WHO COUNTRY COOPERATION STRATEGY

FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

2002-2005

CONTENTS

ACKNOWLEDGEMENT

We enjoyed working on this paper which is our WHO Ethiopia-specific identity card and our road map. It gives us clear policy directions and indications of ways and means of fulfilling our intended goals.

When we say "our", We refer to the team of people who reached a consensus and made a commitment for effective implementation of the policy. We know well the human faces who wrote its various sections and we have endorsed what they have stated. Even though WHO Ethiopia staff have mainly fuelled the engine of this endeavour, our Regional Office for Africa and headquarters have also given us important support. That's how it is a "One WHO" endeavour.

We strongly believe that the credibility of this stated commitment is rooted on the one hand in the relevance of its vision (what to do now for ensuring better health for the next generation of 100 million Ethiopian people) and on the identified organizational shift to translate this vision into reality on the other.

We have high hopes and ambitions, especially when we focus on the health of the people with the lowest capacity. But we are confident that we will realize our ambitions because, first of all, Ethiopia possesses tremendous natural and human resources, and, secondly, because our modest catalytic contribution can go a long way in supporting the efforts of civil society organizations, governmental institutions and the international community.

Together we will succeed.

WHO, Ethiopia

ABBREVIATIONS

ADLI	Agricultural Development-Led Industrialization
AFRO	(WHO) Regional Office for Africa
AIDS	Acquired immunodeficiency syndrome
CCS	Country Cooperation Strategy
CJSC	Central Joint Steering Committee
COO	WHO country office budget
CRDA	Christian Relief and Development Association
CSA	Central Statistical Authority
DAG	Development Assistance Group
DHS	Demographic and Health Survey
DOTS	Directly-observed treatment short-course (for TB)
EC	Ethiopian calendar
EFY	Ethiopian fiscal year
EPI	Expanded Programme on Immunization
ESRDF	Ethiopian Social Rehabilitation and Development Fund
MOH	Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross domestic product
GNP	Gross national product
HC	Health centre
HIV	Human immunodeficiency virus
HOAI	Horn of Africa Initiative
HP	Health post
HPN	Health, Population and Nutrition Donor Group
HS	Health station
HSDP	Health Sector Development Programme
HTP	Harmful traditional practice
IMCI	Integrated Management of Childhood Illness

MTR	Mid-Term Review
NGO	Nongovernmental organization
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission (of HIV)
PRSP	Poverty Reduction Strategy Paper
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
SNNPR	Southern Nations, Nationalities and Peoples Region
STI	Sexually transmitted infection
TB	Tuberculosis
UNDAF	UN Development Assistance Framework
VCT	Voluntary counselling and testing
WR	WHO Representative
WHO/HQ	WHO headquarters

FOREWORD

In the year 2000, the Executive Board of the World Health Organization (WHO) approved a Corporate Strategy to guide the work of the WHO Secretariat. This Corporate Strategy emphasized the central role of countries in the work of WHO; hence, the global strategy was revised and adapted to the needs of each country. These measures constitute the basis for the WHO Country Cooperation Strategy (CCS).

The Country Cooperation Strategy describes WHO strategic priorities for each country in order to obtain an integrated response from the three levels: country office, regional office and headquarters. The CCS is a clear expression of the WHO country focus: the strategic agenda will guide cooperation between WHO and Member States for the medium term. The CCS will serve as a reference for WHO workplans and resource allocations, whether those resources are from countries, region, HQ or other sources such as collaborating centres.

The WHO Cooperation Strategy was developed through an extensive consultative process involving the Organization at all levels, the Ministry of Health, other government agencies, private sector and civil society organizations, training and research institutions, development partners and other key stakeholders in health. The process involved questioning, in-depth analysis of key health and development challenges of each country and consideration of the WHO comparative advantage.

I acknowledge the exhaustive process that has led to the formulation of this document, and I would like to thank the government and all stakeholders in health for their efforts and active participation. I have no doubt that the CCS process will help countries in their efforts to focus on priority health issues and coordinate the actions of different partners and stakeholders.

Our challenge now is to transform these strategies into concrete actions, with a view to improving WHO performance at country level as well as the health outcomes for populations in greatest need.

Dr Ebrahim Malick Samba
Regional Director
World Health Organization
Regional Office for Africa

1 INTRODUCTION

The aim of the Country Cooperation Strategy (CCS) in Ethiopia is to reflect on WHO's values, principles and the global and regional directions, including the Millennium Development Goals (MDGs). It defines the broad framework of collaboration between WHO and the Federal Democratic Republic of Ethiopia for the period 2002-2005 in view of its long-term plan (i.e. up to 2020).

The future strategic agenda fulfils the following criteria:

(a) relevance in addressing future health development issues;

(b) cohesiveness of all components to make the greatest impact;

(c) responsiveness and feasibility, especially in terms of resource requirement and implementation capacity;

(d) building effective relationships with partners;

(e) multiplying the effects of selected entry points, especially those related to capacity-building and partnership mobilization.

The strategic thinking is using a selective and focused approach in a range of activities and putting emphasis on WHO's role as a policy adviser and honest broker. It also encourages the Organization to consider broadening its partnerships at the country level.

Ethiopia has an articulate health development programme which uses a sector-wide approach. Most of the relevant partners had participated in programme formulation and had been involved in the monitoring and evaluation of the first five-year Health Sector Development Programme (HSDP I). The lessons learnt from the sector review, the country's policies and development strategies and the activities of other development partners served as a basis for the formulation of the CCS. In addition, the discussions held by the Health, Population and Nutrition Donors Group (HPN) and several NGOs helped to identify issues raised most frequently by partners to determine what the role of WHO should be in the coming years. The privileged position that WHO enjoys with the government, particularly with the Ministry of Health (MOH), was an added advantage during the formulation of the CCS.

The CCS document was produced as a result of extensive interactions between WHO, the government, particularly the Ministry of Health, other UN agencies, NGOs, and civil societies. At the initial stage, discussions were held with partners. Their comments and suggestions were considered while preparing the document. The draft document was circulated among colleagues at the WHO Regional Office and

headquarters. Their inputs helped to make substantial adjustments in it. During the second stage, additional information was included and the draft was finalized. In order to obtain more inputs, a consultation was held with the UN Country Team members. Subsequently, over 150 participants drawn from bilateral agencies, embassies, NGOs, civil societies and government partners were invited to a presentation of the CCS. The final draft was then presented to the minister and high officials of the Ministry of Health. Their comments and suggestions helped to improve the document further.

2 PEOPLE AND GOVERNMENT: HEALTH DEVELOPMENT AND CHALLENGES

Ethiopia is situated in the Horn of Africa. The total area of the country is approximately 1.1 million sq km and it borders Djibouti, Eritrea, Sudan, Kenya and Somalia. It is a country with great geographical diversity. Its topographical features range from the highest peak of Ras Dashen, 4,620 metres above sea level, down to the lowest point in the Afar (Danakil) depression, 110 metres below sea level. The highlands are located primarily in the central part of the country, including Addis Ababa, the capital, while the lowlands make up most of Ethiopia's periphery. The climatic conditions in the country vary with the topography, but in general, the highlands receive more rain than the lowlands. The climate is temperate. However, even the highlands fail to get rain from time to time and thus the country is prone to recurrent drought.

2.1 Demographic overview

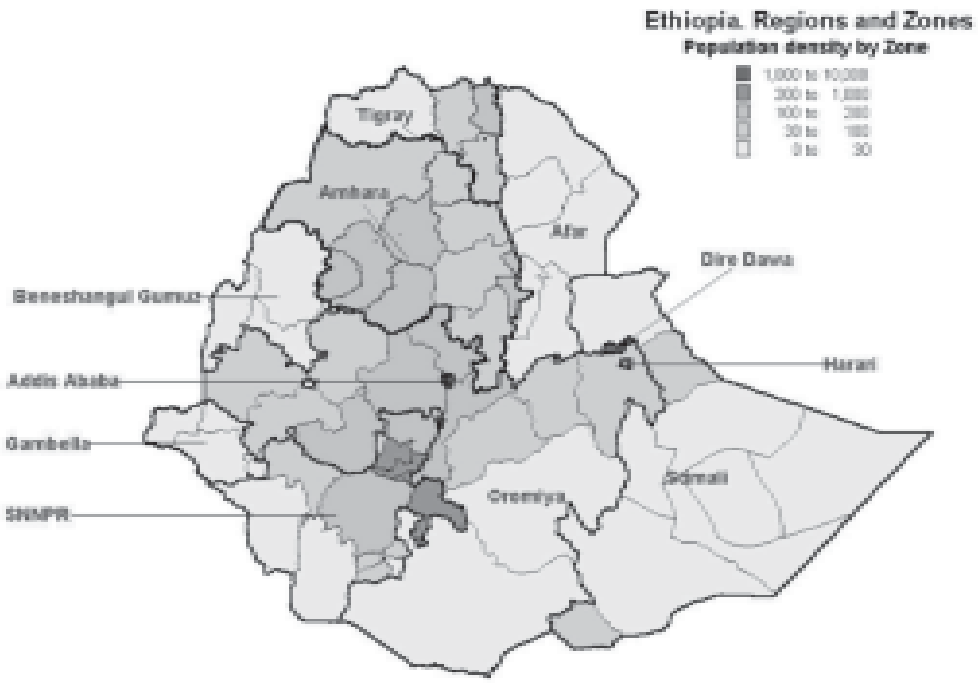
Ethiopia's population was estimated to be 65.4 million in 2001. With the annual population growth rate of 2.9% (according to the 1994 census projection), the population is expected to reach 106 million by the year 2020. The average population density is 52.2 per sq km but it varies greatly from region to region.

Ethiopia is one of the least urbanized countries in the world, with less than 15% of the population living in urban areas in 1994.

The age structure of the population shows a typical sub-Saharan African pattern with 44% of the population being under the age of 15 years and a large proportion (24%) of women being within the reproductive age group (15-49 years). The recent (2000) National Demographic and Health Survey (DHS) stated that the total fertility rate was 5.9 children per woman during the last five years. According to the 1999 national labour force survey, the overall dependancy ratio for the country was estimated at 102 dependants per 100 people in the working age group (15-64 years).

According to the 2001 World Population Data Sheet of the Population Reference Bureau, the average life expectancy at birth is 54 years (53 years for males and 55 years for females). However, the 3rd edition of the document entitled "AIDS in Ethiopia (2000)" states that the life expectancy of the population at the present level of HIV infection rate is 46.5 years.

Maternal deaths, which are amongst the highest in the world, range from 560-850 per 100,000 live births.



TB and Leprosy Control Programme Ethiopia. MOH. 2001

The majority of the population lives in the highland areas of the country. The main occupation of the settled population is farming, while in the lowland areas the population is mostly pastoral and moves from place to place in search of grass and water for its livestock.

Ethiopia is a multi-ethnic country having more than 83 languages. The main languages are Amharic (the official government language), Tigrinya and Oromiffa. Christianity and Islam are the main religions of the people.

2.2 Socioeconomic situation

Ethiopian economy is agrarian and agriculture accounts for about 90% of the exports and for about 54% of the gross domestic product (GDP). The agriculture sector, which relies on traditional labour-intensive technologies and is strongly rain-dependent, employs approximately 80% of the population. The principal exports of this sector are coffee, hide and skin, oil-seeds, pulses, flowers, vegetables and sugar. There is also a thriving livestock sector, exporting live animals and animal products. The other sources of income for the government include taxes from

services (commercial services, tourism and small-scale industries) and mining. The GDP grew at an annual average rate of 5.5% from 1992 to 1998, with sector growth rates of 3.4% for agriculture, 7.3% for industry and 7.7% for services. The public expenditure on health is 1.7% of the GNP.

Ethiopia is a developing country with GNP of US$ 6.4 billion representing a per capita income of US$ 100 per annum. The Ethiopian currency is the birr and at present US$ 1 is equivalent to about birr 8.5. In recent years, Ethiopia has moved toward a market-oriented economy. There are 15 micro-financing institutions established by private organizations giving support for economic development.

2.3 Governance

Ethiopia is one of the few African countries that were never colonized except for the brief period of Italian occupation from 1936 to 1941. Similar to many other countries in Africa that have experienced turmoil in the post-independence period, Ethiopia has had episodes of civil war, border conflict and general unrest within the country, but has remained a united country with a rich diversity of people.

At present, Ethiopia is a Federal Democratic Republic. The government is made up of two chambers of parliament: the House of the Council of People's Representatives (whose members are elected from the regions, zones, woredas and kebeles) and the House of Federal States (whose members are designated from their respective regions). The administrative boundaries (of regions, zones and woredas) have changed three times since the mid-1970s, and at present Ethiopia has nine regional states (divided on ethnic basis) and two Administrative City Councils. Each region is headed by a president assisted by heads of various regional bureaux. Each region has its own regional state council. The regions are responsible for their own legislative and administrative functions, except for foreign affairs and defence.

The nine National Regional States and the two Administrative City Councils include the following:

(a) National Regional States: Tigray; Afar; Amhara; Oromia; Somalia; Benishangul-Gumuz; Southern Nations, Nationalities and Peoples Region (SNNPR); Gambella; and Harari;

(b) Administrative City Councils: Addis Ababa; and Dire Dawa.

The National Regional States as well as the Administrative Councils are further divided into 75 zones, 551 ***woredas*** (i.e. districts) and approximately 10,000 ***kebeles*** (i.e. counties). There are also two zones and seven ***woredas*** classified as 'special' because they are medium-size towns or cities or they are the traditional sites of

ethnic minorities. The smallest administrative unit is the ***kebele*** representing urban-dweller associations in towns and farmers' associations in rural villages. Each region has a Regional Health Bureau (RHB) and ***Woreda*** Health Office. The responsibility of the zone has been substantially reduced in favour of a strengthened ***woreda*** structure.

2.4 Development policies

During the last decade, the government formulated various development policies, of which the following are the most relevant:

(a) National Health Policy;

(b) Population Policy which makes provision for the reduction of the current fertility rate through increasing the prevalent use of contraceptives, reducing maternal, child and infant morbidity and mortality rates as well as promoting the level of the general welfare of the population;

(c) National Policy on Women, which provides for gender mainstreaming and promotion/protection of women's health;

(d) Education Policy, which aims at expanding access to education by raising primary enrolments to improve gender, urban-rural and regional disparities, to improve the quality and efficiency of education, and to increase resource availability for education;

(e) Agricultural Development-Led Industrialization (ADL);

(f) sector-specific policies and programmes on roads and water services;

(g) Poverty Reduction Strategy Paper (PRSP). The four main components of this strategy paper include ADLI as the overall development policy in the country; judiciary and civil service reforms; decentralization and empowerment; and capacity-building in the public and private sectors. The PRSP elaborates upon sector development programmes including health, education, water and roads.

Historically, the health system had been highly centralized and the services had been delivered in a fragmented manner, with greater reliance on vertical programmes. There was little collaboration between the public and private sectors. The administrative arrangements were also highly centralized until 1991. To address the issues of access to health-care services, the National Health Policy was approved by the Council of Ministers in September 1993. This policy commits the government to the following:

(a) decentralization of the health service management and delivery system;

(b) development of the prevention and promotion components of health care;

(c) equitable distribution of health services;

(d) intersectoral collaboration;

(e) national self-reliance in health development;

(f) accessibility of health care;

(g) working closely with neighbouring countries and regional and international organizations;

(h) Development of appropriate capacity based on needs;

(i) Payment for health care according to ability;

(j) Participation of the private sector and nongovernmental organizations.

In 1996, the government presented (in a Consultative Group Meeting) a 20-year health sector development strategy based on the stated policy comprising a series of five-year health sector development programmes (HSDP). In July 2002, the HSDP entered its fifth year. The Central Joint Steering Committee, consisting of the Central government and donor representatives, is the coordinating and advisory board of the HSDP. Regional Joint Steering Committees, made up of regional governments, donor representatives and NGOs, coordinate the overall implementation of the development programme at regional level.

2.5 Health profile

The health status of the people of Ethiopia is poor in relation to even low-income countries, including those in sub-Saharan Africa. The population suffers from potentially preventable diseases such as HIV/AIDS, malaria, tuberculosis, intestinal parasites, acute respiratory infections and diarrhoeal diseases. Health indicators are generally poor even though there are some improvements observed.

Statistics on hospital admissions are not readily available. Health sector reviews, however, indicate that patients suffering from HIV-related problems may occupy more than 50% of hospital beds at any given time. Other conditions for admission include tuberculosis, malaria, respiratory infections, trauma, pregnancy-related conditions and complications of measles.

2.6 Determinants of ill-health

Living conditions: According to the Human Development Report of 2001, about 45% of the people in Ethiopia live on less than one US dollar per day.

Literacy rate: The adult literacy rate is 36% (46% for males and 25% for females). The primary school enrolment rate is 57.4% for both sexes, out of which girls constitute 47%.

Access to safe drinking water: Only 33% of the population had access to safe drinking water in 1999. The coverage in urban areas is 80% and in rural areas it is 14.3%.

Sanitation facilities: Sanitation coverage is estimated at 25%. According to MOH (HSDP II), 74% of urban-dwellers have access to reasonable sanitation facilities.

Health care performance: The health system provides health care for 52% of the population. Most of the rural population has limited access to modern health-care services. In terms of service delivery, it is estimated that only 75% of urban households and about 42% of rural-dwellers have access to health facilities. There is seasonal shortage of medicines and medical supplies. Like in many other African countries, the main causes for the shortage of medicines and medical supplies are lengthy procurement procedures, limited access to information and an inefficient distribution system. The issue of health-care services delivery to the pastoral communities, who account for 10% of the population, calls for special attention.

Agricultural productivity and food safety: Low agricultural productivity and recurring drought are responsible for nutritional deficiencies. According to DHS-2000, 51.5% of children below the age of five were stunted while 10.5% were wasted and 42.7% were underweight. The same survey found out that 3.6% of the women were stunted and 30.1% were undernourished. Micronutrient deficiencies, in particular vitamin A deficiency and iodine deficiency disorders, are also widespread.

Unemployment/underemployment/migration: According to the report of the Central Statistics Authority (CSA) on the 1999 national labour force survey, 8% of all people aged 15 years and above were unemployed. This means that most of the rural population in this age category is employed, but they produce enough for the subsistence of the family only. Thus, no surplus is available to earn an income for the improvement of the economic well-being of the population. Of the total population of the country, 19.6% are migrants. The reasons for population movement (migration) are search for work, marriage arrangements and return home or going back to place of origin, and search for grazing area. Pastoralists constitute about 10% of the population. It was found that females were more likely to migrate than males.

Status of women: Violence against women is still prevalent in the country and harmful traditional practices (female genital mutilation, abduction, early marriage, etc.) are common. These have negative consequences on the health of women. Therefore, mainstream gender issues in all aspects of development, including health, are important.

2.7 Key health issues

Maternal mortality: As has been mentioned in the earlier section, Ethiopia has a maternal mortality ratio (MMR) ranging from 560 to 850 per 100,000 population. The identified causes of maternal mortality are mechanic dystocia, eclampsia (high blood pressure during pregnancy), bleeding and sepsis following abortion or delivery. The death of a mother is not only a loss of a human life but also something that negatively impacts the child's survival and development.

HIV/AIDS/STI: According to MOH estimates, the HIV/AIDS prevalence rate among adults has been increasing steadily from 2.7% in 1989 to 7.3% in 2000. According to the 3rd edition of the MOH document called "AIDS in Ethiopia", there might have been about 2.6 million people infected with HIV/AIDS and about 400,000 actual AIDS cases in Ethiopia at the end of 2000. The number of AIDS cases reported countrywide at the end of 2000 was 83,487. According to the Ethiopian DHS-2000, 3% of all men had experienced symptoms of sexually transmitted infections (STI) a week before the survey. This is indicative of the high prevalence of unprotected sexual activity predisposing many people to HIV infection. The rapid spread of the HIV infection poses a special challenge to the health and other sectors of the country. The Voluntary Counselling and Testing (VCT) sites in the country are not sufficient and are not easily accessible to the population.

Tuberculosis: In 2001, about 93,000 new cases of tuberculosis were reported, with a death rate of 7% among sputum smear-positive cases. With the advent of HIV/AIDS, the prevalence of TB has been increasing. The management of TB poses a special challenge to the health sector. Directly-observed treatment short-course for TB (DOTS) was introduced, but it has still to cover the whole country, as only about 50% of the population is within walking distance from health facilities.

Malaria: The incidence of malaria has been increasing steadily over the years. In 1995, there were 1.1 million cases while the caseload increased to 1.5 million in 2001. Positives actions taken by the government include community-based malarial control, epidemic control and the introduction of mosquito nets. There have been occasional shortages of anti-malaria drugs and this problem needs to be addressed in the future.

Vaccine-preventable diseases: The average national DPT3 coverage is 42%. The national immunization days (NIDs) have achieved a high oral polio vaccine (OPV) coverage in children less than five years of age. The number of children under 5 years of age vaccinated during NIDs increased from 294,000 in 1996 to 14.1 million in 2001.

Noncommunicable diseases: The prevalence of noncommunicable diseases, including hypertension, cardiovascular diseases and diabetes mellitus, is increasing with changes in people's lifestyles. According to the Health and health-related indicators of MOH (2000-2001), hypertension was the seventh leading cause of death in the country in 2001.

Blindness: According to the National Plan for Eye Care in Ethiopia (MOH 2001), the estimated prevalence rate of blindness is 1.25%. With appropriate public health measures, two-thirds of these cases could be prevented. They could be due to trachoma, vitamin A deficiency and cataract. According to the Health and health-related indicator of MOH (2000-2001), cataracts were responsible for 2.4% of all admissions to hospitals in 2001.

Mental health: Mental illness is one of the health issues that has not received the attention it deserves. Health workers do recognize that mental illness is on the increase and the government and partners recently commissioned an assessment of the situation. The result, which is believed to serve as background information for the formulation of strategies for addressing mental health, is being awaited.

Reproductive and adolescent health: The problem of high maternal mortality, high teenage pregnancy, low contraceptive prevalence rate and a relatively high incidence rate of STI in young people calls for improvement in the provision of preventive, promotive and curative reproductive health services.

2.8 Health sector strategic plans

The Health Sector Development Programme (HSDP 1990-1994 EC) was developed between 1995-1998 by the Prime Minister's Office, the Federal Ministry of Health, the nine National Regional States and the two Administrative City Councils on the basis of existing health policies and strategies. The strategies served as inputs to develop implementation programmes jointly with responsible bodies of the regions and international partners. After presentation of these programmes at a Consultative Meeting in 1997, constructive suggestions were incorporated. Based on that, a plan of action was developed which created favourable conditions to enhance cooperation among a number of partners for implementation. The HSDP was completed in July 1998 [1990 Ethiopian calendar (E.C.)]. The intense central and regional planning preparations were followed by the development of a detailed Programme Action Plan

in August 1998 and a Programme Implementation Manual in October 1998. These two documents defined the objectives, strategies, activities and responsibilities of all actors at various levels.

The MOH and the Regional Health Bureau (RHB) are the implementing agencies, guided and coordinated by the Central Joint Steering Committee, with membership from ministries of Health, Finance and Economic Development and five participating donor and NGO representatives. There is a similar organization known as the Regional Joint Steering Committee at the regional level. Most donors active in the health sector work through the Health, Population and Nutrition Donor group (WHO is the elected chair) to support the HSDP while many others have committed funds to the programme. This is a sector-wide approach in action.

The main objectives of the HSDP for the period 1997-2002 are to:

(a) increase access to and coverage of health care from 40% to 50-55%;

(b) improve service quality through training and improved supply of necessary inputs;

(c) strengthen management of health services at Federal and Regional levels;

(d) encourage participation of the private and NGO sectors by creating an enabling environment for participation and for coordination and mobilization of funds.

The five-year health development programme is designed to emphasize the preventive aspects of healthcare and to develop comprehensive and integrated primary health care services. The focus is on communicable diseases, common nutritional disorders and environmental health and hygiene. In addition, this programme also aims at supporting activities for improvement in reproductive health care, family planning, immunization, control of epidemic diseases (such as malaria and tuberculosis) and control of sexually transmitted diseases, particularly HIV/AIDS/STI. The current vertical programmes will be gradually phased out as capacity at the ***woreda*** level increases. The eight components of HSDP and their specific share of the budget are given in Table 1.

Table 1: Health system component budget allocations

Health components	Budget (x1000 Br)	%
1. Service delivery and quality of care	2,311,800	51.0
2. Health facility rehabilitation and expansion	1,236,500	27.0
3. Human resources development	137,600	3.0
4. Pharmaceutical supply and management of essential drugs	638,700	14.0
5. Information, education and communication	56,900	1.2
6. Health management/Management Information System	85,600	2.0
7. Health care financing	7,400	0.2
8. Monitoring and evaluation (E + Research)	25,100	0.6
9. Contingencies	500,000	10.0
TOTAL 5-YEAR BUDGET (HSDP 1997-2002)	**5,000,000**	**100.0**
Capital: birr 1,620 million Recurrent: birr 2,880 million		

2.9 Health-care financing

The health-care service in Ethiopia is financed by the government and by donor/ partner grants, user fees, insurance and community contributions. The government contributes approximately 55% of the annual health budget, while donors contribute 42.5% and user fees amount to 2.1%.

In the Ethiopian fiscal year (EFY) 1990 (i.e. 1998/1999), a total of birr 776.15 million was made available by the government to the health sector while in EFY 1991 (i.e. 1999/00) about birr 813.74 million was available. In EFY 1993 (2000/01) the amount available was birr 1,222 million. The budget was for capital development and recurrent costs. The per capita expenditure on health in Ethiopia is estimated at US$ 4.5 as compared to an average per capita of US$ 10 for health in the rest of sub-Saharan Africa.

Health sector expenditures in Ethiopia tend to be concentrated on urban-based curative services rather than rural-based preventive primary health-care services. Regions whose population predominantly live in urban areas tend to have more budget allocation per capita than their predominantly rural counterparts.

The five-year budget for HSDP (see Table 2) was raised by the government and donors. During previous years, the amount spent out of the allocated capital budget was low (about 40.4% in 2000/01). This was due to lack of capacity in programme planning, implementation, management, monitoring and reporting.

Table 2: Government recurrent health budget, 1997-2002 (US$ 1 = birr 8.5).

Year	Budget (million birr)
1997/98	368.36
1998/99	418.17
1999/00	478.87
2000/01	406.80
2001/02	466.11

From 1996 up to 1998/99, there was a steady increase in the amount of recurrent budget allocated for health. The border conflict with Eritrea after that did not provide a favourable climate for budget increase. After the end of the conflict, the allocation to the health sector was increased significantly.

(a) In the financing of the health sector, the general government revenue shows an increase from 23% of the national recurrent budget in 1986 to 43% in 1996. This resulted in an increased share of the health sector from the total national budget from 2.8% in 1989 to 6.2% in 1996, which corresponded to an annual per capita of US$ 1.40.

(b) Donor aid/external assistance and foreign loans have increased fourfold in absolute terms over the past decade. These constituted 17.3% of the recurrent expenditure and 40% of the capital expenditure in the sector in 1996.

(c) In 1998, a new health-care financing strategy was proposed by MOH and adopted by the Council of Ministers. The strategy was implemented by the health care financing secretariat of MOH. The three principal components were cost-recovery, revolving drug fund, and health insurance. It was found that various types of health insurance and community contributions made only a minimal input to the health expenditure.

The budget allocated by the government to the health sector was inadequate. However, through the sectoral approach, donors and partners made supplementary resources available to MOH. The proportion of salaries in the recurrent budget was declining and stood at 53% in 1996. However, there was a corresponding increase in the health expenditure on medicines and other non-salary items.

2.10 Health delivery system

In 2000, there were 103 hospitals (all denominations), 338 health centres (HC), 2,029 health stations (HS), 833 health posts (HP) and 1,119 private clinics in the country. Although there is no data available on the number of traditional healers in the country,

it is well known that many Ethiopian households use them for various health problems. The population per primary health care (PHC) facility was 27,456, and this was three times higher than the population per PHC in the rest of sub-Saharan Africa. The total number of hospital beds was 11,685, which meant that there was only one bed for a population of 4,900 and this was about five times higher than the average for sub-Saharan Africa. Currently, as part of HSDP, the previous six-tier health care management system is transformed into a four-tier system characterized by a PHC unit (1 HC and 5 satellite HPs), district hospital, zonal hospital and specialized hospital. HSs are presently being either upgraded to HCs or downgraded to HPs. There are 311 pharmacies, 249 drug shops and 1917 rural drug vendors in the country. Of these, about 95% are privately owned. The limited number of health institutions, inefficient distribution of medical supplies and disparity between urban and rural areas have made it difficult to increase people's access to health-care services.

HCs are, on an average, staffed by one medical officer, several nurses and health assistants (who have 18-months' basic health training), one laboratory technician and one pharmacy technician. Three health assistants staff the average health station. The physician: population ratio is 1:48,000 and the nurse: population ratio is 1:12,000. Overall, there are 20 trained health workers per 100,000 population.

According to the report of the Federal Ministry of Health, there are 25 nursing schools (5 universities and 20 regional schools) and the number of graduates in EFY 1993 was 2171 (1452 male, 719 female). The human resource development plan under HSDP I was to train an additional 9579 professionals of all categories by the end of the planning year. Achievement in this respect between EFY 1990 and 1993 was 14,062 (28% of these were female). Despite the increase by an absolute number of 4483 over and above the plan (47%), and an annual graduate increase from 700 to 4500, there is still shortage in some key professional categories (midwives and front-line health workers). Based on the present number of trained health workers, the population growth rate of 2.9%, an annual attrition rate of 3% among the public service health workforce and an assumed 2.8% continued expansion of the output of health worker training schools, it will take more than 25 years to double the current number of health professionals. Medical and nursing schools and training institutions for paramedical professionals in the country attempt to increase the annual output of trained personnel to meet the demand. However, the quality and quantity of trained manpower need to be reviewed from time to time.

2.11 Challenges and prospects in the health system

Access and equity: In order to address the issue of access and equity, the government has developed HSDP I followed by HSDP II. Development of an appropriate health care package to meet the priority needs of the people as well as to

upgrade the current health delivery system to ensure access to a modern health system are under way. The efforts of the government in this direction need to be supported.

Infrastructure: The government and partners are committed to expand and rehabilitate the physical infrastructure in order to provide adequate health care coverage for the people. A programme to rehabilitate and construct the physical infrastructure in phases needs to be developed and implemented over the period of the WHO/CCS.

Finance: The budget allocation for the health sector has increased over the past three years. Resources for health from all sources are under-utilized due to gaps and delays in financial disbursement and reporting. The government and partners need to increase the budget allocation to the health sector in accordance with its expected expansion. They also need to advocate for more resources from donors. Financial reporting for different donors needs to be harmonized to facilitate fast and smooth flow of funds.

Referral: There is no national guideline on referrals. The ambulance system to support the referral system also seems not to be fully functional. Therefore, there is a need to formulate national guidelines for patient referrals and to improve the ambulance system. The development of the referral system is critical to make pregnancy safer.

Human resources: The programmes of health training institutes need to be continuously monitored, reviewed and improved to better respond to government policies and the country's current reality. There is a substantial need for the training institutes to produce more midwives and nurses. An in-depth study on the long-term need of health professionals in the regions should be commissioned.

Health information management system: It is difficult to determine the reliability of the health information management system given the problems so far observed in reporting. There is a need to develop a reliable health management information system for the country to generate information for monitoring the implementation of health programmes.

Medicines: The government has recently revised the list of essential medicines required by the various tiers of the heath systems. In order to make essential medicines available in many places at all times, the procurement and distribution system needs to be improved.

2.12 Emergencies and disasters

Ethiopia has experienced recurrent problems as a result of droughts and conflicts. There have been periodic droughts (once every 7-10 years) affecting the country since 1983. Drought has become a chronic occurrence in the country. In 2001, approximately 10.2 million people were reported to be in need of food and non-food assistance. Crop failures have also become commonplace. From time to time there have been cases of internal displacement of people due to floods. The widespread food shortages associated with these natural disasters have resulted in malnutrition and under-nutrition.

The incidence of certain diseases increases during droughts. The main diseases most commonly encountered are: malaria, diarrhoea, intestinal helminthiasis, acute respiratory infections including pneumonia, tuberculosis and skin diseases. Outbreaks of meningitis, measles and diarrhoeal diseases including cholera are also common during droughts.

People from neighbouring countries have been taking refuge in Ethiopia due to conflicts in their own countries. There have also been internally-displaced people within the country. Refugees and displaced people are vulnerable to all kinds of health problems, including the conditions stated above.

Therefore, it is important that the health sector is prepared to meet the additional health burden resulting from natural disasters and man-made emergencies. One of the steps in this regard would be to build its capacity to make nutritional and health needs assessments of the vulnerable groups. The other step is to build the required health care services. Additional logistics may also be required to assist the implementation of the programmes in times of emergency and disaster. Mechanisms of monitoring of the nutritional status of children as well as the impact of interventions (nutritional surveillance system) need to be put in place.

3 DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

The decentralization policy of the government aims at devolving power to woredas (districts). This will enable the society to fully participate in the planning, execution, monitoring and evaluation of development programmes, including health. This will further encourage civil societies and others to mobilize resources to increase access to health services, particularly by the poor.

In such a conducive working environment, different members of the civil society can integrate their approach to health with other sectors such as agriculture, education, water, and environmental protection. As a result, health can be incorporated into other local development programmes. A sense of ownership within communities of their own health programmes would empower them to be active participants in the prevention and control of communicable diseases and this would help to reduce poverty.

The government has already taken the lead by initiating the Sector-Wide Approach. This approach is designed to create an efficient and effective system that phases in the health sector development programme in the long term. It promotes improved coordination between the Federal government and the regions and between international donors and the health sector.

Despite this cooperative working environment, the flow of donor funds is still slow due to lack of alignment between donor resources and government resources. Coordination between donors, the Federal Ministry of Health/Regional Health Bureaux and the Ministry of Finance and Economic Development is not as strong as it should be and donor funds are not disbursed on a timely basis. On the other hand, there is need to utilize all available internal as well as external resources in order to implement the Health Sector Development Programme (HSDP). The government's capacity to absorb additional health funds has not expanded to the desired level. For example, the government spent 82% of the funds earmarked for health in 1998 and the absorption capacity fell to 77% in 2000. This means that resource management capabilities at all levels need to be upgraded.

External assistance grew from 11.8% in 1986 to 17.3% of the total health expenditure in 1996. External assistance is expected to exceed 25% of the total cost of HSDP. For 2002-2003, WHO allocated US$ 4.5 million from its Regular budget and also

earmarked US$ 69 million from Other Sources funds. As of July 2002, WHO was able to mobilize US$13 million for polio eradication, malaria, emergencies, and HIV/AIDS prevention and control.

The government is preparing a Poverty Reduction Strategy Paper (PRSP) which would help to narrow down the health-funding gap. A national PRSP Task Force coordinates consultations with various groups, including the NGO Task Force. In addition, the Development Assistance Group (DAG), composed of UN agencies and multilateral and bilateral groups, has provided technical assistance amounting to US$ 960,000 for the preparation of the strategy paper. Once the full PRSP is approved, Ethiopia will be entitled to debt relief for highly-indebted poor countries and the money could be diverted to poverty reduction activities.

The PRSP health component is based on the recommendations of the HSDP mid-term report and the annual review meeting in 2001. It offers specific instructions for improvement in major areas such as health service coverage, immunization programmes, comprehensive reproductive health services, prevention and control of communicable diseases, human resources development and access to essential medicines.

WHO, on its part, is coordinating the work of a group of bilateral organizations to establish pool funding for specific functions such as technical assistance, operational research, human resources development and pharmaceutical supply, distribution and management.

3.1 Major development agencies in the health sector

Government agencies: The Federal Ministry of Health and regional health bureaux are the two main government bodies responsible for health and for the implementation of the Health Sector Development Programme. Most of the health facilities and institutions are either under the Ministry of Health or under the regional health bureaux. The Ministry of Education, which is responsible for the training of health workers through its colleges, also has health facilities required for the training programmes. Other ministries also play a role. The Ministry of Defence, the police force, and the Ministry of Trade and Industry and other institutions also run various types of health facilities. Another key player in the regions, the Ethiopian Social Rehabilitation and Development Fund, is a government body involved in the construction of health facilities and the delivery of safe water supply. Although WHO should maintain its close relationship with MOH, it also needs to extend its cooperation to other sectors of the government. It should also clarify its role with the regional health bureaux, particularly in the emerging regions.

Health, Population and Nutrition Group: WHO chairs the Health, Population and Nutrition (HPN) Donors Group, which represents the key international agencies that support the HSDP. The group meets bimonthly with MOH in a joint consultative meeting co-chaired by the Vice-Minister and the WHO Representative. The main countries participating in the HPN are Belgium, Germany, Ireland, Italy, Japan, Norway, The Netherlands, Sweden, USA and the Christian Relief and Development Association (CRDA). UN agencies participating in the meeting are UNDP, UNFPA, UNICEF and WHO. USAID has committed US$ 71 million for the health sector while UNICEF has committed US$ 48.8 million over five years. Four projects in nutrition, immunization and reproductive health including HIV/AIDS, malaria and child health are the main beneficiaries. The World Bank's current commitment to the social sector includes US$ 100 million for health, US$ 60 million for HIV/AIDS, US$ 100 million for social fund and US$ 10 million for women's development. 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. It is also involved in the preparation of the Ethiopian FY 1995-97 HSDP plan and its alignment with the second Five-Year National Development Plan. Phase II of the HSDP, which begins in 2002, is being reviewed and finalized by donors and MOH through a joint coordinating committee composed of two members from MOH and five donor representatives, chaired by MOH. In general, the use of external HSDP funding is low due to inadequate absorptive capacity. Caution should be observed so that this situation does not imperil the HSDP II plan.

Nongovernmental organizations: NGOs involved in both preventive and curative health services are important partners in the health sector. Close to 200 NGOs work under the CRDA, the umbrella organization that coordinates the overall NGO effort in the country. Sixty per cent of the CRDA members are involved in the provision of curative and preventive health services. Some of the priority activities of NGOs include HIV/AIDS, reproductive health, child health, environmental health and human resources development/training. Overall, NGOs provide about 10% of the total health care in the country. The role of CRDA as a liaison agency between NGOs and MOH needs to be strengthened. Although WHO works with selected NGOs on hygiene and environmental health, capacity-building and HIV/AIDS, it lacks a clearly defined mechanism to guide the type and degree of work that it undertakes with these groups.

Private sector: There is a growing trend towards private provision of health care in urban centres, particularly in Addis Ababa, where about 340 private clinics and 51 pharmacies have been established in the past few years alone. The rapid growth of these facilities presents a serious challenge to the government's oversight and regulation functions. Here, WHO can play a vital role as a technical and policy adviser. To cite a recent case, it collaborated with MOH in a study on contracting out non-medical public health services to the private sector. A key recommendation of the

study was that a policy on the contracting- out methodology needed to be designed. Subsequently, WHO convened a meeting on contracting-out among ten English-speaking African countries and the meeting was followed by a national workshop. It is now time to consider implementing the main recommendations of these meetings.

3.2 Mechanisms for donor coordination

Health Sector Development Programme (HSDP) governance: The Central Joint Steering Committee (CJSC) and the Regional Joint Steering Committees (RJSCs) coordinate the implementation of the HSDP. The CJSC is chaired by the Minister of Health, with members from the Ministry of Finance and Economic Development, the World Bank, WHO two other members of the HPN group (Government of Norway and USAID) and CRDA. The RJSCs, chaired by the social sector heads of regional councils, play a similar role as the CJSC. Due to various problems, including lack of coordination between the central and regional committees, the RJSCs are barely functional.

Immunization: The Interagency Coordinating Committee (ICC) serves as an advisory body to MOH. The ICC coordinates the activities of the Polio Eradication Initiative (PEI), surveillance and routine immunization. The ICC membership includes: MOH, WHO, UNICEF, USAID, JICA, the Ethiopian Health and Nutrition Research Institute (EHNRI), CRDA, the Ethiopian Public Health Association (EPHA) and the Red Cross Association.

Integrated Management of Childhood Illness (IMCI): IMCI has a national task force composed of MOH, EHNRI, WHO, UNICEF, USAID, CRDA the medical faculties of the Addis Ababa University and Gondar and Jimma training institutes. It focuses on all programmes relevant to child health.

National Micronutrient Committee: This is a multisectoral committee (including Trade and Industry) and deals with the standardization of micronutrients focusing on salt idolization and other food fortification initiatives.

Communicable Diseases Control, Integrated Disease Surveillance and Response: The task force on Integrated Disease Surveillance and Response advises MOH on the surveillance of major communicable diseases and on response to epidemics. Its membership includes MOH, WHO, NGOs as well as experts from the Addis Ababa University, the Public Health Association and EHNRI.

HIV/AIDS: At the national level, HIV/AIDS prevention and control is coordinated by the AIDS Council Secretariat in collaboration with MOH, UNAIDS and other agencies (multilateral and bilateral). Within the UN, UNAIDS coordinates the HIV/AIDS-related

activities of the main agencies. WHO, over the last three years, has chaired the UNAIDS technical working group. Despite substantial investments in this mechanism, there is still ample scope for an effective coordination mechanism on HIV/AIDS prevention and control.

Malaria control: The Malaria Control Support Team offers technical advice to the national malaria control programme. Team members include MOH, WHO, UNICEF, UNDP, the World Bank, USAID, Ireland and Italy. Due to shortage of professionals at the national level, coordination among partners within the malaria programme is less than optimal.

Safe Motherhood: There is a task force dealing with reproductive health issues such as family planning and pregnancy management. UN agencies such as WHO, UNFPA and UNICEF and key NGOs (such as the Family Guidance Association, the Packard Foundation, and Pathfinder) are its members. Some mechanisms are being established to make pregnancy safer.

Global Health Fund: HIV/AIDS, tuberculosis and malaria are the major areas of emphasis of the Global Health Fund. At the national level, efforts are coordinated through the Country Coordination Mechanism, composed of the government, NGOs, civil society, multilateral and bilateral agencies and the private sector. MOH prepared and submitted a proposal to the Global Fund secretariat. The TB component was accepted for funding while the malaria and HIV/AIDS components were recommended to be revised and re-submitted by 27 September 2003.

3.3 Other partnerships

UN Development Assistance Framework (UNDAF): An UNDAF document, signed by UN agency heads and submitted to the Federal government, is in the process of being implemented. The six strategic areas of emphasis contained in the document are: sustained economic growth; productive employment; food security and sustainable agricultural development; access to basic social services; good governance; HIV/AIDS; and development. Cross-cutting issues include gender equality and advancement of women, globalization, increased use of information technology and human rights.

UNICEF, UNDP and UNFPA have already started to adapt their programmes as per the UNDAF recommendations. The World Food Programme (WFP) is almost ready to synchronize its programmes as well. It is clear that there is a risk of duplication of effort among UN agencies if interagency activities are not properly coordinated. WHO,

on its part, needs to analyse its comparative advantage as a technical agency for optimal resource utilization within UNDAF, taking into account particularly the recommendations of the WHO Commission on Macroeconomics and Health.

UN emergency response: The UN Disaster Management Team, jointly with the Disaster Prevention and Preparedness Commission and the Disaster Prevention and Preparedness Bureaux, coordinates emergencies resulting from natural disasters and man-made calamities. Members of this highly-effective committee include UNDP, UNICEF, UNHCR, ILO, UNAIDS, the World Bank, WFP and WHO.

Potable water: A technical working group whose membership includes UNDP, UNICEF, the World Bank, UNIDO, FAO and other donors was established to ensure safe water supply. Given the importance of safe water for health, this group deserves technical support from WHO.

National Task Force on Blindness Prevention: A task force chaired by MOH, with membership from WHO, the Ethiopian Ophthalmological Association and NGOs, was established to coordinate the prevention and control of blindness throughout the country. WHO will provide support to MOH for this purpose.

While the creation of all these coordinating groups is a positive move, the problem of overlap of programmes among agencies still remains. In addition, the proliferation of task forces is over-extending the human resources capacity of the Ministry of Health.

4 CURRENT WHO COUNTRY PROGRAMME

4.1 Evolution of programme cooperation

The first basic agreement for technical assistance between the Government of Ethiopia and WHO was signed in July 1951, only three years after the establishment of the Organization. Ethiopia was one of the original signatories.

WHO agreed to give technical assistance in the form of personnel, equipment, supplies and fellowships based on an agreed plan of work. The responsibility of the government as stipulated in the agreement was to provide or permit access to adequate information and facilitate appropriate contacts with government agencies. The current basic agreement was signed in January 1962.

WHO's presence in Ethiopia has evolved from a three-person office to a team of more than 100 staff. A representative, a secretary and a driver largely managed the first decade of WHO's collaboration. Later, an increased workload and extended mandate prompted a new management approach in which the country support team was drawn form MOH on a part-time basis. This arrangement continued until international and national professional officers were assigned. The introduction of professional positions raised the expertise of the WHO country office to a higher level. International experts for intercountry cooperation such as IMCI, emerging diseases and the Horn of Africa cross-border initiative are also attached to the office.

To give more efficient technical support to the health sector, experts were assigned to work in priority areas which included immunization and disease surveillance, HIV/AIDS, malaria control, polio, TB/leprosy, making pregnancy safer, health management, IMCI and essential medicines. Staff members are seconded to both the Federal and regional levels.

4.2 Areas of WHO support

Given the size of its population and the magnitude of health problems, Ethiopia has been a priority country for WHO support. Over the years, WHO has intensified its cooperation in communicable diseases control and prevention, maternal and child health, health promotion, essential medicines and environmental health. WHO has also worked to strengthen the health system through technical support, human resources development and policy advice. Some of the ongoing programmes are Africa-specific. An example of this is the priority given to the emergency preparedness and response programme in Ethiopia in order to address the country's increasing susceptibility to natural and man-made emergencies. The current Regular budget allocation can be grouped into eight major areas, namely: Communicable

diseases control and surveillance (30%); Organization of health services (21%); Maternal and child health (17%); Emergency preparedness and humanitarian action (10%); Health promotion (7%); Mental health and substance abuse; essential medicines; and environmental health, each accounting for 5% of the budget (see Figure 1).

An amount of US$ 4.5 million from the WHO Regular budget has been allocated for the biennium 2002-2003 to Ethiopia. This cooperation is based on the continuation of existing successful efforts and the integration of those especially related to poverty reduction into socioeconomic development policies. Furthermore, WHO is involved in special interventions targeting drought- and war-affected areas, border and pastoralist territories and families affected by HIV/AIDS. Consequently, substantial Regular and Other Sources funds are deployed in support of disease control and prevention programmes, notably polio, malaria, tuberculosis and HIV/AIDS, as well as systems development, family health and health promotion. The polio eradication initiative has the largest share (more than 60%) of WHO's resources in terms of staff and budget (please refer to Annex I for details of the current budget).

WHO supports the government's Health Sector Development Programme to ensure that both domestic and external resources, including new funding opportunities, are used to make a long-term health impact. WHO is also advising on the development of adequate policies and capacities within MOH to enable it to respond to the challenges of polio eradication, HIV/AIDS, malaria, TB as well as IMCI, and making pregnancy safer.

Figure 1: WHO regular budget allocations

5 WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

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

5.1 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 Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 New emphases[1]

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

(a) Adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;

(b) Playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

(c) Triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;

(d) Creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

[1] WHO EB105/3. A Corporate Strategy for the WHO Secretariat

5.3 Strategic directions[1]

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

(a) Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) Promoting healthy lifestyles and reducing risk factors to populations;

(c) Developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;

(d) Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

5.4 Core functions[1]

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

(a) articulating consistent, ethical and evidence-based policy and advocacy positions;

(b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;

(c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;

(d) negotiating and sustaining national and global partnerships;

(e) setting, validating, monitoring and pursuing proper implementation of norms and standards;

(f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, healthcare management and service delivery.

5.5 Global and regional priorities[2]

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002-2005). The global priorities selected on the basis of those criteria are:

[1] WHO EB105/3. A Corporate Strategy for the WHO Secretariat
[2] WHO: General Programme of Work 2002-2005.

malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO Regional Office for Africa[3] is facing enormous challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS; tuberculosis; malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control including mental health; and poverty and health.

5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at getting the balance right between its key functions at the country level. This means the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed based on the broader core functions presented above.

The specific functions at country level are:

(a) supporting routine long-term implementation;

(b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;

(c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;

(d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;

(e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spendings of government and development partners.

[3] The Work of WHO in the African Region, Strategic Framework 2002-2005.

6 STRATEGIC AGENDA FOR WHO IN ETHIOPIA

WHO cooperation with Ethiopia is guided by the vision of 2020 which provides clear directions for the current tasks and for what ought to be done in the next four years (2002-2005). The strategic agenda of WHO in the country is a specific road map with indications of a cohesive mix of approaches for the best possible long-term impact. The long-term vision is the economic improvement of all citizens, especially those with the lowest capacity and opportunity, by providing adequate investment for health.

6.1 Selecting directions

With the overriding objective of poverty reduction, the government of Ethiopia has adopted several policies, namely: the Agricultural Development-Led Industrialization (ADLI) strategy; the sector development programme (being implemented in education-health-road-water supply sectors); the judiciary and civil service reform; decentralization (covering decision-making, capacity development and integrated development); and empowerment and capacity-building in the public and private sectors. While investing in health for equitable economic growth, WHO in Ethiopia will follow four interrelated strategic directions. These will be used as policy frameworks directing WHO in terms of objectives, expected outputs and activities. These directions will also guide the country programme towards providing targeted cooperation interventions and shifting towards a policy advisory role. With this broad policy perspective, its corporate policy framework enables WHO to face future challenges. The four strategic choices identified for WHO cooperation in Ethiopia are briefly discussed below.

6.2 Health as part of macroeconomic and social policy environment

How could WHO ensure that the public health impact of decentralization influences macroeconomic and social policies at the Regional and Federal levels? How will WHO use the opportunities arising from decentralization to help increase the provision of basic public health goods and facilities, e.g. food, water and access to public health programmes? How will WHO assist the country in promoting health and food security through agriculture-led integrated development?

In order to address the above questions, the following would be the entry point. If the full PRSP is accepted and approved, a good proportion of the resources obtained as a result of debt relief will hopefully be invested in the health sector. In terms of content, safe drinking water, food safety, sanitation and hygiene and vector control will be high on WHO priorities. In terms of process, this means that WHO, in close

consultation with MOH, will have to work with a whole new set of institutions (for example, the Ministry of Capacity Building, Ethiopian Social Rehabilitation and Development Funds, the Institute for Economic Studies, the Parliamentarian Commission, the Credit Schemes Institution and the Ministry of Agriculture).

The role of WHO should be to:

(a) document the investment that has to be made from a macroeconomic point of view and advocate the mobilization of resources;

(b) promote research on the improvement of health in community-based integrated programmes to build evidence-based policies for government at all levels;

(c) assist in the long-term planning and forecasting of basic health needs required for drinking water and sanitation;

(d) provide assistance for quality control in the delivery of basic public health goods;

(e) advocate technological development, institutional support and organizational capacity-building;

(f) support the health sector financing and budget allocation as a result of debt relief.

6.3 Health sector development

How will WHO facilitate better performance in a decentralized health system and in a situation with an increased number of people? How could WHO improve systems at the woreda level through the Health Sector Development Programme, which provides the umbrella policy and the budget framework for government-led interagency coordination?

Experience shows that WHO can best exercise its advocacy role as a catalyst and an honest broker and perform its policy advisory functions by providing high-quality technical leadership and by assisting MOH. The key focus would be to improve the overall management of the health sector by focusing on areas such as human resources development, health financing and private sector and NGO partnerships to promote public health goods. The most critical areas are: development of human resources including career development, retention, incentives, manpower management and performance monitoring; providing continuous supply of medical commodities such as medicines and vaccines; ensuring access to essential health services for those living in remote or pastoralist areas; and bridging the increasing gap between public demand and available access to health facilities.

The role of WHO should be to:

(a) provide technical assistance for capacity-building (e.g. production of guidelines, training, monitoring of performances and evaluation);

(b) pool resources with other agencies and facilitate contractual arrangements;

(c) assist the health sector in interagency coordination through technical advice, joint planning and consultative and executive bodies;

(d) provide technical support and encourage the government to contract out health services to the private sector and NGOs.

6.4 Reduction of poverty-related diseases

How could WHO help to reduce high health risks and the economic burden of diseases that impact household assets and reduce the productivity of the poorest populations? How could WHO help in accessing global funds and initiatives and in ensuring that financing opportunities are not missed?

WHO's task will be to improve the absorptive capacity of government infrastructures in terms of channelling of funds, using them in effective and efficient ways and providing timely reporting. As the infrastructures focus on specific diseases, they also challenge the health system and its long-term viability. Polio eradication, the measles initiative and the Global Alliance for Vaccines and Immunization (GAVI) are the first to come up with clear outcome indicators and incentives. The recent focus of the Global Fund for HIV/AIDS is also on tuberculosis and malaria. In future, other areas of social and economic concern such as maternal deaths, childhood illnesses, access to essential drugs, blindness, mental health and injuries will become the focus of global attention and solidarity.

The role of WHO should be to:

(a) provide assistance in the design of proposals for funding and in ensuring sustainability;

(b) organize structured partnerships through interagency coordination committees;

(c) provide support for routine implementations;

(d) facilitate timely reporting and evaluation.

6.5 Health emergencies and vulnerability reduction

How could WHO respond faster and better to health emergencies? What kinds of capacities have to be developed for emergency preparedness and management?

Ethiopia will continue to face natural disasters such as droughts, floods, epidemics of meningitis and diarrhoeal diseases, and population movement (refugees, internally-displaced populations, economic migration). Most of these health risks have the highest impact on the poorest population groups, border areas and pastoralist groups.

WHO should build on its very positive experience of collaboration with the UN Emergency Unit. It should also build relationships with institutions such as the Federal and regional disaster preparedness and prevention committees and bureaux, the pastoralist associations, the UN Emergency Unit, and the intercountry administrations. Special communication and transport facilities will have to be developed.

The role of WHO should be to:

(a) provide guidance and support for the development of local capacities among the populations at high risk to anticipate and respond to some of the risks;

(b) respond to ad hoc emergencies through embarking on urgent resource mobilization, leading interagency coordination in health and providing timely technical assistance;

(c) use its subregional location to develop, and sometimes to implement, special programmes to improve health and to reduce poverty in highly vulnerable populations that are not sufficiently covered by government institutions (e.g. cross-border activities and intensified technical assistance to emerging regions).

6.6 WHO cooperation with Ethiopia, 2002-2005

The 2002-2003 WHO Programme Budget and the Proposed Budget for 2004-2005 have been reviewed. Each Area of Work identified as a priority will be revised in terms of objectives, activities and approaches to check if it is consistent with the strategic directions clearly given in this document. The structure of the cooperation programme will follow the four strategic directions and will include the proposed additional activities listed below:

Health as part of the macroeconomic and social policy environment

(a) Sustainable health development including nutrition and health:

(i) to develop and promote a national nutrition policy with a view to improving protein energy malnutrition as well as micronutrient deficiencies of the vulnerable groups;

(ii) to establish a food quality-testing laboratory;

(iii) to promote health components into agricultural development projects.

(b) Hygiene and environmental health:

(i) to improve access to safe water through water quality control;

(ii) to improve sanitation capacity at the woreda level;

(iii) to identify pollution issues.

(c) Health promotion including adolescent and women's health:

(i) to develop material for dissemination to the media;

(ii) to accelerate network of health information and education, including Blue Trunk Libraries.

Health sector development

(d) Health systems development including human resources, Management Information Systems and private/public sector relations:

(i) On human resources development

- to provide training for the health extension package;
- to assist in pooling resources to develop adequate manpower;
- to build-up fund for technical assistance.
- health system management
- to accelerate region/woreda health management system;
- to formulate policies on private health service;
- to develop operational research on pastoralist health;
- to participate in public health expenditure review;
- to assist in monitoring allocation of grant packages.

Making Pregnancy Safer

To reinforce and expand the capacity of emergency obstetrical care and management of high-risk pregnancies, including abortions.

(e) Integrated Management of Childhood Illness (IMCI)

(i) to increase immunization coverage in the country through a combination of strategies, micro planning and commitment to implement the plan effectively and efficiently;

(ii) to improve supervision of IMCI.

Reduction of poverty-related diseases

(f) Communicable diseases such as HIV/AIDS, malaria, tuberculosis

(i) to assist in the finalization of policies on HIV/AIDS addressing such issues as prevention of mother-to-child transmission of HIV (PMTCT) and treatment with triple antiretroviral drug therapy and the care of AIDS orphans;

(ii) to increase voluntary counselling and testing VCTs;

(iii) to ensure adequate supplies of antimalaria drugs at community level and in health facilities at all times;

(iv) to improve the directly-observed treatment, short-course (DOTS) coverage for TB through health facilities and community organizations.

(g) Noncommunicable diseases such as blindness, injuries and maternal health

(i) to coordinate the blindness prevention and control programme;

(ii) to put a blindness prevention programme in place;

(iii) to develop a national policy and guideline for mental health;

(iv) to document the public health importance of injuries.

Health emergencies and vulnerability reduction

(h) Emergency preparedness and response

(i) to develop a health sector preparedness plan;

(ii) to improve capacity for nutritional assessment and assessment of the health needs. Logistics may also be required in times of emergencies and disasters to facilitate the implementation of the programmes. Mechanisms for monitoring the nutritional status of children as well as the impact of the intervention measures (i.e. nutritional surveillance system) need to be put in place;

(iii) to reinforce and expand cross-border health activities of the Horn of Africa Initiative.

7 SUPPORTING AND IMPLEMENTING THE WHO COUNTRY COOPERATION STRATEGY

WHO Ethiopia, WHO/AFRO and headquarters staff, in close collaboration with their executive, identified and agreed to make changes on an incremental and structural basis over the next few years. With a view to streamlining these reforms, three broad categories of changes have to be considered: (a) working with the government (this requires mutual understanding and agreement on changes); (b) working with development partners; and (c) taking note of WHO's response (“One WHO”). Shifts in policy directions obviously require shifts in management, particularly in WHO personnel management. These shifts would redirect WHO's technical and financial resources and develop new capacities.

7.1 Strengthening WHO response capacities

Human resources capacity strengthening

Getting relevant, adequate and quality staff at the right time is very important and this has to be supported by appropriate administration and management. To do this, the following requirements should be fulfilled:

(a) A plan for staff development that clarifies the structure and competence required in WHO Ethiopia, and for the development of skills and attributes of existing staff to apply for new positions and take on new roles.

(b) Recruitment of specialist technical staff for a fixed term if the existing staff are not able to play this role (possible examples are in areas such as human resources development, health economics, nutrition, HIV/AIDS, water and sanitation, health information and drought).

Management and follow-up

In order to ensure effective programme management in the sprit of "One WHO", the following need to be considered:

(a) Strengthening the administrative and financial management capacity to a level to allow the WHO country office to take responsibility for the management of all financial and human resources issues for its country operations.

(b) Ensuring that WHO has a “One WHO” pool of technical resources which are able to support Ethiopia on a sustained basis, and supplying a universally high quality of these resources in a coherent manner. To achieve this end, the following is required:

(i) Joint WR/AFRO/HQ planning, monitoring and evaluation of the technical assistance in Ethiopia, led by the country team, for a more focused and coherent WHO mission time table;

(ii) WHO country office with its own travel budget to facilitate easy mobility of experts at relatively short notice.

Resource mobilization

In order to implement the identified strategic agenda, additional resources will be required. Even though WHO Ethiopia, is involved in the mobilization of resources locally, strengthening the capacity of the office in resource mobilization is essential. The following crucial activities need to be performed:

- Developing a system for pooling of donor funds;
- Improving the mechanism for signing agreements at local level;
- Ensuring accountability and transparency.

An internal memorandum on the CCS was worked out and addressed to the WHO Director-General and the Regional Director for further support.

Time Frame

The time frame for incremental changes is as follows:

December 2002	-	Mid-term annual review of WHO cooperation taking into account the recommendations of the joint Government-Agency Meeting on Health Sector Development Programme II.
January 2003	-	Submission of a WHO plan of reallocations to the regional offices by MOH. WHO will also initiate mobilization of resources from Other Sources.
April 2003	-	Review of the 2004-2005 Programme Budget based on this CCS.
April 2004	-	Review of the implications of CCS.

7.2 Innovative ways of providing technical support

Working with UN and other partners

WHO will play a ***leading role*** in all health development areas, particularly in providing technical support to supervision/evaluation missions of UN agencies, especially the World Bank. The agencies include Interagency Coordination Committee (polio, GAVI,

blindness, Making Pregnancy Safer, malaria, tuberculosis, HIV/AIDS), global funds (CCM) and coordination of international development partners who support the Health Sector Development Programme.

WHO's ***supportive role*** will be in areas where it can make complementary contributions such as food security, HIV/AIDS, gender, etc.

WHO will assist in mobilizing and pooling resources for the development of the health sector by linking the country's health needs with global health initiatives, reinforcing financial investments for the sectoral approach and mobilizing resources at the country level.

7.3 Subregional initiatives

The nature of subregional health issues has led to some recent initiatives, which have to be sustained and/or expanded. The Horn of Africa countries have agreed on intercountry and cross-border activities. Additional human and financial resources have to be mobilized to scale up this initiative. Expertise is required in specific areas for developing the capacities of the Horn of Africa countries to engage in the prevention and control of diseases, reproductive health and IMCI.

7.4 Working with government in a decentralized system

The most important change that WHO should make is to gradually move away from the function of supporting routine implementation towards a policy advisory and advocacy function. In Ethiopia, WHO will continue to build the capacity of MOH over the next decade while also supporting routine programme implementation.

Another critical shift is towards fostering intersectoral partnerships entering into cooperation agreements with other organizations (such as Trade, Capacity-building, Ethiopian Social Rehabilitation and Development Funds, Disaster Preparedness and Prevention and Control, etc.) and establishing working relationships with implementing partners such as NGOs and civil society organizations.

A new cooperation agreement will be included in the WHO country programme budget. As is the case now, only the WHO country office budget (COO) is used as seed money for policy advocacy development. This should be progressively institutionalized within the country cooperation programmes. WHO will explore with the government on how best to engage with civil societies as part of the general movement to empower communities on health matters. This direction is fully consistent with government policies, especially in regard to decentralization.

7.5 Other implications

Other managerial implications for WHO to ensure CCS implementation are:

(a) to keep sufficient Regular budget under the WR office budget (COO) to monitor and evaluate CCS and accelerate it. Flexibility in WHO leadership role requires the availability of adequate resources;

(b) to have rapid access to a contingency budget and specialized expertise within WHO (AFRO or HQ) for emergencies (natural and man-made);

(c) to reinforce institutional, financial and managerial mechanisms for cooperating with NGOs and civil society groups towards integrated health development;

(d) to establish a platform in the country for mobilizing resources to fund WHO technical assistance;

(e) to initiate a health information network for health institutions, the media and partners;

(f) to formalize a CCS monitoring process to ensure that these changes do take place and to perform evaluation based on identified indicators which could measure accomplishments of the Areas of Work within the two-year period.

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ANNEX 1 WHO AREAS OF WORK AND BUDGET 2002-2003

Ser nº	Areas of Work	Budget US$		
		Regular budget	Other Sources	Total
1	Country office operations	1,500,000	500,000	2,000,000
2	Emergency preparedness and response	300,000	300,000	600,000
3	Organization of health services	650,000	650,000	1,300,000
4	Health promotion200,000	325,000	525,000	
5	Women's health100,000	125,000	225,000	
6	Making pregnancy safe200,000	264,000	464,000	
7	Child and adolescent health	126,000	406,000	532,000
8	Essential medicines150,000	120,000	270,000	
9	Mental health and substance abuse	150,000	150,000	300,000
10	Communicable disease surveillance	150,000	200,000	350,000
11	Communicable diseases prevention, eradication and control	50,000	350,000	400,000
12	Malaria	350,000	1,200,000	1,550,000
13	Tuberculosis	100,000	450,000	550,000
14	HIV/AIDS	200,000	500,000	700,000
15	Blood safety and clinical technology	50,000	115,000	165,000
16	Health and environment150,000	60,000	210,000	
17	Immunization and vaccine development	100,000	61,282,700	61,382,700
	Total	**4,526,000**	**66,738,700**	**71,264,700**

ANNEX 2 PROPOSED ORGANOGRAM FOR WHO, ETHIOPIA