World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2011

ETHIOPIA

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ABBREVIATIONS

ACF	:	Action Contre la Faim
ACT	:	Artemisinin-based combination therapy
ADLI	:	Agricultural Development-Led Industrialization
ADRA	:	Adventist Development Agency
AfDB	:	African Development Bank
AFRO	:	WHO Regional Office for Africa
AIDS	:	Acquired Immunodeficiency Syndrome
AOW	:	Area of Work
APOC	:	African Programme on Onchocerciasis Control
ARM	:	Annual Review Meeting
ART	:	Antiretroviral Therapy
BCCBPR	:	Behavior Change Communication Business Process Reengineering
CCA	:	Common Country Assessment
CCM	:	Country Coordination Mechanism
CCS	:	Country Cooperation Strategy
CDC	:	Centers for Disease Control and Prevention
CDTI	:	Community-Directed Treatment with Ivermectin
CIDA	:	Canadian International Development Agency
CJSC	:	Central Joint Steering Committee
CMH	:	Commission on Macroeconomics and Health
CRDA	:	Christian Relief and Development Organization
CSACSO	:	Central Statistical Authority Civil Society Organization
DAG	:	Development Assistance Group
DFID	:	Department for International Development
DHS	:	Demographic and Health Survey
DOTS	:	Directly-observed Treatment, Short course
DPPA	:	Disaster Prevention and Preparedness Agency
DST	:	Drug Sensitivity Testing
EC	:	Ethiopian Calendar
EDHS	:	Ethiopia Demographic and Health Survey
EFY	:	Ethiopian Fiscal Year
EHNRI	:	Emergency Health and Nutrition Task Force
ENA	:	Essential Nutrition Action
EPI	:	Expanded Programme on Immunization
ERCS	:	Ethiopian Red Cross Society
ESRDF	:	Ethiopian Social Rehabilitation and Development Fund
EU	:	European Union

FCTC	:	Framework Convention on Tobacco Control
FHAPCO	:	Federal HIV/AIDS Prevention and Control Office
FMOH	:	Federal Ministry of Health
GAVI	:	Global Alliance for Vaccines and Immunization
GDP	:	Gross Domestic Product
GFATM	:	Global Funds for AIDS, Tuberculosis and Malaria
GNP	:	Gross National Product
GTZ	:	German Development Agency
HBV	:	Hepatitis B Virus
HC	:	Health Centres
HCV	:	Hepatitis C Virus
HHA	:	Harmonization for Health in Africa
HHM	:	Harmonization and Alignment Manual
HIV	:	Human Immunodeficiency Virus
HMIS	:	Health Management Information System
HOAI	:	Horn of Africa Initiative
HP	:	Health Posts
HPN	:	Health, Population and Nutrition Donor Group
HRH	:	Human Resources for Health
HS	:	Health Stations
HSDP		Health Sector Development Programme
HTPs	:	Harmful Traditional Practices
IAEA	:	International Atomic Energy Agency
IDSR	:	Integrated Disease Surveillance and Response
IEC	:	Information, Education and Communication
IFAD	:	International Food and Agricultural Development Agency
IFF	:	International Finance Facility
IHP	:	International Health Partnerships
IMAI	:	Integrated Management of Adult Illnesses
IMNCI	:	Integrated Management of Neonatal and Childhood Illnesses
IOM	:	Office of International Migration
ITN	:	Insecticide-treated Net
JBAR	:	Joint Budget and Aid Review
JICA	:	Japan International Cooperation Agency
JRM	:	Joint Review Mission
LLIN	:	Long-Lasting Insecticide-treated Net
MDG	:	Millennium Development Goal
MDR	:	Multidrug Resistance
MTR	:	Mid-Term Review
MTSP	:	Medium Term Strategic Plan

NCD	:	Noncommunicable Diseases
NEPAD	:	New Partnerships for Africa's Development
NGO	:	Nongovernmental Organization
NHA	:	National Health Accounts
OCHA	:	UN Office for Coordination of Humanitarian Affairs
ODA	:	Official Development Assistance
PASDEP	:	Poverty Reduction Strategy Plan for Accelerated and Sustained Development to End Poverty
PHC	:	Primary Health Care
PMTCT	:	Prevention of Mother-to-Child Transmission
PRSP	:	Poverty Reduction Strategy Papers
RDT	:	Rapid Diagnostic Test
RHB	:	Regional Health Bureau
RJSC	:	Regional Joint Steering Committee
SCF	:	Save the Children Fund
SDPRP	:	Sustainable Development and Poverty Reduction Programme
SIDA	:	Swedish International Development Agency
SNNPR	:	Southern Nations, Nationalities and Peoples Region
SO	:	Strategic Objectives
SSA	:	Sub-Saharan Africa
STI	:	Sexually-transmitted infection
SWAP	:	Sector-wide Approach
TB	:	Tuberculosis
U5 MR	:	Under-five mortality
UNDAF	:	UN Development Assistance Framework
UNESCO	:	United Nations Education and Cultural Organization
UNFPA	:	United Nations Population Fund
UNHCR	:	United Nations High Commission for Refugees
UNICEF	:	United Nations Children Fund
USAID	:	United States Agency for International Development
USG	:	United States Government
VCT	:	Voluntary Counseling and Testing
VPD	:	Vaccine-preventable Diseases
WB	:	World Bank
WCO	:	WHO Country Office
WR	:	WHO Representative

EXECUTIVE SUMMARY

WHO aims to reduce morbidity, disability and mortality and improve the health status of the Ethiopian people through supporting and advocating for the provision of comprehensive essential health packages of preventive, promotive, curative and rehabilitative health services as well as support for achieving the health-related Millennium Development Goals for sustainable national development.

A Country Cooperation Strategy is the WHO Medium-Term Strategic Framework that serves as the basis for dialogue, advocacy, resource mobilization, and planning for WHO Country Offices. WCO defines the strategic framework for the work of WHO with the country and clarifies the Organization's strategic priorities in supporting the country's national health and development agenda. In the Ethiopian context, the WCO has developed and used its first-generation CCS and currently has produced this document to be used for the period 2008-20011.

The Health Sector Development Programme (HSDP) of Ethiopia has been in place since 1997/98. Its third phase covers a period of five years i.e. July 2005 to June 2010. The Country Cooperation Strategy (CCS) sets forth the way in which the Organization will support health development priorities within the period 2008-2011, which is two consecutive bienniums. This period was selected to address the need for alignment with the country's strategic plan, the UNDAF as well as the WHO biennial system of planning. The CCS is also inspired by the changes in development policies in Ethiopia and global commitments such as the International Health Partnerships for Health (IHP), the attainment of Millennium Development goals as well as the global and regional WHO policy framework.

The development of this second generation of CCS involved consultation with key stakeholders including and mainly the FMOH. In addition, comments from the different levels of WHO as well as the guides prepared for preparation of CCS were used.

As stated in detail in the document, the WCO will support Ethiopia's efforts in reducing morbidity, disability, mortality, and in improving the health outcomes of the people through advocacy, health promotion and support for the delivery of comprehensive essential health packages and health service organization thus creating an enabling environment for the attainment of the health-related Millennium Development Goals. The CCS will focus on the following three domains, as its contribution to achieving the implementation of the following priorities outlined in the HSDPIII:

(a) health security;

(b) health system capacities and governance;

(c) partnerships, coordination and resource mobilization.

The Health Security domain will support the health sector priorities for reducing social and economic burden of communicable and noncommunicable diseases through promoting the use of evidence-based information for decision-making and action. It will also focus on reducing infant, child and maternal morbidity and mortality, and promoting responsible and healthy sexual and reproductive health behavior. In this regard, the use of the life-course approach for promoting maternal, neonatal and adolescent health, sexual and reproductive health, and active and healthy ageing for all individuals will be supported.

Health systems strengthening through better governance, financing, staffing and management is to be supported by generating reliable evidence for health policy and ensuring quality health service delivery and improved access to the use of medical products and technologies. WHO will also continue to collaborate with other UN agencies through the implementation of UNDAF, with multilateral, bilateral, and civil society organizations and other sectors.

The implementation of the identified strategic agenda will require US$ 172 402 000.00 which will be raised through WHO regular budget and voluntary contributions. WCO will participate in the government-led joint planning and budgeting processes, synchronizing its budgeting processes with the Government budget cycles. As outlined in the harmonization manual, Government-approved funding channels will be used to channel most of the funds from the WCO to support costed strategies in HSDPIII. WCO will also strengthen its collaboration with CSOs to support HSDP priorities.

The Country Office will fully participate in all coordination mechanisms with the health sector Ministry, the UN and other partners by actively engaging in joint reviews (Annual Review Meetings (ARM), joint annual review mission (JRM) and joint field visits). Mid-term and end-of-plan period assessments/evaluations as well as periodic population-based research and surveys will be used for monitoring and evaluation

In addition to the common country review processes, reviews of the implementation of the biennial Plan of Action (semi-annual, annual and mid-term reviews), using the WHO results-based matrix, will provide additional information for performance-based monitoring and assessment of the CCS.

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This document is the product of a collaborative effort between WHO/Ethiopia FMOH, other UN agencies and partners. We would like to express our appreciation to the FMOH for its supportive role during the preparation of this document.

Furthermore, our sincere thanks go to the partners and the UN family in Ethiopia for their useful suggestions that enriched the document.

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

SECTION I

INTRODUCTION

The Country Cooperation Strategy (CCS) is one of the most important pillars of the WHO Country Focus Policy. The CCS is a "Medium-term Strategy for the work of WHO at country level under the leadership of WHO Representatives". It describes how the three levels of the Organization work at country level. The 1st Generation CCS for Ethiopia was developed in 2001 covering the period 2002-2005.

The development of the 2nd Generation CCS is timely because of the new development at country, regional and global levels. It takes into account the Common Country Assessment (CCA) of UNDAF, the WHO Medium Term Strategic Plan (2008–2013), and the various Country Policy Documents as well as the move in terms of planning cycles of WHO, the UN System and that of the country to be served. It is seen as a contribution to the implementation of the Health Sector Development Programme (HSDP) and the Plan for Sustained and Accelerated Development to End Poverty (PASDEP). The CCS defines the broad framework of collaboration between WHO and the Federal Democratic Republic of Ethiopia for 2008-2011.

WHO considers the opportunities offered by various debt reduction and poverty alleviation funds as well as the new funding mechanisms such as the Global Alliance for Vaccines and Immunization (GAVI), Global Fund to fight AIDS, TB and Malaria and other new initiatives in the health sector. Significant shifts have been noted in the administration of Official Development Assistance (ODA), e.g. the shift from the project approach to the programme approach.

Furthermore, the Millennium Development Goals (MDGs) and the African Union's Africa Health Strategy (2007–2015) are agreed milestones through which progress at country level can be monitored and measured. The new International Health Partnership (IHP) for which Ethiopia and WHO are signatories will facilitate the process for better coordination, harmonization and alignment within the sector.

The revision of the 1st Generation CCS is intended:

(a) to facilitate the harmonization of the CCS with other planning frameworks. The Ethiopian Government has also developed and launched the Health Sector Harmonization and Alignment Manual (HHM), on which the Road Map of the International partnership Initiative (IHP) was based;

(b) to bring the CCS in line with the recent developments regarding programme implementation in the Health Sector Development Programme (HSDPII, 2005/6 2009/10) in the Ethiopian context;

(c) to take into account the major shift made by the World Health Assembly to move from planning by Area of Work (AOW) to planning by strategic objectives (SO) and alignment with MDG and MTSP (2008-2013);

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 GENERAL INFORMATION

Ethiopia is a Federal Republic having nine Regional States, two city administrations, 611 Woredas and 15,000 Kebeles with a population of over 79.2 million and a growth rate of 2.7%. Regional States which are subdivided into Woredas are governed by Presidents, with a regional council and elected members. The Woredas are further divided into Kebeles. Ethiopia has a total area of 1.1 million square kilometers and is bordered by Kenya in the south, Somalia in South-West (East), Eritrea in the North, Djibouti in the East and Sudan in the West.

Eighty-five per cent of the population lives in rural areas (PASDEP 2005) and is young, with high dependency ratio, since 44% of the population is under the age of 15 years with average life expectancy at birth of 54 years (53.4 year for males and 55.4 years for females). Ethiopia experiences recurrent drought with attendant famine due to irregular rainfall pattern. Being a low- income country with a per capita gross national income of US$ 180 in 2005, (WB, the 2006 World Development Report), Ethiopia ranks 169 out of 177 on the Human Development Index. About 38.7% of the population live in absolute poverty (down from 44% in 1999/2000).[1] Since 1991, comprehensive economic reform has been implemented based on free-market economy and with emphasis on social and infrastructure development which has given rise to macroeconomic stability. The total adult literacy rate is 38% (50% for males and 26.6% for females). The number of students in primary schools increased to 14 million, taking the gross primary enrolment ratio (GPER) to 91.6% with the ratio of girls to boys (in primary school) being 0.93 (PASDEP Annual Progress Report 2006/7).

The Government is fully committed to implementing its second Poverty Reduction Strategy and the Plan for Accelerated and Sustained Development to End Poverty (PASDEP), which aims at achieving all the MDGs targets. As a result, the third phase of the Health Sector Development programme (HSDPIII) has been aligned and constitutes the health sector chapter of the PASDEP. The UNDAF (United Nations Development Assistance Framework) is also in alignment with PASDEP and the HSDPIII.

2.2 MATERNAL ADOLESCENT AND CHILD HEALTH

Maternal mortality ratio has decreased from 871/100 000 live births in 2000 to 673/100 000 live births in 2005. Skilled attendance at birth is only 6% (DHS, 2005) and access to emergency obstetrical care is still limited. Hemorrhage (25%), puerperal infections (15%), eclampsia (13%) and complicated abortion (10%) are the leading causes of maternal

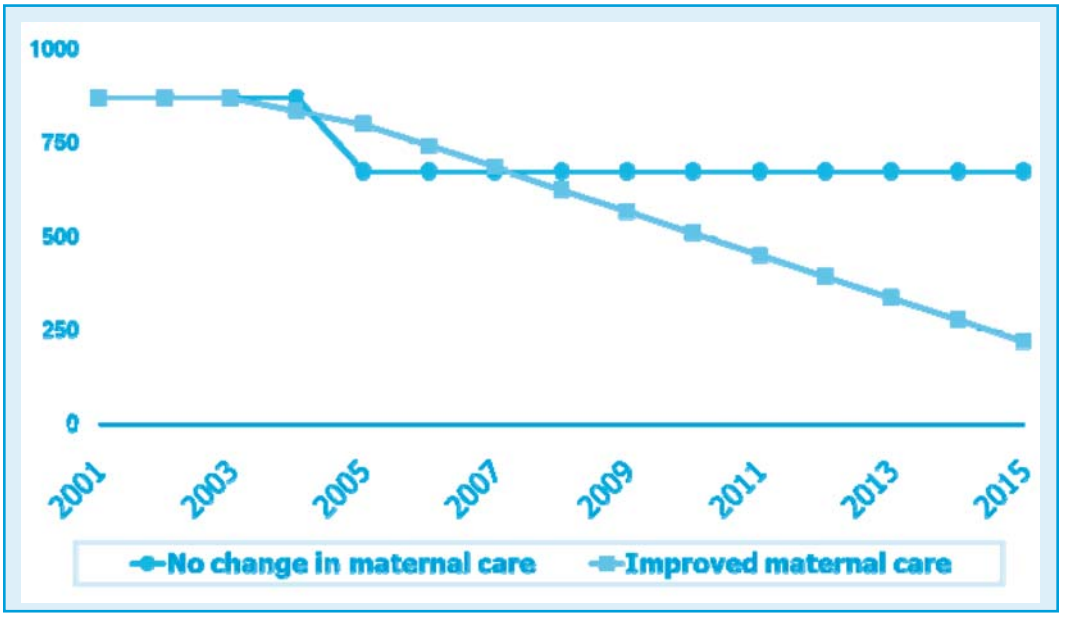
[1] Emerging Ethiopia: Strengthening Efforts to Eradicate Poverty and Hunger, including through the Global partnership for development. ECOSOC report, June 2007.

death, with the leading underlying factors associated with the three known delays. High teenage pregnancy, insufficient Contraceptive Prevalence Rate of 34% and relatively high incidence of Sexually Transmitted Infections (STI) in young people are also known contributory factors.

In spite of the decreasing maternal mortality rate, the progress is not adequate for attaining the MDG-5 target in 2015. There is a need to accelerate the rate of decline of maternal mortality rate to a level of 5.9 percentage points in order to reach the MDG-5 in 2015 (HSDPIII) (Fig 1). The major challenges for maternal health are weak health system (critical lack of midwives, equipment and supplies), poor referral linkages, shortage of skilled attendance at birth and especially lack of emergency obstetric and neonatal care.

Under-five mortality (U5MR), at 123 per 1 000 live births, has, on average, declined by

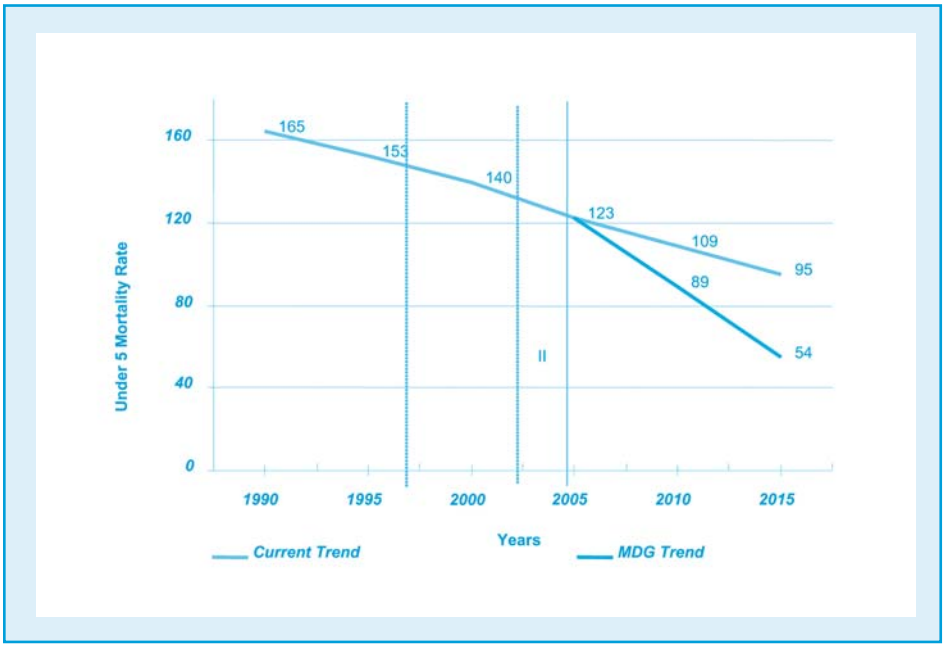
Fig 1: Reducing Maternal Mortality Deaths in Ethiopia 2001-2015



1.8 percentage points annually since 1990 (DHS, 2005). Pneumonia, diarrheal diseases, malaria and neonatal complications each accounts for nearly a quarter of U5MR while malnutrition underlies over 50 % of deaths. The nutritional status for children under 5 years of age for the three indices: weight for age (under weight), height for age (stunting), weight for height (wasting) are 38%, 47% and 11% respectively (EDHS 2005). Though child mortality rate is decreasing, the progress is not adequate for attaining the MDG-4 target in 2015 which requires accelerated reduction of under-five mortality rate to a level of 7.9 percentage points annually (Fig 2). Shortage of financial and human resources, low access and utilization of health services, weak referral system from the community up to referral facilities, lack of adequate supportive supervision, poor organization of services at facility level and shortage of essential medicines and supplies were some of the major constraining factors affecting the scaling up of key child survival interventions.

Adolescents and young people aged 10 to 24 constitute over one-third of the total

Fig 2: Under-five mortality rate



population of Ethiopia and their number is expected to increase from 21 million in 2000 to 25 million by 2010. The majority of them are highly vulnerable to sexual and reproductive health problems that include pregnancy and child bearing at early age, complications of unsafe abortion, sexually transmitted infections and HIV/AIDS. Inadequate availability and access to sexual and reproductive health information and services friendly to different groups of the youth is a major challenge affecting adolescent health.

Violence against women and harmful traditional practices (female genital mutilations, abductions, early marriage, etc.) are prevalent, and are among the main factors that contribute to the high maternal mortality and disability. In recognition that the health sector has a strong preventive role, the prevention of the various acts of violence against women has been prioritized by the FMOH and receives WHO's support. The same issues are also addressed in partnership with other Government sectors, donors and NGOs. The challenges are the existing gender inequality and the lack of awareness on the part of the general public including health providers.

Immunization against Vaccine Preventable Diseases

Immunization coverage has shown significant improvement in the last four years. The DPT coverage (HepB-Hib3 and measles) improved from 66% and 55% in 2004 to 73% and 65% respectively in 2007. This is mainly a result of implementing the RED approach, and the provision of technical, financial and material support by partners including WHO, and other initiatives. The coverage improvement is noted in the populated regions like SNNPR and Oromia, whereas the emerging regions like Afar, Somali and Gambella have coverage of less than 50%. Certification standard AFP surveillance indicators have been maintained since 2004 and five separate importations of wild poliovirus have been successfully controlled. Accelerated measles control strategies have been successfully implemented since 2002 and the mortality and morbidity due to measles have reduced significantly. The main challenges

in improving immunization coverage currently are persistent low immunization performance in emerging regions (Gambella, Afar and Somali), maintaining immunization high on the agenda of ongoing health reforms, operationalizing the integrated child survival interventions and the risk of importation of wild polioviruses from neighboring countries. In addition, the frequent measles outbreaks due to low measles routine immunization coverage and suboptimal measles vaccination campaigns in some areas are also a challenge.

2.3 COMMUNICABLE DISEASES AND EMERGENCY HEALTH

Infectious and communicable diseases account for about 60-80% of the health problems in the country.

2.3.1 HIV/AIDS, Tuberculosis and Malaria

2.3.1.1 HIV/AIDS

The main source of information about HIV in Ethiopia is antenatal clinic (ANC)-based sentinel surveillance, Demographic and Health Surveys (DHS) and Behavioral Surveillance Surveys (BSS). In 2005, DHS and the sentinel surveillance of pregnant women attending antenatal clinics (ANC) produced national adult prevalence estimates of 1.4% and 3.5% respectively. Reconciliation of these two estimates has been done and a single-point estimates for national adult HIV prevalence was developed in 2007. Accordingly, the national adult HIV prevalence in 2008 is 2.2%. Data shows relatively higher prevalence among females (2.6%) than males (1.8%). Also, the adult HIV prevalence in urban areas is much higher (7.7%) than in rural areas (0.8%). The data from urban areas indicates a generalized epidemic while the rural epidemic appears to be relatively widespread and heterogeneous ranging from 0.3% to 1.5%. Another sentinel surveillance of pregnant women attending antenatal clinics (ANC) is planned during 2009 and the next DHS is being planned for 2010.

Over the years, Ethiopia's response to HIV/AIDS epidemic has shown considerable progress and achieved encouraging results. However, the nature of the epidemic and the fueling factors create a formidable challenge to the ability of the health and other sectors to meet the targets for HIV/AIDS control in Ethiopia (2nd Health Sector Road Map and Multisectoral Plan of Action for Achieving Universal Access by 2010). Insufficient human resources, weak supply management/distribution, and weak mid-level managerial capacity at regional and district (Woreda) levels are key challenges in the country's response to HIV/AIDS.

2.3.1.2 Tuberculosis

Tuberculosis has been recognized as a major public health problem in Ethiopia since the 1950s. Ethiopia ranks 7th out of the world's 22 high-burden countries for TB, with incidences of about 379/100 000 population for all forms of TB and 168/100 000 for smear-positive tuberculosis. The prevalence of all forms of TB is 643/100 000 population with TB morality rate of 84 per 100 000 population per year (WHO Report 2008). The targets for case detection rates for smear-positive forms of TB set at 70% stands at only 34% as of 2008. The treatment success rate for smear-positive forms set at 85% has been achieved during the year 2007.

The emergence of Multidrug Resistant (MDR) TB is also another challenge faced by the country already overburdened by high prevalence of the disease. The country survey between 2003 and 2006 has shown the prevalence of MDR TB of 1.6 % in new TB cases and 11.8% for re-treatment of cases. The high TB/HIV co-infection rate is also a major concern with a quarter of registered TB cases in the country testing positive for HIV (FMoH, 2008).

2.3.1.3 Malaria

Malaria is one of the leading causes of morbidity and mortality in Ethiopia. Malaria transmission in the majority of Ethiopia shows marked yearly, seasonal and geographical variations. This situation makes the disease highly unstable and epidemic-prone. Most malaria epidemics, when they occur, are often severe and devastating with high morbidity and mortality. The Government of Ethiopia, financially and technically supported by partners and donors, has scaled-up efforts to control the disease. Due to the intensive scale up of control interventions, the disease has shown relative decline in the number of reported cases and deaths at health facilities, and in the number of epidemics that occur. Lack of adequate resources for control interventions and epidemic response, and weak disease surveillance system are the main challenges to the malaria control programme.

2.3.2 Disease Surveillance, Prevention, Control and Eradication

2.3.2.1 Neglected Communicable Diseases

Leprosy, onchocerciasis, leishmaniasis, schistosomiasis, soil-transmitted helminthiasis, lymphatic filariasis, and trachoma are among the neglected diseases although they are prevalent, to varying degrees, in different parts of the country. Among these diseases, onchocerciasis, leishmaniasis, leprosy and trachoma have a relatively better national control and elimination programmes.

Onchocerciasis is endemic in the western parts of the country, with an estimated 17% (more than 12 million) people at risk of infection. Community-directed Treatment with Ivermectin (CDTI), launched in 2001, targeting an estimated 1.2 million people, showed an improvement of therapeutic and geographic coverage over the years. The challenges include poor prioritization of the control programme and high turnover of programme coordinators. The APOC financial and technical support will phase out from Ethiopia starting from 2010 as most of the CDTI projects will be more than 5 years by then.

Endemic in the central rift valley and in the northwestern southern parts of Ethiopia, visceral leishmaniasis is considered a major clinical and public health problem due to its high morbidity and mortality. The disease is endemic usually in the remote but fertile parts of the country with poor infrastructure, diagnostic and treatment capacities. The disease burden is hugely underestimated due to the absence of surveillance system and lack of data on the distribution and magnitude of the disease in the endemic areas.

Leprosy notification rate has remained relatively stable over the past five years between 4000 and 5000 annually. With its prevalence rate of less than 0.8 per 10 000 inhabitants, Ethiopia qualifies as a country that has achieved the goal of elimination. However, the presence of pocket areas that have not reached this target and the stagnation of annual incidence require further investigation and effort by the elimination programme.

The 2006 National Blindness Survey Results show that the prevalence of blindness and low vision is among the highest in sub-Saharan Africa (1.6% and 3.7% respectively). More than 80% of the blindness is preventable. Cataract (49.9%) and trachomatous corneal opacity (11.5%) are the two leading causes of blindness in Ethiopia, making up two-thirds of all causes of blindness. The rest of the causes of blindness are refractive error (7.8%), glaucoma (5.2%), macular degeneration (4.8%) and others (13.0%). A Five-year VISION 2020 plan on eye care with the aim of eliminating avoidable blindness by the year 2020 has been developed based on the WHO strategy to address the above challenges.

2.3.2.2 Integrated Disease Surveillance and Response

Ethiopia developed a five-year strategic plan and started implementing the IDSR consisting of 23 priority diseases that are epidemic-prone, have public health importance and are targeted for eradication and elimination. The systematic evaluation of the first five years of implementation indicated that the country has successfully expanded its surveillance system up to the health centre and hospital level, improving the early detection, reporting, epidemic preparedness and response activities. However, IDSR remains limited to the health centre level. Inadequate epidemic preparedness and response, poor capacity to diagnose epidemic-prone diseases and inadequate contingency stocks for epidemic response at each level are the main challenges. Avian human influenza is also a menace to Ethiopia because of the presence of numerous water bodies for resting birds and their geographic location along the route of migratory birds, backyard poultry rearing and unhygienic handling practices compounded by a weak surveillance system.

The current IDSR working guidelines and manuals that would serve as a platform for the enforcement of the International Health Regulation (IHR) require revision in order to address the existing gaps and demands in the country's health system.

2.3.3 Emergency and Humanitarian Action

Ethiopia is prone to both natural and man-made disasters and this situation has, for many years, disrupted the lives of the people. Flooding, drought and disease epidemics including insurgencies and resource-based ethnic conflicts are major causes of displacement, morbidity, mortality and loss of livelihood in the country. The most prevalent health and nutrition emergencies identified as priorities that require immediate response during droughts are severe acute malnutrition, diarrhoeal diseases, malaria, acute respiratory infections, and other diseases of epidemic potential (meningitis, measles etc).

The presence of coordination bodies such as Emergency Health and Nutrition Task Force, UN country team led by the Resident Coordinator, Health Partners' Forum, UN Technical Officers, UN Cluster Leads and Ethiopian Humanitarian Country Team has enhanced emergency response in the country. Inadequate human resources, high staff turnover, weak health infrastructures, weak government multisectoral coordination approach, weak coordination and collaboration between FMOH and DPPA in dealing with health emergency situations, weakness of the existing early warning system for health, limited financial resources, inadequate capacity to utilize available resources, insecurity in some regions, and staff capacities in the emergency health sector interventions are the major constraining factors. It is now critical to strengthen the early warning system for health emergency, sustain increased funding for emergency preparedness and response, strengthen cross-border collaboration, and strengthen the Emergency Public Health Management Agency of the FMOH. In addition, support is required to strengthen cluster roll out in the regions to facilitate and improve coordination of emergency response.

2.4 NONCOMMUNICABLE DISEASES

2.4.1 Chronic Noncommunicable Diseases

Although national data is not available, small-scale studies show that chronic noncommunicable diseases are emerging as public health problems. The prevalence of noncommunicable diseases including hypertension, cardiovascular diseases and diabetes

mellitus is increasing due to changes in lifestyles. Hypertension was the sixth leading cause of death among hospitalized patients (health and health-related indicators of FMOH 2005 –2006).

Chronic diseases, along with injuries and cancers, accounted for about 30.6% of all deaths in 2005 in Ethiopia, and this proportion is projected to increase to 43.2% by 2030 (i.e. 41.2% rise from the level in 2005). Among the chronic diseases, cardiovascular diseases (CVDs) account for the largest proportion of causes of death both in 2005 and in the projections for 2030 (WHO Global Infobase). Studies have shown an increasing trend of mental health problems with 3.5-17 % prevalence and female dominance. The Government and partners recently commissioned a situation assessment and the result of the study will serve as background information for the formulation of strategies for addressing mental health concerns.

2.4.2 Injuries and Disabilities

Injury which is becoming a serious threat to the health and well-being of Ethiopians requires concerted efforts by various stakeholders. Road traffic injury and fatality rates were 946 and 80 per 10 000 registered vehicles respectively and account for over a third of all injuries. In 2007/2008 nearly 19 000 road traffic accidents occurred claiming over 2500 lives and property worth US$ 56 million (National Road Safety Coordination Office of Ethiopia, annual report 2008). Homicide and injury purposely inflicted by other persons (not in war) are the second leading cause of outpatient visit for females and the fourth among all the population (health and health-related indicators of FMOH 2006/7). Violence is also a major reason for the high burden of injuries and would require the strengthening of pre-hospital and trauma care. About 10% of the Ethiopian population has disabilities. Less than 10% of those in need of rehabilitation have access to appropriate services. Ownership and capacity in designing and implementing prevention programmes remain ill-defined.

2.5 HEALTH SYSTEM'S RESPONSE

The national health policy and health sector development strategy of the country, which is based on the principle of equitable access to quality and effective promotive, preventive and curative health services, has documented a notable improvement over the last years. However, meeting equitable and quality health services remains a challenge. The Ethiopian Ministry of Health, as part of the public sector reform plan of the Government of Ethiopia, has been engaged in a major reform initiative in a form of business process re-engineering (BPR). MOH's BPR was started about three years ago, but it has been done more intensively in the last one year. Accordingly, MOH's businesses have been regrouped into eight core and five support processes[2]. WHO has been providing technical support in re-designing some key processes. More importantly, WHO's normative guidelines and technical documents were used.

Key health systems responses have emphasized review of policies and plans in line with the PHC approach, decentralized management of health service delivery focusing on district health systems, human resource management and health financing, medicines and health technologies, information for health planning and management, and strengthening of partnerships for health.

[2] The eight core processes are financial resource mobilization and health insurance; health care delivery; pharmaceutical supplies; public health emergency management; policy planning, monitoring and evaluation; research and technology transfer; health and health-related services and products quality regulation; health infrastructure expansion and rehabilitation.

2.5.1 Access and Utilization of Health Services

The health care facility expansion effort has noticeably enhanced physical access to health services with emphasis on the primary health care units that included health centres and health posts. Public health facilities account for 85% of health service provision (143 hospitals, 690 health centres and 9914 health posts). The private health sector, though skewed to urban centres, has also shown significant increase and accounts for 15% of health services (397 private not-for-profit clinics and 1756 private clinics for profit). The potential health service coverage based on availability of health services (physical access or reachability) is therefore estimated at 86.7%.

Utilization of services for the country is as low as 0.32%. On average only 18 per cent of children with fever are brought for treatment and this sharply decreases to 4.4 per cent in pastoralist children (DHS, 2005). Such low rate could entail low availability including basic service capacity standards, affordability and quality of services. There are still huge disparities among geographic areas and populations. Weak organization, planning and management of health care services delivery within districts and weak systems of referral between the PHCUs and the secondary and tertiary health care levels contribute to the avoidable but high maternal and child mortalities in the country.

2.5.2 Human Resources for Health

Shortage, uneven distribution, poor skill mix and high attrition of trained health professionals remain the major concern impeding transfers of competency. Based on 2006/07 data, there were 1806 physicians of all types, 792 health officers, and 18146 nurses, 1012 midwives and 24 571 health service extension workers, giving a health workers ratio of 0.27/1000 population. This is far below the threshold ratio of 2.3 per 1000 populations, required to reach the MDGs targets. Currently, the FMOH has started working on a new design which is expected to radically change production, motivation and retention as well as equitable distribution. An HRH technical group has been set up with the support of development partners and a final draft of the national HRH strategy is under discussion.

2.5.3 Essential Medicines and other Health Technologies

Unreliable medicine supply system and long procurement procedures have resulted in low availability of essential medicines (77% in 2004). The challenges include unaffordable medicines especially to low-income people; donor- dependent medicines financing with low government per capita medicines expenditure (US$ 0.37 in 2005/06); irrational use of medicines; unreliable quality of medicines, weak drug regulatory control and lack of evidence-base on safety, efficacy and quality of traditional medicines.

For greater greater access to safe blood transfusion, the Ethiopian Red Cross blood service which is providing the service through its 12 blood banks has been designated by the Federal Ministry of Health to manage and coordinate this service. The total blood collections currently meet only approximately 40% of the national needs. About 70% of this collection is in Addis Ababa. All blood supplies are tested for HIV/AIDS, 75% for HBV and about 30% for HCV (ERCS data). Through the WHO technical assistance, the Ministry of Health now has a policy on blood transfusion from which a five-year strategic plan has been developed and is being implemented. However, failure to follow the road map developed in March 2006 for total conversion of blood donors from replacement to voluntary blood donors and delays in implementing donor mobile sessions are some of the constraints noted.

2.5.4 Health Management Information System

In order to design and monitor the performance of health services that are equitable, each health authority needs an appropriate health management information system which must include measuring health determinants, health systems performance and health status and inequities in access to health care. Recent assessment of the Health Information System shows weaknesses in data generation, dissemination and use for decision making at different levels of the health system, both on regular basis and in emergencies. The overall evidence-based decision-making capacity needs to be strengthened and standardized. To this effect, therefore, the Government designed and adapted a new HMIS and has now launched its implementation country-wide. Partners, including WHO and the HMN, are currently in support of the implementation and further development of the health information system of the country.

2.5.5 Health Care Financing

According to the Ethiopia third National Health Account (NHA) Report, the expenditure on health as percentage of GDP increased from US$ 4.5 in 2001 to US$ 7.14 in 2004/5. This is far below the US$ 34 identified as necessary to provide essential services. Of the total health expenditure, 30% is borne by households, while 31% is by the Government. Thus the health care financing mechanism is still dominated by public and individual household share, overburdening poor households. To increase the efficiency of health resource utilization, fiscal decentralization and reform in the management and administration of public finance have been put in place. According to the third NHA, 80% of the private sector spending is administered by households, followed by local NGOs (15%) reflecting the insignificant share of health insurance in the country. Currently, the Government is in the process of designing a social health insurance scheme with an aim to enhance universal essential health care coverage through risk pooling and improved access and quality of services with emphasis on the poor and vulnerable population.

2.5.6. Health Promotion

Health promotion cuts cross all primary health care health programmes and, as such, it is one of the eight priority issues identified by the health policy of the country and among the seven components of the Health Sector Development Programme. The Federal Ministry of Health has developed a ten- year national health communication strategy (2005-2014) to strengthen national capacity to incorporate health promotion in all primary health care activities. In its effort to expand primary health care at the grassroot level, the Government of Ethiopia is training and deploying, at community health posts, Health Service Extension Workers (HEWs) whose main function is health promotion. Therefore, strengthening the capacity of HEWs to undertake effective community health promotion interventions is of paramount importance.

Nevertheless, capacity is inadequate at the different levels of the MOH as well as the WCO. This includes capacity at the national level and across all programmes to plan, implement and coordinate evidence-based health promotion interventions.

2.6 HEALTH DETERMINANTS

Ethiopia is party to global and regional treaties and conventions addressing health-related rights. Respecting, protecting and fulfilling human rights can reduce vulnerability to ill health such as the right to good nutrition, safe water and sanitation and non-discrimination in health services provision and access. Human rights issues should be mainstreamed into health

programmes using the human-based approach to programming. The challenge for the health sector, therefore, lies in taking the lead to mobilize intersectoral action in guaranteeing access to affordable health care and in creating an enabling environment for health by ensuring that people have the basic requirements for maintaining good health.

2.6.1 Water and Sanitation

Government is working on achieving 100% coverage of sanitation and water supply through the Universal Access Plan. However, the rapid assessment report on safe drinking water published by FMOH, WHO and UNICEF in March 2007 estimated coverage at 37%. The rest of the population relies on unsafe sources such as ponds, lakes, rivers and open dug wells. Access to sanitation increased from 12.5% to 17%. The most important challenges include poor collaboration of stakeholders and inadequate financial resources.

2.6.2 Nutrition and Food Safety

Malnutrition has been a serious obstacle to economic development in Ethiopia. There is increasing concern about the health risks posed by microbial pathogens and potentially hazardous chemicals in food. Ethiopia faces the five major forms of malnutrition: acute and chronic malnutrition, iron deficiency anemia (IDA), vitamin A deficiency (VAD), iodine deficiency disorder (IDD), and zinc deficiency. The 2005 DHS has shown that about 47% and 11% of children under five were stunted and wasted respectively. Thirty-eight per cent of children under-five were underweight. Malnutrition is also prevalent in women and 27 per cent of women are chronically malnourished (BMI is less than 18.5). The prevalence of low birth weight (LBW) in Ethiopia, estimated at 14%, is one of the highest in the world. Government response measures have been in terms of rural development extension strategies and related programmes to address food insecurity problems; and formulation of the National Nutrition Strategy (NNS)/National Nutrition Programme (NNP). It is expected that through strengthened collaboration and coordination of efforts among all stakeholders, the NNS/NNP will be successfully implemented. The recurrent drought, insufficient coordination, and shortage of financial and human resource are the main challenges to the nutrition and food safety programmes.

2.6.3 Environment and Climate Changes

The reduction of the capacity of the environment to meet social and ecological needs has potential effects in increasing vulnerability, frequency and intensity of the natural hazards. Climate systems are under pressure as a result of land degradation, deforestation and excessive production of greenhouse gases. Ethiopia has experienced floods and droughts with consequences on health. As a result, drought affects more than 5 million people annually, leading to extreme food insecurity with attendant malnutrition and starvation. In 2006/2007 floods displaced approximately 200 000 people and killed 700 people. It affected more than 1 000 000 people in 8 regions in 2006 and 6 regions in 2007. In response, there is utmost need in the country to put in place strong collaboration efforts, both at central level with stakeholders and at the community levels.

2.6.4 Inequity in Health Services

The country is challenged by gross disparities in the health status of families, communities and population groups in the some of the regions of the country. Inequalities in health status reflect inequity in the health care system. There is gross inequality in terms of health service access and utilization in the emerging and pastoralist regions of the country. Health services

access, in the pastoralist communities who represent 10% of the population, deserves special attention. Mothers, children, disabled and elderly people in the emerging and pastoralist communities deserve special focus as these are the vulnerable segments. The level of malnutrition as well as morbidity and mortality due to malaria and other diseases are very high.

2.6.5 Gender Inequity

Gender which describes sociocultural characteristics of women and men is observed to result in different and sometimes inequitable pattern of exposure to health risk, and in differential access to and utilization of health information, care, and services. These differences have a clear impact on health outcomes. WHO, having long-standing concern with health equity, will, as a matter of policy and good public health practice, continue to integrate gender considerations in all facets of its work.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIP

3.1. HARMONIZATION AND ALIGNMENT

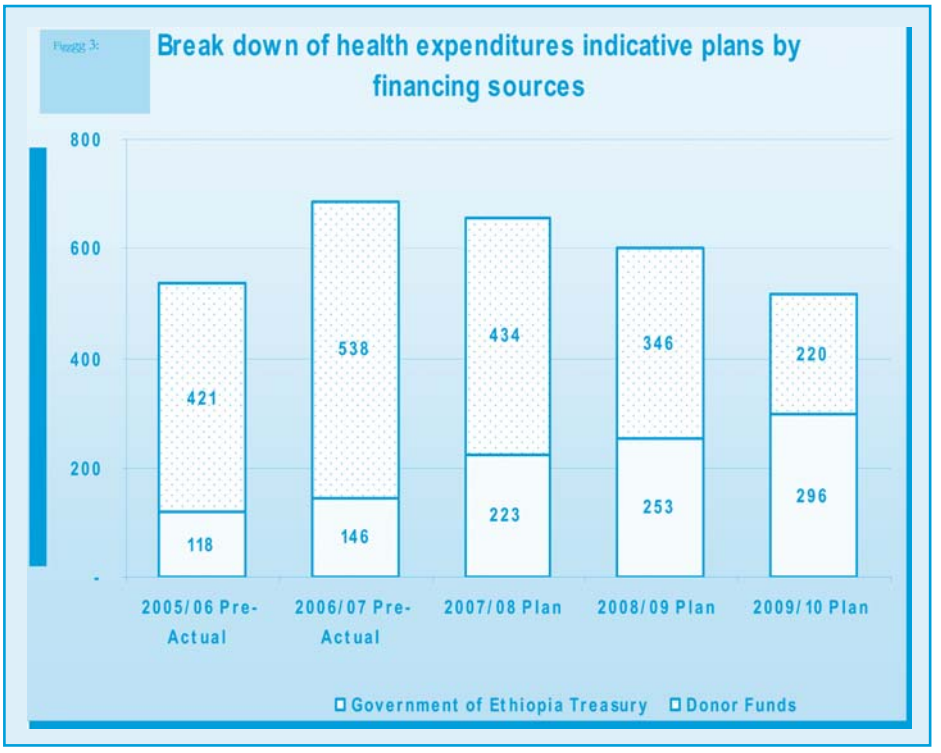
The Paris Declaration on Aid Effectiveness, adopted in March 2005, committed international development agencies to harmonize their support and align it with nationally-defined development priorities and systems so as to help countries to meet the MDGs by 2015. The World Health Organization (see Resolution WHA 58.25), the Global Alliance for Vaccines and Immunization, the World Bank, UNICEF and UNFPA and other partners have firmly committed themselves to implement the declaration.

Following the development of HSDP III as an agreed health sector strategic plan among the HPN group and the FMOH, a Code of Conduct was drawn up and many of the major development partners are expected to adhere to it in their support to its implementation. Subsequently, an operational manual entitled "HSDP Harmonization Manual" (HHM) that focuses on promoting 'one-plan, one-budget and one-report' at all levels of the health system, including development partners, has been developed and is being pursued. The MDG Performance Fund under discussion, aimed at enhancing broader harmonization and alignment in support of the health extension programme, maternal health and technical assistance, was also put in place. This has resulted in the development of a Revised Programme Implementation Manual detailing the processes and procedures for joint planning and monitoring/evaluation. A road map for harmonization and alignment has also been charted and agreed upon and shows the way forward to a progressive process towards the aim of full alignment. The current governance structures between the Government and donors are the Central Joint Steering Committee, the HPN Donors Group, the Joint Consultative Forum and the Joint Core Coordinating Committee. Furthermore, arrangements were made for Joint Review Missions, Mid-Term Reviews, Annual Review Meetings (ARM), and other monitoring and evaluation activities like joint field visits and operational research.

3.2 RESOURCES AVAILABLE FOR HEALTH SECTOR FINANCING BY MAJOR DEVELOPMENT PARTNERS AND IDENTIFIED GAP

Financial allocations from international development partners have been substantially increasing recently because of initiatives such as the Global Fund to fight AIDS, Tuberculosis and Malaria; Polio Eradication; GAVI; funds associated with poverty reduction programmes; and MDGs; and have become significant sources of health sector financing. A decreasing trend is being observed in donor contribution even though some contributions from few donors may have not been captured because of delays in official pledging of commitments. The initiative of the MDGs Performance Fund is a major progress but the level of funding remains as unpredictable as ever before. Due to lack of firm commitment beyond 2010, health sector planning faces significant uncertainty (fig 3).

Figure 3: Break down of health expenditures indicative of plans by financing sources



The financial gaps to implement HSDPIII are shown in three scenarios namely: Scenario 1 financial gap of US$ 3.3 billion while the gaps in Scenario 2 and Scenario 3 are US$ 4.1 billion and US$ 4.6 billion, respectively. The financing gap for the remaining three years is about US$ 1.561 billion while it is US$ 2.344 billion and US$ 2.840 billion for the second and third scenario. In order to realize the planned scaling up which is necessary to attain the MDGs, it would require a significant increase in the share of public spending going to the health sector. Despite the challenges faced in fund channeling mechanisms, Ethiopia has shown that it can absorb large amounts of funding by implementing better funded disease-specific programmes.

3.3 MAJOR DEVELOPMENT AGENCIES IN THE HEALTH SECTOR

Government Agencies: - They are Federal Ministry of Health, Regional Health Bureaux, Ministry of Finance and Economic Development, Ministry of Education, Ministry of Agriculture and Rural Development, Ministry of Women's Affairs and Water Development Authority.

Health, Population, and Nutrition Group (HPN): - The main bilateral partners are Ireland, Italy, Japan, The Netherlands, Sweden, USA, and Austrian Development Cooperation. UN agencies participating are UNFPA, UNICEF, WHO, UNDP and World Bank. The HPN Group in collaboration with the HSDP Secretariat is involved in the implementation of the recommendations of the joint review missions and the annual review meetings as well as the mid-term report.

Nongovernmental Organizations (NGOs) and the Private Sector: - Other key partners that participate in the health sectors are nongovernmental organizations (NGOs). Over 280 NGOs work under the coordination of Christian Relief and Development Agency (CRDA), the umbrella organization that represents all NGOs in HSDP coordination mechanisms. Sixty per cent of the CRDA members are involved in the provision of curative and preventive health services, and together with other non–CRDA associated NGOs, their input in financial terms account for 7% of the national health expenditure. The growing private health sector provides primarily clinical and diagnostic services, while training of health workers is also gaining their attention. However, their services are largely limited to the Federal and State capitals of the country. The private sector provides health care in urban centres. The main concentration of their services is in the Federal and State capitals.

Professional Associations: Health Professional Associations are more and more involved in programme implementation and provide substantial assistance for the country.

Table 1: Areas of contribution/participation by main development partners

Programme Area	Multilateral	Bilateral/ Private /NGOs
HIV/AIDS, plus malaria and TB prevention and control.	UN System/UNDAF, WB/EMSAPII, Global Fund	Italian Development Cooperation, IDC, USG, CIDA, SIDA,GTZ, Bill and Melinda Gates Foundation, USAID
Food and Nutrition, including promotion, relief, recovery and development.	WHO, WFP, FAO, UNICEF, IOM, IAEA, UNFPA, WB, AfDB, IFAD, OCHA, UNHCR, UNESCO.	USAID, SCF UK ,SCF US, ACF, World Vision, Goal, Concern ADRA, IMC, Care, Merlin
Health System strengthening, monitoring, HMIS and quality assurance.	WHO, UNICEF, UNFPA.Health Metrics Network	CDC, Tulane University Ethiopia, GAVI, GF, IDC, GFATM
Support to Maternal and Child Health Services, and health protection of women/ girls based on gender equality.	WHO, UNICEF, UNFPA.	USAID, SIDA
Support to Health Extension Programme and training of HEWs.	WHO, UNICEF, UNFPA.	USAID, DFID, GTZ
Strengthening health care referral system for serious cases of HIV/AIDS, obstetrics and malnutrition.	WHO, UNICEF, UNFPA	Clinton Foundation, USAID
Capacity building for Human Resource Development in the health sector.	WHO, UNFPA.	USAID, Tulane University, IC
Strengthening control of immunisable diseases and other major communicable diseases.	WHO, UNICEF.	EU, GAVI, JICA, CDC, Irish AID, Rotary, IFF, IM, Russian Global
Capacity development for health laboratories to improve on quality and efficiency in diagnostic services and research performance.	WHO	USAID, CDC, JICA
Support to appropriate and widely disseminated IEC/BCC programmes for health.	WHO, UNICEF, UNFPA	GFATM
Capacity building for adequate and timely availability/distribution of health commodity supplies.	WHO, UNICEF, UNFPA	Royal Netherlands Embassy, Irish AID, DFIDUSAID, PFSCMS

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS[3]

WHO has been – and is still – undergoing significant changes in the way it operates, with the ultimate aim of better supporting its Member States to address key health and development challenges, and achieve health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy.

4.1. GOAL AND MISSION

The mission of WHO remains "the attainment, by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). The Corporate Strategy and the 11th General Programme of Work 2006-2015 outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States including achieving the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage, namely:

(a) providing leadership in matters critical to health and engaging in partnership where joint action is needed;

(b) shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;

(c) setting norms and standards and promoting and monitoring their implementation;

(d) articulating ethical and evidence-based policy options;

(e) providing technical support, catalyzing change, and building sustainable institutional capacity; and

(f) monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas. These include:

[3] Based on: orporate strategy for the WHO Secretariat .11th General Programme of Work 2006-2015. A Global Health Agenda; and Strategic Orientations for WHO Action in the African Region 2005-2009.

(a) investing in health to reduce poverty;
(b) building individual and global health security;
(c) promoting universal coverage, gender equality, and health-related human right;
(d) tracking the determinants of health;
(e) strengthening health systems and equitable access;
(a) harnessing knowledge, science and technology; and
(b) strengthening governance, leadership and accountability.

Furthermore, the Director-General of WHO has proposed a six-point agenda as follows:

(a) health development;
(b) health security;
(c) health systems;
(d) evidence for strategies;
(e) partnerships; and
(f) improving the performance of WHO.

In addition, the WHO Director-General has indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The Global Priority Areas have been outlined in the 11th General Programme of Work 2006-2015:

(a) providing support to countries in moving to universal coverage with effective public health interventions;
(b) strengthening global health security;
(c) generating and sustaining action across sectors to modify the behavioral, social, economic, and environmental determinants of health;
(d) increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
(e) strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities take into account the Global documents and the resolutions of the WHO governing bodies, as well as the health Millennium Development Goals, the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the WHO strategic objectives which are outlined in the Medium Term Strategic Plan (MTSP) 2008-2013[4]. These regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009." They include prevention and control of

[4] Medium Term Strategic plan 2008-2013

communicable and non-communicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructures.

In addition to the priorities mentioned above the Region is committed to supporting countries to attain the health MDGs and assist in tackling its human resource challenge. In collaboration with other agencies, the problem of how to assist countries to source financing for achieving the goals of the countries will be addressed under the leadership of the countries. To meet these added challenges, one of the important priorities of the Region is decentralization and the installation of Intercountry Support Teams to further support countries in their own decentralization process so that communities may benefit maximally from the technical support provided to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

(a) strengthening the WHO country offices;

(b) improving and expanding partnerships for health;

(c) supporting the planning and management of district health systems;

(d) promoting the scaling up of essential health interventions relating to priority health problems; and

(e) enhancing awareness and response to key determinants of health.

4.6. MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO's cooperate strategy at country level will vary from country to country depending on the country-specific context and health challenges. Building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization as outlined in section 4.2 may be adjusted to suit each individual country's needs.

SECTION 5

CURRENT WHO COOPERATION

The first generation Country Cooperation Strategy (CCS1) for Ethiopia spans the period 2002-2005 covering two WHO biennia (2002-2003 and 2004-2005). A biennium (2006-2007) has elapsed between CCS1 and CCS2. WHO cooperation within the period 2002-2005 falls under the following Health priorities.

(a) tackling health as part of the macroeconomic and social policy environment;

(b) health sector development;

(c) reduction of poverty related diseases including Making Pregnancy Safer;

(d) integrated Management of Childhood Illness;

(e) health emergencies and vulnerability reduction.

5.1 SOCIAL POLICY AND ENVIRONMENT

The WCO supported the Government, Civil Society and donors through the development and implementation of the Sustainable Development and Poverty Reduction Programme (SDPRP), Health Sector Development Programme (HSDP), the Millennium Development Goals (MDGs) and the decentralization process within the health sector. It also supported the development and dissemination of a project on Accelerated Expansion of Primary Health Care Coverage in Ethiopia, preparation of the Essential Health Services Package, and advocacy work on the need for increased commitment of regional governments and the private sector in delivering and bringing services within the reach of the population.

Its support has been crucial to the development of the National Hygiene and Environmental Health Strategic Plan, the healthy cities initiative, environmental health and sanitation at health facilities and school sites, as well as the promotion of health care waste management. Nutrition has remained a national concern and priority. A National Strategic Plan was developed and launched with the support of WB, UNICEF and WHO.

Monitoring of water quality was done only once although it needs to be conducted on regular basis. Scaling up of the healthy cities initiatives to support the implementation of the national strategic plan for hygiene and sanitation, the implementation of the new national nutrition strategic plan and integration of nutrition into PHC service delivery has still to be achieved.

5.2 HEALTH SECTOR DEVELOPMENT

WCO has contributed to:

(a) the design, development, implementation and review of HSDP, HMIS/Monitoring and Evaluation, heath system strengthening in Woredas (district), and Woredas-based national health sector plan;

(b) the development of curriculum, training manuals, and the Training of Trainers course for Health Extension Workers as well as reactivated the training of midwives;

(c) the conduct of situation analysis on Human Resources for Health (HRH), an enabling environment for skilled birth attendance, development of a profile of health managers in the health sector and district health system;

(d) the development of policy on the private sector and the provision of technical assistance to establish the health pool fund;

(e) several assessments which also include studies on subcontracting of health services, health service delivery in the pastoralist area of Afar Region, third national health account (NHA III) survey, resource mapping, national assessment of the pharmaceutical sector, medicines financing and medicine price study;

(f) the development of the pharmaceutical sector and logistics master plans, and the establishment of Pharmaceutical Fund and Supply Agency;

(g) the health expenditure review, finalization of HRH Strategy, and health system strengthening which are some of the uncompleted activities.

5.3 REDUCTION OF POVERTY-RELATED DISEASES

Through the support of the WHO Country Office, proposals on HIV, TB and malaria for funding were developed, leading to the approval of the GFATM funding for TB, malaria and HIV/AIDS proposals. Significant funding was secured for the Vaccine-Preventable Diseases (VPD) Programme and coverages were improved. Funding was also secured for Integrated Disease Surveillance and Response (IDSR), outbreak diseases surveillance, preparedness, and response and for neglected tropical diseases.

Normative activities included support to the Ministry of Health in developing national strategic plans; policy guidelines on the rapid scale up of essential interventions for HIV/AIDS and TB; updating of policies on malaria diagnosis and treatment; vector control and epidemic prevention and control in malaria control; EQA for sputum examination HRD in TB management and care; and development of strategic plans, guidelines and training manuals on neglected communicable diseases.

WHO supported improvements of access to service provision through scaling up services for access and quality of basic and comprehensive obstetric and newborn care in the context of MPS strategic framework, ART, VCT, IMAI, DOTS; launch and scale up of TB/HIV collaborative initiative; nationwide deployment of ACT medicines; and increased coverage of LLIN, IRS.

Support was given for in-service capacity building for health professionals in the essential health sector.

Ethiopia achieved the leprosy elimination target at national level, interruption of dracunculiasis local transmission and full implementation of onchocerciasis control activity in all hyperendemic areas.

The WHO Country Office partnered with other agencies in planning and implementation of programme activities and these coordination mechanisms included the CCM for GFATM, as well as HIV, IDSR, National Onchocerciasis, National Blindness and NCD task forces, TB/HIV advisory committees, and malaria control support team. The unfinished agenda include strengthening monitoring and evaluation particularly for TB and other diseases, improving case detection in TB, scaling up IDSR implementation to the Health Post/Community level, assessing the magnitude and distribution of neglected diseases and developing control strategies and programmes.

5.4 MATERNAL AND CHILD HEALTH

Maternal Death Audit was institutionalized, clinical guidelines, training manuals, guidelines and tools for MPS were adapted, and new national integrated maternal-neonatal client cards were introduced. Focused antenatal care review of Making Pregnancy Safer (MPS) programme implementation at different levels was carried out.

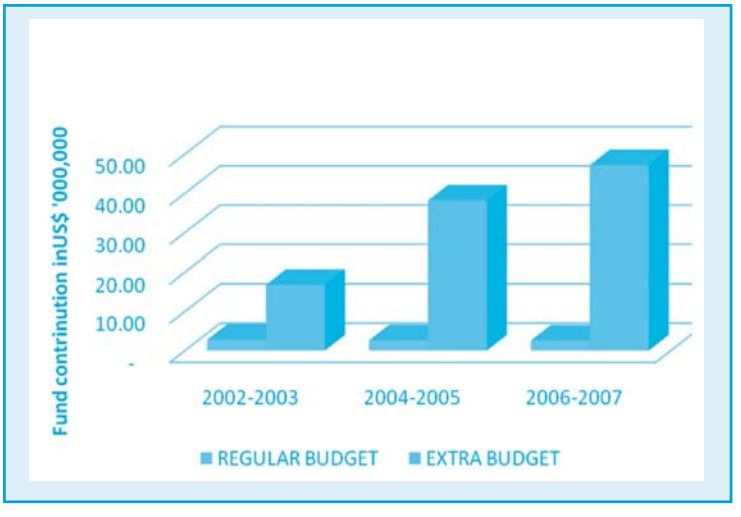
Ethiopia is in the expansion phase with all regions implementing IMNCI and there has been progress in all the three components of IMNCI. Forty-five per cent (45%) of public hospitals and health centres have IMNCI-trained health workers providing care for managing under-five children. Seventy per cent (23/31) of Government health professional training institutions are conducting pre-service IMNCI training for nursing, health officers and, recently, medical students. Community IMNCI (C-IMNCI) interventions are well underway in sixty-two (62) districts in ten (10) regional states with the exception of Somali region. A 6-day IMNCI Case Management skills training course material incorporating care and management of newborns below the age of 7 days, childhood HIV/AIDS, and the new WHO technical updates was developed and has replaced the previous 11- day course as of mid 2006. A similar but simplified IMNCI training material was also developed for the training of Health Extension Workers and has been translated into Amharic.

5.5 HEALTH EMERGENCIES AND VULNERABILITY REDUCTIONS

The Country Office supported the development of guidelines, training of surveillance focal persons, mobilization of resources, deployment of consultants, and supplies of emergency health kits and medicines as a response to the outbreaks in the affected areas. As the secretariat for inter-agency coordination, it provided technical support for preparation of the emergency project appeals and organizes regular monthly forums with other health partners on health emergency and epidemic matters, emergency project appeals as well as discussion on cross-border activities.

It is now critical to strengthen the early warning system for health emergency, sustain increased funding for emergency preparedness and response, strengthen cross-border collaboration, and support the establishment of the emergency unit in FMOH.

Fig 5: Resources mobilized for the implementation of the CCS (in Million US Dollars)



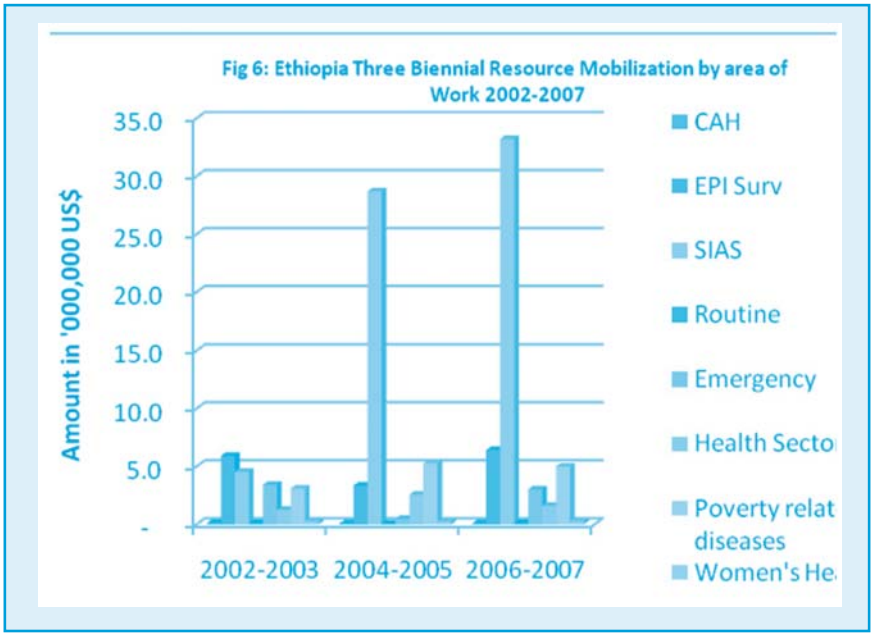
5.6 RESOURCES MOBILIZED

Analysis of the three biennia covering 2002-2007 showed that the highest contribution to the WCO budget came from supplemental immunization campaign activities for polio eradication and measles control (60%). This is followed by EPI surveillance (14.4%), poverty related diseases (12%), emergencies (4%), health sector development (5%), women's health, routine immunization, child and adolescent health, each contributing less than 1% to the budget (Fig 6).

5.7 SUPPORT FOR THE COUNTRY OFFICE

The WHO Country Office benefits from direct support from the Regional Office in line

Fig 6: Ethiopia Three Biennial Resource Mobilization by area of Work 2002-2007



with its mandate and with the objective of strengthening its interactions with the Member States as well as through the decentralized system of intercountry support (IST). These supports are provided on request to the regional and intercountry teams. In addition, Ethiopia has assisted in hosting some meetings organized by the WHO Regional Office and headquarters.

SECTION 6

STRATEGIC AGENDA OF THE COUNTRY COOPERATION: 2008 - 2011

6.1 MISSION STATEMENT

The Mission of WCO is to assist Ethiopia in reducing morbidity, disability, mortality, and in improving the health status of the people through supporting and advocating for the provision of comprehensive essential health packages of preventive, promotive, curative and rehabilitative health services as well as supporting the achievement of the health-related Millennium Development Goals for sustainable national development. WHO will accomplish this mission through strengthened technical and managerial support, coordination and leadership in health matters, and in forging partnership with a wide range of local, regional and international collaborators. The Country Cooperative Strategy 2008-2011 (CCS2) is aligned with the WHO Medium-Term Strategic Plan (MTSP) 2008-2013 encompassing two biennial Plans of Action (PoA).

6.2 STRATEGIC PRIORITIES

Based on analysis of health and development challenges of the country, existing WHO collaborative work, assessment of the country health policy, health development strategic plan and analysis of the work of development partners, four strategic priorities (Table II) have been identified. The Strategic priorities fall within three WHO organization-wide Strategic Domains

Table 2: WHO Strategic Priorities

WHO Strategic priorities 2008 - 2011

Strategic Domain	Strategic Priorities
A: Health Security	1: Reduce the health, social and economic burden of communicable and noncommunicable diseases.
B: Health System Capacities and governance	2: Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behavior.
C: Partnership, coordination and resource mobilization	3: Strengthen policies and systems to improve the accessibility and quality of services. 4: Foster partnerships and coordination for national health development.

The domains as well as the strategic priorities and focus areas contribute to the HSDP III components as presented in Table 3.

Table 3: CCSII Contribution to HSDPIII Priorities

No.	HSDP Components	Focus Areas	CCS
1	Health Service Delivery and Quality of Care	Health Service Extension Programme (HSEP) Family Health Service Prevention and Control of Diseases HIV/AIDS Malaria and Other Vector-Borne Diseases TB and Leprosy Blindness Integrated Disease Surveillance Medical Services Hygiene and Environmental Health	Health Security
2	Access to Service: Health Facility Construction, Expansion and Transport	- PHC Service - Capacitate District Health Offices - Resource Mobilization-Medical Supplies	Health System Capacities and Performance
3	Human Resource Development	- Training Institutions - HR Development plan - Gender equality on HR Development	Health System Capacities and Performance
4	Pharmaceutical Service	- PASS, DACA capacity building - Information on Medicines Traditional Medicine	Health System Capacities and Performance
5	Health Management, Management Information Systems and Monitoring and Evaluation	- Health Management Health Management Information System (HMIS	Health System Capacities and Performance
6	Health Care Financing	- Health Care Financing - Public/Private Partnership	Health System Capacities and Performance
7	Cross-cutting Issues	- Gender - Pastoralist Health Service - Nutrition	Health Security MCAH

Domain 1: Health Security

STRATEGIC PRIORITY 1: Reduce the health, social and economic burden of communicable and noncommunicable diseases

Main focus

Strategic priority 1.1: Scale up HIV/AIDS and TB intervention

(a) Provide technical assistance and support in scaling up comprehensive, health sector-focused HIV prevention, treatment, care and support services towards the goal of universal access by 2010. This will take place within the Joint UN Team on HIV/AIDS in Ethiopia, guided by the UN Division of Labor in HIV/AIDS and will focus mainly on expanding access to HIV testing and counseling, scaling up ART, care and support, maximizing HIV prevention in the health sector, generating and using strategic information as well as strengthening and expanding health systems.

(b) Continue to provide technical support and guidance in alignment with the FMOH strategic plan developed for the prevention and control of TB and TB/HIV 2007/8 – 2009/10. This will focus on:

(i) Strengthening the capacity of managerial and service-delivery level human resources, strategies, guidelines and other managerial tools to increase DOTS coverage, case detection rate and treatment success rate;

(ii) Strengthening the integration and expansion of TB/HIV service delivery, addressing appropriately the MDR/TB threat and controlling TB transmission at health facilities and congregate settings, strengthening community empowerment and promotion of Stop TB Partnership.

(c) Provide technical support to improve the national and regional data management, monitoring and evaluation system.

Strategic priority 1.2: Strengthen malaria prevention and control

(a) Provide technical and financial support for the implementation of the country plans to scale up malaria prevention and control activities. These include ensuring access to prompt diagnosis and effective treatment using RDTs and ACTs, increasing access to multiple prevention and control measures such as scaling up the coverage and utilization of Long Lasting Insecticide-Treated Nets (LLINs), Indoor Residual Spraying with Insecticides (IRS) and other control measures, and strengthening malaria epidemics monitoring and response.

(b) Strengthen the scaling up of coverage with LLIN by integrating LLIN distribution with health campaigns.

(c) Among other supportive strategies, strengthen RBM partnership at all levels, strengthen health systems and human resource capacity with special focus on Health Service Extension Programme (HSEP) and Health Extension Workers (HEWs), build community capacity to fight malaria through improving access to IEC/BCC activities, strengthen supportive supervision, strengthen monitoring and evaluation including operational research activities to guide decisions and provide support to enhance the capacity of surveillance system for forecasting, early detection and containment of epidemics.

Strategic priority 1.3: Improve the capacity of the national immunization programme

(a) Build the capacity of the public health system to provide immunization services by facilitating training in programme management, cold chain and vaccine management, immunization safety, and monitoring and evaluation of the programme at all levels.

(b) Continue its support in building the capacity of health workers to improve data quality and conduct EPI coverage surveys, data quality assessments and other internationally-accepted data quality measures.

(c) Maintain the certification standard AFP surveillance at national level and in all regions by providing support to national and subnational levels of the public health system. WHO provides trainings to the focal persons at all levels, supports the polio and measles laboratory technically, financially and materially in order to maintain its accreditation level.

(d) Support the nation in improving the immunity level of the children by conducting supplemental immunization activities when the need arises. Such activities are also synchronized with neighboring countries.

(e) Support the accelerated measles control activities by strengthening case-based measles surveillance, facilitating supplemental immunization activities and improving routine immunization coverage.

(f) Continue supporting the Government in building capacity in case-based MNT surveillance and strengthen WHO's support to surveillance of other vaccine-preventable diseases like rotavirus, pneumococcal and other vaccine-preventable diseases.

(g) Support the introduction of priority new vaccines like pneumococcal vaccine in the coming three years by facilitating consultative meetings, supporting the Government in the preparation of the proposal, building the capacity of health workers in introduction of the new vaccine and supporting the surveillance of pneumococcal diseases.

Strategic priority 1.4: Enhance effective integrated disease surveillance, early warning and response capacity including the implementation of the IHR.

(a) Provide technical assistance and support to strengthen the national capacity to conduct effective surveillance and response activities, strengthen laboratory capacity and involvement in confirmation of pathogens, monitor drug sensitivity and scale up community surveillance.

(b) Provide support for the implementation of the International Health Regulations (IHRs).

Strategic priority 1.5: Mitigate the health consequences and socioeconomic impact of emergencies, disasters, crises, and conflicts

(a) Support health assessments, surveillance and monitoring activities to measure ill-health and identify health needs of populations affected by crisis, identify priority causes of ill-health and death. In this regard, health partners will be provided with advice, tools and guidelines including international best practices adopted to update national guidelines within the national context to make sure that epidemiological quality control is ensured.

(b) Provide assistance to ensure that critical gaps in response to ill-health and life-threatening conditions are promptly identified and filled with CFR maintained within international norms.

(c) Support the coordination of emergency health response among health partners to ensure the survival, and healthy and sustainable livelihood of the population. WHO will work with the FMOH and partners to support revitalization and capacity building of the local health systems for preparedness and response with national partners fully integrated in relief.

Strategic priority 1.6: Improve the integration and development of strategies and implementation of appropriate interventions to combat neglected tropical diseases (NTDs)

(a) Provide support to the country to increase access by populations at risk to interventions for the prevention, control, elimination and eradication of neglected tropical diseases (NTDs), including leprosy, leishmaniasis, trachoma, schistosomiasis, soil-transmitted helminthiasis, lymphatic filariasis and other tropical diseases.

Dracunculiasis eradication interventions will be intensified with particular focus on strengthening surveillance in endemic, formerly endemic and at risk areas.

(b) Provide assistance for the development of guidelines, strategic plan documents, manuals, and for the establishment of databases and studies to determine the magnitude and distribution of the neglected tropical diseases in addition to helping to strengthen health-systems-related capacities.

Strategic priority 1.7: Prevent and reduce disease, disability, and premature deaths from noncommunicable conditions, mental health and injuries

(a) Support the development of strategies and guidelines to promote mental health services and prevention and control of chronic noncommunicable diseases (NCDs), injury, disability and violence.

(b) Support evidence-based approach through the development of a sustainable institutional system for effective data management and research on chronic NCDs, mental health, injury, disability and violence.

(c) Provide support for capacity building to strengthen the health system to provide adequate care for chronic noncommunicable diseases, including mental disorders, and strengthen emergency and trauma care for victims of injury and integration of rehabilitation services into primary health care.

Strategic priority 1.8: Promote healthy environment, food safety and nutrition, and prevent other risk factors

(a) Support the Ministry of Health to promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to public health.

(b) Support the healthy cities initiatives, school health and sanitation, environmental health activities in health facilities including health care waste management, occupational health and safety and health and climate initiatives.

(c) Provide technical assistance and support to improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.

This will involve four main tasks, namely:

(i) improve coordination, partnership, leadership and networking with all stakeholders at Federal and Regional levels to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food safety and food security interventions, and develop and support a research agenda;

(ii) produce, revise and disseminate guidelines, training materials, standards and field manuals on key nutrition actions of importance in the country;

(iii) support national nutrition unit of FMOH to put in place a systematic monitoring and nutrition surveillance system including early warning system under humanitarian crisis situation; and

(iv) strengthen food safety inspection system in the country and food safety laboratory at the Ethiopian Health and Nutrition Research Laboratory.

Strategic priority 1.9: Promote health, prevent and reduce risk factors for health condition

(a) Provide support in the form of training, provision of guidelines and equipment to the Federal Ministry of Health to strengthen its capacity to plan, implement and coordinate evidence-based health promotion interventions nationally and across all relevant programmes in the country with a view to preventing communicable and noncommunicable diseases and reducing the occurrence of major risk factors associated with lifestyles and behaviours.

(b) Support strengthening of the capacity of HEWs to undertake effective advocacy and health promotion activities through the provision of training and educational support material/equipments.

Strategic priority 2: Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behavior

WHO's strategic objective aims to reduce morbidity and mortality and improve health during key stages of life including pregnancy, childbirth, the neonatal period, childhood and adolescence, while also improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps. Based on current challenges remaining from the first CCS as outlined above and WHO's comparative advantages, the WCO's strategic agenda for the four years of this CCS (2008-2011) will be as follows:

Main focus

Strategic priority 2.1: Reduce neonatal, infant and child morbidity and mortality

Support the scaling up of high-impact Newborn and Child Survival interventions in order to achieve MDG-4 through advocacy for more resources; the promotion of evidence-based policies, guidelines and interventions; capacity building of providers, tutors and programme managers through both in-service and pre-service training; promotion of key household/family practices using the HEP approach and health system support especially for improving integrated supportive supervision, availability of essential supplies and referral system. Particular focus will be on the expansion of IMNCI both at the community and health centre levels, institutionalization of pre-service training and improvement of the quality of referral care for children in hospitals.

Strategic priority 2.2: Promote maternal health and improve access to quality adolescent, sexual and reproductive health services

(a) Strengthen national capacity for the provision of essential and emergency maternal and neonatal care for the reduction of maternal mortality (MDG5) through interventions that reach across the household/community up to the highest level of the health system, i.e. the continuum of care for mothers and newborns.

(b) Continue to lead the work with partners on advocacy through evidence-based findings that indicate the availability and distribution of essential and emergency obstetrics care in the country.

(c) Improve MPS component: training of human resources, providing them with skills for the provision of basic and comprehensive Emergency Obstetric Care, strengthening the health facilities with equipment and supplies, and ensuring that the referral linkages are functional.

(d) Family Planning will be repositioned through the development of tools and guidelines because the prevention of unwanted pregnancies through acceptable modes of Family Planning methods is one important intervention for the reduction of maternal mortality.

(e) Support national capacity building efforts with focus on availability of skilled attendance at birth through measures that could increase the midwifery skills of all health providers to address the lack of midwives. This includes provision of technical assistance for the development of standardized tools and guidelines.

(f) Address the limited access and utilization of maternal services by women which can be improved through the work of health extension workers; these are very well placed to teach women on danger signs, provide clean and safe delivery where there are no facilities, and promote the establishment of community mechanisms that could assist women with complications to reach facilities.

Domain 2: Health System Capacities and Governance

Strategic Priority 3: Strengthen policies and systems to improve the accessibility and quality of services

The Country Office will support the Ministry of Health to improve health services through better governance, financing, staffing and management based on reliable and accessible evidence and research as well as ensuring improved access, quality and use of medical products and technologies. Since this is a cross-cutting issue under this strategic priority, WHO will support the MoH in the implementation of the redesigned core processes of the BPR mainly through provision of technical support for the development of required materials, conduct of ToT at national level, training of staff at lower levels through officers based at Regional level, and monitoring and evaluation of the piloting/implementation status.

Main Focus

Strategic priority 3.1: Strengthen the organizational, human resource and managerial capacity of the national and district health systems for delivering high quality and safe care, with special focus on vulnerable groups

(a) Provide support to strengthen the organizational and managerial capacity of the national and local health systems for delivering accessible, quality and safe care with focus on vulnerable groups. WHO will provide support to enhance the service mix, service quality and service responsiveness of health service delivery institutions, particularly at the district level. Special attention will be given to interventions that focus on eliminating demand-side barriers.

(b) Provide support to address risks associated with health care through patient safety measures such as blood safety, hand hygiene, safe injection practices, and hospital waste management.

(c) Support the development of standards and guides on the development of appropriate diagnostic facilities to improve the facility-based quality of services.

(d) In line with findings of recent assessment and the ongoing design of the Human Resources for Health and Health Information System, give technical and material support in setting norms, guidelines and standards for capacity building of staff. In the same direction, support and guidance will be given to build the capacity of the health sector in production and use of evidence for decision making.

Strategic priority 3.2: Enhance national capacity to ensure access to quality essential medicines, vaccines and medical technologies, including safe blood transfusion, medicines and medical supplies, and laboratory services

(a) Support the Government's effort in strengthening the procurement and distribution system through training, development of rational use of drugs, tools such as essential drug list, manuals as well as the establishment of medicines and therapeutic committees.

(b) Provide support for strengthening the national drug information centre, building the national drug regulation and quality assurance capacities, facilitating the monitoring of the quality of medicines in the market through post-marketing surveillance.

(c) Provide technical assistance and support to expand and consolidate the blood safety programme so as to establish efficient and sustainable national blood transfusion services that can assure the quality, safety and adequacy of blood and blood products to meet the needs of all patients requiring transfusion in Ethiopia. This will be achieved through an expanded and stable base of regular voluntary non-remunerated blood donors through improved mobilization of the community as well as improved mechanisms of communication at the societal interface, cost-effective quality testing and processing of blood products as well as reduction in unnecessary transfusion through promotion of appropriate and judicious use of blood and blood products at the clinical interface. Quality management as well as systems for regular monitoring, evaluation, review and re-planning will be strengthened.

Strategic priority 3.3: Promote evidence-based decision making by improving health information including operations research and address social determinants of health.

(a) Support the design and implementation of stronger and integrated health information systems (HIS) to meet the specific needs of the country. This aims to increase the availability and use of health information that helps to monitor the performance of health services that are equitable and that enables countries to measure health determinants, health systems performance, health status and inequities in access to health care.

(b) Work on increasing research and partnership with training and research institutions. WCO will advocate and support the generation of evidence for informed decision-making on uptake of new vaccines and other innovative technologies.

(c) Work on addressing the social determinants of health through different mechanisms including the generation of relevant information on the social and economic determinants. WHO will also work on enhancing leadership in intersectoral action on the broad social and economic determinants of health.

Domain 3: Partnership, Coordination and Resource Mobilization

Strategic priority 4: Foster partnerships and coordination for national health development

Main focus

Strategic priority 4.1: Promote partnership harmonization and alignment to accelerate the attainment of the MDGs

(a) Continue coordination and leadership responsibility in health development, foster collaboration with other UN agencies through the implementation of UNDAF, IHP/HHA, with multilateral, bilateral, and Civil Society Organizations and with other sectors.

(b) Harness the WHO staff strength using team building techniques and streamlining WHO procedures. As a signatory to the IHP+ compact and the secretariat for the IHP, WCO will assure alignment in its planning, implementation, monitoring and evaluation (Annex 2). The Country Office will reposition itself according to the changing environment to enable it to tackle internal as well as global challenges.

Strategic priority 4.2: Strengthen WHO country presence and resource mobilization efforts

(a) WHO will broaden its collaborative experiences with partners, professional associations and NGOs to address priority issues in a strategic manner.

(b) Provide technical support for the development of proposals for global partnership funding such as the GFATM, GAVI Fund and mobilize resources locally.

(c) Continue building the capacity of the Country Office staff as well as MOH in mobilization and effective use of resources.

(d) Support the design, implementation and monitoring of schemes which target increased flow of resources to the health sector, the main one of which is the ongoing work to implement social and community health insurance. In this regard, WHO support will mainly be in making available technical assistance for the design, implementation and monitoring of health care financing schemes and for the production and dissemination of evidence on health care financing.

(e) WCO will participate in the Government-led joint planning and budgeting processes and synchronize its budgeting processes with the Government budget cycles. To facilitate the alignment processes, the biennium plans will be grouped into the six-monthly planning cycles (Annex 2). The WHO Regional Office and headquarters consultation on new funding channels in Ethiopia will help determine the appropriate channelling of funding to Government in the long term. In the short term, some of the regular budget funds will be disbursed based on WHO rules and regulations to support the MDG fund.

In order to implement the identified strategic agenda, additional resources of US$ 141 495 900.00 will be needed (Annex 4).

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

7.1 COUNTRY OFFICE

The CCS will serve as the basis for the formulation of two WHO biennial plans within the period 2008-2011 and the framework for feeding into the health component of the UNDAF and for supporting country health development priorities.

The number and quality of WCO staff has significantly improved since 2002. Currently, WCO has a workforce of more than 160 employees in different thematic areas of work distributed in different parts of the country. Two-thirds of the staff were recruited for polio eradication which implies that there will be a considerable reduction in the workforce once polio eradication goals are achieved. The Office will streamline staff deployment and reform staff structure, thereby ensuring that country core capacities for mobilizing resources and implementing the CCS are available.

Given the importance and current emphasis on partnerships, harmonization and alignment, and the attendant increasing demand on staff time, WCO will strengthen its overall policy, planning and coordination capacity by recruiting additional qualified staff for health systems strengthening including health care financing. Recruitment of national consultants to boost local capacities and relieve project officers of time-consuming tasks will be encouraged. This will require resources for developing or recruiting staff in identified gaps in core competencies that need to be filled for effective implementation of the CCS.

7.2 REGIONAL OFFICE (AFRO) AND INTERCOUNTRY SUPPORT TEAM (IST)

Given the unique profile of WCO Ethiopia, managing a budget of over US$ 65 million per biennium, the high disease burden, and the huge population, the Regional Office needs to consider expediting decision-making by designating a specific desk officer at the WHO Regional Office or by delegating considerably more administrative, managerial and financial authority to the Country Office. Greater support for rapid response to emergencies and health crises, health systems strengthening and health care financing will be needed to respond much more rapidly and effectively to the country requests. WCO will require the intercountry team to share its expertise through well-planned supportive visits to the country to support programmes.

7.3 WHO HEADQUARTERS

The Country Office will use the CCS to engage the Regional Office and headquarters in dialogue in order to mobilize resources as well as managerial and technical support.

Guidance and directives will be expected from WHO headquarters on IHP+ funding mechanism and financial disbursements by WCO within the country in line with the alignment and harmonization principles. WCO will also expect the WHO headquarters to mobilize international expertise to assist the WCO in fulfilling its IHP+ obligations.

SECTION 8

MONITORING AND EVALUATION

8.1 MONITORING AND EVALUATING THE COUNTRY COOPERATION STRATEGY

The Road Map for Harmonization and Alignment outlines a common monitoring and evaluation mechanism for the Government and partners which will be the basis for monitoring and evaluating the CCS. The new HMIS which is the national officially-recognized data-generating source used for monitoring progress in the implementation of the health sector development programme will be used to monitor the CCS. To address any possible limitation in this HMIS, WCO will work closely with FMOH and other partners to support the implementation of studies/efforts that yield the desired information for use by decision-makers at all levels (facility, Woredas, zone, region, national and international).

WHO will actively and regularly participate in the joint review mechanisms in place (Annual Review Meetings (ARM) and joint annual review mission (JRM)). In addition, it will participate in joint field visits, support mid-term and end-of-plan period assessments/ evaluations and encourage periodic population-based research and surveys/surveillances to make evidence-based conclusions on health status and health care in the country at any a given time. The ARM provide a forum for dialogue on country plans and annual budget in addition to providing a platform for FMOH and partners for reviewing policy, strategy, performance and capacity of the previous year and the first half of the year under review.

Access to Government information management systems and surveys such as household income expenditure and consumption surveys, Demographic and Health Surveys, Participatory Poverty Assessments and EthioInfo software will also provide basic socioeconomic data for monitoring.

In addition to the common country review processes, reviews of the implementation of the biennial Plan of Action (semi-annual, annual and mid-term reviews) using the WHO results-based matrix, will provide the basis for performance monitoring and assessment of the CCS. Joint UNDAF monitoring framework will also provide some indicators for monitoring progress.

8.2 EVALUATING WHO COUNTRY OFFICE STRATEGY

In order to evaluate progress towards achieving the objectives of the strategic plan, mid-term and final evaluation will be conducted using the indicators set for the strategic objectives and OSERs for each biennium..

The HSDPIII and UNDAF will end in 2010 and 2011 respectively while the CCS ends in 2011. The review and development of a new health sector plan will provide good opportunities for joint reviews of the implementation of the CCS, UNDAF and HSDP. The CCS may also be reviewed and updated in case of major policy shifts in Global, WHO or Health Sector policy before the end of the CCS period.

ANNEXES

ANNEX 1: HEALTH STATUS INDICATORS

Indicators	Status
Total Population	77 127 000
Average Annual Growth Rate	2.7%
Population Distribution percentage (Rural)	85%
Infant Mortality rate	96.8/1000 live births
Under 5 mortality rate (DHS 2005)	123/1 000 live births
Maternal mortality rate (DHS2005)	673/100 000 live births
Skilled attendance at birth	12%
Immunization coverage by DPT3 (2007)	73%
Malaria at-risk population	68% of total population
Annual reported malaria cases	3 149 741
Indoor residual insecticides praying (IRS) coverage	25% of epidemic prone districts
Population protected by IRS	8 million inhabitants
Estimated adult HIV prevalence	2.1%
Estimated HIV incidence	0.28%
Number of patients ever started on ART (December 2007)	122 243
Number of patients currently on ART (December 2007)	90 212
TB incidence for all forms (WHO report 2006)	353/100 000
TB incidence for smear positive TB (WHO report 2006)	154/100 000
Prevalence of all forms of TB (WHO report 2006)	533/100 000
TB case notification rate (FMOH 2004 cohort report)	47%
TB case detection rate (FMOH 2004 cohort report)	36%
% Government Expenditure on Health	31
Annual Per Capita Expenditure on Health	US$ 7.14

ANNEX 2

Harmonization with the HSDP in the planning process

Specific items in the planning		Description of item	Alignment with national plan (efforts from the WHO)
Strategic planning		• WHO Country Office develops a Country Cooperation Strategy (CCS) which is a multi-year strategic plan from which stem the biennial plans; • The FMOH has the HSDP which is a five-year strategic document.	The time frame of the CCS is modified to fit with the HSDP i.e. as HSDP III ends at 2010 the CCS2 of the WHO will be from 2008-2011 and CCS III will be from 2012-15 (similar to HSDP IV which will cover 2011-15).
Operational plan		• The FMOH uses annual plan which is developed using the bottom-up/top-down approach. • The WCO develops a biennial plan.	The Mid-Term Review of the Biennial Plan will take into account the recommendations of the Annual Review Meeting (ARM) of the HSDP.
Operational plan development process			Apart from using relevant documents, each programme in WCO consults its counterpart at MOH in a continuous manner throughout the planning process. The biennial plan as well needs endorsement and signing of the ministry for implementation.
Planning calendar		• The FMOH uses the Ethiopian calendar and WHO, the Gregorian one.	The planned items will be divided into four quarters so that WHO will be able to comply with both MOH and WHO internal requirements.
Specific calendar events	Budget commitment	• In February each year, the MOH expects partners to express their budget commitment.	The WCO provides its budget commitment for the year at the mentioned time.
	Woreda-based national plan	• Each year, between January and April, Woreda-based national plan is prepared by the Ministry	WHO actively participates by assigning staff for the planning process and uses the wealth of information for the planning process

ANNEX 3

Key events in the annual cycle of planning, monitoring and evaluation in the Ethiopian Health Sector.

A. The yearly plan and budget preparation exercises represent a major activity at the Federal level:

- Resource identification: by Feburary 10
- Developing the core plan: 28 Feburary - 9 March.
- Preparing and submitting capital and rec.
  plan/budget to MOFED: 10-23 March.
- Preparing and submitting National Annual Health Plan: 20 April - 31 June.

B. Associated with plan implementation and budget execution:

Quarterly and annual reports are submitted from PHCUs to Woreda head office by Sept. 8;

From Woreda head office to Zonal/Regional HDs by Sept. 15; From Zonal HDs to RHDs

by Sept. 21; and from RHDs to FMOH by September 28.

This pattern is repeated in December, March and June.

C. Monitoring/Review activities at Federal level:

(i) Joint Review/evaluation mechanism – July

(ii) National HSDP Annual review Meeting - October (1st week)

(iii) HSDP III Mid-term Review- April 2008

(iv) CJSC quarterly meetings in July, October, and January. CJSC and RJSCs also meet twice a year in October and April.

(v) FMOH and RHDs hold joint meetings every other month in July, September, November, January, March, and May.

(vi) FMOH and HPN consultative meetings take place every other month in August, October, December, February, April and June. The JCCC meets on 1 weekly basis.

ANNEX 4

WHO Projected Budget for two Bienniums 2008-2011

No.	WHO Strategic Priorities	BUDGET IN US$
1	Reduce the health, social and economic burden of communicable and noncommunicable diseases (HIV/AIDS, MAL, TUB, IVD, CPC, EHA, NCD/INJ, MNH, IDSR, NUT, PHE, HPR…).	99 409800.00
2	Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behavior (FHP/RH, CAH, MPS, HSP, IRS).	11 589 900.00
3	Strengthen policies and systems to improve access and quality of services (BLS, EDM, HFS, HSS, HSD, HRH, HSP).	22 314 600.00
4	Foster partnerships and coordination for national health developments (ADM).	8 181 600.00