households (84% of the eligibles)

Budget allocation

12.1% of the total government budget allocated to health

Development partners' contribution

334.8 million USD

In conclusion, Ethiopia's health sector has made notable progress in 2017 EFY through the implementation of high-impact interventions guided by national strategic and annual plans, including strengthening health system building blocks and priority health programs. Despite the gains, significant disparities in health access, utilization, and outcomes persist across regions, particularly in pastoralist and underserved areas, highlighting the need for targeted, equity-focused interventions.

The sector continues to face challenges, including conflicts, epidemics, and other emergencies that disrupt service delivery, sub-optimal supply chain management, shortages and maldistribution of health workforce, inadequate infrastructure and basic amenities at facilities, and insufficient financial resources. Addressing these challenges while sustaining ongoing reforms and investments will be critical to achieving equitable, high-quality, and resilient health services nationwide.

Chapter

1

Introduction

Chapter 1: Introduction

Health is a foundation for sustainable development, and Ethiopia has demonstrated considerable progress in expanding access to essential health services across its diverse population. Through a three-tiered health system that includes Primary level of care (health posts, health centers, primary hospitals), secondary level (general hospitals), and tertiary level (comprehensive specialized hospitals), the country aims to ensure access to and utilization of equitable and quality care and improve the health status of the population.

Guided by the Health Sector Development and Investment Plan (HSDIP), aligned with the Sustainable Development Goals (SDGs), and informed by national and global health priorities, Ethiopia has focused on strengthening service delivery, improving health system inputs and the overall health system to accelerate progress toward universal health coverage and improved population health outcomes. By building on successes and addressing gaps, Ethiopia is continuing its commitment to improve the health and wellbeing of all its citizens, and to ensure that health becomes a driver of national development.

This Annual Performance Report (APR) presents a comprehensive review of the health sector's performance and challenges during the 2017 Ethiopian Fiscal Year (Hamle 2016 – Sene 2017). The report aims to provide evidence-based information to policy makers, development partners and other stakeholders in a transparent, accountable manner to assist in future planning, resource allocation and decision making. The scope of the report covers key health system building blocks and programmatic areas.

This report primarily uses data from the routine Health Management Information System (HMIS) captured through the DHIS2 platform, covering all levels from health posts to the Ministry of Health. Additional sources include the Public Health Emergency Management system, Human Resource Information System, Ethiopian Food and Drug Administration database, Health Insurance Information System, Health Commodity Management Information System, administrative program reports, and global reports or estimates for selected areas. Population data are based on 2017 EFY projections from the Ethiopian Statistical Service. Service utilization was assessed using selected core indicators for each program area. Indicator values were calculated based on eligible populations and compared with baselines and targets to track progress. Coverage was disaggregated by region, age, sex, and other equity parameters, and trends over the past five years were reviewed. The report also summarizes key initiatives, challenges, and proposed actions for the upcoming fiscal year.

The process of compiling this report engaged all relevant stakeholders – government institutions at federal and regional levels, development partners, and other relevant stakeholders. The overall preparation was coordinated by a senior technical team from the Strategic Affairs Executive Office of MOH, in close consultation with directors and program experts from all executive offices.

Period: The fiscal year 2017 covers the period from Hamle 2016 to Sene 2017 in the Ethiopian calendar, corresponding to 2024/25 in the Gregorian calendar (GC). Unless otherwise stated, years in this report are expressed in EFY. Gregorian calendar dates are used only where specifically indicated.

Contents and organization of the report: The report is organized into sections that highlight performance across major thematic areas (based on the strategic objectives of HSDIP). The contents are divided into ten chapters

Chapter 1: Introduction - Includes the background, data sources, data analysis, contents and process of the preparation of the APR

Chapter 2: Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health and Nutrition – Includes family planning, reproductive health, maternal, neonatal and child health, immunization, adolescent and youth health and Nutrition programs and services

Chapter 3: Disease Prevention and Control – Includes major disease prevention and control programs including, HIV/AIDS, malaria and other vector-borne diseases, Tuberculosis and leprosy, non-communicable disease, neglected tropical diseases and mental illnesses

Chapter 4: Community engagement and primary health care – includes community engagement, primary health care including the health extension program, hygiene and environmental health

Chapter 5: Medical Health Services – Covers Pre-facility emergency, facility-based emergency, injury and Critical Care Services; Hospital and Diagnostic services; Specialty and sub-specialty Services; Rehabilitation Services and Blood and tissue bank services

Chapter 6: Public Health Emergency Management – deals with early warning, preparedness, response, and rehabilitation of public health emergencies such as disease epidemics

Chapter 7: Health system capacity and regulation – Covers health infrastructure, Human Resource development and management, regulation of medicines, food and other health products, regulation of health and health related institutions, regulation of health professionals; Health Information System and research, digital health and governance and leadership

Chapter 8: Innovation for health system quality, equity and safety – includes achievements and major initiatives on health innovation, quality, equity and patient safety

Chapter 9: Pharmaceuticals, medical devices management and pharmacy service –covers pharmaceutical supply chain management, management of medical devices, pharmacy services and traditional medicine

Chapter 10: Health Financing and private engagement– Covers resource mobilization, health care financing reforms, budget allocation, private engagement and health insurance

Chapter 2

Reproductive and Maternal, Neonatal, child and adolescent Health and Nutrition

Maternal and Child Mortality

Maternal Mortality ratio:
195 per 100,000 live births

Under 5 Mortality Rate:
46 per 1,000 live births

Neonatal Mortality rate:
27 per 1,000 live births

Chapter 2: Reproductive and Maternal, Neonatal, child and adolescent Health and Nutrition

2.1. Reproductive and maternal Health Services

Reproductive and Maternal Health

Family planning service

17.6 million (79%)
women of reproductive age received a modern contraceptive method

Immediate post-partum contraceptive acceptance rate
18% of women who delivered in health facilities

Antenatal Care (ANC) service

Early ANC initiation:
33%
of pregnant women-initiated ANC at or before 12 weeks of gestation

ANC 4+ coverage:
More than 3.22 million (86%)
pregnant women attended four or more ANC contacts

ANC 8+ coverage:
>1.4 million (37%)
pregnant women attended eight or more ANC contacts

Syphilis screening:
80%
of pregnant women were tested for syphilis

Testing for Hepatitis B:
73%
of pregnant women were tested for hepatitis B virus

Delivery and Postnatal Service

Skilled Delivery Attendance:
>3 million (80%)
pregnant women attended delivery at health facilities

Caesarean Section (C/S) service:
6%
pregnant women delivered by a C/S

Delivery and Postnatal Service

Uterotonic after delivery:
98%
of women who delivered at health facilities received uterotonics within the first minute after delivery

Early Post Natal Care within 2 days
78%
women received PNC within two days after delivery

Abortion Care

Abortion Service:
281,446
women received comprehensive abortion care service: 51% were safe abortion service 49% were post-abortion care services

Institutional stillbirth rate

Decreased to
9.1 stillbirths per 1,000 births

Ethiopia has significantly reduced maternal mortality over the past two decades, reducing maternal mortality ratio (MMR) from 953 per 100,000 live births in 2000 to 195 in 2023. Even though there is improvement in reducing MMR, the current performance is far from the SDG target of 70 per 100,000 live births and the 140 target of MOH. With only five years remaining to the SDG targets, this implies the need to accelerate progress in reducing MMR by implementing high impact interventions in the remaining five years. The significant reduction in MMR is related to the enabling policy environment, improved access to health services, expansion of infrastructure and skilled health workforce at primary health care level, implementation of high impact interventions during pregnancy and childbirth, especially through strengthened health extension program and the overall primary health care system.

This section presents the 2017 EFY performance on reproductive and maternal health services, benchmarked against the fiscal year's baseline and targets. In addition to the quantitative performance data, the section provides a narrative on key initiatives, major activities, achievements, and challenges observed across each program area during the fiscal year. A summary of selected key reproductive and maternal health indicators is presented in the table below, followed by a detailed report for each program area.

Table 1: Summary of selected key reproductive and maternal health indicators, 2017 EFY

Indicator	Baseline	Performance (2017 EFY)	Target for 2017 EFY	Change from baseline
Contraceptive Acceptance Rate (CAR)	75%	79%	84%	4%
Immediate Postpartum CAR	15%	18%	30%	3%
Proportion of pregnant women that initiated ANC before 12 weeks of gestational age	26%	33%	40%	7%
Antenatal Care 4+ coverage	78%	86%	85%	8%
Antenatal Care 8 coverage	27%	37%	45%	10%
Proportion of pregnant women tested for syphilis	79%	80%	95%	1%
Deliveries attended by skilled health personnel	74%	80%	85%	6%
Caesarean Section rate	6%	6%	8%	
Early Postnatal care coverage (within 2 days)	69%	78%	92%	9%
Still birth rate (per 1000 births)	10.8	9.1	8	

2.1. 1. Family Planning services

Family planning (FP) service has been one of the key health programs to improve the health of women in Ethiopia. The country is committed to increase family planning financing and improve family planning commodity security, as witnessed through the family planning compact. The FP program aims to improve access to and utilization of family planning services by ensuring the availability of quality family planning information and services to the community.

The core indicators to measure and track the performance of family planning program through the routine health management information system include contraceptive acceptance rate (CAR), contraceptive method mix, immediate postpartum contraceptive acceptance rate and removal of long-acting family planning methods. The performance of these indicators and the major activities conducted in the fiscal year are presented in this sub-section.

Contraceptive Acceptance Rate

Contraceptive acceptance rate (CAR) is the proportion of women of reproductive age (15-49 years) who are not pregnant and are accepting a modern contraceptive method (new and repeat acceptors) during the fiscal year. It measures the volume of acceptance to contraceptives and can be a proxy to contraceptive prevalence. CAR measures the uptake of contraceptive methods among new and repeat users during the fiscal year, showing the reach and effectiveness of family planning services in expanding coverage and can be used as a proxy for the overall service utilization. Over the past six years, CAR has been increasing steadily, increasing from 68% in 2011 EFY to 79% in 2017 EFY.

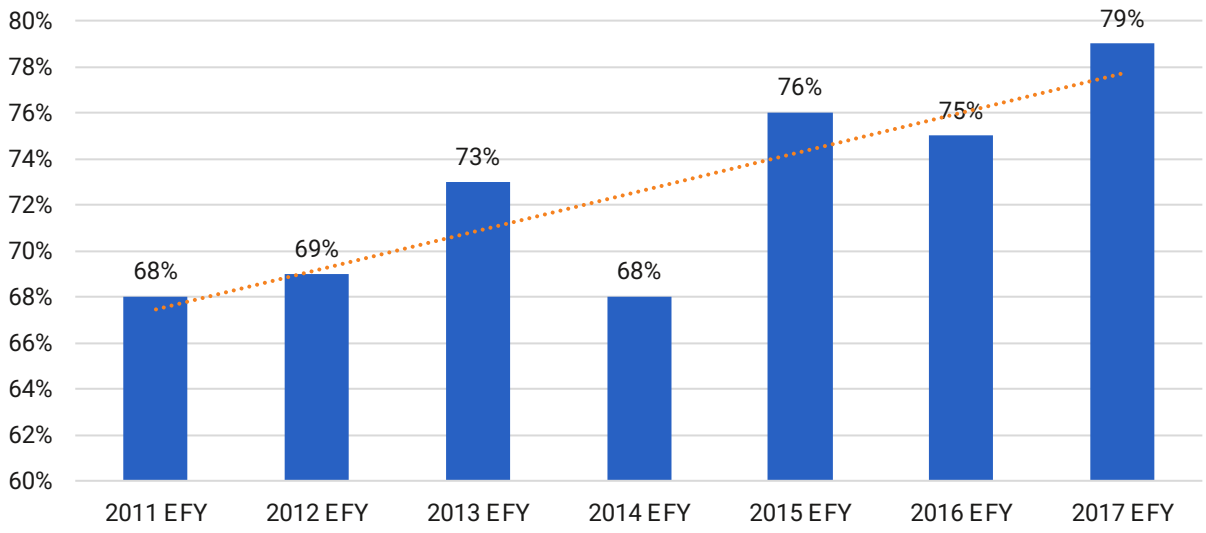
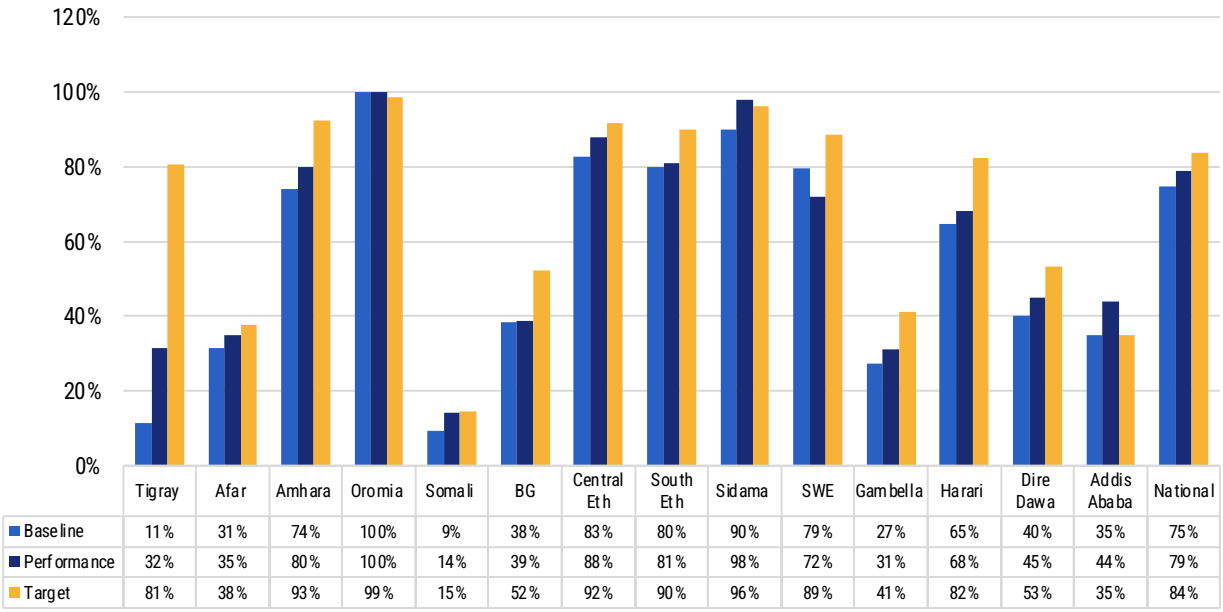


Figure 1: Trend of Contraceptive Acceptance Rate in Ethiopia, from 2011 EFY to 2017 EFY

In the fiscal year, over 17.6 million women of reproductive age received a modern contraceptive method, representing 79% of women in this age group. The performance in 2017 EFY is higher than the baseline by 4 percentage points but a little lower than the 84% target. CAR performance varies widely across regions, from as low as 14% (Somali) to more than 100% (Oromia). Three regions, namely, Oromia (105%), Sidama (98%) and Addis Ababa (44%) have achieved the annual target while all other regions have a performance lower than their target. Most regions have improved CAR during the year, compared to their baseline. For example, Tigray increased from 11% to 32% and Somali has increased from 9% to 14%. South Ethiopia and Southwest Ethiopia regions have a lower performance than their baseline.

Overall, most regions increased their contraceptive acceptance rates during 2017 EFY. However, there are gaps in Tigray and pastoralist regions (Somali, Afar, Gambella) that show persistent gaps in performance, both in baseline and current performance.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central Eth	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline	11%	31%	74%	100%	9%	38%	83%	80%	90%	79%	27%	65%	40%	35%	75%
Performance	32%	35%	80%	100%	14%	39%	88%	81%	98%	72%	31%	68%	45%	44%	79%
Target	81%	38%	93%	99%	15%	52%	92%	90%	96%	89%	41%	82%	53%	35%	84%

Figure 2: Contraceptive Acceptance Rate by region, 2017 EFY

Modern Contraceptive Method mix

Ensuring equitable access to a diverse range of contraceptive options is a priority of the family planning program. In 2017 EFY, 32% of contraceptive users were using long-term contraceptive methods, while 68% used short-term methods. Among all users, the majority used injectables (50%), followed by implants (29%) and oral contraceptive pills (17%).

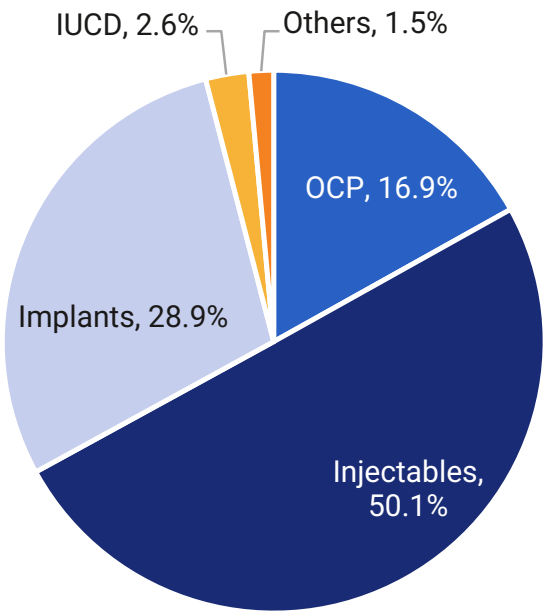
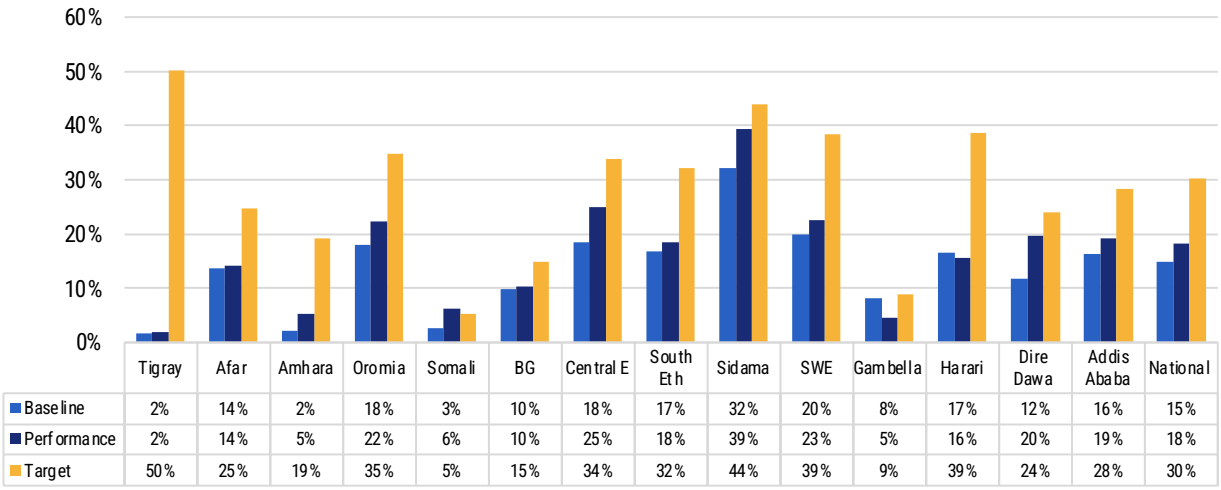


Figure 3: Modern contraceptive Method mix, 2017 EFY

Immediate Post-Partum Contraceptive Acceptance Rate (IPPCAR)

Expanding access to postpartum family planning (PPFP) service is prioritized as a key strategy to prevent unintended and closely spaced pregnancies. Over the past few years, MOH has significantly expanded the availability of PPFP services. Currently, 90% of hospitals and 70% of health centers that provide delivery services also offer immediate postpartum family planning (IPPFP) services.

During the fiscal year, about 545,810 (18%) of women who delivered in health facilities have received modern contraceptive methods during the immediate post-partum period (within 48 hours after delivery). This is a performance higher than the baseline by 3 percentage points but lower than the 30% target for the fiscal year. All regions except Gambella and Harari have a performance higher than their baseline. There is a huge regional disparity, ranging from 5% in Gambella to 39% in Sidama region.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline	2%	14%	2%	18%	3%	10%	18%	17%	32%	20%	8%	17%	12%	16%	15%
Performance	2%	14%	5%	22%	6%	10%	25%	18%	39%	23%	5%	16%	20%	19%	18%
Target	50%	25%	19%	35%	5%	15%	34%	32%	44%	39%	9%	39%	24%	28%	30%

Figure 4: Immediate post-partum contraceptive acceptance rate by region, 2017 EFY

To strengthen PPFP services, various activities have been implemented during the fiscal year, as a result of which contraceptive use during the postpartum period has increased and facilities with high institutional delivery had high PPFP uptake. The major activities include the following:

- **Integration of PPFP with MCH and other services**: PPFP counseling and services are integrated into ANC, delivery, and postnatal care services during which health facilities provide FP counseling during pregnancy and provide IPPFP service after delivery
- **Task shifting and capacity building:** Midwives, health officers, and nurses were trained to deliver PPFP services. In addition, healthcare workers receive regular refresher training and mentorship
- **Strengthening Community-Based Health Services:** Health Extension Workers promote PPFP awareness at the community level. Home visits and community education sessions emphasize the benefits of birth spacing and modern contraceptive use
- **Expanding Access to Long-Acting Reversible Contraceptives (LARCs):** Increased availability of implants and intrauterine devices (IUDs) in health facilities, including immediate postpartum insertion/dedicated PP-IUD. Training was provided for healthcare providers on postpartum IUD and implant insertion to improve service delivery
- **Guideline Development:** PPFP guidelines/training manual was developed to standardize service provision during the post-partum period. In addition, the national FP guideline emphasizes immediate postpartum FP and post-abortion FP.

- **Demand Creation and Social Behavioral Change Communication:** Mass media campaigns (radio, TV) and community dialogues were conducted to increase awareness, mainly focusing on male involvement to encourage spousal support for FP use.
- **Strengthening Referral Systems:** Improved linkages between health posts, health centers, and hospitals to ensure continuum of care and use of maternal health cards and registers to track PPFP uptake during follow-up visits. High delivery load public facilities were selected, equipment were distributed and provided orientation to revitalize PPFP

Despite these efforts, there are challenges with IPPFP service uptake. Some of the challenges include the following

- **Health system-related challenges:** Many health facilities, particularly in rural areas, lack the necessary resources (equipment, trained staff, and contraceptives) to provide effective PPFP services. There is a shortage of skilled healthcare providers trained in PPFP counseling and service delivery, leading to missed opportunities for postpartum contraceptive uptake.
- **Socio-cultural Barriers:** Low Awareness and misconceptions; religious and traditional Beliefs and opposition from male partners
- **Programmatic Challenges:** The level of integration of PPFP with maternal health Services is still weak, leading to missed opportunities
- **Accessibility Issues:** women in remote and humanitarian areas like IDP face difficulties reaching health facilities that provide PPFP services- as all facilities providing delivery aren't providing the PPFP service

Premature removal of long-acting family planning Methods

In the fiscal year, 331,694 long-acting family planning (LAFP) methods—primarily implants and IUDs—were removed. Among these, 48,958 (15%) were removed prematurely within six months of insertion, with implants constituting the majority. The rate of premature removals has declined from 30% in 2013 EFY to 15% in 2017 EFY, reflecting significant improvements in client counseling, follow-up services, and overall program quality.

2.1.2. Adolescent and Youth Health Services

Adolescents and youth constitute one-third of Ethiopia's population, with the majority living in rural areas where access to health information and services is limited. They face multiple challenges, including early marriage, high rates of teenage pregnancy, and high unmet need for family planning, as well as increased vulnerability to STIs and HIV. In addition, they are disproportionately affected by malnutrition, substance use, and mental health conditions such as depression. Risk-taking behaviors, involvement in domestic violence and conflicts, and exposure to road traffic accidents further increase their vulnerability, making adolescents and youth one of the most at-risk groups in the population.

The Government of Ethiopia has recognized the importance of prioritizing adolescents and youth, as they have a significant and vital role in the country's socio-economic development. Adolescent and youth health (AYH) issues have been integrated into national policy documents. In addition, specific strategic frameworks have been developed, including the AYH strategy, AYH Service Standards, the Adolescent and Youth Engagement Guideline, and the Smart Start Institutionalization and Scale-up Guideline.

In 2017 EFY, several adolescent and youth health–focused activities have been conducted. Some of the major activities include the following:

- **National and regional launch of the Smart Start Integrated Health Expansion Project:** The launch events were held at both national level and in selected regions (Benishangul-Gumuz, Harari, Addis Ababa and Dire Dawa). The project supports the national ISM scale-up and includes components such as Smart Start, IUCD scale-up, and the DMPA-SC self-injection (MPSC-SI) self-care initiative in selected sites
- **Capacity building on AYH:** Capacity building training was provided to health workers, HEW supervisors, HEWs, program experts, managers, and youth council members. About 13,780 HEWs were trained to support the scale-up of Smart Start in RISE woredas. In addition, healthcare providers serving in workplaces (industrial parks, flower farms, mega projects, and other employment sites) were trained on the minimum service package for workplaces to initiate and strengthen AYH services in these settings
- **Endorsement of roadmap to reduce teenage pregnancy:** Following the development of a roadmap to reduce teenage pregnancy in Ethiopia, the document was endorsed by four ministries—Ministry of Health, Ministry of Education, Ministry of Women and Social Affairs, and Ministry of Labour and Skills. Each ministry subsequently signed a Memorandum of Understanding outlining their respective responsibilities in implementing the roadmap
- **Advocacy activities:** The 5th Annual Adolescent and Youth Health Forum was celebrated with a theme "*Access and Quality: Responsive Health System for All adolescent and Youths*" in Addis Ababa, in the presence of Ministers, RHB MCH directors, AYH focal points, adolescent and youths and partner organizations. An advocacy was conducted on Smart Start and family planning, with Afar regional parliamentarians, with religious and community leaders in Tigray and with community elders and influential people in Southwest Ethiopia region. In addition, a national workshop on youth engagement was conducted on meaningful youth engagement at health facilities
- **Smart Start counselling tool development:** Smart Start counseling tools and supporting materials were developed using human-centered design methods. The tools were specifically developed for Benishangul-Gumuz and Gambela regions and translated into local languages. Additionally, an urban version of the tools was developed for use in Addis Ababa, Harari, and Dire Dawa. The tools were printed and distributed to each region.

Challenges and gaps of adolescent and youth program implementation

- **Minimal youth engagement:** Youth councils have a limited role due to budget and resource constraints, minimal engagement with RHBs, and limited action by RHBs to involve youth
- **Limited alignment among actors:** Nationally endorsed programs are poorly coordinated, partly because RHBs have not sufficiently led and coordinated partners
- **Service delivery gaps and missed opportunities:** Particularly for long-acting reversible contraception, especially IUCDs, due to limited training, follow-up, review, and advocacy
- **Inadequate mental health services:** Adolescents have limited access to mental health support
- **Persisting stigma around sexual and reproductive health (SRH):** Use of SRH services is hindered by stigma, which could be mitigated through sustained IEC/BCC efforts, advocacy, and adequate resources

- **Insufficient coverage and quality of youth-friendly services:** Contributing factors include lack of capacity-building resources, inadequate facility equipment, and absence of robust monitoring and evaluation systems

Way forward

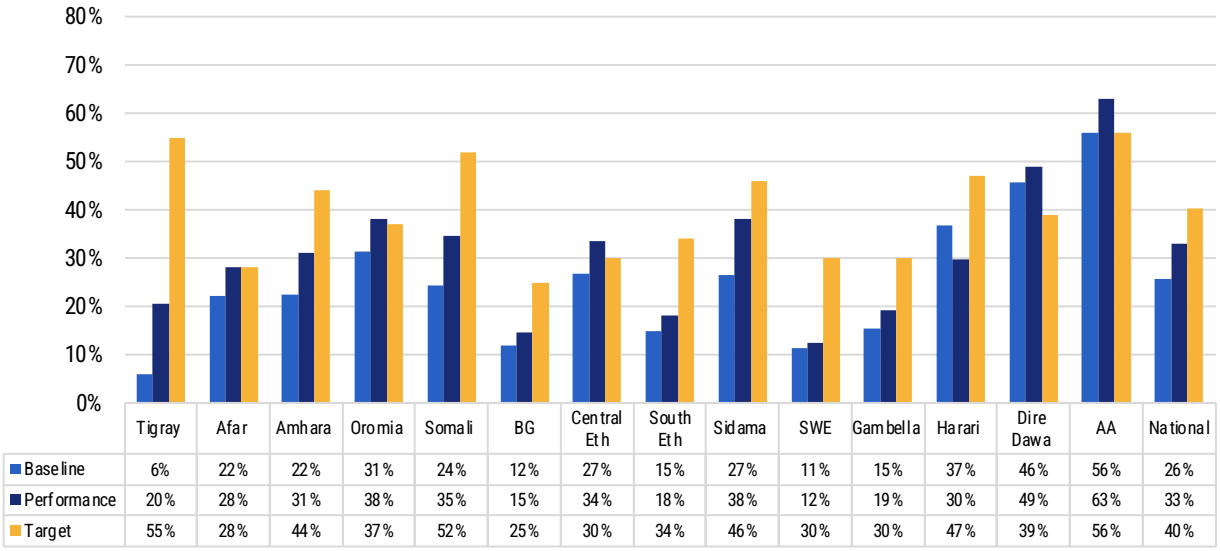
- Mobilize adequate resources for capacity building, commodities, and other program needs
- **Strengthen youth-friendly services:** Enhance provider capacity, equip facilities, provide supportive supervision and mentoring, and implement robust monitoring and evaluation systems
- **Implement the teenage pregnancy reduction roadmap:** Ensure commitments are formalized through ministerial agreements and follow-up on responsibilities.
- **Empower youth councils:** Provide adequate budgets and capacity-building opportunities to strengthen youth engagement.
- **Align partner activities:** Map partners and ensure their performance aligns with targeted support areas.
- **Follow up on advocacy action points:** Ensure actions, particularly those with institutions, are systematically implemented.
- **Address misconceptions and barriers:** Reduce stigma and misinformation using scientifically proven interventions.

2.1.3. Maternal Health Services

Antenatal Care coverage – First contact and Early Initiation

Antenatal care (ANC) is an essential component of maternal and newborn health, providing regular medical attention and support throughout pregnancy. Early initiation of ANC—ideally within the first trimester—offers numerous advantages. It enables timely identification and management of health risks such as hypertension, anemia, infections, and gestational diabetes, which can affect both mother and child. Early ANC ensures that preventive interventions, including vaccinations, iron and folic acid supplementation, and counseling on nutrition and birth preparedness, are provided promptly. It also allows healthcare providers to educate mothers on danger signs, healthy lifestyle practices, and family planning options. By starting ANC early, the risk of complications during pregnancy and childbirth is reduced, neonatal outcomes are improved, and overall maternal health is strengthened, contributing to safer pregnancies.

In 2017 EFY, almost all expected pregnant women have attended ANC at least once during their pregnancy. However, only 33% of them have started the ANC contact early (before 12 weeks of gestational age), with regional disparity ranging from 12% in SWE to 63% in Addis Ababa. Compared to the baseline, early ANC initiation has improved during this fiscal year with seven percentage points but lower than the target of 40%. The performance of all regions, except Harari, is higher than the baseline.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central Eth	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	6%	22%	22%	31%	24%	12%	27%	15%	27%	11%	15%	37%	46%	56%	26%
Performance	20%	28%	31%	38%	35%	15%	34%	18%	38%	12%	19%	30%	49%	63%	33%
Target	55%	28%	44%	37%	52%	25%	30%	34%	46%	30%	30%	47%	39%	56%	40%

Figure 5: Proportion of pregnant women that started ANC early (<=12 WKs of gestational age), 2017 EFY

Antenatal Care 4+ coverage – Four or more contacts

Attending at least four ANC contacts ensures that pregnant women receive adequate and timely care throughout the gestational period. Attending at least four ANC contacts ensures comprehensive monitoring, timely preventive interventions, education, and continuity of care. This significantly reduces risks to both mother and baby, promotes healthy pregnancies, and improves the likelihood of safe delivery and positive neonatal outcomes. Over the past six years, the trend of ANC 4+ contacts coverage has consistently increased, from 70% in 2011 EFY to 86% in 2017 EFY.

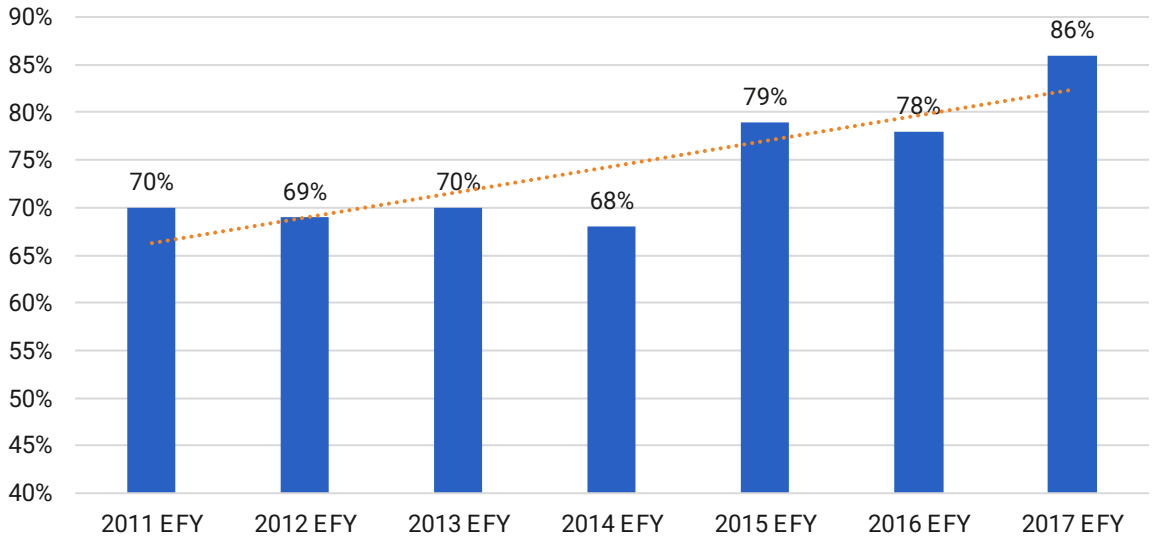
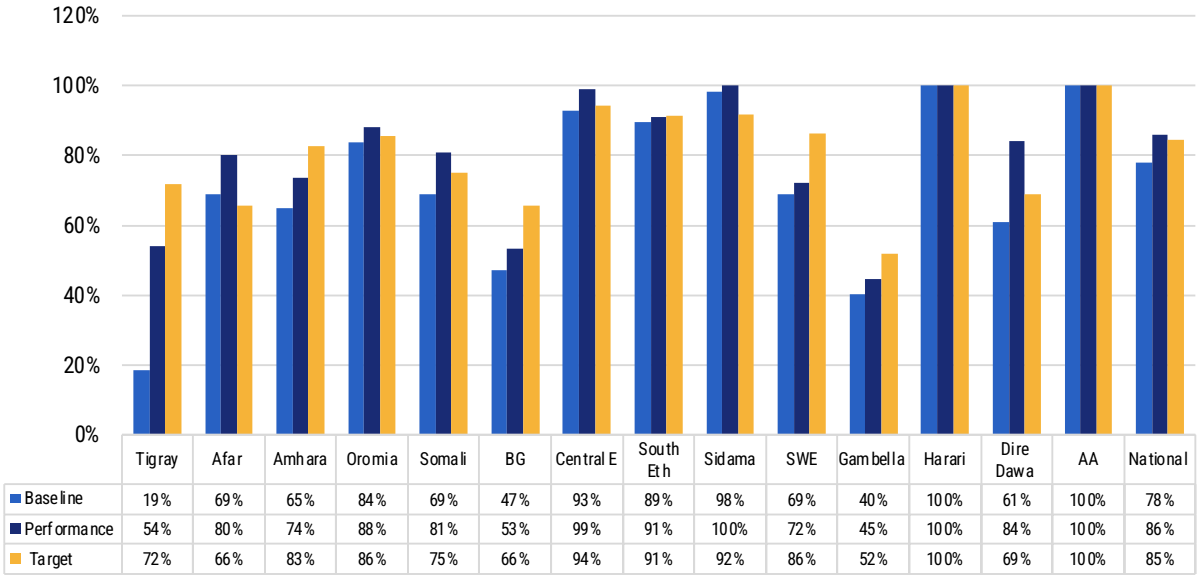


Figure 6: ANC 4+ Coverage: Trend from 2011 EFY to 2017 EFY

More than 3.22 million (86%) pregnant women received ANC services for four or more than contacts in the fiscal year. This is more than the baseline by 8 percentage points and higher than the target (85%) for the fiscal year. All regions have a performance higher than the previous year showing progressive improvement in ANC 4+ coverage. However, there is a huge disparity among regions, ranging from 45% in Gambella to more than 100% in Addis Ababa (185%), Harari (110%) and Sidama (107%).



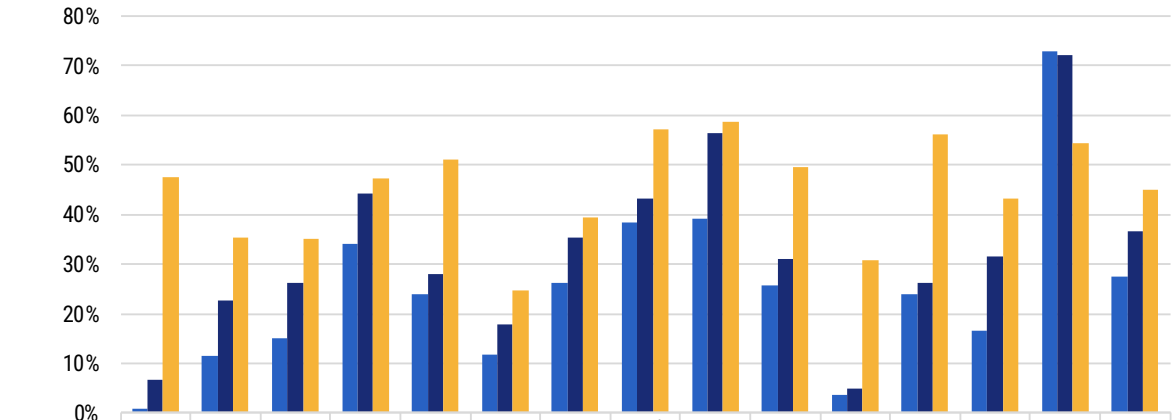
	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	19%	69%	65%	84%	69%	47%	93%	89%	98%	69%	40%	100%	61%	100%	78%
Performance	54%	80%	74%	88%	81%	53%	99%	91%	100%	72%	45%	100%	84%	100%	86%
Target	72%	66%	83%	86%	75%	66%	94%	91%	92%	86%	52%	100%	69%	100%	85%

Figure 7: Antenatal Care four or more contacts coverage by region, 2017 EFY

ANC 8 contacts coverage

The World Health Organization recommends at least 8 ANC contacts during pregnancy, replacing the old 4-contacts model. Ethiopia has adopted this recommendation and currently implementing the 8 or more contacts model. More frequent contacts allow for earlier and repeated detection of complications, delivery of essential preventive services, better counseling, and stronger trust between women and providers.

In 2017 EFY, more than 1.4 million (37%) pregnant women received at least eight ANC contacts during their pregnancy period. Compared to the previous year, this year's performance is higher by 10 percentage points. All regions except Addis Ababa had a better performance compared to last year's performance. However, this year's performance is lower than the target for the fiscal year (45%) and there is a huge performance disparity between regions, ranging from as low as 5% in Gambella to 72% in Addis Ababa.



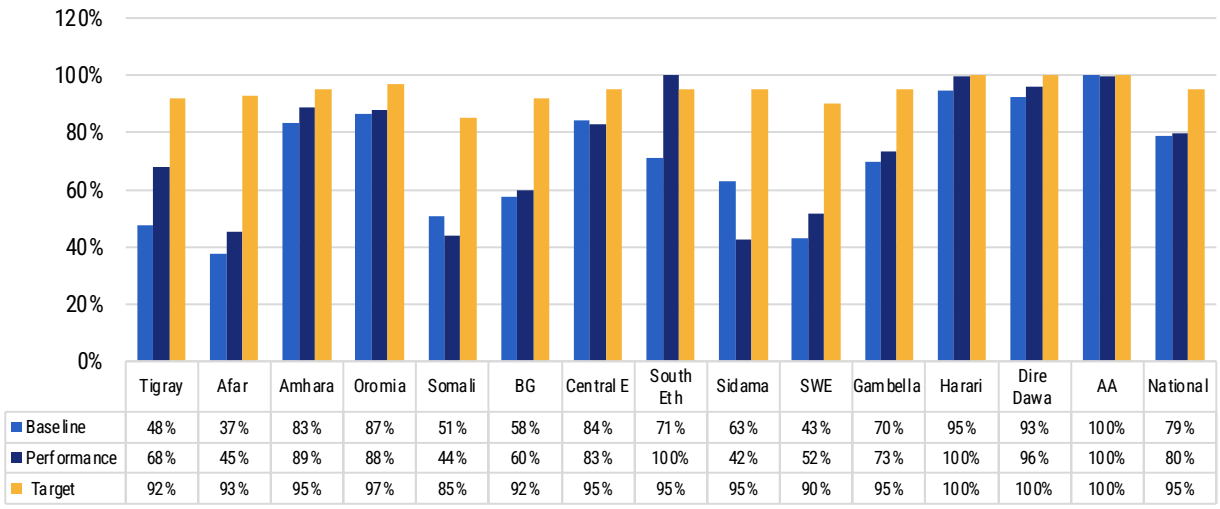
	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	1%	12%	15%	34%	24%	12%	26%	39%	39%	26%	4%	24%	17%	73%	27%
Performance	7%	23%	26%	44%	28%	18%	35%	43%	56%	31%	5%	26%	32%	72%	37%
Target	48%	35%	35%	47%	51%	25%	39%	57%	59%	50%	31%	56%	43%	55%	45%

Figure 8: Antenatal Care eight contacts coverage by region, 2017 EFY

Syphilis Screening for pregnant women

Routine syphilis screening during pregnancy—ideally at the first ANC contacts—ensures timely detection and treatment, preventing congenital syphilis and significantly reducing stillbirths, neonatal deaths, and birth defects. Syphilis screening in high-burden settings is a cost-effective and life-saving intervention.

In 2017 EFY, more than 3.35 million (80%) pregnant women were tested for syphilis. This year's performance is higher than the baseline (79%) but lower than the 95% target for the year. Most regions, except Somali, Central Ethiopia and Sidama, had a performance higher than the baseline. However, there is a wide regional disparity in performance, ranging from 42% in Sidama to 99.5% in Harari, 99.8% in Addis Ababa and 109% South Ethiopia.



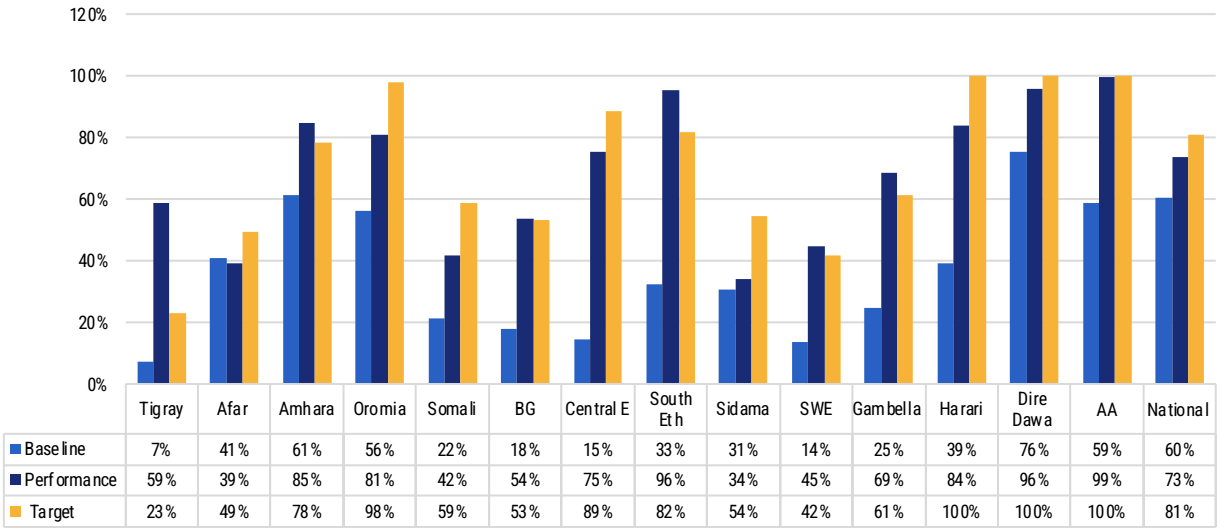
	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	48%	37%	83%	87%	51%	58%	84%	71%	63%	43%	70%	95%	93%	100%	79%
Performance	68%	45%	89%	88%	44%	60%	83%	100%	42%	52%	73%	100%	96%	100%	80%
Target	92%	93%	95%	97%	85%	92%	95%	95%	95%	90%	95%	100%	100%	100%	95%

Figure 9: Proportion of pregnant women screened for syphilis, 2017 EFY

Testing of pregnant women for hepatitis B virus

Testing pregnant women for hepatitis B at the first ANC contact is essential to identify infections early, and prevent mother-to-child transmission, which is the main source of chronic HBV infection. Early detection allows newborns to receive a timely birth dose of the hepatitis B vaccine and enables linkage of mothers to treatment and follow-up. This intervention protects both mother and child and is key to achieving hepatitis B elimination targets.

In the fiscal year, 73% of pregnant women were tested for hepatitis B virus, which is higher than the baseline (60%) but lower than the target by 8 percentage points. All regions except Afar had a performance higher than their baseline. There was a wide regional disparity between regions, ranging from 39% in Afar to 99% in Addis Ababa. Among those tested for HBV, 26453 (0.86%) were reactive for HBV.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	7%	41%	61%	56%	22%	18%	15%	33%	31%	14%	25%	39%	76%	59%	60%
Performance	59%	39%	85%	81%	42%	54%	75%	96%	34%	45%	69%	84%	96%	99%	73%
Target	23%	49%	78%	98%	59%	53%	89%	82%	54%	42%	61%	100%	100%	100%	81%

Figure 10: Proportion of pregnant women tested for hepatitis B virus, 2017 EFY

Iron folate supplementation during pregnancy

Daily iron–folate supplementation during pregnancy prevents maternal anemia, reduces the risk of complications, and protects the baby from neural tube defects and low birth weight. It is a simple, cost-effective intervention that should start early in pregnancy and continue until delivery. As part of comprehensive ANC, it is recommended that pregnant women take daily oral iron and folic acid supplements for a minimum of 90 days.

In 2017 EFY, all expected pregnant women (>100%) have received iron folate supplementation 90+ during pregnancy. Iron folate supplementation performance over the past few years has been high and there is no wide regional disparity across regions. Even though the performance is more than 100% for most regions and at national level, this may be due to population census issue and there may be double counting of pregnant women while they receive iron folate for three consecutive months. This requires further data quality assessments in the future.

Table 2: Proportion of women with Iron folate supplementation during pregnancy, 2017 EFY

Region	Baseline	Performance	Target
Tigray	41%	105%	100%
Afar	84%	102%	95%
Amhara	81%	93%	100%
Oromia	135%	131%	100%
Somali	78%	106%	95%
BG	71%	82%	95%
Central E	112%	109%	100%
South Eth	123%	120%	100%
Sidama	116%	120%	100%
SWE	102%	99%	100%
Gambella	78%	83%	95%
Harari	181%	169%	100%
Dire Dawa	95%	110%	100%
AA	169%	180%	100%
National	109%	116%	100%

Skilled Birth Attendance

Over the past six years, the proportion of women delivering at health facilities with the assistance of health professionals has shown steady growth, rising from 62% in 2011 EFY to 80% in 2017 EFY.

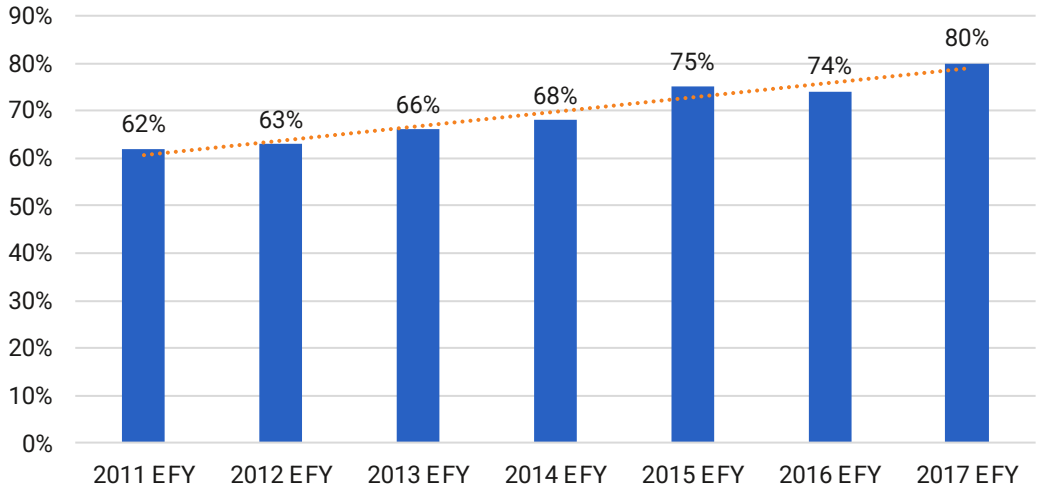
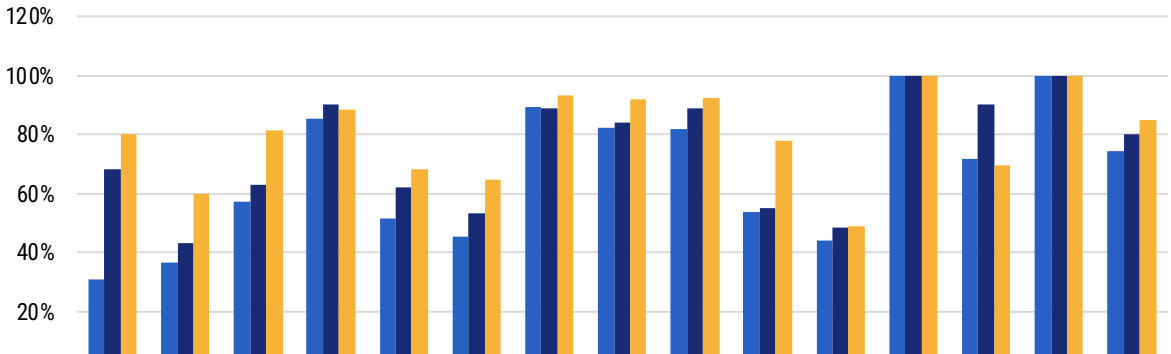


Figure 11: Trend of skilled birth attendance coverage, 2011 EFY to 2017 EFY

During the fiscal year, more than 3.0 million women (80%) delivered at health facilities with the assistance of skilled health professionals. This represents an increase from the baseline of 74%, though slightly below the annual target of 85%. Despite the overall high national skilled birth attendance rate, wide regional disparities persist—ranging from 43% in Afar to over 100% in Harari (135%) and Addis Ababa (164%). Nearly all regions, except Central Ethiopia and Southwest Ethiopia (SWE), performed better than their baseline.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline	31%	37%	57%	85%	51%	45%	89%	82%	82%	54%	44%	100%	71%	100%	74%
Performance	68%	43%	63%	90%	62%	53%	89%	84%	89%	55%	48%	100%	90%	100%	80%
Target	80%	60%	81%	88%	68%	65%	93%	92%	92%	78%	49%	100%	69%	100%	85%

Figure 12: Proportion of births attended by Skilled health personnel, 2017 EFY

Skilled birth attendance by facility type

The distribution of deliveries by health facility type in 2016 and 2017 EFY shows that the majority occurred in health centers, which accounted for 68.9% in 2016 and 69.0% in 2017 EFY. Hospitals contributed the second-largest share, at 27.5% in 2016 and 27.3% in 2017. Deliveries at health posts

increased marginally from 1.6% in 2016 to 2.1% in 2017 (in terms of absolute number, number of skilled birth attendants at CHP increased from 44,096 to 62,006 from 2016 to 2017EFY). Overall, the findings indicate that health centers continue to serve as the main providers of delivery services, complemented by hospitals, while clinics and health posts play only a limited role. The slight increase in health post utilization may signal growing access at the community level.

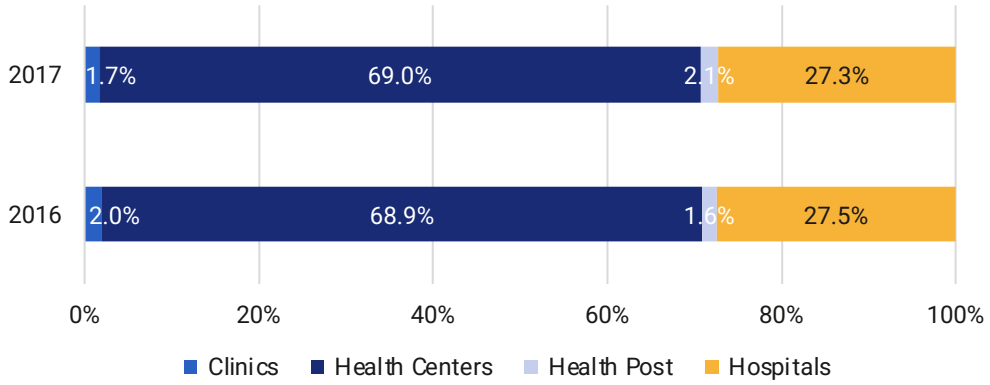


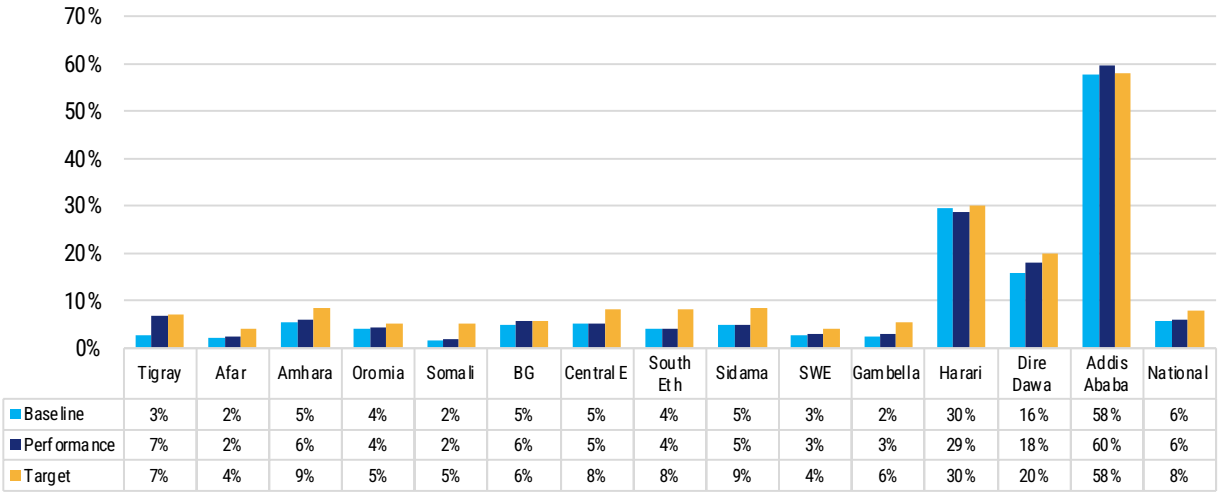
Figure 13: Skilled birth attendance by facility type

Caesarean Section Rate

The Caesarean Section (C/S) rate refers to the proportion of live births delivered through a surgical operation out of the total number of births. It is a key indicator of access to and utilization of comprehensive obstetric care. A very low rate may indicate limited access to life-saving surgical interventions, while a very high rate may suggest overuse of the procedure without clear medical indications. The World Health Organization recommends a population-based C/S rate of 10–15% as optimal for reducing maternal and newborn mortality. It is a life-saving intervention in cases of fetal distress, obstructed labor, maternal complications, or abnormal fetal positions, and ensures safer outcomes for both mother and newborn.

In 2017 EFY, the national C/S rate was 6%, which is below the WHO recommended population-based rate of 10–15%. This year's performance is similar to the previous year's performance and lower than the annual target of 8%. This indicates that, nationally, access to surgical delivery is limited, and some women who need life-saving C/S may not be receiving it. The regional C/S performance shows that there was a wide disparity among regions. The highest C/S rate was reported from urban regions such as Addis Ababa (60%), Harari (29%) and Dire Dawa (18%), significantly above the national average, likely reflecting urban access to comprehensive obstetric care but may also indicate unnecessary C/S which requires further investigation. The majority of regions have a moderate C/S rate (Tigray, Amhara, Oromia, Benishangul-Gumuz, Central Ethiopia, Sidama, Southern Ethiopia) between 4%-8%, showing moderate access to C/S. The lowest C/S rate regions include Afar, Somali, Gambella and SWE, indicating limited access to life-saving surgical obstetric care.

The C/S rate performance shows that the national C/S rate is low, suggesting many women in need may not access surgical delivery. Urban areas (Addis Ababa, Harari, Dire Dawa) have much higher rates than rural regions, reflecting urban-rural inequities in healthcare access. It shows that there is a need to strengthen C/S access in underserved regions, particularly Somali, Afar, and rural parts of other agrarian regions to reduce maternal and neonatal mortality.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline	3%	2%	5%	4%	2%	5%	5%	4%	5%	3%	2%	30%	16%	58%	6%
Performance	7%	2%	6%	4%	2%	6%	5%	4%	5%	3%	3%	29%	18%	60%	6%
Target	7%	4%	9%	5%	5%	6%	8%	8%	9%	4%	6%	30%	20%	58%	8%

Figure 14: Caesarean section rate by region, 2017 EFY

Contribution of facility types for caesarean section

The distribution of Caesarean Sections by health facility type shows that hospitals are the primary providers, consistently performing the majority of procedures (85.2% in 2016 and 85.0% in 2017). Health centers demonstrated a slight increase in their contribution, rising from 5.5% in 2016 to 6.4% in 2017, while clinics registered a minor decline, from 9.2% in 2016 to 8.6% in 2017.

These findings highlight that while hospitals remain the dominant providers of C/S, there is a gradual shift toward increased involvement of health centers. This is mainly due to the expansion of OR blocks at health centers, from 125 in 2016 to 185 in 2017 EFY. This trend suggests the need to strengthen the capacity of health centers to further expand access to safe surgical delivery.

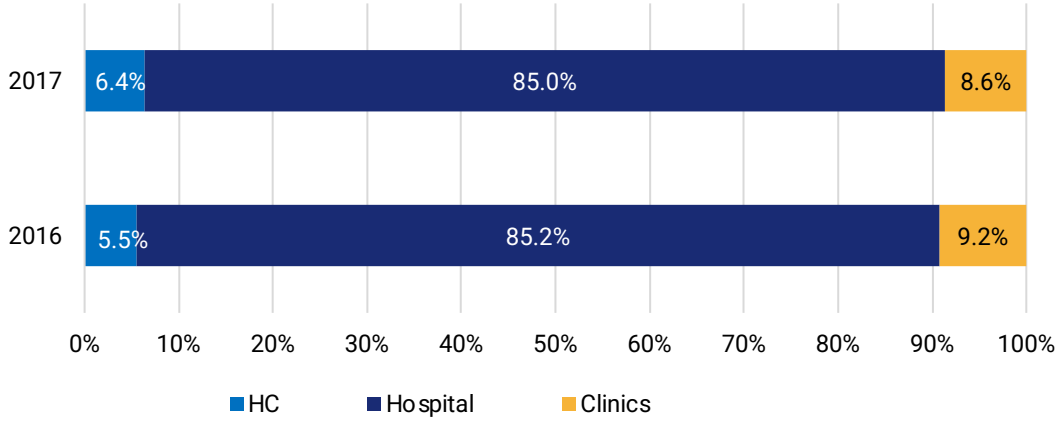


Figure 15: Proportion of caesarean sections performed by facility type

Uterotonic in the first one minute after delivery

Uterotonic in the first minute after delivery refers to giving a medicine that stimulates uterine contractions immediately after the baby is born. Administration of uterotonic agents after delivery of the baby is an effective strategy to reduce maternal mortality and morbidity by preventing excessive bleeding after birth (postpartum hemorrhage) which is the major cause of maternal mortality in Ethiopia.

In 2017 EFY, 98% of women who delivered at health facilities received uterotonics within the first minute after delivery, ranging from 79% in Somali to 99%-100% in the majority of the regions (Figure below). The performance by region is as follows: Tigray (93%), Afar (91%), Amhara (100%), Oromia (99%), Somali (79%), BG (94%), Central Ethiopia (97%), South Ethiopia (97%), Sidama (99%), SWE (96%), Gambella (98%), and 100% in Harari, Dire Dawa and Addis Ababa. From the total women that received uterotonics, the majority (99%) were given oxytocin, while a few number received misoprostol and ergometrine.

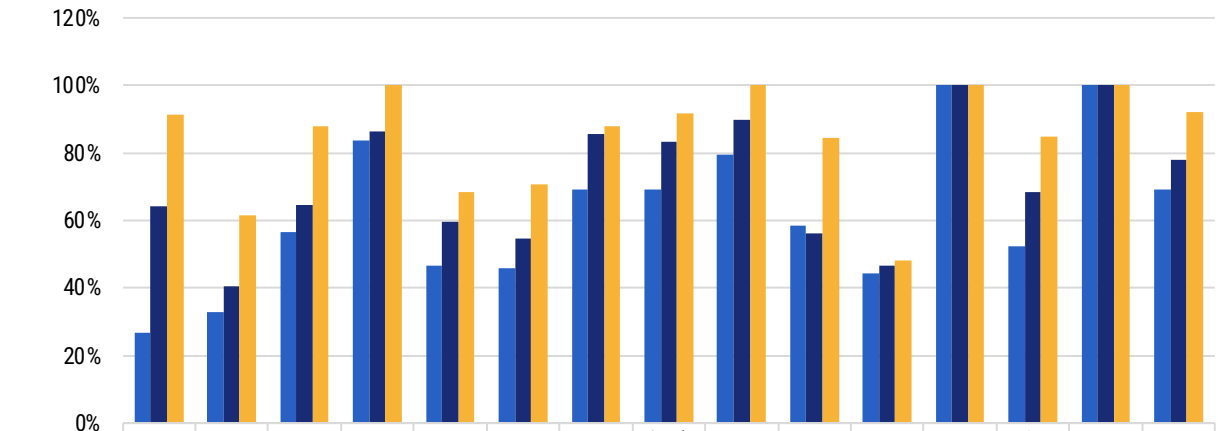
Post Partum Hemorrhage

During the fiscal year, a total of 78,658 women experienced postpartum hemorrhage (PPH). The majority (93%) of cases were reported from health facilities, while the remaining 7% occurred at home. The reported data shows that the incidence of PPH was 2.1% nationally, though all community PPH cases may not be reported. The PPH incidence ranged from 0.6% in Sidama to 7.1% in Gambella.

Early Postnatal Care Coverage within 2 days

Early Postnatal Care (PNC) coverage within 2 days refers to the proportion of mothers and newborns who receive postnatal care within the first 48 hours (2 days) after delivery. This period is critical because most maternal and neonatal complications, including death, occur within the first 2 days after birth. This period is important to detect and manage complications early (e.g., bleeding, infections, neonatal distress), to provide essential interventions such as counseling on breastfeeding, immunizations, and danger signs and to promote maternal and newborn health, improving survival and well-being.

In 2017 EFY, 78% of pregnant women received PNC service within 2 days after delivery. All regions except SWE have a performance better than the baseline. There is a wide disparity in performance across regions, ranging from 41% in Afar to more than 100% in Harari (124%) and Addis Ababa (133%).



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	27%	33%	57%	84%	47%	46%	69%	69%	80%	59%	44%	100%	52%	100%	69%
Performance	64%	41%	65%	86%	60%	55%	86%	83%	90%	56%	47%	100%	69%	100%	78%
target	91%	62%	88%	100%	68%	71%	88%	92%	100%	85%	48%	100%	85%	100%	92%

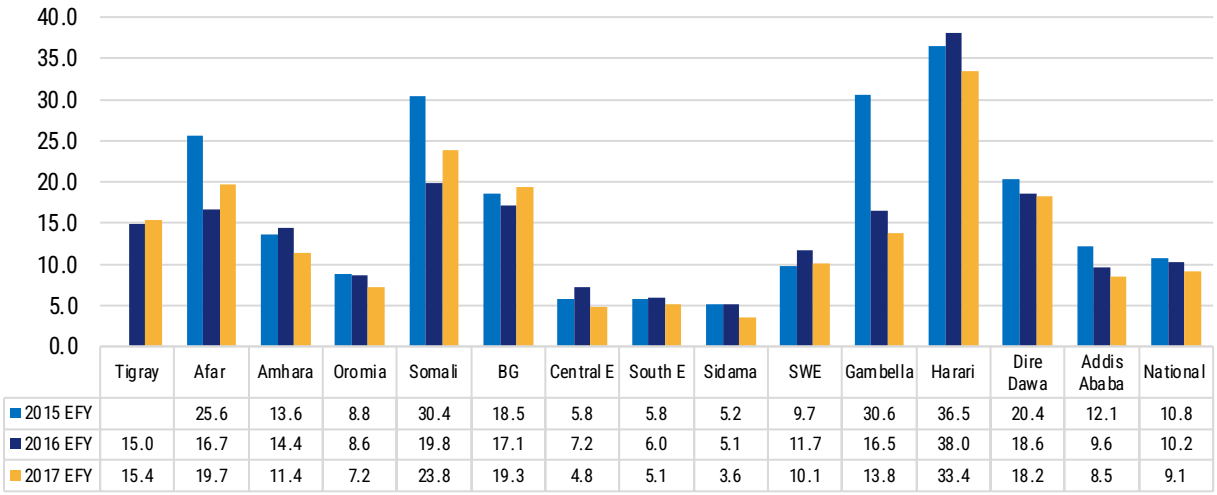
Figure 16: Early PNC Coverage within 2 days, 2017 EFY

Comprehensive abortion Care

During the fiscal year, 281,446 women received comprehensive abortion care services. This shows that from the total expected pregnancies, 7% had abortion and received comprehensive abortion care. Of the total women that received abortion service, 143,272 (51%) received safe abortion services, while 138,174 (49%) received post-abortion care services. Disaggregated by age, of all women who received comprehensive abortion care, 14% were teenagers aged 10–19 years, 63% were aged 20–29 years, and 23% were aged 30 years or older. Regarding the timing of abortion services, the majority of women (79%) received comprehensive abortion care during the first trimester (before 12 weeks of gestation), while 21% received services during the second trimester. Post Abortion family planning service was provided to 61% of those that had abortion service. Post abortion family planning service provision ranged from 25% in Benishangul Gumuz to 76% in Addis Ababa.

Institutional Stillbirth Rate

In 2017 EFY, the national institutional stillbirth rate was 9.1 per 1,000 total births attended at health facilities, showing a slight decline from 10.2 in 2016 EFY. However, there is wide regional disparity, ranging from as high as 33 in Harari to as low as 3.6 in Sidama. Regions with consistently high institutional stillbirth rates include Harari, Gambella, Dire Dawa, Somali, Benishangul Gumuz and Afar.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South E	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
2015 EFY		25.6	13.6	8.8	30.4	18.5	5.8	5.8	5.2	9.7	30.6	36.5	20.4	12.1	10.8
2016 EFY	15.0	16.7	14.4	8.6	19.8	17.1	7.2	6.0	5.1	11.7	16.5	38.0	18.6	9.6	10.2
2017 EFY	15.4	19.7	11.4	7.2	23.8	19.3	4.8	5.1	3.6	10.1	13.8	33.4	18.2	8.5	9.1

Figure 17: Institutional Still Birth Rate per 1000 total births, trend from 2015 EFY to 2017 EFY by region

Missed opportunities across the continuum of Care

Maternal continuum of care refers to a comprehensive approach in maternal health that ensures women receive seamless, coordinated, and comprehensive quality health services throughout the reproductive cycle, from pre-pregnancy to postnatal periods—to improve maternal and newborn health outcomes.

Missed opportunity: Nearly 1 in 10 pregnant women (12%) who attended their first ANC contact missed syphilis testing, and about 1 in 5 (19%) missed HBV screening.

Service dropout: Nearly 2 in 3 Pregnant women attended their first ANC contact did not receive ANC 8, 1 in 5 for Skilled birth attendants and early PNC within 2 days. The dropout rate from skilled birth attendance to early postnatal care (within 2 days) is low, at only 1%.

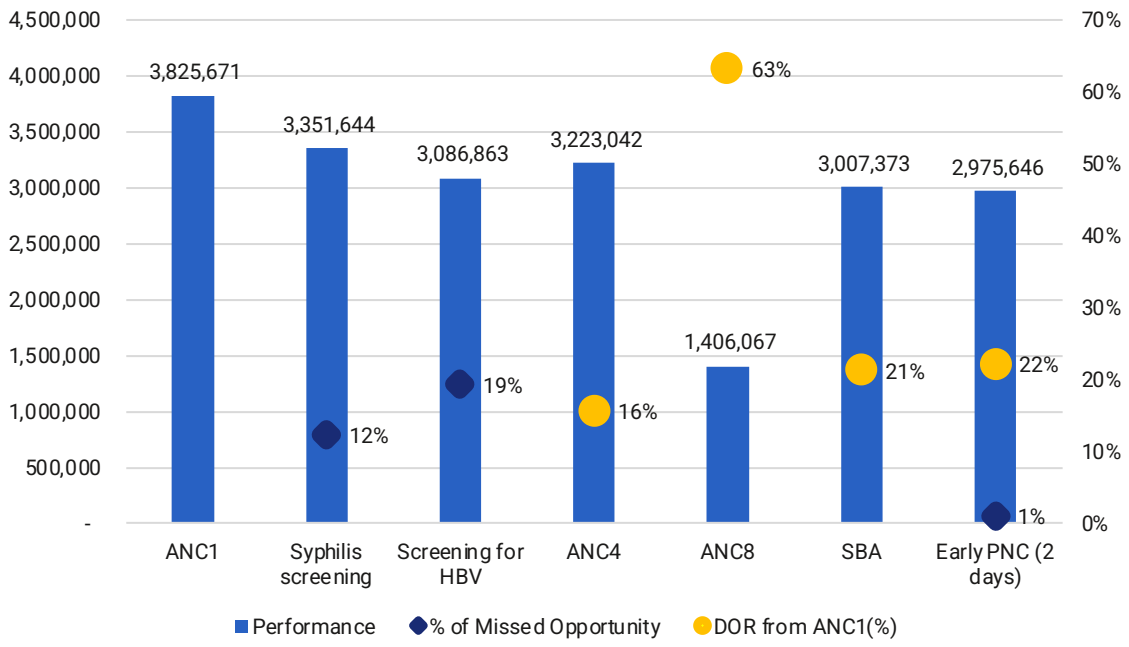


Figure 18: Missed Opportunities and dropout: Number of Women that received maternal health services, across the continuum of care, 2017 EFY

Other maternal health related activities and achievements

The national reproductive and maternal health program is developed and implemented based on the continuum of care approach, encompassing interventions to improve access to quality preconception care, ANC, delivery, PNC, comprehensive abortion care, and the identification and management of obstetric fistula and Utero-vaginal prolapse (UVP) cases. In addition to the achievements described above on key maternal health indicators, the following major initiatives, activities, and achievements were recorded during the fiscal year.

Strengthening access to quality preconception care services: Preconception care (PCC) refers to evidence-based interventions provided to individuals or couples before conception and during the inter-conception period. To strengthen access to PCC services, MOH developed a PCC guideline back in 2016 EFY, provided capacity building training and conducted advocacy workshops. By the end of 2017 EFY, PCC implementation is expanded to 222 health facilities. Various activities were conducted to strengthen PCC in 2017 EFY.

- **Advocacy:** PCC advocacy sessions were conducted for 65 program owners, including representatives from RHBs, ZHDs and WoHOs. Additionally, 130 members of the Consortium of Christian Relief and Development Associations (CCRDA) were reached by integrating PCC with ANC guidelines.
- **Training:** Preconception care Training of Trainers (TOT) was provided to 36 healthcare workers from all regions using blended training materials alongside ANC
- **Supportive Supervision and review meeting:** Integrated supportive supervision was conducted in selected regions, including Somali, Tigray, Southern Ethiopia, Amhara, Sidama, and Dire Dawa. In addition, an annual review meeting focusing on PCC services was held, during which key issues were discussed, including the need to improve the expansion of PCC services.

Improve access and quality ANC, skilled delivery and PNC services: various initiatives and activities were done during the fiscal year to improve access to and utilization of quality ANC, skilled delivery and PNC services. Some of these are:

- **Ultrasound Training:** To ensure that every pregnant woman receives at least one ultrasound scan before 24 weeks of gestation, a TOT was provided for 25 senior healthcare workers (obstetricians/gynecologists, radiologists, IESOs, MRTs, and clinical midwives) from all regions. Additionally, 93 healthcare workers received basic obstetric ultrasound training

- **Orientation on maternal health policies:** Orientation training on maternal health policy documents was provided to 32 healthcare workers from comprehensive health posts and to 99 participants representing different levels

- **RMNCAYH-N Self-Care Training:** Orientation training on RMNCAYH-N self-care was provided to healthcare workers from regions affected by manmade and natural disasters. In addition, a self-care experience-sharing session was held for delegates from 19 African countries

- Training on E-MOTIVE was provided to 40 healthcare workers, and implementation has commenced

- **Implementation of integrated catchment-based clinical mentorship (ICBCM):** A total of 25,000,000 ETB was transferred to regions to support the implementation of ICBCM in 86 hospitals. Additionally, ICBCM skill training was provided to 124 healthcare workers from all mentoring hospitals. In addition, a budget of 10,000,000 ETB was transferred to regions to cascade training on maternal health policy documents. ICBCM annual review meeting was conducted

- The national Safe Motherhood month commemoration was conducted in Addis Ababa with a theme *"Quality Labor and Delivery care for all women for a Positive Childbirth Experience"* - ጥራቱን የጠበቀ የምጥና የወሊድ እንክብካቤ ለሁሉም እናት፤ ለጤናማ እናትነት*!"*. In addition to the national level commemoration event, each RHB has cascaded the event to health facilities by conducting various activities such as advocacy, blood donation and resource mobilization. National pre-eclampsia day was also commemorated at St. peter hospital

- To strengthen the Maternal and Perinatal Death Surveillance and Response (MPDSR) and Obstetric Fistula Surveillance and Response systems, training was provided to 97 healthcare workers from all regions. Additionally, MPDSR training materials were revised, and the national hemorrhage response plan is under revision. The confidential inquiry into maternal and perinatal morbidity and mortality guidelines was developed and implemented to support the MPDSR system

- **Guidelines and Tools:** Final draft guidelines were prepared for the midwifery model of care, pregnant women conferences, postnatal care, and integration of oxytocin into the EPI cold chain system, along with a maternal health counselling pocket guide. In addition, a comprehensive PPH training manual emphasizing the E-MOTIVE approach was finalized.

Strengthening identification and management of Obstetric fistula and Utero Vaginal prolapse

- In Ethiopia, there is a gap in the identification of obstetric fistula and Uterovaginal prolapse (UVP) cases. The Ministry of Health is working to improve its detection, referral, and management by integrating case identification with national immunization campaigns. As a result, about 1,335 suspected cases were identified during the measles campaign and 269 during the national polio campaign. Among these suspected cases, 82 obstetric fistula cases and 64 UVP cases were confirmed and referred to health facilities for follow-up and management. The International Obstetric Fistula Elimination Day was commemorated in Assosa town, Benishangul Gumuz region, in the presence of senior officials from the MOH, RHBs, and other relevant stakeholders.

Improve access to Maternal Health program medical supplies and equipment

- **Maternal health commodities:** Maternal health lifesaving commodities were secured for the 2017 EFY from the SDG budget. However, there were delays in procuring the planned 555 and 600 obstetric ultrasound machines for the previous and current fiscal years, respectively. To date, only 238 ultrasounds have been procured.

- **Service cost and supply gaps:** Despite securing funding for maternal health commodities, significant gaps remain in reimbursing exempted service costs. Additionally, there are substantial shortages of some priority I, II, and III maternal health drugs, supplies, and equipment. In response, a multi-donor compact agreement draft document is prepared.

Challenges

Some of the challenges and gaps in maternal health program implementation include the following:

- Delayed procurement of maternal health commodities and equipment, particularly ultrasound machines
- Delayed approval of reimbursement protocols
- Impact of conflict and natural disasters on service delivery in different parts of Ethiopia
- Inadequate local production for maternal health equipment and supplies
- Wide disparities in service utilization and health outcomes across regions
- Weak maternal mortality and morbidity tracking and response system at the subnational level
- Absence of a mechanism linking supply availability with service delivery reporting and utilization monitoring
- Limited functionality of Comprehensive Emergency Obstetric and Newborn Care (CEMONC) health centers
- Shortages of blood and blood products in health facilities

Focus areas for the next fiscal year

- Finalize and implement the multi-donor compact agreement
- Monitor and follow up the implementation of maternal health policy documents
- Scale up preconception care services in 50% of health facilities throughout the country
- Expand health facilities implementing the comprehensive PPH bundle of care using the E-MOTIVE approach
- Strengthen RMNCAYH-N integrated catchment-based clinical mentorship
- Improve identification, referral, and management of obstetric fistula and UVP cases
- Expand and enhance utilization of maternity waiting homes
- Strengthen confidential inquiries into maternal and perinatal morbidity and mortality
- Improve availability of medical equipment, including ultrasounds and delivery couches
- Enhance accessibility of maternal health services in humanitarian settings
- Monitor utilization of obstetric ultrasound services and strengthen mentorship
- Strengthen the MPDSR and referral system through interregional forums
- Expand CEmONC-capable health centers and monitor their performance

2.1.4. Maternal and Perinatal death surveillance and response (MPDSR)

Maternal death surveillance – Maternal death notification

According to the latest estimate by the United Nations Maternal Mortality Estimation Inter-Agency Group (UN-MMEIG), the MMR in Ethiopia is 195 per 100,000 live births as of 2023, which translates to an estimated 7,460 maternal deaths annually. In 2017 EFY, out of an estimated 7,460 maternal deaths in Ethiopia, 1,252 were notified through the MPDSR system, representing 17% of the total estimated deaths. Across regions, performance varied widely. Tigray had an estimated 403 maternal deaths, with 150 notified (37%), which was among the higher notification rates. Amhara and Oromia, which recorded the highest estimated maternal deaths—1,585 and 2,993 respectively—had notification rates of 20% and 12%. Somali and BG notified 20% and 23% respectively. Some regions had notably low reporting levels, such as Sidama, with only 17 of 333 estimated deaths notified (5%), and Central Ethiopia, with 39 of 450 (9%). By contrast, smaller regions achieved higher proportions: Harari notified 14 of 18 estimated maternal deaths (78%), Dire Dawa 22 of 36 (61%), and Addis Ababa 58 of 184 (32%). Overall, the data highlight significant regional variation, with some regions performing relatively well in maternal death notification despite smaller cases, while larger regions with higher maternal deaths demonstrated weaker notification performance.

Of all notified maternal deaths, 89% were reviewed to determine the cause of death. Among these, the leading cause was hemorrhage (58%), followed by hypertensive disorders of pregnancy (24%). The remaining 18% of deaths were attributed to other causes. Disaggregated by type of delay, the majority of deaths were attributed to Delay 3 (35.4%), followed closely by Delay 2 (34.1%) and Delay 1 (30.5%)

Figure 19: Number and proportion of maternal deaths notified through MPDSR system in 2017 EFY

Region	Estimated no. of maternal deaths (2017 EFY)*	No. of maternal deaths notified in 2017 EFY	% of notified maternal deaths in 2017 EFY
Tigray	403	150	37%
Afar	123	14	11%
Amhara	1,585	317	20%
Oromia	2,993	369	12%
Somali	434	87	20%
BG	86	20	23%
Central E	450	39	9%
South E	540	99	18%
Sidama	333	17	5%
SWE	241	40	17%
Gambela	33	6	18%
Harari	18	14	78%
Dire Dawa	36	22	61%
Addis Ababa	184	58	32%
National	7,460	1252	17%

*MMR of 195 per 100,000 live births used to proportionate to the regions (Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division

Perinatal death surveillance - Perinatal death notification

The perinatal mortality rate measures the number of stillbirths and deaths of newborns within the first week of life per 1,000 total births. In 2017 EFY, the MPDSR system has notified a total of 15,652 perinatal deaths, with wide regional variations. The highest proportion was reported from Amhara region (4,761 deaths, 30%), followed by Oromia (2,573 deaths, 16%) and Addis Ababa (2,293 deaths, 15%). Other regions with notable contributions include Tigray (1,233 deaths, 8%), Somali (1,108 deaths, 7%), and Central Ethiopia (957 deaths, 6%). Regions such as BG (2%), South Ethiopia (4%), Sidama (3%), SWE (3%), and Harari (3%) reported smaller shares. The lowest figures were from Dire Dawa (205 deaths, 1.3%), Afar (60 deaths, 0.4%), and Gambela (39 deaths, 0.2%). This distribution highlights a concentration of reported perinatal deaths in a few regions, particularly Amhara, Oromia, and Addis Ababa, which together account for more than 60% of the national total.

From the 15,652 total perinatal deaths notified nationally, the cause of death was determined for 95% of them. Accordingly, the majority of the perinatal deaths were due to prematurity (33%) followed by asphyxia (32%).

2.2. Newborn and Child Health Services

Neonatal and Child Health Service

Pneumonia treatment:
>4.0 million (92%)
of under5 children with pneumonia treated with antibiotics

Diarrhea treatment:
26%
of children under 5 with diarrhea received treatment with ORS and Zinc

Asphyxia management:
58,480
neonates with asphyxia were resuscitates, among which 51,381 (88%) survived

Kangaroo mother care (KMC):
41,715
reported very low birth weight or premature infants, 80% received Kangaroo Mother Care

Chlorhexidine (CHX) for newborns:
52%
of the estimated newborns received at least one dose of Chlorohexidine to the cord on the first day after birth

Neonatal Intensive Care Unit (NICU) services:
168,437
neonates treated at NICU, with a mortality rate of 7.4%

Over the past two decades, Ethiopia has achieved substantial reductions in child mortality. The under-five mortality rate declined from 140 deaths per 1,000 live births in 2000 to 46 in 2023. Similarly, neonatal mortality declined from 48 to 27 deaths per 1,000 live births during the same period. Despite this notable progress, Ethiopia remains off track to meet the 2030 SDG targets of reducing the under-five mortality rate to 25 and the neonatal mortality rate to 12 per 1,000 live births. To accelerate progress towards the 2030 targets, interventions need to be strategically directed at the leading causes of child mortality. The major causes of neonatal deaths are prematurity, birth asphyxia, and sepsis, while pneumonia, diarrhea, and malaria remain the primary contributors to under-five mortality.

The Ministry of Health has been implementing a broad range of newborn and child health initiatives aimed at improving survival and development outcomes. These interventions include specialized newborn health packages that focus on lifesaving care, the establishment of newborn care corners, the expansion of Neonatal Intensive Care Units (NICUs), and implementation of Kangaroo Mother Care (KMC), which is a proven, cost-effective intervention that significantly reduces mortality and morbidity among preterm and low-birth-weight babies. In addition, Integrated Management of Newborn and Childhood Illnesses (IMNCI) provides comprehensive clinical care, while Integrated Community Case Management of Newborn and Childhood Illnesses (ICMNCI) expands access to treatment through trained HEWs. Additionally, the country focuses on Early Childhood Development (ECD) to ensure nurturing environments for children. These initiatives collectively aim to improve child survival and early development across Ethiopia.

This section details the performance of key interventions related to newborn and child health in 2017 EFY.

Treatment of newborn and childhood illnesses

Treatment for Pneumonia

Treatment of pneumonia in under-five children involves the timely use of appropriate antibiotics. Early diagnosis and prompt treatment are critical to reducing mortality and preventing severe complications. Over the past few years, the proportion of under five children treated for pneumonia has increased consistently, increasing from 57% in 2012 EFY to 92% in 2017 EFY. In this fiscal year, more than 4.0 million children under five were treated for pneumonia with antibiotics.

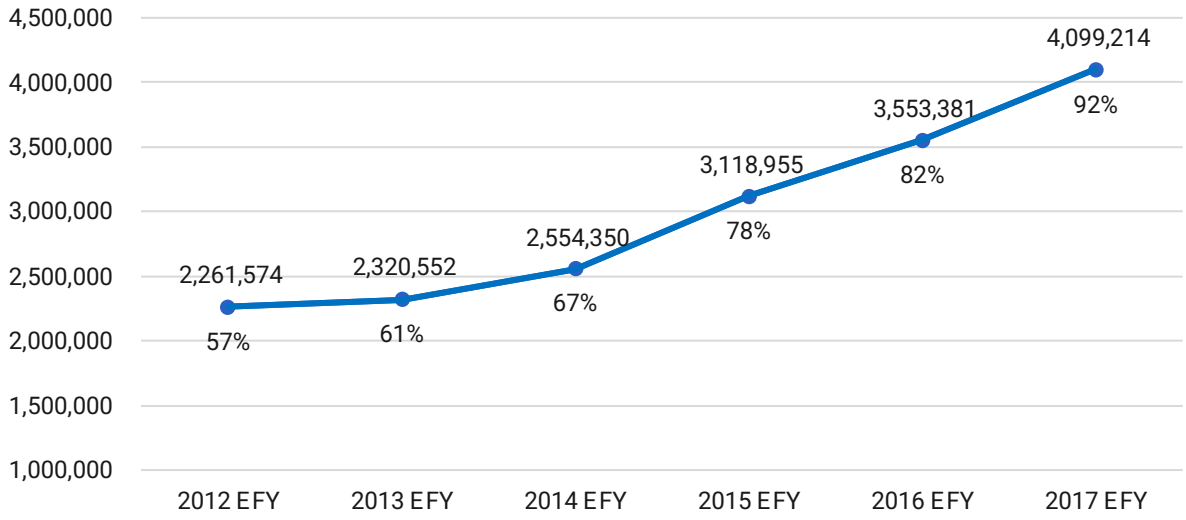


Figure 20: Number and proportion of under 5 children treated for pneumonia, trend from 2012-2017 EFY

Treatment for Diarrhea

Treatment of diarrhea in children relies on the combined use of Oral Rehydration Salts (ORS) and zinc supplementation. ORS prevents and treats dehydration, while zinc reduces the duration and severity of diarrhea and lowers the risk of recurrence. The number and proportion of children under five treated for diarrhea has increased over the years, increasing from 16% in 2012 EFY to 26% in 2017 EFY. During the 2017 EFY fiscal year, more than 4.3 million under five children were treated for diarrhea, with ORS and zinc.

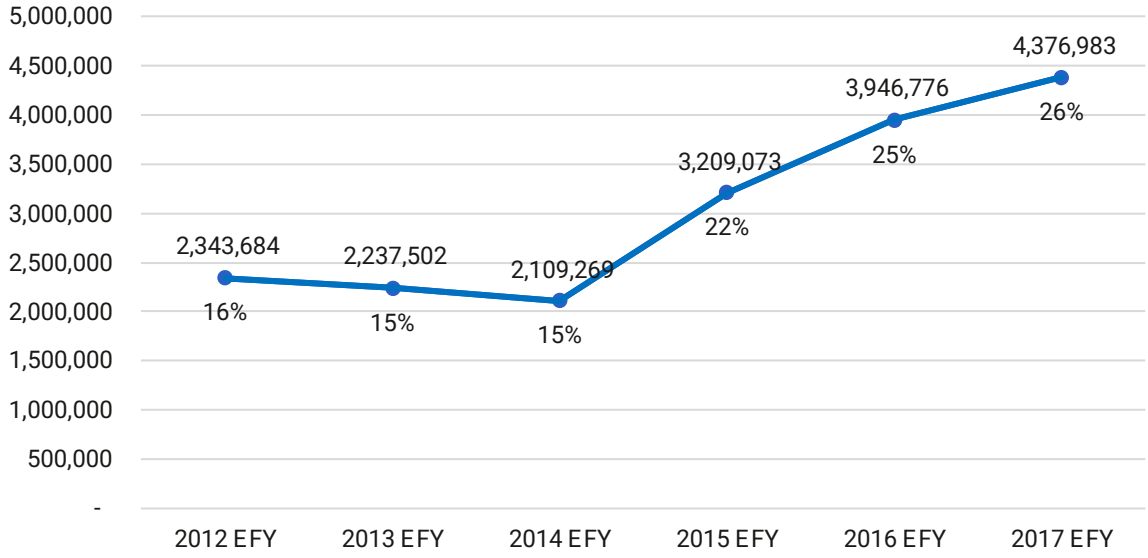


Figure 21: Number and proportion of children under 5 years treated for diarrhea, Trend from 2012-2017 EFY

Number of sick young infants 0-2 months treated for critical illnesses: In 2017 EFY, a total of 222,799 infants aged 0-2 months were treated for critical illnesses (98,227 for very severe disease and 124,572 for local bacterial infection). This shows that from the estimated number of sick young infants aged 0-2 months with newborn infection (with very severe disease), 77% were treated. This is an achievement higher than the baseline (32%) and the target for the year (39%).

Asphyxia management: In the fiscal year, 58,480 neonates with birth asphyxia were resuscitated, of whom 51,381 survived, resulting in a survival rate of 88%.

Kangaroo mother care: From the total 41,715 reported very low birth weight (weighing <2000gm) and/or premature newborns, KMC was initiated for 80% of them.

Chlorhexidine (CHX) for newborns: In the fiscal year, from the total estimated deliveries, 52% of the newborns received at least one dose of Chlorohexidine to the cord on the first day after birth.

Integrated community-based management of newborn and childhood illnesses (ICMNCI)

ICMNCI service at health posts was strengthened through various activities during the fiscal year. The following are the major activities conducted in the fiscal year:

- Community-Based Kangaroo Mother Care (CKMC) training manual is developed and translated into three local languages—Amharic, Afan Oromo, and Tigrigna—to improve service accessibility and quality
- Performance Review and Clinical mentoring Meetings (PRCMM) training was provided to 125 health care professionals across all regions, with participants selected from the lowest performing woredas in each region.
- IMNCI and ECD guidelines, registers, and job aids were printed and distributed, including 13,050 IMNCI Chart Booklets, 5,760 IMNCI Sick Child Registers (birth to 2 months, English), 12,850 IMNCI Sick Child Registers (2 to 59 months, English), 360 PNC Posters, 360 ECD counseling Cards, and 360 ECD On-the-Job Aid Tools.

- Service integration: During the SIA Measles integration campaign, 46,462 children were reached for different services. Sick children were identified and referred to health facilities for treatment, while children with congenital anomalies were identified and referred for specialized care.

- Advocacy and awareness creation: Awareness-raising activities were conducted during World Pneumonia Day, and a spot message was aired on television and radio to raise awareness about newborn danger signs and the importance of Kangaroo Mother Care.

Integrated Management of Newborn and Childhood Illness (IMNCI)

To strengthen the implementation of IMNCI at health facilities, the following activities have been performed during the fiscal year.

- **Training:** IMNCI TOT was provided for 50 health professionals from all regions. In addition, the TOT was provided for 25 instructors from selected universities. A post-training follow-up was conducted in 23 health science colleges with the aim to strengthen IMNCI education at the preservice level.

- **Strengthening pre-service IMNCI education:** A consultative workshop was held with 20 Academic Deans from selected health science colleges. The workshop focused on discussing findings from supportive supervision and developing strategies for future collaboration and action.
- **Integrated mentorship:** To reinforce the implementation of IMNCI, ECD, ENC, and ICMNCI, integrated mentorship was conducted in 30 woredas across 15 selected zones in all regions
- **Blended IMNCI training material preparation:** A blended IMNCI training material development is completed, and the material is now ready for use.

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

In the fiscal year, a total of 168,437 neonates were reported as discharged from NICU, among which 83% of them recovered, while 7.4% died. Compared to the previous year, recovery rate has improved by 1 percentage point and death rate remains the same. To strengthen NICU and ENBC services, various activities have been conducted, including the following:

- **Targeted mentorship:** Twenty-five hospitals with high neonatal mortality rates were identified nationwide, and two rounds of integrated mentorship were conducted. The mentorship targeted pediatricians, NICU nurses, midwives, and biomedical professionals working in these facilities.
- **World Prematurity Day:** During the commemoration of world prematurity day, an awareness-raising event was held at Abebech Gobena Hospital in the presence of key stakeholders, complemented by media coverage to enhance community awareness.
- **NICU leveling standard:** A draft "NICU Leveling Standard" was developed and on review by different stakeholders
- **Integrated mentorship on ENC:** Targeted mentorship on ENC implementation in labor and delivery wards and NICUs was conducted in 30 hospitals with low performance in asphyxia management across all regions.

- **Blended KMC training material:** Preparation of blended Kangaroo Mother Care (KMC) training material completed.
- **Hands-on surfactant training:** Practical training on surfactant administration was provided to 50 healthcare professionals at St. Paul Hospital Millennium Medical College Training Center
- **Integrated clinical mentorship:** Conducted by pediatricians, neonatologists, obstetricians, biomedical engineers, and quality and data experts at selected hospitals in Sidama, Tigray, Amhara, and Oromia regions
- **Co-financing framework:** A co-financing document for the Newborn and Child Health Program was developed and is currently awaiting approval
- **Media engagement:** Eighty media professionals were trained on key RMNCAYH issues that require effective media engagement
- **Safe Birth Bundle of Care (SBBC):** An awareness and promotion workshop was conducted for partners and stakeholders to support the implementation of SBBC, aimed at reducing maternal and neonatal mortality
- **Immediate Kangaroo Mother Care (iKMC):** An advocacy and awareness workshop was held with regional representatives, development partners, and government stakeholders to promote iKMC
- **NICU and KMC Plus TOT:** Capacity-building sessions were provided to 75 pediatricians, medical doctors, and neonatal nurses from hospitals nationwide to strengthen newborn care services

Supply and commodity availability Intervention

- During 2017 EFY, a budget was allocated based on quantified needs for newborn and child health services. A purchase order list was submitted to the Ethiopian Pharmaceuticals Supply Service (EPSS) and the procurement process was monitored, and payments were processed. For 2018 EFY, Newborn and Child Health Medical Equipment and Commodity Procurement Quantification and Forecasting was done and the finalized document was disseminated to stakeholders
- A distribution and allocation plan for new newborn and child health program supplies—including the Caffeine Citrate Distribution Plan—was developed. EPSS monitored the delivery of these supplies to health facilities as per the plan.
- A procurement order for NICU medical equipment for Tikur Anbessa Specialized Hospital was issued to UNICEF. The required budget was secured jointly from government and partner contributions, and the procurement process is currently under monitoring

Early Childhood Development (ECD) Intervention

The health sector has been implementing various ECD related activities in 2017 EFY. Some of the major activities and accomplishments include the following

- **ECD Trainings:** A TOT on ECD was provided to 76 health care professionals from five regions, with the aim of establishing model ECD health facilities. In addition, basic ECD training was provided to 200 health workers from 65 selected woredas across all regions, including 42 low-performing and 23 conflict-affected woredas. A post-training follow-up was conducted at model ECD health facilities in selected regions, during which feedback was provided to strengthen program implementation.

- **ECD training manual:** A Community ECD training manual was prepared and officially endorsed. The Community ECD training manual was translated into three local languages—Amharic, Afan Oromo, and Tigrigna
- **ECD performance review and experience-sharing:** A workshop was conducted with senior executives from all regions and key stakeholders.
- **Advocacy:** An advocacy workshop was held in Addis Ababa in collaboration with partners, attended by representatives from various organizations, regional health bureaus, sector ministries, and media outlets.

Challenges of newborn and child health program

- Inadequate budget allocation for the newborn and child health program, limiting the scale-up of key interventions and support to regions.
- Frequent shortages and interruptions of medical equipment, essential lifesaving commodities, consumables, and spare parts.
- Insufficient health workforce deployment for newborn, child health, and development programs at both national and sub-national levels.
- Low health-seeking behavior among caregivers for newborn-related illnesses.
- Suboptimal data quality and limited use of evidence for decision-making across all levels.

Next year's priority areas for newborn and child health program

- Enhance equitable access to quality newborn and child health services at health facilities.
- Expand national implementation of Kangaroo Mother Care
- Scale up Immediate Kangaroo Mother Care in selected health facilities with high neonatal mortality.
- Develop and update strategic documents to guide program implementation.
- Roll out digital/blended training programs to build capacity at all levels.
- Strengthen Maternal and Perinatal Death Surveillance and Response (MPDSR) and ensure timely follow-up
- Improve IMNCI and ICMNCI implementation through targeted capacity building, integrated supportive supervision, and strengthened pre-service education.
- Expand the ECD program at both community and facility levels
- Strengthen integrated clinical mentorship on NICU care, Essential Newborn Care ENC, KMC, and labor and delivery
- Adapt and scale up innovative health initiatives across all levels of the system
- Improve program implementation through consultative workshops, performance review sessions, and clinical mentorship meetings.
- Ensure consistent availability of essential medical equipment, spare parts, and supplies.
- Reinforce cross-program and cross-sectoral integration to maximize impact.

2.3. Immunization Program

Immunization Service

Penta 3 coverage:
>3.8 million (>100%)
infants received the third dose of pentavalent vaccine

Measles 1 Coverage:
>3.6 million (>100%)
infants were vaccinated with measles first dose

Measles 2:
97%
of children aged 15-23 months of age received the second dose of Measles

Full immunization:
>3.5 million (100%)
infants received all types of basic antigens before celebrating their first-year birthday

Dropout Rate (Pentavalent-1 to Measles Vaccination):
9%

Zero dose children:
1,413,793
zero-dose children were identified and vaccinated with a catch-up vaccination campaign

HPV – Multi-Age Cohort (MAC) Vaccination:
7,085,236
girls aged 9–14 years were vaccinated

Supplementary measles campaign:
18,561,834
children vaccinated for measles

New vaccine introduction

Malaria vaccine:
planned to be initiated in 58 woredas in 2018 EFY

Hep B birth dose:
Preparations completed, will be implemented in 2018 EFY

Measles 5-dose switch:
Preparations completed and will be implemented once the on stock 10 dose is finished

Yellow fever vaccine:
preparations undergoing

The national immunization program targets more than 3.8 million infants annually with child vaccines, while also reaching adolescents with the HPV vaccine for cervical cancer prevention and adults with the COVID-19 vaccine. To reach all eligible populations, vaccination services are delivered through a mix of routine immunization at health facilities, outreach services, and campaigns targeting diseases such as measles, polio, and cholera. These campaigns have been critical in maintaining high coverage, especially among children and communities in remote, pastoralist, and conflict-affected areas. This section highlights the performance of national immunization program in 2017 EFY.

Pentavalent-3 Vaccination Coverage

Over the past six years, the number of infants vaccinated with the third dose of pentavalent vaccine has increased, increasing from 3.1 million in 2012 EFY to more than 3.8 million in 2017 EFY

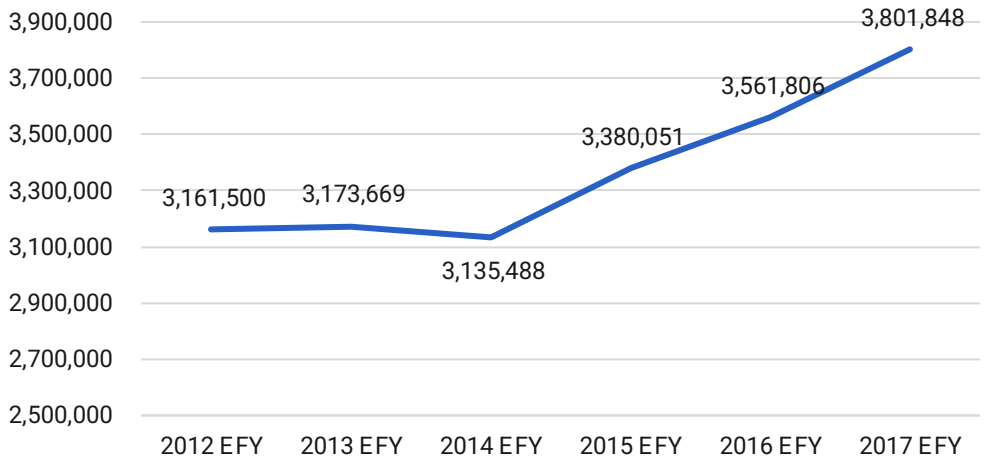


Figure 22: Number of infants vaccinated with third dose of pentavalent vaccine, 2012-2017 EFY

In 2017 EFY, more than 3.8 million under 1-year infants were vaccinated with the third dose of pentavalent vaccine, with an overall coverage of more than 100% of the expected eligible infants. Some regions exceeded a coverage more than 100% coverage, including Amhara (103%), Oromia (112%), Somali (117%), Central Ethiopia (108%), South Ethiopia (105%), Sidama (105%), Harari (124%), Dire Dawa (102%) and Addis Ababa (162%). More than 100% coverage in the majority of the regions may be due to population projection issue as Ethiopia's census was conducted more than 17 years ago. A national equity survey in 2023 showed that pentavalent 3 coverage was 71% in 2022. In addition, WUENIC estimates penta 3 coverage to be 73% in 2024 and an estimation by the Countdown method (using penta1 dervied denominator) shows Penta 3 coverage of 71% in 2024.

Measles-1 Vaccination (MCV1) Coverage: In the fiscal year, more than 3.6 million infants received the first dose of measles containing vaccine (MCV1), which is a coverage of more than 100% among the eligibles. Most regions have a coverage of 100% or more, including, Oromia, Somali, Central Ethiopia, South Ethiopia, Sidama, Harari and Addis Ababa. The only region with a performance less than 90% coverage is Benishangul Gumuz region (83%). The reason for more than 100% coverage in most regions may be due to the population projection issue described above and also due to catch-up campaigns. WUENIC estimate in 2024 shows MCV1 coverage of 72% and the Countdown estimation method estimates MCV1 to be 71% in 2024.

Measles-2 Vaccination (MCV 2) Coverage: In the fiscal year, more than 3.3 million children aged 15-23 months of age received second dose of measles vaccine, which represents a coverage of 97% of the eligible children. This performance is higher by 10 percentage points compared to the previous year. Oromia, Central Ethiopia, Sidama, Harari and Addis Ababa had a performance more than 100%. The performance of the other regions is: Tigray (69%), Afar (81%), Amhara (93%), Somali (85%), BG (65%), South Ethiopia (98%), SWE (91%), Gambella (78%) and Dire Dawa (91%).

Full Vaccination Coverage: More than 3.5 million infants (100%) received all basic vaccinations before their first birthday, which is a performance higher than 5 percentage points compared to the previous year. The performance is also higher than the target for the year. Only Gambella region has a performance lower than the baseline while all others have a higher performance than the baseline. Compared to their target, five regions did not achieve their target, namely Afar, Somali, BG, SWE and Gambella.

Figure 23: Performance of Pentavalent 3, MCV1 and full immunization by region, 2017 EFY

Region	Pentavalent 3rd Dose Coverage (< 1 year)		MCV1		Full immunization	
	Baseline	Performance	Baseline	Performance	Baseline	Performance
Tigray	39%	99%	28%	90%	25%	83%
Afar	94%	97%	83%	91%	70%	81%
Amhara	93%	103%	90%	100%	88%	99%
Oromia	117%	112%	111%	107%	108%	105%
Somali	101%	117%	90%	109%	75%	86%
BG	81%	87%	79%	83%	72%	77%
Central E	108%	108%	105%	105%	102%	104%
South Eth	104%	105%	99%	101%	95%	98%
Sidama	105%	105%	103%	104%	101%	103%
SWE	93%	94%	93%	90%	85%	86%
Gambella	99%	99%	95%	95%	77%	74%
Harari	117%	124%	109%	117%	110%	117%
Dire Dawa	83%	102%	76%	95%	75%	94%
AA	169%	162%	169%	155%	167%	155%
National	104%	108%	98.7%	104%	95%	100%

Dropout Rate (Pentavalent-1 to Measles-1 Vaccination)

In 2017 EFY, the national dropout rate (DOR) from pentavalent 1 to measles 1 was 9%, which is reduced by 1 percentage points compared to the previous fiscal year. Most regions have reduced DOR in 2017 EFY compared to the previous year. Significant reduction was reported in Tigray region, reducing DOR from 37% to 14%. However, four regions have increased the DOR: South Ethiopia, SWE, Gambella, Harari and Addis Ababa.

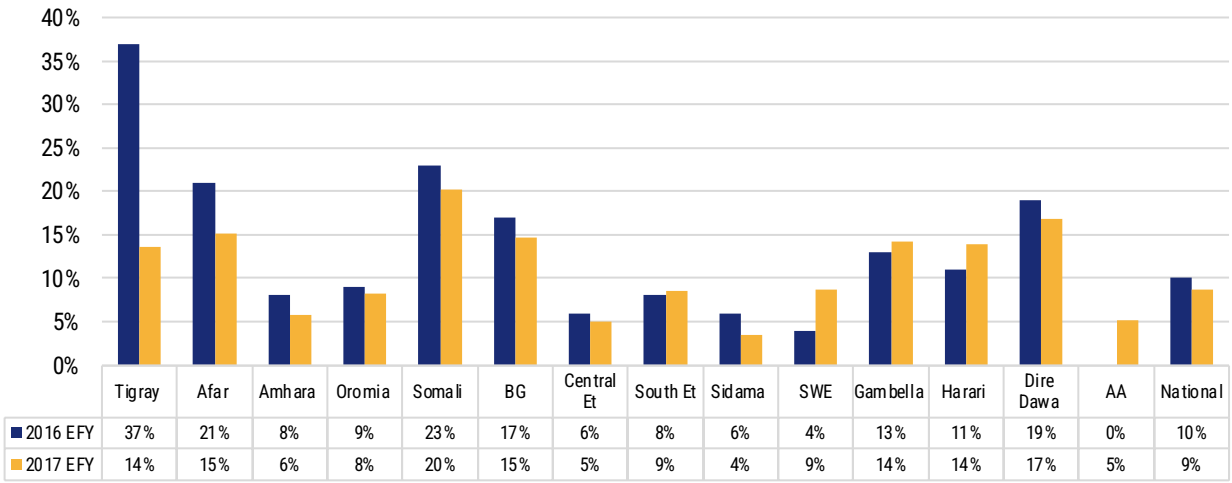


Figure 24: Pentavalent-1 to MCV-1 Vaccination dropout rate, 2016 EFY Versus 2017 EFY

Catch up vaccination – reaching zero dose and under-vaccinated children

Many children—particularly those in conflict-affected areas, internally displaced persons (IDP) settlements, and drought-affected regions—are missing out vaccines. Since 2019, the number of "zero-dose" children (those who had never received any routine vaccine) had been increasing.

To address this, the Ministry of Health launched a catch-up vaccination policy targeting zero-dose and under-vaccinated children under five years of age. Over the past two years, the initiative has been integrated into the routine system. In 2017 EFY, identifying and vaccinating zero-dose children became a flagship agenda of MOH. To date, more than 1.4 million zero dose children were reached and vaccinated. This success was driven by several key strategies, including advocacy and community mobilization, outreach services, and periodic intensification of routine immunization (PIRI) through mobile teams. The program also integrated vaccination with measles and polio campaigns, strengthened supervision, and introduced rapid community surveys for local-level monitoring. Regions additionally provided financial support to expand targeted outreach, PIRI, and routine immunization services.

Overall, since the launch of the catch-up vaccination initiative in 2015 EFY, more than 1.4 million children have been identified and vaccinated.

Table 2: Number of zero dose children vaccinated since the initiation of big catch-up vaccination, August 2025

Region	Number of zero dose children vaccinated		Total Zero dose children vaccinated
	Integrated catch up (Five different SIAs + RI catch up)	Big-catch up, as of July, 2025	
Tigray	35,449	43676	79,125
Afar	22,119	68099	90,218
Amhara	56,450	130516	186,966
Oromia	137,881	282709	420,590
Somali	70,196	284778	354,974
BG	7,977	16030	24,007
Central Eth	9,517	31360	40,877
South Eth	13,745	61059	74,804
Sidama	3,216	66397	69,613
SWE	7,330	46270	53,600
Gambella	5,487	7805	13,292
Harari	259	962	1221
Dire Dawa	1,421	2246	3,667
Addis Ababa	216	623	839
Total	371,263	1,042,530	1,413,793

Despite major progress in reaching zero dose children, significant gaps remain and vaccination coverage continues to vary widely across regions. Conflict, displacement, urban poverty, and remote geography still leave many children unprotected. At the same time, weak monitoring at lower levels, misconceptions among some health workers that "no zero-dose children exist" without proper community verification, limited prioritization by local leadership, and gaps in awareness have further constrained progress.

As of July 2025, an estimated 1,115,011 zero-dose children remain at high risk of vaccine-preventable diseases. These children are concentrated in conflict-affected areas, hard-to-reach rural and pastoralist communities, IDP settlements, urban slums with poor healthcare access, households facing severe economic hardship, and other underserved pockets. In addition, persistent financial shortfalls continue to limit the full rollout of catch-up vaccination efforts.

Next Steps to address zero dose children: To close these gaps and protect every child, the ministry of health has planned the following major activities

- Revise the accelerated catch-up vaccination strategy to reach more zero-dose children by prioritizing hard-to-reach areas.
- Strengthen microplanning at the community level to ensure no child is missed.
- Conduct targeted mini local campaigns to reach more zero-dose children.
- Enhance community engagement through local leaders, religious groups, and volunteer health leaders (VHLs).
- Expand mobile outreach services to reach remote and displaced populations.
- Integrate vaccination services into nutrition and maternal health programs to increase contact opportunities.
- Mobilize additional resources to maintain outreach activities.
- Target high-risk areas with tailored strategies based on local barriers

HPV – Multi-Age Cohort (MAC) Vaccination

In 2017 EFY, MoH conducted a nationwide multi-age cohort (MAC) HPV vaccination campaign from Tahsas 9-13, 2017 EFY, targeting girls aged 9–14 years with a single-dose quadrivalent HPV vaccine to protect the most at-risk adolescents. Preparations included a two-day TOT for regional coordinators, cascaded training for frontline staff, and the development of bottom-up micro plans across all regions. As a result, 7,085,236 girls—96% of the target—were vaccinated, with 77% reached through schools and 23% through outreach sites.

Since the introduction of HPV vaccination program in 2018, a cumulative of 14,693,724 girls received the first dose and 4,191,443 girls received the second dose of HPV vaccine.

Table 3: Number of girls vaccinated for HPV through HPV MAC as of Nehassie 2017

Region	Target	No. of girls vaccinated	Coverage (%)
Tigray	308,568	294,221	95%
Afar	92,840	90,540	98%
Amhara	1,503,824	1,378,236	92%
Oromia	3,223,180	3,147,145	98%
Somali	478,896	454,840	95%
BG	61,541	61,541	100%
Central Ethiopia	411,027	411,027	100%
South Ethiopia	487,014	480,239	99%
Sidama	342,625	340,474	99%
SWE	165,816	162,481	98%
Gambella	40,828	39,453	97%
Harari	16,889	15,482	92%
Dire Dawa	30,060	30,060	100%
Addis Ababa	179,497	179,497	100%
Total	**7,342,605**	**7,085,236**	**96%**

Challenges of HPV vaccination initiative: The HPV vaccination program faces several challenges. Gaps in microplanning have made it difficult to generate accurate estimates of eligible adolescent girls at the woreda level. Reaching out-of-school adolescents remains a persistent challenge, while myths and misconceptions about HPV vaccination in some communities hinder acceptance. In addition, as the program transitions from campaign-based to routine delivery, there is a risk of reduced focus and momentum.

To address these challenges, MOH has outlined several next steps. Priority actions include developing sustainable vaccine delivery strategies to routinize HPV vaccination and preparing more robust micro plans for implementation. Efforts will also focus on conducting catch-up vaccination campaigns for girls who missed the MAC round, strengthening school–community linkages to improve adolescent reach, and using targeted social mobilization to counter cultural barriers and misinformation. Furthermore, targeted outreach will be expanded to reach hard-to-reach and out-of-school girls to ensure equitable access to HPV vaccination.

Integrated Campaign: Measles SIA, Zero Dose identification and vaccination, nutrition, and MCH Campaign

In 2017 EFY, integrated measles supplementary activity (SIA) was conducted, targeting 18.5 million under-five children, achieving 100% national coverage. The campaign also delivered a package of essential health services, including zero-dose catch-up vaccination, COVID-19 vaccination, nutrition screening, vitamin A supplementation, deworming, and referrals for maternal and child health services.

Several key strategies contributed to the success of the campaign. Leadership at all administrative levels played a central role in guiding and coordinating implementation. Strong readiness assessments, intra-campaign monitoring, and supportive supervision ensured quality and timely corrective actions. Comprehensive orientation was provided to all health workers and supervisors on the integrated approach, while robust microplanning helped to identify and prioritize high-risk areas. Advocacy and community mobilization were conducted through multiple platforms to raise awareness and encourage participation. Independent monitoring was deployed to track performance in real time, and partners supported the government by strengthening logistics delivery, supervision, advocacy, and other critical areas.

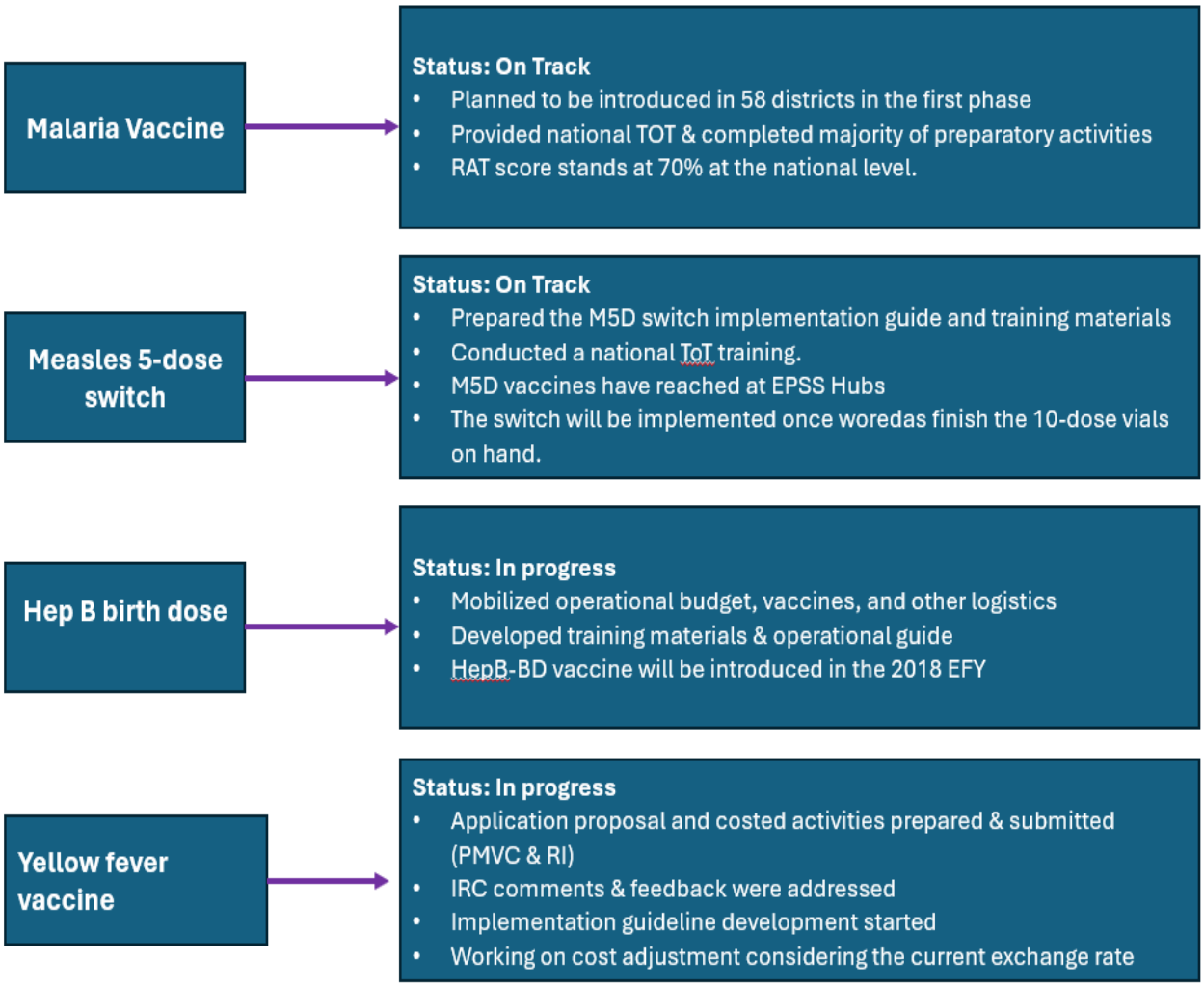
Table 4: Integrated Measles campaign performance by region, 2017 EFY

Region	Target	No. vaccinated (Measles)	Performance Coverage
Tigray	807,920	784,935	97%
Afar	332,305	331,444	100%
Amhara	3,752,338	3,627,636	97%
Oromia	7,276,883	7,420,401	102%
Somali	1,575,770	1,518,433	96%
BG	204,468	168,140	82%
Central Ethiopia	1,019,614	1,089,089	107%
South Ethiopia	1,240,751	1,290,702	104%
Sidama	919,883	907,364	99%
SWE	527,954	530,004	100%
Gambella	122,848	126,052	103%
Harari	43,387	49,000	113%
Dire Dawa	82,065	81,363	99%
Addis Ababa	628,463	637,271	101%
Total	**18,534,649**	**18,561,834**	**100%**

During the measles SIA campaign, a range of essential health services were integrated alongside measles vaccination. About 1,325 obstetric fistula cases were identified and linked to care, while over 15.6 million children received vitamin A supplementation. In addition, more than 11 million children were dewormed with albendazole, over 18.5 million children and more than 4 million pregnant and lactating women were screened for nutrition. This demonstrates the added value of integrated service delivery during nationwide campaigns.

New vaccine introduction

In 2017 EFY, the Ministry of Health has planned and prepared for the introduction of malaria vaccine, the Hepatitis B birth dose (HepB-BD), and the Yellow Fever vaccine, alongside the transition to a five-dose measles schedule. The status of these new vaccines' introduction is summarized as follows.



2.4. Nutrition Program

Nutrition

Growth monitoring and promotion:

>3.8 million (67%)

children under 2 years of age participated in growth monitoring and promotion service

Vitamin A Supplementation:

>20.5 million (>100%)

children aged 6-59 months received two doses of vitamin A

Deworming Service:

>14.49 million (>100%)

children aged 24-59 months received bi-annual deworming service

Nutritional screening:

>12.4 million

under 5 children were screened for malnutrition

Seqota declaration expansion phase:

Implementation in **334 Woredas**

Preparations completed to expand to 520 Woredas in the next fiscal year

The government of Ethiopia approved the Food and Nutrition Policy in 2018, followed by the endorsement of the 10-year Food and Nutrition Strategy and the Seqota Declaration expansion Phase roadmap in 2021. These initiatives aim to implement high-impact, cost-effective, and sustainable interventions that are nutrition-specific, nutrition-sensitive, and nutrition-smart, while integrating climate-resilient infrastructure solutions

Over the past two decades, the prevalence of stunting has decreased from 58% to 39% between 2000 and 2022, but it is still above the HSDIP and SDG targets, indicating it as a critical issue to be improved. In the same period, the proportion of underweight children declined from 41% to 22% and Wasting decreased from 12% to 11%, which is still a high prevalence. Nutrition-specific and sensitive interventions are mainly required to improve the nutritional status of the population. The food and nutrition strategy emphasizes the importance of a multi-sectoral response and approach.

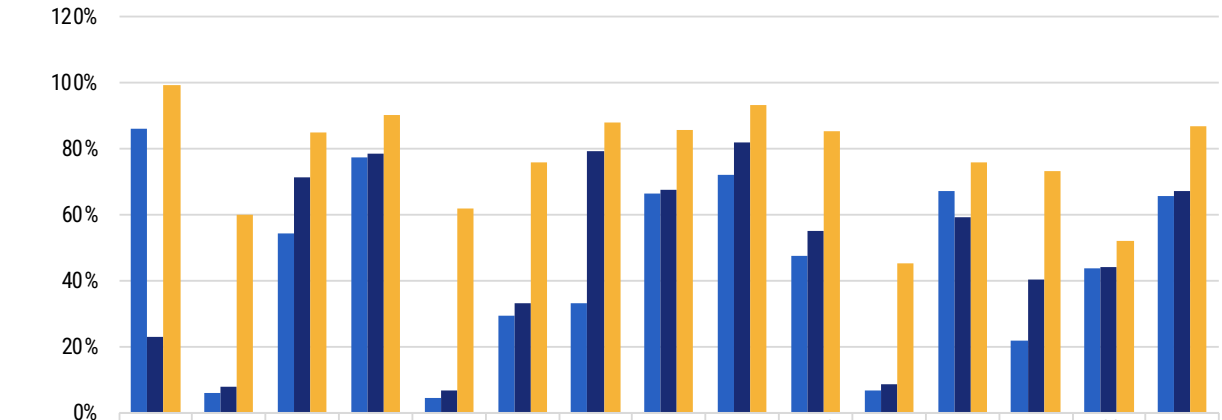
In 2017 EFY, the Nutrition Coordination office (NCO) at MOH has undertaken various interventions. This report provided the high-level achievements of the NCO through nutrition-specific and Multi-sectoral and Seqota Declaration-related activities, the challenges and priorities for next year.

Growth Monitoring and Promotion

Growth monitoring and promotion (GMP) during the first two years of age helps to reverse nutrition-related problems early through nutritional assessment and counseling. GMP uses regular community dialogue to engage community members to assess the overall nutritional status of children in their community, to understand the barriers and potential supports for improved nutrition, and to develop consensus on plans of action to make a difference. GMP revitalization is being undertaken to increase the quality of service delivery and promote the use of GMP as a multi-sectoral performance scorecard.

2017 EFY, more than 3.88 million (67%) of children under 2 years of age received growth monitoring and promotion services. There was a high disparity in performance across regions. The lowest performance was reported in Somali (7%), Afar (8%) and Gambella (9%), while the high performing regions were Sidama (82%), Central Ethiopia (79%) and Oromia (78%). Tigray region has significantly reduced its performance compared to the baseline.

Growth monitoring and promotion interventions have been comprehensively reviewed across five clusters, leading to actionable insights and strategic directions for enhancing child health and development.



	Tigray	Afar	Amhara	Oromiya	Somali	Ben/Gumuz	Central E	South Eth	Sidama	South west Eth	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline	86%	6%	54%	77%	4%	29%	33%	66%	72%	47%	7%	67%	22%	44%	66%
Performance	23%	8%	71%	78%	7%	33%	79%	68%	82%	55%	9%	59%	40%	44%	67%
Target	99%	60%	85%	90%	62%	76%	88%	86%	93%	85%	45%	76%	73%	52%	87%

Figure 25: Proportion of children under 2 years of age that received GMP service by region, 2017 EFY

Vitamin A Supplementation

Vitamin A supplementation is crucial for child survival. The national guideline protocol recommends that children should receive vitamin A and deworming (albendazole supplementation) twice within a 12-month period. Monitoring the biannual administration of both for children is essential for tracking progress towards child survival-related SDGs.

In 2017 EFY, more than 20.57 million children aged 6-59 months received two doses of vitamin A supplementation. The coverage of vitamin A supplementation is higher than 100% in all regions except in Somali (35%), Afar (64%), BG (77%) and Gambella (89%). The reason for most regions to have a coverage of more than 100% in Vitamin A supplementation is due to population denominator issue and due to vita A campaign that was done and reported in the fiscal year.

Table 5: Proportion of children aged 6-59 months of age who received two doses of Vitamin A supplementation, 2017 EFY

	Baseline	Performance	Target
Tigray	26%	110%	80%
Afar	149%	64%	100%
Amhara	87%	166%	93%
Oromiaa	107%	136%	100%
Somali	20%	35%	60%
BG	31%	77%	75%
Central E	104%	155%	100%
South Eth	79%	118%	88%
Sidama	99%	144%	100%
SWE	65%	120%	96%
Gambella	65%	89%	90%
Harari	86%	183%	95%
Dire Dawa	25%	101%	99%
Addis Ababa	123%	239%	100%
National	90%	135%	94%

Deworming service

De-worming is a crucial intervention for preventing anemia in children and reduces mortality in children. In 2017 EFY, more than 14.49 million children aged 24-59 months received deworming twice a year. Regions with low deworming service are Somali (34%), Afar (53%) and Benishangul Gumuz (79%), while the other regions have more than 100% performance.

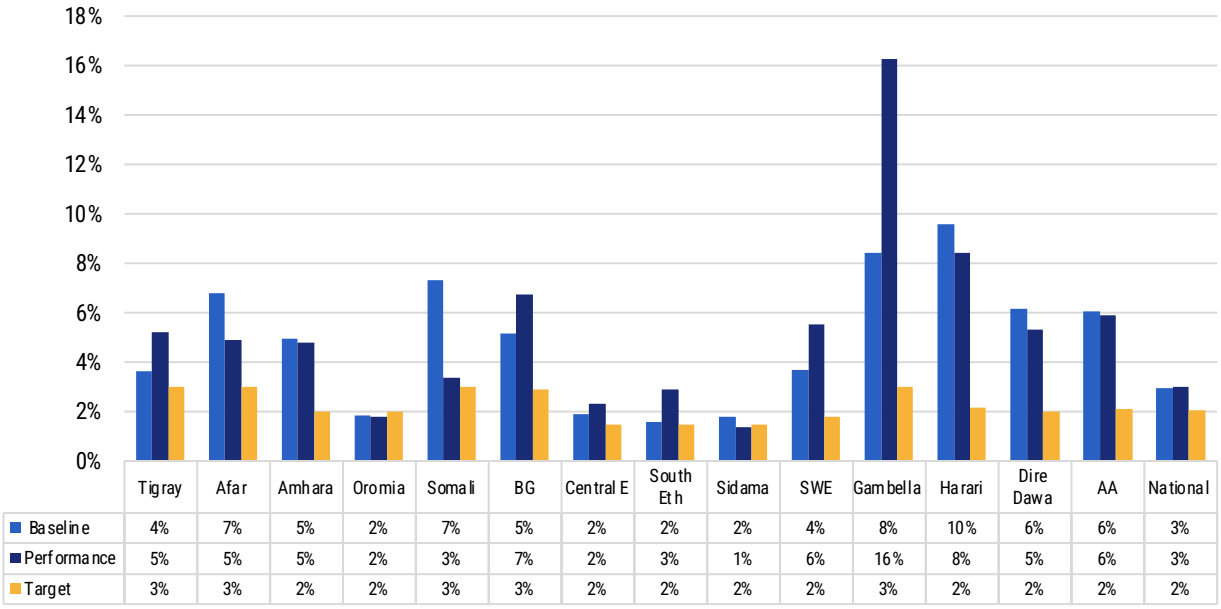
Table 6: Proportion of Children aged 24 - 59 months de-wormed twice a year, 2017 EFY

	Baseline	Performance	Target
Tigray	49%	105%	85%
Afar	47%	53%	75%
Amhara	90%	171%	95%
Oromia	101%	133%	100%
Somali	21%	34%	70%
BG	42%	79%	70%
Central E	100%	147%	100%
South Eth	88%	142%	95%
Sidama	108%	137%	100%
Southwest Eth	69%	121%	92%
Gambella	60%	97%	90%
Harari	102%	242%	100%
Dire Dawa	62%	117%	99%
Addis Ababa	100%	225%	100%
National	89%	135%	95%

IFA 90 plus Supplementation: For performance regarding iron folate supplementation for pregnant women, please refer to the maternal health section of this report.

Low birth weight

Birth weight is a critical indicator of newborn survival, maternal health, and long-term disease risk. Low birth weight is influenced by maternal nutrition, lifestyle habits, and prenatal exposures, and it linked to health risks, predicts neonatal survival, and is higher in lower socioeconomic groups. In 2017 EFY, 3% of all the weighted live births were low birth weight (<2500 grams). The highest low birthweight rate was in Gambella (16%), followed by Harari (8%) and BG (7%).



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	4%	7%	5%	2%	7%	5%	2%	2%	2%	4%	8%	10%	6%	6%	3%
Performance	5%	5%	5%	2%	3%	7%	2%	3%	1%	6%	16%	8%	5%	6%	3%
Target	3%	3%	2%	2%	3%	3%	2%	2%	2%	2%	3%	2%	2%	2%	2%

Figure 26: Proportion of low birth weight by region, 2017 EFY

Nutrition related major activities performed during the fiscal year

- **Integration of Measles SIA, Nutrition, and other Services:** By preparing an integrated measles campaign field guide, a total of 15,664,679 children aged 6-59 months were provided with Vitamin Supplementation (VAS), and 11,102,934 children aged 24-59 months were dewormed during the campaign period.
- **Adolescent nutrition screening:** Adolescent nutrition screening was conducted alongside HPV vaccination in three regions, during which 44,858 female adolescents were screened. Of these, 42,566 (95%) had normal weight, 2,095 (4.7%) were underweight, 177 (0.4%) were overweight, and 20 (0.04%) were classified as obese. A supportive supervision for adolescent nutrition service has been effectively implemented in collaboration with the Ministry of Women and Social Affairs and the Ministry of Education across three selected regions, with valuable feedback provided to enhance program effectiveness.
- **Workplace diet-related NCD screening** was conducted at MOH, revealing that 13.3% were obese, 44.8% were overweight, and 1.8% were underweight.
- **Multiple Micronutrient Supplementation expansion roadmap Development:** A Multiple Micronutrient Supplementation (MMS) expansion roadmap for pregnant women was developed and made ready for use
- **Developing Participant Manuals and Facilitator Guides:** A catchment-based mentorship for nutrition and Baby Friendly Health facility Initiative (BFHI) Participant manual and Facilitator guide has been developed.

- **World Breastfeeding Week Celebration:** World Breastfeeding Week was celebrated at Abebech Gobena Maternal and Children's Hospital with the theme 'Filling the Gap and Supporting All Mothers to Breastfeed.' During the event, support for incapacitated mothers, along with maternal and child hygiene kits, was provided.
- **Neural Tube Defect Day Celebration:** was celebrated with a collaborative awareness creation campaign for the House of Peoples and Representatives.
- **Capacity Building:** Various capacity building trainings were conducted in the fiscal year, including the following:
- ToT training on Baby-Friendly Hospital Initiative (BFHI): provided for 60 nutrition experts and maternal & child health program heads across all regions, followed by cascading training for 209 health workers
- Growth Monitoring blended training conducted for 185 health professionals from all 14 regions.
- Catchment-Based Mentorship training delivered for 254 health professionals.
- Infant and Young Child Nutrition ToT training provided for 124 health professionals.
- 80 health information and consultation professionals trained on healthy diet
- Training on Multiple Micronutrient Supplementation (MMS): provided for 383 health professionals across four regions.

Nutrition screening for Pregnant & lactating women (PLW) and Under 5 children

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

Screening of pregnant and lactating women: In 2017 EFY, 58% of the expected pregnant and lactating women were screened for nutritional status. The lowest screening performance was in Gambella (14%), Dire Dawa (18%) and Addis Ababa (23%), while highest performance was reported in Oromia, Tigray (66%), Central Ethiopia (62%) and Sidama (62%).

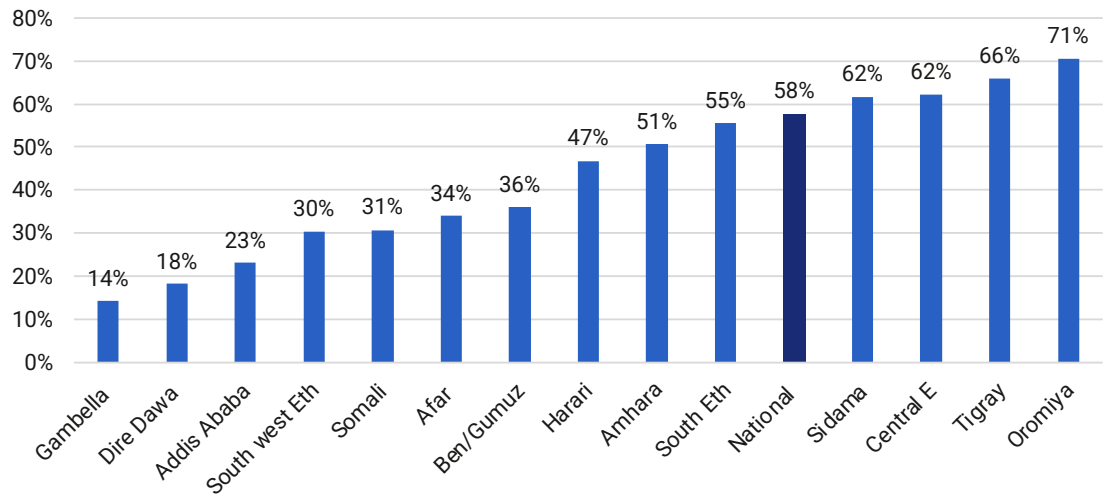


Figure 27: Proportion of pregnant and lactating women screened for nutritional status, by region, 2017 EFY

Nutrition screening of under 5 children: In 2017 EFY, more than 12.4 million under 5 children were screened for their nutritional status. The lowest performance was observed in Afar (16%), Somali (13%), Dire Dawa (23%) and Gambella (31%). High screening performance was reported in Amhara (87%), Oromia (86%) and Sidama (85%).

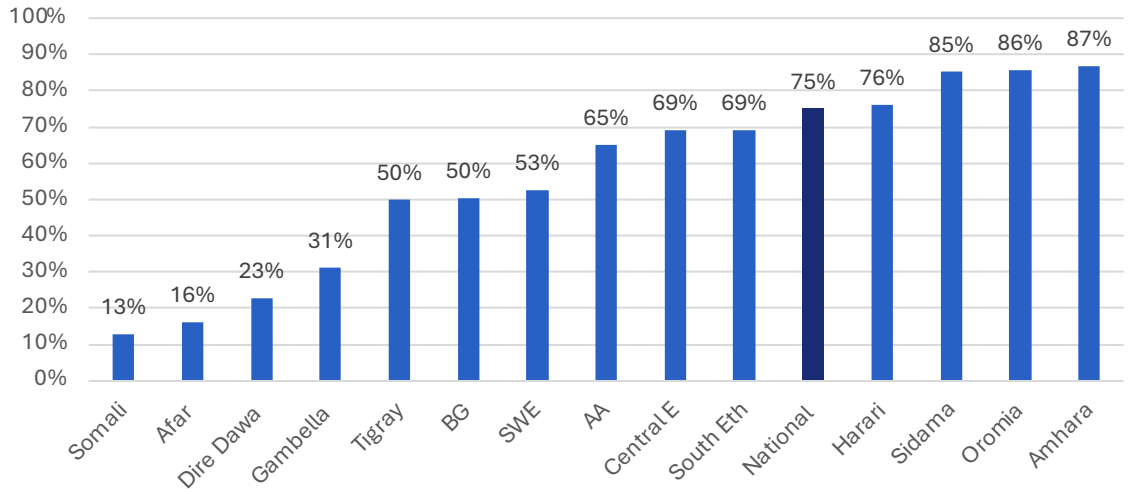
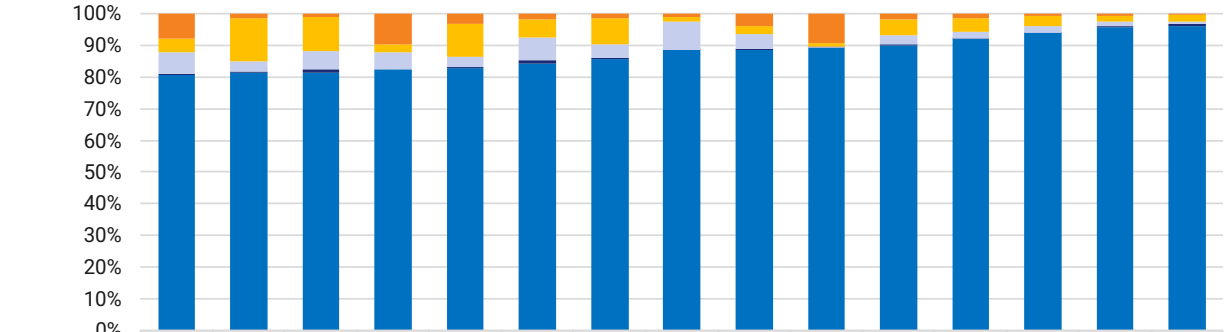


Figure 28: Proportion of under-5 children screened for nutritional status by region, 2017 EFY

Treatment of acute malnutrition in under 5 children

Treatment outcome of acute malnutrition in under 5 children at OTP showed that 90% of them were recovered/cured, while 5% were defaulted. Regions with low cure rate include Tigray (81%), Amhara (81%), BG (82%), Harari (83%), Dire Dawa (83%) and Gambella (84%).



	Tigray	Amhara	BG	Harari	Dire Dawa	Gambella	Afar	AA	SWE	Sidama	National	South Eth	Oromia	Central E	Somali
Non-respondent	8%	1%	1%	10%	3%	2%	1%	1%	4%	9%	2%	2%	1%	1%	0%
Defaulted	4%	14%	11%	3%	10%	6%	8%	2%	3%	1%	5%	4%	3%	2%	2%
Transferred out	7%	3%	6%	5%	3%	7%	4%	9%	5%	0%	3%	2%	2%	2%	1%
Died	0%	0%	1%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cured	81%	81%	82%	83%	83%	84%	86%	89%	89%	89%	90%	92%	94%	96%	96%

Figure 29: Severe acute malnutrition treatment outcome at OTP centers, by region, 2017EFY

In the fiscal year, the following main activities were performed to improve screening and management of acute malnutrition

- The Family MUAC pilot was implemented in 121 woredas across 11 regions, targeting children under five years old. Physical support and monitoring were conducted in three selected woredas—Deno, Shala, and Chifra—across two regions. The pilot emphasized community-level engagement, leveraging local capacity to ensure effective and sustainable implementation.
- A total of 219 million ETB from the World Bank has been allocated to five regions—Amhara, Afar, Benishangul Gumuz, Oromia, and Tigray—to strengthen services for children under five and pregnant and lactating women through capacity building, nutrition screening, and rapid assessments. An additional 7 million ETB has been provided to further enhance nutrition services for the same target groups across these regions.
- Ethiopia has begun adapting the 2023 WHO guideline on wasting and nutritional edema in children under five to its national context. A roadmap was developed, and a task force established. The process involved stakeholder engagement through situational analysis and co-creation workshops, culminating in a zero draft guideline that was reviewed and updated.
- A timely evaluation was conducted in collaboration with regional nutrition experts, Addis Ababa University, and the World Food Programme to strengthen the pilot implementation of the 'Local Food for MAM' program. This initiative targets moderately acute malnourished children under five, as well as pregnant and lactating women, and is being implemented in the Sidama, Oromia, and South Ethiopia regions
- Efforts were made to monitor and support the distribution of nutrition-related services across regions. Partners mobilized $18.6 million worth of supplies to prevent and treat severe acute malnutrition. In response to fourth-quarter shortages of RUTF, F75, and F100, interim guidance was developed and shared with regions to support distribution.
- A guideline has been developed to establish a Center of Excellence (CoE) for delivering nutrition services in a coordinated and standardized manner.
- To support the procurement of Ready-to-Use Therapeutic Food (RUTF), the government allocated a matching fund of 70 million birr, which was transferred to UNICEF to facilitate the purchase.
- RUTF, F75, and F100 are included in the Essential Medicines List (EML) as they are critical for treating severe acute malnutrition (SAM) in children.
- In collaboration with the Ethiopian Public Health Institute, the Disaster Risk Management Commission, and partner organizations, a coordinated response has been carried out to address food and health emergencies caused by both human-made and natural disasters in the Tigray, Oromia, Afar, and Benishangul-Gumuz regions.
- In collaboration with the Ethiopian Public Health Institute, the Disaster Risk Management Commission, and partner organizations, a coordinated response has been implemented to address food and health emergencies in Tigray, Oromia, Afar, and Benishangul-Gumuz regions. Key actions taken include:
  - Responding to earthquake-related displacement in the Afar region by identifying relocation sites.
  - Establishing Emergency Operation Centers and Health & Nutrition Clusters.
  - Preparing emergency response plans and mapping partners.
  - Setting up service clinics and training health professionals.
  - Mobilize and supply essential items to IDP sites

- **Capacity building**
  - **DHIS2 Training:** 46 professionals (regional nutrition focal points, regional HMIS focal points, and MOH nutrition experts) trained to address nutrition data management
  - **CMAM Training of Trainers:** 35 professionals from hospitals and RHBs trained on Community-Based Management of Acute Malnutrition
  - **Emergency Malnutrition Treatment ToT:** Health workers from 40 woredas in Amhara, Oromia, Afar, Tigray, Somali, and BG trained to strengthen frontline capacity in implementing the Simplified and Combined Approach for Wasting treatment in emergencies, ensuring timely care for acute malnutrition in crisis-affected areas.
  - **IYCF-E Training:** 40 professionals received IYCF-E ToT, and 30 health professionals completed IYCF-E basic training.

Food and Nutrition Strategy (FNS) implementation

Multi-sectoral Coordination and Governance

Since the factors contributing to malnutrition are multifaceted, addressing them requires the engagement of multiple stakeholders and a variety of solutions. In Ethiopia, multisectoral coordination and linkages have been implemented to tackle malnutrition in all its forms. Following the development and implementation of the National Nutrition Program I (2008) and II (2016), multisectoral coordination platforms were established at both national and regional levels to enable sectors to collaborate and work together effectively.

These coordination platforms are mandated to oversee the planning, implementation, and monitoring of nutrition programs. They were revitalized following the endorsement of the Food and Nutrition Policy, the National Food and Nutrition Strategy, and the launch of the Seqota Declaration expansion phase. Furthermore, to accelerate the implementation of the strategy and the Seqota Declaration roadmap, a multisectoral coordination implementation guide, standard operating procedures, and a training manual have been developed.

Supportive supervision findings indicate that the Food and Nutrition Council has been established in all regions (100%) and in 54% of woredas.

In 2017, EFY, the 14 food and nutrition implementing sectors, undertook various activities, including production, consumption, and promotion of diversified nutrient-dense foods, school feeding, water supply, women's empowerment, income generation, food safety and quality, and food fortification. The major multi-sectoral activities and achievements are as follows:

- **Food System and Nutrition Coordination Platforms:** 13 regional states have established food systems and nutrition councils through legal procedures, replacing the previous nutrition coordinating body. The food system and nutrition inter-ministerial steering committee was established in the previous year to provide high-level leadership and guidance for implementation of the food and nutrition strategy, the Seqota Declaration, and the food system transformation roadmap. The steering committee is composed of 14 implementers and co-chaired by the MOH and the Ministry of Agriculture (MOA), depending on the agenda. In addition, the food and nutrition technical committee is coordinating the planning, implementation, and monitoring of the food and nutrition activities at the national level. It has met three times and conducted a performance review in the reporting year.

- **Scaling Up Nutrition: To s**ustain the government and its partners' commitment to the Scaling Up Nutrition (SUN) movement, the government of Ethiopia has six active scaling up nutrition networks, namely government, Ethiopian Civil Society, Donors, Academia, Business, and UN Nutrition. The networks under the leadership of the SUN Multi-Stakeholder Platform (SUN-MSP), with the leadership of the Ministry of Health, conduct regular meetings to support food and nutrition multi-sectoral implementation
- **Procurement and distribution of potassium iodate (KIO3) for salt manufacturing industries**- Overall, twenty-five **salt manufacturing industries** received 201.4 Quintals of KIO3 to iodize salt.
- **Monitoring and Evaluation:** A standard Monitoring and Evaluation operating procedure (SOP) was prepared and validated in the previous year. This year, the SOP was piloted in selected 7 Woredas and shared with the regions for wider implementation. To support the multisectoral implementation of food and nutrition interventions, national-level supportive supervision was conducted in all regions and city administrations jointly with FNS implementing sectors and partners.

Seqota Declaration Expansion Phase

In the 2017 EFY, which marked the fourth year of the Seqota Declaration (SD) expansion phase, the Government of Ethiopia reaffirmed its commitment by allocating approximately 750 million ETB for the implementation of the costed woreda-based plan across 334 expansion phase woredas. In parallel, the regions allocated an additional 698.3 million ETB, effectively matching the federal budget. The Ministry of Finance transferred the earmarked treasury budget to the regions and city administrations to support implementation. Furthermore, technical support was provided to regions and woredas to strengthen the execution of the expansion phase interventions in all 334 woredas. The following are the major SD activities conducted during the fiscal year.

- **High-level meeting conducted**: To strengthen the multi-sectoral food system and nutrition coordination and the Seqota declaration implementation, a high-level meeting was convened under the leadership of the Deputy Prime Minister. This meeting brought together ministers, mayors, regional presidents, and bureau heads. During the session, the annual reports on food and nutrition and the Seqota Declaration were reviewed, strategic guidance was issued, and the treasury budget for the 2018 EFY was officially approved. Importantly, the meeting resulted in a decision to expand the Seqota Declaration's second-phase implementation: the number of designated expansions woredas increased from 334 to 520, adding 186 new woredas for the 2018 EFY. Following this decision, regional and city administrations compiled and submitted basic data for these newly selected woredas. The FSN council was established through legal procedure in 11 regions and two city administrations

Photo: High-level Food and Nutrition and SD performance meeting,

- **Multi-sectoral approach for stunting reduction project (MASReP**): This is a four-year, USD 48.17 million initiative jointly funded by the African Development Bank and the Government of Ethiopia, aimed at supporting the Seqota Declaration. The project focuses on implementing nutrition-specific and nutrition-sensitive, climate-smart infrastructure across 40 SD woredas in Amhara and Tigray regions. Key sectors include health, agriculture, water supply, and education. The following is the major interventions conducted in 2017 EFY coordinated and supported through MASReP, targeting the SD commitments:
    - **Infrastructure:** Out of the nine health posts targeted for construction, four were completed during the fiscal year. All six Nutrition Demonstration Centres (NDCs) were successfully established, and four Model Nutrition Schools (MNS) were finalized. In addition, 30 cows and 20 heifers were distributed to support nutrition-sensitive interventions.
    - **Water Supply Projects:** 17 new constructed, 58 existing projects maintained and become operational
    - **Small-Scale Irrigation (SSI)**: 26 projects completed, benefiting 2,551 households
    - **Livestock & Poultry Support**: During the reporting period, 17,362 dairy goats were distributed to 3,880 selected pregnant and lactating women, and 114,766 poultry were provided to 9,562 PLWs to enhance nutrition and livelihood support.

- **Capacity Building**
    - 418 individuals received training on water and soil conservation. 970 religious leaders were trained on nutrition, harmful traditional practices (HTP), and fasting. A total of 1,934 participants received training on nutrition-sensitive agriculture and social and behavior change communication. In addition, 187 health workers and 2,165 HEWs were trained on growth monitoring practices. For water, sanitation, and hygiene, 1,592 WASH committee members (including 288 women) received training
    - Capacity building efforts to advance SD innovations and multisectoral coordination included training 235 regional and national implementing sectors on FN coordination and governance, 28 FNTC members on food fortification, and 63 health and nutrition experts on PR and GMP. Additional initiatives involved Nutrition Leadership training for 80 sectors, UNISE training for 424 participants, orientation on NC-HDPTN for NCO and regional staff, GMP-R orientation for 260 participants, RASME for 45 participants, fiduciary training for 40 MASReP sectors, and FN sensitization for 54 media and communication experts.
- As part of the expansion phase of Seqota Declaration implementation, proven innovations are being scaled up, including costed Woreda-based planning, the UNISE, Community Lab, Resource Tracking and Partnership Management, and the Triangle of Knowledge Partnership. Notably, UNISE was implemented in 226 Woredas in 2017 EFY

Challenges of nutrition programs

- Low awareness of healthy diets and weak implementation of adolescent nutrition programs
- Security issues limiting access to food and nutrition services & information in some areas
- Budget constraints hinder full implementation of food and nutrition activities
- Delays in establishing the Federal Food and Nutrition Council.
- Insufficient budget allocation and lack of accountability for implementing food and nutrition strategies at federal and regional levels.
- High disparities in coverage and performance of nutrition interventions, with data quality concerns, particularly in pastoralist areas.

Way forward

Key Actions to Strengthen Food and Nutrition Interventions in 2018 EFY includes the following

1. Governance and Coordination

- Strengthen coordination and governance systems at all levels
- Strengthen governance platforms for the Federal Nutrition Council and Seqota Declaration implementation
- Enhance multisectoral coordination and linkages among actors.

2. Resource Mobilization and Budgeting

- Allocate adequate budgets for food and nutrition interventions
- Mobilize sufficient resources, primarily from domestic financing sources, to support nutrition programs.
- Mobilize resources to expand food-based approaches for micronutrient deficiency and develop a resilient service delivery framework

3. Monitoring, Evaluation, and Planning

- Strengthen multisectoral monitoring and evaluation systems.
- Ensure timely forecasting, procurement, and distribution of nutrition supplies.

4. Nutrition Service Delivery

- Strengthen growth monitoring and promotion activities
- Improve access to and utilization of nutrition-specific and nutrition-sensitive interventions at health facilities and community levels.
- Enhance nutritional screening for children under five, pregnant women, and lactating mothers.
- Integrate moderate acute malnutrition treatment programs into the health care system.

5. Maternal and Infant Nutrition

- Establish a breast milk bank in collaboration with relevant stakeholders.
- Strengthen implementation of the Baby-Friendly Health Facility Initiative in selected facilities.

6. Emergency Preparedness and Resilience

- Strengthen nutrition emergency preparedness and response.
- Mobilize resources to support the government's humanitarian efforts and build a resilient, nutrition-centric humanitarian-development nexus

Chapter

Disease Prevention and Control

Chapter 3: Disease Prevention and Control

3.1. HIV/AIDS and viral hepatitis Prevention and Control

HIV Prevention and Control

HIV/AIDS estimations in 2024

0.85%
HIV prevalence in 2024

601,039
Estimated number of people living with HIV/AIDS (PLHIVs) in Ethiopia

7,962
Estimated annual new HIV infections

9,560
Estimated annual AIDS deaths

13,618
Estimated number of HIV positive pregnant and lactating women

9.05%
PMTCT transmission rate

PMTCT

>4.1 million (100%)
pregnant and lactating women were tested for HIV and know their status

11,825 (87%)
HIV-positive pregnant and lactating women received ART to reduce the risk of mother-to child transmission

Early Infant Diagnosis:
10,687 (78%)
HIV exposed infants received virological test within 12 months after birth

ARV prophylaxis for HIV exposed infants:
9,759 (72%)
of HIV exposed infants received ARV prophylaxis for 12 weeks

HIV testing and counselling service

>6.6 million
individuals received HIV testing and counselling service, among which 36,216 (0.47%) new HIV positives were identified

People receiving ART

A total of **536,067**
PLHIVs were on ART

First 95 performance

94%
From the total estimated PLHIVs in Ethiopia, 94% of them know their HIV positive status

Second 95 performance

97%
From the total PLHIVs who know their status, 97% were receiving Anti-Retro therapy (ART) service

Third 95 performance

97%
Among PLHIVs who were receiving ART, 97% of them had viral load suppression (<1000 copies/ml)

Pre-Exposure Prophylaxis of HIV (PrEP)

22,438
Individuals at high risk of HIV were newly enrolled to PrEP

Post-Exposure Prophylaxis of HIV (PEP)

6,479
Individuals received PEP service

The 2024 Ethiopia HIV Estimates and Projections Report indicates that the estimated number of people living with HIV/AIDS (PLHIV) in 2024 was 601,039. Of these, 64% were female and 36% male. Adults accounted for 573,136 (95%), while 27,903 (5%) were children. The national HIV prevalence was estimated at 0.85%, with regional variations ranging from 0.17% in Somali region to 3.2% in Addis Ababa and 3.09% in Gambella. In 2024, there were an estimated 7,962 new HIV infections and 9,560 AIDS-related deaths.

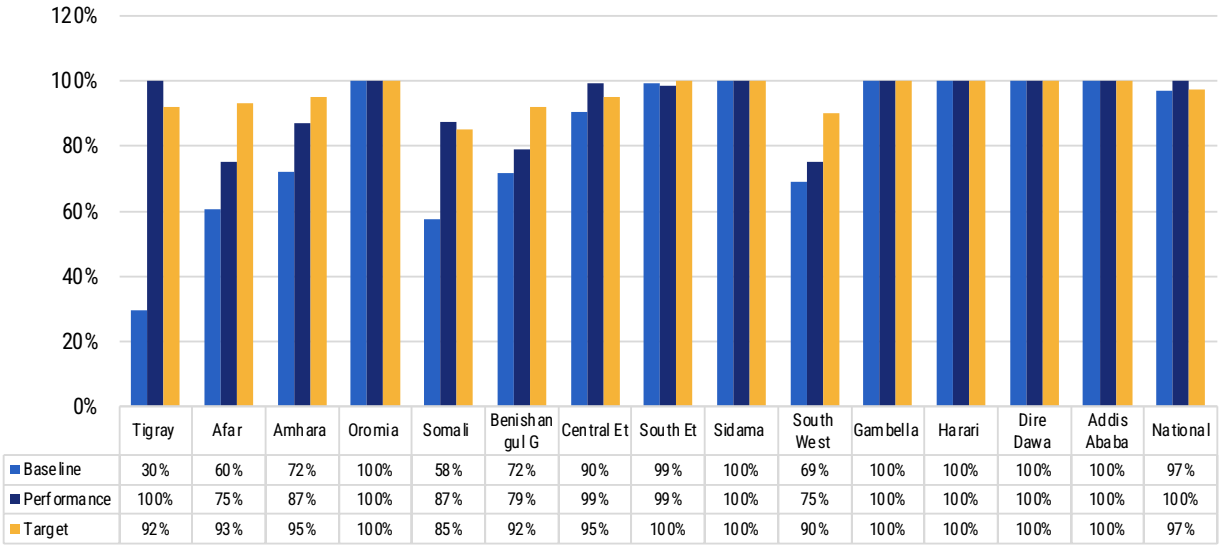
This section describes the 2017 EFY annual performance and progress on the prevention and control of HIV/AIDS and viral hepatitis program.

3.1.1. Prevention of mother to child transmission of HIV, syphilis and hepatitis

Testing of pregnant and lactating women for HIV, syphilis and hepatitis B virus

Ensuring the health of pregnant women and their newborns requires routine screening and timely treatment for HIV, syphilis, and hepatitis B virus (HBV). Universal screening during pregnancy enables timely detection and prompt initiation of prevention of mother-to-child transmission (PMTCT) interventions, including antiretroviral therapy (ART) for HIV, treatment for syphilis, and antiviral prophylaxis for HBV. Strengthening these triple strategies is key to achieving the goal of triple EMTCT.

In 2017 EFY, more than 4.1 million pregnant and lactating women were tested for HIV and know their status, which is more than 100% of the estimated pregnancies (112%). This performance is higher than the baseline and the target for the year. The majority of the regions have achieved more than 100% coverage while some regions have low performance, including Afar (75%), South Ethiopia (75%), Benishangul Gumuz (79%) and Amhara (87%).



	Tigray	Afar	Amhara	Oromia	Somali	Benishangul G	Central Et	South Et	Sidama	South West	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline	30%	60%	72%	100%	58%	72%	90%	99%	100%	69%	100%	100%	100%	100%	97%
Performance	100%	75%	87%	100%	87%	79%	99%	99%	100%	75%	100%	100%	100%	100%	100%
Target	92%	93%	95%	100%	85%	92%	95%	100%	100%	90%	100%	100%	100%	100%	97%

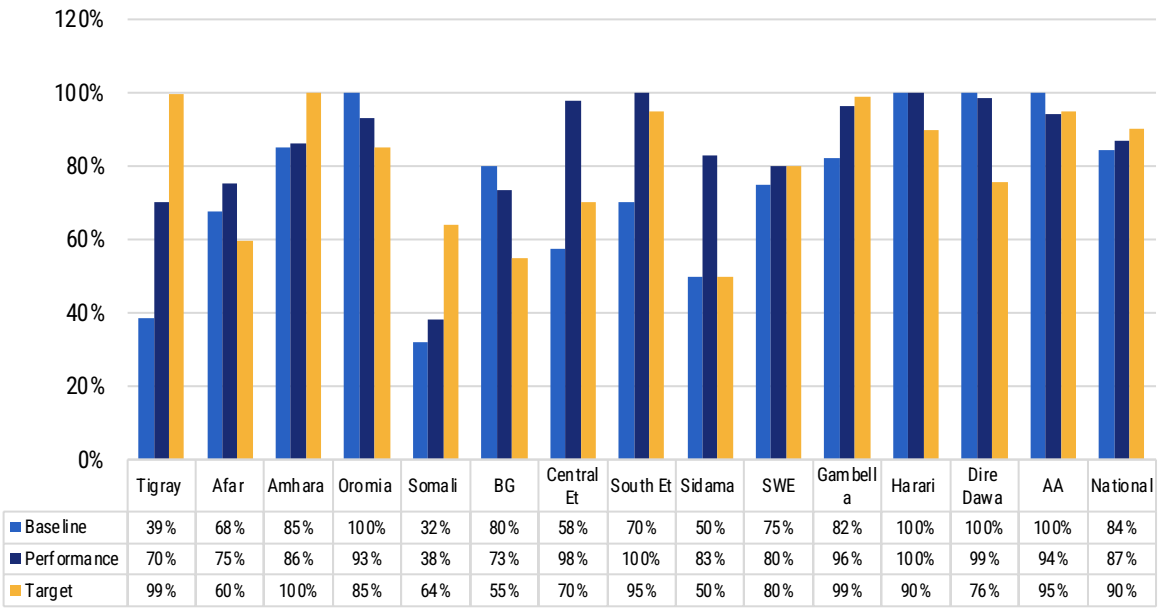
Figure 30: Percentage of pregnant, laboring and lactating women who were tested for HIV and know their status, 2017 EFY

As part of the triple elimination initiative, syphilis screening and testing for HBV services were also provided to pregnant women. More than 3.35 million (80%) pregnant women were tested for syphilis and more than 3.08 million (73%) were tested for HBV. For more details on syphilis screening and HBV testing, refer to the “maternal health” section of the report.

ART to reduce the risk of mother-to child Transmission of HIV

Timely initiation of antiretroviral therapy (ART) is critical to preventing mother-to-child transmission of HIV. Antiretroviral therapy plays a vital role in preventing mother-to-child transmission of HIV, improving maternal health, and ensuring HIV-free child survival. The percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to child Transmission is one of the good indicators to monitor PMTCT performance.

Based on the 2024 HIV estimation report, about 13,618 pregnant and lactating women need PMTCT ART service, with a PMTCT transmission rate of 9.05%. From the total women that require ART, a total of 11,825 (87%) of them were on ART by the end of 2017 EFY. Among those who were on ART, the majority 8,333 (70%) were known HIV-positive positives linked from ART program to PMTCT services, while 3,492 women (30%) were newly diagnosed during ANCre, labor and delivery, or early PNC and initiated on ART. Despite the high PMTCT ART coverage at national level, there was a wide regional disparity in performance across regions, ranging from 38% in Somali to more than 100% in South Ethiopia and Harari.



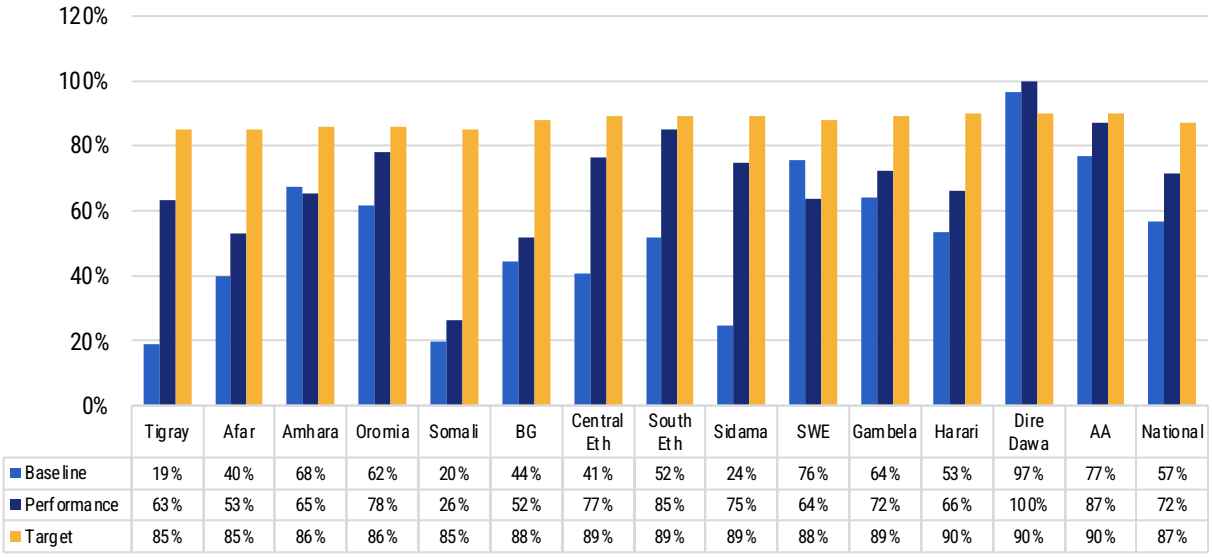
	Tigray	Afar	Amhara	Oromia	Somali	BG	Central Et	South Et	Sidama	SWE	Gambella	Harari	Dire Dawa	AA	National
Baseline	39%	68%	85%	100%	32%	80%	58%	70%	50%	75%	82%	100%	100%	100%	84%
Performance	70%	75%	86%	93%	38%	73%	98%	100%	83%	80%	96%	100%	99%	94%	87%
Target	99%	60%	100%	85%	64%	55%	70%	95%	50%	80%	99%	90%	76%	95%	90%

Figure 31: Percentage of HIV positive pregnant and lactating women who received ART, 2017 EFY

Care for HIV exposed infants

Antiretroviral prophylaxis for HIV exposed infants: Antiretroviral (ARV) prophylaxis for HIV-exposed infants (HEI) is provided alongside maternal ART to further reduce the risk of vertical HIV transmission. This intervention is critical to achieving the elimination of new pediatric HIV infections and ensuring HIV-free survival. Per PMTCT guideline, all newborns exposed to HIV should receive a six-week regimen of AZT and NVP, followed by an additional six weeks of NVP alone, to significantly lower the risk of perinatal HIV transmission.

In the fiscal year, a total of 9,759 (72%) of HEIs received ARV prophylaxis for 12 weeks, showing an improvement from 57% of the previous year. ARV prophylaxis performance ranges from as low as 26% in Somali to 100% in Dire Dawa.

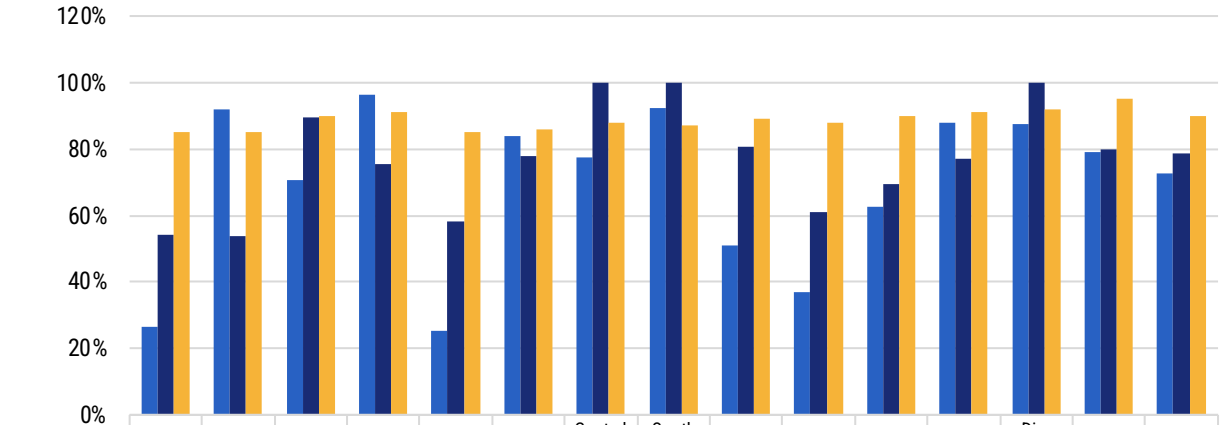


	Tigray	Afar	Amhara	Oromia	Somali	BG	Central Eth	South Eth	Sidama	SWE	Gambela	Harari	Dire Dawa	AA	National
Baseline	19%	40%	68%	62%	20%	44%	41%	52%	24%	76%	64%	53%	97%	77%	57%
Performance	63%	53%	65%	78%	26%	52%	77%	85%	75%	64%	72%	66%	100%	87%	72%
Target	85%	85%	86%	86%	85%	88%	89%	89%	89%	88%	89%	90%	90%	90%	87%

Figure 32: Proportion of HIV exposed infants that received ARV prophylaxis, 2017 EFY

Cotrimoxazole prophylaxis for HIV exposed infants: Cotrimoxazole prophylaxis is an essential component of the care package for HIV-exposed infants, providing crucial protection against opportunistic infections. Co-trimoxazole prophylaxis is recommended for all HIV-exposed children born to mothers living with HIV starting at 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding. During the fiscal year, a total of 10,389 (75%) infants born to HIV positive mothers started cotrimoxazole prophylaxis within two months of birth. This year's performance has increased by 6 percentage point compared to previous year's performance.

Early Infant Diagnosis of HIV exposed infants: Early infant diagnosis (EID) of HIV infection increases ART initiation, which reduces pediatric HIV-related morbidity and mortality. All HIV-exposed newborns receive a virological nucleic acid test within four to six weeks of birth. Point-of-care early infant diagnosis (POC EID) is an innovative technology that allows for the rapid return of HIV test results to caregivers and timely initiation of ART and care. In 2017 EFY, a total of 10,687 (78%) of HEIs received virological tests within 12 months. Compared to the previous year's performance, there is an increment with 5 percentage points. However, compared to the target for 2017 EFY, performance is less by 12 percentage points. From the total tested HEIs, 159 (1.5%) were tested positive by virological test. Confirmatory test (Antibody test) for HIV exposed infants by 18 months was done to a total of 8,573 HIV exposed infants, out of which 41(0.48%) had a positive test result. Compared to the previous year, the positivity rate of virologic tests among HIV-exposed infants this year is lower by 0.42% (It was 0.9% last year)



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central Eth	South Eth	Sidama	SWE	Gambela	Harari	Dire Dawa	AA	National
Baseline	27%	92%	71%	96%	25%	84%	77%	92%	51%	37%	63%	88%	88%	79%	73%
Performance	54%	54%	89%	75%	58%	78%	100%	100%	81%	61%	70%	77%	100%	80%	78%
Target	85%	85%	90%	91%	85%	86%	88%	87%	89%	88%	90%	91%	92%	95%	90%

Figure 33: Proportion of HIV exposed infants with virological test within 12 months of birth, 2017 EFY

Other major activities related to PMTCT

In addition to the above-mentioned achievements, other PMTCT related initiatives and activities have been conducted during the fiscal year. Some of the additional PMTCT program initiatives and activities performed during the fiscal year are as follows.

Capacity building: Training on preconception care was conducted for health care workers in the PMTCT units. The training aimed to strengthen the integration of preconception services into existing maternal and HIV programs, supporting early identification and management of risk factors before pregnancy. In addition, a national TOT on comprehensive PMTCT and basic training on dual HIV and Syphilis and PMTCT mentorship were conducted.

Pre exposure prophylaxis (PrEP): To reduce HIV transmission among high-risk pregnant and lactating women, a national PrEP screening tool is developed and implemented across regions. National-level training is conducted for ANC and PMTCT service providers to implement PrEP effectively. The training also included sessions on Index Case Testing and HIV self-testing, strengthening prevention interventions and improving case finding among partners and family members.

PMTCT-EMR: To improve data quality and continuity of care, PMTCT EMR training provided to service providers. The number of PMTCT EMR sites has expanded from 100 to 150, allowing for more efficient tracking of mother and infants, better follow-up, and timely decision-making.

Advocacy: High level Advocacy workshop on HIV/AIDS and PMTCT-EID for the Ethiopian House of Representatives Social Standing Committee Leaders and members was conducted, aiming to increase political commitment and ensure oversight of the national HIV agenda.

Point-of-Care EID Testing Site Expansion: To accelerate early infant HIV diagnosis and prompt linkage to care, the number of POC EID sites was expanded to additional 103 POC EID testing sites. Furthermore, Amhara, Oromia, and Gambella regions independently expanded their POC EID HFs, demonstrating strong regional ownership. As a result, the national total has now reached approximately 367 POC EID sites. This significant scale-up enhances access to same-day testing and results at the facility level, reducing diagnostic delays and improving outcomes for HEIs.

HIV positive infant audit: A standardized national tool for HIV-positive infant audits has been developed and implemented across all regions, and all regions report the audit monthly. Review meetings are held with regional PMTCT focal persons and stakeholders to discuss findings, address missed opportunities and implement targeted follow-up actions.

Awareness Creation: Media professionals have received focused training on PMTCT programs to enhance their understanding and improve public awareness through impactful messaging.

Performance review and supportive supervisions: EID improvement plan performance review was conducted to enhance both the coverage and quality of EID services, focused on identifying service gaps, improving accountability, and tracking progress toward EID targets. In addition, program specific and integrated supportive supervision was conducted, including conflict affected regions, to strengthen PMTCT of HIV, Syphilis and HBV programs, aimed to strengthen the quality of PMTCT services, identify and resolve site-level challenges, and ensure effective implementation of EMTCT interventions for HIV, Syphilis, and HBV.

Challenges of PMTCT program

- Frequent interruptions in the supply of EID reagents, cotrimoxazole, AZT syrup, and HBV viral load reagents
- Limited accessibility of HBV viral load testing sites
- Conflicts and security challenges in various parts of the country disrupt service delivery
- Viral load/EID machine failures affecting testing capacity
- Regional disparities in data reporting and performance
- Prolonged turnaround time (TAT) for EID and VL results

Way forward for PMTCT program

- Strengthen supply chain management to ensure uninterrupted availability of reagents through improved forecasting, procurement, and distribution.
- Expand and decentralize HBV VL testing sites to enhance accessibility
- Expand Point-of-Care EID/VL testing sites and strengthen referral networks
- Enhance continuous quality improvement through PMTCT cohort monitoring, regular mentorship, and supportive supervision
- Strengthen HBV testing and initiate treatment for eligible HBV-positive pregnant women
- Improve leadership and coordination of PMTCT program at national and sub-national levels
- Expand and strengthen the use of PMTCT electronic medical records to improve data management and service delivery
- Establish comprehensive equipment maintenance programs, including regular preventive maintenance and timely repairs
- Conduct regular data quality assessments to systematically identify and address inaccuracies, inconsistencies, and reporting gaps

3.1.2. Prevention of HIV and STIs

Social behavioral change communication

One of the components of combination HIV prevention interventions is Social Behavior Change Communication (SBCC). Various activities have been done including intensive one-on-one and peer-to-peer education for Key and priority populations (KPPs), public meetings, community dialogues, development and distribution of print and electronic SBCC materials, documentaries, and radio and television commercials. Different types of SBCC approaches have been implemented to foster the desired behavior among populations at higher risk of HIV acquisition.

Intensive social behavioral change communication interventions (ISBCC) were implemented during the fiscal year targeting KPPs in the identified 265 priority woredas and 35 conflict affected woredas. This was done primarily through peer-based small group learning with at least 85% of the intended sessions implemented over two to three months by community level implementers to bring an intended positive behavior. Accordingly, a total of 2,366,958 KPPs were reached with ISBCC, which is greater than 100% of the planned 2,282,204 KPPs. Guidelines, training materials, and job aids were developed to support program implementation. These included the Methadone-Assisted Therapy (MAT) Guide, HRAGYW Mentor-Based Guide, CAB-LA Implementation Guideline, Peer Service Providers' Service Provision Guide, Female sex workers (FSW) Mapping and Size Estimation Guide, CAB-LA Training Manual, MAT Training Manual, and job aids on harm reduction and overdose management. The 2024 World AIDS day was commemorated under the theme "**Take the rights path: My health, my right**", in the presence of higher officials from federal and regional governmental offices, representatives from key stakeholders.

In and out of school youth reached by HIV prevention SBCC intervention: The in-school HIV prevention program is designed to specifically address to the HIV prevention needs of high school, college, and university students. The interventions for these groups include AIDS clubs and mini media strengthening, as well as condom distribution and promotion at the university and college levels. In 2017 EFY, a total of 5,213,885 in and out of school adolescent and youth were reached with SBCC (>100% of the planned 3,808,301 million).

Prevention and treatment of Sexually Transmitted Infections (STIs): In 2017 EFY, 289,087 STI cases were diagnosed and treated. Out of the total STI cases seen 284,934 (98.6%) cases were tested for HIV, among whom 3,262 (1.14%) were tested positive for HIV. The syndromic disaggregation of STI cases showed that the majority (52%) were vaginal discharge cases, followed by Urethral discharge (33%), Pelvic inflammatory disease (6.6) and scrotal swelling 3.6%), while the remaining accounts for 4.4%. In addition, 253 neonates were diagnosed and treated for neonatal conjunctivitis and herpes. Fifty health workers from uniformed forces health facilities received national level TOT training on STIs. On the other hand, a validation study for STI treatment is carried out in collaboration with EPHI and the previous STI implementation guideline is revised based on the finding from the validation study.

Biomedical HIV prevention interventions: Biomedical HIV prevention interventions including condom distribution, pre-exposure prophylaxis, post-exposure prophylaxis, and voluntary medical male circumcision services were part of the combination HIV prevention interventions implemented in the country. The annual performance of these interventions is described below:

- **Condom distribution:** Condom promotion and distribution is one of the most significant biomedical interventions for the prevention of HIV and other STIs and for prevention of unintended pregnancy among PLHIVs. The national condom program adopts a total market approach (TMA) as its business model, integrating free condom distribution, social marketing, and commercial market, although the contribution from the commercial market remains minimal. KPPs are the primary recipients of the free condom distribution, which can take the form of DICs, KPP clinics, and peer service providers. For the general public, it was distributed through public channels, private outlets, and social market platforms. More than 67 million condoms were distributed in the 2017 EFY, from which 76.2% were distributed to KPPs. A consultative workshop was conducted to advocate condom tax exemption with various stakeholders and media professionals.

- **Pre-Exposure Prophylaxis (PrEP):** is a biomedical intervention aimed at reducing HIV transmission among population groups at substantial risk. In the 2017 EFY, PrEP services were provided in all ART providing facilities across the country. During this period, a total of 22,438 high-risk individuals were newly enrolled in PrEP, including 19906 (89%) female sex workers and 2,232 (11%) HIV negative partners of sero-discordant couples. On the other hand, pilot implementation of long-acting injectable PrEP (CAB-LA) was closely monitored to inform future scale-up.

- **Post-Exposure Prophylaxis of HIV:** Post exposure prophylaxis (PEP) service is provided for individuals that are exposed to the virus due to occupational and non-occupational risks. PEP refers to the use of antiretroviral medications by HIV-negative individuals following possible exposure to prevent HIV transmission to an exposed person. In the fiscal year, 6,479 people have received PEP services. Of them, 2,247 (35%) were related to sexual violence, 2,094 (32%) to occupational risk, and 2,138 (33.1%) to other non-occupational risks.

- **Voluntary Medical Male Circumcision (VMMC):** is a key public health intervention for HIV prevention, especially in regions with traditionally low circumcision rates, such as Gambella. In the 2017 EFY, a total of 18,259 individuals received VMMC services in Gambella region. Of these, 4,231 were tested for HIV, with 12 individuals testing positive and subsequently linked to appropriate HIV care and treatment services.

3.1.3. HIV testing and counseling services and the first 95 performance

Targeted HIV testing is a crucial strategy in the fight against HIV, aimed at identifying new HIV-positive individuals and advancing progress towards achieving the first of the 95-95-95 targets. This first target focuses on diagnosing 95% of all PLHIVs. Targeted testing efforts concentrate on high-yield case-finding modalities, which have proven effective in identifying undiagnosed HIV cases in various populations including the following:

Index Case Testing (ICT) and Partner Notification Services (PNS): This approach involves testing individuals who are partners or close contacts or biological children of known HIV-positive clients. By focusing on these contacts, healthcare providers can identify new cases that might otherwise remain undiagnosed. These methods not only help in diagnosing new cases but also assist in breaking the chain of transmission by promptly linking individuals to care and treatment.

Voluntary Counseling and Testing (VCT): VCT is a well-established service where individuals can voluntarily seek testing in a supportive and confidential environment. This service is crucial for empowering individuals to take control of their health and for reducing the stigma associated with HIV testing.

The Provider Initiated Testing and Counseling (PITC) model: This model has been optimized to increase the uptake of HIV testing. This model involves healthcare providers offering HIV tests as a routine part of medical care in various healthcare settings, ensuring that more people are tested during their healthcare interactions.

To effectively reach populations at risk, targeted HIV testing utilizes a comprehensive HIV risk screening tool across diverse service delivery points within a given facility. These include outpatient departments, family planning clinics, maternal and child health services such as ANC, delivery, and PNC services, inpatient departments, specialty clinics, and key population points, as well as youth-friendly clinics. By integrating HIV testing into these routine health service delivery points, the approach ensures that testing is accessible and convenient for those who need it most.

In addition to conventional testing methods, innovative approaches such as HIV Self-Testing (HIVST) have been introduced to expand testing coverage. HIVST empowers individuals to perform the test themselves in private, thus overcoming barriers related to stigma and accessibility. This method has shown promise in increasing testing uptake among adults who may be hesitant to visit healthcare facilities. For children aged 2 to 15 years, Caregiver-Assisted HIVST is available, where caregivers facilitate the testing process, ensuring that this vulnerable age group is not left behind in the quest for comprehensive HIV diagnosis.

In 2017 EFY, more than 7.7 million individuals were tested for HIV, including those who are tested as part of the PMTCT program. Among those tested, 36,216 individuals were found to be HIV-positive, resulting in an overall yield of 0.47%. The HIV positivity rate (yield) ranged from 0.07% in Somali to 1.21% in Addis Ababa and 2.2% in Gambella. These regional variations underscore the importance of tailoring HIV testing strategies to meet the unique needs and challenges of each area, taking into account cultural, social, and epidemiological factors.

To enhance the demand for conventional HIV testing and ensure that individuals are aware of their status, a total of 101,388 HIV Self-Testing kits were distributed. These kits were disseminated through two primary approaches: Directly assisted and unassisted. The directly assisted approach accounted for 62% of the distribution, where healthcare workers or trained counselors provided guidance and support individuals using the self-testing kits. This method was particularly effective in increasing confidence in the accuracy of the test and encouraging individuals to follow up with confirmatory testing at health facilities. The remaining 38% of the kits were distributed through the unassisted approach, allowing individuals to conduct the test privately without direct supervision. This approach is designed to reach populations that may face barriers to accessing healthcare facilities, such as stigma, privacy concerns, or geographical distance.

Table 7: Number of individuals tested for HIV and positive result by region, 2017 EFY

Region	Tested		Positives		Total tested	Total Positives	Yield
	PITC	VCT	PITC	VCT			
Tigray	277,172	61,634	1,384	755	338,806	2,139	0.63%
Afar	101,434	24,482	306	145	125,916	451	0.36%
Amhara	1,125,133	295,647	6,783	1,798	1,420,780	8,581	0.60%
Oromia	3,063,156	422,686	8,916	1,706	3,485,842	10,622	0.30%
Somali	278,400	16,461	170	41	294,861	211	0.07%
BG	50,638	24,432	177	124	75,070	301	0.40%
Central Eth	314,428	31,657	879	113	346,085	992	0.29%
South Eth	329,096	38,415	1,910	243	367,511	2,153	0.59%
Sidama	300,806	35,819	963	133	336,625	1,096	0.33%
SWE	166,072	18,665	860	108	184,737	968	0.52%
Gambella	43,412	11,621	973	239	55,033	1,212	2.20%
Harari	39,056	3,235	132	32	42,291	164	0.39%
Dire Dawa	62,100	4,133	361	90	66,233	451	0.68%
AA	474,524	91,651	4,995	1,880	566,175	6,875	1.21%
National	6,625,427	1,080,538	28,809	7,407	7,705,965	36,216	0.47%

Pediatric HIV Program Accelerated Initiative (PHPAI): This initiative has a primary objective of improving the pediatric HIV case finding and initiation of ART for those children identified as HIV positive. Targeted HIV testing using HIV risk screening tools and intensifying index case testing are implemented to increase the yield in case identification. The initiative has been implemented in all health facilities that are providing pediatric HIV care and treatment services and performance review has shown improvement in reducing missed opportunities in HIV testing among children. Through this initiative, from a total of 444,212 children tested for HIV, a total of 1,242 children were tested positive, indicating a yield of 0.3%.

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

First 95 performance: The first 95 target of HIV aims that 95% of all PLHIVs will know their HIV status (diagnose 95% of HIV positives). According to the 2024 national HIV and related estimates and projections, 94% of the estimated 601,039 PLHIV knew their status in 2024. However, there is a high disparity in 1st 95 performance among regions, ranging from 48% in Somali and 60% in Afar to 100% in Addis Ababa. In addition, there is high disparity by age in the first 95 performance status – only 52% among children aged 0-15 years but 95% among adults.

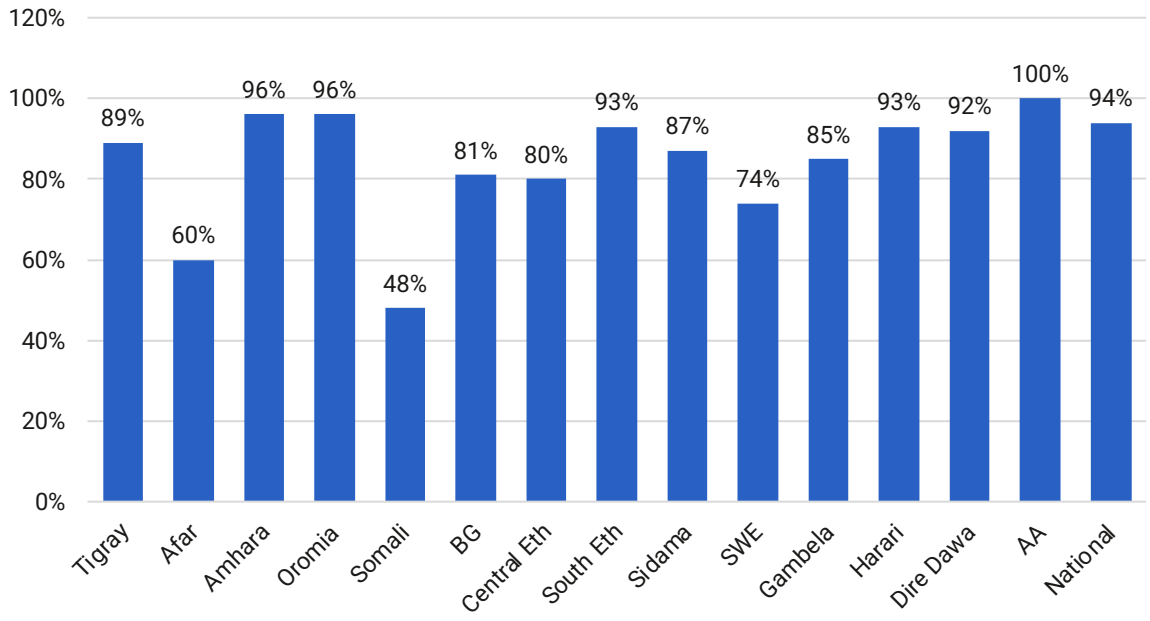


Figure 34: First 95 performance: Percentage of PLHIVs who know their HIV positive status in 2017 EFY

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

At the end of Sene 2027 EFY, a total of 536,067 PLHIVs were receiving ART service. This shows that from the total estimated PLHIVs in the fiscal year (601,039), 89% of them were on ART. However, the ART coverage from the total estimated PLHIVs shows significant gap between children and adults. ART coverage from the total estimated under 15 children living with HIV was only 37% while the adult coverage was 92%. This calls for a strengthened program for pediatric age groups.

Table 8: Number and percentage of PLHIV currently on ART in Ethiopia, disaggregated by age, 2017EFY

Region	Estimated PLHIV in 2017 EFY			No. of PLHIVs currently on ART (Sene 2017 EFY)			ART coverage from the total estimated PLHIV		
	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total
Tigray	4548	42,197	46,745	664	36,860	37,524	15%	87%	80%
Afar	745	9,787	10,532	84	5,169	5,253	11%	53%	50%
Amhara	7,952	161,633	169,585	2,823	157,753	160,576	36%	98%	95%
Oromia	6550	158,059	164,609	3,678	130,449	134,127	56%	83%	81%
Somali	1000	6,213	7,213	60	2,488	2,548	6%	40%	35%
BG	282	5,482	5,764	91	4,500	4,591	32%	82%	80%
Central Eth	575	14,977	15,552	290	11,525	11,815	50%	77%	76%
South Eth	1030	20,261	21,291	559	19,326	19,885	54%	95%	93%
Sidama	564	13,075	13,639	235	11,348	11,583	42%	87%	85%
SWE	674	12,832	13,506	256	8,764	9,020	38%	68%	67%
Gambela	1,194	11,149	12,343	406	9,595	10,001	34%	86%	81%
Harari	337	5,071	5,408	47	3,992	4,039	14%	79%	75%
Dire Dawa	253	8,678	8,931	84	7,293	7,377	33%	84%	83%
AA	2,198	103,722	105,920	1,060	108,867	109,927	48%	105%	104%
OGA				115	7,686	7,801			
National	**27,903**	**573,136**	**601,039**	**10,452**	**525,615**	**536,067**	**37%**	**92%**	**89%**

Second 95 Performance

The second 95 HIV target aims that 95% of all people with diagnosed HIV infection will receive sustained ART (95% PLHIVs who know their status will be on HIV treatment). As discussed above, the first 95 performance in 2017EFY was 94% and this is used as a denominator to compute the performance of the second 95. Accordingly, the second 95 performance in 2017 EFY was 97%, but with a huge difference between pediatric age group (0-14 years) and adults. The second 95 performance among children was 72% while it was 98% among adults. By region, six regions have a lower than 95% performance, namely, Somali (83%), Harari (84%), Oromia (86%), Afar (88%), SWE (90%) and Dire Dawa (91%).

Table 9: The performance of the 2nd 95 HIV target, 2017 EFY

Region	Estimated PLHIV in 2017 EFY			No. of PLHIVs currently on ART in 2017 EFY			No. PLHIVs who know their status (i.e the first 95 result)			2nd 95 performance from those who know their HIV status (using 1st 95 result as denominator)		
	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total	Children (<15)	Adults (>=15)	Total
Tigray	4548	42,197	46,745	664	36,860	37,524	1,137	37,555	38,692	58%	98%	97%
Afar	745	9,787	10,532	84	5,169	5,253	112	5,872	5,984	75%	88%	88%
Amhara	7,952	161,633	169,585	2,823	157,753	160,576	4,135	155,168	159,303	68%	102%	101%
Oromia	6550	158,059	164,609	3,678	130,449	134,127	4,782	151,737	156,518	77%	86%	86%
Somali	1000	6,213	7,213	60	2,488	2,548	90	2,982	3,072	67%	83%	83%
BG	282	5,482	5,764	91	4,500	4,591	130	4,440	4,570	70%	101%	100%
Central Eth	575	14,977	15,552	290	11,525	11,815	374	11,982	12,355	78%	96%	96%
South Eth	1030	20,261	21,291	559	19,326	19,885	670	18,843	19,512	83%	103%	102%
Sidama	564	13,075	13,639	235	11,348	11,583	310	11,375	11,685	76%	100%	99%
SWE	674	12,832	13,506	256	8,764	9,020	546	9,496	10,042	47%	92%	90%
Gambela	1,194	11,149	12,343	406	9,595	10,001	454	9,477	9,930	89%	101%	101%
Harari	337	5,071	5,408	47	3,992	4,039	94	4716	4810	50%	85%	84%
Dire Dawa	253	8,678	8,931	84	7,293	7,377	144	7,984	8,128	58%	91%	91%
AA	2,198	103,722	105,920	1,060	108,867	109,927	2,198	103,722	105,920	48%	105%	104%
OGA				115	7,686	7,801	-		-			
National	**27,903**	**573,136**	**601,039**	**10,452**	**525,615**	**536,067**	**14,510**	**538,748**	**553,257**	**72%**	**98%**	**97%**

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

- The number of health facilities that provide second line ART drugs is increased to more than 600 facilities, which is increased from by 34 this year from the previous year
- Adherence to care, retention and Pediatric ARV Optimization: - ARVs are optimized for almost all children on ART (DTG based), psychosocial support and adherence support was provided, strengthened interventions to address lost to follow ups via –home-to-home visit and through a "Bring back to care" campaigns
- Capacity building training on ART were organized to health workers: TOT and refreshers training was provided for 180 health professionals

Differentiated Service Delivery models for PLHVs receiving ART

Differentiated service delivery (DSD) is a person-centered approach to HIV prevention, testing, and treatment. Moving from a one-size-fits-all model, DSD tailors HIV services to diverse groups of PLHIVs while maintaining the principles of the public health approach to enable high-quality service delivery at scale. Differentiated antiretroviral therapy (DART) includes both innovative less-intensive service delivery models for people doing well on ART as well as more-intensive service delivery models for people newly starting HIV treatment, those with opportunistic infections and/or co-morbidities, people with unsuppressed viral load, groups who typically need close follow-up such as children, adolescents, and pregnant people, and those with psychosocial barriers to adherence and retention.

Ethiopia adopted DSD eight years ago, since then it is scaled up to different models at community and facility levels. DSD reduces the burden for patients (reduced time and cost of travel to clinic and less income loss) and the health system (reduced clinic attendance), while maintaining high retention in care. In 2017 EFY, more than 98% of ART providing health facilities implemented DART. At the end of 2017 EFY, among the total PLHIVs on ART, about 91% of them were using one of the DSD models. From the total PLHIVs on DSD model, 51% were on Appointment Spacing Model (ASM/6MMD), 36% were on three multi-month dispensing model (3MMD), 3% were on Peer lead community-based ART distribution (PCAD). To strengthen DSD model implementation, DSD quality standard tools prepared and DSD focused review meeting was conducted.

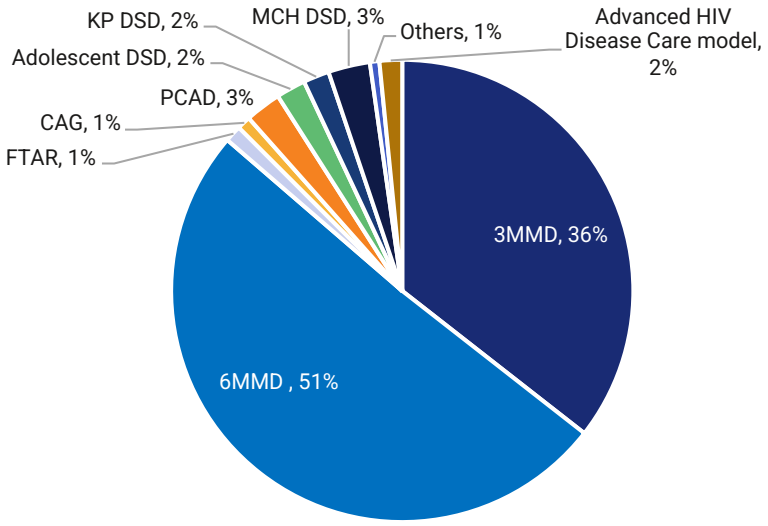


Figure 35: Proportion of PLHIVs on DSD model, by model type in 2017 EFY

3.1.5. Viral load testing and the third 95 performance

In the fiscal year, 403,042 PLHIVs on ART received a viral load test, accounting for 75% of all PLHIV on ART. From the total PLHIVs tested for viral load, 97% of them had a suppressed viral load (Viral load of less than 1000 copies per ml). This is a high viral load suppression performance, which has significant positive individual and public health impacts. High viral load reduction is also an indication that there is high retention and adherence to ART treatment. Viral load suppression performance has been consistently improving over the years, increasing from 89% in 2011 EFY to 97% in 2017 EFY. All regions have a viral load suppression performance of more than 95%.

Table 10: Viral load testing and suppression rate by region, 2017 EFY

Region	Total VL tests done	<VL copies 1000 per ml (Suppressed)	Suppression rate (%)
Tigray	22,742	21,843	96%
Afar	2,759	2,694	98%
Amhara	121,468	117,577	97%
Oromia	107,735	104,637	97%
Somali	3,287	3,228	98%
BG	3,267	3,176	97%
Central Eth	8,323	8,075	97%
South Eth	11,155	10,667	96%
Sidama	9,333	9,006	96%
SWE	6,700	6,383	95%
Gambela	7,945	7,629	96%
Harari	3,252	3,187	98%
Dire Dawa	5,736	5,564	97%
Addia Ababa	89,340	87,821	98%
National	403,042	391,487	97%

Third 95 performance: The third 95 target aims that 95% of all people receiving antiretroviral therapy have a viral suppression. In 2017 EFY, as described above, the viral load testing coverage was 75% of PLHIVs on ART, among which 97% had viral suppression. Since the viral load testing coverage is more than 75%, the third 95 can be estimated from the routine VL test result. Therefore, the third 95 performance in 2017 EFY was 97%.

3.1.6. Integration of HIV with other programs

TB Preventive Therapy (TPT): Three types of TPT courses have been provided, including 6H, 3HP and 3HR to PLHIVs screened negative to TB. In the fiscal year, 32,618 PLHIVs on ART started a standard course of TPT. The majority (72%) were on 3HP, followed by 6H (26%) and 3HR (2%). On the other hand, among the total number of ART patients who started TPT 12 months prior to the reporting period, 88% have completed a full course of therapy. LF-LAM was utilized as a better diagnostic tool to enhance the early diagnosis of active TB among PLHIV in advanced stage, accordingly a total of 1,702 LF-LAM test kit were procured and distributed to facilities.

HIV integration with cervical cancer screening: During the fiscal year, 95,042 HIV positive women aged 15 and above were screened for cervical cancer (79556 screened by VIA and 15486 screened by HPV DNA). From those screened by VIA, 94% had a normal cervix, 5.1% had precancerous lesion and 0.7% had suspicious cancerous lesion. Those with precancerous cervical lesion were treated with cryotherapy, LEEP or thermal Ablation.

HIV integration with Malnutrition: Nutrition screening has been done to PLHIVs on ART. In the fiscal year, 21472 PLHIVs were provided with therapeutic or supplementary food.

HIV integration with NCDs and mental health: To strengthen integration of HIV services with NCD and mental health services, service implementation SOP developed, and basic training was provided to health workers, and NCD service integration expanded to additional health facilities.

Hepatitis prevention and control: To strengthen viral hepatitis prevention and control, comprehensive prevention and treatment guidelines were revised and distributed to treatment sites, Screening kits for Hepatitis B & C, drugs and laboratory reagents were procured and distributed to facilities. Demand creation activities were done through national radio and television spot messages for 2 consecutive months. Viral hepatitis prevention, diagnosis and treatment TOT was provided for 58 Health workers from all regions. In the fiscal year, a total of 1,048,417 individuals were tested for viral hepatitis (709,976 for hepatitis B and 338,441 for hepatitis C). Among those tested 26,348 (2.5%) were tested positive for hepatitis B and 4,504 (0.4%) for HCV. Treatment was provided to 7,758 hepatitis B patients and 929 hepatitis C patients.

3.1.5. Multi-sectoral response and coordination

As part of the response to the HIV epidemic, various multi-Sectoral responses related interventions are performed. The major multi sectoral response coordination initiatives and activities performed are presented as follows.

Strengthening HIV/AIDS Prevention interventions among in-school and out of school youth and the general population: Rapid assessment on integration and implementation of HIV prevention interventions in public and private higher learning institutions was conducted. An advocacy workshop with participation of higher officials from relevant sectors and university presidents was conducted. A total of 2,882,771 in school and out of school adolescent and youth were reached with HIV prevention SBCC interventions.

World AIDS Day World AIDS: It was commemorated on December 1, 2024 at national level in Addis Ababa with the presence of higher officials from MOH, Addis Ababa city administration and RHB, representatives of HIV/AIDS infected and affected communities, representatives of community and religious leaders, and representatives from different stakeholders, as well as media organizations. During the celebration day, SBCC was done through mass media and printing materials.

Strengthening Multi-sectoral HIV/AIDS Response Coordination and Leadership: A consultative workshop with the House of People Representatives' Health, Social, and Culture Affairs standing committee was conducted to enhance their roles and strengthen their involvement in the multi-sectoral HIV/AIDS response.

HIV/AIDS mainstreaming implementation review meeting: It was conducted with federal sector offices. HIV mainstreaming training was provided to focal people from selected federal sectors.

TOT on the HIV strategic plan for war affected woredas: TOT on the HIV strategic plan was conducted to update program managers and experts from 35 war-affected woredas

HIV/AIDS Program Community led Monitoring (CLM): A national HIV/AIDS CLM coalition was established, engaging international partners, CSOs, and NEP+. Efforts to create an enabling environment for CLM implementation included TOT to the leadership and program coordinators. In addition, supportive supervision was conducted to monitor the implementation of CLM

Reducing HIV/AIDS-Related Stigma, Discrimination, and Gender-Based Violence (GBV): A stigma-focused human rights, advocacy, and communication manual was developed. A TOT on GBV prevention and post-violence care was conducted, and comprehensive GBV prevention and survivor care training was provided to 132 health care providers from Drop-In Centers (DICs)

Care and Support to Orphans and Vulnerable Children (OVC) and PLHIV: A total of 443,705 OVC and PLHIV received support, including food, education, training, and start-up capital assistance.

Monitoring and Evaluation: Joint supportive supervision on comprehensive HIV/AIDS prevention and control was conducted twice a year, with written feedback provided. Following the supervision, Joint Review Meetings were held twice a year to assess progress and address identified gaps.

Resource Mobilization and Utilization: Orientation was provided to participants from regions and CSOs on the Global Fund grant. Pre-grant assessments of sub-recipients were conducted, and agreements were signed for the Global Fund HIV program. Supportive supervision on program implementation in selected regions and GF sub-recipients was conducted, with written feedback provided. Quarterly review meetings were held on Global Fund utilization with regions and GF sub-recipients.

Challenges of HIV program

- Reduction in donor funding and limited engagement with U.S.-supported partners due to the stop work order from the U.S. government
- Gaps in targeted HIV testing, including under-testing among children, low case detection rates, and missed opportunities in implementing index case testing across the cascade
- Limited accessibility of viral load testing services in Gambella, Benishangul-Gumuz, and Southwest Ethiopia regions
- Delays in procurement and distribution of HIV/AIDS, STI, and hepatitis commodities
- Shortage of reagents for viral hepatitis diagnostics and lack of treatment drugs
- Disruption of viral load sample transportation due to security concerns
- Conflicts leading to interruption of HIV prevention, care, and treatment services
- Budget shortages and delayed release of Global Fund allocations
- Limited ownership and weak leadership commitment to HIV prevention and HIV mainstreaming activities
- Absence of legal frameworks and enforcement mechanisms to ensure accountability in HIV/AIDS mainstreaming
- Absence of policies and regulations addressing people who inject drugs (PWID) and HIV status disclosure
- Inconsistencies in regional HIV/AIDS program coordination structures
- Weak multisectoral monitoring and evaluation system for the HIV/AIDS response

Way forward

- Strengthen engagement of leadership and parliamentarians to ensure domestic resource allocation at all levels, and revitalize the National AIDS Committee and HIV Boards
- Enhance integration of services and monitoring systems to ensure efficient use of available resources
- Scale up high-yield HIV testing and improve case finding through RoTA and the Pediatric HIV Program Accelerated Initiative

- Strengthen initiatives to achieve and sustain the UNAIDS 95-95-95 targets.
- Provide intensive service recovery support in areas affected by conflict
- Build the capacity of health workers and managers at all levels of the health system.
- Strengthen regular monitoring and evaluation of HIV prevention and control interventions
- Conduct high-level advocacy and develop a mainstreaming legal framework to ensure strong commitment and accountability
- Support sectors to establish structures for effective HIV mainstreaming
- Enhance regular monitoring and evaluation of HIV prevention and control interventions
- Conduct high-level advocacy and develop a mainstreaming legal framework to ensure commitment and accountability for HIV prevention and control
- Strengthen follow-up with sectors to ensure effective implementation of HIV mainstreaming activities

3.2. Tuberculosis and leprosy prevention and control

Tuberculosis and leprosy prevention and control

TB Incidence:
146
new TB cases per 100,000 population

TB notification rate:
150,654
TB cases were detected and treated, which is a notification rate of 134 cases per 100,000 population

TB Cure rate:
89%
among bacteriologically confirmed new PTB cases

Treatment success rate:
97%
among bacteriologically confirmed new PTB cases

Community contribution to TB detection:
21.3%

Drug resistant Tuberculosis (DR-TB)
652
drug resistant TB (DR TB) cases were detected and put on DR TB treatment

Leprosy:

2,787
new cases were detected

Leprosy notification:
0.25 per 10,000 population

Grade II disability rate:
9% among new cases of leprosy

Tuberculosis (TB) remains a significant public health issue in Ethiopia, with an incidence rate higher than the global average. The Ministry of Health prioritizes TB prevention and control, implementing interventions that have reduced the disease burden over the years. Despite setbacks in incidence after COVID-19, Ethiopia has exited the list of MDR-TB high burden countries and aims to end the TB epidemic by 2035, aligning with global strategies. The National End TB strategy focuses on reducing TB deaths by 95% and cases by 90% from 2015 to 2035, emphasizing equitable access to services and innovative research to meet these targets.

The annual TB incidence in Ethiopia decreased by 38% from 192 cases per 100,000 population in 2015 to 119 in 2021 GC, achieving the 2020 target. However, post-COVID-19 rose to 126 in 2022 and 146 in 2023 as per the WHO's World TB report. The WHO estimates are used for planning and M&E of TB program.

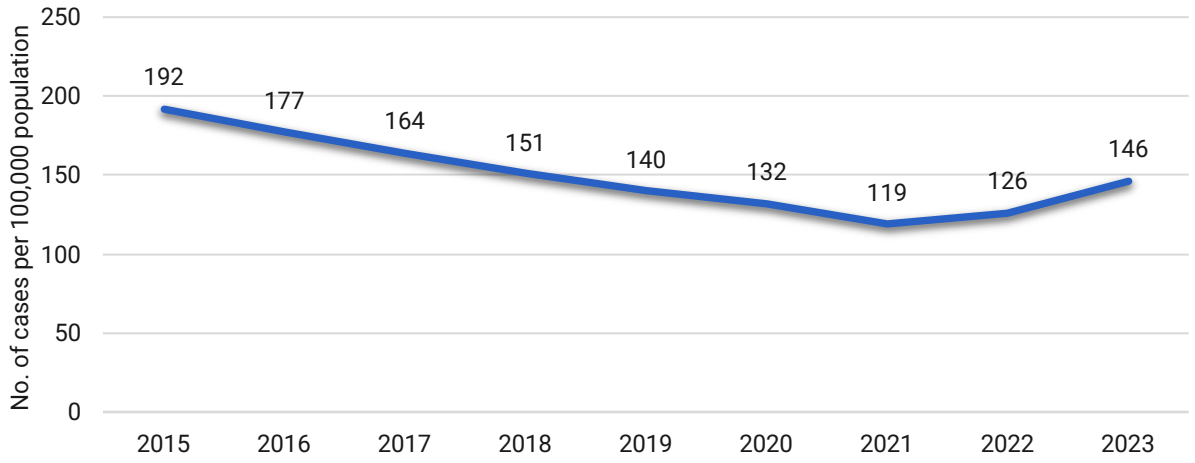


Figure 36: TB incidence rate in Ethiopia (number of cases per 100,000 population), 2015 to 2023 GC

Tuberculosis case notification

As shown in the figure below, the national TB case notification rate per 100,000 population for this year is 134 and it has increased by two persons per 100,000 population, compared to the previous year. The regional disaggregation reveals significant regional variations in notified TB cases, with some regions, Amhara and Dire Dawa experienced a slight decrease and regions such as Gambella, Harari, and Dire Dawa consistently reported higher case numbers in both years compared to the national average. A total of 150,654 cases were notified in 2017 EFY, and it has consistently increased for the last five years.

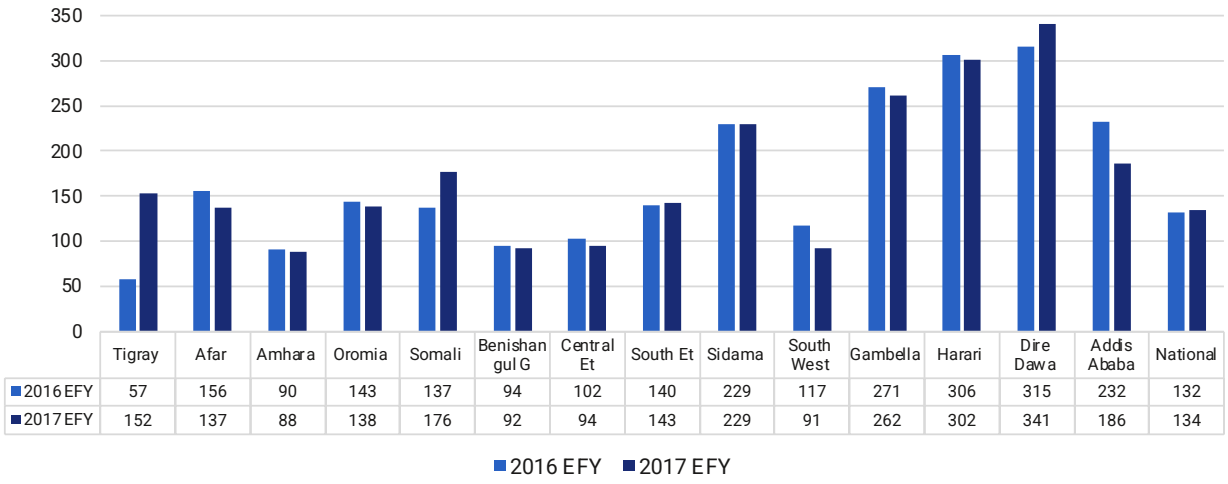


Figure 37: Tuberculosis notification rate per 100,000 population by region, 2016 EFY and 2017 EFY

Compared to the 2023 WHO TB incidence of 146 people per 100,000 population, the 2017 EFY performance of 134 cases per 100,000 population is lower than the estimated figure. This may signify a critical gap in detection and reporting of TB cases. In addition, the WHO's data is usually an epidemiological estimate of the total disease burden, including undiagnosed and unreported cases. This will help us to ensure that more patients receive timely diagnosis and treatment, ultimately reducing disease transmission.

Tuberculosis treatment Coverage

In 2017 EFY, 150,654 tuberculosis cases were notified and treated according to the national protocol (56.6% male and 43.4% female). This makes the annual TB treatment coverage 92% of the total estimated TB case nationally. Regional variations were significant ranging from a minimum of 61% treatment coverage in Amhara region to more than 100% coverage in regions like Sidama, Harari, Dire Dawa, Addis Ababa, Gambella, Somali and Tigray. Regions which have a low performance, less than the national average were Amhara (61%), Benishangul Gumz (63%), Southwest Ethiopia (63%), and Central Ethiopia (65%).

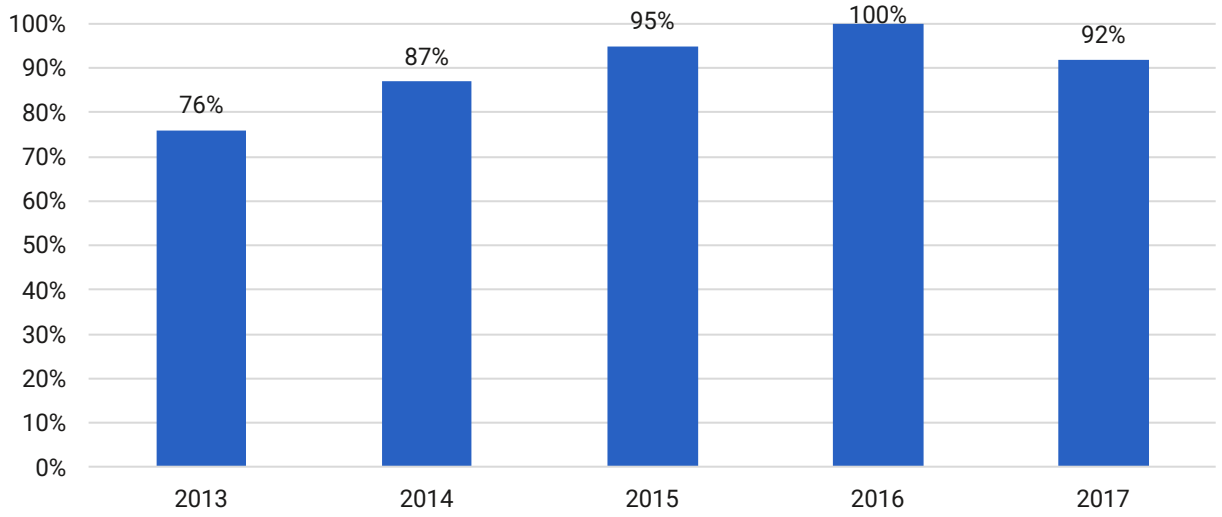


Figure 38: Trend of TB treatment coverage in Ethiopia, 2013-2017 EFY

The figure below reveals that the highest incidence of TB cases is concentrated in the 25-34 age group, which accounts for a quarter of the total cases. This finding is consistent with global and LMIC trends, where TB disproportionately affects the economically active young and middle-aged adult populations. Overall, the data illustrates a pattern where TB cases are low in children, peak in early adulthood, and gradually decline in older age groups.

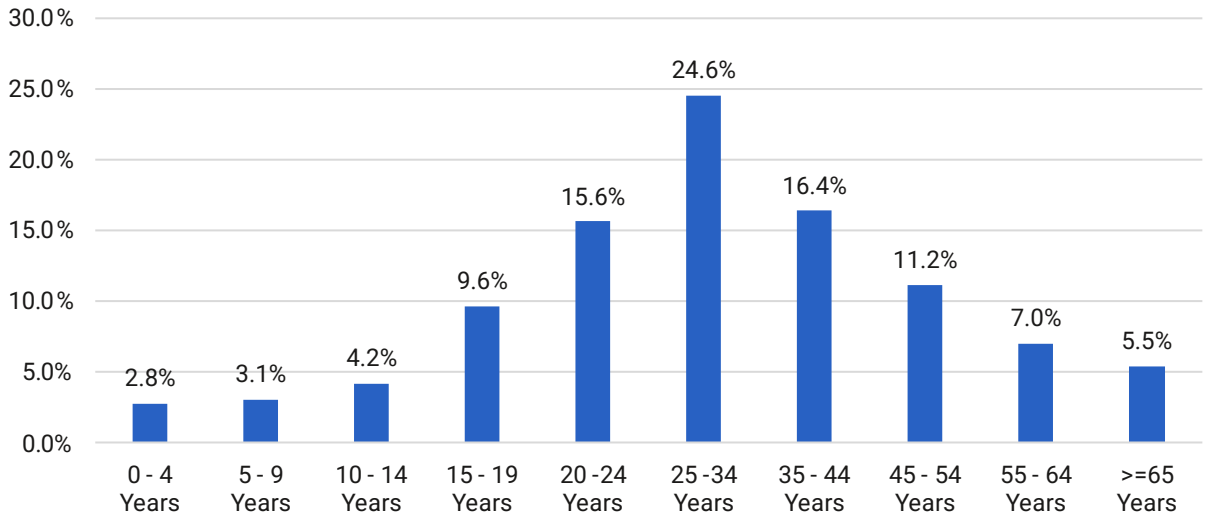
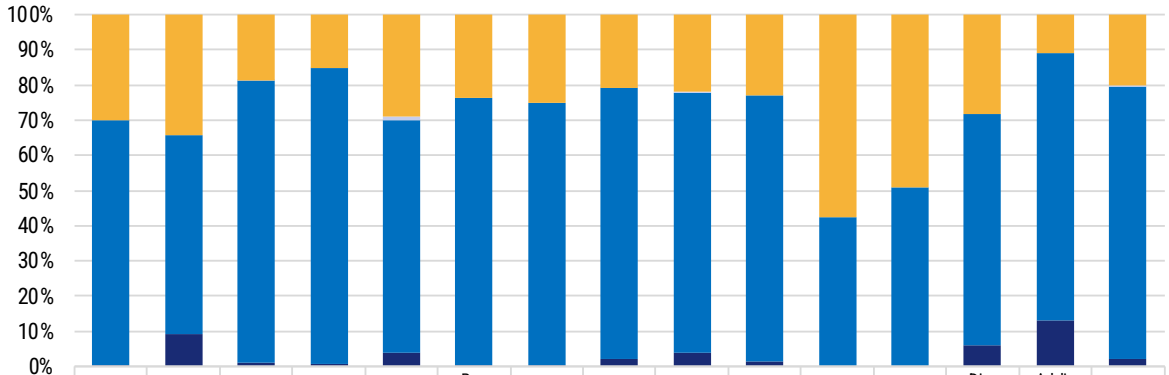


Figure 39: Percentage of notified TB cases by age, 2017 EFY

When examining the national treatment coverage by facility type, 77.5% of cases are from health centers, and 20.2% are from hospitals. Nationally, clinics report less than 3% of cases. There are also few cases from health posts. As illustrated in the figure below, Gambella (49%) and Harari (57.7%) have a higher percentage of cases in hospitals compared to health centers, unlike other regions.



	Tigray	Afar	Amhara	Oromia	Somali	Ben Gumz	Central Et	South Et	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
Hospitals	30.2%	34.2%	18.6%	15.1%	28.9%	23.8%	25.0%	20.9%	21.8%	22.9%	57.7%	49.0%	28.4%	11.1%	20.2%
Health Post	0.0%	0.0%	0.1%	0.2%	1.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Health Centers	69.4%	56.7%	80.3%	84.1%	66.4%	76.0%	74.7%	77.0%	73.7%	75.9%	42.3%	51.0%	65.7%	75.7%	77.5%
Clinics	0.4%	9.1%	1.0%	0.6%	3.7%	0.3%	0.3%	2.1%	3.9%	1.3%	0.0%	0.0%	6.0%	13.2%	2.1%

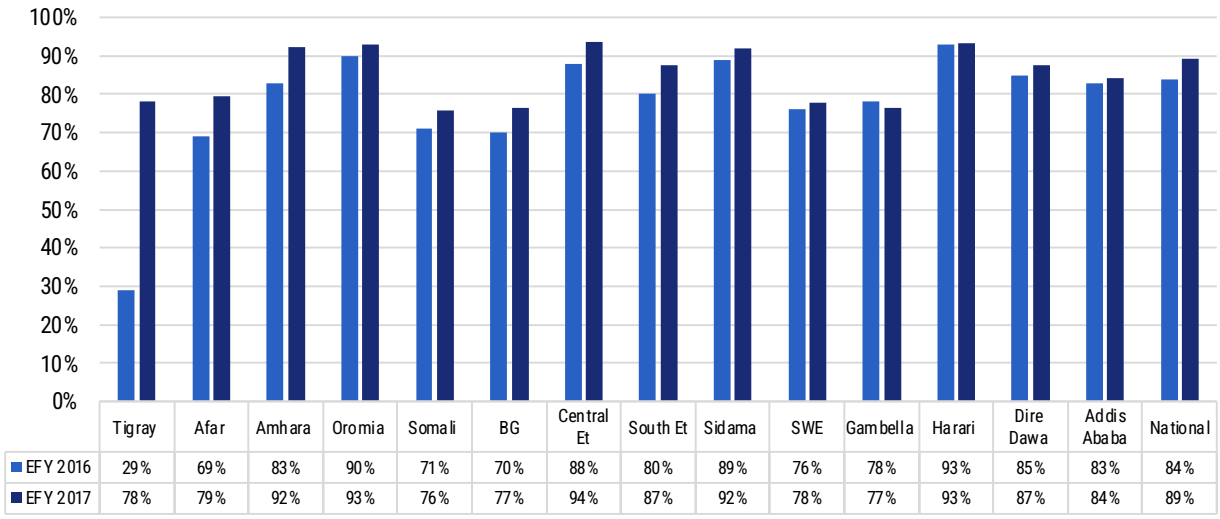
Figure 40: Notified and Treated TB cases by region and facility Type, 2017 EFY

In EFY 2017, about 32,019 TB cases, representing 21.3% of the total notifications, were initially referred through the community, showing a 3% decrease from the previous year. Community contributions to TB detection exceeded the national average in Harari (42.6%), Sidama (41%), South Ethiopia (30.1%), and Central Ethiopia (28.8%). The lowest community referrals were in Tigray (3.3%), Afar (5.8%), and Gambella (6%), each contributing less than 10%. Regarding private health facilities, 25,970 TB cases, or 17% of the total, were initially referred by Public Private Mix (PPM) sites for TB diagnosis, marking a 1% decrease from the previous year.

Tuberculosis Treatment Outcomes

Tuberculosis treatment success rate and cure Rate: Helps to monitor the effectiveness of TB treatment program. As shown in the figure below a clear and consistent improvement in tuberculosis treatment outcomes across all measured categories, including the Cure Rate (89%) and the Treatment Success Rates (TSR) for bacteriologically confirmed (97%), clinically diagnosed (96%), extra-pulmonary (97%), and relapse cases (94%) was observed in 2017 EFY compared to the previous year's performance.

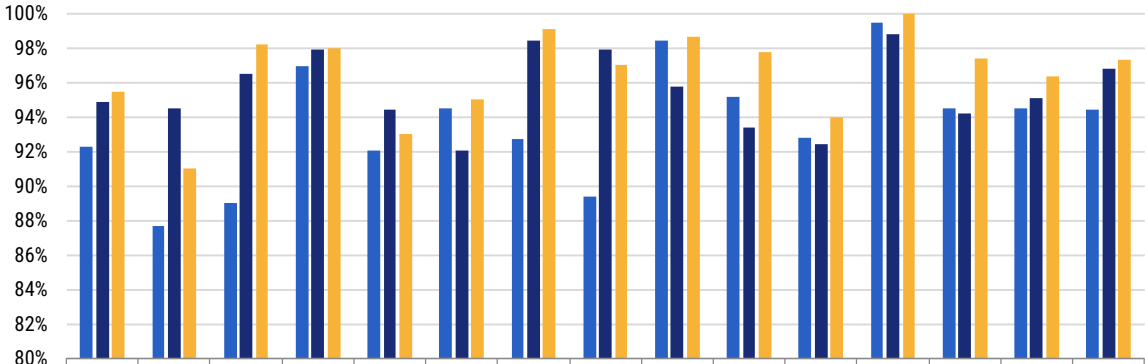
Tuberculosis treatment outcomes for new bacteriologically confirmed pulmonary TB cases by region indicate a notable improvement in TB cure rates across all regions when comparing 2017 EFY to the previous year's performance. Nationally, the average cure rate rose from 84% to 89%. Nonetheless, regional performance shows significant variation, with Central Ethiopia attaining the highest rate at 94%, closely followed by Oromia and Harari at 93%.



	Tigray	Afar	Amhara	Oromia	Somali	BG	Central Et	South Et	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
EFY 2016	29%	69%	83%	90%	71%	70%	88%	80%	89%	76%	78%	93%	85%	83%	84%
EFY 2017	78%	79%	92%	93%	76%	77%	94%	87%	92%	78%	77%	93%	87%	84%	89%

Figure 41: TB Cure rate among cohort of bacteriologically confirmed TB cases by region, 2016 EFY and 2017 EFY

Besides the cure rate, the treatment success rate for confirmed PTB+ cases significantly improved in 2017 EFY, with all regions achieving a success rate above 90%, as illustrated in the figure below.



	Tigray	Afar	Amhara	Oromia	Somali	Benishangul G	Central Et	South Et	Sidama	South West	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline %	92%	88%	89%	97%	92%	95%	93%	89%	98%	95%	93%	100%	94%	95%	94%
Performance %	95%	94%	97%	98%	94%	92%	98%	98%	96%	93%	92%	99%	94%	95%	97%
Target %	96%	91%	98%	98%	93%	95%	99%	97%	99%	98%	94%	100%	97%	96%	97%

Figure 42: TB treatment success rate among cohort of bacteriologically confirmed TB cases by region, 2017 EFY.

TB Contact tracing and screening: Contact tracing and screening are crucial for TB prevention in children and are a major part of the national TB program. Those exposed to active TB have a higher risk of infection, with rates over 5% among household contacts, especially children. The goal is to identify high-risk individuals and assess their need for TB preventive treatment. In 2017 EFY, there were 227,937 contacts with TB index cases, and 205,246 (90%) were screened for TB. Among those screened, 36% were children under 15, while 64% were over 15 years. After screening, 133,872 individuals received various TB preventive therapies due to their negative screening results.

Drug Resistance Tuberculosis (DR TB): In 2017 EFY, 652 drug resistant TB (RR/MDR TB) cases were detected and initiated treatment at DR TB treatment initiating centers (TICs). Currently DR TB treatment initiation service has been provided in 75 hospitals in all regions and follow-up was provided in health facilities whenever DR TB case is identified in their catchment.

Leprosy Prevention and Control Program

In 2017 EFY, 2,787 new leprosy cases were detected and started treatment. Of these, 1,983 (71%) were multi-bacillary, and 804 (29%) were pauci-bacillary. The national notification rate for new leprosy cases was 0.25 per 10,000 population. The highest notification rate was in the Gambella region (0.62 per 10,000), followed by Harari (0.61 per 10,000) and Amhara (0.46 per 10,000). The lowest rates were in South Ethiopia (0.02 per 10,000) and Somali region (0.03 per 10,000). Additionally, 93 retreatment and 316 relapse cases were detected and treated during the year.

Out of the 2,787 new leprosy cases, 237 (8.5%) had grade 2 disabilities, and 147 (5.3%) were children under 15 years old. The highest disability rates were in Southwest Ethiopia (40%), Addis Ababa (30.5%), Gambella (20%), and Somali (18%) regions. No grade II disabilities were reported in Dire Dawa, South Ethiopia, and Harari regions.

Table 11: Number of leprosy cases detected, incidence and Grade II disability, 2017EFY

Region	New leprosy cases detected	Leprosy case notification per 10,000 population	Relapse Leprosy cases detected	Retreatment cases other than relapse	New leprosy cases with Grade II disability	Grade II disability Rate
Tigray	33	0.05	3		1	3%
Afar	16	0.07	2	3		0%
Amhara	1,104	0.46	142	44	81	7%
Oromia	1,319	0.31	120	26	106	8%
Somali	22	0.03	3		4	18%
Benishangul G	58	0.45	7	3	7	12%
Central Eth	44	0.07	9	1	3	7%
South Eth	14	0.02	4	1		0%
Sidama	37	0.08	2	2	4	11%
Southwest Eth	15	0.04	5	5	6	40%
Gambella	35	0.62	9	2	7	20%
Harari	18	0.61	1			0%
Dire Dawa	13	0.22	4			0%
Addis Ababa	59	0.14	2	6	18	31%
National	2,787	0.25	313	93	237	9%

Contact screening of leprosy cases: During the reporting period, a total of 11,248 household contacts of leprosy cases were registered and screened for leprosy and 551 of these contacts were diagnosed with leprosy.

Leprosy treatment outcome: In 2017 EFY, the treatment completion rate for Pauci-Bacillary (PB) leprosy cases reached 96%, while for Multi Bacillary (MB) cases it was 99%. This marks a significant improvement from previous years, where the completion rates were 89.8% for PB cases and 93.4% for PB cases.

Other major activities performed in TB and leprosy prevention and control program

- AFB reagent is prepared domestically and distributed to health facilities via the EPSS system.
- TB drugs and GeneXpert cartridges are purchased with capital budget through the national supply purchasing mechanism.
- To enhance TB case detection, 225 AI-equipped digital X-ray machines were purchased and distributed to high-load hospitals. In addition, adult TB preventive treatment for adult household contacts of index TB cases and other clinical risk groups like dialysis and oncology patients, and prison inmates were introduced in the fiscal year
- Initiation of leprosy preventive treatment for households and close contacts of index leprosy cases

Challenges

- Low Drug resistance -TB Case detection rate
- High attrition and turnover of trained manpower at health facilities
- Shortage of budget for GeneXpert cartridges
- Conflicts in different parts of the country
- Poor data quality reported via DHIS2

Way Forward

- Strengthen Drug-Resistant TB (DR-TB) detection
- Secure sustainable financing for essential diagnostics like GeneXpert cartridges through diversified funding and an optimized supply chain
- Improve health workforce retention
- Ensure continuity of care in conflict affected areas
- Improve data quality reported from facilities

3.3. Malaria and other vector-borne diseases prevention and control

Malaria prevention and Elimination

Number of malaria cases

10.9

million cases were diagnosed and treated

Malaria incidence:

141

malaria cases per 1,000 population at risk

Malaria deaths:

754

deaths due to malaria in 2017 EFY

IRS spraying:

1.9-million-unit

structures in 1,870 kebeles in 168 Woredas

LLTIN distribution:

>2.2 million

LLINs were distributed

Malaria elimination activities:

Implementation in 565 Woredas

Ethiopia is facing one of its most critical malaria crises in recent years, placing it among the countries with the highest global increases in malaria burden. This escalation occurs against the backdrop of Ethiopia's endemic malaria challenge, where approximately 75% of the landmass remains malaria-endemic and around 69% of the population faces infection risk. The persistent malaria threat to public health in Ethiopia highlights the urgent need for strengthened prevention, treatment, and surveillance strategies to address this escalating crisis that continues to impact millions of Ethiopians across the country's diverse regional landscapes. Despite challenges Ethiopia has a target to eliminate malaria by 2030, and the following are key activities conducted in 2017 EFY to prevent and control malaria.

Malaria Cases and Deaths

From 2009 EFY to 2013 EFY, Ethiopia's malaria cases remained stable at 1-1.5 million annually. However, from 2014 to 2017 EFY, confirmed cases surged dramatically from 1.6 million to over 10 million, a six-fold increase in three years.

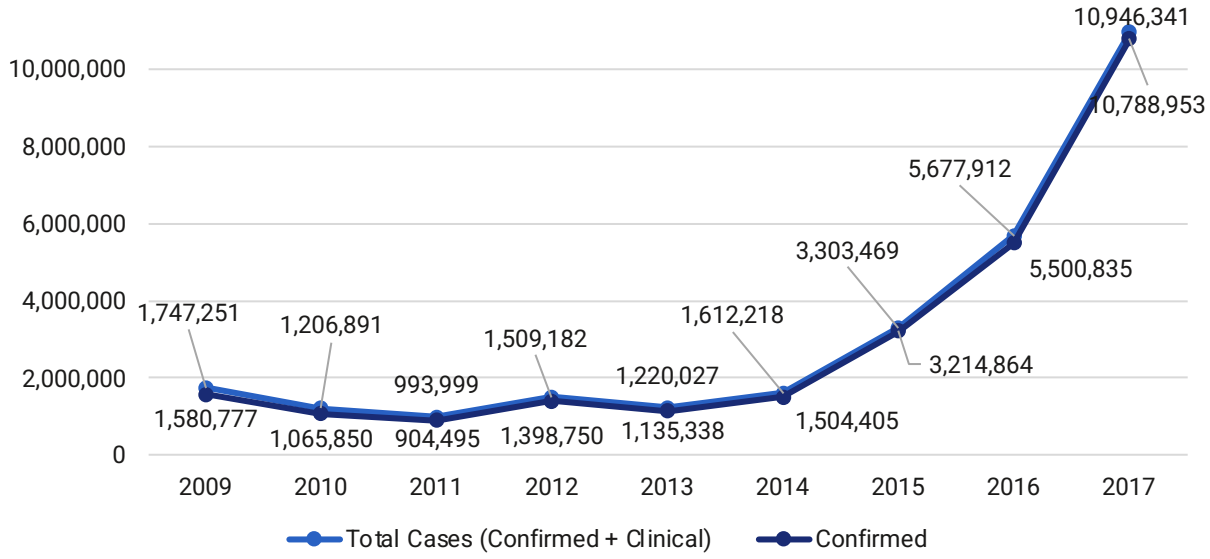


Figure 43: Trend of total malaria and confirmed cases, 2009 EFY to 2017 EFY

The annual incidence of malaria per 1,000 population at risk has consistently increased over the years, from 18 in 2009 to 141 per 1000 population at risk.

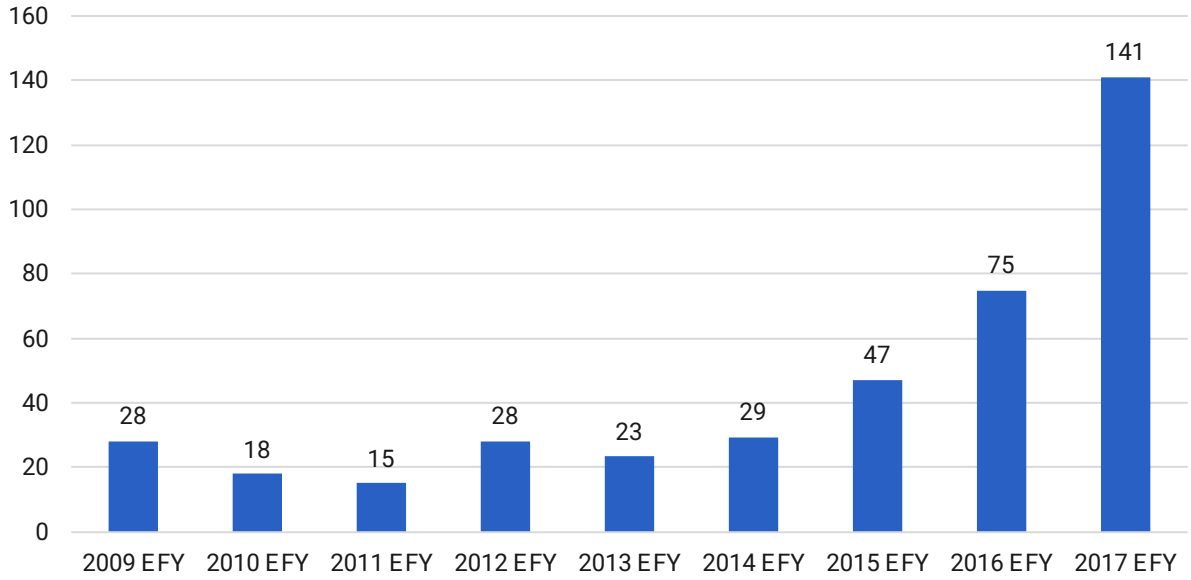


Figure 44: Malaria incidence per 1,000 population at risk, trend from 2009 to 2017 EFY

In 2017 EFY, Ethiopia reported 10.9 million malaria cases (confirmed and clinical) and 99% of the cases are laboratory confirmed via microscopy or rapid diagnostic test (RDT). Those confirmed 10.7 million cases are from the total 27.7 million tests done and the overall positivity rate is 38.8%.

Of the confirmed cases 16% were children under five years, 28% were between the ages of 5 and 14 years and the remaining 56% were 15 years and above.

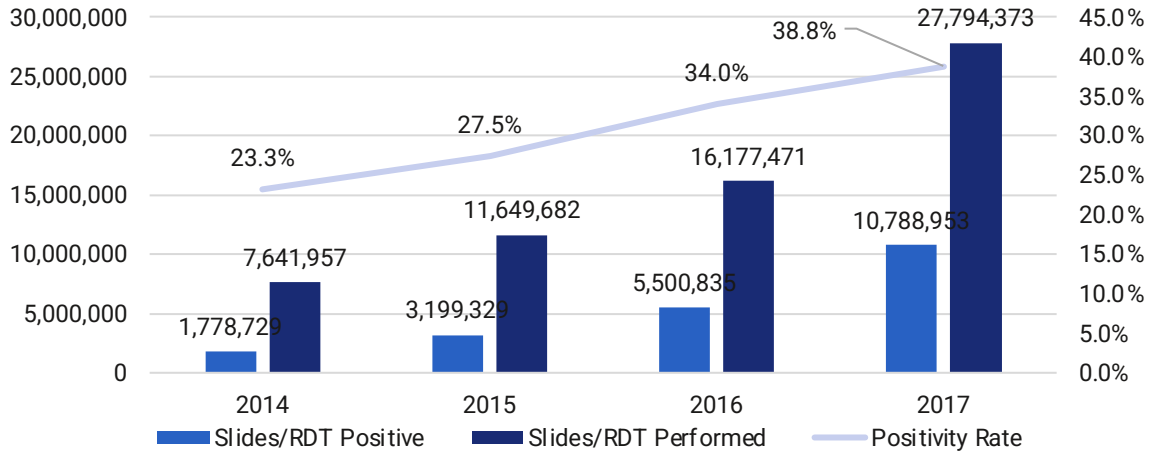


Figure 45: Confirmed malaria cases, malaria lab tests and positivity rate per year, 2014 - 2017 EFY

Regional variations in malaria risk, malaria cases and mortality

The number of population at risk of malaria varies significantly across regions in Ethiopia. Afar, Somali, Benishangul Gumuz, Gambella, and Dire Dawa have 100% populations at risk. In 2017, the national malaria incidence rate was 141 cases per 1,000 population at risk, a 65.95% increase from 2016 EFY. The highest malaria incidence was reported in Southwest Ethiopia (405 per 1000), Benishangul Gumz (344 per 1000) and Gambella (324 per 1000 population at risk).

A total of 754 malaria deaths were reported in 2017 EFY, less than the previous year's reported mortality of 766 individuals. The malaria death rate per 100,000 population at risk was 0.97 per 100,000 population at risk, almost like the World Health Organization's target of 1.

Table 12: Malaria Incidence rate per 1,000 populations at risk and Malaria Deaths per 100,000 populations at risk, 2017 EFY

Region	Total pop	Population at risk	Total Cases			Incidence per 1000 pop at risk	Death			Malaria Death per 100,000 pop at risk
			< 5 years	>= 5 years	Total case		< 5 years	>= 5 years	Total Death	
Tigray	6,074,928	4,871,484	31,551	270,947	302,498	62	3	4	7	0.144
Afar	2,163,588	2,163,588	40,836	122,773	163,609	76	0	1	1	0.046
Amhara	23,888,491	14,280,247	245,017	1,641,681	1,886,698	132	21	73	94	0.658
Oromia	43,128,704	28,421,816	703,953	3,831,001	4,534,954	160	68	301	369	1.298
Somali	6,957,603	6,957,603	16,000	47,069	63,069	9	1	1	2	0.029
BG	1,303,297	1,303,297	85,892	363,046	448,938	344	14	20	34	2.609
Central E	6,476,405	4,391,002	118,180	454,365	572,545	130	17	35	52	1.184
South E	7,918,311	6,833,503	181,186	915,393	1,096,579	160	14	20	34	0.498
Sidama	4,873,216	3,162,718	45,269	221,649	266,918	84	0	3	3	0.095
SWE	4,141,562	3,387,798	199,031	1,173,328	1,372,359	405	21	118	139	4.103
Gambella	563,362	563,362	41,836	140,445	182,281	324	1	2	3	0.533
Harari	295,701	229,759	1,034	7,373	8,407	37	1	3	4	1.741
DD	581,279	581,279	6,227	18,814	25,041	43	0	0	0	-
AA	4,104,862	677,302	1,488	20,957	22,445	33	1	11	12	1.772
National	**112,471,310**	**77,717,675**	**1,717,500**	**9,228,841**	**10,946,341**	**141**	**162**	**592**	**754**	**0.970**

Long-lasting Insecticidal Nets (LLINs) Distribution

The Ethiopian government is striving to ensure that all eligible households in malaria-endemic areas have access to long-lasting insecticidal nets (LLINs). Over 2.2 million LLINs were procured and distributed to high-burden communities in the fiscal year. To ensure smooth distribution, a micro-planning workshop coordinated logistics, a distribution plan was shared with stakeholders, pre-distribution registration formats and record books were provided, and vector control experts monitored regional distribution. Household visits in malaria-endemic regions show differences in the use of long-lasting insecticidal nets, with usage as low as 35% in Sidama and as high as 83% in Benishangul Gumz, emphasizing the necessity for increased awareness and behavior change to enhance utilization.

Indoor Residual Spraying (IRS) of Unit Structures

IRS operations were carried out in 168 selected Woredas across 11 regions, targeting over 2-million-unit structures based on epidemiological suitability. The overall performance is 97%. Due to IRS, more than 5.9 million people were protected from malaria.

Table 13: Indoor residuals spraying (IRS) coverage by regions, 2017 EFY

Region	District	Kebele	Estimated people protected	# Household plan	Unit structure Planned to Spray	Performed	Coverage (%)
Tigray	6	57	242,695	55,138	153,175	149,286	97
Afar	5	30	76,865	12,973	21,471	22,128	103
Amhara	21	232	1,110,595	172,476	390,773	353,935	91
Oromia	22	472	1,713,520	367,603	510,680	507,663	99
Centra	30	120	408,559	84,515	125,070	125,360	100
South	23	102	411,115	75,823	123,568	113,735	92
SWE	8	73	409,118	102,279	132,880	133,339	100
Sidama	4	39	265,321	55,928	87,487	91,106	104
Somali	23	155	236,745	36,521	59,554	55,487	93
BG	16	381	560,972	140,243	264,809	257,522	97
Gambella	10	209	498,634	124,658	136,028	131,187	96
Total	**168**	**1870**	**5,934,139**	**1,228,157**	**2,005,495**	**1,940,748**	**97**

Larva Source Management

Larval Source Management (LSM) is being implemented in high mosquito-breeding Woredas, targeting 22 billion m² of habitats for larviciding. This effort involves the use of 4,400 units of 5L Aquatain and 22,000 liters of other larvicides. Additionally, there has been an emergency distribution of 295 units of Aquatain to various regions, including Dire Dawa. The initiative includes cluster-based monitoring, with leadership and community engagement focused on draining stagnant water, environmental management, and habitat clearing.

Malaria Elimination Activities

Ethiopia's malaria elimination efforts, which aim for zero indigenous cases by 2030, face severe challenges following resurgence of the disease. In 2017 EFY, of 288,837 eligible index cases 83,590 index cases were identified that were investigated within a 70-meter radius in 565 Woredas selected for malaria elimination. As a result, 26,576 secondary cases were identified and treated for malaria. In terms of identifying and responding to mosquito breeding sites, 30,629 breeding sites were identified and responded to during the fiscal year.

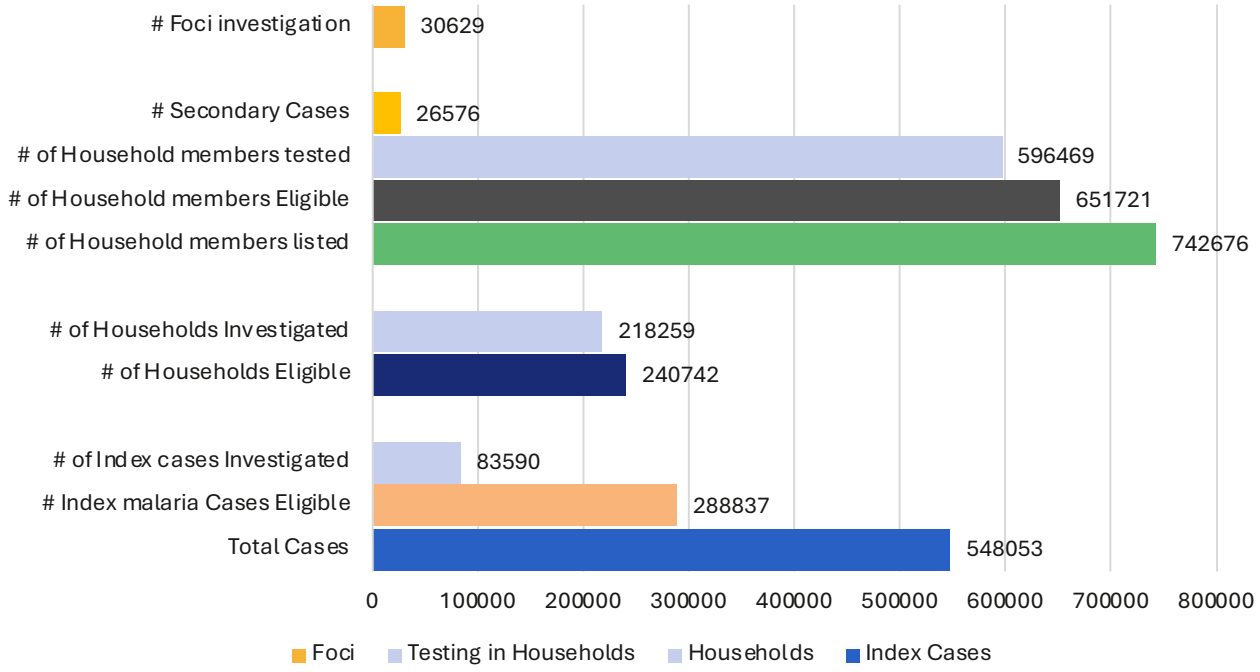


Figure 46: Malaria elimination activities, 2017 EFY

Other major achievements and other activities on malaria prevention and control

Social and Behavioral Change Communication: In the fiscal year, efforts were made to increase community awareness and advocacy for elimination of malaria through various initiatives. Key achievements included the organization of Malaria Week across 13 regions, 383 districts, and over 5,475 kebeles. The 18th World Malaria Day, themed "*Malaria Ends with Us: Reinvest, Reimagine, Reignite*" was hosted in Jimma Town, featuring press briefings, symposia, and community events. A targeted cluster initiative organized 222 high-burden woredas into advocacy clusters, prioritizing malaria on political agendas and sustaining grassroots mobilization. Mass media efforts included radio and TV spots aired during peak transmission seasons. Advocacy materials, such as the brochure "Malaria Elimination Starts with Me," were produced and distributed, with regional adaptations for schools and health facilities.

Capacity Building: Comprehensive malariology training was provided to 112 malaria coordinators. Additionally, 235 laboratory technicians received specialized training in malaria microscopy and quality control, ensuring high standards in diagnostics. A total of 476 technicians were trained in laboratory, clinical, and pharmacy mentorship. Furthermore, 30 health professionals were equipped with advanced knowledge in malaria case management, while 250 pharmacists were trained in effective malaria drug management.

Quality Assurance: Of the 3,888 health facilities providing malaria laboratory testing, 2722 (70%) were participating in malaria External Quality Assurance (EQA) which has increased by 5 percentage point from previous year's performance of 65% (2,528 facilities).

Challenges

- Funding gaps and partners accidental stop of work due to the international situation
- Suboptimal community practices in implementing recommended vector control mechanisms like consistent use of LLINs
- Service disruption in conflict affected areas

Way Forward

- Identify alternative funding sources and strengthen partnerships to mitigate the impact of international disruptions.
- Enhance community engagement and education programs to improve adherence to vector control practices, such as the consistent use of LLINs.
- Prioritize and accelerate the restoration of health services in areas affected by conflict.

3.4. Prevention and control of non-communicable diseases and mental illnesses

Prevention and Control of Non-Communicable Diseases and mental illnesses

Hypertension

>25.9 million

individuals were screened for hypertension

384,762

newly diagnosed hypertension patients were enrolled to care

Diabetes Mellitus (DM)

>6.1 million

individuals were screened for diabetes

92,252

individuals were newly enrolled to DM care

Cervical Cancer screening

1,450 facilities

Cervical cancer screening and treatment sites

>1.1 million

women aged 30-49 were screened for cervical cancer

Mental and neurological services (MNS)

More than 1,600

health facilities integrated MNS services

Total MNS cases treated:

498,836

The current HSDIP prioritizes the prevention and control of non-communicable diseases (NCDs), supported by the National Strategic Action Plan. This plan aims to enhance national capacity and public policies to address NCDs. It targets major NCDs like hypertension, diabetes, cardiovascular diseases, eye health issues, cervical and breast cancers, and mental, neurologic, and substance use disorders, emphasizing interventions throughout the life course. The following are the major activities achievements in 2017 EFY.

Advocacy and Social mobilization on NCDs

Awareness creation activities were conducted during commemoration of World Heart Day, World Hypertension Day and World Diabetes Day. World kidney day was conducted in Addis Ababa and 5 other locations, focusing on kidney health and chronic kidney disease risk factors. Orientation was provided to members of the House of Peoples Representatives on the importance of imposing taxation on unhealthy products.

Hypertension and Diabetes Screening and Treatment Services

Hypertension: Screening for hypertension and diabetes is crucial for early disease detection, preventing costly complications, and reducing the burden of NCDs. In 2017 EFY, more than 25.9 million individuals were screened for hypertension (HTN). Among them, 80% were aged 30 and above, while 20% were under 30 years. Compared to the previous fiscal year, HTN screening increased by over 5 million individuals. Of those screened, 3.2% (823,771) had raised blood pressure, and 384,726 individuals were newly enrolled in HTN care. The goal in the fiscal year was to increase the number of patients with controlled blood pressure from 603,572 to 718,836, achieving 680,648 (95% of the target).

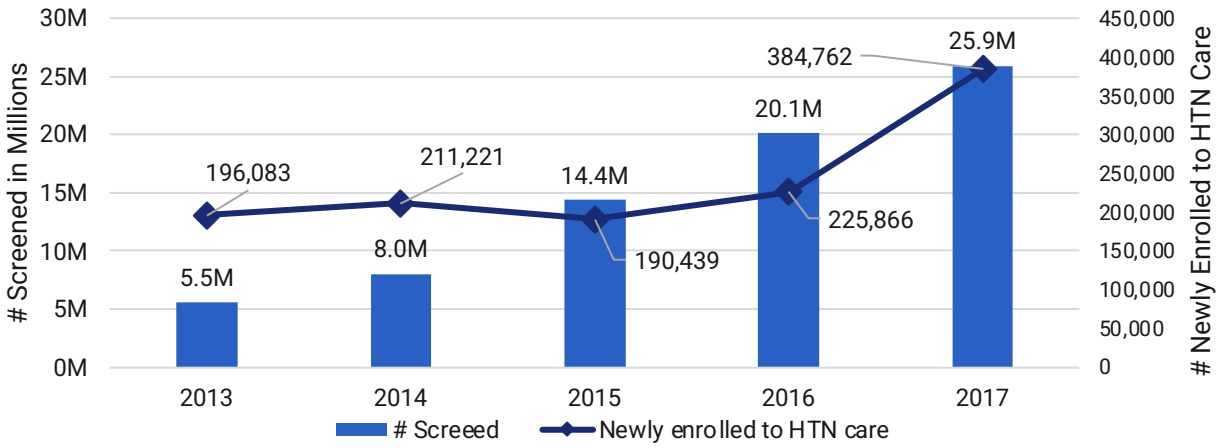


Figure 47: Number of people screened for hypertension and Newly Enrolled to Care, 2013 EFY –2017 EFY

Diabetes: In 2017 EFY, more than 6.1 million individuals underwent diabetes screening. Among them, 3.6% had elevated blood sugar levels. During this fiscal year, 92,252 individuals were newly enrolled in the diabetes care and treatment program. The total number of patients in diabetes care reached 316,835, achieving 83% of the target. Additionally, 294,197 individuals, representing 90% of the target, maintained controlled blood sugar levels.

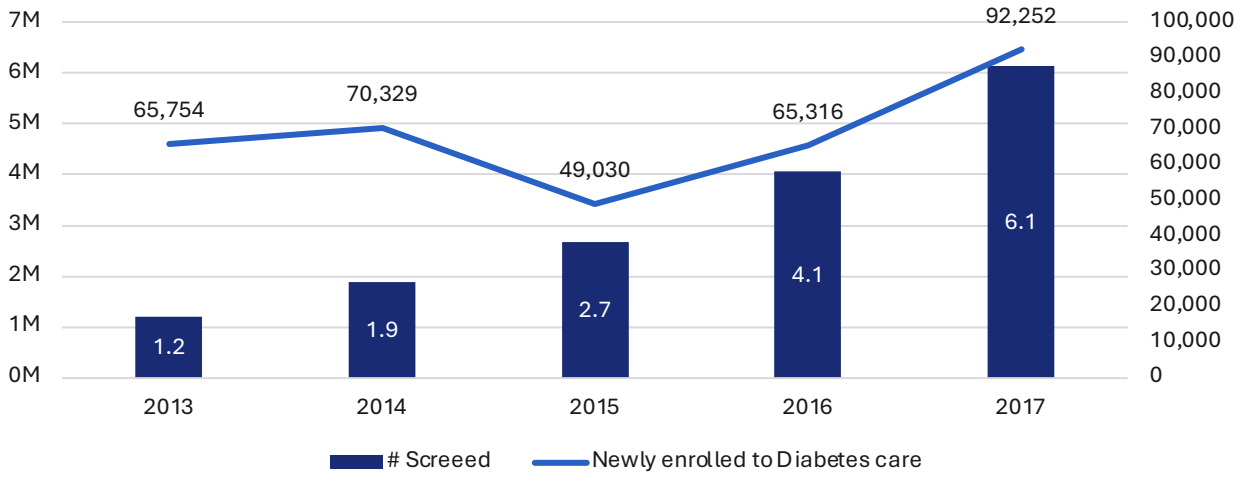


Figure 48: Number of people screened for diabetes and Newly Enrolled to DM Care, EFY 2013 – EFY 2017

Cancer Screening and Treatment Program

Cervical cancer is a major health concern globally, ranking as the fourth most diagnosed cancer among women. In Ethiopia, it is the second most common cancer and the leading cause of cancer deaths among women, with 99.7% of cases linked to Human Papilloma Virus (HPV). Annually, Ethiopia reports around 8,168 new cases and 5,775 deaths, with over 80% diagnosed at a late stage due to limited awareness. The Ethiopian Ministry of Health is committed to the WHO's 90-70-90 targets, focusing on HPV vaccination, cervical screening, and treatment coverage by 2030. Efforts include expanding screening services from five to 1,450 facilities since 2009 and introducing HPV vaccination in 2018 GC, initially targeting 14-year-old girls. By 2024 GC, a single-dose, multi-age cohort strategy was implemented for girls aged 9–14, achieving 96% coverage and vaccinating over 7 million girls.

Significant progress has been made in cancer care in Ethiopia, with a national cancer control strategy emphasizing prevention, early detection, diagnosis, treatment, and palliative care. Radiotherapy services have expanded, with 3D-LINAC machines installed in several hospitals, increasing comprehensive cancer care centers from three to five. These advancements ensure better regional accessibility and treatment options, contributing to the reduction of cervical cancer incidence and supporting the elimination goal. In addition, cancer care has expanded from 24 to 33 health facilities, improving access across regions.

In the fiscal year, 1.1 million women aged 30 to 49 were screened for cervical cancer, marking a 66% increase from the previous year. The goal was to screen at least 9% of women in this age group, and 61% of this target was achieved. Half of the regions met or surpassed the 9% target, including Addis Ababa, Harari, Dire Dawa, South Ethiopia, Oromia, Sidama, and Central Ethiopia.

Of those with precancerous cervical lesions and eligible for treatment, 77% received appropriate care, which is a 3% improvement from the previous years, though further efforts are needed to enhance performance.

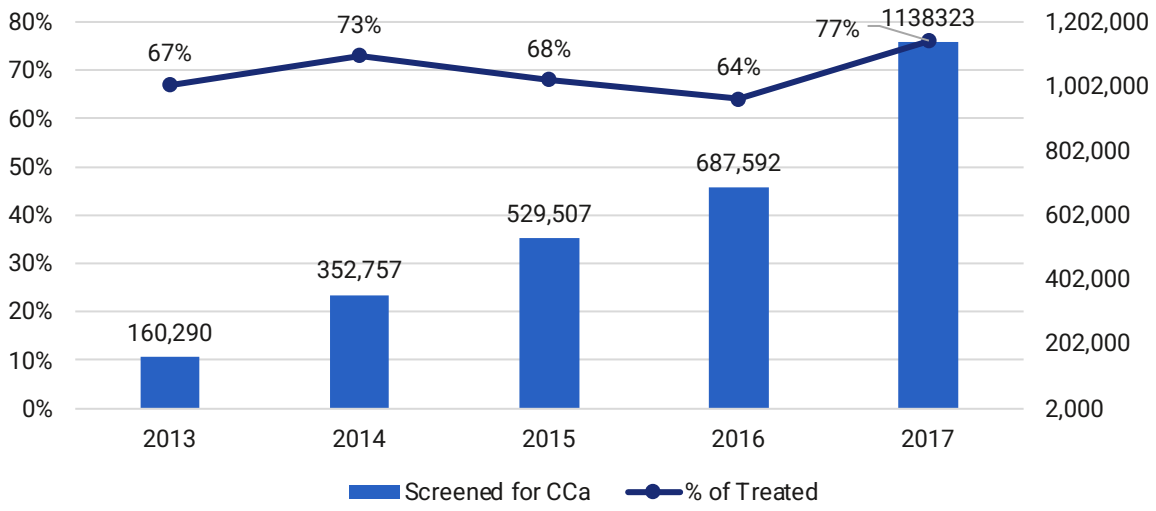


Figure 49: Trends of Cervical Cancer Screening and proportion of women with precancerous cervical lesion treated., 2013 – 2017 EFY

Eye Health Program

It is estimated that by 2021, 5.4 million people in Ethiopia would be living with visual impairment, primarily due to cataract, refractive error, trachoma, corneal blindness, glaucoma, and diabetic eye diseases. In response, the Government of Ethiopia, alongside other Member States, endorsed Resolution No. 73.4 on Integrated People-Centered Eye Care (IPEC) in 2020, focusing on preventing visual impairment and blindness. The National Eye Care Strategy (2023/24–2025/26 G.C.) was developed to implement IPEC and reorient the eye care model, aiming to strengthen the eye health system from community-based services to specialized tertiary care.

In 2107 EFY, 105,073 cataract surgeries, achieving 88% of the target, were done. The goal is to reach 1,016 individuals per 1 million population, and currently, we have reached 934. To maintain quality, the National Guideline for Provision of Quality Cataract Services in Ethiopia was developed, and cataract surgical audits were conducted in three selected tertiary and secondary eye care facilities.

Mental Health Program

Ethiopia has made notable progress in addressing mental health through the adoption of a National Mental Health Strategy (2020–2025), integration of WHO's mhGAP program into primary care, and the expansion of training for psychiatric nurses and practitioners. To date more than 1,600 health facilities integrated MNS services. Mental health services are provided by all hospitals in the Amhara, Tigray, AA, Dire Dawa, and Harara regions. These services are integrated into health post packages, and HEWs are trained in priority MNS disorders to promote early detection of mental health conditions.

According to the monthly disease reports from health facilities, a total of 498,836 MNS cases were reported nationwide, marking a 22% increase from the previous year's report. As indicated in the table below, Epilepsy has the highest number of cases, followed by psychosis. The reported numbers for all five MNS categories increased in 2017 EFY compared to 2016 EFY.

Figure 50: Number of people treated for mental illness, neurological and substance use disorders

Priority MNS	2012 EFY	2013 EFY	2014 EFY	2015 EFY	2016 EFY	2017 EFY
Psychosis	113,172	171,961	138,973	115,505	124,743	147,825
Depression	34,288	46,623	42,791	39,895	47,116	60670
Bi-polar disorder	23,866	29,496	26,220	17,618	19,156	30259
Epilepsy	263,372	278,799	259,329	183,782	207,222	249071
Substance use Disorder	28,792	16,587	15,227	8,291	10,189	11011
Total	463,490	543,466	482,540	365,091	408,426	498,836

Challenges

- Insufficient leadership commitment and budget allocation for NCDs and mental health
- Inadequate resources, both human and financial, for program implementation
- Limited support from partners to bolster the program's efforts
- Insufficient indicators for monitoring and evaluating health facilities
- Poor communication and integration among disorders with high comorbidity rates.

Way Forward

- Optimal program ownership and commitment at all levels
- Allocate adequate resources for NCDs
- Capacity building for MNS program managers from federal to regional levels to lead the program effectively

3.5. Prevention and control of Neglected Tropical Diseases

Neglected Tropical Diseases

Trachoma

MDA for **27.1** million individuals

81,317

people received corrective eye lid surgery for trachomatous trichiasis

Leishmaniasis

4,018

visceral and 2,613 Cutaneous leishmaniasis patients treated

Onchocerciasis

23.2 million

people treated with Ivermectin MDA

Schistosomiasis

6.3 million

were treated for schistosomiasis

Lymphatic filariasis

1.39 million

people received mass drug administration in 22 endemic areas

Soil Transmitted Helminthiasis (STH)

13.7 million

school age children were treated for soil transmitted helminths

Ethiopia is one of the top three countries in Africa burdened by neglected tropical diseases (NTDs). Since 2013 GC, the government has implemented strategic plans to combat NTDs, achieving expanded access to prevention, diagnosis, and treatment services, integrating NTD interventions into PHC, and improving data use for decision-making. Efforts have strengthened local leadership, increased resource mobilization, and enhanced public health infrastructure. Priority NTDs include onchocerciasis, trachoma, soil-transmitted helminths, lymphatic filariasis, schistosomiasis, leishmaniasis, Podoconiosis, and dracunculiasis (Guinea-Worm).

Trachoma Elimination Program

Ethiopia, facing the highest global burden of trachoma, has been using the WHO's SAFE strategy to eliminate it. This includes Surgery for trachomatous trichiasis, Antibiotics for Chlamydia trachomatis, and promoting Facial cleanliness and Environmental improvement.

During 2017 EFY, mass drug administration (MDA) for trachoma was conducted in 250 out of 299 endemic districts (83.6%), as well as in six refugee camps, reaching over 27,163,876 individuals. Additionally, child MDA was implemented in 16 woredas, reaching more than 579,909 children.

Out of the 264 woredas planned for trachoma surveys, trachoma impact surveys (TIS) and trachoma surveillance surveys (TSS) were conducted in 117 woredas (44.3%)—comprising 89 TIS and 28 TSS. Furthermore, 81,317 individuals (82% of the annual target of 98,980) underwent corrective eyelid surgery for trachomatous trichiasis (TT) management.

Onchocerciasis Elimination Program

The primary strategy for onchocerciasis control and elimination is MDA using ivermectin, a safe and cost-effective medication and as of May 2024 GC, the number of onchocerciasis-endemic woredas in Ethiopia reached 312, along with 10 refugee camps. Among these, 29 Woredas have transitioned to post-treatment surveillance. Ethiopia has adopted biannual MDA in endemic areas in 2012 GC, targeting individuals aged five years and above. Since 2014 EFY, Ethiopia has also collaborated with Sudan and South Sudan to implement an integrated and coordinated approach to onchocerciasis elimination in border areas.

In 2017 EFY, over 23.2 million people—representing 98% of the annual target—were provided ivermectin MDA for onchocerciasis.

Schistosomiasis and Soil transmitted helminthiasis

In 2017EC, over 13.7 million school-age children (ages 5-14) in 452 woredas were treated for soil-transmitted helminthiasis, and more than 6.3 million were treated for schistosomiasis.

Podoconisosis and lymphatic filariasis (LF)

MDA for LF was conducted in 22 eligible and endemic woredas, reaching over 1,392,314 people with Ivermectin and Albendazole treatment. Additionally, an LF program impact assessment study was carried out in 7 woredas that have implemented MDA for at least five years, in line with WHO's recommended number of treatment rounds. Training was provided for 962 healthcare providers in Morbidity Management and Disability Prevention across 149 facilities in seven regions. As a result, 80,397 Lymphedema and 653 hydrocele cases received care and surgery.

Leishmaniasis Control

Ethiopia faces a significant challenge with Visceral Leishmaniasis (VL), or Kala-azar. A national risk mapping identified millions at risk for both Visceral and Cutaneous Leishmaniasis. The disease is a major public health concern in regions like Afar, Amhara, Oromia, Southern Ethiopia, Somali, and Tigray. The country currently operates 33 treatment centers and 66 diagnostic centers for Visceral Leishmaniasis, along with 28 centers for Cutaneous Leishmaniasis. In 2017 EFY, as part of capacity-building initiatives, 1,384 professionals—including medical doctors, lab technicians, and health information technicians—received training. The annual report indicates that 4,018 cases of Cutaneous Leishmaniasis and 2,613 cases of Visceral Leishmaniasis were treated.

Guinea Worm Eradication Program

Ethiopia is close to interrupting Guinea worm transmission, but challenges like limited access to safe drinking water and inadequate surveillance of the disease in wild animals persist. Since 2013, Ethiopia Dracunculiasis Eradication Program identified 99 infected animals in Gog and Abobo districts of Gambella region and introduced interventions like active animal surveillance, tethering pets, safe disposal of fish entrails, treating water with Abate, and environmental management. These efforts, along with increased cash rewards for reporting cases, have significantly reduced infections. In 2016 EFY, Ethiopia reported zero human cases and one dog infection, but in 2017 EFY, two animal infections and one suspected human case were identified and sent for confirmation.

Challenges

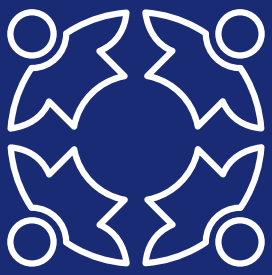
- A lack of sustained and sufficient funding for NTD programs significantly impedes progress
- Inadequate Water, Sanitation, and Hygiene (WASH) Infrastructure and Behavioral Change

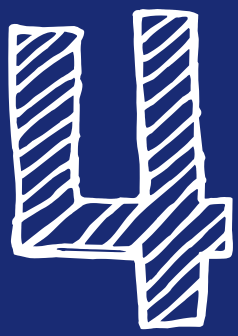
Way Forward

- Ensure sustained and sufficient funding for NTD programs.
- Improve WASH infrastructure along with promoting behavioral change.

Chapter

Community Engagement and Primary Health Care





Community Engagement and Primary Health Care

Community engagement

330

Number of woredas implementing re-designed community engagement approach

Service provision at health posts (HPs)

2,419

Number of merged health posts with health centers

80%

Proportion of health centers with community health program units

260

Numbers of Comprehensive HPs

Woreda Transformation Status

11% model

25% medium

21% low

42% very low performing

Health Centers Emergency Surgery Service (OR-Block health centers)

185

Health centers with OR block and surgical service

14,777

Caesarean sections done at health centers

Urban PHC reform

381

health centers implementing urban PHC reform

Ethiopian health center reform implementation guideline (EHCRIG)

79%

Average score

Ethiopian Primary Health Care Clinical Guidelines implementation

3,606 (92%)

health centers

The Ethiopian Primary Health Care Alliance for Quality (EPAQ)

52%

in 570 clusters

Hygiene and Environmental Health

Household Sanitation

38%
Proportion of households with access to basic sanitation

43%
Proportion of households with solid waste management

33%
Proportion of households with Liquid waste management

Institutional Sanitation

54%
Proportion of facilities with access to basic sanitation

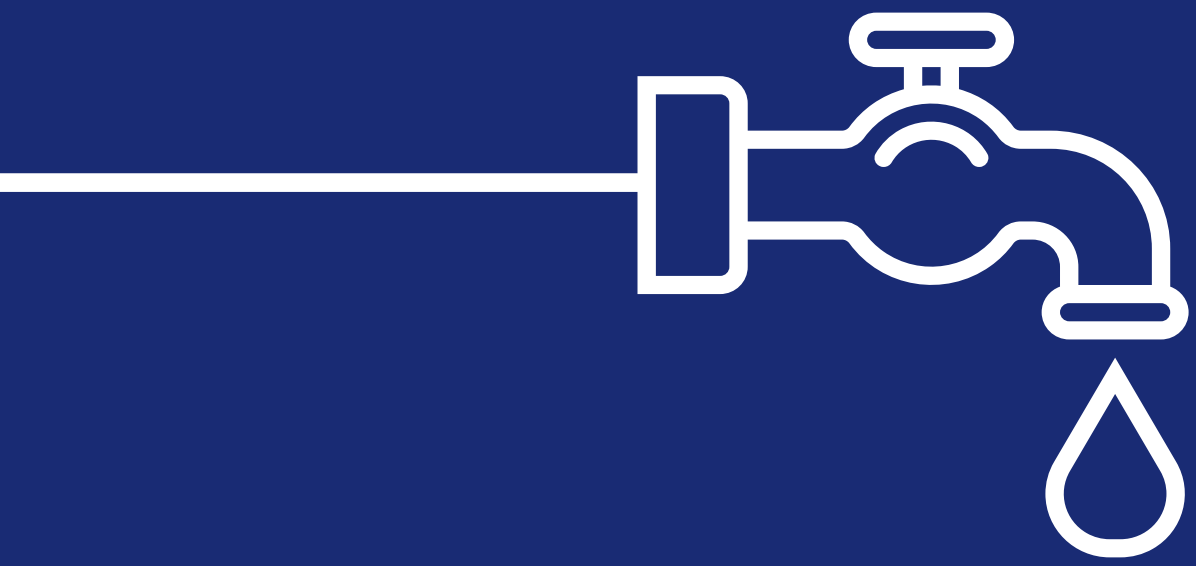
74%
Proportion of facilities with healthcare waste management

52%
Proportion of facilities with water

Sanitation marketing

143
New sanitation marketing centers have been established

1,094
Cumulative number of sanitation marketing centers reached



Chapter 4: Community Engagement and Primary Health Care

4.1. Community Engagement and Empowerment

Community engagement in Primary Health Care (PHC) is one of the foundational principles identified in the 1978 Alma-Ata Declaration and reaffirmed in the 2018 Astana Declaration. It emphasizes that communities should not only be recipients of care but also active participants in shaping, delivering, and evaluating health services. Community engagement has been a primary approach to expanding access to primary healthcare through health education, demand generation, health promotion, and community mobilization towards joint action.

The revised community engagement strategy has been scaled up to 330 woredas across the country since its pilot rollout in 2013 EFY, initially in four woredas, with Village Health Leaders (VHLs) serving as coordinators between community groups and Health Extension Workers (HEWs) to enhance coordination and communication. To make it effective across diverse settings, the strategy was contextualized for pastoralist areas and facilitated the mobilization of pastoralist populations for disease prevention and health promotion, while regional advocacy, woreda-level sensitization, and recruitment, training, and deployment of VHLs facilitated its implementation.

The optimization and capacity-building of the Women Development Unions (WDUs) also continued, with a cumulative total of 1,342,416 WDU members trained through competency-based training (CBT), from which 727,617 (54%) passed competency tests.

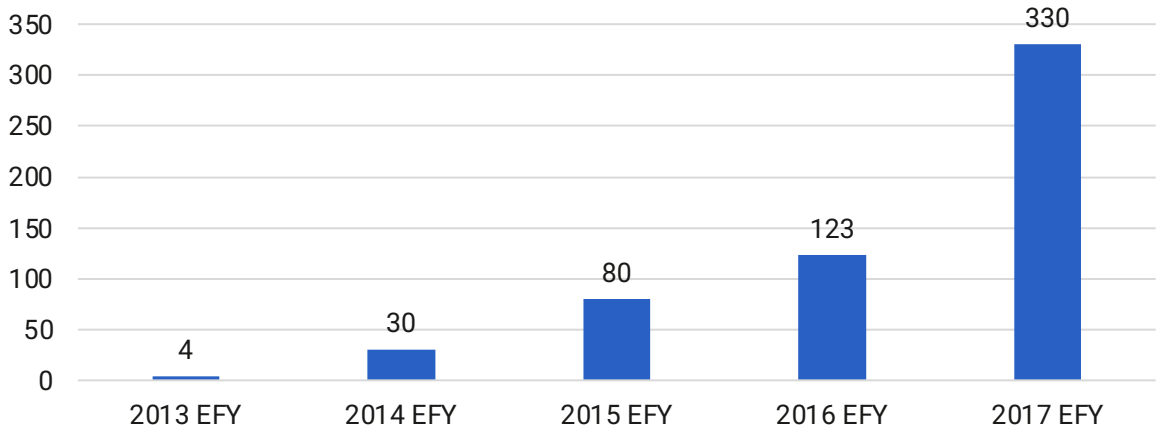


Figure 51: Number of woredas implementing the re-designed community engagement approach

4.2. Health Extension Program and Primary Health Care

Based on the Health Extension Program Optimization (HEPO) recommendations, a total of 17,735 health posts—covering 99% of health posts nationwide—were categorized into three groups. The majority, 13,159 (74%), were classified as basic health posts (BHP); 1,942 (11%) were categorized as comprehensive health posts (CHP); and the remaining 2,634 (15%) were recommended to be merged with the nearby health center. This restructuring aims to improve service delivery and optimize the overall functionality of health posts across the country.

Service provision at Health Posts: In the fiscal year, the number of health posts merged with nearby facilities increased from 1,900 to 2,419 (92% of the expected). The proportion of health centers that established Community Health Program (CHP) units to strengthen linkages with health posts increased from 2,190 in 2016 EFY to 3,133 (80%) in 2017 EFY, while the number of CHPs grew from 107 to 260 during the same period though this remains only 40% of the five-year target and only 13.4% of the total expected CHPs. Additionally, 766 BHPs were staffed with at least a nurse and two level IV HEWs to deliver basic HEP services. In the fiscal year, over 1.6 million clients received outpatient visits, and more than 14,600 women received delivery services at comprehensive health posts.

Health Post Infrastructure Improvement: As per the revised HEPO roadmap,149 comprehensive and 54 basic health posts have been constructed in the newly developed design. Among these 90 comprehensives and 28 BHPs became functional, and the remaining 59 comprehensives and 26 BHPs are waiting for medical equipment. Currently, 173 comprehensive and 62 BHPs are under construction by the newly developed design through community contributions, support from local governments, and MOH. Additionally, in collaboration with the Ministry of Agriculture and the Development Response to Displacement Impact-II (DRDIP II) project financed by the World Bank, the construction of 37 HPs began in Tigray, Afar, Amhara, Benishangul-Gumuz, and Gambella targeting areas with foreign refugees, among these 28 (76%) HPs have been completed and ready for service, while the remaining are at various stages of construction. To support these efforts, over 5.7 billion birr has been mobilized from various sources, including local governments, community contributions, and non-governmental organizations.

Strengthening Health Sector Woreda Transformation Interventions: The Woreda Transformation initiative is part of Ethiopia's health sector strategy to enhance and transform the health system mainly at woreda level, aiming to enhance the health status of the community through improving UHC. To monitor the woreda transformation, 64 composite indicators were selected (11 for HPs, 40 for HCs, and 13 for WoHOs), focusing on five thematic areas - Quality and Equity, Health Workforce, Leadership and Governance, Information Revolution, and Health Financing. A tracking dashboard has been successfully integrated into DHIS2, and an implementation manual and simple user guide have been developed, and orientation is provided for RHBs to track the performance of Woredas, PHCUs, and Health posts uniformly across the country. Based on the Q4-2017 Self-assessment report, 119 (11%) woredas were model, 274 (25%) were medium performing, 228 (21%) were low performing and 467 (42%) were very low performing.

Table 14: Woreda transformation model woreda status, quarter IV of 2017 EFY

Region	Proportion of Woredas with Woreda Transformation status			
	Model	Medium	Low	Very Low
Tigray	0%	0%	6%	91%
Afar	0%	2%	8%	80%
Amhara	29%	38%	30%	3%
Oromia	11%	30%	24%	34%
Somali	0%	0%	7%	92%
BG	0%	13%	33%	54%
Central E	14%	41%	23%	22%
South E	4%	39%	24%	33%
Sidama	24%	37%	24%	13%
SWE	14%	25%	25%	32%
Gambella	0%	0%	7%	93%
Harari	0%	22%	22%	56%
DD	NA	NA	NA	NA
AA	NA	NA	NA	NA
National	11%	25%	21%	42%

Primary Health Care System Framework and an investment plan: To overcome challenges in planning, implementation, and financing in PHC, a PHC Strategic Framework was finalized in the previous year. An investment plan, aligned with the PHC strategic framework and structured into three phases, has been developed to support the implementation. In the first phase, the plan targets construction and availing medical equipment for 3,127 basic and 842 comprehensive health posts across 325 woredas. Additionally, construction and equipping 56 Health centers with medical equipment is planned. Further investments include building surgical blocks in 89 health centers, establishing community pharmacies at the woreda level, and setting up skill labs in health science colleges. Both short- and long-term capacity-building initiatives will be financed through the investment plan.

Health Center Service Delivery: To strengthen the critical roles of health centers, MOH introduced key reforms and quality improvement initiatives such as the Ethiopian Health Center Reform Implementation Guideline (EHCRIG), the Ethiopian Primary Healthcare Alliance for Quality (EPAQ), and the Ethiopian Primary Healthcare Clinical Guideline (EPHCG). In addition, efforts to expand emergency surgery services, improve infection prevention and control, and integrate public health emergency management have been implemented to ensure health centers deliver safe, quality, and equitable healthcare for all. The implementation status of these reforms is described as follows.

Ethiopian health center reform implementation guideline (EHCRIG): The implementation of EHCRIG is closely monitored through DHIS2, which reported an average national performance (all chapter's average) of 79%. While this represents an improvement compared to previous quarters, it remains below the national target of 85%. The highest score was reported for chapter 1 -Governance and leadership with a score of 83%; while the lowest score was for Chapter-9 (medical equipment) scoring 71%.

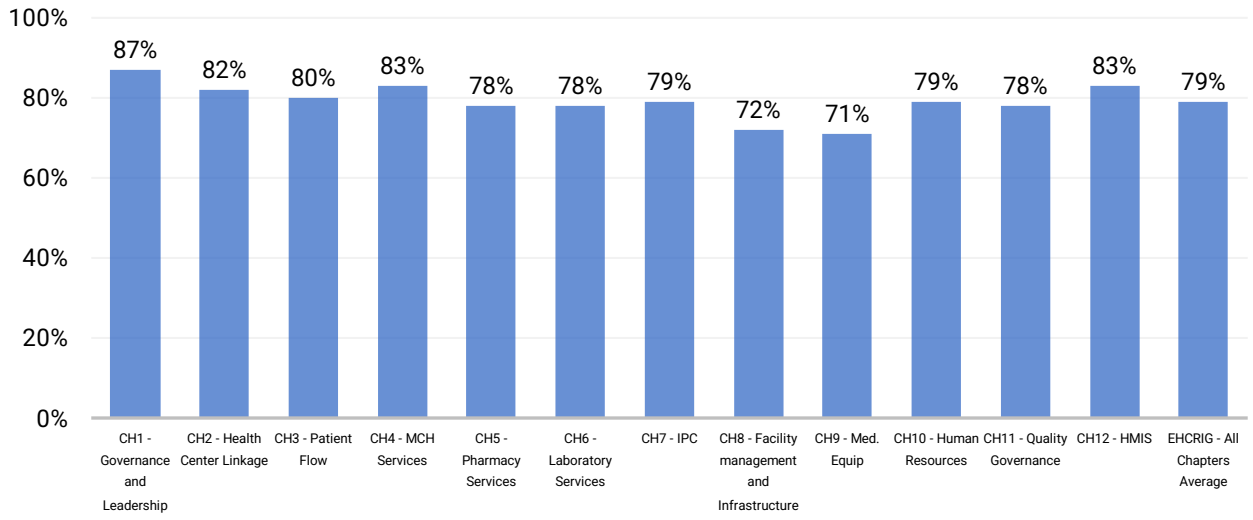


Figure 52: EHCRIG Score by Chapter - Quarter IV of 2017 EFY

In terms of EHCRIG scores by region, the highest performance was recorded in BG (100%), Harari (91%) and Addis Ababa (92%). In contrast, the lowest scores were observed in Gambella (53%), Afar (55%) and Tigray (60%).

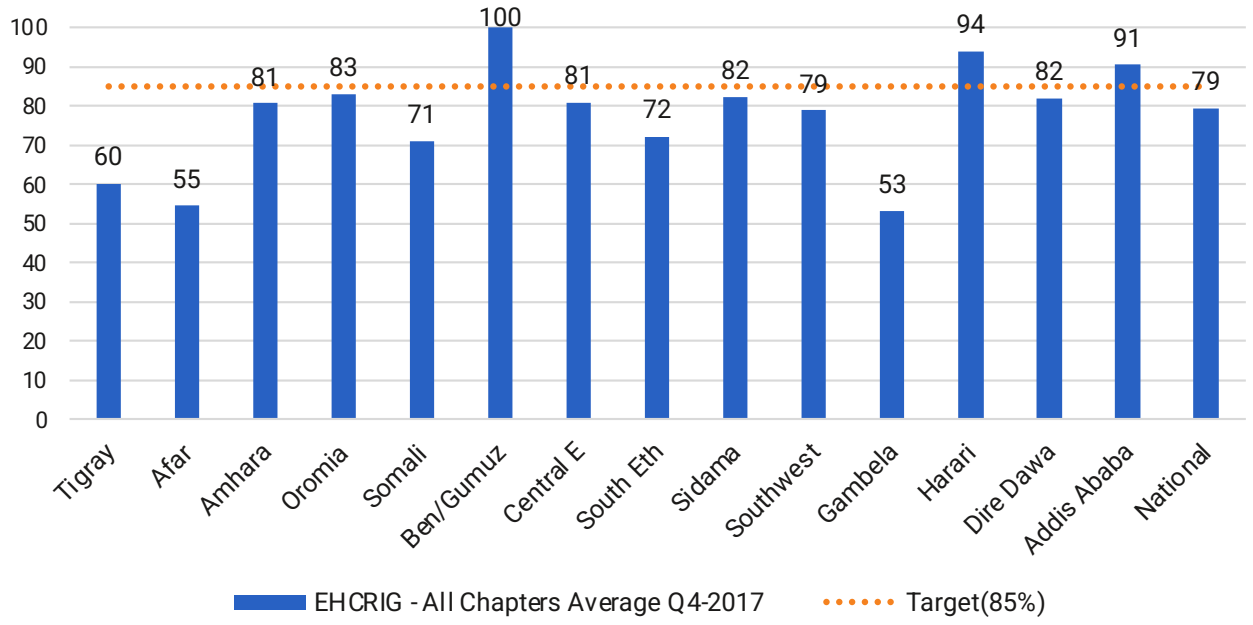


Figure 53: EHCRIG all chapter's average score by region, quarter IV of 2017 EFY

The Ethiopian Primary Health Care Alliance for Quality (EPAQ): As part of efforts to strengthen quality improvement across primary health care, key activities were carried out. In 2017 EFY, a national EPAQ first-cycle performance review was conducted, during which a recognition program acknowledged the best-performing 42 health centers, 21 woreda health offices, and three top-performing regions (Addis Ababa, Sidama, and Oromia), awarding them 120 desktop computers and certificates. Furthermore, the revised EPAQ guideline, the second cycle BRIDGE project document, and the audit tool were officially launched. Two rounds of Training of Trainers sessions were conducted

for regional focal points, and cascading training was provided to 688 EPAQ clusters, including lead health centers, woreda health offices, and catchment hospitals. Currently, EPAQ has been rolled out in 570 clusters/woredas, accounting for 52% coverage. Annual EPAQ experience sharing has been conducted in Jimma zone, Sokoru woreda. To fill the knowledge and skill gaps of health workers, MoH and RHBs conducted integrated PHC mentorship in five regions on selected key focus areas (EHCRIG, EPHCG, EPAQ, HPRIG standards). The integrated mentorship covers mentorship for WoHOs, health centers and health posts.

The Ethiopian Primary Health Care Clinical Guidelines (EPHCG): To enhance professional capacity and ensure access to quality health services, the EPHCG is being strengthened through a digital e-learning platform, which enables health workers to access training at any time and from anywhere. Implementation began in 2012 EFY, initially reaching 572 health centers, and has now expanded to 3,606 centers, covering 92% of all health centers nationwide. In 2017 EFY, one round of training of trainers and three rounds of basic training were conducted for 120 trainers nationwide, resulting in 11,231 health professionals enrolling in the EPHCG e-learning platform. The program has now been launched in all regions and supported by a dedicated Telegram group for technical assistance. Additional capacity-building was provided to 540 professionals from 350 conflict-affected facilities, 10,000 manuals were distributed, and 230 computers were procured to initiate EMR services in 50 facilities.

Urban PHC Reform/Family Health team Implementation: The Family Health Teams (FHT) provided essential services, including NCD screening with referrals to primary health units, maternal and child health care focused on early detection, prenatal services, and immunization, as well as health promotion and preventive interventions targeting adolescents, workers, and other underserved urban populations. In the 2017 EFY, the FHT model was implemented in 381 Health Centers across 202 cities, with a total budget allocation of 19,337,042 ETB to RHBs. A total of 1,513 professionals (812 male and 701 female) were trained to implement the approach and provided services to more than 2.4 million people through home visits, schools, youth centers, workplaces, and street outreach programs.

Health Centers Emergency Surgery Service (OR-Block health centers)

To expand access to emergency surgical care, MOH in collaboration with RHBs and partners, has been implementing a national initiative to operationalize surgical services at health centers equipped with OR blocks. To build the capacity of the required workforce, 62 general practitioners from across all regions were trained at 26 hospitals and graduated after passing competency exams. In support of this, 40 specialist doctors were trained as national trainers, and a total of 742 professionals, including doctors, nurses, and anesthesiologists, received clinical training. Refresher coaching was also conducted at 80 facilities.

The number of health centers with OR blocks that began providing emergency surgical service has increased from 125 in 2016 EFY to 185 in 2017 EFY. This helped increase the total number of mothers delivering by C/S at health centers from 11,456 in 2016 EFY to 14,777 in 2017 EFY — an increase of 3,221 C/S deliveries at health centers. The biggest improvements in health center C/S deliveries were seen in Oromia, Amhara, Addis Ababa, and Tigray, where the number of C/S deliveries went up by over 400 cases in each region. Somali and Dire Dawa also showed encouraging progress. Smaller but positive increases were recorded in regions like SWE, South Ethiopia, BG, and Gambela. However, a few regions — including Afar, Central Ethiopia, and Harari — experienced slight declines compared to the previous year.

Overall, the trend shows that more mothers are gaining access to life-saving cesarean delivery services at health centers, which is a positive step toward improving maternal and newborn health in the country.

Table 15: Number of health centers with OR block and number of C/S deliveries at health centers

Region	No. of HCs with OR block (2017 EFY)	No. of deliveries by C/S at health centers		
		2016 EFY	2017 EFY	Change in 2017 EFY (#)
Oromia	63	4373	5420	1047
Amhara	38	1707	2390	683
AA	20	4348	4851	503
Tigray	22	58	511	453
Somali	11	105	323	218
Dire Dawa	2	101	305	204
SWE	2	70	215	145
South Eth	7	154	211	57
BG	5	326	377	51
Gambela	0	0	0	0
Sidama	1	0	4	4
Harari	1	10	0	-10
Central E	6	99	87	-12
Afar	7	105	83	-22
National	185	11456	14777	3321

4.3. Water, Sanitation, Hygiene and Environmental Health programs

Water, Sanitation and Hygiene (WASH), together with environmental health focuses on addressing environmental determinants that significantly affect public health. Its primary aim is to prevent the spread of communicable diseases and to promote overall health and wellbeing by ensuring access to safe water, improved sanitation, and proper hygiene practices. The major achievements and performance highlights in 2017 EFY are summarized below:

Sanitation and Hygiene

During the fiscal year, efforts to improve personal hygiene were intensified through targeted awareness campaigns. The initiatives focused on facial hygiene, oral hygiene, and general body cleanliness, with messages broadcast nationwide via the Ethiopian Broadcasting Corporation and other media channels to maximize public engagement.

Menstrual Hygiene Day was commemorated under the theme "ለወር አበባ ንፅህና ተደራሽ የሆነች ሀገርን በጋራ እናረጋግጥ". The event brought together various stakeholders, including government ministries, private media outlets, and manufacturers. Activities featured include student testimonies, panel discussions, and the dissemination of key messages through social media, mass media, and mobile messaging platforms.

National Handwashing Day was celebrated with the theme "ንፁህ እጆች ለጤናችን ዋስትና ናቸው". The event engaged multiple stakeholders and emphasized the importance of hand hygiene through coordinated outreach efforts.

Expanding Market based sanitation

In the 2017 EFY, 143 new market-based sanitation (MBS) centers were established, bringing the total number of centers across the country to 1,094. This achievement was the result of several coordinated efforts and strategic investments. A total budget of 127 million birr was allocated and disbursed to support the initiative, accompanied by ongoing technical support provided to all regions. To build local capacity, 95 woreda-level WASH experts responsible for leading MBS initiatives received specialized training. A functional assessment of the existing MBS centers revealed that approximately 63% were operational, while 37% were not functional, indicating areas for targeted improvement. Furthermore, a sanitation subsidy program was introduced and implemented in eight districts across two regions, aiming to improve access to sanitation services for low-income households.

Households with access to sanitation facilities

At the end of 2017 EFY, 38% of households had access to basic sanitation, 43% of HHs had safe solid waste management system and 33% had liquid waste management.

Table 16: Proportion of households with access to sanitation facilities by region, 2017 EFY

Regions	Proportion of households with basic sanitation facilities	Proportion of HHs with safe solid waste management	Proportion of HHs with liquid waste management
Tigray	3%	9%	4%
Afar	8%	9%	9%
Amhara	46%	58%	54%
Oromia	44%	42%	28%
Somali	2%	3%	2%
BG	16%	34%	22%
Central E	51%	53%	42%
South E	36%	54%	39%
Sidama	42%	37%	30%
SWE	47%	55%	38%
Gambella	10%	6%	5%
Harari	18%	54%	11%
DD	49%	53%	16%
AA	26%	48%	39%
National	**38%**	**43%**	**33%**

Strengthen activities for sustainable ODF

In 2017 EFY, the major activities that improved progress in the Open Defecation Free (ODF) kebele initiative include a dedicated budget and continuous technical support, which enabled 1,300 kebeles to achieve ODF status. To ensure sustainable open defecation practices, cascading training was provided for 95 participants from zones and woredas. The efforts were highlighted during World Toilet Day, celebrated under the motto *"Toilet is a Place for Peace,"* with participation from various stakeholders, including the MOH, Ministry of Education, Ministry of Water and Energy, development partners, school communities, media representatives, and private sector entities involved in the WASH sector.

Institutional WASH and Environmental Health

Access to basic WASH services in healthcare facilities showed notable coverage improvement, with 52% having basic water supply, 54% having basic sanitation facilities, and 74% having basic healthcare waste management services.

Table 17: Proportion of health facilities with basic sanitation, waste care management and water services, 2017 EFY

Regions	Proportion of Health facility with basic sanitation service	Proportion of health facilities with healthcare waste management serviceS	Proportion of health facilities with water
Tigray	36%	66%	51%
Afar	25%	63%	39%
Amhara	48%	81%	55%
Oromia	57%	68%	48%
Somali	37%	60%	56%
BG	61%	91%	52%
Central E	69%	87%	57%
South E	55%	75%	51%
Sidama	68%	93%	62%
SWE	62%	79%	45%
Gambella	66%	78%	61%
Harari	47%	84%	92%
DD	86%	89%	82%
AA	100%	100%	103%
National	54%	74%	52%

Institutional WASH by facility type: The availability of basic WASH services in health facilities shows variation across facility types. Hospitals have the highest coverage, with 84% having basic sanitation, 98% equipped with healthcare waste management, and 99% with water services. Health centers followed with 74% sanitation, 91% waste management, and 82% with water services. In contrast, health posts lagged, with only 48% having basic sanitation, 69% waste management, and 43% water services. Overall, while hospitals and health centers demonstrate relatively good WASH service coverage, health posts remain underserved and require greater attention to ensure safe and hygienic service delivery.

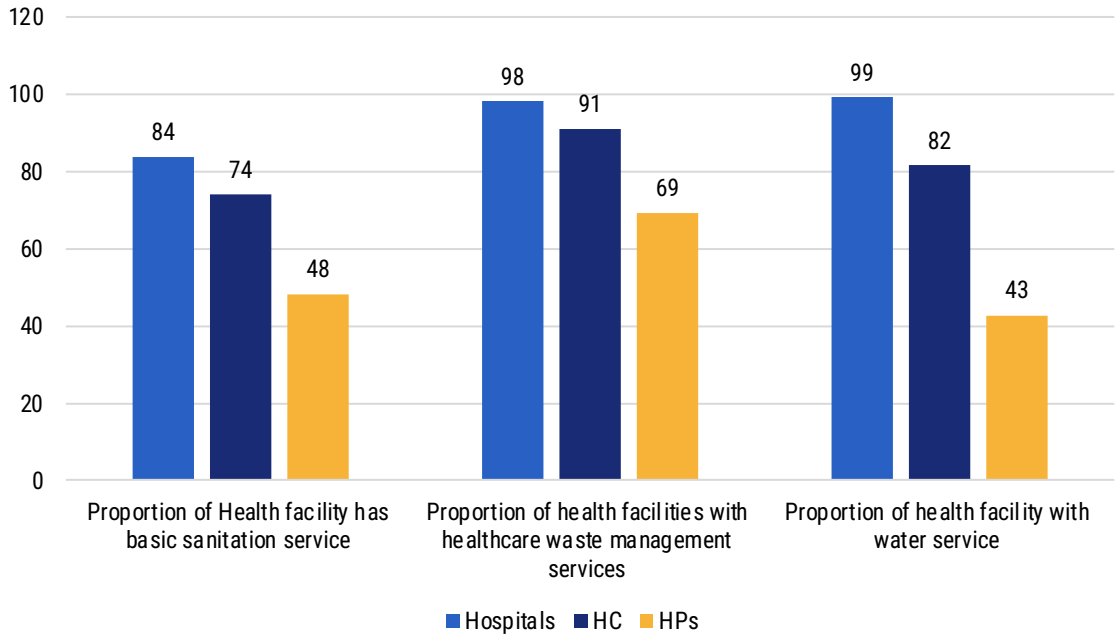


Figure 54: Institutional WASH by facility type, 2017 EFY

A ten-year WASH in Healthcare Facilities Roadmap was developed and officially launched with the presence of different stakeholders. In support of this effort, 278 experts from all regions and federal hospitals received training on the WASH-FIT (Water and Sanitation for Health Facility Improvement Tool), aimed at improving WASH service delivery in healthcare settings. To guide effective implementation, intervention guidelines were developed for environmental health professionals working in healthcare facilities. Furthermore, a Training of Trainers was conducted for 50 experts from federal hospitals and regional health bureaus on Occupational Health and Safety. Infrastructure improvements were also a major focus during the year. A total of 132 new water supply systems were constructed and 22 existing systems rehabilitated. Additionally, 190 latrines, 222 incinerators, and 63 placenta pits were built in healthcare facilities located in One WASH program woredas, contributing to safer and more hygienic healthcare environments.

4.4. TSEDU-Ethiopia program

The implementation of the TSEDU–Ethiopia Program has continued to expand, with the number of participating woredas increasing from 50 to 102. Alongside this progress, three public toilet facilities have been fully constructed and made operational. To enhance public engagement, continuous advocacy and awareness-raising campaigns have been broadcast on various television channels, playing a vital role in mobilizing communities, strengthening awareness, and promoting positive behavioral change toward improved hygiene and sanitation practices. As part of this broader initiative, TSEDU–Healthcare Facility was initiated at ALERT and St. Peter's Hospital in the previous fiscal year. Currently, additional healthcare facilities are adopting the TSEDU–Healthcare Facility initiative to transform their environments into clean, safe, and comfortable spaces for both patients and healthcare providers.

In addition, four hospitals that had previously served as treatment centers for COVID-19 patients have undergone full renovation and related improvement works, creating cleaner, safer, and more comfortable spaces for patients and healthcare providers. Furthermore, seven hospitals in selected regions identified both as demonstration sites for the TSEDU Healthcare Facility initiative and as institutions facing major infrastructural challenges have been prioritized for renovation and expansion. Implementation of these activities has reached 80%, marking significant progress in transforming healthcare facilities into model clean, green, and patient-friendly environments.

Climate Change and Health

To strengthen climate change and health interventions within the health sector and to build climate-resilient health systems, a national consultative workshop was convened with 51 participants representing key ministries and agencies to enhance multi-sectoral collaboration on climate change and health. To equip health workers with climate change knowledge, emergency preparedness and response skills, a comprehensive handbook and training package on climate change and health emergency preparedness and response were developed. Five regional training sessions were conducted, reaching 180 health professionals from Woreda health offices, RHBs and health facilities, including Climate-Sensitive Disease sentinel sites.

All regions and city administrations developed costed sub-national Health National Adaptation Plans (HNAP) for the period 2025–2028. Implementation of these plans has commenced, marking a significant step toward regional context climate resilience in the health sector. To foster public awareness and community involvement, SBCC materials were produced and disseminated. Spot messages were broadcast via the Ethiopian Broadcasting Corporation, reaching over 17 million households nationwide.

Challenges [Community engagement and PHC]

- The implementation of the HEP optimization roadmap is hindered by overlapping and conflicting priorities across the health system
- Coordination and collaboration among different sectors remain sub-optimal
- Frequent changes in leadership at lower levels of the health system disrupt continuity and strategic direction
- Some healthcare providers perceive EPHCG as a reference document rather than a practical tool for delivering care
- Many health centers with OR blocks lack essential medical equipment (e.g., operating tables, surgical lights), basic utilities (e.g., water, electricity), and sufficient human resources to initiate surgical services
- Financial limitations restrict the full-scale rollout of the redesigned community engagement strategy
- The medical equipment procurement process is lengthy and inefficient, delaying service readiness
- Inadequate allocation of resources for WASH and Environmental Health activities at regional and local levels

Next year priorities

- **Sustain Advocacy Efforts:** Continue robust advocacy for the HEPO roadmap across all administrative levels to ensure sustained commitment and visibility
- **Innovative Financing:** Design and implement innovative financing mechanisms to support the effective rollout of the HEPO roadmap.
- **Supply Chain Strengthening:** Ensure consistent availability of essential supplies at health centers and health posts to maintain service delivery standards.
- **Enhanced Multisectoral Collaboration:** Strengthen coordination among sectors to advance primary healthcare, with a particular focus on HEP implementation.
- **Operational Readiness for Surgical Services:** Equip health centers with operating rooms with the necessary medical equipment and basic amenities to initiate surgical services.
- Enhance primary health care quality improvement efforts EPHCG, EPAQ
- Advocate for the TSEDU-Ethiopia program at federal, regional, and city administration levels,
- Community-Led Sanitation Initiatives: Support social mobilization efforts to eliminate open defecation in Kebeles
- **Expansion of Sanitation Centers:** Establish new market-based sanitation centers and strengthen the capacity of the existing 951 centers.
- **Climate and Health Capacity Building:** Provide targeted capacity-building programs on climate change and health to enhance resilience and preparedness.

Chapter 5

Medical Health Services

Medical Services

OPD attendance per capita

>233.8 million
OPD visits

2.08
OPD attendance per capita

Inpatient admission rate

17.7
Per 1,000 population

Average Length of Stay (ALOS)

4.4 days

Hospital Bed Occupancy Rate

67%

Bed Density Per 10,000 Population

3.2

Inpatient Mortality Rate

1.5%

Functional Ambulances

3,014

Emergency and critical care

0.16%
Emergency mortality rate

Intensive Care Unit (ICU) mortality rate was **23%**

Blood Services

Blood banks

56

Blood donation

423,295
units of blood was collected

Post donation counselling

25%
of blood donors received post donation counseling

Blood Component Production

14%
of the donated blood converted to components

Blood testing for transfusion transmissible infections (TTIs)

All collected blood was screened for the four TTIs (HIV, Hepatitis B, Hepatitis C and Syphilis_

Positivity rate:

HIV positives = **0.58%**; Hepatitis B positive = **1.7%**;
Hepatitis C positive = **0.8%**; Syphilis positive = **1.2%**

4.2%
Positivity rate to at least one of the TTIs

Chapter 5. Medical Health Services

5.1. Pre-Facility Emergency Services

As part of efforts to strengthen community-level first aid services, a Community First Aid Response (CFAR) training manual has been prepared and approved. Following this, 70 professionals received training of trainers. The aim of this initiative is to provide immediate support, efficient transport, and referral for continuous care.

To enhance the standardization and effectiveness of basic and advanced ambulance services, 370 new ambulances have been procured and distributed nationwide. Consequently, the total number of operational ambulances has increased from 2,680 to 3,014. Additionally, 29 ambulances secured through the Global Fund are prepared for deployment, while procurement is underway for 17 advanced ambulances. Eight mobile clinics have also been distributed. Essential medical equipment for 409 ambulances has been procured to support life-saving care during patient transport. Furthermore, 40 million Birr has been transferred to regional and city administrations for the repair and maintenance of 100 ambulances.

Table 18: Number of Functional Ambulances by Region, 2017 EFY

Region	Number of functional Ambulances
Tigray	156
Afar	69
Amhara	570
Oromia	1,045
Somali	215
Benishangul Gumz	66
Central Ethiopia	126
Southwest Ethiopia	111
Sidama	85
South Ethiopia	356
Gambella	30
Harar	13
Dire Dawa	25
Addis Ababa	147
Total	3,014

To monitor ambulance services, a dashboard was developed, and 100 professionals were trained in Basic Life Support and Prehospital Trauma Care where dispatch centers exist. A total of 544,527 ambulance dispatches were reported during the fiscal year nationally.

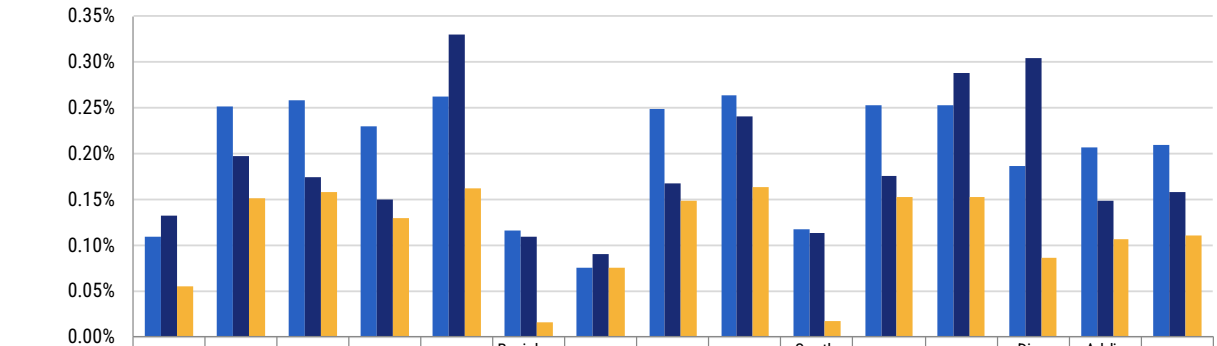
5.2. Facility-based Emergency, Injury and Critical care Services

A web-based patient referral service has been launched in Addis Ababa hospitals to improve referrals between facilities under the national tiered health structure. The National Patient Referral Guideline has been updated, training manuals prepared, and a forum on the Outbound Patient Referral Directive was held for 120 medical board members. Additionally, a digital outbound board referral-authentication

system was developed, integrated with the MESOB one stop service center, and is now providing board authentication services.

The Basic Emergency Care (BEC) toolkit and key WHO registration forms are now fully digitized and integrated with Electronic Medical Records in 40 hospitals. Sixteen hospitals with high emergency mortality rates are implementing quality improvement projects. WHO's standard BEC training and toolkit were introduced in 46 facilities (23 health centers, 23 hospitals). Facilities meeting Emergency Department Leveling standards rose from 70 to 100 in 2017 EFY. Additionally, 50 professionals received Training of Trainers in Pediatric Emergency across different regions.

Mortality occurring within the first 24 hours of emergency department admission is regarded as a good quality metric, with an optimal rate below 0.6%. In 2017 EFY, the national emergency mortality rate was documented at 0.16%. Of these cases, males accounted for 59% of deaths, and females comprised 41%. Furthermore, individuals aged 15 years and older represented 71% of deaths. Among the 15,300 emergency room deaths, 10,538 (69%) happened within the initial 24-hour period. Emergency room mortality has decreased slightly from last year but remains above the target. In the fiscal year, there were over 6.6 million emergency visits, with only 5% staying longer than 24 hours—a 1% improvement from 2016 EFY.



	Tigray	Afar	Amhara	Oromia	Somali	Benishangul G	Central Et	South Et	Sidama	South West	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline %	0.11%	0.25%	0.26%	0.23%	0.26%	0.12%	0.08%	0.25%	0.26%	0.12%	0.25%	0.25%	0.19%	0.21%	0.21%
Performance %	0.13%	0.20%	0.17%	0.15%	0.33%	0.11%	0.09%	0.17%	0.24%	0.11%	0.18%	0.29%	0.30%	0.15%	0.16%
Target %	0.06%	0.15%	0.16%	0.13%	0.16%	0.02%	0.08%	0.15%	0.16%	0.02%	0.15%	0.15%	0.09%	0.11%	0.11%

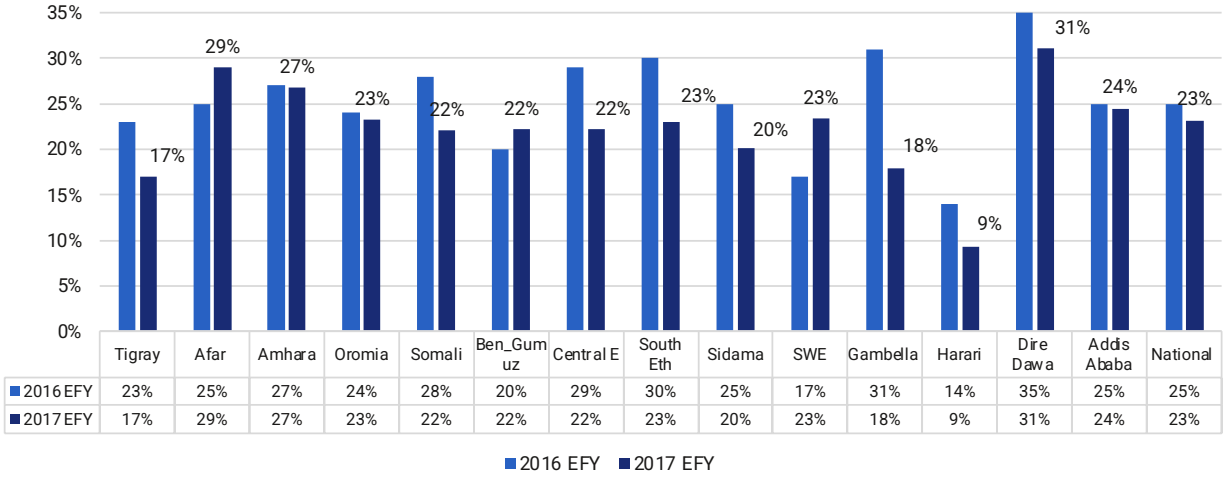
Figure 55: Emergency mortality Rate by Region, Baseline, Performance and Target, 2017 EFY

Critical Care: The need for critical care medicine is continually increasing, leading to a focus on expanding access to and improving the quality of Intensive Care Unit (ICU) services within the national Emergency and Critical Care Strategic Plan. Mentorship and coaching were provided by critical care specialists to 65 hospitals, including newly established ICUs and existing ones requiring support, using the "Hub and Spoke" hospital linkage model. As a result, over 500 professionals received on-the-job training.

Tele-ICU (remote consultation) services have been successfully operationalized in three facilities: Hiwot Fana Specialized University Hospital, Jigjiga University Sheikh Hussen Yebere Hospital, and Arba Minch General Hospital. Through the World Bank, essential medical supplies for ICU services were procured for 60 hospitals. These supplies have been distributed to 30 of the facilities, while the remaining 30 is pending distribution.

The national ICU mortality rate is 23%, down two percentage points from last year. Most ICU deaths (56%) involved mechanical ventilation. Dire Dawa has the highest ICU mortality at 31%, followed by Afar (29%), Amhara (27%), and Addis Ababa (24%), with other regions at or below the national average. Most regions saw mortality rates drop from 2016 to 2017—Harari had the largest decline (18% to 9%), while Tigray, Gambella, and Dire Dawa showed notable decreases.

Poisoning care services have been strengthened through a clinical toxicology ToT for 50 professionals and a multi-sectoral workshop on toxic substance management with key stakeholders.



	Tigray	Afar	Amhara	Oromia	Somali	Ben_Gumuz	Central E	South Eth	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
2016 EFY	23%	25%	27%	24%	28%	20%	29%	30%	25%	17%	31%	14%	35%	25%	25%
2017 EFY	17%	29%	27%	23%	22%	22%	22%	23%	20%	23%	18%	9%	31%	24%	23%

Figure 56: Intensive Care unit mortality rate by region, 2016 EFY and 2017 EFY

Road Traffic Injuries: At a national level, 222,795 road traffic injuries were reported during the 2017 fiscal year, representing a decrease compared to the preceding two years, which saw totals of 306,390 and 233,617 respectively.. In 2017 EFY, motorcyclists accounted for 27% of those injured, vehicle occupants comprised 24%, and pedestrians made up 13%. These statistics underscore the importance of implementing targeted safety measures to enhance road safety for all groups.

Through the third-party insurance fund service, 1,000 health facilities are now providing emergency medical treatment for individuals affected by road traffic accidents. During the fiscal year, 40 million ETB was distributed to these health facilities for delivering the service.

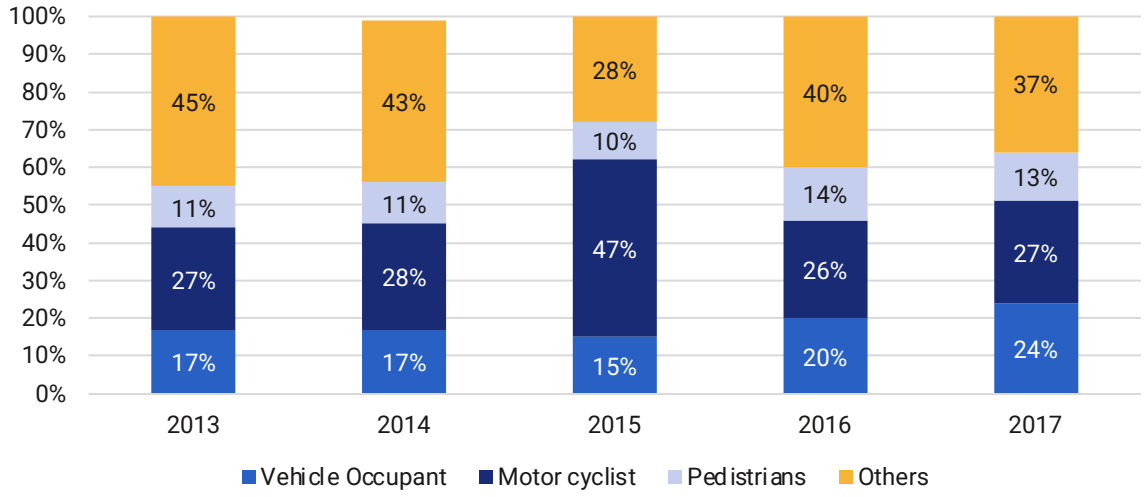


Figure 57: Road Traffic Injuries by type and year, 2013 to 2017 EFY

5.3. Hospital and Diagnostic Services

Enhancing laboratory services, implementing hospital reforms, expanding access to surgical care, improving medical oxygen services, and strengthening nursing and infection control programs are key activities to strengthen hospital and diagnostic services in 2017 EFY. Here are the key achievements in each area

Diagnostic Services: The Five-Year National Strategic Plan for Diagnostic Services has been developed, approved, and launched. Additionally, a training package on "Quality Management in Diagnostics" has been created. In EFY 2017 turnaround time for critical tests reached 80% and 87% for laboratory and pathology tests at the health facility level.

Hospital Service Improvement initiatives: The Ethiopian Hospital Alliance for Quality (EHAQ) program was revitalized to facilitates resource sharing, mentorship programs, and knowledge exchange. Recently the program involved 73 coordinating hospitals and connects over 1,100 stakeholders through established communication platforms. Efforts are underway to conclude the 4th cycle and initiate the 5th, with guidelines developed for documenting and sharing ten best practices. The revised Ethiopian Hospital Service Transformation Guideline (EHSTG) guidelines, along with an assessment checklist and training manuals, have been completed. To support implementation, integrated supervision and follow-up visits were conducted, and a Training of Trainers course was provided to 210 professionals. National implementation has improved, with average scores rising from 33% to 68.4%. The Hospital Service Performance Monitoring for Improvement (HSPMI) Implementation efforts include two rounds of supportive supervision and follow-up visits at RHBs and selected hospitals, training 280 professionals on HSPMI guidelines, and compiling key data into a Fact Sheet from all regions.

Enhancing Access and Quality of Surgical and Anesthesia Care: During the fiscal year, "Day Care Surgery" services were launched at ten hospitals. Collaborative initiatives with international medical teams contributed to the reduction of surgical waiting lists by facilitating over 2,085 procedures, as well as supporting skills transfer and the donation of medical supplies. The Surgical Quality Improvement Program provided capacity-building training to 50 surgical professionals. Over the same period, a total of 451,427 major surgeries were performed, with 44% classified as elective and 56% as emergency procedures. This represents a 13% increase in the total number of surgeries compared to the previous year. The average number of days a patient delayed for surgery is 13.6 in the fiscal year.

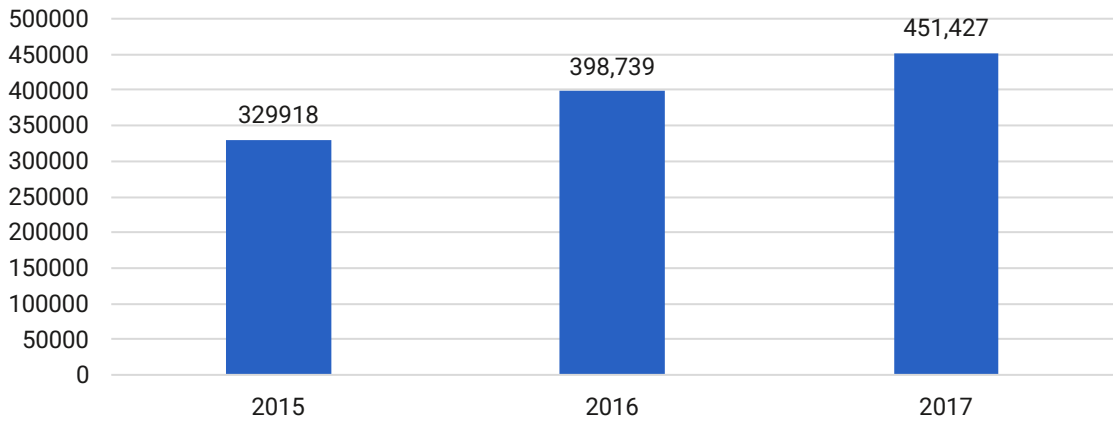


Figure 58: Number of major Surgeries Conducted between 2015 EFY and EFY 2017 EFY

Expanding Medical Services for Birth Defects: To address congenital anomalies such as clubfoot, cleft lip and palate, spina bifida and hydrocephalus, a national strategic document and clinical guideline were developed, supportive supervision conducted, capacity building delivered, new services launched in several hospitals. During the nationwide Birth Defects Week campaign, 1,218 children were treated from surgical waiting lists, and a total of 6,628 patients received treatment during the fiscal year.

Strengthening equitable access and quality of medical oxygen services: The initiative strengthens medical oxygen access and quality by implementing an operational guideline across 10 regions, commissioning ten new oxygen plants (bringing the national total to 58 facilities and annual capacity to 724,168 m3, ~120,695 standard cylinders), celebrating World Oxygen Day with the inauguration of Adama Hospital's plant, delivering a training of trainers on rational oxygen use to 60 professionals, and finalizing a pocket guide for oxygen therapy administration.

Strengthening the Nursing and Midwifery Service: To strengthen nursing and midwifery care, a comprehensive "Change Package" of interventions is being piloted in 20 hospitals. National compliance with nursing care standards has significantly increased from 38.8% to 68.1%..

OPD Attendance Per Capita

Outpatient Department (OPD) attendance per capita in Ethiopia showed a strong and consistent increase between 2013 EFY and 2017 EFY. The rate nearly doubled, increasing from 1.09 visits per person to 2.08 visits per person. This key indicator, which measures the average number of outpatients visits an individual makes in a year, saw an overall increase of approximately 91% over the five-year period, reflecting a significant rise in the use of healthcare services across the country or improvement in reporting.

In the fiscal year, there were more than 233.8 million OPD visits, among which females made up 53%, while males accounted for 47%. Children under five comprised 27% of visits, and adults 66 or older just 6%, consistent with last year's trend. Most OPD visits were attended at Health Centers (47.5%) and Health Posts (31.9%), highlighting PHCU as primary care providers. Hospitals saw 16.4% of attendance and clinics 4.3%, a 1.4-point increase from previous years.

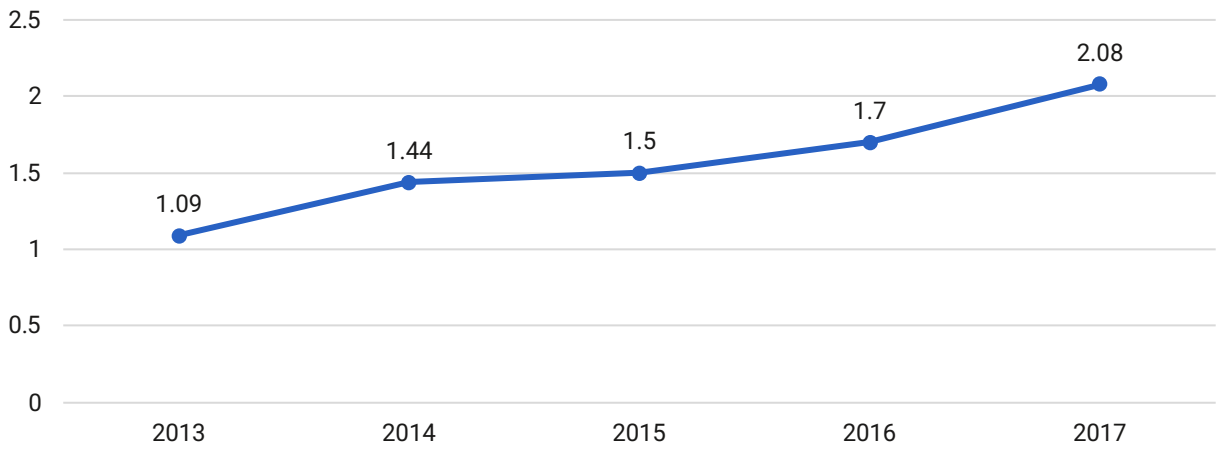
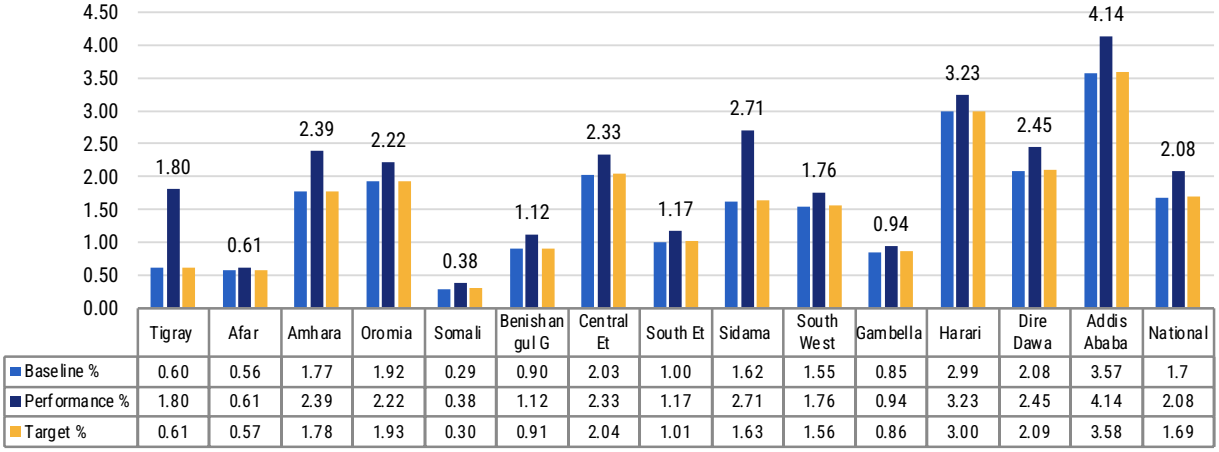


Figure 59: OPD attendance per capita, 2013 EFY -2017 EFY

As shown in the figure below, the highest OPD attendance per capita is in urban areas. Addis Ababa had an exceptionally high rate of 4.14 visits per capita, more than double the national average. Other strong performers included Harari (3.23), Sidama (2.71), and Dire Dawa (2.45). In contrast, pastoralist regions lagged far behind. The Somali region recorded the lowest rate at just 0.38 visits per capita, followed by the Afar region at 0.61. These rates are less than a third of the national average. The country's most populous regions, Amhara and Oromia, both performed above the national average at 2.39 and 2.22, respectively. Private health facilities contributed 3.4% to national OPD attendance, up from 3% the previous year.

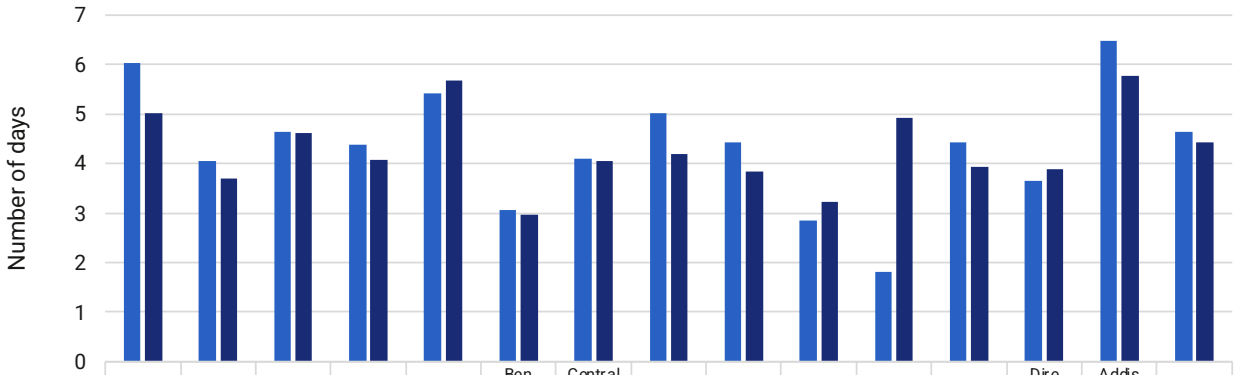


	Tigray	Afar	Amhara	Oromia	Somali	Benishangul G	Central Et	South Et	Sidama	South West	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline %	0.60	0.56	1.77	1.92	0.29	0.90	2.03	1.00	1.62	1.55	0.85	2.99	2.08	3.57	1.7
Performance %	1.80	0.61	2.39	2.22	0.38	1.12	2.33	1.17	2.71	1.76	0.94	3.23	2.45	4.14	2.08
Target %	0.61	0.57	1.78	1.93	0.30	0.91	2.04	1.01	1.63	1.56	0.86	3.00	2.09	3.58	1.69

Figure 60: OPD attendance per capita by region, 2017 EFY

Average Length of Stay

The national average length of stay (ALOS) in hospitals slightly declined from 4.63 days in 2016 EFY to 4.44 days in 2017 EFY, indicating modest improvements in patient turnover and hospital efficiency. Regional patterns, however, varied significantly. Addis Ababa consistently recorded the highest ALOS (5.78 days), followed by Tigray (5.03 days) and Somali (5.68 days), both above five days. In contrast, Benishangul-Gumuz and Harari had relatively short stays, while Gambella experienced a sharp increase from 1.82 to 4.92 days, suggesting notable changes in patient case mix, service availability, or reporting. The mixed trends point to improvements at the national level but highlight the need for region-specific strategies to address disparities in hospital stay durations.



	Tigray	Afar	Amhara	Oromia	Somali	Ben Gumz	Central Et	South Et	Sidama	SWE	Gambella	Harari	Dire Dawa	Addis Ababa	National
2016 EFY	6.03	4.05	4.63	4.39	5.43	3.05	4.11	5.01	4.43	2.84	1.82	4.42	3.64	6.47	4.63
2017 EFY	5.03	3.69	4.62	4.09	5.68	2.98	4.06	4.19	3.84	3.23	4.92	3.95	3.88	5.78	4.44

Figure 61: Average length of stay: Comparison of baseline with performance by region, 2017 EFY

As shown in the figure below, the average length of stay in hospitals varied significantly by hospital type from 2013 to 2017 EFY. Referral hospitals consistently had the longest average stays, peaking at 6.5 days in 2016, likely due to handling more complex cases. General hospitals showed a stable trend with a slight increase over the period, while primary hospitals maintained the shortest average length of stay, remaining between 3.5 and 3.8 days. This data suggests a clear correlation between the complexity of cases handled by a hospital and the average duration of a patient's stay.

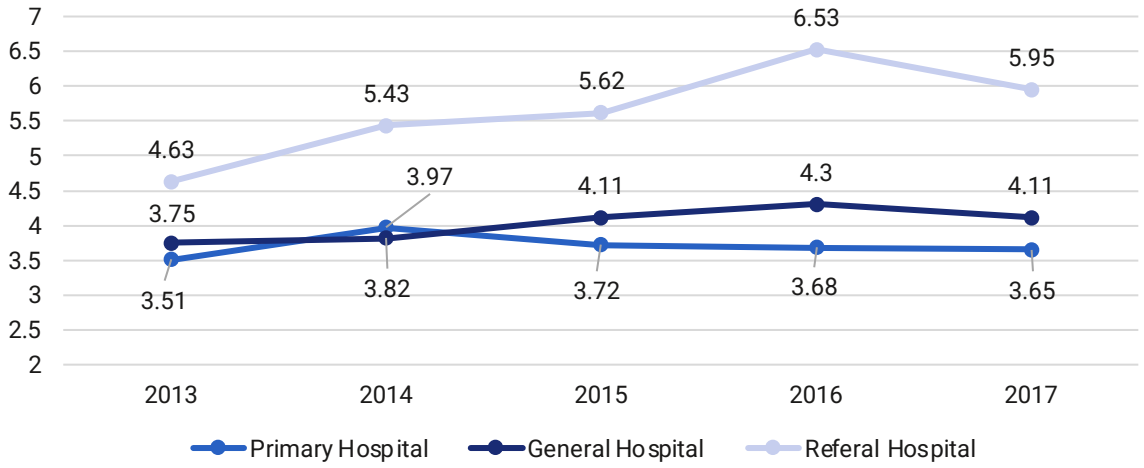
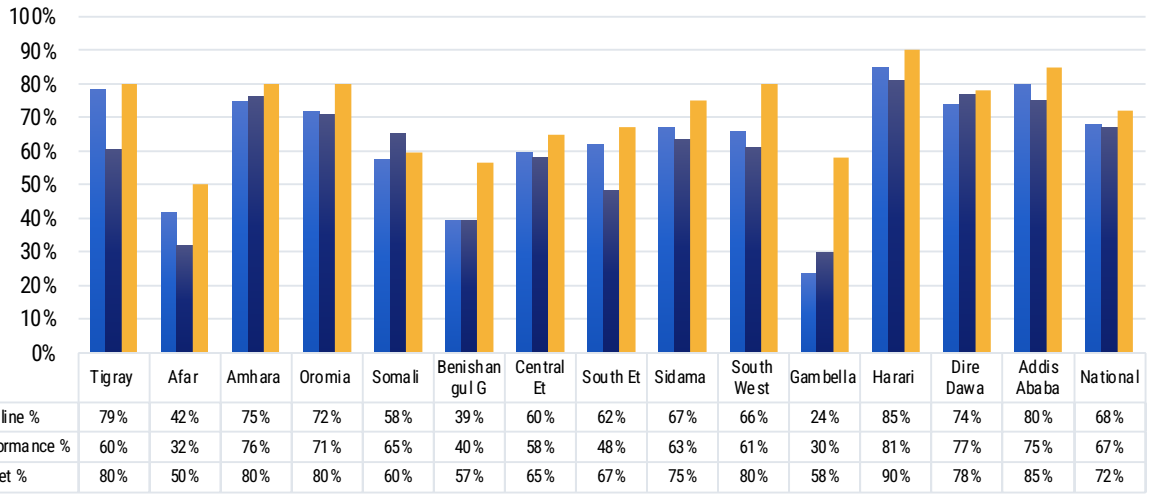


Figure 62: Average length of stay by hospital type, 2013 to 2017 EFY

Bed Occupancy Rate

Bed occupancy rate (BOR) is a key indicator of hospital efficiency, measuring the percentage of available beds that are occupied over a given period. In 2017 EFY, Ethiopia's national bed occupancy rate for public hospitals was 67%, which fell short of the 72% national target and previous year's performance of 68%. Regionally, there were significant disparities in performance. Harari region demonstrated the highest efficiency with a bed occupancy rate of 81%. In contrast, regions like Gambella Afar and Benishangul Gumz had the lowest rates at 30% 32% and 40% respectively, indicating substantial underutilization of hospital beds and falling well below their targets. Oromia (71%), Addis Ababa (77%), Amhara (76%), Dire Dawa (77%) and Harari (81%) are the only regions who performed above the regional average. This data highlights a wide variation in bed utilization across different regions, with some regions performing very well while others face significant challenges in filling their hospital beds.



	Tigray	Afar	Amhara	Oromia	Somali	Benishangul G	Central Et	South Et	Sidama	South West	Gambella	Harari	Dire Dawa	Addis Ababa	National
Baseline %	79%	42%	75%	72%	58%	39%	60%	62%	67%	66%	24%	85%	74%	80%	68%
Performance %	60%	32%	76%	71%	65%	40%	58%	48%	63%	61%	30%	81%	77%	75%	67%
Target %	80%	50%	80%	80%	60%	57%	65%	67%	75%	80%	58%	90%	78%	85%	72%

Figure 63: Hospital bed occupancy Rate baseline Performance and Target, 2017 EFY

Bed Density Per 10,000 Population

As shown in the figure below, hospital bed density per 10,000 population in Ethiopia varies by region. The national average is 3.2 beds per 10,000 people showing an improvement from previous year's 2.74 beds/10,000 population. Some regions have higher densities, with Harari at 14.3, Addis Ababa at 10.6, and Dire Dawa at 9.0, all above the national average. Other regions, such as Somali and Southwest Ethiopia, have lower densities at 2.0 beds per 10,000 population, while Afar (2.4) and Oromia (2.6) also remain below the national average.

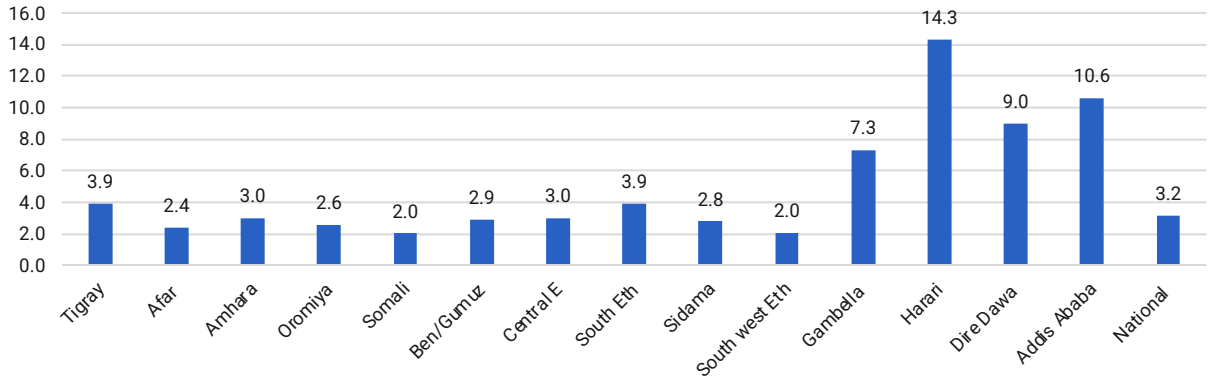


Figure 64: Hospital Bed Density per 10,000 Population by Region, 2017 EFY

Admission Rate and Inpatient Mortality Rate

The 2017 report showed that the national inpatient admission rate was 17.7 per 1,000 population, with regional variation ranging from 11.3 to 84.5. Compared to EFY 2016, the national admission rate increased by 4.5 admissions per 1,000 population. Harari recorded the highest rate at 84.4, followed by Addis Ababa at 58.8. The national inpatient mortality rate was 1.5%. Recommendations include improving access and admissions in underserved regions and continuing to monitor mortality rates and care quality as admission rates change.

5.4. Specialty and Subspecialty Services

Through the provision of targeted professional support tailored to facility preparedness, 14 new specialty services were introduced in 8 hospitals during EFY 2017. According to a comprehensive survey assessing specialty and sub-specialty service availability against national standards, the current national coverage for specialty services stands at 60.65%. This includes 57.36% in Primary Hospitals, 73.1% in General Hospitals, and 51.5% in Tertiary Hospitals. TOT was conducted in Ophthalmology, Dermatology, Palliative Care, and Forensic Medicine. A national clinical guideline for Neurology services was also developed.

Medical and Wellness Tourism: To make Ethiopia a medical and wellness tourism destination the national strategic roadmap for Medical and Wellness Tourism and its implementation guideline have been launched and introduced to stakeholders, and a branding framework for "Ethiopian Medical and Wellness Tourism" has been developed to guide marketing. Key advancements in specialty services include new hip and knee replacement services, interventional cardiology services, neurosurgery and gastrointestinal surgery. In addition, nuclear medicine and telemedicine services with a range of laboratory tests are being expanded.

5.5. Rehabilitation Services

Strengthening and expanding assistive technology production and services is an initiative to make services accessible for citizens with disabilities by boosting local production and provision of assistive technologies. In 2017 EFY, different activities were conducted to establish a system for duty-free importation of raw materials, mentorship programs conducted at 17 governmental and non-governmental rehabilitation centers and a new training manual and clinical guideline for Prosthetics, Orthotics, and Physiotherapy services were developed. A nationwide assistive technology awareness conference was held in Assosa, Benishangul-Gumuz region that concluded with a grand celebration and the launch of a rehabilitation campaign attended by high-ranking MOH officials and the production and national distribution of various assistive devices through rehabilitation centers was also conducted.

Through EPOS, various components of assistive devices, such as support maneuvers, assistive and body-support joints, wheelchairs, crutches, walkers, CP chairs, physiotherapy motion devices, and prosthetic components (including feet, knees, hands, concave and convex discs), were manufactured and supplied to 15,472 individuals requiring body support. Besides EPOS, other centers nationwide have also manufactured and distributed a total of 41,102 assistive devices.

Nationally, 41% of general hospitals and 85% of tertiary hospitals provide physiotherapy services, while only three hospitals in the entire country currently provide Speech Therapy and Audiology services. Assistive technology provision includes wheelchair services at 15 hospitals, hearing aids at 4 hospitals (2 general and 2 tertiary), and vision aids at 7 hospitals (3 general and 4 tertiary). For integration of rehabilitation medicine services into Primary Health Care Units, a new training curriculum was developed.

Challenges [Medical health services]

- Delay in release and shortage of budget
- Security problems in different parts of the country
- Shortage of trained workers at health institutions
- Lack of awareness by patients and families about the available rehabilitation services

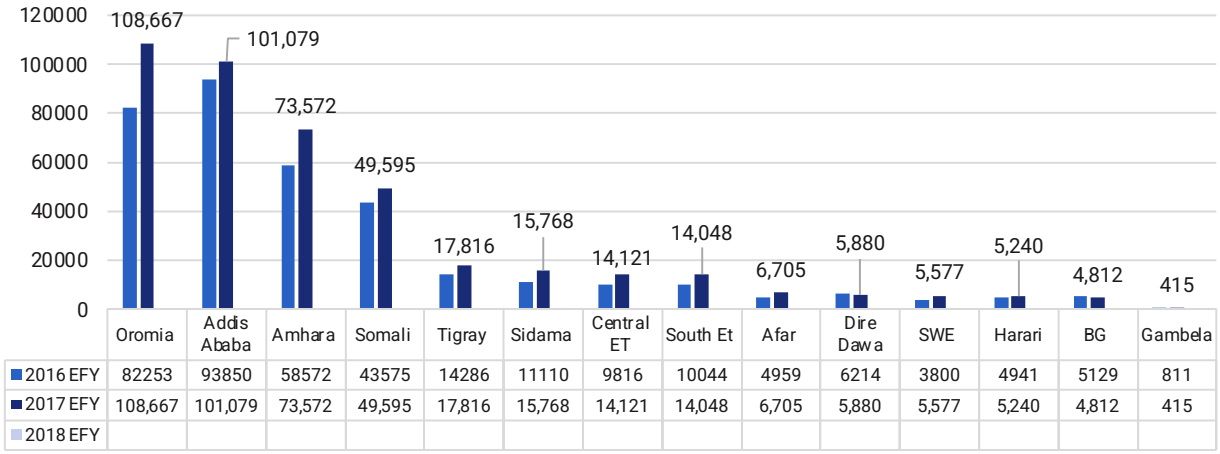
Way Forward – medical health services

- Expand service locations and hours to reach more patients, especially in underserved areas
- Adopt evidence-based practices and standardized treatment protocols to enhance recovery rates and patient satisfaction
- Promote teamwork among healthcare providers through regular training and joint case management meetings
- Create comprehensive educational materials and programs to educate patients and families about rehabilitation processes and available resources

5.6. Blood and Tissue Bank Services

Blood Donation: In 2017 EFY, 423,295 units of whole blood were collected, achieving 83% of the planned 513,031 units. Of these, 99% were from voluntary donors. This represents a 21% increment from the previous year's total of 349,360 donations nationally.

In 2017 EFY, Oromia region had the highest number of donations at 108,667, followed by Addis Ababa with 101,079 and Amhara with 73,572. While most regions saw an increase in donations from EFY 2016 to EFY 2017, some regions like Dire Dawa, Gambella, and Benishangul-Gumuz experienced a decrease.



	Oromia	Addis Ababa	Amhara	Somali	Tigray	Sidama	Central ET	South Et	Afar	Dire Dawa	SWE	Harari	BG	Gambela
2016 EFY	82253	93850	58572	43575	14286	11110	9816	10044	4959	6214	3800	4941	5129	811
2017 EFY	108,667	101,079	73,572	49,595	17,816	15,768	14,121	14,048	6,705	5,880	5,577	5,240	4,812	415
2018 EFY														

Figure 65: Number of units of blood collected by regions, 2016 EFY and 2017 EFY

A total of 56 blood banks participated in blood collection during the fiscal year, with varied performances. In Oromia, several blood banks excelled, with Ambo exceeding its plan by 18% and Sheger by 12%. The Bahir Dar blood bank in Amhara also performed well, surpassing its plan by 3%. Somali region had a notable achievement, collecting 49,595 units and exceeding its adjusted annual plan by 1%. Conversely, some regions fell short of their targets; South Ethiopia collected only 56% of its plan, and Benishangul-Gumuz reached 60% of its goal. The lowest performance was in Gambella, which collected just 415 units, achieving only 14% of its annual plan.

Table 19: Number of units of blood collected by blood banks and regions, 2017 EFY

Region	Blood Bank	Annual plan	Annual Performance	
			Units of Blood Collected	Percent
Addis Ababa	**EBTBS**	**128,000**	**101,079**	**79%**
Tigray	Mekele	12,000	8,973	75%
	Axum	8,000	5,243	66%
	Maichew	3,000	1,410	47%
	Adigrat	3,000	2,190	73%
	Tigray Total	**26,000**	**17,816**	**69%**
Amhara	Bahir dar	20,789	21,431	103%
	Gonder	13,266	13,001	98%
	Dessie	14,624	10,735	73%
	D/Markos	9,146	8,169	89%
	D/Birhan	9,500	8,351	88%
	D/Tabor	6,200	4,604	74%
	Woldiya	4,970	3,687	74%
	Sekota	3,350	1,118	33%
	Metema	3,500	1,314	38%
	Kemisie	3,350	1,162	35%
	Amhara Total	**88,695**	**73,572**	**83%**
Oromia	Adama	24,000	22,163	92%
	Jima	13,000	11,257	87%
	Nekemte	8,000	5,953	74%
	Woliso	7,000	6,567	94%
	Bale Goba	8,000	6,822	85%
	Chiro	6,000	4,078	68%
	Metu	7,000	5,864	84%
	Shashemene	9,000	9,294	103%
	Bule Hora	6,000	5,322	89%
	Negele	4,500	3,851	86%
	Ambo	7,000	8,256	118%
	Sheger	10,000	11,186	112%
	Maya	5,000	4,806	96%
	Gimbi	3,000	3,248	108%
	Oromia Total	**117,500**	**108,667**	**92%**
Central Ethiopia	Hossana	12,431	11,235	90%
	Butajira	3,000	2,886	96%
	Central ET Total	**15,431**	**14,121**	**92%**
South Ethiopia	Arba Minch	9,000	6,502	72%
	W/Sodo	8,000	4,427	55%
	Dila	4,000	1,350	34%
	Jinka	4,000	1,769	44%
	South Et Total	**25,000**	**14,048**	**56%**
S.West Ethiopia	Bonga	3,700	3,422	92%
	Tercha	3,000	2,155	72%
	SWE Total	**6,700**	**5,577**	**83%**

Region	Blood Bank	Annual plan	Annual Performance	
			Units of Blood Collected	Percent
Sidama	Hawassa	14,000	10,708	76%
	Yirgalem	5,000	5,060	101%
	Sidama Total	**19,000**	**15,768**	**83%**
B.Gumuz	Asossa	5,000	3,938	79%
	Gilgel	3,000	874	29%
	BG Total	**8,000**	**4,812**	**60%**
Afar	Semera	6,000	3,919	65%
	Awash	6,000	2,786	46%
	Afar Total	**12,000**	**6,705**	**56%**
Somali	Jigjiga	26,000	24,771	95%
	Gode	7,000	6,104	87%
	Hargele	3,400	2,577	76%
	Fike	3,000	2,532	84%
	Biki	3,500	3,138	90%
	Wardher	3,405	2,877	84%
	Gashamo	3,000	2,102	70%
	Kebridhar		1,390	
	Gerbo		2,597	
	Filtu		1,507	
	Somali Total	**49,305**	**49,595**	**101%**
Gambella	Gambella	3,000	415	14%
Harari	Harar	7,200	5,240	73%
Dire Dawa	Dire Dawa	7,200	5,880	82%
Total		513,031	423,295	83%

POST DONATION COUNSELING SERVICE: Providing post-donation counseling services (PDCS) is essential for monitoring transfusion-transmissible infections and for encouraging and supporting donors to seek treatment or healthier lifestyles; in 2017 EFY a total of 105,780 (25%) blood donors received PDCS, showing a significant increase compared to previous years when only 7.2% donors received such services.

BLOOD COMPONENT PRODUCTION: During the year, 59,387 (14% of the total donated blood; and 21% from the plan) whole blood units were processed into blood components. Of these, 38,092 units were converted at the Ethiopian Blood and Tissue Bank Service in Addis Ababa. This indicates limited performance in other blood banks for component production, impacting the availability of blood component therapy to health facilities in their areas.

Table 20: Number of units of blood converted to blood components, 2017 EFY

Blood Component	Unit of Blood
Whole Blood separated into components	59,387
Concentrated Red Cells (CRC)	54,131
Platelet	51,133
Fresh Frozen Plasma (FFP)	50,920
Cryoprecipitate	86

LABORATORY TESTING: All blood units collected, 423,295 (100%), were screened for the four-transfusion transmitted infectious diseases (TTIs) namely HIV, Hepatitis B, Hepatitis C and Syphilis per national standards. The performance of blood donation screenings for TTIs showed an increase in both volume and positivity rates from 2016 EFY to 2017 EFY. The proportion of donors with at least one TTI increased from 3.23% in 2016 EFY to 4.2% in 2017 EFY. This trend of increasing positivity rates was consistent across all four types of infections tested. This result may be an indication of a potential rise in the prevalence of these infections within the donor population or a shift in the donor demographics and needs further study.

Table 21: Proportion of blood donors tested for transfusion transmitted infections, 2017 EFY

Name of Transfusion Transmissible infection (TTI)	Total Units of Blood Tested	Tested positive for TTIs	
		Number	Percent
HIV positive	423,295	2,459	0.58%
Hepatitis B positive	423,295	6,978	1.7%
Hepatitis C positive	423,295	3,563	0.8%
Syphilis positive	423,295	4,865	1.2%
Total TTIs positive		17,865	4.2%

QUALITY ASSURANCE AND SAFETY SERVICES: The Ethiopian Blood and Tissue Bank Service (EBTBS) maintains safe, quality-assured blood through daily quality control, internal audits across the transfusion chain, Internal quality control programs and regional mentorship. An AfSBT workshop in Adama and WHO-supported good manufacturing practice (GMP) training strengthened managers and staff involved in component preparation. EBTBS and 24 regional banks joined EPHI-led External Quality Assessment (recently affected by partner-support gaps); EBTBS supplies National Quality Assurance Scheme (NQAS) samples to seven automated TTI labs biannually, which performed well.

Both existing and new SOPs and manuals were reviewed with updates pending approval. Equipment maintenance, new installations, calibration of 68 devices by the Ethiopian Metrology Institute and training for 20 regional biomedical engineers were completed. Regular health/environmental safety assessments and Hepatitis B vaccination for high-risk staff were successfully implemented.

APPROPRIATE CLINICAL USE OF BLOOD: Blood service is provided in 741 transfusing facilities and supplied 409,516 of 498,699 requested units (82.1% nationwide). Addis Ababa improved disposition-form return rates from 31% in 2016 to 42% in 2017, while regional blood banks lagged at 16%, exposing gaps in compliance and reporting.

The national center in Addis Ababa received 30 reports of transfusion reactions; 14 were confirmed attributable to transfusion and all 14 were appropriately managed. Reporting on transfused units remains very limited, indicating a need to strengthen the hemovigilance system.

Two key guidelines to strengthen Ethiopia's blood transfusion system—the updated Appropriate Clinical Use of Blood and Blood Products guideline and the new Blood Bank Emergency Preparedness and Response guideline—were finalized this year; both have completed thorough reviews and are ready for nationwide implementation to improve routine blood use and emergency response across all healthcare facilities.

EYE BANK AND CORNEA TRANSPLANT SERVICE: In 2017 EFY the Eye Bank of Ethiopia harvested a total of 355 corneas, of which 269 corneal units were processed and sent to health facilities for transplant.

The eye bank staff were trained, with experts from India, on local preparation of amniotic membrane for corneal transplant—a procedure not previously conducted in Ethiopia—and have successfully prepared 81 amniotic membrane preparations locally. The Eye Bank Service also conducted graft outcome surveys quarterly for all transplanted units and ensured all corneal units for transplantation were tested and found safe from HIV, HBV, HCV, syphilis and COVID-19.

Internal quality control according to international standards and quarterly environmental monitoring of the Eye Bank Laboratory were conducted; following assessment, the eye bank received international recognition and a certificate valid for three years.

Challenges [Blood and tissue services]

- Supply-demand gap in blood and blood components due to limited donor base, poor repeat donor retention rates, and seasonal fluctuations
- Inappropriate clinical practices including misuse of blood products and weak quality management systems across blood bank operations
- Absence of regulatory oversight with no national framework and standardized infrastructure guidelines for blood banking facilities.
- Poor coordination and standardization across regional blood banks, eye banks, and the Hospital-Based Cornea Retrieval Program.
- Inadequate infection prevention and control implementation throughout blood banking facilities.
- Insufficient operational infrastructure including manual data management systems and inadequate budget allocation for operations and mobile collection services

Way forward

- Strengthen donor mobilization and retention through enhanced community awareness campaigns, establishing more blood donor clubs, and implementing the National Donor Motivation and Retention Strategy.
- Improve clinical practices and quality systems by promoting appropriate blood use, implementing Patient Blood Management, building quality culture across departments, and introducing advanced testing methods.

- Establish regulatory framework and standardization to create national oversight, implementing ISBT 128 labeling system, and developing unified organizational structures for regional blood banks
- Enhance coordination and specialized programs by rolling out the National Blood System Strengthening Project, improving Hospital-Based Cornea Retrieval Program effectiveness, and strengthening eye bank services
- Develop integrated information systems through expanding Blood Safety Information System to all facilities, implement Enterprise Resource Planning system, and create dedicated Eye Bank Information System.
- Optimize resource utilization and infrastructure by developing national infrastructure standards, converting surplus plasma into medicinal products, and preparing investment cases to mobilize resources for blood and transplant services.

5.7. Laboratory Capacity

During the 2017 EFY, several key interventions were implemented to strengthen the national and regional laboratory systems and services, focusing on quality improvement, capacity building, equipment tracking, and emergency preparedness.

Accreditation Support: Support was provided to 20 selected laboratories to work toward ISO 15189 and/or ISO 17025 accreditation and as a result they got international ISO accreditation. These efforts were coordinated in collaboration with EFDA and EPHI, including targeted mentorship and resource support. The following table shows the list of ISO 15189 accredited health institutions.

Table 22: List of ISO 15189 accredited health institutions, 2017 EFY

Region	Name of institutions where the laboratory is accredited
Harari	▪ Adare Hospital
Addis Ababa	▪ Addis Ketema Health center ▪ Kolifie Health Center ▪ Zewuditu Memorial Hospital ▪ Eka kotebie Hospital ▪ Meshualekia Health Center
South Ethiopia	▪ Ariba Minch Hospital ▪ Ariba Minch branchi Laboratory Center
Sidama	▪ Yirgalem Hospital
Afar	▪ Afar PHI
Southwest Ethiopia	▪ Mizan Aman hospital
Amhara	▪ Debre Birhan Hospital ▪ Woldia hospital ▪ Deneba Hospital, ▪ St Lalibela Hpspital ▪ Debark Hospital ▪ Tibeb Goin Hospital
Oromia	▪ Nekemitie Hospital ▪ Nekemitie regional branch laboratory ▪ Limu Genet hospital ▪ Bale robe hospital

In addition, 15 regional-level laboratories advanced in the implementation of quality management systems. Their progress was closely monitored and supported by using the Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) standard. As a result, these laboratories achieved accreditation at Level III, demonstrating significant improvement in laboratory quality, reliability, and compliance with international standards

Laboratory Mentorship and Supervision: A total of 21 laboratories received direct mentorship and supportive supervision, conducted jointly by EPHI and EFDA, aiming to enhance the quality management systems of public health laboratories and improve readiness for accreditation.

Equipment Tracking and Management: In response to the growing demand for improved laboratory asset management, a national-level laboratory equipment mapping and gap assessment was carried out across 10 regional laboratories. The findings are being used to inform future planning and budgeting.

Laboratory Quality Assurance: In collaboration with regions, laboratory Quality management system (basic LQMS) was launched and 75% of Health centers were reached.

Emergency Preparedness and Response: EPHI conducted multiple supportive supervision visits and distributed essential laboratory supplies (e.g., reagents, sample collection kits, PPE) to ensure preparedness for public health emergencies. Additionally, rapid outbreak response support was provided to regions affected by Monkeypox and Dengue fever outbreaks.

Essential laboratory tests at health facilities: Availability of essential laboratory tests is a foundation of effective healthcare delivery, enabling accurate diagnosis, and timely treatment. Between 2016 EFY and 2017 EFY, availability of essential laboratory tests has increased from 17% to 29% for Health Centers and from 47% to 52% for Hospitals.

Table 23: Availability of essential laboratory tests by facility type, 2017EFY

Region	Health Centers		Hospitals	
	2016 EFY	2017 EFY	2016 EFY	2017 EFY
Tigray	10%	16%	31%	37%
Afar	6%	11%	23%	45%
Amhara	22%	43%	52%	58%
Oromia	18%	26%	45%	49%
Somali	21%	28%	70%	87%
BG	4%	14%	26%	27%
Central E	13%	22%	45%	51%
South E	7%	13%	43%	54%
Sidama	12%	29%	60%	64%
SWE	5%	13%	29%	30%
Gambella	12%	11%	25%	30%
Harari	25%	43%	75%	81%
DD	65%	81%	45%	34%
AA	39%	53%	49%	51%
National	17%	29%	47%	52%

Chapter 6

Public Health Emergency and Disaster Risk Management

Public Health Emergency Management

Measles Outbreak Response

8,274
cases and 56 deaths due to measles, in 413 Woreda

Measles vaccination campaign done as part of outbreak response

Cholera Outbreak Response

Cholera outbreak was reported from 163 Woredas

11,759
suspected Cholera cases and 119 deaths were reported

236
temporary treatment centers established for Cholera response

More than 3.7 million
population at risk vaccinated

Monkeypox

487
samples have been tested, with 26 confirmed cases

Meningitis

11,723
meningitis cases and 133 deaths were reported

Chapter 6: Public Health Emergency and Disaster Risk Management

Public health emergencies have far-reaching consequences, significantly affecting the livelihoods of communities through increased morbidity and mortality, economic losses, and disruptions to essential life-saving services. Effective public health emergency management is therefore vital to ensure risk-based preparedness, timely early warning, and coordinated response.

In Ethiopia, the Ethiopian Public Health Institute (EPHI) is mandated to lead efforts in establishing a robust system for public health emergency preparedness, early warning, response, recovery, and rehabilitation across the country. Key surveillance and response events and accomplishments are summarized below.

Epidemic Prevention and Control

During the fiscal year, the public health surveillance system responded to multiple priority public health emergencies, including epidemic-prone diseases such as Monkeypox and Malaria, as well as outbreaks of Dengue fever, Pertussis, and suspected cases of Anthrax, Measles, and other reportable conditions. Below is a summary of key surveillance and response performances for each disease and condition.

Cholera

In 2017 EFY, Ethiopia reported 11,759 cholera cases and 119 deaths, showing a decline in cases and deaths compared to the previous year. Although the outbreak persisted in 21 woredas (12.8%) across nine regions, five regions successfully controlled 100% of their outbreaks (BG, South Ethiopia, Somali, Sidama and Tigray successfully controlled it). Surveillance performance improved, with all suspected cases detected within 7 days, 80% reported within 24 hours, and 75% of outbreaks receiving adequate response within 7 days. Of the 163 woredas affected, 77% maintained a case fatality rate below 1%. Response efforts included the establishment of 236 temporary treatment centers and laboratory testing of stool samples, with 303 out of 369 cultures confirming Vibrio cholerae.

A total of 236 temporary Cholera treatment centers were established and operational within the 12-month period. From the affected woredas, 1,196 stool samples were collected, of which 369 underwent culture testing. Out of these, 303 tested positives for Vibrio cholerae. As part of cholera prevention and control, 3.7 million people were vaccinated across 40 affected woredas and IDP sites in Oromia, Afar, Somali, Tigray, Gambela and Amhara regions.

Between 2016 and 2017, Ethiopia saw a marked reduction in cholera cases and deaths, alongside improved surveillance, faster reporting, and stronger outbreak response capacity. While the outbreak spread to more regions, the overall intensity declined, and most woredas maintained CFR below 1%, demonstrating progress in epidemic preparedness and response.

Measles

In the 2017 EFY, measles outbreaks were reported in 140 woredas, with 8,274 cases and 56 deaths recorded. The highest number of measles cases were reported from Oromia, South Ethiopia, and Benishangul-Gumuz regions. When reviewing the vaccination status of reported cases, the majority (over 64%) were found to have not received any measles vaccination.

Monkeypox

Since the first confirmed human case of Monkeypox (Mpox) on May 25, 2025 (Ginbot 17, 2017 E.C), 487 samples have been tested, with 26 confirmed cases. Around 340 individuals were identified as close contacts of confirmed or suspected cases. As of July 7, 2025 (Sene 30, 2017 E.C), Mpox cases have been reported in six regions. One child (21 days old) died, while 24 patients have been treated and reintegrated into their communities. One patient remains under care and is in stable condition.

In response, isolation centers have been established in affected regions, with additional preparedness underway in others. Over 1,300 alerts were received via the 8335 hotline, with appropriate case identification and follow-up. Awareness campaigns have reached millions through radio, TV, print, social media, and religious leaders, with over 9,500 volunteers mobilized and more than 2 million people receiving health education. Medical supplies valued at over 31.5 million ETB have been distributed to isolation and treatment centers in 78 sites across multiple regions to support the ongoing outbreak response.

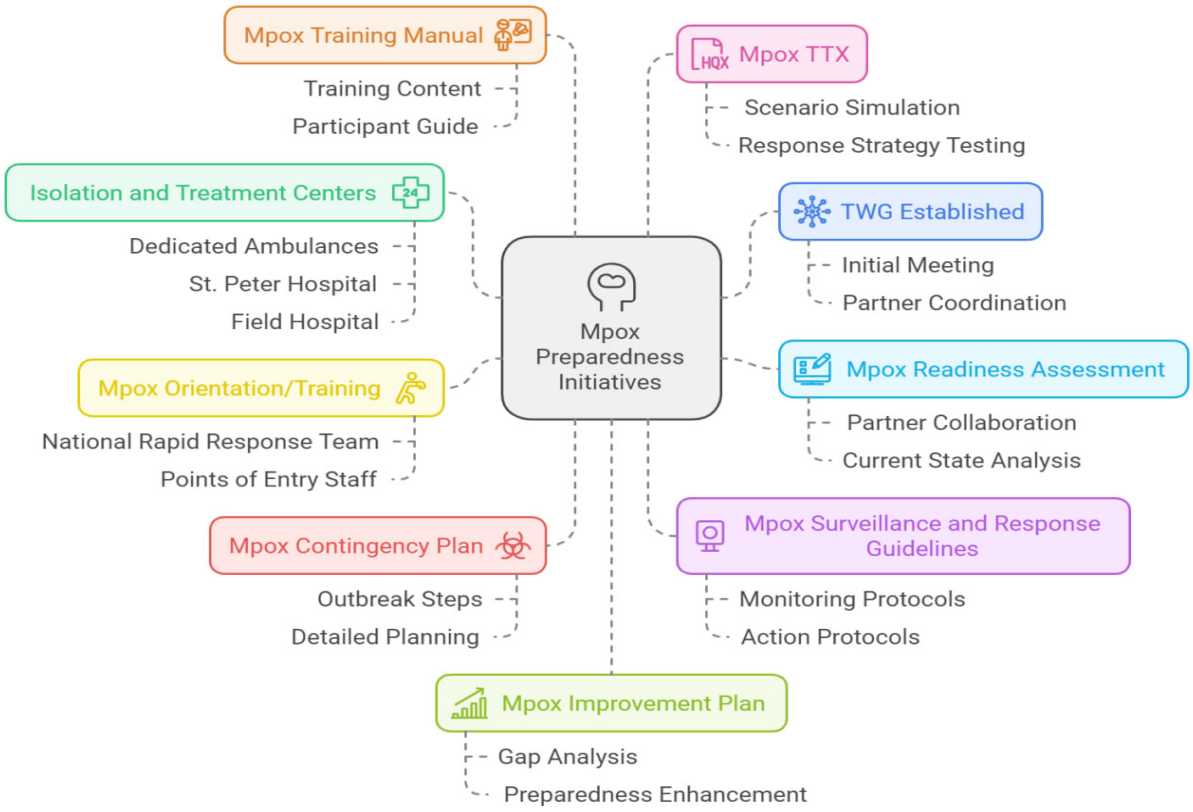


Figure 66: Mpox Preparedness Initiatives and Key Components

Malaria

In the 2017 EFY, a total of 222 high-malaria-burden woredas across 10 regions were prioritized and included in the Integrated Action Plan. The plan was shared with the regional authorities, and its implementation has been monitored. A national-level malaria response readiness assessment was conducted. Additionally, a malaria Incident Management System (IMS) functionality assessment was carried out across all 222 woredas, categorized by cluster levels (regional, zonal, and woreda). Over 685 professionals were trained in case management, more than 140 in laboratory and external quality assurance, and over 125 in vector control and environmental management.

Health facility performance data collected during the malaria response period showed that 1,645 primary health care facilities (HCs and HPs) across the 222 cluster woredas were not functioning for various reasons. These included partial or complete damage from conflict, flooding, or wind; looting or destruction of health infrastructure; health worker displacement due to conflict; shortages of anti-malaria commodities and supplies; and disruption of services. While the pace of facility recovery varies by region, about 38% (632 PHCUs) have resumed service delivery.

Following the establishment of the Malaria Response Emergency Operations Center (EOC), 286 malaria-related deaths were reported from the selected cluster woredas. Out of these, 156 deaths were audited, and the findings were used to recommend corrective actions aimed at preventing similar deaths in the future. In community mobilization efforts, around 997,135 volunteers and 346,883 religious leaders took part in malaria prevention and control activities, while > 49 million people were reached with health education through various approaches.

Overall, during the malaria response, 167 woredas carried out anti-malarial chemical spraying in targeted kebeles, achieving 97% of the annual coverage target and protecting over 5.8 million people. In addition, about 2.2 million insecticide-treated nets were distributed, reaching 99% of the annual target and safeguarding approximately 4.1 million people from malaria. In addition, different anti malaria drugs and test kits procurement and distribution have been done that costs about 1.3 billion ETB.

Polio surveillance

In the fiscal year, 71 vaccine derived polio cases (cVDPV2) were reported and most of them were from Oromia (51), followed by Amhara (5),, Somali (4), Gambella (3), Harari (3), South Ethiopia (2), Tigray (1), BG (1) and Dire dawa (1).

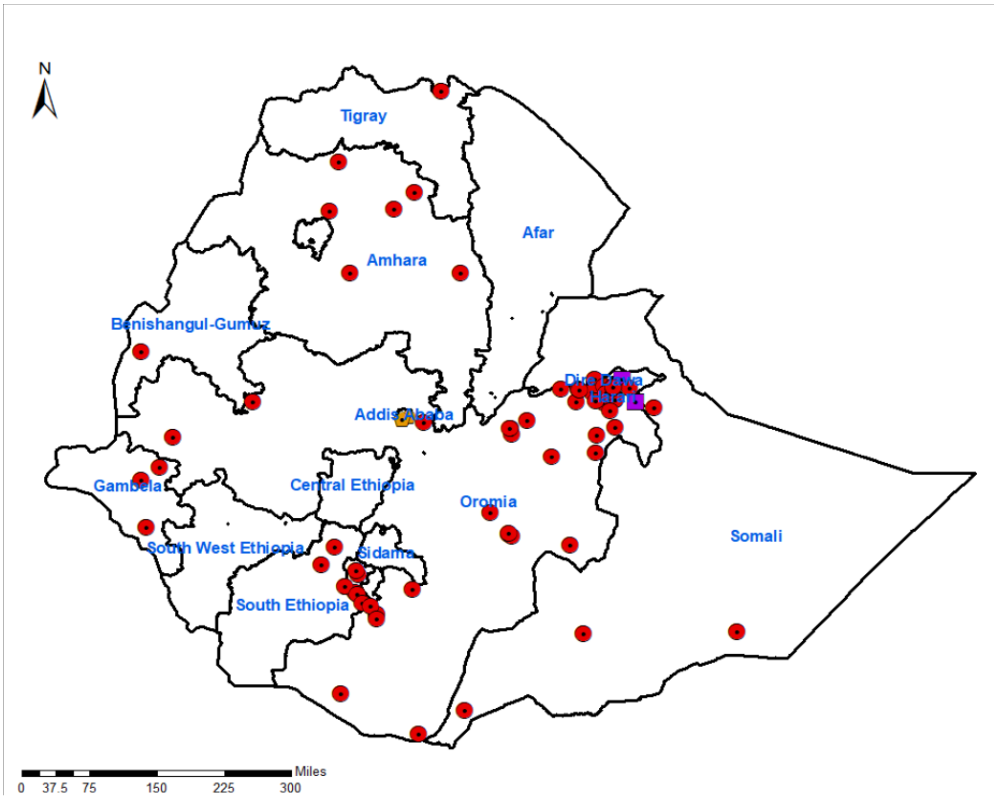


Figure 67: Number of Polio cases (cVDPV2) reported by region 2017 EFY

Polio surveillance was conducted nationwide in line with standards, with two key performance indicators: Non-Polio Acute Flaccid Paralysis (NP-AFP) rate and stool adequacy rate meeting international benchmarks. However, gaps were observed in NP-AFP performance in four regions (Amhara, Gambela, Sidama, and Tigray) and in stool adequacy only in Benishangul Gumuz.

Meningitis

In 2017 EFY, a total of 11,723 meningitis cases and 133 deaths were reported, with a case fatality rate of 1.1%. This reflects a 5% increase in cases compared to the previous year, with the highest increment observed in Tigray (90.7%), Central Ethiopia (72.7%) and Harari (70.7%).

Table 24: Number of meningitis cases and deaths by region, 2017EFY

Region	Cases in 2016 EFY	Cases in 2017 EFY	Difference	Deaths in 2016	Deaths in 2017	Difference
Tigray	182	347	90.7	2	3	1
Afar	266	167	-37.2	4	2	-2
Amhara	1,889	2,371	25.5	62	37	-25
Oromia	3,212	4,377	36.3	13	25	12
Somali	732	796	8.7	0	4	4
BG	130	111	-14.6	8	2	-6
Central Eth	513	886	72.7	5	13	8
South Eth	988	796	-19.4	6	4	-2
Sidama	696	533	-23.4	10	13	3
SWE	456	296	-35.1	13	3	-10
Gambela	89	132	48.3	1	1	0
Harari	123	210	70.7	1	10	9
Dire Dawa	147	144	-2.0	4	5	1
Addis Ababa	643	557	-13.4	12	11	-1
National	**10,066**	**11,723**	**5.0**	**141**	**133**	**-8**

Dengue Fever: Dengue cases were reported from urban woredas, mainly in areas with poor drainage and high mosquito breeding sites. Surveillance remained passive, with limited entomological monitoring and no confirmed outbreak-level clustering. While no deaths occurred, significant gaps were identified in vector surveillance and case-based reporting.

Pertussis: Localized pertussis outbreaks were reported in pastoralist and hard-to-reach zones. Case investigations were conducted, but laboratory confirmation was limited due to challenges in sample transport. The response focused on treatment and community sensitization, though follow-up documentation remained inconsistent.

Anthrax: In 2017 EFY, a total of 3,463 anthrax cases and 24 deaths were reported, marking an 28.9% increase compared to 2016 EFY. The highest case numbers were from Amhara (1,582), Tigray (1,255), Southwest Ethiopia (509), South Ethiopia (80), and Oromia (35), while Addis Ababa and Gambela each reported only one case.

Ethiopia National level Risk Profile

The hazard risk profile shows that cholera/acute watery diarrhea, measles, rabies, and malaria pose

a very high risk, with recurrent threats across the year and seasonal peaks, particularly for malaria in May – June and October - November. Other high-risk hazards include poliomyelitis, mpox, floods, landslides, drought, dengue, Ebola, Marburg, and earthquakes, many of which cluster around the rainy seasons (June–September). Moderate-risk hazards such as meningococcal disease, anthrax, yellow fever, influenza, COVID-19, and Rift Valley fever also show seasonal patterns, with meningococcal disease and yellow fever peaking in early months, and Rift Valley fever and chikungunya appearing toward year-end. Overall, the findings underscore the need for seasonal preparedness, strengthened surveillance, and rapid response capacity to minimize health impacts.

Table 25: Ethiopia National level Risk Profile

S. No	Specific Hazard	Risk Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	Cholera/ Acute Watery Diarrhea	Very high												
2	Measles	Very high												
3	Rabies	Very high												
4	Malaria	Very high												
5	Poliomyelitis	High												
6	Mpox (formerly monkeypox)	High												
7	Flood	High												
8	Landslide	High												
9	Drought	High												
10	Dengue	High												
11	Ebola disease	High												
12	Marburg virus disease	High												
13	Earthquake	High												
14	Meningococcal Disease	Moderate												
15	Pertussis	Moderate												
16	Anthrax	Moderate												
17	Yellow fever	Moderate												
18	COVID-19	Moderate												
19	Pandemic Influenza	Moderate												
20	Chemical Event	Moderate												
21	Conflicts	Moderate												
22	Chikungunya	Moderate												
23	Rift valley Fever	Moderate												

Challenges

- Shortage of skilled personnel
- Delays in procurement processes due to various reasons
- Security problems in some regions affects service delivery and Access

Way forward

- **Outbreak response and surveillance**: Improve sample referral systems and expand regional lab capacity for timely diagnosis, particularly for Monkeypox, Measles, and Anthrax. Contact tracing and follow-up should be made more consistent through training and standardized protocols. Vector control and entomological surveillance need to be better documented and scaled up, especially for Malaria and Dengue.

- **Zoonotic disease response**: Involve stronger multisectoral coordination with animal health sector. Expanding immunization in low-coverage areas and decentralizing lab testing can improve Measles control. Case investigation and foci classification for Malaria need to be scaled up, and cross-border disease coordination should be formalized. Efforts must continue to maintain high reporting performance and rapid response readiness across all levels

- **Strengthen Data Use Culture:** Scale up data-informed platforms across districts to promote regular use of evidence in planning, monitoring, and decision-making. Provide ongoing training and mentorship for health workers on data analysis and interpretation.

- **Enhance Health Systems Performance Monitoring:** Invest in standardized tools and frameworks to track effective coverage and quality of services, especially for maternal, newborn, and child health programs.

- **Expand Genomic and Surveillance Capacity:** Support national laboratories and surveillance systems with resources and training to continue genomic monitoring of emerging and re-emerging diseases, including AMR threats and outbreak-prone infections.

- **Integrate Nutrition and WASH Interventions:** Strengthen multisectoral collaboration to align food fortification, dietary education, and sanitation improvements within broader health and development strategies.

- **Address Health Equity and Vulnerabilities:** Target interventions to underserved populations by prioritizing geographic and socio-demographic equity in health services, nutrition, and disease prevention programs.

- **Institutionalize health technology assessment (HTA) and Research Use:** Formalize the use of HTA and promote policy-relevant research uptake by building capacity among policymakers and fostering strong linkages between researchers and decision-makers

Chapter

7

Health System Capacity and Regulation

Chapter 7: Health System Capacity and Regulation

7.1. Health Infrastructure

Health Infrastructure

Public Hospitals

415
415 functional hospitals (275 primary, 108 general and 32 specialized)

47
Hospitals on construction

Health Centers

3,932
Functional health centers

71
Health centers on construction

Health Posts

15,407
Functional health posts

15,147
Basic HPs

260
Comprehensive HPs

188
Health posts on construction

Health infrastructure serves as the foundation of the health system. Over the past decades, major efforts have been made to expand and rehabilitate facilities, resulting in notable progress. The health infrastructure program encompasses the construction of new facilities, rehabilitation of existing ones, and ensuring they are properly equipped, staffed, regulated, and customer-friendly in line with national standards. In addition, the program places strong emphasis on sustainable maintenance and the integration of IT systems. This section presents the status of functional facilities, facilities under construction, and key accomplishments in 2017 EFY, including mega-projects and maintenance activities.

Number of Health Posts: By the end of 2017 EFY, the total number of functional health posts in the country was 15,407, among which 15,147 are basic health posts and 269 are comprehensive health posts. In addition to the functional health posts, 188 health posts are under construction (new for basic and upgrading for comprehensive health posts). The detailed distribution of these health posts per region is as follows.

Table 26: Number of functional and under construction health posts by region, 2017 EFY

Regions	Basic HP	Comprehensive HPs	Total HPs	Under construction
Tigray	508	10	518	0
Afar	366	2	368	8
Amhara	2,812	66	2,878	16
Oromia	5,782	118	5,900	120
Somali	1,474	21	1,495	4
Benishangul Gumuz	348	1	349	1
South Ethiopia	1,452	18	1,470	5
Central Ethiopia	1,011	8	1,019	19
Sidama	478	2	480	3
SWE	730	6	736	10
Gambella	121	4	125	0
Harari	27	2	29	0
Dire Dawa	38	2	40	2
Addis Ababa	NA	NA	NA	NA
National	**15,147**	**260**	**15,407**	**188**

Number of Health Centers: By the end of 2017 EFY, there were 3,932 functional health centers, with an additional 71 under construction. These new construction projects are part of an effort to improve equity in health center distribution by targeting regions with coverage below the national target. The national distribution of health centers per region is shown in the table below.

Table 27: Number of functional and under-construction Health Centers by Region, 2017 EFY

Regions	Functional	Under construction	Total
Tigray	233	1	234
Afar	102	3	105
Amhara	918	8	926
Oromia	1435	2	1437
Somali	245	9	254
Benishangul-Gumuz	61	5	66
South Ethiopia	290	17	307
Central Ethiopia	222	6	228
Sidama	142	2	144
SWE	133	6	139
Gambella	30	4	34
Harari	9	0	9
Dire Dawa	16	0	16
Addis Ababa	96	8	104
National	**3,932**	**71**	**4003**

Number of Public Hospitals

In Ethiopia's health service delivery tier system, hospitals are classified into three levels based on the size of the population they serve and the complexity of care they provide: primary hospitals, general hospitals, and comprehensive specialized hospitals.

By the end of 2017 EFY, a total of 415 public hospitals were functional nationwide, consisting of 275 primary hospitals, 108 general hospitals, and 32 comprehensive specialized hospitals. In addition, 53 hospitals were under construction—43 primary, 9 general, and 1 comprehensive specialized hospital. Altogether, this brings the total number of government-owned hospitals (functional and under construction) to 468. Their distribution across regions is presented in the table below.

Table 28: Number of functional and under construction public hospitals by type and region, 2017 EFY

Regions	Number of functional hospitals				Hospitals under construction			
	Primary	General	Comprehensive	Total functional Hospitals	Primary	General	Comprehensive	Total hospitals under construction
Tigray	24	14	2	**40**	3	0	0	**3**
Afar	9	1	0	**10**	0	0	0	**0**
Amhara	74	19	8	**101**	12	3	0	**15**
Oromia	75	37	8	**120**	6	1	1	**8**
Somali	11	6	1	**18**	12	0	0	**12**
BG	5	2	0	**7**	0	0	0	**0**
South Eth	24	4	2	**32**	5	0	0	**5**
Central Eth	24	4	2	**30**	3	1	0	**4**
Sidama	13	6	1	**20**	2	1	0	**3**
SWE	11	4	0	**15**	0	0	0	**0**
Gambella	4	1	0	**5**	0	0	0	**0**
Harari	0	1	1	**2**	0	0	0	**0**
Dire Dawa	0	2	0	**2**	0	0	0	**0**
AA	0	6	7	**13**	0	3	0	**3**
National	**275**	**108**	**32**	**415**	**43**	**9**	**1**	**53**

Construction of tertiary hospitals and advanced care centers

The Government of Ethiopia has designed a medical tourism strategy aimed at expanding access to advanced health care services. The strategy seeks not only to attract international clients but also to ensure that Ethiopian citizens benefit from high-quality, specialized medical care within the country, thereby reducing the need for outbound medical travel and saving lives. Thus, the construction of mega hospitals or advanced care centers is in progress, and their status is described as follows.

- The construction of oncology, cardiac, and GI centers with a total of 1200 bed capacity is in the completion stage
- The construction of the 1st national trauma center, Dermatology and plastic centers with a total of 1000 bed capacity for Alert Hospital is in progress, with a construction status of 65% and 35% respectively.

- The construction of the emergency comprehensive hospital for Amanuel Mental Health Hospital and the radiology center for Saint Peter Hospital are progressing well, with an average construction status of 30%.
- The construction of the national mental rehabilitation and ENT centers in different hospitals are also in progress.
- The construction of the Complex Apartment for mental health senior medical staff in Addis Ababa, Mekanissa Area is in progress with a status of 65%.
- The construction of a modern vehicle garage and warehouse for the Ministry of Health headquarters is in progress, with the status of 75%.

Modern Laboratories and Related Construction

- The construction the first national food and drug quality control center of excellence managed by the Ethiopian Food and Drug Control Authority, located in Addis Ababa, has been completed in the reporting year
- The construction of modern medical warehouses, including a 9,000 m3 vaccine cold room capacity center for the Ethiopian Supply Service located in its headquarters compound in Addis Ababa, has been completed
- Site preparations, development of detailed designs, and related tasks have been completed to construct the first national reference laboratory (BSL3) in the Ethiopian Public Health Institute. The construction will start in 2018 EFY.
- The construction of fifteen modern regional laboratories is underway with an average progress of 85%, to improve national public health research and laboratory services.
- The construction of the bio bank, PT panel production, and the central warehouse national center located in the Ethiopian Public Health Institute is in progress with a status of 30%.

Restorations of Health Facilities: Renovations are currently underway on 247 health facilities damaged by conflict in the regions of Oromia, Amhara, Tigray, Afar, and Benishangul Gumuz. The average completion status for these projects is 50%.

Health Facilities Standards: Nineteen health facility standards categorized as primary health care, secondary care, tertiary care, laboratories, health research institutions, and related ones have been developed considering the national standards, international inputs, local needs from health professionals, and the actual challenges faced before as major criteria.

TSEDU Facility initiative: In the 2017 EFY, numerous renovations, expansions, waste management, and safe water supply projects were executed under the new TSIDU FACILITY initiative. The performance of the major TSIDU projects is summarized as follows:

- The renovation and expansion of four tertiary hospitals: Eka-Kotebe, Alert, St. Peter, and Amanuel Mental Health, serving in Addis Ababa, and renovation and expansion works for seven general hospitals in seven regions have been completed in the reporting year.

- The supply and installation of four modern liquid waste treatment plants with a total capacity of 900m3 per day are in the completion stage to protect public health and the environment by treating the hazardous wastes generated from high-volume hospitals and big laboratories. Similarly, the supply and installation of three modern incinerators are in progress to treat infectious solid medical wastes.
- Three national pilot projects: Biomedical Waste Treatment Decontamination and Sorting to treat the Infectious medical waste generated from high-volume hospitals and laboratories located in Addis Ababa.
- Generally, hundreds of OPD clinics, operating rooms, Emergency areas, ICU rooms, inpatient rooms, male and female duty rooms, patient and staff toilets, patient and staff cafeteria, security and safety systems, safe water supply, and both liquid and solid waste disposal facilities are fundamentally improved under the TSIDU FACILITY initiative.

Challenges

Although several transformative national health infrastructure mega-projects were completed in recent years, their construction faced significant challenges.

- **Market Inflation**: The market prices of all construction materials are highly inflated, which is attributable to various factors
- **Foreign currency shortage**: Although economic reforms significantly improved access to foreign currency from banks, importing specific items for mega-projects remained challenging
- **Poor performing contractors**: Local contractors faced critical limitations due to insufficient financial capacity, poor project management, and a lack of skilled manpower

7.2. Health Workforce development and management

Human Resource for Health

Number of Health workforce

492,181
Total health workforce in public and private institutions

325,010 (66%)
are health professionals and 167, 171 (34%) are admin staff

HWF density for core health professionals

1.62 per 1000 population

Continuing Professional Development (CPD)

Accreditation has been granted to 38 accreditors and 334 CPD providers

All regions integrated CPD with pre-licensing process

Health Professional to population ratio

Physician to population ratio:
1: 4,902

Nurses to population ratio:
1: 1035

Midwives to population ratio:
1: 4001

Health Officers to population ratio:
1: 4862

The Ministry of Health has implemented strategic interventions to reduce geographic disparities in the distribution and professional diversity of the health workforce. The major objectives during the fiscal year included:

- Improve accessibility and quality of health science education, covering pre-service and in-service training.
- Ensure adequate availability of critical priority cadres, including specialized and sub-specialized professionals.
- Strengthen motivation mechanisms and accountability within the health workforce.
- Facilitate access to and oversight of continuing professional development programs.
- Enhance data-driven approaches for health workforce demand forecasting, strategic planning, and development.

Additionally, the MOH focused on fostering collaboration with stakeholders by coordinating voluntary engagements of health professionals, providing targeted support to RHBs and strengthening partnerships with universities and public/private health science colleges. The following sections detail the major activities undertaken during this reporting period, organized by thematic areas.

Health workforce deployment

To improve community access to healthcare and create job opportunities for new graduates, various strategies have been implemented to enhance the absorption of health professionals into the health sector. Key approaches include the matching fund model, direct regional hiring based on budget availability, and facilitating overseas employment opportunities.

Under the matching fund initiative, RHBs and city administrations recruited health workers per signed MOU, with close monitoring and support to ensure effectiveness. Accordingly, about 30 million Birr was transferred to the regions through the Matching Fund, and 896 new graduates have been employed under this scheme in 2017 EFY, with 100% matching fund utilization.

Table 29: Number of general practitioners hired with matching fund by regions, 2017EFY

No	Region	Plan	Performances (Achievement)	
			No	%
1	Amhara	303	303	100%
2	Oromia	361	361	100%
3	Sidama	126	126	100%
4	Southwest Ethiopia	91	13	14%
5	South Ethiopia	89	75	84%
6	Central Ethiopia	6	6	100%
7	Gambella	4	4	100%
8	Harari	8	8	100%
Total		**988**	**896**	**91%**

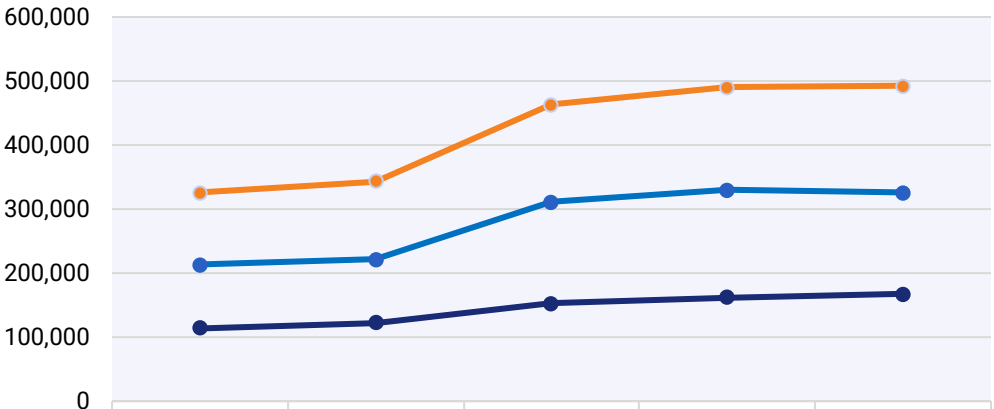
Note: Matching fund wasn't planned for Tigray, Afar, Somali, Benishangul-Gumuz, Dire Dawa, and Addis Ababa in EFY 2017

Other deployments by regions and city administrations: Among the 206 specialist doctors who graduated from different medical institutions during the 2017 fiscal year, 188 doctors have been assigned to the regions and health institutions, and 12 doctors who breached their training agreements were made to pay for their training expenses.

Distribution of the health workforce

Health workforce Stock

According to 2017 EFY human resources data collected from all regions, the total health workforce, including personnel in university hospitals and private health facilities—increased slightly from 490,016 in 2016 EFY to 492,181 in 2017 EFY. Of the total workforce, 325,010 (66%) were health professionals and 167, 171 (34%) were administrative/supportive staff. Over the last five years, the number of the health workforce has increased both in health professionals and supportive staff. However, the increment in the reporting year, EFY 2017, is minimal, and even the number of health professionals has declined compared to the 2016 EFY. The significant data shift between 2014 and 2015, shown in the figure below, may be partially due to the lack of data from Tigray region and private health facilities in the 2013 EFY and 2014 EFY.



	2013	2014	2015	2016	2017
Health Professionals	212,185	221,046	310,591	328,951	325,010
Supportive Staff	113,189	121,853	152,229	161,065	167,171
Total	325,374	342,899	462,820	490,016	492,181

Figure 68: Number of Health workforce by year, 2013-2017EFY

Among the total health professionals, the top four professional categories were: Nurses (32.6%), Health extension workers (14.2%), Pharmacists (9.8%), Medical laboratory personnel (8.9%) – together representing 66% (214,246) of the whole health professionals. General practitioners and specialists constituted a smaller proportion, at just 6.9% (22,366) of the professional workforce. The distribution and proportion of these selected health professionals are illustrated in the figure below.

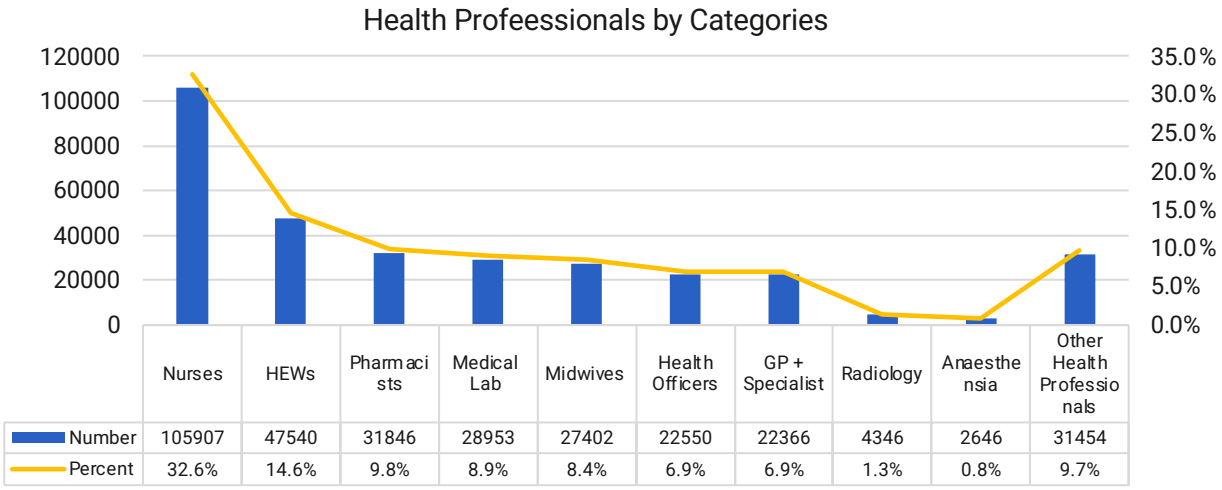


Figure 69: Number and proportion of health professionals by type, 2017 EFY

Distribution of Health Workforce by Region

Over the past twenty years, Ethiopia's health sector has prioritized equitable distribution of health workers and optimal professional mix nationwide. Given the direct link between workforce distribution and access to quality, equitable healthcare, regional disparities in staffing have been a key metric for assessing progress. Despite sustained efforts, significant imbalances persist across regions, with lower health worker-to-population ratios indicating ongoing inequities. These disparities serve as a critical equity indicator, helping target areas needing interventions.

In the fiscal year, Addis Ababa City Administration recorded the highest total health professional (THPs) density (16 THPs per 1,000 population), followed by Gambella (6.5 THPs per 1000 population) and Harari (4.5 THPs per 1000 population) regions. The national total health professional's ratio was 3 health professionals per 1,000 population, with six regions— Oromia (2.0), Afar (2.3), S/W/Ethiopia (2.3), Amhara (2.5), Somali (2.6), and Central Ethiopia (2.9)—falling below the national average.

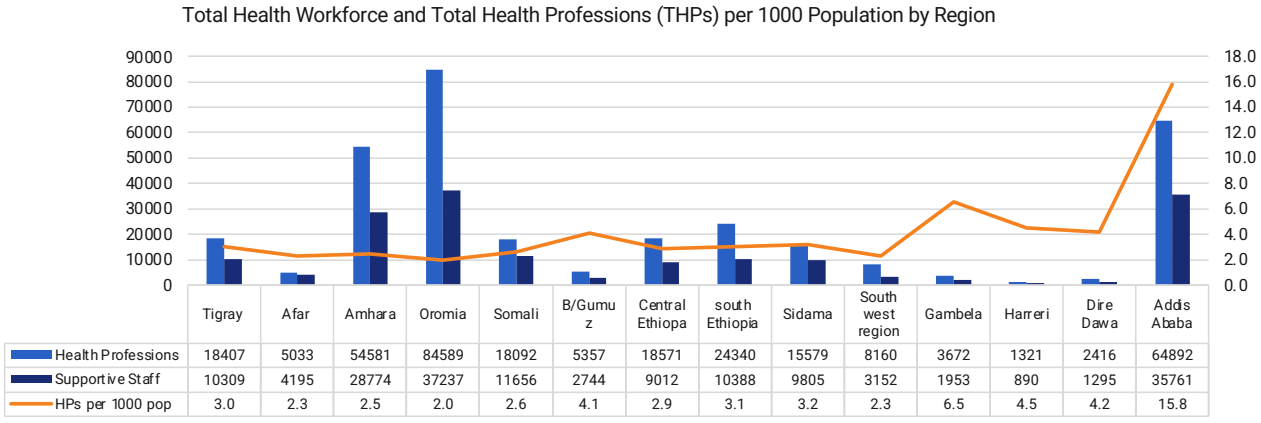


Figure 70: Number of health workforce, and total health professionals per 1000 population, 2017 EFY

Health Professionals to Population Ratio

Health professional density is an important metric to gauge health sector staffing. The standard health professional density level for core professional categories - medical doctors, nurses, and midwives (for all three professionals together) is 4.45 per 1,000 population, based on the WHO set target, the minimum core health workforce density required to achieve SDGs and UHC. The HSTP II target was 2.3 per 1000 population by the end of 2025, which is considered in HSDIP's target. In Ethiopia, physicians, health officers, nurses, and midwives are categorized as core health professionals. Accordingly, Ethiopia's core health professional density at the end of 2017 EFY was 1.62 per 1,000 people, which is considerably below the set target, 2.3 per 1000 people.

As indicated in the figure below, the core health professionals per 1,000 people have shown encouraging progress, where it declined in 2017 EFY.

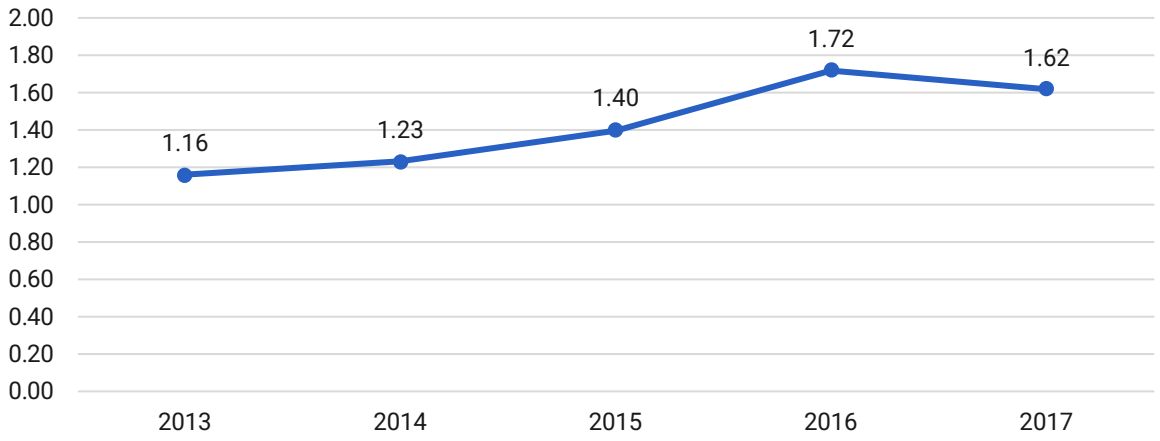


Figure 71: Core health professionals (Physicians, Nurses, Midwives & Health officers) per 1,000 population, from 2013 to 2017 EFY

Regarding the health professionals to population ratio by professional category, nationally physician to population ratio (GPs, specialists, and subspecialists) is 1:4,900 (one MD for 4900 population). Addis Ababa has a physician-to-population ratio of 1:474, Dire Dewa city Administration with 1:1794, and Harari Region with 1:2688 are the regions with better physician-to-population ratios. The lowest ratio is in Oromia and BG regions, which are the lowest physician to population ratio, which are 1:11,044 and 1:10771, respectively.

At the national level, there is 1 nurse for every 1,035 people (1:1035). The nurse-to-population ratio is also greatly varied among the regions. Addis Ababa (1 Nurse: 211 population), Gambela (1:308), Dire Dawa (1:688), BG (1:691), Harari (1:758), and Sidama (1:910) are regions with to population ratio above the national average. Disparities in the health professionals to population ratio are observed in all types of professional categories (for detail information, see the table below).

Table 30: Selected Health Professionals to Population Ratio by Region, 2017 EFY

Region	GP + Specialist		Nurses		Midwives		Pharmacy		Medical Lab		Health Officers		HEW	
	Num	1GP: Pop	Num	1Nurse: Pop	Num	1Midwife: Pop	Num	1Pharm: Pop	Num	1lab: Pop	Num	1HO: Pop	Num	1HEW: Pop
Tigray	1322	4,595	6,688	908	1,826	3327	1977	3073	1249	4864	1201	5058	1,805	3366
Afar	230	9,407	1,851	1169	394	5491	471	4594	408	5303	353	6129	867	2495
Amhara	2924	7,572	15,621	1417	5,726	3867	5085	4354	4319	5126	3932	5631	9,963	2222
Oromia	3863	11,044	29,369	1453	6,287	6786	8218	5191	5607	7609	5867	7272	17,567	2429
Somali	1160	5,998	6,446	1079	2,619	2657	1294	5377	1422	4893	1183	5881	2,844	2446
BG	121	10,771	1,886	691	643	2027	672	1939	460	2833	285	4573	943	1382
Central Eth	965	6,711	5,965	1086	1,876	3452	1205	5375	1633	3966	1692	3828	2,964	2185
South Eth	867	9,133	7,227	1096	2,102	3767	2112	3749	1780	4448	1698	4663	3,652	2168
Sidama	1333	3,656	5,356	910	1,251	3895	1067	4567	1095	4450	811	6009	2,485	1961
SWE	408	8,656	2,978	1186	687	5141	639	5527	463	7628	552	6398	1,828	1932
Gambela	77	7,316	1,829	308	187	3013	180	3130	283	1991	192	2934	629	896
Harari	110	2,688	390	758	143	2068	161	1837	120	2464	82	3606	183	1616
DD	324	1,794	845	688	163	3566	196	2966	199	2921	84	6920	305	1906
AA	8662	474	19,456	211	3,498	1173	8569	479	9915	414	4618	889	1,505	2727
National	22366	4,902	105,907	1035	27,402	4001	31846	3443	28953	3787	22550	4862	47,540	2306

Health Professional Development

To meet the growing demand for quality healthcare services, MOH has sustained its efforts to enhance the quality of training, professional mix, and adequacy of healthcare cadres in the sector. During this fiscal year, key activities were carried out, which include revision of training documents and curriculum, strengthening enrollment in the Ethiopian Residency Matching program (ERMP), the Ethiopian Field Epidemiology and Laboratory Training Program (EFELTP), the TVET initiative, and Continuing Professional Development (CPD).

Curriculum Revisions and Launch of DrPH Program: During the fiscal year, a document containing five revised post-basic programs (Pharmacy, Laboratory, Health IT, Anesthesia, and Radiography) and two generic programs (Public Health Officer and Laboratory) were prepared and submitted to the Ministry of Education. Additionally, the curriculum for Medical Laboratory Science and Public Health was updated, along with the professional standards for Dental Therapy and Prosthetic and Orthotic professions. Furthermore, the Doctor of Public Health (DrPH) program was launched, tailored for mid- to senior-level public health practitioners seeking to enhance their expertise in leadership, policy development, evidence-based practice, communication, and applied research.

Enrollment in the Ethiopian Residency Matching Program (ERMP): An automated system that was established to manage the registration, assessment, and placement of physicians applying for medical specialty training was used to screen physician candidates. During the fiscal year, 2,347 physicians applied through the system, of which 1,985 met the registration criteria and were approved to sit for the entrance exam, where a total of 1,810 candidates took the exam across 15 testing centers. Following the entrance exam, 1,509 medical doctors were assigned to residency training programs at 22 universities and hospital medical colleges in 22 specialties. These placements included candidates selected through a matching fund, as well as 125 doctors admitted under special quotas (including personnel from the Ministry of Defense, Police, and candidates from neighboring countries such as South Sudan, Somaliland, and Rwanda). Additionally, the European Joint Initiative has supported eight medical specialty programs across seven universities to strengthen specialized medical training in Ethiopia.

Ethiopia Field Epidemiology and laboratory training program (EFELTP): The EFELTP operates at three levels—Advanced, Intermediate, and Frontline—with training durations of two years, nine months, and three months, respectively. To date, the program has produced 811 graduates and currently has 115 residents in training. The program is delivered through eight universities nationwide, ensuring comprehensive coverage in field epidemiology and laboratory training.

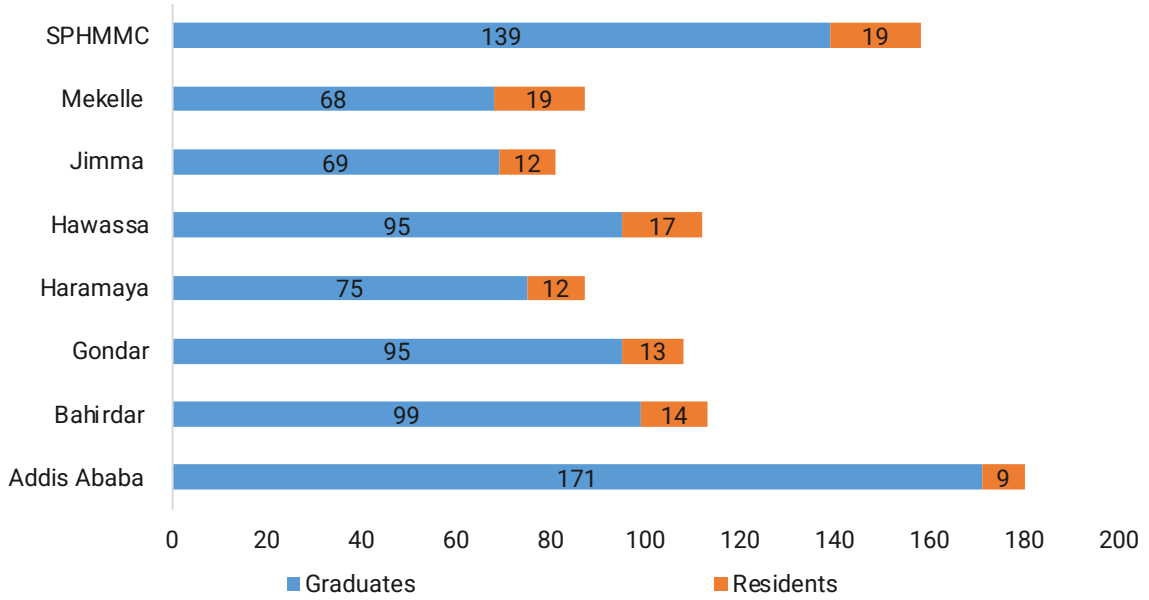


Figure 72: Ethiopia Field Epidemiology and laboratory training program (EFELTP) Profile by universities and graduation status, 2017 EFY

As part of their training, EFELTP residents must conduct five key epidemiological activities: Surveillance data analysis, Health profile assessment, Surveillance system evaluation, Outbreak investigation and management, and Disaster assessment. To date, EFELTP graduates and current residents have collectively completed 4,295 epidemiological activities. From the total epidemiological activities, 875 (20.4%) were surveillance data analysis, 874 (20.3%) were health profile assessments, 851 (19.8%) were surveillance system evaluations, 851 (19.8%) were outbreak investigation and management and 844 (19.7%) were disaster assessment.

The 4th EFELTP Scientific Conference was held from July 1 to 4, 2025, with more than 450 participants, including experienced researchers and experts from the field, all over the country and abroad. The one-day pre-conference sessions were held on July 1, 2025, and provided training on five topics for 300 participants. A panel discussion was also held based on the conference theme. The event featured presentations and research papers by various experts. About 28 oral presentations and 15 poster presentations were presented at the event. A photo gallery showing the activities of the field epidemiology trainees while they were working in the field was released for viewing. In addition, a documentary film showing the activities of the Field Epidemiology Training Program was produced and presented at the conference. At the closing ceremony held on July 4, 2025, a recognition ceremony was held for institutions and individuals who contributed to the success of the training program.

Photo: The 4th EFELTP Scientific Conference participants, 2017 EFY

TVET initiative: To fulfill the vacant positions of Health Extension Workers at the bottom level of the health tier system, technical and financial support was provided to RHBs to enroll 6760 HEWs level IV generic and upgrade trainees, including family health degree program in their respective regional health science colleges in each region.

Degree initiative: The degree initiative has developed a roadmap for nursing and midwifery residency training programs and started the residency training in the four health science schools, including Addis Ababa University, Jimma University, St. Paul's Hospital Millennium Medical College (SPHMMC), and Debre Birhan University.

Continuing Professional Development

Continuing professional development (CPD) is a top national priority to maximize the health workers' skills, which will directly impact the efficiency and effectiveness of the health system. The main objective of CPD is to improve health care quality by strengthening the workforce's competencies and facilitating a smooth transition from CPD to license renewal. Thus, access to need-based CPD is essential for health workers to sustain and advance their competencies. Accordingly, CPD has been implemented with due attention, where a strong quality control framework is in place that accredits courses, CPD providers, and accreditors.

In the reporting period, accreditation was given to 38 accreditors and 334 CPD providers to ensure that the workforce is continually enhancing its competencies, and all regions have integrated CPD with the re-licensing process, which is pivotal in reinforcing the importance of ongoing professional development as a prerequisite for license renewal.

Regarding technological advancements, MOH has developed an E-Learning platform that has improved from 5 courses in 2022 to 44 in 2025 GC. About 27 blended courses were developed, which reflects a commitment to harnessing technology for an accessible and flexible learning process.

Human Resource Data Management

The integrated human resource information system (iHRIS), which handles three functionalities: HR administration, HR Development, and HR Licensure services, has been developed and deployed at the national level. As a continual effort to deploy iHRIS at different levels, several activities were executed in the fiscal year to implement it at the RHB level and other institutions. Accordingly, training was provided on iHRIS for 2320 experts from 12 RHBs and 2 city administrations. Currently, the deployment of iHRIS is initiated in RHBs, health facilities, universities, and the Health Science College with financial and technical support of MOH. So far, a total of 367,233 health workers have been registered in the iHRIS database, among whom job assignments have been assigned for more than 267,548.

Capacity building and technical support

iHRIS training was given to 300 CPD accreditors and providers. Training on facilitation skills, IDS, and CPD center management was also given to 160 CPD accreditors, providers, experts, and coordinators of various CPD centers. About 338 accredited training courses were registered in the iHRIS system. Among these, training is provided on 210 accredited courses for 27488 health professionals, who are registered in the iHRIS. Currently, 251 CPD centers have implemented the iHRIS digital learning design and development training provided for 67 experts selected from the MoH and CPD centers.

Policy documents related to category 2 CPD, and a digital learning guide were developed and distributed to users, mainly CPD providers and health facilities. International short-term training was provided for 53 health professionals selected from hospitals, RHB, agencies, and the MOH.11580 health professionals took online training through the MoH CPD platform and got certified.

Developed Talent Mapping System (TMS) software aimed at improving the delivery of accessible, efficient, and inclusive health care by ensuring that all healthcare professionals are effectively utilized. (https://tms.moh.gov.et/#/login)

Challenges on iHRIS implementation

- Frequent HWF turnover
- Limited Technology (electricity, network connection, laptop, and desktop computer) infrastructure for iHRIS implementation
- Low leadership commitment
- Lack of iHRIS interoperability with other systems like
- Shortage of budget
- Low access, quality and relevance of CPD and lack of CPD awareness in some regions
- Emerging issues of malpractice and non-compliance

Way forward for next year

- Fully implement the system in all public and private health facility levels.
- Make iHRIS interoperable with other related systems
- Enhance Capacity of CPD centers
- Strengthen monitoring and regulation of CPD centers
- Improve standardization and institutionalization of CPD
- Strengthen partnership with stalk-holders
- Conduct continuous advocacy and awareness creation
- Improve access, quality and relevance of CPD (Online and blended learning)

7.3. Health Information System and Research

Health Sector Planning

Preparation of Health Sector Woreda-Based Plan (HSWBP): The development of the 2017 EFY HSWBP was completed within the first month of the fiscal year, following reconciliation with regional plans and incorporating feedback from senior leadership. The finalized HSWBP document was printed and disseminated during the 26th ARM forum. Subsequently, a preliminary framework, an indicative plan was developed for the 2018 EFY Woreda-based planning process, informed by the HSDIP and findings from the assessment of previous planning efforts.

The HSWBP software was updated, and a new hospital planning module was introduced. This planning software was integrated into the upgraded DHIS2 version and utilized for the current year's planning activities. Consequently, all regions employed the software to prepare the woreda-based and hospital plans. MOH provided comprehensive support to regions, including financial and technical support through TOT sessions, budget transfer and technical assistance.

Comprehensive Plan Preparation: After the development of the HSWBP, a comprehensive activities plan was prepared at the national level for each Lead Executive Office, Executive Office, and Agency, with the expectation that similar planning efforts would be adopted across all administrative levels. This process was facilitated by newly developed planning software designed to make plan preparation more efficient. The preparation of the HSWBP and the comprehensive plan was conducted with the active participation of key stakeholders, with the engagement of leadership at every level.

National HIS Performance Review Platform

The National HIS performance review meeting was conducted twice in the fiscal year to evaluate the status of HIS functions, identify gaps, and develop agreed-upon action points. Key stakeholders, including RHBs, CBMP universities, and partners, participated in the performance review meeting. Finally, action points and recommendations were developed, presented to the audience, and shared with participants to enable prompt implementation and regular follow-up.

National Routine Data Quality Assessment

Routine Data Quality Assessment (RDQA) was used to evaluate the national health information system. Its objectives were to review data management capabilities, determine the quality of HMIS data, and assess the functionality of Performance Monitoring Teams (PMTs). The assessment identified the system's status, highlighted gaps, and proposed interventions to address them (The detail is available on the 2025 national RDQA report). Subsequently, the findings were presented, and key recommendations were shared with regions during the EFY 2017 HIS review meeting. Some of the gaps identified during the 2017 EFY RDQA and recommendations are listed as follows.

Challenges and gaps of the health information system

The findings of the 2017 EFY RDQA showed that the Ethiopian health information system faces several critical challenges and gaps that hinder efficient data management, decision-making, and digital health scale-up. These challenges and gaps include:

- **DHIS2 and server-related problems:** Frequent DHIS2 system and server-related problems affect timely data entry and reporting
- **Infrastructure challenges:** Shortages of essential hardware, including computers, tablets, power banks, and networking materials, limit the functionality of digital solutions and constrained EMR scale-up efforts
- **Human Resource Constraints:** Critical shortage of Health Information Technology (HIT) professionals and Medical Records Unit (MRU) staff at health facilities compromises data quality and management. In addition, there is a high turnover of HITs at all levels
- **Capacity and Training Gaps:** Limited training on dashboards, surveillance, and ICD-11 for health centers, hospitals, and private health facilities
- **Budgetary and Logistical Challenges:** Inadequate budget for HIS activities, including printing of data collection tools, affect routine operations. In addition, shortages of HMIS tools further hinder routine data collection and reporting

Recommendations based on the RDQA findings

- Speed up the scale of eCHIS deployment
- Strengthen LQAS and RDQA follow-ups to reduce data transfer errors.
- Reinforce consistent use of medical records (e.g., women's card for family planning and integrated RH-card for ANC, delivery, and PNC services) and proper documentation
- Increase budget allocation for HMIS tools and HIS activities
- Prioritize pastoralist areas in CHIS tools distribution and support implementation.
- Enhance PMT functionality through regular training and accountability.
- Target low-performing regions with tailored support.
- Promote gender balance in PMTs (increase female representation).
- Establish a continuous learning platform on HIS/HMIS (digital system)
- Standardize HMIS tools for private health facilities
- Facilitate orientation on DHIS2 and HMIS tools for Private health facilities
- Facilitate access to the internet (improve health net coverage), and upgrade internet bandwidth for hospitals

Collaboration between CBMP Universities and Ministry of Health

The Capacity Building and Mentorship Program (CBMP) platform was launched and has been implemented since 2010 EFY, collaborating with six selected universities: Addis Ababa, Jimma, Gondar, Haramaya, Mekele, and Hawassa, along with their consortium universities and colleges. The program aims to enhance HIS through various initiatives, including improving data quality, training health workers, implementing eHealth applications, and ensuring their sustainability via establishment of Center of Excellence, integrating HIS into pre-service, providing in-service training, documenting best practices, and promoting research and publication. The number of woredas supported by CBMP universities has increased from 36 to 100+. Currently, 2,274 health institutions, including 104 WoHOs, 62 hospitals, 449 health centers, and 1,657 health posts, are receiving HIS related support from CBMP universities.

In the fiscal year, MOH developed a CBMP governance document to strengthen collaboration, ensure accountability, and enhance the effective implementation of the program. Similarly, there was CBMP advocacy session held in the presence of higher officials and different stakeholders during the Data and Digital Health Week forums, during which CBMP documentary was presented, and all six universities presented their HIS related best practices on the exhibition. Moreover, the eCHIS paperless woreda initiative was one of the big initiatives in which universities were engaged.

In summary, different lessons can be learned through the CBMP platform, some of which are:

- Collaborative partnerships between CBMP universities and health systems enabled knowledge sharing and created sustainable HIS support
- The academia-health system model is a promising strategy for enhancing HIS performance locally and at the point of care. Sustaining and expanding these efforts requires building local ownership, developing in-house mentors, and strengthening university based HIS expertise.
- Involving academics in the health system helped identify community problems worthy of research. Embedded implementation science, co-led by government and academia, was vital for setting agendas, building trust in evidence, and ensuring findings are translated to action.

Report Completeness and Timeliness

High-quality data, underpinned by complete and timely reporting, is essential for informed decision-making. Report completeness improved from 85% in 2016 EFY to 92% in 2017 EFY. However, timeliness declined from 57% to 49% over the same period.

Significant regional variations exist, as shown in the table below. For completeness, seven regions (Harari, Amhara, Central Ethiopia, South Ethiopia, Southwest Ethiopia, Sidama and Oromia) achieved 95% or more, while three (Gambela, Benishangul-Gumuz, and Tigray) fell below the national average.

For timeliness, only the Harari region (85%) scored significantly above the national average. Five regions (Addis Ababa, Somali, Amhara, Oromia, and Afar) slightly exceeded it, while the remaining eight fell below. Some timeliness issues are attributed to the DHIS2 system, which resets the submission period upon data editing.

Table 31: Report completeness and Timeliness rate of routine HMIS report, Hamle 2016 to Sene 2017 EFY

	Completeness - All Monthly Reporting Rate	Timeliness - Monthly reporting rates are on time
Tigray	75%	22%
Afar	91%	52%
Amhara	99%	57%
Oromia	91%	55%
Somali	95%	58%
Benishangul Gumuz	65%	27%
Central Ethiopian	97%	41%
South Ethiopia	97%	32%
Sidama	96%	47%
South West Ethiopia	96%	39%
Gambella	56%	15%
Harari	99%	85%
Dire Dawa	95%	44%
Addis Ababa	91%	59%
National average	92%	49%

Information Revolution implementation status

The Information Revolution (IR) initiative seeks to leverage information and communication technologies (ICTs) to significantly improve the availability, accessibility, quality, and utilization of health information, thereby enabling informed decision-making. Health institutions are required to evaluate their progress quarterly by conducting an IR self-assessment using a standard checklist, which categorizes them into one of four pathways: Emerging, Low Candidate, High Candidate, or Model.

While all health institutions are required to implement IR and conduct IR self-assessments, the Ministry of Health has launched the "100 IR Woredas" program to provide intensified support. RHBs directly support these woredas, besides the existing CBMP woredas, and create models for improved implementation.

In 2017 EFY, the proportion of health institutions that report their IR self-assessment result through DHIS2 was as follows: 55% of WoHOs, 64% of health centers and hospitals; and 63% of health posts.

Improving the practice of IR self-assessment has led to a noticeable increase in the proportion of IR models at the institutional level. For example, among the health institutions supported by CBMP, the IR model at the institution level improved from 39% to 46% (for health centers, hospitals, and WoHOs) and from 16.5% to 22% for health posts for the EFY 2016 and 2017 EFY, respectively. Despite encouraging improvements in the IR model status, the number of woredas recognized as IR models based on composite measures remains very low. In the reporting period, there were only 5 woredas/ sub cities verified as IR Model by composite measure and received recognition from the Ministry of Health.

Birth, Death, and causes of death Notification

Civil Registration and Vital Statistics (CRVS) is a continuous system that records vital events and provides reliable data for measuring fertility, mortality, life expectancy, and other key health indicators, supporting evidence-based policy, planning, and monitoring of national and global goals. The health sector plays a central role in notifying births and deaths, including causes of death, to the civil registrar and the primary user of the vital information generated through CRVS.

In 2017 EFY, birth notification performance was 70% from the total expected births, ranging from 25% in Afar and Somali to more than 100% in Harari and Addis Ababa. However, death registration remains a major challenge, standing at only 5% against an annual target of 10%, while the HSDIP goal was set at 25% by 2017 EFY. Death notification performance varies significantly across regions. Harari, Addis Ababa, and Dire Dawa lead with notification rates of 56.4%, 35.3%, and 23.6%, respectively. In contrast, all other regions are at or below the national average of 5%, indicating substantial gaps in timely death reporting.

Cause of death: In addition to notifying death, accurate and consistent recording of disease and causes of death is fundamental to public health data, which informs policy decisions, resource allocation, and ultimately, our understanding of disease burden and trends. The annual facility mortality data collected through DHIS2 analysis shows that the majority of deaths occur in the under-5 age group, accounting for 27% of total deaths. Male deaths are higher than female deaths across most age categories.

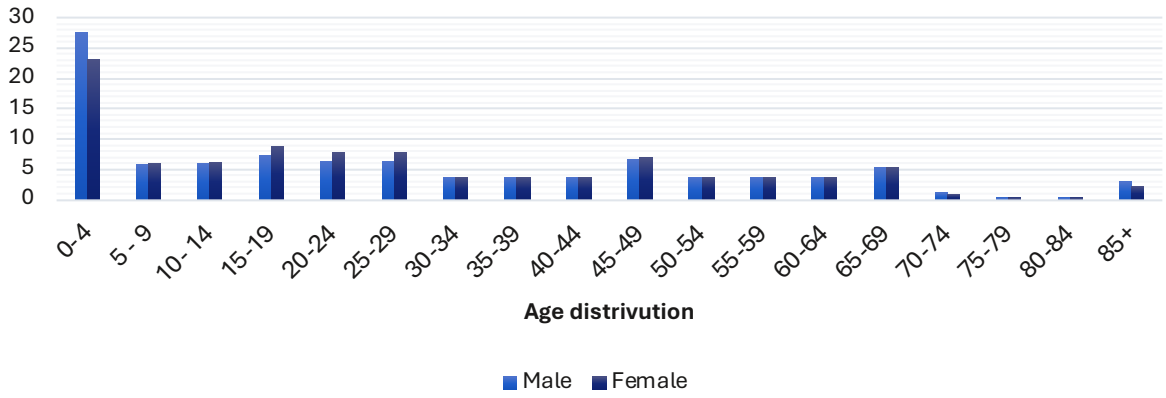


Figure 73: Proportion of deaths reported through the routine HMIS, by age group and sex, 2017 EFY

Aiming at improving the quality and completeness of facility mortality and morbidity reporting, a national-level assessment was conducted on the implementation of the International Classification of Diseases (ICD) and Medical Certificate of Cause of Death (MCCD**)** in 50 health facilities across seven regions. The course **"Civil Registration in the Health System"** was developed in collaboration with the Ministry of Education, and universities to ensure medical students are capable of accurate mortality and morbidity recording and reporting. The course mainly covers ICD and MCCD and has been officially launched to strengthen training and capacity in mortality and morbidity reporting.

Most of the mortality (more than 80%) happened outside of the health facilities, which is the major reason for low coverage of death notification, as families often do not report them to the nearest health post due to limited awareness of the system's importance. To capture deaths and causes of death for this large proportion, the Ministry of Health has begun implementing verbal autopsy in over

60 Woredas nationwide. Based on the verbal autopsy results, acute cardiac disease is the leading cause of death across all age groups, followed by stroke, other cardiac diseases, and pulmonary tuberculosis. See the figure below.

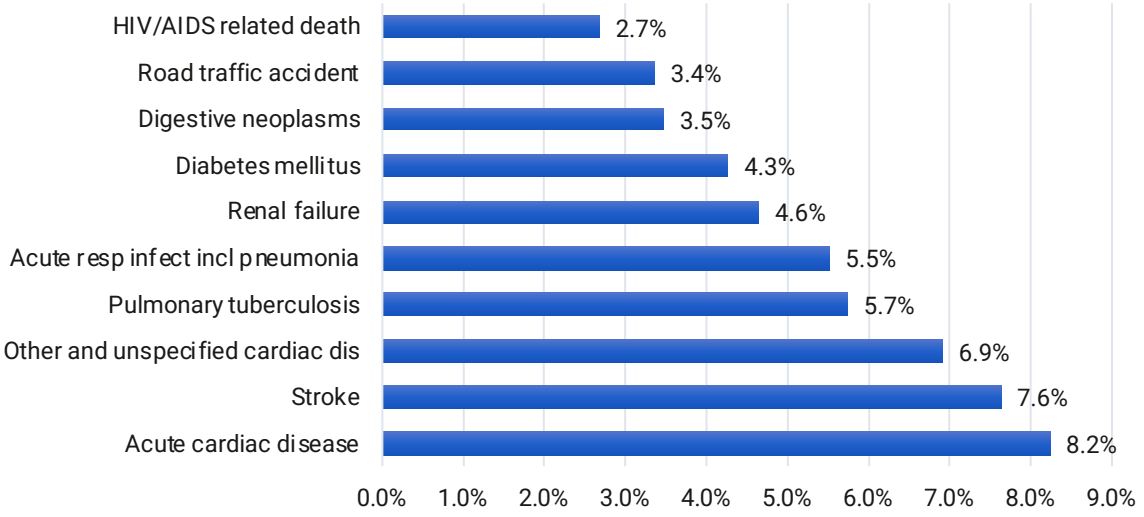


Figure 74: Top 10 causes of community death reported through Verbal Autopsy, July 2025 GC

The verbal autopsy results also showed that among neonates, birth asphyxia, neonatal sepsis, and neonatal pneumonia are the leading causes of death, contributing 35.4%, 19%, and 12.7%, respectively.

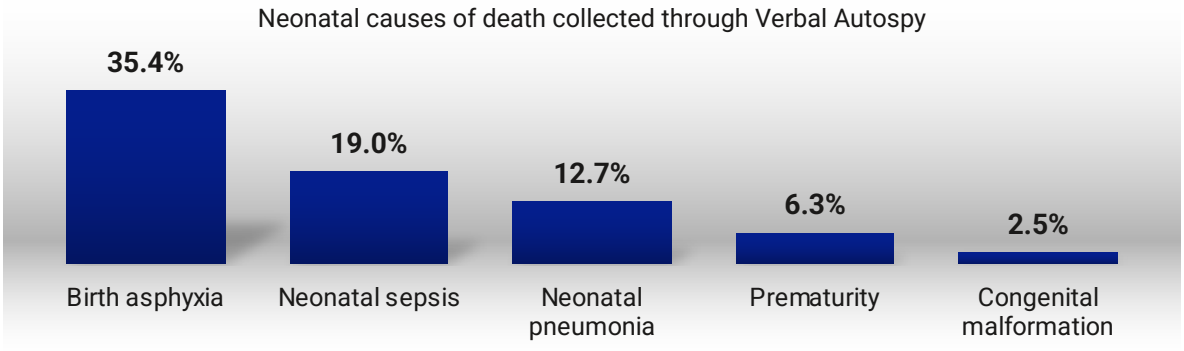


Figure 75: Neonatal causes of death collected through Verbal Autopsy, July 2025 GC

Challenges of CRVS implementation

- Low community awareness.
- Paper-based systems
- High staff turnover disrupts consistent documentation.
- Insufficient training limits data use for decision-making.
- Shortage of standardized tools (e.g., patient folders, cards, registers).
- Limited technical support for ESV-ICD 11 and MCCD systems.
- Difficulties integrating coding into EMRs for effective reporting.
- Poor data quality and inadequate analysis tools.

Way forward for CRVS initiative

- Community sensitization and awareness campaigns
- Strengthen community-based reporting
- Introduce digital notification systems
- Enhance Training on CRVS and cause of death reporting
- Promote Data Use by analyzing and using morbidity/mortality data for decision-making.
- Conduct periodic assessments, mentorship, and supportive supervision
- Implement regular audits, feedback, and supervision for accurate and complete data

Operational and basic Research, and Innovation

Operational and basic research play a crucial role in strengthening evidence-based decision-making in Ethiopia's health sector. The Ministry of Health collaborates closely with two key agencies—EPHI and the Armauer Hansen Research Institute (AHRI)—which focus primarily on operational and basic research.

In 2017 EFY, EPHI and AHRI produced scientific evidence and published in scientific journals. EPHI published 93 articles in reputable scientific journals, the research areas include infectious diseases (COVID-19, TB, malaria, HIV, AMR), NCDs, maternal, newborn, and child health, nutrition, WASH, and cross-cutting themes of health equity and system performance. In addition, AHRI has produced 80 scientific publications, covering diverse areas including communicable and non-communicable diseases, one Health research, diseases caused by mycobacteria and other bacteria, viral infections, malaria and other priority diseases, vaccine, drug, and diagnostic development, as well as research on both traditional and modern medicines. In addition, to strengthen scientific knowledge and evidence translation to action, AHRI produced three policy briefs addressing the following issues

- Time to contemplate the suitability of a single-dose and more inclusive HPV vaccine for Ethiopia
- Enhancing the safety of Blood transfusion through nucleic acid pooling strategies, and
- Integrating targeted HIV drug resistance testing in routine practice.

National Data Management Center: In 2017 EFY, significant efforts were made in the national health data organization, research, and analysis. The following key activities and achievements were recorded by ePHI:

- **Community-Focused Research & Dissemination**: Short analytical summaries were produced on key public health issues, and panel discussion platforms were organized to share findings, including analysis based on HDSS data
- **Health Data Compilation**: Over 86 datasets were compiled and organized from EPHI and partner institutions. Several core documents were developed, including: A data management and sharing guideline; a data quality assurance framework and public information dissemination tools

- **Bioinformatics Collaboration**: Platforms were established to enhance data analysis, collaboration, and promote early detection and response systems, especially for high-impact diseases like malaria, cholera, and measles. Dengue research could not proceed due to data limitations.
- **Satellite Data Modeling**: A new model was developed using satellite data for disease surveillance. Investigations related to immunization (MCV1, MCV2, and Penta) were conducted, notably contributing to the national measles campaign.
- **University Partnerships**: Strong collaboration was formed with multiple universities (e.g., Debre Birhan, Haramaya, Addis Ababa, Debre Markos) for knowledge transfer and joint research, supporting broader implementation of planned activities.
- **Mortality Estimation Using HDSS**: Mortality estimation was carried out using HDSS data. Three research manuscripts were submitted for publication, and six studies were fast-tracked using the IHME system.
- **Strengthening Research Platforms**: HDSS sites based in universities fostered collaborative environments between institutions and professionals, improving local research capacity and data use. Shortage of skilled personnel, delays in procurement processes, suspension of financial support from partner organizations, and security problems in some regions are among the major challenges encountered.

7.4. Digital Health

Health Information System and Digital Health

Service Report Completeness
92%

Service Report Timeliness
49%

Birth Notification
70%
of the expected births

Death Notification
5%
of the estimated deaths

eCHIS
>9,000
Health posts implementing eCHIS; Registered 6.8 million households and 28.5 million individuals

Electronic Medical Record system
Implemented in 120 health facilities

Master Facility Registry (MFR)
Total number of registered facilities in MFR =>57K

Interoperability
MFR/DHIS2 Interoperability successfully completed

MOH has been implementing various digital health initiatives to improve service delivery, strengthen the health system, and support evidence-based decision-making. Key areas of focus include DHIS2, electronic community Health Information System (eCHIS), Electronic Medical Records (EMR), Unified Nutrition Information System for Ethiopia (UNISE), expansion of the Integrated Human Resource Information System (iHRIS), development of various national health information systems, and use of mobile health applications for patient care and health worker support. These initiatives aim to make health services more accessible, efficient, and integrated. This section describes the achievements of digital health initiatives in 2017 EFY.

DHIS2 implementation

The implementation of DHIS-2 version 2.40 was rolled out across the country. Through extensive training, supportive supervision, and technical assistance, over 95% of public health facilities began reporting using the upgraded system. Reporting coverage reached 95.6% in Health Centers, 92.2% in Hospitals, 70.3% in Comprehensive Health Posts, 91.6% in Basic Health Posts, and 40% in Clinics. Facilities without internet access continued reporting through offline systems, later transferring their reports to nearby facilities for online submission.

Major activities done included the following: The customization of DHIS2 V40 and TOT for the Ministry of Defense, technical support was provided to other sectors such as Ministry of Defense and Ministry of Agriculture on DHIS2 customization and training. The DHIS2 system was successfully integrated with the Master Facility Registry (MFR) to enable real-time access to facility lists, while legacy backlog data from previous years was migrated into the new platform. Additional subsystems, including woreda-based planning and UNISE, were also incorporated into DHIS2 version 2.40. To ensure sustainability, capacity-building activities were provided, and TOT and user-level training were also provided.

Implementation of electronic Community Health Information System (eCHIS)

The eCHIS was initiated in 2018 GC as part of its broader strategy to leverage digital technologies in enhancing the delivery of community-based health services. It was developed to revolutionize essential services provision to households and individuals across the country, moving away from traditional paper-based systems (CHIS) to a digital platform.

Since its launch, the system has seen significant expansion, with implementation reaching over 9,000 health posts and 2,000 health centres nationwide, covering all regions and the Dire Dawa City Administration. Among these, 3,696 health posts have started using the full-service delivery modules. To date, eCHIS has registered over 6.8 million households and 28.5 million individuals.

To advance toward a fully digital system, MOH has introduced the “Paperless Woreda” initiative, which focuses on transitioning health services from household registration to full digital service delivery. In 2017 EFY, paperless eCHIS initiative was rolled out across 100 selected woredas, involving 2,053 health posts. To support this expansion, 4,410 tablets and power banks were distributed. Additionally, 475 tablets were distributed to five regions (Amhara, Tigray, Afar, South Ethiopia, and Oromia) and 126 tablets to four pastoralist woredas in Afar.

A scoping study has been completed to assess the feasibility of introducing an urban edition of eCHIS. In addition, supportive supervision visits have been conducted across seven regions to monitor progress and identify gaps. A national eCHIS implementation status assessment is currently underway to evaluate the status of deployment, identify challenges, and provide need-based support.

Although eCHIS has expanded in recent years, it still faces major challenges, including Poor HIS infrastructure (lack of tablets and network connectivity), Poor performance of tablets mainly for service provision, capacity limitations, and financial constraints for trainings, mentorship, and supportive supervision.

Electronic Medical Record (EMR)

The number of health facilities implementing the EMR system reached 120, and of these, 46 facilities (36 hospitals and 10 health centers) are now providing fully paperless services. To strengthen EMR scale-up, more than 35 facilities received equipment support, while 58 facilities benefited from ICT procurements, including 12 mid-range servers, 15 server racks, 28 server UPS, 43 layer-2 switches, and 74 unmanaged switches.

To improve connectivity and data sharing, seven hub hospitals are being established to serve catchment facilities. The procurement process for these hubs has been finalized and suppliers are selected. Laboratory machines were linked with EMRs in Ambo Referral Hospital and Bishoftu General Hospital, and EMR–eAPTS integration was also implemented in four hospitals (Bishoftu, Karamara, Deder, and Adare General Hospitals). Training was delivered on both EMR system operations and software customization to enhance capacity.

The SMART_CARE ART system, which manages HIV/AIDS data, was integrated with the ETHIOHRI system and Bahmni-EMR to unify service delivery. Based on successful pilots, this integration is being scaled up to over 900 facilities implementing SMART_CARE ART and other Bahmni-EMR-supported sites. To support sustainability, a Hackathon-based training session was conducted for MoH staff and partners on the OpenMRS framework. Additionally, the development of the Referral Linkage System Version 2 reached 75% completion, with requirements gathered and system features upgraded, including integration with Master Facility Registry.

Unified Nutrition Information System for Ethiopia (UNISE)

The implementation of UNISE was expanded and integrated with DHIS2 version 2.40, enabling over 600 previously inactive users to capture data and update 75% of UNISE metadata. Training was provided for 42 new woredas, regional presidents' advisors, and M&E experts. Additionally, from the Southwest Ethiopia Region, eight woredas that implement food and nutrition strategy were also trained. For Seqota declaration woredas, GMP analysis reports were produced regularly for priority woredas. In addition, a customized HPV vaccination data collection form was developed, refresher training was delivered, and new user accounts were prepared for woredas and regions starting implementation.

Expansion of the Integrated Human Resource Information System (iHRIS)

Progress was made in the implementation and scale-up of the Integrated Human Resource Information System (iHRIS). Enhancements were introduced to the iHRIS-Admin dashboard, including the integration of updated indicators and improved reporting functions. The iHRIS-Licensure module was expanded to 12 regions, while preparations were made to integrate National ID with the system and align it with the Civil Service HR system.

The coverage of iHRIS increased from 60% to 90% of government institutions, with 657 additional facilities adopting the system. More than 367,233 health workers were registered in the iHRIS-HRA system. The licensure platform enabled health professionals to renew licenses online, strengthening

efficiency and accessibility. Furthermore, iHRIS-development was implemented in over CPD institutions, capturing 32,799 training records to support continuous professional development. To sustain progress, quarterly supportive supervision was conducted across all regions, and 1,635 professionals received training on iHRIS utilization and data management. These efforts contributed to improved human resource planning, monitoring, and management across the health sector.

Digital Health Infrastructure: MOH made progress in strengthening health information infrastructure by expanding HealthNet connectivity and bandwidth for 3,060 health institutions and offices, while also initiating the connection of 40 new facilities and planning SD-WAN technology integration for 300 institutions in collaboration with Ethio Telecom. More than 28 digital health systems were installed on ministry servers, with 15 operating through Tele Cloud, alongside efforts to expand national and emergency database storage capacity. To enhance system security, a cybersecurity baseline assessment and vulnerability analysis were conducted, gaps were addressed, and a five-day training was provided to experts to build cybersecurity capacity and safeguard digital health systems from potential threats.

Development and Customization of Digital Health Applications: Different digital health applications were developed and customized in the fiscal year including Tenenete (ጤንነቴ), Referral System, and Facility Licensing system with user training. Preparatory assessments and alignment were completed for new systems such as Tele-Radiology, Personal Health Records, Multi-Tenant EMR, Digital Health Payment, Facility Service Portal, and Appointment System. A national digital payment initiative was launched with project design, guidelines, and agreements signed with eight financial institutions, followed by pilot implementation in 12 regions and two city administrations, integrated with Bahmni-EMR and PulseCare-EMR. Performance-Based Financing data management with DHIS2 based system was introduced in 46 facilities across Addis Ababa, Somali, and Central Ethiopia, while requirements for developing the National Data Warehouse were finalized and submitted for procurement.

Digital Health Innovation Center Strengthening: Progress in digital health innovation includes ongoing efforts to establish prerequisites for Tele-Health platforms as part of civil service reform, develop a Digital Health Innovation Center, and foster collaboration with private developers through innovation competitions and system testing, including an upgraded ambulance dispatch and call center system. Feasibility studies are underway to evaluate new technologies, including AI and machine learning solutions, in partnership with the Ethiopian Artificial Intelligence Institute and Addis Ababa Science and Technology University. AI chatbots have been piloted to support HEWs and malaria parasite detection, with plans for a DHIS2 chatbot under review. An MoU was signed with key ministries and Orbit-Health to locally manufacture Bright Box hardware for facilities with limited connectivity. The GEEKS Project trained 24 regional health experts on immunization data systems, while work has begun to transform the Digital Health Innovation Center at St. Peter's Specialized Hospital into a Standard and Interoperability Lab (SIL) and sandbox hub for quality assurance of digital health solutions.

7.5. Regulation of food, medicine, medical equipment and other Health Products

Regulatory Services

Quality and safety regulation of food

Food market authorization: license to **4,186** food items

Certificates issued to **128** new manufacturers

Accredited **1,354** food importers and exporters

Regulation of medicine products

License: 746 new medicine licenses and approved 856 re-registrations

Certification and inspection of pharmaceutical establishments: 591 importers and wholesalers; accredited 51 small-scale manufacturers

Medicines valued at **1,098,180,644 Birr** that are considered not useful for human health were disposed

Regulation of medicine products

License was provided to 302 Stringent Regulatory Authority (SRA) devices, 291 standard non-in-vitro diagnostic (NIVD) devices, and 334 IVDs

Regulation of Cosmetic Products

License was provided for 170 cosmetic products

Cosmetics estimated at Birr 1,000,000 were disposed due to non-compliance with the standards

Inspections before licensing: to 15 cosmetics manufacturers, 65 importers/wholesalers

Inspections after licensing: to 81 cosmetics manufacturers, 93 importers/wholesalers

Regulation of health and health related facilities

Health Facility Inspections

32,329

Health facilities were inspected (261 faced temporary suspensions, 24 had their licenses revoked due to unsafe services)

Self-Regulation

2,394

health institutions implemented the self-regulation system

Regulatory standards

21

health and health-related institution standards were revised and developed

Ensuring Health Professional Competence and Licensure

Competency assessment exams administered for 19,653 health professionals, a pass rate of **61%**

Licensure of health professionals:

New professional license issued

42,074

Health professionals

Renewal of licenses

48,395

Professionals

The Ethiopian Food and Drug Authority (EFDA) regulates food, medicines, and medical products to ensure their safety, quality, and efficacy, licenses their manufacture, import, export, and distribution, conducts inspections and quality control, monitors adverse effects, and develops regulations while educating the public on safe product use. The major activities and achievements in 2017 EFY are described as follows.

7.5.1. Food Safety Regulation

The EFDA's regulation of food safety ensures that Ethiopian consumers have access to safe, high-quality food options while fostering a compliant industry. During the reporting period, EFDA intensified its focus on both expanding legal market access and safeguarding food quality across the supply chain.

Market Authorization and Establishment Licensing: The annual target was to register and license 3,656 distinct food items, with special categories earmarked for children's and infant foods. Through streamlined dossier reviews and increased outreach to manufacturers, EFDA licensed 4,186 items, including 85 additional food types, 24 children's and infant products, and 761 other varieties. This represents an overachievement, reflecting both strong industry engagement and the capacity to expedite evaluations while maintaining rigorous safety checks. Certification of food establishments competence ensures that food manufacturers, importers, and wholesalers adhere to Good Manufacturing Practices and hygiene standards. In the fiscal year, certificates were issued to 128 of 132 new manufacturers (96.97%) and accredited 1,354 importers and exporters. These certificates empower businesses to operate legally while giving consumers confidence in product origins and handling.

Inspection, Auditing, and Quality Control Initiatives: Audit-based inspections form the backbone of post-market regulations. EFDA completed 606 inspections of licensed manufacturers (94.5% of the target) and conducted 1,303 audits of importers and wholesalers. Each audit reinforces compliance with labeling, storage conditions, and hygiene protocols. Implementing the internal Quality Management System (QMS) among food sector establishments remains a critical priority. Roll out of standardized procedures was done to 47.4% of targeted manufacturers and 79.6% of importers and wholesalers. This phased approach allows to refine processes, train auditors effectively, and

ensure consistent documentation laying the groundwork for full uptake. Consignment quality testing is essential for preventing unsafe imports. Of 55 food types planned tests on high-risk food categories, EFDA completed 43 (78.2%) food types, analyzing 385 samples. While 292 met national standards and entered commerce, 19 failed outright, and 74 were pending analyses. Expanding the laboratory capacity will be crucial to achieving 100% coverage.

Enforcement Actions and Market Surveillance: Market surveillance activities led to 81 targeted surveys in major urban centers resulting in the disposal of products worth Birr 53,553,928 that were expired, adulterated, or illegally labeled. In parallel, 558 tons of products valued at Birr 77,977,513 were returned to their origin for not meeting regulations. These actions show commitment to protecting consumers and supporting fair business practices.

7.5.2. Regulation of Medicines

The medicines regulation program aims to ensure patient access while maintaining safety, quality, and effectiveness. In the fiscal year, EFDA planned 1,724 new medicine licenses, covering new biologics, generics, low-risk OTC products, and reviews by recognized Stringent Regulatory Authorities (SRAs). EFDA granted 746 new licenses and approved 856 re-registrations. All six applications for new molecular entities succeeded, while generics and low-risk products had completion rates of 45.4% and 37.7%, respectively. Delays were mainly due to incomplete Good Manufacturing Practice certificates and lengthy coordination for foreign inspections.

Certification and inspection of pharmaceutical establishments strengthen supply chain integrity. EFDA issued certificates to 591 importers and wholesalers and accredited 51 small-scale manufacturers. Audit inspections covered all 12 domestic pharmaceutical manufacturers and 1,685 wholesalers. However, audits of micro and small manufacturers reached only 69.4%, highlighting the need for additional field inspectors and risk-based scheduling.

Foreign GMP inspections are vital for validating overseas manufacturing quality. EFDA completed 18 of 96 planned audits, constrained by government approvals for international travel. To mitigate this bottleneck, virtual assessments are initiated and prioritized inspections in high-risk regions.

Post-market surveillance activities included sampling 308 batches of antimalarials and prescription medicines. Of the 134 samples tested, 94 passed laboratory tests. Specific tests included 49 batches of Artemether and Lumefantrine tablets (44 tested, 4 failed dissolution), 4 batches of Chloroquine Phosphate (1 failed), 8 batches of Artesunate injection (2 failed), and 9 batches of Artemether injection (1 pending). Additionally, 78 facilities were closed or had their licenses suspended, and fines totaling Birr 450,000 were imposed. Joint enforcement operations with customs and law enforcement seized medicines worth Birr 1,098,180,644 at entry points. In total, during the fiscal year, medicines valued at 1,098,180,644 Birr that are considered not useful for human health were disposed of. In addition, medicines valued at 230,325,215 Birr were collected for disposal."

7.5.3. Regulation of Medical Devices

Medical devices, ranging from diagnostic reagents to sterile equipment, demand robust regulatory over- sight to ensure patient safety. EFDA reviewed 1,200 device dossiers, including 200 SRA-listed non-IVDs, 500 standard non-IVDs, and 500 IVDs. License was provided to 302 Stringent Regulatory Authority (SRA) devices (151% of target), 291 standard non-IVDs (58.2%), and 334 IVDs (66.8%). The high success rate for SRA-listed products reflects international reliance, while further capacity building is needed for standard reviews.

Microbiological and performance testing ensures device sterility and functionality. Of 96 planned registration samples, only 26 microbiological tests (27.1%) were completed, and consignment testing on imported equipment reached 5 (26.3% of targets), highlighting the need for better lab equipment and specialized staff.

Pre-license inspections certified 2 device manufacturers, 40 importers/distributors, and 23 low-risk facilities. Audit inspections covered 97 (98% of importers and 26 (83.9%) of low-risk establishments, but only 17 (54.8%) of local manufacturers were audited, showing gaps in field operations.

7.5.4. Regulation of Cosmetic Products

Cosmetics regulation protects consumers from harmful ingredients and misleading claims. From the planned 424 cosmetics registration, license was provided to only 170 (40.1%) as many dossiers lacked complete safety data. Strengthening pre-submission guidance and harmonizing labeling standards will help industry meet requirements more consistently. At border checkpoints, monitoring was done to cosmetic imports worth Birr 75,587,490,642.12 and raw materials worth Birr 1,886,832,859.38. During routine checks, cosmetics estimated at Birr 1,000,000 were disposed of due to damage or non-compliance with the standards. Pre- and post-license inspections ensure proper manufacturing and storage practices. EFDA completed 15 (62.5% of the plan) manufacturer inspections and 65 (61.9%) of importer/wholesaler inspections before licensing, and 81 (61.8%) and 93 (53.8%) after licensing.

7.5.5. Regulation of Tobacco and Tobacco Products

Tobacco control is integral to public health, reducing exposure to harmful substances and ensuring adherence to packaging and marketing restrictions. Enforcement operations resulted in the seizure of 670 packs of illegal tobacco brands (Nyala, ORIS, Shamlan, Green Apple, and Mond Int.) worth Birr 103,640. Market surveys and checkpoint inspections collected 16,348,864 individual units and 5.4 quintals of loose tobacco significantly disrupting illegal supply chains. Simultaneously, the Authority worked with regional health and law enforcement agencies to fully inspect smoke-free public spaces in major cities, including Addis Ababa, Dire Dawa, Harar, Arba Minch, Halaba, Wolaita Sodo, and Hosaina. These efforts support the country's commitments under the WHO Framework Convention on Tobacco Control

Quality Management System (QMS)

Sustaining regulatory excellence requires a mature QMS aligned with international standards. In collaboration with WHO, EFDA finalized corrective actions to achieve WHO Maturity Level 3 (ML3) in the pharmaceutical sector, marking a significant milestone for Ethiopia, particularly in the realm of vaccines. This achievement enhances capabilities in ensuring the quality and safety of pharmaceutical products, which is crucial for public health. In addition, EFDA have achieved ISO accreditation for 12 parameters of food, 16 parameters of medicines, and 16 parameters of medical device quality assurance tests. Accreditation for the Drug Inspection, Medical Device Laboratory, and Food Laboratory was successfully maintained.

Challenges

- Insufficient Human Resources in the Regulatory System
- Non-Compliance of Local Medicine Manufacturers
- Inadequate Regulatory structure
- Lack of Infrastructure for Quality Assurance
- Heterogeneous Organizational Structures

Focus areas for the next fiscal year

- Attaining WHO maturity level 3
- Expedite the Construction of center of Regulatory Excellence
- Accelerate Organizational Reforms
- Strengthening National and Regional Collaboration
- Establish Partnerships with Higher Institutions and Professional Associations

7.6. Regulation of health and health related institutions

The regulation of health and health-related institutions ensures that all facilities and organizations delivering health services operate in compliance with established laws, standards, and guidelines. It safeguards the quality, safety, and accountability of healthcare services, protects communities through oversight of sanitation and environmental health, and promotes ethical and professional conduct. Regulation involves licensing, inspections, audits, certification, monitoring, and enforcement measures to maintain a reliable and safe health system

Regulation of Health Institutions: Regulation of health institutions ensures the quality, safety, and accountability of healthcare services through licensing, inspections, audits, certification, and professional standards enforcement. Key achievements during the reporting period include the following:

- **Health Facility Inspections:** A total of 32,329 health facilities were inspected nationwide, among which 261 faced temporary suspensions, 24 had their licenses revoked due to unsafe services, and 2,732 were newly licensed in line with national standards. A sudden and surprise inspections were conducted in 263 health facilities across all regions. In addition, waste management and disposal of 25 hospitals were inspected. Moreover, 18 health facilities that employ professionals from abroad underwent surprise inspections

- **Self-Regulation:** 2,394 health institutions (34 federal level) implemented the self-regulation system. and regional regulatory bodies trained, supported, and monitored to oversee and expand the self-regulation system.

- **Master Facility Registry (MFR):** All health facilities are registered with a signature domain, and the service domain coverage has reached 91% of the health facilities. Training of trainers was provided to all regional MFR focal persons, and 690 regional-level inspectors received basic MFR training. Technical support was also provided to develop an MFR Governance Protocol in all regions. In addition, data cleaning and validation activities were carried out, and an MFR roadmap was developed through the active engagement of key stakeholders.

- **Clinical Audits:** Clinical audit was done in 295 facilities that provide five service types: obstetrics and gynecology, surgery, emergency, intensive care unit, and laboratory services.

- **Regulatory document and tools**: In partnership with the Ethiopian Standards Institute, a total of 21 health and health-related institution standards were revised and developed, achieving 79% of the annual target. In addition, more than 21 regulatory documents were developed. Five health institution standards were revised, and technical support was provided to five health institutions for the development of new standards. Furthermore, two health-related facility standards were fully developed. Health facility inspection checklists was completed, with 14 checklists developed. The Clinical Audit Procedure Guidelines have been prepared, validated through stakeholder consultations, and finalized. In addition, the Governance Protocol for health and health-related institution standards has been reviewed and completed, while the roadmap for implementing these standards has reached 90% completion. Seven legal frameworks (laws and regulations) are under preparation and are being finalized.

- **Capacity Building:** Training provided to 3,190 health institutions

Regulation of Health-Related Institutions: Regulation of health-related institutions includes, safeguards public health by enforcing hygiene, sanitation, environmental health, and occupational safety standards in non-health service settings such as universities, schools, prisons, refugee camps and food and drink establishments. Key achievements during the reporting period include the following

- **Inspections:** 222,617 health and food service establishments inspected nationwide for hygiene and environmental standards**.**

- **Self-Regulation:** 5,711 (115 federal level) health-related institutions implemented the self-regulation system.

- **Standard**: 21 health and health-related institution standards revised/developed

- **Registration:** 85,951 health-related and food and beverage service institutions were registered across the country

- **Risk-Based Checks:** 1,268 selected institutions underwent risk-based inspections

- **Capacity Building**: Training provided to 9,669 food and health-related service providers

Table 32: Health related institutions hygiene and environmental health standards compliance status, 2017 EFY

Type of institutions	Non-compliance (≤50) No. (%)	Significant compliance (>50≤75) No. (%)	Optimal compliance (>75)No. (%)	Total
Hotel	46 (19%)	94 (39%)	100 (42%)	240
Bar and restaurant	123 (38%)	139 (43%)	65 (20%)	327
Juice houses	51 (32%)	78 (48%)	32 (20%)	161
Butchery houses	135 (43%)	143 (45%)	38 (12%)	316
Breakfast houses	168 (44%)	167 (43%)	49 (13%)	384
Men and women hair salon	72 (38%)	89 (46%)	31 (16%)	192
Total	**595 (36.5%)**	**710 (43.8%)**	**315 (19.5%)**	**1620**

7.7. Health Professionals' Competency Assessment and Regulation

Health professional regulation and competency assurance focus on licensing, certification, and continuous monitoring of practitioners to ensure they are qualified, ethical, and competent to deliver safe and quality healthcare services. Key achievements during the reporting period were:

Health professional's competency assessment: Computerized competency examinations were conducted in three rounds, covering 17 professional categories, while a practical competency exam was administered in one field (Anesthesia). In total, 19,653 candidates sat for the computer-based exams, with a pass rate of 61%. Additionally, 339 Anesthesia candidates were assessed through the Objective Structured Clinical Examination, with a pass rate of 96.5%. Significant cost savings of over 25 million ETB were achieved by reusing validated questions from the national question bank. Innovation was introduced through the integration of artificial intelligence, resulting in the development of AI-assisted software to support exam question preparation, thereby improving efficiency, quality, and standardization of the examination process. Moreover, a comprehensive guide on the competency assessment process has been developed. The guide documents past activities, key results, and future directions, serving as an important reference for strengthening the assessment system. It provides valuable insights for both national and international stakeholders engaged in healthcare workforce quality assurance.

Table 33: Number of health professionals assessed for competency and pass rate by profession, 2017 EFY

Field of Study	Number of examinees	Number Passed	Pass Rate (%)
Anesthesia	162	131	81%
Dental Medicine	131	101	77%
Emergency and Critical Care Nursing	4	3	75%
Environmental Health	45	24	53%
Human Nutrition	38	27	71%
Medicine	1,178	1,161	99%
Midwifery	1,449	922	64%
Medical Laboratory Science	2,021	1,311	65%
Medical Radiology Technology	277	245	88%
Nursing	6,157	2,944	48%
Optometry	26	26	100%
Pediatric and Child Health Nursing	45	36	80%
Pharmacy	5,928	3,711	63%
Psychiatric Nursing	153	136	89%
Public Health	1,982	1,167	59%
Surgical Nursing	57	54	95%
Total	**19,653**	**11,999**	**61%**

Licensure of health professionals: Nationwide, 42,074 health professionals were issued new professional licenses, while 48,395 professionals had their licenses renewed. In addition, 5,572 professionals received certifications, clarifications, and letters of good standing. An assessment on the status of 4,230 health professionals showed that 77% had an active license while 23% of them had their license expired. The proportion of health professionals with active license ranges from 50% in central Ethiopia to 90% in Addis Ababa.

Table 34: Status of professional license from assessed professionals in 2017 EFY

Region	Total assessed	With active license		License expired	
		Number	Percent	Number	Percent
Tigray	240	176	73%	64	27%
Afar	182	149	82%	33	18%
Amhara	630	462	73%	168	27%
Oromia	607	509	84%	98	16%
Somali	175	106	61%	69	39%
Benishangul Gumuz	161	117	73%	44	27%
Central Ethiopia	187	93	50%	94	50%
South Ethiopia	236	152	64%	84	36%
Sidama	323	256	79%	67	21%
Southwest Ethiopia	126	90	71%	36	29%
Gambella	107	58	54%	49	46%
Harari	297	221	74%	76	26%
Dire Dawa	296	257	87%	39	13%
Addis Ababa	663	594	90%	69	10%
Total	4,230	3240	77%	990	23%

7.8. Reform and Governance

Strengthening social accountability and institutionalizing good governance aims at fostering community ownership, ensuring timely feedback, and enhancing the quality of health service delivery. The following major activities and achievements were recorded during the fiscal year.

Strengthening Social Accountability in the Health Sector: During the fiscal year, efforts were made to strengthen social accountability in the health sector. A Health Sector Social Accountability Strategy was developed, consolidating ongoing sectoral initiatives as well as regional and national experiences, and has now been put into action. The strategy emphasizes accountability of health leadership at all levels and coordinated participation of stakeholders. It was disseminated across regions and city administrations, reaching a total of 1,445 participants (1,040 male, 405 female). To facilitate broader access, 600 copies of the strategy were printed in both Amharic and English and made available for download on the official website.

Community scorecard: To enhance community engagement and ownership, a Community Scorecard (CSC) system was operationalized in all regions. This system enables health facilities to collect and respond to community feedback, improving service delivery in primary health care facilities. As a result, the implementation of the community feedback mechanism has improved over time. By the end of 2017 EFY, 79% of PHCUs were implementing CSC and the average CSC score was 65%, ranging from 42% in Tigray and Afar to 92% in Addis Ababa.

Table 35: Number of PHCUs implementing Community Scorecard and average score by region, 2017EFY

Region	Proportion of PHCUs that conducted CSC assessment	CSC Average Score of PHCU
Tigray	37%	42%
Afar	68%	42%
Amhara	93%	68%
Oromia	76%	68%
Somali	58%	66%
BG	70%	53%
Central E	92%	74%
South E	83%	60%
Sidama	98%	78%
SWE	82%	59%
Gambella	27%	36%
Harari	100%	89%
DD	88%	88%
AA	98%	92%
National	79%	65%

The new Community Scorecard system was rolled out in six regions (Oromia, Amhara, Afar, Somali, Central Ethiopia, and Southern Ethiopia). A total of 829 health workers and professionals were trained, and ongoing awareness activities were conducted at all levels. These efforts have strengthened organizational processes, improved planning and monitoring, and enhanced support for social accountability initiatives across the health sector. The CSC score by six domains ranges from 70% for clean and safe health center to the lowest 60% for availability of Ambulance.

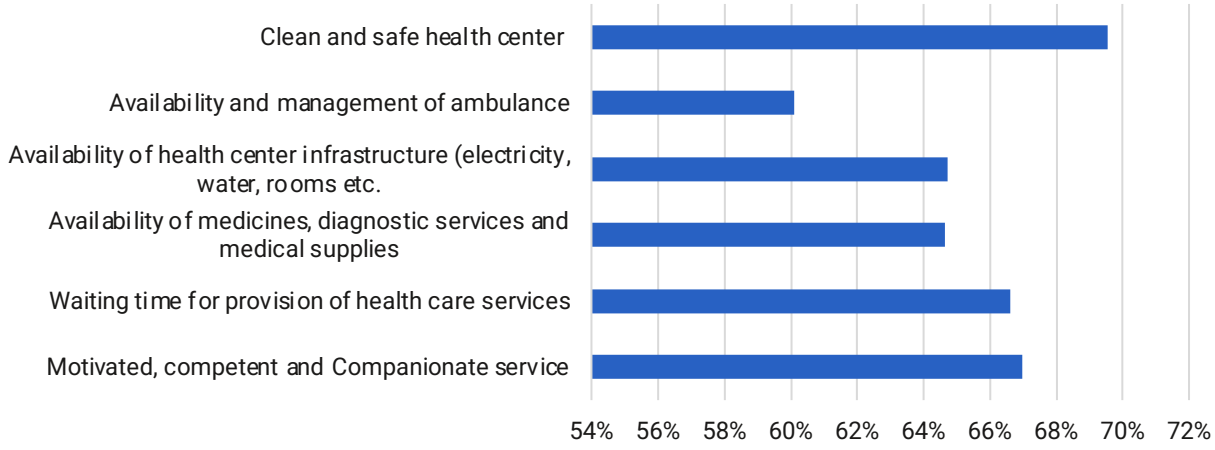


Figure 76: Average community score card score by domain, 2017 EFY

Good Governance

The health sector's Good Governance Package was prepared, and the package identified 35 challenges faced primarily by communities and staff and guided higher management to address them. It was disseminated to relevant institutions and RHBs, with implementation monitored and reported quarterly to relevant stakeholders. Out of the 35 identified challenges, 30 have been resolved at various levels, 3 are in progress, and 2 remain unresolved.

In hospitals, achieving good governance has been supported by a structured approach incorporating service users' feedback to design corrective measures. Implementation of the Good Governance Index (GGI) has shown positive results, particularly through community engagement mechanisms. Hospitals conducted quarterly self-assessments using the Index to identify challenges and address them. A GGI implementation study was prepared for 20 newly selected hospitals, providing training to 160 leaders and health professionals. During the fiscal year, among the 476 hospitals implementing GGI, 68% conducted quarterly self-assessments. The national average GGI score for public hospitals reached 55%, ranging from 83% in Sidama and 82% in Addis Ababa to the lowest 26% in Gambella.

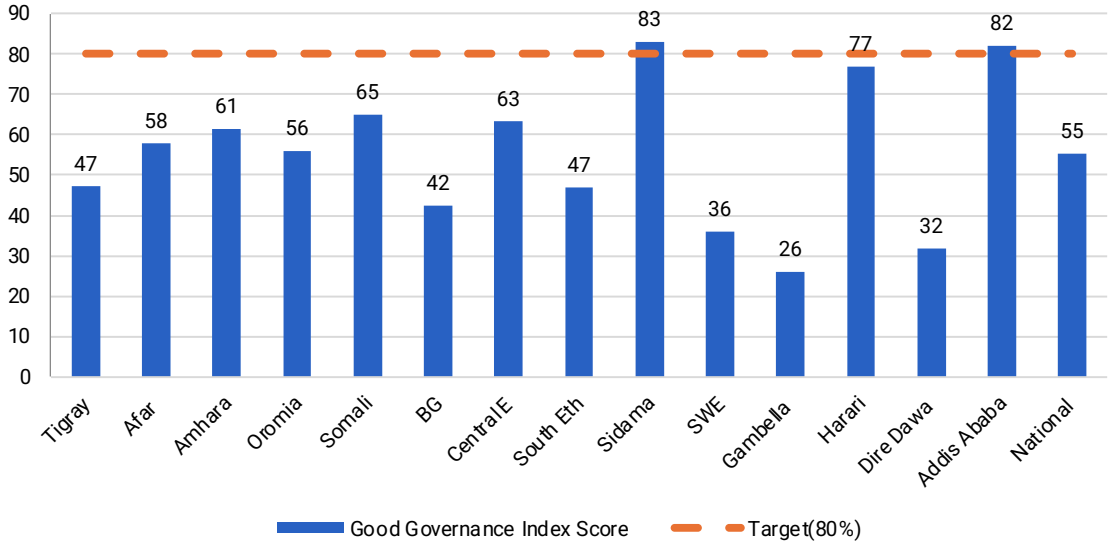


Figure 77: Average good governance score of Public Hospitals by regions 2017EFY

In Summary, health facilities have become more accountable to the community, and community participation and ownership in health service delivery at all levels of the health system have improved. Health information is now received more promptly, fostering a culture of responsiveness and accountability among leaders across the health sector. By institutionalizing social accountability mechanisms, strong relationships have been established between health facilities and the communities they serve.

Challenges

- Regional offices demonstrated limited understanding of social accountability tools, leading to inconsistent implementation
- Inconsistent implementation of the Good Governance Index in hospitals.
- Misalignment between Ministry of Health and Regional Health Bureau frameworks hindered efficiency and coordination

Next year priority

- Increase the proportion of health facilities implementing community feedback mechanisms to 80%.
- Improve the institutionalization of the Good Governance Index in hospitals from to 70%
- Prepare the Health Sector Good Governance Package and monitor quarterly
- Conduct quarterly sessions of the National Good Governance Forum

7.9. Gender, People with Disability and Social affairs Inclusion

Various initiatives have been implemented to ensure equal participation, strengthen women's capacity and engagement, increase the participation of persons with disabilities and youth, and protect children. The Women and Social Affairs Inclusion Executive Office of MOH has been working to make health programs more inclusive and responsive. The following are the major activities and achievements in 2017 EFY.

Gender Mainstreaming in Health: Progress was made in mainstreaming gender within the health sector. Gender training manual was revised, and 108 senior professionals (65 women and 43 men) were trained on gender mainstreaming. A DHIS2 dashboard was developed to monitor 16 key indicators related to gender, disability, gender-based violence (GBV), and women's leadership. In addition, 13 federal institutions (agencies and hospitals), were assessed using gender levelling tool. Training on gender analysis was also conducted, and analyses were carried out in four programs (HIV/AIDS, Women's Leadership, Nutrition, and Youth Health). Furthermore, guidelines were developed to promote gender equality and social inclusion in primary health care services.

Women's Leadership and Empowerment: To strengthen women's leadership in the health sector, 176 female leaders and potential leaders received targeted leadership training. In addition, a coaching program was launched for 20 women, and a mentoring program was introduced for 30 female potential leaders to support their professional growth. International Women's Day was celebrated at all levels, reaching 15,381 people with awareness activities focused on cervical and breast cancer. As a result, 5,126 individuals were screened, and treatment was initiated for 53 suspected cases.

Child Daycare Centers: Efforts to support working mothers and promote child welfare continued with the establishment of 46 new daycare centers in the fiscal year, bringing the total to 88 across the health sector. Training on childcare and child rights was provided to 40 female caregivers and nurses. Additionally, 60 participants (38 women, 22 men) were trained on child rights, wellbeing, and alternative childcare approaches. Ongoing support was also provided to 40 vulnerable children as part of the sector's commitment to child protection.

Disability Inclusion in Health: Progress was made in promoting disability inclusion during the 2017 fiscal year. A total of 101 professionals (71 women and 30 men) were trained as trainers on disability inclusion, and 135 participants (94 women and 41 men) received basic sign language training. To date, the total number of professionals trained in sign language has reached over 700. To strengthen accessibility, 45 health facilities received awareness sessions on disability corner standards. In EFY 2017, 37 new disability corners were established and bringing the total to 45 nationwide. Additionally, 13 health facilities were audited to assess disability inclusion and equitable access. To promote inclusive communication, 11 health messages and programs were adapted with sign language, and a documentary was produced to showcase the growing availability and impact of disability inclusive services in the health sector.

Gender-Based Violence (GBV) Prevention and Response: During the fiscal year, a GBV prevention and response pocket guide was developed, and service mapping was conducted in 38 health facilities. A TOT was delivered to 30 staff members (21 women, 9 men) from the MOH's hotline (952) and EPHI's hotline (8335) to support the integration of GBV response services. In addition, 89 participants (38 women; 51 men) received training on GBV prevention and response. Thirteen new integrated one-stop centers for GBV survivors were established during the year, bringing the total number of centers nationwide to 95. In the fiscal year, a total of 42,878 GBV survivors received care at national level, which is higher by 26% compared to the previous year.

Table 36: Number of GBV survivors that received care by region, 2017 EFY

	2016 EFY	2017 EFY
Tigray	3,146	9,670
Afar	412	770
Amhara	5,108	5,993
Oromia	7,544	13,520
Somali	2,048	1,001
BG	213	183
Central Eth	513	870
South Eth	3,665	4,652
Sidama	799	806
SWE	6,374	1,223
Gambella	167	63
Harari	213	184
DD	181	161
AA	3,638	3,782
National	34,021	42,878

Workplace Harassment Prevention and Response: To prevent and respond to workplace harassment, a training module was developed and launched as an e-learning course on the Ministry of Health's CPD website. A total of 953 health sector staff (485 men and 446 women) completed the training. In addition, a grievance reporting system was developed to address cases of sexual exploitation, abuse, and workplace harassment, aiming to strengthen protection and accountability across the sector.

Major Challenges

- Limited staff and structures at lower levels affected implementation.
- Budget constraints hindered planned activities.
- Inconsistent exempted fee healthcare for GBV survivors
- Low representation of women in leadership positions at all levels.
- Underreporting and poor data quality on GBV

Next Year Priority

- Mainstream gender in all health programs and strengthen capacity at all levels
- Promote women's leadership through training, support, and experience sharing
- Expand one-stop canters and ensure consistent, fee-exempt GBV services.
- Strengthen prevention and response of sexual exploitation, abuse and harassment
- Ensure disability-inclusive services through audits, more disability corners, specialized training, and accessible communication

Chapter 8

Innovation for Health system quality, Equity and safety

System Bottleneck Focused Reform (SBFR) project

42 High-load public hospitals

Primary Healthcare Unit System Bottleneck Focused Reform (PHCU-SBFR)

31 Woredas

Chapter 8: Innovation for Health system quality, Equity and safety

The Ministry of Health's Health Innovation, Quality, Equity, and High-Impact Leadership Program aims to establish a high-quality, responsive, and accountable health system that improves health outcomes, strengthens public confidence, and contributes to economic development. The program focuses on building strong leadership and regulatory capacity, reducing health inequities by addressing social determinants of health, and fostering a culture of innovation, quality, safety, and continuous system improvement. This section presents major initiatives and activities, key achievements, and challenges during the 2017 EFY, and future priorities.

8.1. Health Innovations

In the Ethiopian context, health innovation involves developing and applying new or improved healthcare practices, products, processes, and systems to address the unique challenges within the health system. Its primary goal is to improve health outcomes, enhance efficiency, optimize resource use, and ensure accessible, high-quality care for the population. Recognizing ongoing challenges such as rising healthcare costs, unequal access, and suboptimal health outcomes, MoH launched the Health Innovation Program to improve both health outcomes and the overall care experience. The program focuses on generating innovative ideas and solutions, testing and validating change concepts, documenting successful approaches, and scaling proven innovations to address systematically identified bottlenecks across all levels of the healthcare system.

Strengthening Health Innovation program: Ethiopia has prioritized health innovation by strengthening structures, strategies, and ecosystems to maximize impact in healthcare delivery, quality, and access. During the 2017 fiscal year, MoH undertook several initiatives to enhance the Health Innovation Program:

National Health Innovation Frameworks

- Developed the National Health Innovation Demand Articulation and Ecosystem mapping document to outline sector demands and map innovation actors and resources
- Launched the first National Health Innovation Strategy as a roadmap for transforming healthcare delivery and addressing population health needs.

Launched the First National Health Innovation Lab

- Established a state-of-the-art lab with facilities for ideation, co-designing and prototyping, knowledge management, partnerships, showcases, and creative spaces
- The lab serves as a homegrown platform for innovation, signaling strong leadership commitment to a thriving health innovation ecosystem
- MoH supported regions (Amhara, Oromia, Sidama) in establishing similar labs by developing standards and providing digital equipment.

Global Health Innovation and Quality Summit (GHIQ 2025)

- MOH hosted the first GHIQ summit, hosted in Addis Ababa from June 25–27, 2025, under the theme "*Leveraging Health Innovation Towards Achieving Universal Health Coverage*". This is made possible following Ethiopia successfully fulfilled the WHO Health Innovation Action Framework requirements, leading to an agreement for the country to host the annual Global Health Innovation and Quality Summit.
- Engaged over 1,200 in-person participants and 10,000 virtual attendees, including high-level government officials, policymakers, innovators, researchers, civil society, and international partners.
- Summit highlights: 11 keynote addresses, 4 plenary sessions, 9 interactive panels, 15 scientific paper presentations, 44 posters, 46 innovation exhibitions, special pitching sessions, and honorary lectures.

National Innovation Networking Platform

- National innovation networking platforms Established to foster collaboration, partnerships, and knowledge exchange among innovative ecosystem actors
- The first networking forum was successfully conducted with key partners

Innovation Identification and Support

- Initiatives to identify, evaluate, and fund problem-solving innovations were undertaken.
- Two priority innovations—reducing maternal deaths and enhancing supply chain efficiency—were selected for scaling, with efforts to secure funding through Grand Challenges Canada

National Innovation Think Tank Group

- Formed at the MoH level, including members from Ministries of Innovation, Technology, Education, Health, hospitals, partners, and private startups.
- Provides technical guidance and advisory support for innovation activities.

System Bottleneck focused reform implementation in 42 public hospitals

The pilot Public Hospitals system bottleneck focused reform (SBFR) Project, launched in May 2022 GC, is an innovative initiative implemented in 42 high-load public hospitals across Ethiopia. The project aims to improve hospital performance by addressing system bottlenecks such as inefficiencies, fragmented systems, poor use of evidence in decision-making, and weak accountability, which have contributed to high institutional morbidity and mortality.

Major Activities Implemented during 2017 EFY:

- Provided onsite technical support and monitoring across all hospitals, including process and output assessments, with regular feedback for improvement
- Supported digitalization in 23 SBFR hospitals to implement EMR; 12 hospitals fully adopted paperless EMR system, while others set up partial paperless systems for clinical services

- Conducted sudden night supervision visits using prepared checklists to identify system bottlenecks and provide corrective measures.
- Organized six rounds of learning and experience-sharing sessions at various hospitals, including Yekatit 12 Hospital Medical College, Alert Comprehensive Hospital, Adama Medical College, Adare General Hospital, Bishoftu, Mojo Hospitals, and Metu Karl Hospital.

SBFR achievements: Improvements in outcomes and outputs were registered compared to the baseline in 2014 EFY. SBFR Project demonstrates measurable improvements in hospital performance, patient outcomes and satisfaction through targeted interventions and system strengthening. Some of the improvements compared to the baseline includes (2014 EFY vs 2017 EFY):

- Inpatient mortality rate: Decreased by 30% (from 3.4 to 2.37)
- Emergency mortality rate: Decreased by 49% (from 0.95 to 0.48)
- Patient satisfaction: Increased by 10% (from 73.1% to 80.4%)
- Emergency room stays >24 hours: Decreased by 26% (from 17.3% to 12.8%)
- Bed occupancy rate: Increased by 4% (from 71.7% to 74.4%)
- Outpatient visits: Increased by 31% (from 5,165,770 to 6,756,296)

SBFR Implementation in selected 31 PHCU

The PHCU-SBFR pilot project is an innovative initiative aimed at improving the quality, efficiency, and cost-effectiveness of health services at the primary healthcare unit (PHCU) level to ensure equitable and high-quality access. The project targeted 31 woredas across Ethiopia, covering agrarian, urban, and rural settings, and incorporates intervention packages designed to address systematically identified bottlenecks at the PHCU level.

PHCU-SBFR project implementation clusters

- **Central cluster:** Addis Ababa, Oromia, and Central Ethiopia regions
- **Eastern cluster:** Harari, Somali, Afar, and Dire Dawa
- **Northern cluster:** Amhara, Tigray, and Benishangul-Gumuz
- **Southern cluster:** Sidama, Southern Ethiopia, Southwestern Ethiopia, and Gambella

Key Activities Implemented in 2017 EFY:

- Conducted regular technical support and sudden supportive supervision visits in selected health facilities across all clusters
- Provided orientation on PHCU-SBFR implementation packages to staff and managers from RHBs, Woredas, and facilities.
- Supported EMR implementation through procurement and installation of computers, Wi-Fi routers, and servers in health offices and facilities in Addis Ababa, Sidama, and Benishangul-Gumuz.
- Organized three rounds of experiential learning sessions and performance reviews at regional levels (Addis Ababa, Sidama, and Oromia).

- Developed a school-community networking guide to strengthen collaboration between schools and communities for improved project implementation.

8.2. Health care quality

The Healthcare quality agenda is mainly guided by the 2nd National Quality and safety strategy (NQSS-II), which aimed to continually improve health outcomes and confidence in the system.

In line with the strategy, several initiatives have been implemented during the fiscal year.

Enhance the coordination and integrated implementation of the National Quality and safety strategy (NQSS): To implement the NQSS-II strategy, the MoH has established governance structures, including the National Steering Committee and the Joint Quality and Equity Forum (JQEF), to coordinate and monitor performance at national and subnational levels. The JQEF facilitates joint planning with RHBs, while the National Innovation and Quality Steering Committee guides resource mobilization, oversees implementation, and ensures quality in health innovation and digital health projects. During the fiscal year, plan alignment and Performance monitoring of the NQSS-II have been conducted with RHBs. Moreover, National Innovation and Quality Steering committee meetings has also been conducted to support implementation and monitoring of the NQSS-II.

Healthcare Quality Community of Practice (COP): The first round of the Healthcare Quality COP forum, aimed at fostering collaboration and sharing best practices, was officially formed and held its inaugural meeting with partner organizations.

Clinical audit tool implementation: Technical support was provided to hospitals and health centers in implementing clinical audit tools by integrating audit training into quality improvement training materials. Innovation and Quality hubs received onsite support for clinical audit implementation, combined with QI coaching and mentoring activities.

Healthcare quality measurement: The National effective coverage guide has been launched. Effective coverage measurement tools have been finalized, and a DHIS2-based database has been developed to support data management and reporting.

NQSS-II Implementation Progress: As of the mid-2017 review of the NQSS-II implementation, out of 56 major activities: 22 (39%) were fully implemented, 22 (39%) were partially implemented, and 12 (22%) were not yet implemented. Performance by strategic objective showed varying achievement levels, with the objective to improve evidence-based healthcare provision reaching the highest performance at 88%, while the objective to reduce preventable harm from care delivery achieved 36%.

8.3. Health facility Accreditation

National Healthcare accreditation roadmap that guides the journey of healthcare accreditation was launched. Accordingly, the health facility accreditation system has been implemented in collaboration with the Ethiopia Standards Institute, and the Ethiopian Accreditation Service following the tripartite agreement made last year. The Hospital Accreditation Standard has been finalized, approved by the Ethiopian Standards Institute, and released for implementation. Accreditation support and benefits packages have also been completed and are ready for endorsement. Development of accreditation survey tools has been undertaken and awareness-creation activities on standards implementation were conducted for high-level leaders and stakeholders, including both public and private hospital

managers. Preliminary standards for health centers and diagnostic facilities have been completed and published online for wider public feedback. In addition, the accreditation program support system is being digitalized along with the preparation of a user guideline.

8.4. Healthcare safety

The Healthcare Safety Program is implemented under the five-year NQSS-II by introducing and applying various initiatives. During the fiscal year, special emphasis was placed on strengthening the healthcare safety system through a range of activities. Key activities carried out include:

- **Safe Care Alliance Project**: Implemented in 23 hospitals (16 public, 7 private) in collaboration with WHO's Global Patient Safety Partnership Initiative. The project supports hospitals with technical and capacity-building assistance to meet patient safety standards and prepare for accreditation.
- **Capacity Building**: Training on patient safety was provided to 31 experts from public and private hospitals in Addis Ababa, Amhara, Tigray, Sidama, Somali, and Harari regions.
- **Advocacy and Awareness**: Ethiopia commemorated *World Patient Safety Day* for the sixth consecutive year under the theme *"Improving diagnosis for patient safety"* and the slogan *"Get it right, make it safe!"*. Activities included panel discussions, scientific publications, and exhibitions.
- **Incident Reporting System**: Pilot implementation of patient safety incident reporting guidelines and a digital tool was conducted in selected hospitals. Based on the lessons learned, the initiative was scaled up to 23 hospitals.

8.5. Infection Prevention and Control Program

The goal of infection prevention and control (IPC) is to promote health care quality, which is safe for patients, health care workers, and others in the health care setting. Effective IPC program is the cornerstone for combating healthcare-associated infections (HAIs), antimicrobial resistance (AMR), patient and healthcare workers safety. Major activities during 2017 EFY include the following

Implementation of IPC Centers of Excellence: It is implemented in five selected hospitals (Yekatit 12 Medical College, Zewditu Memorial, St. Peter Specialized, Adama Medical College, and Felege-Hiwot Hospital). Technical support was provided to establish IPC teams in these hospitals to enhance implementation and monitoring activities, accompanied by supportive supervision and mentorship visits. Supplies and equipment were provided and distributed to promote effective environmental sanitation practices. Performance review and learning forums were conducted, and environmental sanitation audit tools were developed to standardize cleanliness methods, timing, and assessment in IPC practices, with training also delivered in these hospitals.

Healthcare-Associated Infection (HAI) Surveillance Implementation: HAIs training material was developed, and HAI Surveillance Readiness and Capacity Assessment was conducted, followed by targeted capacity-building activities. A survey was also carried out in ten hospitals to assess the extent of HAIs, identify major types of infections, and provide recommendations to improve healthcare quality and safety. The study included 1,281 eligible patients, with an average data collection period of 18 days per hospital across all departments. Findings showed HAI prevalence ranging from 5% to 47%, with the highest rates in ICUs (28%), followed by maternity wards (22%) and pediatric ICUs (22%).

The most common infections identified were surgical site infections (15%) and urinary tract infections (13%). In addition, a performance review meeting was held, bringing together hospital management and IPC focal persons to share experiences and lessons learned from implementation.

IPC Program Performance Tracking Tool (IPC-FLAT): The IPC FLAT tool (Facility Level Assessment Tool) is designed for healthcare facilities to evaluate system capacity and compliance with IPC practices, ensuring safe healthcare services. It assesses both the facility's IPC infrastructure and healthcare workers' compliance with standards, helping to guide work plan development and track progress over time. Following the launch of the Hospital Clinical Audit Tool, several activities were carried out to support its implementation. Orientation training on the Hospital IPC FLAT tool was provided to IPC focal persons in 60 hospitals. In addition, an IPC FLAT tool for PHCUs was developed, and pilot implementation began through orientation training for 280 health professionals from selected primary SBFR sites in Addis Ababa, Sidama, and Oromia.

IPC Education and Training: To integrate IPC education and training into the pre-service health science curricula, preparatory activities are ongoing focusing on Nursing, Midwifery, Public Health, Medicine, and Laboratory departments through providing basic IPC training for university instructors.

IPC Budget support: Through the World Bank support, a total of 52 million Birr budget has been transferred to the regions and city health bureaus aimed to enhance IPC program implementation anti-microbial medicines and preparation for outbreak readiness and response activities through the Health Emergency Preparedness, Response, and Resilience program.

8.6. Health Equity

Ethiopia has made strong commitments to advance health equity in pursuit of national and global SDG targets. This commitment is reflected in the development and launch of the National Health Equity Strategic Plan (NHESP), which sets ambitious goals to reduce equity gaps, expand coverage and utilization of essential health services, improve healthcare quality, and strengthen implementation capacity across all levels of the health system, aligned with the UHC principle of *"leaving no one behind"* by 2030. Key initiatives implemented during the fiscal year include:

- The integration of the implementation of National Health Equity Strategy with the National Steering Committee and the Joint Quality and Equity forums to enhance coordination and monitoring
- The National Health Equity Measurement and Improvement Guide was launched, and training materials were finalized
- For the Social Determinants of Health project regions (Afar, BG, Gambella, and Somali), emergency transport vehicles worth ETB 150 million and advanced medical supplies worth ETB 95 million were procured and distributed
- Mobile health services training materials were developed, and an essential medical supplies kit was standardized to strengthen implementation
- Two rounds of supportive supervision were conducted across facilities in six woredas implementing mobile health services in Afar, Tigray, and Somali
- Health Equity Leveling Project document was finalized and is ready for launch

8.7. High Impact leadership program (HIL-PH)

The Ethiopian health sector has recognized the importance of leadership and governance in achieving its goals of improving the health status of the population and leadership has been identified as a key pillar in HSDIP for driving positive change and innovation. The HIL-PH program emphasizes strategic, mid-level, and frontline leadership development, women's leadership empowerment and participation, accountability systems for health leadership and Succession planning and mentorship for emerging leaders. During 2017 EFY, the following are conducted and achieved.

- Training Resources: Strategic, mid-level, and frontline leadership training resources were fully developed, endorsed for CPD, and are being integrated into e-learning platforms. A women's health-leadership training manual was also finalized to strengthen female participation in leadership roles
- Training of Trainers: 90 mid- and lower-level health leaders from all regions successfully completed TOT, equipping them to cascade trainings
- Basic Leadership Training: 453 mid- and frontline leaders from five regions received basic leadership training. In addition, 190 female mid- and frontline leaders from the same regions completed the program
- Coaching and Mentorship: On-site coaching and mentoring support was launched and provided to training participants throughout the implementation period
- Managerial Accountability: A pilot accountability system was introduced in 140 woredas, with 50 professionals trained in managerial accountability.
- Leadership Incubation Program (LIP): Networking platforms were established to support peer learning and mentorship. The program graduated 56 trainees in its 6th cohort and 57 in its 7th, bringing the total graduates to 274. Comprehensive coaching and shadowing programs were also implemented to reinforce on-the-job learning and sustain leadership development across the health sector.

Knowledge management and Learning

In the 2017 EFY, a knowledge management and learning initiative was launched to enhance knowledge management and learning across health innovation, quality, equity, and leadership functions of the MoH. The initiative aimed to institutionalize evidence-based decision-making, strengthen data systems, and expand digitalization efforts. Key knowledge management tools and sessions were undertaken in the fiscal year

- An integration Implementation Guideline was developed as one of the pilot innovation projects to support integrated execution of programs across all levels of the health system
- Research Advisory Committees were established in four thematic areas—Health Innovation, Healthcare Quality and Safety, High-Impact Leadership, and Health Equity—to strengthen evidence-informed policy and program improvements
- The Abrehot Session, a monthly learning and knowledge exchange forum, was organized
- Performance review and planning alignment sessions were conducted to improve coordination and accountability

Way forward

Health Innovation

- Disseminate the Health Sector Innovation Strategic Framework and Innovation Demand Articulation and Ecosystem Mapping Document
- Organize Health Innovation Week to showcase innovations
- Establish an "AI for Health" platform for human-centered AI initiatives
- Support Health Innovation Labs in RHBs and institutions

Health care Quality

- Strengthening Quality Management Systems
- Advancing Continuous Quality Improvement and Learning in Health Services
- Organize Global Health Innovation and Quality summit 2026

Health facility accreditation

- Strengthen implementation of Health Facility Accreditation
- Support the digital implementation of the health facility accreditation system
- Conduct advocacy campaigns to promote health facility accreditation

Health care Safety

- Improving multisectoral collaboration and governance for patient safety
- Building capacity and promoting learning in patient safety

Infection Prevention and Control

- Improving Infection Prevention and control policies and strategic implementation
- Enhancing Facility-based infection control systems
- Strengthen IPC Centers of Excellence program implementation in the selected hospitals
- Provide technical support for selected pilot HFs in the implementation HAI

Health Equity

- Strengthen implementation of National Health Equity Strategy and related projects
- Implement National Health Equity Monitoring and Improvement Guide
- Strengthen mobile health services through supply provision

High Impact Leadership Program for Health-HIL-PH

- Strengthening leadership learning and development
- Build capacity for strategic, mid-level, and frontline health leaders
- Enhance accountability systems and promote women's leadership
- Advance clinical leadership programs and the 8th round of LIP training
- Conduct annual national health leaders' forum
- Support managerial accountability implementation in 524 districts

Knowledge Management and Learning

- Strengthening Monitoring, Evaluation, and Knowledge Management Systems for Innovation, Quality, Equity, and Leadership Programs
- Strengthen research and advisory committee for innovation and quality (IQ-RAC).

Chapter 9

Pharmaceuticals and medical device management and pharmacy services

Procurement

> 52.3 billion Birr

worth of pharmaceuticals and medical supplies was procured

Distribution

Ethiopian Pharmaceuticals Supply Service (EPSS) has distributed pharmaceuticals and medical supplies worth of

ETB 64.5 Billion Birr

to health facilities

Availability of essential drugs

81%

The availability of tracer essential medicines at EPSS hubs

84%

The availability of tracer essential medicines at health facilities

Wastage rate

0.64%

The wastage rate of pharmaceuticals at EPSS hubs

Procurement lead time

201 days

Medical equipment management

6,497

Medical devices distributed and installed

3,123

Medical devices installed at health facilities

1,294

Medical devices repaired

Chapter 9: Pharmaceuticals and medical device management and pharmacy services

This section highlights the health sector's initiatives, achievements and performance in pharmaceutical supply, medical equipment management, pharmacy services, and traditional medicine.

9.1. Supply of Pharmaceuticals and medical devices

The Ethiopian Pharmaceutical Supply Service (EPSS) is a national agency mandated to procure, store, and distribute pharmaceuticals, laboratory reagents, medical supplies and equipment to health facilities across Ethiopia. With its wide network of regional hubs, EPSS ensures accessibility for the population and contributes to improving health outcomes by guaranteeing the availability of essential health commodities. Its mission is to provide a sustainable, affordable, and uninterrupted supply of quality medicines and supplies, thereby playing a vital role in the resilience and effectiveness of the country's healthcare system. The following are the major achievements in 2017 EFY.

Procurement: In the fiscal year, a total of 52.3-billion-birr worth of pharmaceuticals, medical supplies, and medical equipment were procured to meet the needs of health facilities. Of this total, 10.1 billion birr was covered by the Revolving Fund, 8.8 billion birr from health programs, 709 million birr from the government treasury, and the remaining 32.6 billion birr was obtained through grants.

Distribution: Pharmaceuticals, reagents, medical supplies, and equipment worth a total of 64.54 billion birr were distributed to health facilities. Of this, 12.2 billion birr was from the Revolving Drug Fund and 52.34 billion birr from health programs. Out of the total distributed, 47.6 billion birr were medicines, 11.14 billion birr were medical supplies, and the remaining 5.8 billion birr were chemical reagents.

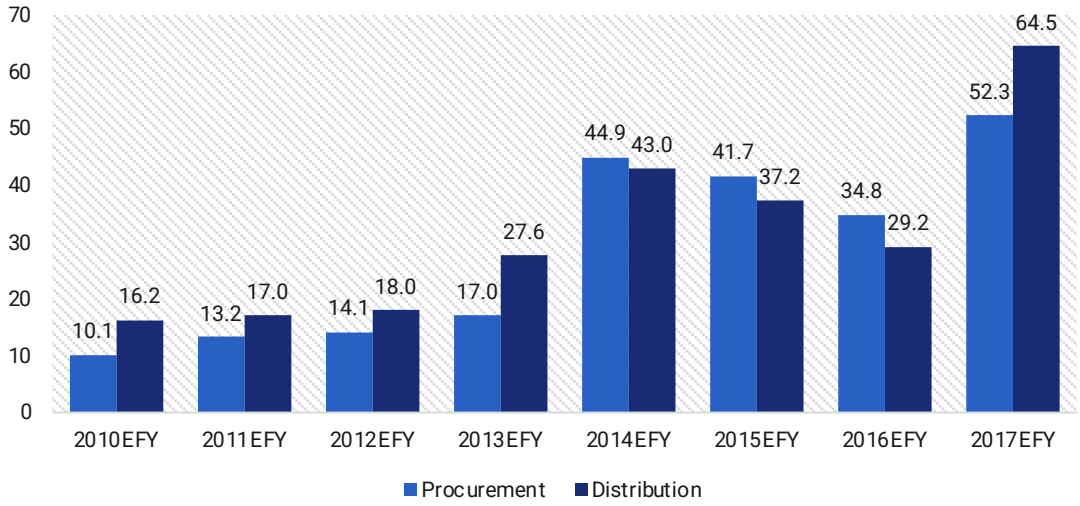


Figure 78: Pharmaceuticals and medical supplies procured and distributed in Billion ETB, 2010 to 2017 EFY

Supply chain Management

In response to national macroeconomic reforms, efforts were made to align the selling prices of pharmaceuticals supplied by EPSS with those in the private sector, in accordance with government subsidy measures. Consequently, the prices of expensive pharmaceuticals worth 38 million birr were reduced to reflect market conditions. To offset this adjustment and maintain market stability, slight price increases were applied to commonly available low-cost medicines.

The 3rd Edition of the Pharmaceutical Procurement List (PPL) was published. In the 2017 fiscal year, the forecasting process was improved by using three-year forecast trend analysis from branch offices, which allowed for more accurate projections compared to previous years. The forecast accuracy was 58.5%, which is lower than the target 75% set for the year.

By revising a Vaccine supply chain strategy, annual operational plans were developed to ensure practical execution. This involved procuring cold chain equipment, vehicles, and other related items to strengthen the Vaccine supply chain. Based on this plan, a total of 210,000,000 birr in financial support from the Global Fund was used to procure 18 NPR Isuzu and 15 FSR vehicles, which have now been deployed for service. Similarly, with financial support of 65,659,292.40 birr from Africa CDC, 10 cold chain land cruiser vehicles were procured and transported to operational sites. In total, combining support from the Global Fund and Africa CDC, 275,659,292.40 birr was used to purchase various vehicles for distribution services, which have now been put into services.

EPSS is directly delivering vaccines to all hospitals and health centers by strengthening the analytical skills and data-use culture of its professionals at all levels, enabling effective segmentation, distribution, and network analysis. In addition, the pilot drone technology, tested for vaccine delivery to health facilities, is being evaluated, and the best practices identified are being scaled up to expand its use to other health facilities.

Domestic supply of pharmaceuticals

Considering the focus on local manufacturers, private manufacturers were contracted to supply pharmaceuticals worth 10.4 billion birr; however, they managed to deliver medical items valued at only 2.18 billion birr (21%).

Additionally, during the fiscal year, tenders worth 37.16 billion birr were awarded to foreign suppliers and 15.82 billion birr to domestic suppliers. This indicates that local manufacturers accounted for an average share of 30%.

Table 37: Key pharmaceuticals and medical supplies procurement performance indicators, 2017 EFY

S. N	Key procurement performance indicator	Performance	Target
1	Forecast accuracy (%)	58.5%	75%
2	Drug Availability (%)	81.3%	90%
3	Average procurement lead time	201 days	200 days
5	International Supplier's fill rate	99.6%	100%
6	Average suppliers lead time	57 days	55 days
8	Local Supplier's fill rate	56%	100%
9	Stock availability	58.20	70%

Warehouse management

Extensive work has been carried out to standardize warehouse operations, develop practical operational guidelines, and ensure the accuracy of information recorded in bin cards and stock records. To achieve this, tools such as Kaizen and the Quality Management System (QMS) have been applied, continuous monitoring and evaluation activities have been conducted, and corrective actions have been established. Additionally, the direct transfer of commodities from the point of receipt (port) to the intended health facilities has been facilitated, and pharmaceutical requests are received and prepared for timely distribution.

Efforts are ongoing to strengthen the direct distribution of medicines and medical supplies to health facilities. With support from USAID, direct distribution services have been successfully implemented across 650 health centers in six branches. Similarly, with funding from GAVI, direct distribution has been expanded to a total of 378 health centers.

When comparing the cost of medicines distributed to health facilities with the total health expenditure, the performance was 0.46%, which is lower than the set target of 0.5%.

During the fiscal year, medicines, medical supplies, medical equipment, as well as chemical and diagnostic items worth 30.4 billon birr were available in stock at the headquarters and branch warehouses.

Table 38: Pharmaceuticals and medical supplies stored in central and branch warehouses, 2017 EFY

S.No	Items	Regular Budget (ETB)	Health program budget (ETB)	Overall store
1	Pharmaceuticals	3,721,670,266.97	15,819,518,290.93	19,541,188,557.90
2	Medical Supplies	3,288,933,820.54	700,680,270.32	3,989,614,090.86
3	Medical Equipment's	729,909,897.54	1,822,581,370.83	2,552,491,268.37
4	Chemical diagnostics	855,183,263.63	3,470,660,103.71	4,325,843,367.34
	Total	**8,595,697,248.68**	**21,813,440,035.79**	**30,409,137,284.47**

Pharmaceutical wastage is minimized by redistributing stock from overstocked to understocked hubs and by conducting a monthly inventory data analysis. The national wastage rate for the fiscal year is 0.64%, which is improved compared to the previous year, which was 0.99%.

Table 39: Performance of key warehouse management indicators, 2017 EFY

S. N	Indicator	Target	Performance
1	Order Fulfillment Percentage	75%	86%
2	Average pharmaceuticals delivery time	3 days	1.1 days
3	Pharmaceuticals wastage rate	0.68%	0.64%
4	Inventory accuracy rate	100%	98%
5	RRF reporting rate	100%	100%
6	Average distribution cost (%)	0.5%	0.46%
7	Vehicle out-of-service time (days)	27 days	29 days
8	Proof of delivery rate (%)	100%	96.9%

Digitizing pharmaceutical supply chain technology & information management system

Activities have been designed to leverage modern technological solutions to enable data-driven decision-making processes. Based on this, the implementation of ERP and other related technologies enables greater information visibility.

Supply Chain Data Visibility: Using advanced technologies on the data visibility and analytics dashboard, the supply chain system has been integrated with government health facilities for real-time monitoring of drug availability, enhancing visibility and supporting decision-making. Additionally, an information exchange system, along with leveraging the facility's internet capacity through VPN, ensures data accuracy and further improves supply chain visibility.

Challenges

- Local suppliers faced foreign currency shortages, delaying pharmaceutical delivery according to contracts
- Security challenges and unrest in some areas caused delays and required costly air transport
- Distribution vehicles experienced wear and extended maintenance due to long-distance travel and equipment shortages
- Health facilities' budget constraints delayed payments, leading to accumulating receivables
- Reporting was sometimes incomplete or inaccurate
- Foreign currency shortages

9.2. Pharmaceuticals and medical devices management and services

Medical Equipment Availability and Management

In 2017 EFY, medical devices, consumables, and parts worth more than 20.3 million USD were identified, a procurement plan was prepared, procurement orders were sent, and a continued monitoring process is implemented. A total of 6,497 medical devices were distributed to health facilities, including mobile X-rays, mechanical ventilators, oxygen cylinders, ultrasounds, and heavy-duty autoclaves. About 3,123 medical devices were installed in health facilities. To enhance the management of medical devices at the facility level, 213 health facilities are now utilizing the Medica Equipment Management Information System (MEMIS), with 93 of them receiving on-site technical support in the fiscal year. To date, over 120,000 medical devices have been registered in MEMIS.

A maintenance campaign was conducted to enhance the functionality of medical devices in selected regional and federal health facilities. As a result, 1,294 medical devices were repaired and restored to operation. Additionally, spare parts were identified for 336 devices, and 255 pieces of equipment were installed, leading to savings of approximately ETB 64.1 million. Simultaneously, a national cold-chain equipment maintenance campaign was carried out across 602 health centers, restoring 742 cold-chain equipment to function, resulting in cost savings of more than ETB 97 million. The combined savings from both campaigns amounted to ETB 161.1 million, significantly optimizing resource utilization.

Pharmaceutical Logistics System strengthening

For the next fiscal year (2018 EFY), pharmaceutical supplies valued at over 875 million USD were quantified to enhance the availability of essential medicines in health facilities. To foster collaboration, 12 forums and three Steering Committees were established, focusing on key issues in health program products and supply chain management.

The assessment of Dagu functionality has been completed, and the Dagu scale-up has been successfully implemented across 57 health facilities in the fiscal year. Total facilities implementing DAGU have reached 1300. Efforts have been made to enhance the functionality and utilization of the national Supply Chain (NSC) dashboard, and mBrana was started in 616 Woreda. The eAPTS was successfully implemented in 32 health facilities, and ePMIS in 56 health facilities through onsite support in 2017 EFY. A new chronic care pharmacy service was rolled out in 24 hospitals. Furthermore, the stock status of 851 health facilities was visualized on the NSC Dashboard by integrating data from MEMIS, DAGU2, eRIS, and ERP, improving transparency and decision-making.

The development of the national medicine and medical policy is finalized, and an implementation roadmap is drafted. This includes Pharmacy Service Reform and Quality Improvement, with developments in these areas.

Improve availability of medicines

Out of over 88 million individuals with prescriptions at health facilities, 77% have received all their prescribed medications. There is a regional variation, and performance mirrors that of the previous year. The availability of essential drugs in health facilities was monitored, with 25 selected essential drugs being available 84% of the time, marking a one percentage point increase from the EFY 2016 performance.

Regarding the trend of antibiotic prescriptions in health facilities, although the recommendation is between 20% to 30%, the EFY 2017 performance showed that 51% of clients received antibiotics. This represents a slight decline from the EFY 2016 performance of 51.7% but remains significantly above global recommendations.

Antimicrobial Resistance (AMR) Prevention & Stewardship

In 2017 EFY, national and regional governance structures with six technical working groups were established. Commemorations like World Antimicrobial Resistance Awareness Week and National AMR Day were held. A mass media campaign, including TV, radio, social media, and print, along with an AMR awareness song, was launched for broader reach. Antimicrobial Stewardship Programs were implemented in 328 health facilities, and AMR-related drug use studies were conducted in 150 facilities across six regions. An AMR M&E training manual was developed, with training provided to 170 health institutions. Additionally, an AMR Pre-service curriculum framework and training manual were developed, and TOT training was provided.

Challenges of pharmacy services

- Delay in releasing approved budgets and insufficient funds for planned digitalization initiatives
- Limited human resources with high turnover at both federal and regional levels
- Fragmented digital health systems

Way Forward (pharmacy services)

- Streamline budget approval processes and ensure timely release of funds to support digitalization initiatives
- Invest in training and retaining skilled human resources to reduce turnover and enhance capacity at all levels
- Integrate and standardize digital health systems to improve efficiency and interoperability

9.3. Traditional Medicine

For the first time, a traditional medicine standard has been developed and submitted to the Ethiopian Standards Institute. The approval of this document, along with a code of practice, will establish a foundation for the service development of Ethiopian Traditional Medicine. Traditional Medicine integration into the Health Sector guide was also developed and this is one step forward in integrating traditional medicine with modern healthcare. Capacity building activities for traditional medicine practitioners were standardized, harmonized and integrated and all institutions are using a traditional medicine education curriculum design by the MOH. The training materials are also translated into different local languages and in the current fiscal year a total of 158 traditional healers were trained.

Many advocacy and awareness workshops were conducted, bringing together traditional healers, regulators, researchers, and both national and regional stakeholders. These advocacy initiatives seek to establish a traditional medicine unit within regional health bureaus, enhance the registration and regulation of traditional healers, and promote awareness about the safe use of traditional medicine.

In addition to the above activities, the following major activities and achievements on traditional medicine were done by the Armoun Hansen Research Institute during the fiscal year

- **Efficacy study**: AHR has conducted studies on a total of 34 plants concerning In-vitro antimicrobial, In-vivo antidiabetic, In-vivo mosquito repellent, In-vitro anticancer, and In-vitro antioxidant research
- **Safety Study**: Safety studies focusing on short-term and medium-term effects were carried out on 16 plants, along with the isolation of 17 fractions from 8 compounds. Furthermore, data from 20 medicinal plants were gathered for the preparation of the Pharmacopoeia.
- **Safety test**: During the reporting period, AHRI has signed a Memorandum of Understanding (MoU) with a traditional healer to offer safety testing services for traditional medicine. The institute has received two medicines, and the safety and quality assessments have been conducted on the medicines received.
- **Conservation of Traditional Medicinal Plants:** 45 different plants used in traditional medicine have been collected from various locations and are being planted and maintained in a botanical garden for conservation and further study.

Chapter 10

Health Financing and private Sector Engagement

Budget allocation

12.1%

of the total government budget was allocated to health

Development partners' contribution to the health sector

Commitment:
524.7
million USD

Disbursed:
334.8
million USD (64% of the commitment)

Public Private Partnership (PPP)

PPP for diagnostic services:

In St. peter hospital for integrated diagnostic services. It is on the final stage of agreement to start the service

PPP for oncology service:

In St. Paul hospital; feasibility study being done

Community Based Health Insurance (CBHI):

Coverage of CBHI implementing Woredas:

1,304 (91%)
Woredas

CBHI Membership:

>13.67 million
Households (84% of the eligible households)

CBHI Membership renewal:

96%
of CBHI members renewed their membership

Pooling

CBHI Membership Fee Collection:

>15.2 billion ETB

The sliding scale system:

("premium payment based on income") – scaled up in
738 Woredas

Higher level Pooling:

Established in **39**
regions and zones

Chapter 10: Health Financing and private Sector Engagement

Ethiopia's pursuit towards UHC is anchored in the goal of ensuring that all citizens have access to affordable, high-quality healthcare services. Central to achieving this vision is health financing, which forms the foundation of a resilient and equitable health system. Recognizing its critical role, the Ministry of Health has prioritized health financing within the HSDIP, spearheading reforms and exploring innovative financing mechanisms to strengthen sustainability and equity in service delivery. Looking ahead, these reforms are expected to expand coverage, reduce out-of-pocket spending, and protect people from catastrophic health expenditures.

Recent innovations in financing—such as public-private partnerships (PPPs), the shift from passive to strategic purchasing (e.g., performance-based financing), and efforts in establishment of an Equity and Resilient Fund—hold promise for enhancing resource allocation and service delivery. However, challenges remain, including securing sustainable funding, improving cost-effectiveness, and financing exempted health services. These hurdles also present opportunities for further innovation and collaboration.

This chapter highlights Ethiopia's key achievements in health financing during 2017 EFY.

10.1. The Revised Health Financing Strategy

The revised Healthcare Financing Strategy (HCFS) was recently approved by the Council of Ministers. The overall objective of the strategy is to accelerate progress towards UHC by defining a 'strategic framework' to achieve better health outcomes, financial protection against catastrophic health illness, and public satisfaction. Key initiatives and interventions are indicated under five strategic objectives:

1. Mobilize adequate resources through traditional and innovative approaches
2. Reduce out-of-pocket spending at the point of use
3. Enhance equity, efficiency and effectiveness
4. Strengthen public-private partnership; and
5. Capacity development for improved healthcare financing

For better implementation of the revised strategy, a detailed implementation plan has been developed consisting of key initiatives, main and sub activities, mapping of stakeholders at all levels, investment need, capacity and monitoring and evaluation framework. The implementation manual was developed through the active engagement of relevant stakeholders, ensuring alignment with national priorities and sector needs. Within the manual, key reform areas for the health financing system have been identified and clearly outlined. The document is currently awaiting validation by stakeholders and final endorsement by the Ministry of Health leadership.

Financing of Exempted Health Services

Ethiopia operates an exempted health service financing model where selected essential PHC services are provided free of charge in public facilities. However, recent years have seen a decline in support from development partners for these services, coupled with inadequate mobilization of domestic resources. As a result, the provision of these high-impact essential services has been challenged. This has become a prominent issue, with health facilities either using their internal revenue to finance

exempted health services to avoid service interruptions, or clients are forced to buy drugs and supplies from private counterparts increase the out-of-pocket spending. This practice has become unsustainable, highlighting the urgent need for an immediate and long-lasting solution as part of the overall healthcare financing system. Hence, a detailed work on standardization and prioritization of the intervention as well as the costing and financing gap analysis were already done in the previous fiscal years.

In this fiscal year, the primary focus has been on resource mobilization from domestic sources. With dwindling international financing and a growing healthcare funding gap, domestic resource mobilization (DRM) has become essential for sustainable health financing. In line with the revised healthcare financing strategy, MOH has been working on DRM activities specifically on increasing government budget for the provision of exempted health services and establishing a health fund as a new channel for mobilizing domestic resources. Several discussions were made with the ministry of finance on the financing need for exempted health services and the different financing options such as increase government budget, innovative financing mechanisms, and strengthening cofinancing arrangements. The key activities and achievements for this year were

- An additional budget has been secured from the federal government for the procurement of commodities for the prioritized exempted health services such as maternal, neonatal and child health services
- A high-level joint committee has been established consisting of members from the MoH and MoF to support the additional DRM efforts such as tax earmarking for health.
- To leverage donor resources, a new co-financing arrangement is under development targeting to fill the financing gap of RMNCH service. Several partners have already given their commitments, and the compact agreement will recently be signed among the MoH, MoF and development partners.

10.2. Performance Based Financing

The Performance-Based Financing (PBF) pilot initiative, launched in October 2023 GC, has made substantial progress in transforming healthcare delivery across pilot sites in Addis Ababa, Central Ethiopia, and Somali regions. Covering 41 health centers and 5 hospitals, this strategic purchasing approach has successfully linked financial incentives to predefined performance targets, fostering efficiency, accountability, and quality improvements in healthcare services.

One of the notable achievements of PBF has been the improvement in data quality and its use for decision-making. The Ethiopian Health Insurance Services, as the purchaser, has been conducting regular performance verification, which has strengthened the capacity of health facilities to utilize data effectively, leading to more informed decision-making at health facilities.

Another significant outcome has been the generation of additional revenue by health facilities. During the 2017 EFY, the pilot facilities recorded quarterly revenues of 18.5 million ETB in the first quarter, 19.6 million ETB in the second quarter, 21.3 million ETB in the third quarter, and 21 million ETB in the fourth quarter, culminating in a total of about 80.4 million ETB. These funds have been reinvested into the facilities to enhance the quality of care.

The initiative has also achieved important milestones in institutional integration. Through collaboration with the Ministry of Finance (MOF), PBF was granted a unique revenue code 1484, facilitating smoother financial transactions and accountability. Additionally, a Subsidy Utilization Manual was developed with MOF support to guide the proper allocation and use of PBF funds, ensuring transparency and efficiency.

Additionally, the alignment of financial incentives with performance targets has led to measurable improvements in healthcare quality, which in turn has increased patient satisfaction. Facilities have reported better service delivery outcomes, attributed to the motivation of health care workers provided by the PBF framework. The pilot PBF initiative has shown improvement in the quality of care provided at health facilities. Between baseline (Q2 2023 GC) and Q1 2025 GC, the average quality score in PBF pilot hospitals has increased from 8% to 70% in Somali, from 29% to 83% in Central Ethiopia, and from 40% to 48% in Addis Ababa. Similarly, the average quality score in pilot health centers has shown significant improvement over a similar period – from 3% to 51% in Somali; from 11%to 66% in Central Ethiopia; and from 38% to 62% in Addis Ababa.

Looking forward, there is a critical need to systematically document the implementation process, including achievements, challenges, and lessons learned. Such documentation will provide valuable insights for program refinement and scaling. Additionally, innovative efforts are underway to explore the blending of capitation with PBF for PHCUs, which could further enhance the efficiency and effectiveness of resource allocation in the health system.

10.3. Evidence-based health care financing

National health account study: National Health Accounts (NHA) provide a comprehensive framework for measuring and analysing the financial flows related to the consumption of health care goods and services. In Ethiopia, NHA study is usually conducted in every two-three year and the evidence generated has been instrumental for various policy inputs and decision makings. Currently the 9th round of NHA is being conducted with the leadership of the SAEO of the MoH. Institutional data collection from government offices, development and implementing partners, insurance agencies, parastatals, and private employers has been conducted and associated data cleaning, validation and mapping activities was carried using the 2011 system of health account (SHA) framework. The household health level service utilization and spending data collection has been completed as part of the recent demographic and health survey which was led by the Ethiopian Statistical Services (ESS). While waiting for the household level data from the ESS, the analysis of the government, donors, insurance health spending data have also been conducted. Once the household data is available by the ESS, the analysis of the full NHA data will be completed followed by report writing, preparation of policy briefs, and dissemination of the study findings.

Digitization of health resource tracking: Having a well digitized health resource tracking (HRT) system is crucial for Ethiopia's healthcare sector to enhance transparency, accountability, and efficiency. Such a system would enable policymakers and administrators to track resource allocation, monitor financial performance, and identify areas for improvement. It helps to consolidate health financing data from various sources, including the government, development partners, public health insurance schemes, private health insurance providers, and healthcare facilities, and provide a comprehensive overview of the health financing landscape. This information can be used to inform decision-making, improve resource allocation, and ensure that funds are used effectively to achieve desired health outcomes.

The ministry of health has conducted a landscape assessment of resource tracking system with a vision of evaluating and build consensus around a common vision and roadmap for digitization of health resource tracking. The main findings of the assessment where financial data collection systems are not generating timely, real-time data on health resource flows with granular insights needed for decision-making and data is fragmented and siloed across multiple systems with multiple owners, with limited interoperability and data sharing. Accordingly, a three-year costed roadmap has been developed for digitizing and integrating health resource tracking systems that ensure real-time tracking of health funding flows, and interoperability across multiple information systems. The implementation of the roadmap has started in January 2025 GC with the involvement of key stakeholders such as the Ministry of Finance. Addis Ababa City Administration and Sidama Regional State are included for the three-year project in addition to the federal level institutions.

Analysis on the implication of the macroeconomic reform and the US funding cut

Following the recent macroeconomic reforms such as the liberalization of the foreign exchange, fiscal consolidation, and efforts to reduce inflation, analysing the implications of the reform on the health sector was crucial for ensuring sustainable and equitable healthcare delivery amid the country's transition to a more market-driven economy. The reform directly influences the health sector financing by affecting budget allocations, donor funding stability, and the affordability of medical imports. Hence, analysis was made regarding the immediate effect of the macroeconomic reform on the overall spending on health – especially on the 2017 EFY government budget allocated and the planned procurement of pharmaceutical products and presented relevant stakeholders. Similarly, following the global funding cut by the US government, analysis was made to understand the far-reaching consequences on the health system to advocate for restored funding, and inform alternative potential solutions. The funding freeze underscores systemic risks of external finance dependency, highlighting the urgent need for Ethiopia to build resilient, domestically funded health systems.

Strategic costing and fiscal space analysis: Strategic costing helps to analyse the costs associated with specific strategic objectives or initiative of various programs of the Ministry of Health. It provides valuable insights to optimize resource allocation, improve decision-making, and enhance healthcare delivery. In the fiscal year the major costing and fiscal space analysis support include the Nursing and Midwifery Roadmap, National Palliative Care Strategy, WASH in Health Care Facilities Roadmap, and Investment Plan for Primary Health Care Units.

Health economics and financing capacity building: Health financing and economics capacity building is a critical aspect of strengthening health systems. Several staff have attended various health economics and financing related trainings in country and abroad as well as in virtual platforms. As part of the tripartite agreement between the MOH, the EHIS and the Korean Foundation for International Health (KOFIH), various health financing capacity building areas were identified and short-term training were provided to the staff of the MoH, EHIS, EPHI and other relevant bodies. The training areas include Health Policy Analysis, Economic Evaluation for Health, Project Management and Finance, and Case-Based Provider payment Mechanism. For the next fiscal year, three training areas were identified based on capacity gap assessment and the relevant training materials were developed. The training planned to be delivered in the next 2018 EFY are: Data analytics for health financing, Advanced economic evaluations for health, Health insurance models and actuarial analysis.

10.4. Private sector engagement in health

Private Health Sector Strategy: A final draft of the Private Sector Engagement Strategy has been developed to define the private sector's role, strengthen its participation, and contribute to national health goals. The strategy was developed through a collaborative validation workshop with RHBs and other key stakeholders. This document is currently awaiting endorsement and approval from the leadership of MOH before its official implementation. To foster a more collaborative environment, a policy dialogue forum was organized with the Ethiopian Private Sector Federation. The forum aimed to strengthen the private sector's contribution and discuss its role in the health sector. As a result of these discussions, a term of reference was established to guide future collective action and policy recommendations, outlining the objectives, tasks, and obligations of each partner.

Public-Private Partnership (PPP) for Diagnostic Services

The Integrated Diagnostic Service Centre (IDSC) project is a pioneering PPP initiative by the MOH to be implemented at St. Peter's Comprehensive Specialized Hospital. The project has advanced through several critical stages including pre-feasibility, feasibility, structuring, and tendering and is now on track for implementation.

Key Milestones

- **Tendering and Award**: Following the approval of a full-fledged feasibility study, a competitive open tender was executed in strict adherence to PPP Proclamation 1076/2018. The tender process culminated in the selection of three winning consortia: Cerba Lancet Africa (CLA), International Clinical Laboratories (ICL), and Pioneer diagnostic Center (PDC). The Public-Private Partnership Board subsequently approved this outcome.

- **Negotiation and Pricing**: The PPP Directorate General established a negotiation committee, as mandated by PPP Proclamation Articles 29(2) and 31. This committee successfully negotiated the detailed pricing for diagnostic services, including unregulated tests, with the winning bidders. The final negotiated prices for these services were approved by senior MOH officials and formally communicated to the consortia.

- **Finalizing the Agreement**: The winning bidders comprising CLA, ICL and PDC have signed a Letter of Intent (LOI) with the Ministry of Finance and St. Peter's Hospital. This LOI signifies a mutual commitment to finalizing the PPP agreement. The consortia are currently working to fulfil prerequisites for the agreement, such as establishing a shareholder agreement and a Special Purpose Vehicle (SPV), which will serve as the project company. The final PPP agreement has been finalized and distributed to the winning bidders. A signing ceremony for the agreement between St. Peter's Hospital and the consortia is scheduled for the near future.

Public-Private Partnership Oncology Project

Cancer is a significant and growing burden in Ethiopia, with limited infrastructure and specialized care leading to poor access and prolonged waiting times. To address this, the MOH has revised the National Cancer Control Plan. In line with this plan, a new, state-of-the-art comprehensive oncology center is being established at St. Paul's Hospital Millennium Medical College, to be operated through a PPP model.

Feasibility Study: Given the current challenges in providing holistic cancer care, PPP is anticipated to be a pivotal solution. An international team of experts conducted a feasibility study to evaluate the technical, financial, legal, institutional, and environmental viability of the proposed project. The study comprehensively assessed the requirements for delivering high-quality cancer care services, which necessitate a multidisciplinary, multi-modality, and patient-center approach. This approach encompasses all relevant medical equipment, trained human resources, advanced technologies, operational efficiency, and sustainable supply chain management. The study's findings concluded that St. Paul's Oncology Centre presents a viable PPP initiative.

Through the planned PPP, St. Paul's Hospital Millennium Medical College aims to offer a comprehensive range of cancer care services, spanning from diagnostics to treatment. These services will include ambulatory and inpatient care, radiotherapy, nuclear medicine (both diagnostic and therapeutic), surgical oncology, chemotherapy, adult and pediatric hematology (including bone marrow transplantation), gynecologic oncology, critical care services, and palliative care. These advanced cancer care services, particularly radiotherapy, nuclear medicine, and bone marrow transplantation, will not only serve the thousands of cancer patients currently traveling overseas but also attract medical tourism to the country.

Financial Metrics: The project's financial projections forecast capital expenses of USD 24.7 million and first-year operational and maintenance expenses of USD 16.5 million. Key financial metrics include an Internal Rate of Return (IRR) of 15.37% for the project and 20.03% for shareholders, with an Average Debt Service Coverage Ratio (DSCR) of 1.69.

Next Steps: With the approval of the feasibility study, the Ministry of Finance has requested support from the African Development Bank for the tender document preparation and the overall tender process. The recruitment of a Transaction Advisor is also underway. Additionally, St. Paul's Millennium Medical College and the oncology Project Management Team have jointly prepared the necessary general medical equipment and other resources required for the project.

MCM Hospital unsolicited PPP Project

The MCM Hospital submitted an unsolicited proposal for a public-private partnership project. The pre-feasibility study was reviewed by the Public-Private Partnership Board, and approval has been granted to proceed with a full feasibility study.

10.5. Development Partners Financial contribution

Development partners have played a critical role in Ethiopia's health system by providing financial and technical support that bridges funding gaps, supports priority programs, and strengthens health system capacity. While their contributions have improved service delivery, enhanced accountability, and supported progress toward UHC and SDGs, reliance on external funding poses challenges due to unpredictable disbursements and sustainability concerns. To address this, Ethiopia is prioritizing stronger domestic resource mobilization, efficient use of funds, and strategic alignment of donor support with national health priorities, ensuring a balanced approach that safeguards progress and builds a resilient, equitable health system.

In 2017 EFY, development partners committed over USD 524.6 million to Ethiopia's health sector; however, USD 334.8 million (64% of the commitment) was disbursed directly to government

administered funding channels (Channel 2). In addition to this contribution, donors also significantly contribute through channel 3 via implementing partners, which is administered by implementing partners themselves. Among the disbursed funds, the largest share came from the Global Fund (38.9%), followed by bilateral partners (32.6%), the SDG Performance Fund (18.9%), Gavi (7.3%), foundations (2%), and UN organizations (0.4%). This distribution highlights the significant role of both multilateral and bilateral partners in supporting the country's health priorities, while also pointing to gaps between commitments and actual disbursements that affect planning and implementation.

Table 40: Amount of fund commitment and disbursed by development partners, 2017 EFY

S.No.	Source of Fund	Commitment in 2017 EFY (USD)	Disbursement in 2017 EFY (USD)	Percentage of Disbursement
1	**SDG Performance Fund**			
	Italian Agency for Development Cooperation (AICS)	3,240,000.00	6,673,933.35	206%
	Spanish Cooperation	756,000.00	761,950.00	101%
	FCDO	21,800,000.00		0%
	UNFPA	50,000.00	50,000.00	100%
	World Bank	74,000,000.00	25,492,866.26	34%
	UNICEF	500,000.00	500,000.00	100%
	WHO	50,000.00	50,000.00	100%
	GAVI	23,000,000.00	23,303,332.00	101%
	Gates Foundation (GF)	4,000,000.00	5,000,000.00	125%
	DKT	1,300,000.00	1,300,000.00	100%
	Total SDG fund	**128,696,000.00**	**63,132,081.61**	**49%**
2	**Bilateral Partners**			
	CDC-Atlanta US	7,144,617.00	4,900,975.00	69%
	AfCDC-WB	28,338,825.31	2,590,989.86	9%
	COVID-19 Emeregency Response World Bank	82,446,852.28	58,664,453.74	71%
	WB Program for Results (Hybrid)	35,621,656.65	7,224,650.00	20%
	Spanish Cooperation COVID 19			
	Sekota-AfDB		2,714,853.94	
	Sekota-Bigwin	13,571,830.00		0%
	Korea foundation for International Health			
	World Bank-Human Capital Project (IPF)	136,363.64	136,363.64	100%
	Italian Agency for Development Cooperation (AICS)	1,200,000.00	4,510,000.00	376%
	Health Emergency Preparedness, Response and Resilience program (HEPR)_World Bank	17,717,000.00	28,095,453.83	159%
	One Wash	526,315.79	167,379.83	32%
	Total from bilateral partners	**186,703,460.67**	**109,005,119.84**	**58%**
3	**UN Organization**			
	UNICEF	2,104,181.17	78,021.71	4%
	UNFPA	717,273.00	717,273.32	100%
	WHO	380,137.49	380,137.49	100%
	Total from UN organizations	**3,201,591.66**	**1,175,432.52**	**37%**
4	**Global Fund**			
	GF Malaria	35,114,294.00	32,284,143.07	92%
	GF TB	23,690,265.00	24,731,299.72	104%

S.No.	Source of Fund	Commitment in 2017 EFY (USD)	Disbursement in 2017 EFY (USD)	Percentage of Disbursement
	GF HSS	11,146,507.82	5,174,977.00	46%
	GF HIV	84,640,202.00	68,104,195.00	80%
	Total from Global fund	**154,591,268.82**	**130,294,614.79**	**84%**
5	**GAVI**			
	GAVI	28,548,697.00	24,360,123.70	85%
	Total from Gavi	**28,548,697.00**	**24,360,123.70**	**85%**
6	**Foundations***			
	CIFF GASHERO-MOH	423,488.00	302,345.00	71%
	CIFF GASHERO- MOH to EPHI	439,729.00	500,000.00	114%
	THE END FUND	5,000,000.00	2,085,425.35	42%
	Sekota-Bigwin	13,571,830.00	463,454.75	3%
	The Susan Thompson Buffett Foundation	3,500,000.00	3,500,000.00	100%
	Total from Foundations	**22,935,047.00**	**6,851,225.10**	**30%**
	Grand Total	**524,676,065.15**	**334,818,597.56**	**64%**

*Foundations that disbursed through SDG fund are mentioned under SDG performance fund above. Example: Gates Foundation is included under SDG fund disbursement section

SDG Performance fund

The Sustainable Development Goals Performance Fund (SDG PF) is a pooled financing mechanism managed by the Ministry of Health. It was established as the successor to the Millennium Development Goals Performance Fund (MDG PF) and is designed to support underfunded priority areas within the framework of the country's strategic plan.

The SDG PF in Ethiopia received funds from multiple development partners to support priority health programs. In the 2017 EFY, the total SDG Performance Fund commitments was USD 128.7 million. However, actual disbursements was USD 63.1 million (49%), reflecting a partial release of the committed funds during the year. Among the contributors, the World Bank provided the largest share of the SDG PF disbursed fund, contributing USD 25.5 million, which accounts for 40.4% of the total SDG PF. Similarly, GAVI disbursed USD 23.3 million (36.9% of the total fund). Other contributions included the Italian Agency for Development Cooperation (AICS), which disbursed USD 6.7 million (10.6%), and the Gates Foundation, which contributed USD 5 million (7.9%). The remaining 4.2% contributions were made by DKT, Spanish Cooperation, UNICEF, UNFPA, and WHO together.

The amount disbursed to the SDG-PF for the health sector between 2011 and 2017 EFY shows a declining trend after peaking in 2012 EFY. In 2011 EFY, the sector received USD 159.9 million, which then increased significantly to USD 219.1 million in 2012 EFY. However, from 2013 onwards, allocations declined sharply to USD 87.2 million and further dropped to USD 44.1 million in 2014, the lowest figure recorded. A slight recovery occurred in 2015 with USD 87.6 million, but the following years again reflected a downward pattern, with USD 68.9 million in 2016 and USD 63.1 million in 2017. Overall, while there were short-term fluctuations, the general trend indicates a substantial reduction in disbursement to the health sector over the seven-year period.

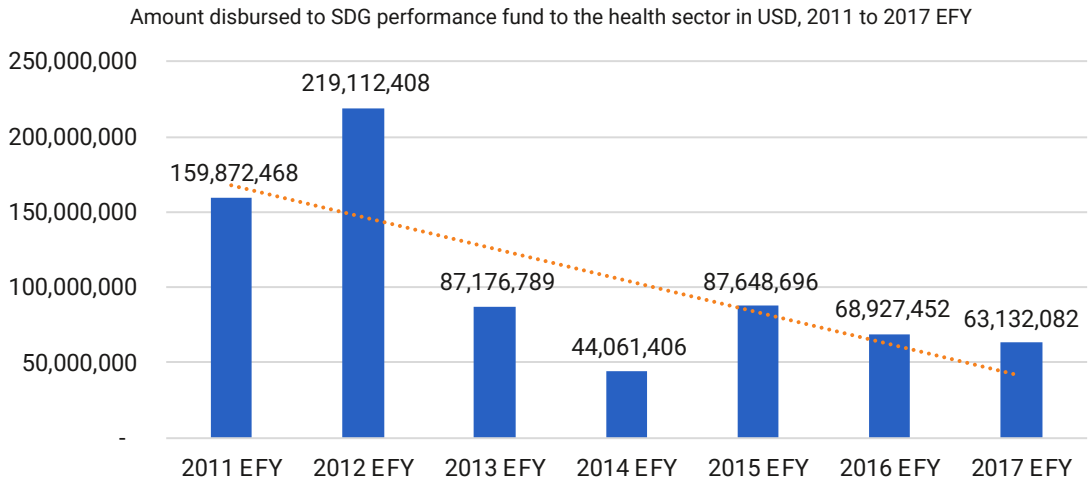


Figure 79: Amount disbursed to SDG performance fund to the health sector in USD, 2011 to 2017 EFY

10.6. Public Budget allocation to health

The proportion of government budget allocated to the health sector in 2017 EFY was 12.1% and shows regional variations, with allocations ranging from 8.0% in Harari to 14.7% in Amhara and BG (14.6%). Other regions with relatively higher allocation to health include Dire Dawa (12.5%) and Somali (12.4%), In contrast, Tigray (9.6%), and Harari (8.0%) recorded the lowest shares.

At the national level, the health sector accounted for 12.1% of the total government budget in 2017 EFY, showing a slight decline from 13.0% in 2016 EFY and 13.8% in 2013 EFY. Overall, the national trend reflects fluctuations over the years, with proportions ranging between 12% and 13.8%. Despite these variations, the general picture suggests that the share of the government budget allocated to health has remained relatively stable, though slightly tapering in the later years, including 2017.

Although the national allocation demonstrates a significant level of commitment to the health sector, the gap between the actual allocation in 2017 EFY (12.1%) and the Abuja target (15%) underscores the need for further resource prioritization to strengthen health systems and accelerate progress toward universal health coverage.

Table 41: Share of total health budget (%) from total government budget, 2012 EFY to 2017 EFY

Region	2012 EFY (%)	2013 EFY (%)	2014 EFY (%)	2015 EFY (%)	2016 EFY (%)	2017 EFY (%)
Tigray	10%	10%	NA	NA	10.7%	9.6%
Afar	13.0%	13.9%	14.4%	10.2%	11.9%	11.7%
Amhara	15.0%	12.7%	15.3%	15.6%	13.7%	14.7%
Oromia	13.0%	14.5%	12.4%	12.3%	10.8%	11.4%
Somali	11.0%	14.4%	10.3%	11.4%	11.3%	12.4%
BG	15.0%	14.3%	14.4%	13.7%	15.0%	14.6%
South Eth.	17%	15%	17%	14%	9.3%	11.8%
Central Eth.					15.8%	11.1%
Sidama	NA	15%	15%	15%	13.7%	11.4%
SWE	NA	NA	NA	11.21	9.8%	12.2%
Gambella	14.0%	19.5%	13.2%	14.4%	16.8%	11.8%
Harari	10.0%	16.0%	11.4%	12.1%	9.2%	8.0%
Dire Dawa	12.0%	12.6%	12.3%	16.1%	12.2%	12.5%
Addis Ababa	6.0%	7.0%	6.8%	8.5%	10.6%	11.5%
National	12.0%	13.0%	13.8%	12.3%	13.0%	12.1%

10.7. Health Insurance

One of the proven mechanisms to ensure sustainable domestic health financing is the expansion of health insurance coverage. Since 2006, Ethiopia has been implementing Community-Based Health Insurance (CBHI) to protect households from the financial risks of catastrophic health expenditures and to accelerate progress toward UHC.

The Ethiopian Health Insurance Service (EHIS) is mandated to oversee the implementation of health insurance schemes nationwide. Two types of health insurance systems are envisioned: Social Health Insurance (SHI), targeting individuals employed in the formal sector, and CBHI, designed for those in the informal sector. CBHI implementation is expanded throughout the country. While the rollout of SHI was previously postponed by government decision, preparations for its implementation are currently underway. These include the collection of data on formal sector employees and their respective employers, who will be subject to SHI. In parallel, the EHIS has defined its organizational structure and human resource requirements, and recruitment processes are ongoing to fill the identified positions.

Community-Based Health Insurance has made health care more accessible and affordable to millions of Ethiopians, especially communities living in rural areas and those with relatively low incomes. During the 2017 fiscal year, EHIS planned activities under four overarching goals: strengthening health insurance implementation capacity, expanding health insurance coverage, and ensuring sustainable financing. This section presents the implementation status of health insurance, mainly CBHI along with other major achievements related to health insurance.

Expansion of Community Based Health Insurance Program

Number of Woredas implementing CBHI: In 2017 EFY, the number of woredas implementing CBHI has reached 1,183 (91 % of woredas), of which 950 are CBHI coordinating schemes, as some woredas operate pooled CBHI schemes. In all regions except Somali (72%) and Gambella (93%), 100% of the woredas have started CBHI implementation.

Note: Data from the Tigray region is not available and has not been included in this report.

Table 42: Number of Woredas implementing CBHI by region, 2017 EFY

Region	Total woreda	Total woreda implemented CBHI	Proportion of woreda covered in CBHI	woreda having Scheme
Tigray	93	NA	NA	NA
Afar	40	40	100%	38
Amhara	238	238	100%	193
Oromia	391	391	100%	356
Somali	95	68	72%	68
BG	23	23	100%	23
Central Ethiopia	82	82	100%	76
Sidama	37	37	100%	37
South Ethiopia	96	96	100%	85
South west	61	61	100%	48
Gambella	14	13	93%	13
Harari	9	9	100%	1
Addis Ababa	124	124	100%	11
Dire Dawa*	1	1	100%	1
TOTAL	1,304	1183	91%	950

*Dire Dawa is considered as one considering the city administration, and there is no Woreda structure in DD

CBHI membership status of households

Community-based health insurance membership registration is conducted annually usually from January to February except in Addis Ababa and Borena zone of Oromia. Members are expected to renew their membership every year, and new members are encouraged to enroll within the designated registration period to avoid adverse selection. In EFY 2017, more than 3 million new households were enrolled, and more than 10.6 million members renewed their membership, bringing the total number of enrolled households to 13.6 million representing 84% of all eligible households and covering nearly 73 million population.

The CBHI members enrollment has rate increased from 73% in EFY 2016 to 84% of the eligible households in 2017 EFY, registering an additional 2.5 million more households, while renewal rate increased from 81% to 96%. Enrollment rates vary among regions, with the lowest recorded in Benishangul-Gumuz Region (51%), followed by Afar Region (58%), and the highest in Oromia Region (96%) and Addis Ababa (93%). Of the total households enrolled in CBHI, more than 9.2 million were paying members, while 4.2 million were indigent households whose annual CBHI premiums were covered by the government.

Table 43: CBHI membership enrollment and renewal rate by region, 2017 EFY

Region	No of eligible HHs	Renewal of CBHI membership			Total no. of CBHI member HHs			Proportion of CBHI member
		Members eligible for renewal	HH that renewed membership	Renewal rate	Paying members	Indigent members	Total CBHI members	
Afar	275,464	53,917	50,621	94%	130,201	28,611	158,812	**58%**
Amhara	4,545,869	2,667,910	2,667,910	100%	2,324,940	1,290,279	3,615,219	**80%**
Oromia	6,474,435	5,598,725	5,386,064	96%	4,535,853	1,695,546	6,231,399	**96%**
Somali	735,930	80,428	59,644	74%	335,733	123,011	458,744	**62%**
BG	245,359	46,005	43,220	94%	80,781	44,083	124,864	**51%**
Central Ethiopia	1,077,371	652,800	610,893	94%	606,979	252,963	859,942	**80%**
Sidama	575,128	367,433	347,709	95%	262,988	148,552	411,540	**72%**
South Ethiopia	1,281,885	875,968	767,724	88%	574,196	307,704	881,900	**69%**
SWE	557,890	289,696	258,776	89%	277,918	143,623	421,541	**76%**
Gambella	85,777	38,596	25,946	67%	32,254	19,167	51,421	**60%**
Harari	46,151	46,180	37,408	81%	26,015	7,478	33,493	**73%**
Addis Ababa	401,862	322,746	296,810	92%	255,666	119,726	375,392	**93%**
Dire Dawa	66,923	50,985	46,383	91%	39,591	9,208	48,799	**73%**
National	**16,370,044**	**11,091,389**	**10,599,108**	**96%**	**9,483,115**	**4,189,951**	**13,673,066**	**84%**

CBHI premium collection, audit and provider payment mechanisms

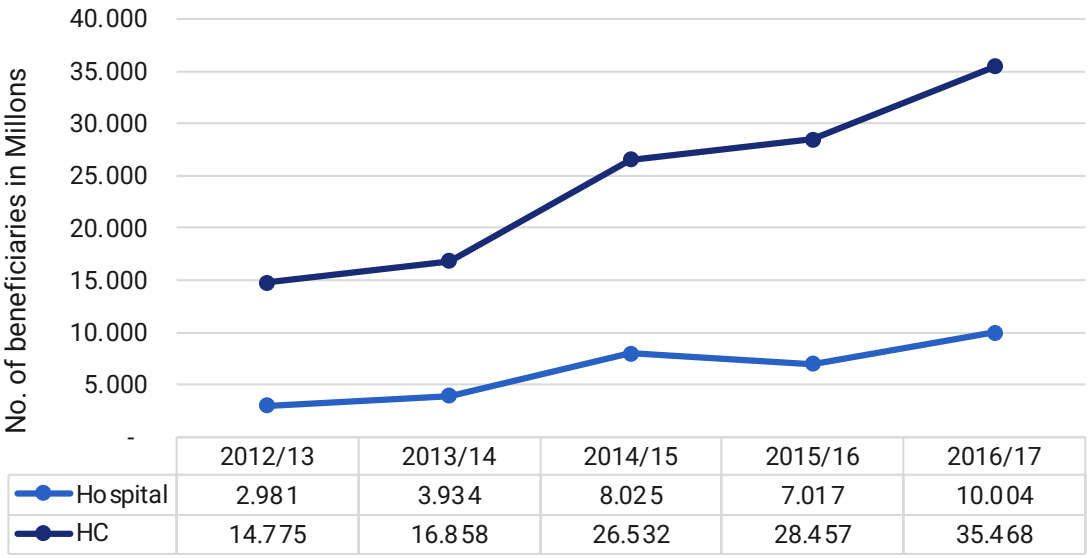
Pooling: For the past decades, the CBHI contribution was collected at a flat rate. Last year, the National Assembly endorsed a sliding scale premium payment system based on income, which was piloted in 13 woredas. This year, the system is scaled up to 738 woredas. A total of 15.2 billion birr (11.9 from paying and 3.3 from government subsidy for indigent HHs) was pooled during the EFY 2017 fiscal year which is 94 % of the planned amount to be collected.

Higher level pooling: This is a mechanism in which multiple woreda schemes contribute a percentage of their annually collected premiums to a higher administrative unit (zonal or regional), or where several woredas establish a single CBHI pool. The purpose is to enable CBHI members to access higher-level health services and stabilize premiums by diversifying risk across a larger membership. In EFY 2017, 10 new zonal pools were established (Oromia = 6, Amhara = 1, Central Ethiopia = 3), bringing the total number of zonal/regional pools to 39.

Financial Audit: Conducting annual financial audit at all level of the premium pooing unit be it woreda CBHI scheme or higher-level pool is a critical activity to ensure accountability and sustainability of the system. Financial audit was conducted in 733 (86%) of the schemes out of the expected 848 to be audited.

Reimbursements to Health Care Providers: In 2017 EFY, a total of 8.7 billion birr was paid to health service providers. Of this, about 7.6 billion birr was paid by regions to health facilities (4.9 billion to health centers, 3.3 billion to hospitals) and 733 million to third parties such as pharmacies or diagnostic service providers where services were not available at health centers or hospitals. The remaining 1.1 billion birr was paid by the Health Insurance Service to tertiary hospitals and Kenema pharmacies in Addis Ababa. The Ethiopian Health Insurance Service conduct claims and make payments on behalf of RHBs to beneficiaries who came through referral to receive tertiary level health services from 10 hospitals under the federal and Addis Ababa City Administration Health Bureaus, which is deducted from the total subsidy budget allocated by the federal government from the woredas where the beneficiaries come.

Across all regions, nearly 1.2 million beneficiaries accessed tertiary-level services in Addis Ababa. Oromia accounted for the highest share of service utilization (41.8%), followed by Amhara (21.05%) and Central Ethiopia (19.82%). The lowest utilization was recorded from Somali and Gambella (0.01%), followed by Benishangul-Gumuz region (0.02%). The claim data revealed that 78% of beneficiaries received health service from HCs and the remaining 22% from hospital



	2012/13	2013/14	2014/15	2015/16	2016/17
Hospital	2.981	3.934	8.025	7.017	10.004
HC	14.775	16.858	26.532	28.457	35.468

Figure 80: Trend in health service utilization by CBHI members (number in millions), 2012 EFY to 2017 EFY

Provider payment mechanisms: For the past years, the major provider payment mechanism has been fee-for-service. To introduce new approaches, a capitation payment system—where healthcare providers receive a fixed payment per patient per period regardless of the number of services provided—has been implemented. This year, the number of districts implementing capitation nationwide expanded to 365 districts and 755 health facilities, bringing the total to 406 districts and 1048 health facilities nationwide. In addition, a tripartite agreement was signed between the Ministry of Health, the Health Insurance Service, and the Korean Government (KOFHI) to study the introduction of a case-based (DRG) payment system in hospital services. Data for this study were collected from six hospitals: Black Lion Hospital, Yekatit 12 Hospital, Gondar Hospital, Jimma Hospital, Butajira Hospital, and Dubti Hospital."

Other activities and achievements

- To improve community awareness on health insurance, messages were transmitted through various media channels (TV, radio stations, and print media) in different local languages. The messages were broadcast through live TV programs, news coverage, radio programs, and print page coverage. In addition, 215 news stories, 120 articles, 35 short videos, and 33 graphic messages were produced and disseminated on social media during the fiscal year.
- Follow up and support provided to CBHI scheme expected to conduct general assembly meeting and 809 Woreda CBHI conducted the meeting.
- A discussion forum was conducted with all regions and branch offices to gather input on the prepared Federal and Zonal Pooling Implementation Manual. In addition, awareness-creation sessions were provided to zonal and woreda leaders
- TOT training was provided to more than 1000 trainers from 107 zones to implement a sliding scale CBHI contribution
- A total of 14,222 complaints and grievances (76%) submitted by health insurance members were reviewed and resolved.
- To initiate a case-based payment mechanism for inpatient health services, an experience-sharing visit was conducted in Ghana. Based on the lessons learned, a guiding document was prepared and introduced to management, cluster teams, and respective regional branch office staff.
- In order to prevent health insurance members from incurring unexpected expenses during the period of lack of medicine supply, During the fiscal year, 173 districts were signed tripartite contracts with institutions that provide medicine services.

Challenges

- Shortages of medicines, laboratory, and diagnostic services at health facilities
- Low commitment of some regions (Afar, Somali, Benishangul-Gumuz, and Gambella) in owning and lead the CBHI implementation.
- Shortage of budget and human resources.
- Lack of fully digitized health insurance system in the country
- Poor Health insurance data management, documentation and failure to report in accordance with the established guide.
- Conflicts in some parts of Ethiopia affecting the implementation of planned activities.
- Failure to send monthly reports in a facility where capitation payment is implemented.
- High turnover of CBHI scheme workers, and delays in carrying out claims and clinical audits.

Way Forward

- Strengthen the digital health insurance information system.
- Scale up various health service payment methods currently being piloted.
- Ensure the provision of quality health services to health insurance members.
- Establish higher-level pooling mechanisms at national, regional, and zonal levels.
- Document and scale up best practices.
- Ensure the proper implementation of legal framework governing CBHI
- Enhance efficient utilization of health insurance resources.
- Identify insurance risk mitigation mechanisms and implement preventive measures.
- Improve public awareness and advocacy on health insurance.
- Implement activities that ensure the sustainability of health insurance financing
- Strengthening health insurance fund and claim management system
- Strengthen the sliding scale (ability to pay) community health insurance contribution system

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The 27th Annual Review Meeting of the Health Sector