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MINISTRY OF HEALTH, ETHIOPIA

IPHCE
International Institute for Primary Health Care - Ethiopia

FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA · MINISTRY OF HEALTH

HEALTH SECTOR MEDIUM-TERM DEVELOPMENT AND INVESTMENT PLAN I

END-TERM REVIEW - ABRIDGED REPORT
EVALUATION PERIOD: 2023/24-2025/26

DISSEMINATION CONTEXT
Annual Review Meeting (ARM)

MINISTRY OF HEALTH
Evidence to Action: Informing HSDIP II

CONTRACTING INSTITUTION
International Institute for Primary Health Care – Ethiopia (IPHC-E)



CONTENTS

About This Abridged Report 3
Key Findings at a Glance 6
Ethiopia's Health System: Scale, Ambition, and Context 8
Overall Performance: 9
Important but Uneven Progress 9
Maternal, Child, Adolescent Health and Nutrition 10
Disease Prevention and Control 13
Community Engagement and Primary Health Care 15
Access to Quality Medical Health Services 16
Public Health Emergency Management and Post-Conflict Recovery 17
Health System Capacity, Governance, Quality, and Innovation 18
Pharmaceutical Management and Domestic Production 19
Health Financing and Private Sector Engagement 19
Six Cross-Cutting Systemic Challenges 20
Findings Based on OECD-DAC Evaluation Criteria 24
Conclusion 26
Six Strategic Transformation Priorities for HSDIP-II 27
Priority Recommendations for HSDIP-II 29

About This Abridged Report

This document is an abridged version of the HSDIP-I End-Term Review (ETR). It is produced for Ministry of Health leadership and senior health sector stakeholders, and is intended to serve as a standalone, authoritative summary of the evaluation's findings, conclusions, and recommendations. It does not replace the full technical report, which provides detailed methodology, disaggregated indicator data, and supporting evidence for all findings presented here.

TECHNICAL REVIEW PROCESS:

The evaluation findings underwent multiple rounds of technical review and consultative exchange with the Ministry of Health Core Technical Team (CTT) prior to finalisation. This iterative engagement — spanning several discussions and document exchanges — allowed the CTT to review preliminary findings, provide technical input, and incorporate key recommendations into the strategic priorities and investment directions of HSDIP-II. This abridged report reflects that consultative process.

The End-Term Review was commissioned by the **International Institute for Primary Health Care – Ethiopia (IPHC-E)** and conducted by an independent, multidisciplinary team of national and international consultants in accordance with the OECD-DAC evaluation criteria: relevance, coherence, effectiveness, efficiency, impact, sustainability, and equity. The evaluation drew on multiple lines of evidence including routine Health Management Information System (HMIS) data, national surveys, facility assessments, key-informant interviews, focus group discussions, stakeholder consultations, and document review across all nine strategic objectives of the HSDIP-I results framework.

The evaluation applied a **Health System Dynamics analytical framework** (Van Olmen et al., 2010), using systems-thinking methods to identify reinforcing feedback loops that link individual programme performance to cross-cutting structural conditions. This approach enabled the ETR to move beyond indicator-level assessment to diagnose the systemic constraints that explain why investments in one area often failed to translate into sustained system-wide improvements.

Data limitation — important: Performance data in this report are drawn primarily from the HSDIP-I indicator framework (118 indicators) as reported through routine HMIS and programme monitoring systems. **For RMNCH and PHC indicators in particular, data quality and source comparability present significant challenges:** administrative data (DHIS2), national household surveys (EDHS), and international programme estimates do not always align, and may reflect differences in measurement methodology, population denominators, recall accuracy, card availability, and data collection timing. These divergences are noted contextually throughout this report. For a small number of indicators where specific values require reconciliation across sources, directional and qualitative assessments are presented in place of exact figures, pending final verification in the full technical report. Readers should exercise appropriate caution in interpreting point estimates for RMNCH and PHC indicators.

EVALUATION TEAM MEMBERS

The evaluation was conducted by a multidisciplinary team of national and international consultants, bringing together complementary expertise in health systems, public health, monitoring and evaluation, financing, and service delivery.

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Key Findings at a Glance

The HSDIP-I End-Term Review assessed Ethiopia's health sector performance across 118 indicators under nine strategic objectives for the period 2023/24–2025/26. The overall finding is one of **important but uneven and incomplete progress** — meaningful gains in several priority areas, alongside persistent or worsening outcomes in others, against a backdrop of significant contextual adversity including armed conflict, drought, disease outbreaks, and large-scale population displacement.

Notable Achievements

- Maternal mortality ratio nearly halved: 267 → 141 per 100,000 live births (target 199)
- TB case detection exceeded target (98%) and Ethiopia exited the high MDR/RR-TB burden country classification
- HIV viral suppression reached 95% and ART coverage 94% among diagnosed PLHIV
- Hypertension control reached 86% (target 45%) and diabetes control 78% (target 55%)
- Ambulance response rate exceeded target at 92%; ICU mortality improved to 21%
- Wasting prevalence declined from 11% to 5%, exceeding the 7.8% target
- Community Scorecard implementation reached 83% (target 75%)
- Domestic pharmaceutical production: 15 factories initiated (target 8); local procurement share rose to 41%

Areas Below Target or Worsened

- Under-5 mortality: 45 per 1,000 live births in 2024 (UNIGME 2025), a marginal decline from the 47 baseline — insufficient progress, unevenly distributed, and set against acute conflict-related disruption
- Immunization coverage remained below HSDIP-I targets across key antigens; performance picture is complex, with programme estimates (WUENIC) showing improvement from baseline while household survey data (EDHS 2024–25) reports lower figures — both sources confirm a gap to target, with persistent regional inequities
- Malaria incidence rose from 47.2 to 58.7 per 1,000 at risk (target 17.9)
- Stunting showed no improvement, remaining at approximately 40% against a target of 25%; chronic malnutrition remains deeply entrenched
- Household sanitation coverage declined from 52% to 38% (target 65%)
- Social Health Insurance was not implemented (0% vs. 100% target)
- Information Use Index declined from 60 to 54 (target 85)

CENTRAL FINDING:

HSDIP-I established platforms and expanded coverage but was substantially less effective in translating these investments into reliable, equitable, and sustained outcomes at the point of care and population level. Six cross-cutting systemic challenges — inadequate accountability, the HEP transformation gap, financing sustainability, supply chain fragility, the quality-trust-utilization cycle, and data quality and learning weaknesses — operated as a self-reinforcing system trap limiting overall health system performance. HSDIP-II must address these as an integrated system, not programme by programme.

Against the OECD-DAC criteria: HSDIP-I was **highly relevant** to Ethiopia's needs and global commitments; **moderately coherent** in design but fragmented in implementation; of **mixed effectiveness** with strong gains in targeted programme areas and persistent gaps in population-level outcomes; **constrained in efficiency** by structural inefficiencies; of mixed impact — landmark gains in maternal health alongside insufficient progress in child survival and immunization; and at **risk of sustainability** given declining domestic financing and persisting external dependency.

The evaluation recommends six strategic transformation priorities for HSDIP-II: strengthening accountability for results; re-envisioning the Health Extension Programme; expanding domestic resource mobilization; integrating supply chains and digital systems; investing in the health workforce; and building an adaptive health system capable of managing future shocks.

Ethiopia's Health System: Scale, Ambition, and Context

Ethiopia operates one of the largest public health systems in sub-Saharan Africa, serving a population of over 120 million people through a tiered network of health posts, health centres, primary hospitals, general hospitals, and tertiary referral hospitals. The system rests on the **Health Extension Programme (HEP)** as its foundational community platform, deploying Health Extension Workers (HEWs) at sub-facility level and supported by community structures including Women's Development Army and Village Health Leaders.

HSDIP-I was designed as the first medium-term implementation plan under the Health Sector Transformation Plan II (HSTP-II) framework. It comprised nine strategic objectives aligned to Ethiopia's Health Policy (2024), the Essential Health Service Package, the Ten-Year Development Plan, and global frameworks including the Sustainable Development Goals, Universal Health Coverage commitments, the UNAIDS 95-95-95 targets, WHO End TB Strategy, and International Health Regulations.

The plan was implemented against a backdrop of extraordinary contextual challenges. Armed conflict and insecurity affected multiple regions during the HSDIP-I period, with an estimated **5.698 million people displaced**† and **76 hospitals, 709 health centres, and 3,217 health posts**‡ damaged, looted, or destroyed. Concurrent threats — drought, flooding, COVID-19 aftershocks, emergence of Anopheles stephensi urban malaria, and economic inflation — compounded the operating environment and placed extraordinary demands on a system already constrained by financing gaps, workforce shortages, and supply chain fragilities.

†OCHA Ethiopia, Humanitarian Needs Overview and Displacement Tracking Matrix, 2023–2024. ‡Ministry of Health Ethiopia, Facility Damage Assessment, 2023–2024, as cited in the HSDIP-I ETR technical report.

120M+ Population served	**29,000+** Facilities in national DHIS2	**118** Core indicators tracked
09 Strategic objectives	**5.7M** People displaced (conflict)	**120M+** Health facilities damaged or destroyed

Overall Performance: Important but Uneven Progress

The HSDIP-I End-Term Review found that Ethiopia's health sector made important but uneven and incomplete progress over the plan period. In a number of high-priority areas — particularly maternal health, tuberculosis, selected HIV treatment cascade management, non-communicable disease control, and emergency and critical care — the sector achieved or exceeded its targets, demonstrating that the health system is capable of strong performance where delivery platforms are mature, technical ownership is clear, and implementation conditions are sufficiently favourable.

However, a significant number of population-health and system-level indicators did not meet targets, and several worsened from baseline. Child mortality, immunization coverage, stunting, malaria incidence and mortality, health workforce density, household sanitation, and health information use all recorded disappointing results despite expanded investment. The evaluation's central finding is that HSDIP-I established platforms and expanded coverage but was substantially less successful in translating these investments into reliable, equitable, and sustained outcomes at the point of care and at the population level.

Beyond what routine data systems can capture, consultations across health workers, community members, facility managers, and officials at all levels of the system consistently surfaced a shared diagnosis: people throughout the system can identify what is not working, but encounter structural barriers to changing it.

> "The path forward requires a fundamental pivot from expanding coverage to ensuring quality, from policy development to implementation effectiveness, and from fragmentation to integration. This is the central message of the HSDIP-I evaluation and the foundation for HSDIP-II."
>
> ***HSDIP-I End-Term Review, Conclusion***

The evaluation identified six interconnected systemic challenges — inadequate accountability mechanisms, the HEP transformation gap, financing sustainability constraints, supply chain fragility, the quality-trust-utilization cycle, and data quality and learning weaknesses — that operated not as isolated programme failures but as a self-reinforcing system trap in which weaknesses in one domain amplified constraints in others. These dynamics explain why improvements in individual health system components have not always translated into sustained improvements in overall health-system performance.

The evaluation findings were shared with the Ministry of Health Core Technical Team (CTT), which reviewed and incorporated key recommendations into the HSDIP-II planning and prioritisation process.

Maternal, Child, Adolescent Health and Nutrition

Strategic Objective 1 delivered a strongly bifurcated result: significant achievement in maternal health and selected service-coverage indicators alongside persistent or worsening outcomes in child health, immunization, family planning, and chronic malnutrition. This divergence reflects a broader pattern across the evaluation — HSDIP-I was most effective where interventions could be managed within relatively bounded delivery pathways, and least effective where outcomes depended on the simultaneous functioning of multiple system components, community behaviour, and socioeconomic determinants.

Maternal Health — A Landmark Achievement

Ethiopia recorded one of its strongest population-health achievements during the HSDIP-I period in maternal mortality. The **maternal mortality ratio declined from 267 to 141 per 100,000 live births**, substantially exceeding the target of 199 — a near-halving of maternal deaths over the plan period. The improvement was driven by major gains in antenatal care (early ANC increased from 22% to 45%, exceeding the 40% target; ANC with eight or more contacts rose from 15% to 52%, exceeding the 30% target) and in skilled delivery attendance (increased from 70.9% to 87% against a 78% target). Early postnatal care within two days increased from 67% to 88%, exceeding the 78% target, while the stillbirth rate declined from 10.8 to 7.9 per 1,000 births against a target of 9.

Despite these remarkable gains, reproductive health performance was less consistent. The contraceptive prevalence rate declined from 39.5% to 35% against a target of 45%, and the total fertility rate declined only marginally from 4.1 to 4.0 against a target of 3.6. Preliminary findings from the Ethiopian Programme Monitoring and Assessment (EPMA 2026) suggest some recovery, with CPR estimated at 37% — an improvement from the EDHS figure, though still short of the 45% target. These results indicate that while facility-based maternal service delivery improved markedly, community-level reproductive health platforms — particularly for family planning — require renewed attention.

Child Health — Marginal Progress, Insufficient Pace

Child health outcomes require careful interpretation given the contextual severity of the HSDIP-I period. According to UN IGME 2025 estimates, **under-five mortality stood at 45 per 1,000 live births in 2024,** compared to a baseline of 47 — a marginal

improvement, though one that falls well short of the pace of progress needed and must be read against a period of acute conflict-related displacement, service disruption, and humanitarian crisis across multiple regions. Infant mortality is estimated at 34 per 1,000 live births (UN IGME 2025), essentially unchanged from the baseline of 34. Neonatal mortality showed only marginal improvement from 26 to 25 — a positive directional movement that nonetheless fell short of the target of 21. The contrast between strong maternal service coverage indicators and insufficient progress in child survival points to weaknesses in continuity of care, commodity availability at point of service, PHC functionality, and the broader socioeconomic and environmental determinants of child health that HSDIP-I investments did not fully reach.

Immunization — A Complex Performance Picture

Immunization performance during HSDIP-I presents a methodologically complex picture that cannot be assessed through a single data source. Assessment is substantially shaped by significant divergence between available data sources — particularly between household survey data (EDHS 2024–25) and international programme estimates (WHO/UNICEF Estimates of National Immunization Coverage, WUENIC 2025) — reflecting differences in measurement methodology, coverage definitions, population denominators, recall accuracy, card availability, and data collection timing. These differences are well-documented in the global immunization literature and do not invalidate either source, but they require that conclusions be carefully qualified.

According to WUENIC 2025, Penta3 coverage increased from approximately 61% (2014 baseline) to 81% by 2025, and measles-containing vaccine first-dose (MCV1) coverage increased from 54% to 77%, indicating continued progress in routine immunization delivery as measured through programme administrative systems. Preliminary findings from the Ethiopian Programme Monitoring and Assessment (EPMA 2026) further suggest ongoing recovery, with Penta3 increasing from 40% to 68%, MCV1 from 51% to 63%, full immunization from 21% to 41%, and zero-dose children declining from 20% to 8% — although these are preliminary figures subject to final verification.

The EDHS 2024–25, which uses household recall and vaccination card verification, reports lower point estimates for the same period. These differences are expected given the methodological variations inherent in comparing administrative programme data with household survey instruments. Across both data sources, coverage levels remain below HSDIP-I national targets and IA2030 benchmarks, with persistent regional inequities. HSDIP-II should prioritise strengthened immunization data validation systems, continued routine service delivery improvements, and targeted outreach for zero-dose and under-immunized children.

Nutrition

Nutrition performance was mixed. Wasting prevalence declined from 11% to 5%, exceeding the 7.8% target and demonstrating meaningful progress in acute malnutrition management. However, stunting remained stagnant at 39.9%, moving away from the 25% target, reflecting the persistent and multi-causal nature of chronic malnutrition. Chronic malnutrition remained constrained by commodity shortages, food insecurity, climate shocks, and weak integration across health, agriculture, and social protection.

INDICATOR	BASELINE	TARGET	ACHIEVEMENT	STATUS
Maternal mortality ratio (per 100,000 LB)	267	199	141	Exceeded
Early ANC coverage	22%	40%	45%	Exceeded
ANC with 8+ contacts	15%	30%	52%	Exceeded
Skilled birth attendance	70.9%	78%	87%	Exceeded
Stillbirth rate (per 1,000 births)	10.8	9.0	7.9	Exceeded
Under-5 mortality (per 1,000 LB)	47	—	45‡	Marginal Improvement
Neonatal mortality (per 1,000 LB)	26	21	25‡	Not achieved

‡ UN IGME 2025 estimates; 2024 reference year

Penta3 immunization coverage	~61%	80%	Under review†	Below target
Full immunization coverage	~44%	75%	Under review†	Below target

† Immunization coverage figures are under final reconciliation across data sources (DHIS2, WUENIC 2025, EDHS 2024–25) in the full technical report. Divergence between sources reflects methodological differences in measurement methodology, denominators, and data collection instruments. Both sources confirm coverage below HSDIP-I targets; programme estimates (WUENIC) show improvement from the 2014 baseline while household survey data (EDHS) reports lower figures for the most recent period. See narrative for detail.

Contraceptive prevalence rate	39.5%	45%	35%	Worsened
Stunting prevalence	39%	25%	~40%	Stagnant
Wasting prevalence	11%	7.8%	5%	Exceeded

06
STRATEGIC OBJECTIVE 2

Disease Prevention and Control

Strategic Objective 2 demonstrated a fundamental distinction within the health system: the capacity to manage patients once identified versus the capacity to prevent disease, identify undiagnosed cases, and control transmission at the population level. Results were strong within mature treatment cascades where systems and supply chains were relatively established, and substantially weaker at the prevention and population-level disease control ends.

HIV/AIDS

HIV treatment outcomes were among the strongest performance results in the HSDIP-I framework. ART coverage among diagnosed people living with HIV reached 94% (target 98%), while viral suppression reached 95% (target 97%). Ethiopia's HIV response has effectively transitioned HIV from a high-mortality epidemic towards a manageable chronic condition for those diagnosed and on treatment. However, only **79% of people living with HIV were estimated to know their status** against a 95% target — a significant gap at the front end of the cascade that limits the overall impact of strong treatment performance.

Tuberculosis — A National Achievement

TB outcomes were among the strongest programme results in HSDIP-I. TB case detection increased from 95% to 98%, exceeding the 96% target, and treatment success increased from 96% to 97%, meeting the target. RR/MDR-TB treatment success reached 83%, meeting the target exactly. Ethiopia achieved **recognition for exiting the high MDR/RR-TB burden country classification** — a landmark public health achievement reflecting sustained investment in quality-assured TB diagnostics and treatment.

Malaria — A Major Setback

Malaria represents one of the clearest areas where health system performance deteriorated during HSDIP-I. Incidence increased from 47.2 to 58.7 per 1,000 population

at risk, against a target of 17.9. The emergence of Anopheles stephensi in urban environments, climate variability, conflict-related displacement into hightransmission areas, insecticide resistance, and supply chain disruptions in vector control collectively undermined prevention effectiveness. Malaria demands urgent, intensified intervention in HSDIP-II.

Non-Communicable Diseases

NCD management showed remarkably strong performance. The proportion of hypertensive adults with controlled lood pressure increased from 40% to 86%, substantially exceeding the 45% target. Diabetes patients with controlled blood sugar increased from 45% to 78%, exceeding the 55% target. These results demonstrate that standardized clinical protocols, applied with adequate commodities and trained workforce, can produce strong management outcomes. The challenge lies in expanding NCD services to primary and community levels, where screening and early detection remain limited.

INDICATOR	BASELINE	TARGET	ACHIEVEMENT	STATUS
PLHIV who know their status	—	95%	79%	Not achieved
ART coverage (among diagnosed PLHIV)	—	98%	94%	Partial
HIV viral suppression	—	97%	95%	Partial
TB case detection rate	95%	96%	98%	Exceeded
TB treatment success rate	96%	97%	97%	Achieved
RR/MDR-TB treatment success	—	83%	83%	Achieved
Malaria incidence (per 1,000 at risk)	47.2	17.9	58.7	Worsened
Hypertension control rate	40%	45%	86%	Exceeded
Diabetes blood sugar control rate	45%	55%	78%	Exceeded

07
STRATEGIC OBJECTIVE 3

Community Engagement and Primary Health Care

Strategic Objective 3 encompasses the Health Extension Programme, community engagement platforms, and water, sanitation, and hygiene — together forming Ethiopia's essential community-level health infrastructure. Performance was mixed in coverage and consistently below expectations in quality, functionality, and community impact.

The Health Extension Programme

The HEP remained Ethiopia's most extensive health delivery platform throughout the HSDIP-I period. However, the evaluation found a fundamental transformation gap: an increasing distance between what HEWs are expected to deliver and what they are equipped and motivated to provide. HEW job satisfaction stood at 48.6%, pay satisfaction at only 13%, and promotion opportunity satisfaction at 29%. Only 23% of PHCUs were classified as high-performing against a 35% target, and health posts providing comprehensive services reached 260 against a target of 1,159. eCHIS coverage reached 58% of health posts, but only 40% used full service modules. HSDIP-I expanded HEP platforms but was less effective in ensuring consistent high-performing PHC units at community level.

Across evaluation interviews, Health Extension Workers described a mandate that has expanded over successive reform cycles without commensurate increases in material support, supervision, or career opportunity. Many reported supervisory visits occurring far less frequently than protocols require, and described performance processes that feel disconnected from daily operating realities. Community members across settings echoed this — characterising their HEW as personally committed but constrained by insufficient supplies and limited backup when referrals are needed.

WASH — Deterioration in a Core Public Health Metric

WASH performance presented one of the most concerning findings in the entire HSDIP-I results framework. Household basic sanitation coverage **declined from 52% to 38%** against a target of 65% — a major regression attributable to conflict-related infrastructure destruction, insufficient structural investment, inadequate hygiene promotion, and the scale of climate and displacement shocks affecting rural communities during the plan period.

INDICATOR	BASELINE	TARGET	ACHIEVEMENT	STATUS
High-performing PHCUs	—	35%	23%	Not achieved
Model household coverage	—	35%	23.8%	Not achieved
Household basic sanitation coverage	52%	65%	38%	Worsened
Health facility basic sanitation	—	80%	54%	Not achieved
Health facility waste management	63%	75%	74%	Near Target

08
STRATEGIC OBJECTIVE 4

Access to Quality Medical Health Services

Strategic Objective 4 produced some of the strongest performance results in HSDIP-I, particularly in emergency and critical care. Service expansion, specialty training, and emergency capacity development represent meaningful progress, though functionality gaps, geographic concentration, and blood service shortfalls constrained system-wide impact.

Emergency and Critical Care

Emergency performance showed genuine improvement across multiple indicators. Ambulance response rate increased from 83% to 92%, exceeding the 90% target. ICU mortality declined from 26% to 21%, better than the 24% target. Emergency mortality declined from 0.20% to 0.14%, exceeding the 0.15% target. Outpatient utilization increased from 1.5 to 2.2 visits per capita, exceeding the 1.68 target. Medical oxygen production capacity expanded from 13 to 58 facilities. These results indicate that HSDIP-I achieved meaningful gains in emergency response — though pre-facility care remains underdeveloped and geographic access is uneven.

Specialist Services and Blood Supply

The proportion of hospitals providing four core specialty services reached 78%, and specialty training enrollment exceeded targets. However, blood services remained a significant constraint: blood donation reached 4.0 per 1,000 population against a target of 5.42, and blood component production reached 25% against a 35% target — limiting surgical capacity, obstetric emergency management, and critical care.

INDICATOR	BASELINE	TARGET	ACHIEVEMENT	STATUS
Ambulance response rate	83%	90%	92%	Exceeded
ICU mortality rate	26%	24%	21%	Exceeded
OPD visits per capita	1.5	1.68	2.2	Exceeded
Blood donations (per 1,000 population)	3.5	5.42	4.0	Not achieved

09
STRATEGIC OBJECTIVE 5

Public Health Emergency Management and Post-Conflict Recovery

The HSDIP-I period was one of the most demanding in Ethiopia's recent public health history from an emergency and resilience perspective. The health system faced armed conflict, COVID-19 aftermath, drought, floods, and multiple disease outbreaks concurrently. Emergency response capability improved — Rapid Response Teams were established and deployed, laboratory testing infrastructure expanded, and epidemic control within mortality thresholds improved from 80% to 100%. However, the Health Security Index declined from 74 to 69 against a target of 76, and institutionalized recovery mechanisms remained less developed than response capabilities. Recovery continued to depend largely on humanitarian financing rather than government systems — a structural risk that HSDIP-II must address through dedicated recovery financing and clearer institutional mandates.

10
STRATEGIC
OBJECTIVES 6 & 7

Health System Capacity, Governance, Quality, and Innovation

Governance and Accountability

Governance structures expanded. Community Scorecard implementation reached 83% (target 75%). Policy frameworks, coordination platforms, and regulatory systems were strengthened. However, the evaluation consistently identified accountability as the weakest governance dimension — weak enforcement, limited corrective action, frequent leadership turnover, and evidence of non-merit-based appointments created an environment in which impunity for poor performance persisted across all levels of the system.

Health Workforce

Health worker density increased from 1.75 to 1.93 per 1,000 population, remaining below the 2.3 target. Emergency medicine training expanded from 1 to 8 institutions. Despite these investments, the evaluation found persistent gaps in retention, motivation, distribution, and supportive supervision — particularly at health post and health centre levels. Workforce deployment remains concentrated in urban centres.

Digital Health and Information Systems

DHIS2 reached over 29,000 facilities; eCHIS registered 30 million individuals across 58% of health posts. Despite this expansion, the Information Use Index declined from 60 to 54 against an 85 target. The evaluation's central finding was that digital health expansion was broad but shallow: data collection infrastructure improved but data use for decision-making at facility, woreda, and regional levels remained predominantly compliance-driven. Interoperability between platforms remained incomplete.

11
STRATEGIC OBJECTIVES 8

Pharmaceutical Management and Domestic Production

Pharmaceutical management demonstrated meaningful improvements in selected indicators: essential medicine availability increased from 83% to 87%; clients receiving all prescribed drugs rose from 68% to 83%; and drug wastage declined to 0.64%, achieving its target. APTS implementation reached 63% of facilities, exceeding the 33% target. However, 86% of assessed facilities experienced stock-outs for at least one essential medicine, and procurement lead time worsened from 194 to 201 days against a 160-day target — a fundamental bottleneck that management improvements alone could not resolve. On domestic manufacturing, 15 pharmaceutical factories initiated production (target 8), and local procurement share rose to 41%, though factory capacity utilization remained at only 28% against a 58% target.

INDICATOR	BASELINE	TARGET	ACHIEVEMENT	STATUS
Essential medicine availability	83%	92%	87%	Partial
Clients receiving all prescribed drugs	68%	90%	83%	Partial
Procurement lead time (days)	194	160	201	Worsened
Local manufacturing share of EPSS procurement	8%	47%	41%	Near Target

12
STRATEGIC OBJECTIVES 9

Health Financing and Private Sector Engagement

Domestic Fiscal Commitment and Financial Protection

Health financing outcomes were constrained by declining fiscal commitment and inadequate financial protection. Government health expenditure as a share of total public expenditure fell substantially below both the HSDIP-I target and the 15% Abuja Declaration commitment — a finding pending final verification in the National Health Accounts report. Out-of-pocket expenditure remained high, representing a persistent financial burden on households seeking care. CBHI expansion was an institutional achievement — population coverage increased from 81% to 85% with a 96% renewal rate, and 29% of enrollees were indigent — but reimbursement delays of 60–90 days constrained facility cash flow. Social Health Insurance was not implemented during the plan period, leaving a major financing architecture reform unfulfilled.

Note: Government health expenditure figures are under final reconciliation in the National Health Accounts report and are excluded from the indicator table pending verification.

INDICATOR	BASELINE	TARGET	ACHIEVEMENT	STATUS
CBHI population coverage	81%	90%	85%	Partial
Social Health Insurance implementation	0%	100%	0%	Not achieved

13
SYSTEMS ANALYSIS

Six Cross-Cutting Systemic Challenges

The evaluation's systems thinking analysis identified six priority systemic challenges consistently present across multiple strategic areas. These challenges did not operate independently — they interacted through reinforcing feedback loops, creating a self-reinforcing system trap in which weaknesses in one domain amplified constraints in others. Addressing them requires integrated, system-level action.

01 Inadequate Accountability Mechanisms

Accountability emerged as the central enabling constraint across the health system. Weak consequences for poor performance reduced incentives for compliance; limited community voice meant underperformance went unchallenged; performance information was rarely converted into management action; and leadership turnover and non-merit-based appointments undermined institutional memory and performance culture.

- Weak enforcement of performance standards at all system levels
- Limited corrective action following joint review meetings and scorecard processes
- Accountability weakness enabled all other systemic challenges to persist

Interviews at multiple levels of the system found that performance shortfalls are documented and discussed in review meetings but rarely produce binding corrective action. Facility managers and woreda officers described the distance between formal accountability mechanisms and actual management response as a shared, systemic norm — not an exception.

02 The HEP Transformation Gap

The HEP faces an expanding service mandate — including NCDs, mental health, and digital health — while confronting persistently low motivation, inadequate compensation, poor career pathways, and unreliable supply and infrastructure support. The gap between the HEP envisioned in policy and experienced in practice is growing, threatening the foundational community platform of the entire health system.

- HEW pay satisfaction: 13%; promotion opportunity satisfaction: 29%
- Only 23% of PHCUs classified as high-performing (target 35%)
- Transformation requires system-wide response: motivation, supply, supervision, governance

Health workers described a growing tension between the breadth of their official service package and their capacity to deliver it reliably given operating conditions. The evaluation found this pattern consistent across regions: adequate foundational training, inadequate operational environment to act on it.

03 Financing Sustainability Constraints

Health financing sustainability is the most critical systemic risk for HSDIP-II. Domestic fiscal commitment declined during HSDIP-I while donor financing faces structural global decline. CBHI reimbursement delays constrain facility cash flow and service readiness. Without addressing financing sustainability, improvements across all other areas will remain fragile and externally dependent.

- Government health expenditure fell substantially below the HSDIP-I target and the Abuja Declaration commitment (figures pending final NHA reconciliation)
- CBHI reimbursement delays: 60–90 days (paperbased claims)
- Social Health Insurance: 0% implementation against 100% target

Finance officials and programme managers described declining domestic expenditure as reflecting both fiscal pressure and insufficient advocacy for health within government budget negotiations. Facility managers under CBHI consistently cited reimbursement delays — not enrolment levels — as their most immediate operational constraint.

04 Supply Chain and Commodity Reliability

Supply chain fragility was the most frequently reported operational constraint across all strategic areas. Despite management system improvements, procurement lead times lengthened, stock-outs remained widespread, and cold chain gaps persisted — creating a reinforcing cycle that made it difficult to sustain facility performance even where clinical competency was adequate.

- Procurement lead time: 201 days vs. 160-day target
- 86% of assessed facilities experienced essential medicine stock-outs
- 80% experienced medical device spare part shortages

In facility-level interviews, commodity stock-outs were the single most consistently cited operational constraint — described by pharmacy staff and clinical officers across regions as a routine experience rather than an exception. Management system improvements had not yet translated into the commodity reliability that providers and communities experience at the point of care.

05 Quality–Trust–Utilization Cycle

A persistent reinforcing cycle links poor servicequality to reduced community trust, lower utilization, reduced facility revenues, and inadequate management response — perpetuating poor quality. The CBHI indigent utilization gap (29% enrolled, only 14% utilizing services) illustrates how enrollment in financial protection schemes does not automatically translate into access when quality barriers remain.

- Patient satisfaction remained below the 85% target
- Community bypass of public facilities in settings with poor quality reputation
- Quality improvement inadequately financed and unevenly applied across regions

Community members in multiple regions described bypassing public facilities not primarily due to physical distance but due to previous experiences with commodity shortages, unpredictable hours, and perceived poor treatment. Among CBHI-enrolled households that did not seek care when needed, cost fear and quality concerns were the most commonly cited barriers — indicating that coverage alone does not generate utilization when facility quality remains low.

06 Data Quality, Learning, and Decision-Making

Investment in digital health infrastructure improved data collection but did not produce commensurate improvements in data quality, analysis, or use for decision-making. Data continue to be collected primarily for compliance and upward reporting, not local learning. Significant discrepancies between administrative and survey-based figures in some areas further limited confidence in the information system as a management tool.

- Information Use Index declined from 60 to 54 (target: 85)
- Digital platforms exist but interoperability between systems remains incomplete
- Weak data culture reduces the corrective function of all other feedback mechanisms

Facility managers and woreda officers described data reporting primarily as a compliance function — performed to satisfy upward reporting requirements rather than to inform local decisions. In many settings, dashboards were displayed but not consulted in operational discussions, and health workers who collected data reported rarely receiving feedback on how it was used.

Findings Based on OECD-DAC Evaluation Criteria

RELEVANCE

High — Strategically Well-Aligned

HSDIP-I demonstrated strong relevance to Ethiopia's epidemiological profile and national and global commitments. The plan appropriately addressed a triple burden of communicable diseases, NCDs, and injuries, with robust alignment to the Health Policy of Ethiopia (2024), EHSP, Ten-Year Development Plan, SDGs, IHRs, Global Health Security Agenda, and UNAIDS targets.

Relevance was partially constrained by limited adaptability to emerging challenges including urban malaria (An. stephensi), displacement-related health needs, and climate-sensitive disease patterns.

EFFICIENCY

Constrained by Structural Inefficiencies

HSDIP-I showed efficiency gains in selected areas but was constrained by fragmented parallel systems creating duplication; weak supply chain systems producing procurement delays and stock-outs; inadequate maintenance systems reducing equipment lifespan; and inefficient CBHI reimbursement constraining facility liquidity. SHI non-implementation and extended leadership turnover further limited timely delivery.

COHERENCE

Moderate — Strong Design, Fragmented Practice

Internal strategic coherence was strong in design — nine objectives configured to be mutually reinforcing, with the "one plan, one report, one budget" principle well-articulated. In practice, integration was uneven: parallel programme financing, non-interoperable digital systems, and inconsistent subnational coordination — particularly in conflict-affected regions — limited the coherence experienced at implementation level.

EFFECTIVENESS

Mixed — Selective Gains, Incomplete Transformation

HSDIP-I demonstrated mixed and highly uneven effectiveness. Strong gains were recorded in maternal health, TB treatment, HIV cascade management, NCD control, emergency care, and selected governance functions. At the same time, child survival, immunization, family planning, malaria control, PHC/HEP performance, health workforce density, and information use remained below target or worsened. The central gap is between platform expansion and reliable, equitable performance at the point of care.

IMPACT

Mixed — Major Gains Offset by Deterioration

HSDIP-I generated substantial positive impacts: maternal mortality nearly halved; HIV viral suppression approached international benchmarks; Ethiopia exited the high MDR/RR-TB burden classification; emergency improvements reduced preventable hospital deaths. These gains were offset by worsening under-five mortality, rising malaria incidence, declining immunization coverage, and stagnant stunting. Financial protection impact was limited, with out-of-pocket expenditure remaining high and inequity persisting across populations and geographies.

SUSTAINABILITY

At Risk — Financing and Dependency Threaten Gains

Sustainability is the greatest overall concern. Domestic health financing declined below the Abuja target; many core programmes remain donordependent; SHI was not implemented; and the HEP — the foundational PHC platform — showed declining performance. If donor support contracts without equivalent domestic resource mobilisation, many HSDIP-I gains will be vulnerable.

Conclusion

The HSDIP-I End-Term Review demonstrates that Ethiopia's health sector made important progress across maternal health, HIV, tuberculosis, health service expansion, and selected health system reforms during the 2023/24–2025/26 plan period. The maternal mortality ratio nearly halved. Ethiopia achieved recognition for exiting the high MDR/RR-TB burden classification. HIV viral suppression approached international benchmarks. Emergency and critical care capacity expanded meaningfully. These achievements reflect the dedication of health workers and health system leadership in an extraordinarily challenging operating environment.

At the same time, a significant number of critical population-health indicators fell short of targets. The evaluation's systems thinking analysis demonstrates that these shortfalls reflect the interaction of six interconnected systemic constraints that collectively limited the effectiveness of even well-designed interventions. Progress was uneven across populations and geographies, with pastoralist, rural, and conflictaffected communities consistently experiencing weaker and less reliable health system performance.

The central message of this evaluation is that HSDIP-II should focus on system transformation and consolidation rather than programme expansion.

The gap between Ethiopia's considerable health investment and observed population-level outcomes is not primarily a gap of coverage or platform — it is a gap of quality, accountability, functionality, and integration.

Future progress will depend on strengthening governance and accountability, transforming primary health care for the evolving demands of the Ethiopian population, increasing domestic resource mobilisation, building a resilient and motivated health workforce, ensuring supply chain reliability, and institutionalising data-driven decision-making as the basis of routine health system management.

The six reinforcing challenges must be addressed as an integrated system. Improving any single loop creates leverage across the others — and failing to do so will continue to produce the same pattern of selective gains without sustained system-wide transformation.

Six Strategic Transformation Priorities for HSDIP-II

01

Accountability for Results

Stronger accountability, performance management, and learning systems should become the foundation of improved governance and service delivery. This requires moving beyond data collection towards enforcing consequences for performance at all levels — from woreda-level management to facility leadership and national programme stewardship — and reforming the conditions that enable impunity for poor performance to persist.

02

Re-envision and Transform the Health Extension Programme

The HEP should be comprehensively redesigned as a contemporary primary health care platform capable of responding to changing disease patterns, urbanization, demographic change, and community expectations. Transformation must be system-wide — addressing HEW motivation, compensation, career pathways, infrastructure, supply chain, digital health, supervision, and governance as integrated requirements, not isolated reform items.

03

Domestic Resource Mobilisation

Expanding fiscal space and implementing health financing reforms are essential for long-term sustainability. This includes increasing government health expenditure towards the Abuja Declaration target, implementing a credible SHI roadmap, automating CBHI reimbursement to eliminate delays, and ensuring that CBHI enrollment for indigent populations translates into actual access and utilization.

04

Integrated Supply Chains and Interoperable Digital Systems

Efficient procurement, logistics, information systems, and data use should support timely, evidenceinformed decision-making across the health system. This requires reducing procurement lead times, eliminating essential medicine stock-outs, integrating parallel digital platforms, and shifting data culture from compliance to learning at facility, woreda, and regional levels.

05

Strengthen the Health Workforce as the Foundation of System Performance

Recruitment, retention, motivation, supportive supervision, and continuous professional development should receive greater strategic attention. The workforce is the single most important determinant of health service quality and cannot be treated as a residual input. HSDIP-II should invest in workforce distribution, incentive structures, career development, and the management environment that enables all health workers — including HEWs — to perform and remain in post.

06

Adaptive Health System Capable of Responding to Future Shocks

Institutionalising emergency preparedness, strengthening inter-agency coordination, and embedding adaptive management will enable the health system to maintain essential services during conflict, outbreaks, climate-related emergencies, and other crises. This includes establishing a dedicated postconflict recovery financing mechanism, institutionalising MHPSS, and clarifying mandates across MOH, EPHI, and EPSS so emergency response and recovery operate as routine government functions.

17
RECOMMENDATIONS

Priority Recommendations for HSDIP-II

Recommendations were prioritized through a structured judgement process informed by the evaluation findings, systems analysis, OECD-DAC assessment, and stakeholder evidence, assessed against systemic impact, urgency, feasibility, and equity implications.

PRIORITY	AREA	RECOMMENDATION
P1 — Critical	Accountability & Governance	Establish enforceable performance accountability at all levels, including merit-based leadership selection, consequence management for persistent underperformance, and empowered community feedback loops linked to management response.
P1 — Critical	HEP Transformation	Initiate comprehensive redesign of the HEP as a contemporary PHC platform — addressing HEW motivation and career development, service package alignment, infrastructure rehabilitation, supply chain support, and supervisory systems as an integrated transformation.
P1 — Critical	Health Financing	Increase domestic government health expenditure towards the Abuja target; implement a credible SHI roadmap; resolve CBHI reimbursement delays through automation; and actively reduce the out-of-pocket burden, ensuring indigent CBHI enrollees access services as well as coverage.
P1 — Critical	Supply Chain	Achieve supply chain reliability through procurement lead time reduction, essential medicine fill rate improvement above 95%, cold chain strengthening, and LMIS-clinical system integration — treating commodity reliability as a non-negotiable system prerequisite.
P2 — High	Child Health & Immunization	Reverse declining immunization coverage through demand-side community engagement, conflict-sensitive service delivery, cold chain strengthening, and improved data validation systems to address the disconnect between reported and actual coverage levels.

PRIORITY	AREA	RECOMMENDATION
P2 — High	Malaria	Scale up integrated malaria control including An. stephensispecific urban vector control, community case management, insecticide resistance surveillance, and conflict-adapted prevention strategies, with supplementary financing for areas of resurgence.
P2 — High	Data Systems	Shift digital health investment from infrastructure expansion to data quality, interoperability, analysis capacity, and a culture of evidence-based decision-making — measuring success by data use, not data collection.
P2 — High	Workforce	Address health worker distribution, incentives, and retention through structural reform of compensation systems, investment in supportive supervision, and deployment strategies targeting underserved areas.
P3 — Medium	Private Sector	Move from participation-based to performance-oriented private sector engagement, with regulation, accountability, and public health function integration as the basis of PPP arrangements and private facility accreditation.
P3 — Medium	Post-Conflict Recovery	Establish a dedicated, funded health system recovery mechanism — including a rapid repair fund, health worker redeployment protocol, and recovery financing outside the humanitarian cycle — and institutionalise post-conflict recovery as a standing government function.
P3 — Medium	Innovation Scale-Up	Create an institutional pathway for health innovations to move from pilot to scale, with dedicated financing, evaluation frameworks, and integration into standard programme budgets to avoid innovation remaining a source of fragmentation.

HEALTH SECTOR MEDIUM-TERM DEVELOPMENT AND INVESTMENT PLAN I

This abridged report was prepared by an independent evaluation team contracted by IPHC-E. The findings, conclusions, and recommendations are those of the evaluation team and do not necessarily represent the official position of the Ministry of Health or any other institution.

The authors' views expressed herein do not necessarily reflect the views of IPHC-E.

FOR FURTHER INFORMATION

CONTACTS

For enquiries about this abridged report or the HSDIP-I End-Term Review, please contact the relevant focal points below. The full technical report is being finalized and will be made available in due course through official channels.

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