

COUNTRY COOPERATION STRATEGY 2021–2025

Ethiopia



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Country Cooperation Strategy 2021-2025 — Ethiopia

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FOREWORD

The signing of the Country Cooperation Strategy 2021–2025 reaffirms the strength of the relationship between the World Health Organization, as part of the wider United Nations system, and the Government of Ethiopia.

It advances the World Health Organization's long history of collaboration with the Ethiopian Government and underscores their mutual commitment to work together towards agreed priorities of great importance and relevance to the people of Ethiopia, as envisioned in national development plans and the Sustainable Development Goals.

In line with the strategic priorities of the World Health Organization's Thirteenth General Programme of Work, the Country Cooperation Strategy emphasizes the need for coherence and coordination at all levels of the Organization when working with Ethiopia to help the Government achieve its health sector and the Sustainable Development Goals priorities to their full extent.

In the past five years, Ethiopia has made significant advances in health. Maternal and child health services have improved, with more children living beyond infancy, a larger number of women delivering in health facilities and more births being attended by skilled providers. Access to and provision of preventive, diagnostic and treatment services for communicable diseases have improved. Initiatives to reduce illness and death due to noncommunicable diseases and injuries are gradually being scaled up.

The Country Cooperation Strategy 2021–2025 builds on these achievements and paves the way for a new level of collaboration that is strategically focused, results-oriented, and built on the longstanding partnerships. We look forward to continuing to work together in the coming years to implement this strategy. Together, we will ensure healthy lives and promote well-being for all people in Ethiopia.

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Minister of Health
Ministry of Health

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Regional Director
WHO Regional Office for Africa





EXECUTIVE SUMMARY

The Ethiopia–WHO Country Cooperation Strategy 2021–2025 (CCS) sets out how the World Health Organization (WHO) will work with Ethiopia over the next five years towards the realization of the health-related Sustainable Development Goals in the Ethiopian context, as embodied in the Ten-Year Development Plan of Ethiopia and the Health Sector Transformation Plan 2020/21–2024/25.

In recent years, Ethiopia has undergone impressive economic and social development due to a series of reforms that have dynamically transformed the economy. This has translated into significant poverty reduction and overall human development. Ethiopia envisions becoming a middle-income country and a leading manufacturing hub in Africa by 2025.

Alongside the socioeconomic development has come significant progress in health outcomes. Life expectancy is now more than 66 years, up from 47 years in 1990. Maternal and child health services have improved, with more children living beyond infancy, a larger number of women delivering in health facilities and more births being attended by professional service providers than ever before. Access to and provision of preventive, diagnostic and treatment services for communicable diseases have improved. Initiatives to reduce illness and death due to noncommunicable diseases and injuries are gradually being scaled up.

Despite the substantial progress, achievements in health have not been uniform, and challenges remain. Inequities persist between regions and population groups. Life expectancy has increased, but preventable mortality remains unacceptably high. And although Ethiopia has witnessed a significant decline in common communicable diseases, including malaria, HIV, tuberculosis and vaccine-preventable diseases, the country is experiencing a triple burden of diseases, with growing prevalence of noncommunicable diseases, injuries and mental illnesses. In addition, neglected tropical diseases still affect a large proportion of the population. The health system remains underfunded and fragmented, which undermines its capacity to provide equitable access to good-quality responsive health services. Frequent occurrence of natural and human-made disasters and public health emergencies also overburden the health system and strain available resources. Little attention to prevention and well-being and limited intersector collaboration have weakened the shared responsibility for health.

This Country Cooperation Strategy (CCS) defines the strategic agenda for addressing country-specific bottlenecks to health and development while leveraging resources and partnerships for health in Ethiopia. It provides a high-level overview of WHO's role at its three levels (global, regional and country) and outlines WHO's commitment to achieving impact at the country level. The strategic priorities specified in the CCS are the outcome of a series of discussions with the Ministry of Health and other stakeholders and are based on a critical analysis of the country's needs and WHO's comparative advantage in addressing those needs. The Ministry of Health and WHO are both invested in the development and implementation of this CCS and are accountable for its results.

The CCS encompasses five strategic priorities to support attainment of the vision of “a healthy, productive and prosperous society”, as articulated in the Health Sector Transformation Plan. Its overarching goal is to ensure that all Ethiopians, regardless of age, gender, socioeconomic status or cultural background, have the opportunity to lead healthy lives with equal access to quality health services.

WHO will pursue an integrated approach with dialogues and complementarities across programmes, disciplines and sectors in providing leadership in health and promoting good health and wellbeing of all Ethiopians.



WHO will harness global knowledge to help deliver evidence-informed, context-specific and innovative solutions that will benefit all Ethiopians. WHO will continue to work closely with development partners, including other United Nations agencies, and other multilateral and bilateral partners. The joint work will be guided by the Sustainable Development Goals, the Ten-Year Perspective Development Plan, the Health Sector Transformation Plan II, the United Nations Development Assistance Framework 2020–2025 and the WHO Thirteenth General Programme of Work. As a learning organization, WHO will use its General Programme of Work’s “triple billion” targets (aligned to national strategic priorities) to monitor performance and adapt the way it works in Ethiopia to maximize its contributions.

WHO will pursue an integrated approach with dialogues and complementarities across programmes, disciplines and sectors in providing leadership in health and promoting the good health and wellbeing of all Ethiopians.

1. INTRODUCTION

The Ethiopia–WHO Country Cooperation Strategy 2021–2025 (CCS) guides the application of the World Health Organization's (WHO) expertise, comparative advantage and global strategic priorities, as spelled out in its Thirteenth General Programme of Work and in line with the Government's development priorities.

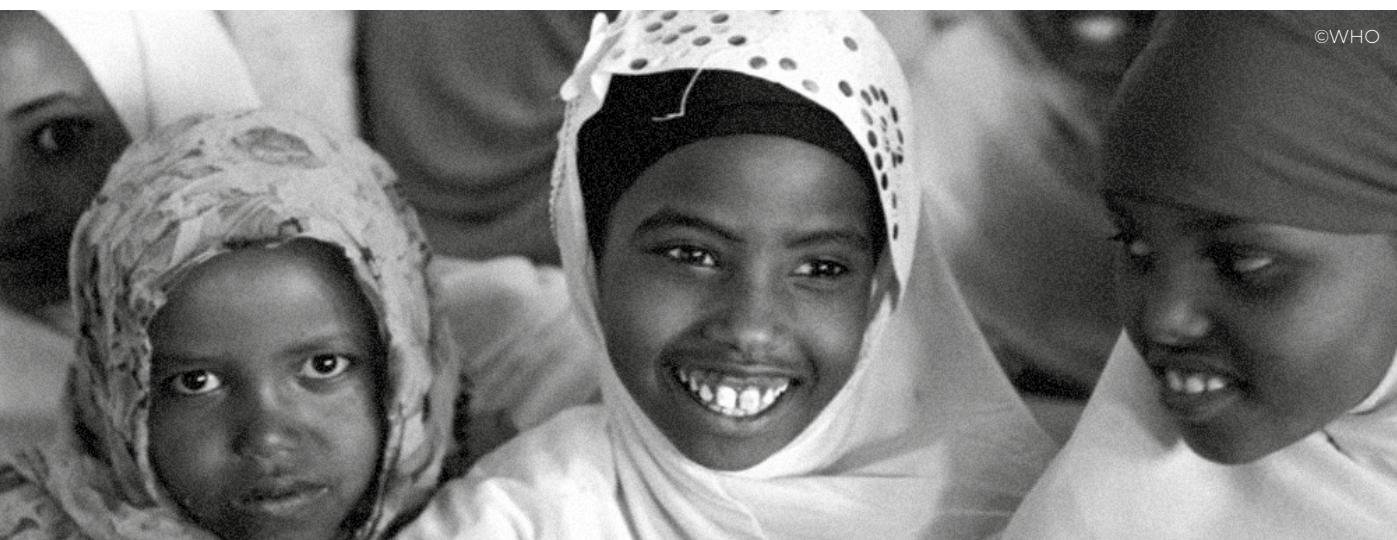
The CCS outlines the framework for WHO's support to the Government of Ethiopia over the next five years. It proposes a strategic approach towards the realization of the health-related Sustainable Development Goals (SDGs) in the Ethiopian context, as embodied in the Ten-Year Development Plan of Ethiopia and the Health Sector Transformation Plan 2020/21–2024/25. It is the vision of WHO in Ethiopia to work for the betterment of the health and well-being of the Ethiopian people and to facilitate the active engagement of Ethiopia in global health.

The CCS priorities were determined in a series of discussions with the Ministry of Health and other stakeholders. They are based on critical analysis of the country's needs and WHO's comparative advantage in addressing those needs. The Ministry of Health and WHO are both invested in the development and implementation of this CCS and are accountable for its results.

The CCS is the strategic basis for WHO's work in Ethiopia, including its results-based planning and programming processes. It represents a high-level overview of WHO's role at its global, regional and country spheres. Signalling WHO's commitment to achieving impact in every country, each CCS provides a clear accountability framework. Central to implementation of the CCS is a coherent One WHO approach.

Recognizing the joint responsibility and accountability of WHO and the Government to improve the health and well-being of Ethiopia's population, the CCS is monitored and evaluated jointly with partners.

In conclusion, the CCS is the principal strategic instrument designating the main domains in which WHO will focus its efforts and resources over the next five years. It does not address the full range of WHO activities. And the Organization remains committed to responding to new needs as they arise.



2. COUNTRY CONTEXT

Understanding the country context is essential for determining the opportunities as well as the health and development challenges in Ethiopia. These are important considerations with huge implications for the work of WHO and other development partners in the country.

2.1 Political, social and economic context



POLITICAL

Ethiopia has an executive prime minister and honorary president as Head of State. The Council of the People's Representatives is the highest authority of the federal Government. The Council of Federation, with 155 seats, has the power to interpret the Constitution. Ethiopia is going through political reforms that will have profound and far-reaching implications for its future.



DEMOGRAPHIC

Ethiopia has a highly diverse population of 114.9 million people (in 2019): 49.8% are women and girls and nearly 50.2% are men and boys. Annual population growth is 2.6%. About 47% of Ethiopians are younger than 15 years. And 80% live in rural areas and depend on rain-fed agriculture for their livelihoods.



SOCIAL

Ethiopia's poverty head count, or the share of the population living on income below the national poverty line, fell from 44% in 2000 to 24% as of 2017. Human development has increased since the mid-1990s. During 2000–2010, Ethiopia's Human Development Index ranking shifted from 0.35 in 2000 to 0.48 in 2019. Keeping pace with economic and human development, the country has done well on gender equality. The Gender Development Index scoring increased from 0.75 in 2000 to 0.84 in 2019.



ECONOMIC

Ethiopia envisions becoming a middle-income country and a leading manufacturing hub in Africa by 2025. This quantitative target is supported by aggressive poverty reduction strategies and advances in health, education and the environment. During the past decade, Ethiopia became one of the fastest-growing economies in the world, with strong, broad-based growth averaging 10% a year. In 2019/20, real GDP growth decreased to 6.1% and is projected to decline further due to the impact of the COVID-19 pandemic.



Ethiopia's strategic location in the Horn of Africa gives it political and economic dominance. Since the mid-1990s, the country has embarked on a series of reforms that has dynamically transformed the economy. For more than a decade, Ethiopia has benefited from unprecedented economic growth—an average gross domestic product (GDP) growth rate of about 10% per annum. This has translated into significant poverty reduction and overall human development.¹ The major engines for the growth include the Government's intensive public sector investment, such as expansion of road infrastructure and the rapid expansion of services, especially in the agriculture, education and health sectors. The latter in particular has had a marked increase in the number of facilities and health workers at the local level.²

Ethiopia envisions becoming a middle-income country and leading manufacturing hub in Africa by 2025.³ This quantitative target is supported by aggressive poverty reduction strategies and advances in health, education and the environment. The recently launched Ten-Year Development Plan of Ethiopia—The Pathway to Prosperity aims to maintain this focus while addressing the macroeconomic imbalances and structural bottlenecks to unlock new growth potential through a comprehensive and well-synchronized set of measures.

The economic fallout of the COVID-19 pandemic could potentially impact the medium- to long-term socioeconomic development, putting at risk development gains achieved to date. According to the International Monetary Fund projections, the economic outlook for Ethiopia looks grim, with a predicted economic growth of 1.9% in 2020 and 0% in 2021.⁴ The pandemic has highlighted key social sectors, like health and education. Encouragingly, the Ten-Year Perspective Development Plan of Ethiopia singles out “quality and universal accessibility of social services and infrastructure” as one of its overarching development objectives. In line with this, the Ministry of Health's Health Sector Transformation Plan II declares the vision of a “healthy, productive and prosperous society”.

2.2 Maintaining the momentum

During the past decade, Ethiopia became one of the fastest-growing economies in the world. Its economy experienced strong, broad-based growth, averaging 10% a year from 2008/09 to 2018/19. In 2019/20, real GDP growth decreased to 6.1%⁵ and is projected to decline further due to the impact of the COVID-19 pandemic. Overall, industry (mainly construction) and services have accounted for most of the growth in past years. More recently, agriculture and manufacturing have made a smaller contribution to growth than in previous years.

The economic dividend has led to positive trends in poverty reduction in both urban and rural areas. The share of the population living on income below the national poverty line decreased from 30% in 2011 to 24% in 2016. The Government launched its new Ten-Year Development Plan in 2020. The plan encourages multisector and diversified sources of development, building up institutional capacity and accountability, creating sustainable job opportunities and ensuring universal access to quality social services and infrastructure. The ten-year plan targets an average of 10% GDP growth annually, with expansion of the industrial sector, manufacturing and services to create more jobs.

Demographically, Ethiopia has a highly diverse population of 114.9 million people (in 2019):⁶ 49.8% are women and girls, and nearly 50.2% are men and boys. Annual population growth is 2.6%. About 47% of Ethiopians are younger than 15 years. And 80% live in rural areas and depend on rain-fed agriculture for their livelihoods.

Ethiopia's poverty head count, or the share of the population living on income below the national poverty line, fell from 44% in 2000 to 24% by 2016. Human development has also increased since the mid-1990s. During 2000–2010, Ethiopia's Human Development Index ranking showed considerable improvement, shifting from 0.35 in 2000 to 0.48 in 2019.⁷ Keeping pace with economic and human development, the country has also done well on gender equality. The Gender Development Index score increased from 0.75 in 2000 to 0.84 in 2019.⁸





2.3 Drivers of progress—Current context and emerging needs

2.3.1 Health and development achievements

Alongside the socioeconomic development has come significant progress in health outcomes. Life expectancy is now more than 66 years, up from 47 years in 1990.⁹ Total health expenditure has increased steadily, growing by 45%, from 49.6 billion Ethiopian birr in 2013/14 to 72.1 billion birr in 2016/17.¹⁰ Government funding for health care has seen a substantial increase, with investments in facility improvements and the deployment of health workers.

Despite encouraging improvements in life expectancy, preventable mortality remains unacceptably high. For instance, while maternal mortality reduced from 676 deaths per 100 000 in 2011 to 401 in 2017, it remains among the highest in the world. Similarly, mortality among children younger than 5 years and infant mortality per 1000 live births remain high, at 59 and 47, respectively, in 2019.¹⁰

Ethiopia is witnessing a significant decline in the morbidity and mortality associated with the common communicable diseases, including malaria, HIV, tuberculosis and vaccine-preventable diseases. However, the country is now experiencing the triple burden of diseases, with growing prevalence noncommunicable diseases, injuries and mental illness. Although the burden of neglected tropical diseases has declined, a large proportion of the population remains affected.

Health services continue to be delivered via the three-tiered system: primary, secondary and tertiary levels of care. Over the years, the primary health care infrastructure, including the Health Extension Programme, has expanded considerably and reached more than 90% of the population in 2019. Similarly, the secondary and tertiary levels of care have been strengthened through strategic initiatives and reforms. Despite this, the outpatient attendance rate remains low, at 0.9 per capita per year.¹⁰

To address the financial barriers to accessing essential health services, several strategies have been implemented. These include the provision of high-impact interventions free of charge through an exemptions programme; subsidization of more than 80% of the cost in public health facilities; implementation of the Community-Based Health Insurance scheme; and full subsidization of indigent population through waiver of user fees and the insurance scheme premiums.



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Measures have also been put in place to address the social determinants of health through multisector engagement. For instance, to support the implementation of the Seqota Declaration multisector collaboration, including health, agriculture, water, irrigation, electricity, education and social protection, the Ministry of Women and Children Affairs was established. The One WASH National Programme brings together the government, development partners and NGO activities into one coordinated programme to modernize the delivery of water, sanitation and hygiene services to people.

2.3.2 Health and equity

Ethiopia is committed to achieving the SDGs by 2030 and to ensuring that no one is left behind. Despite considerable progress, inequalities persist between geographic regions, urban and rural areas and socioeconomic groups. Health financing mechanisms, such as household out-of-pocket expenditures, further sharpen the inequitable access to health services. See Table 1 for a summary of the gender, equity and human rights analysis used when developing the CCS.



Table 1. Gender, equity and human rights analysis for the Country Cooperation Strategy

Evidence and analysis of gender, equity and human rights¹⁰

The coverage of reproductive, maternal, neonatal and child health services remains consistently lower in rural areas and special support regions than in urban locations and non-special support regions. For instance, wide urban-rural disparity exists in facility-based deliveries.

The use of modern family planning methods varies significantly across regions: couple protection rates ranged from 3.4% in Somali Region to 49.5% in Amhara Region. Immunization rates for all basic vaccines range from 18.2% in Somali Region to 73% in Tigray and 83.3% in Addis Ababa.

Access to health services tends to disproportionately benefit those with greater economic means or higher levels of education. Despite government efforts to address financial barriers, large variations in use of reproductive, maternal, neonatal and child health services by educational status and wealth quintiles are observed.

Women in Ethiopia are less likely to receive health services than their male counterparts. Among the major challenges in addressing gender disparities in health are limited enforcement of the laws and policies on the rights of women and girls, limited capacity of health care workers in designing and implementing gender-responsive health services and limited capacity for the provision of comprehensive and multisector services to survivors of sexual gender-based violence. However, efforts to address the gender inequalities in health are still in the early stages.

Gender inequalities resulting from harmful cultural practices and structural and social discrimination contribute to poor health, nutrition, education and livelihood opportunities for women and girls. Compared with men and boys, women and girls are strongly disadvantaged in all sectors.

Despite gains in poverty reduction, major challenges remain. Around 87% of the population is “multidimensionally poor”, suffering from some combination of food insecurity, insufficient access to adequate education and health services and inadequate employment opportunities. These challenges are experienced differently among different population groups, owing to gender and other systemic inequalities. Pastoral and lowland areas, mainly in the regions of Afar, Oromia and Somali, lag on nearly all social indicators.



Overall, there is a pressing need in the health sector to address the sociodemographic and regional disparities in health service access, utilization and outcomes. Unless a strong rights-based approach to health is adopted and inequality reduction mechanisms are substantially scaled up, the proportional progress towards reducing inequities and achieving the health-related SDGs across the regions will be less feasible. There is also a need to further investigate the context-specific barriers and their root causes to reduce the health inequalities in Ethiopia.

2.4 Remaining challenges

Systems fragmentation

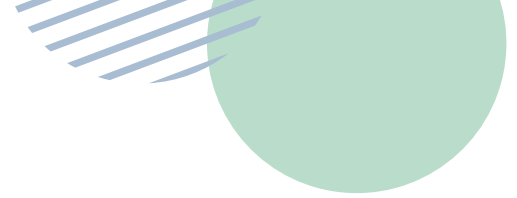
Ethiopian decentralization proceeded in two stages. In the early 1990s, the Government devolved powers to geographically defined ethnolinguistic regions, resulting in the creation of regional and woreda councils (local governing units).¹¹ Beginning in 2001, regional constitutions were revised to pave the way for fiscal decentralization from regions to the woredas.¹²

In the health sector, the Ministry of Health and regional health bureaus focus more on policy matters and technical support, while the woreda health offices manage and coordinate the operations of the district health systems under their jurisdiction. The Health Extension Programme and the Health Development Army network have critical roles in linking with communities.

At the woreda and regional levels, public health spending is driven by recurrent expenditures (89%), whereas it has remained driven by capital expenditure at the federal level. Also, low budget execution at the woreda and regional levels is also a lost opportunity.¹³ Weak institutional capacities have compounded the problem, with suboptimal vertical and horizontal alignments that have significantly affected implementation of the health sector strategies and policies against the targets.

The resulting fragmentation compromises the availability, accessibility and quality of health services. This often leads to clients regularly bypassing primary health care facilities to go directly to secondary and tertiary facilities, thus causing congestion and a waste of resources.





High preventable mortality and morbidity

Ethiopia is facing the triple burden of disease: infectious or communicable diseases, noncommunicable diseases and injuries. Too many Ethiopians suffer from diseases for which well-proven, cost-effective interventions are available.

Although the country is committed to achieving the global targets for ending the HIV and tuberculosis epidemics and elimination of malaria, progress towards the three “95” global HIV targets of 2030 was suboptimal. For the first “95”, 86% of the estimated people living with HIV knew their HIV status. Achievements were better for the second and third 95 targets, with 90% of the known HIV-positive individuals on antiretroviral therapy, of whom 93% had achieved viral suppression.¹⁴ Ethiopia is on track to achieving one of the three targets of the global End TB Strategy—tuberculosis incidence has reduced by 21% from the 2015 estimate. However, progress to reduce tuberculosis mortality was only 15% against the target of 35%. Between 2015 and 2019, malaria deaths dropped from 3.6 to 0.3 per 100 000 population at risk. And malaria incidence dropped from 5.2 million in 2015 to less than 1 million in 2019.¹⁰

Ethiopia is facing a rapid rise in noncommunicable diseases and the main common risk factors causing these conditions, namely tobacco use, harmful use of alcohol, unhealthy diet, physical inactivity and environmental pollution. The country is also witnessing an increase in injuries and mental disorders. Today, noncommunicable diseases account for 42% of deaths in Ethiopia.¹⁵ Despite the increasing burden of noncommunicable diseases, health service delivery in the area is limited. In determining the 2018 services availability and assessment survey (SARA) reported that only 36% of health facilities (excluding health posts) offered diagnosis and treatment for diabetes, while 49% could diagnose and treat cardiovascular diseases, 53% could manage chronic respiratory diseases and 9% could manage cervical cancer. The overall readiness score for these services is low, ranging from 18% for chronic respiratory disease diagnosis and management to 51% for cervical cancer diagnosis.¹⁰

Low focus on prevention and well-being

More needs to be done to empower people to manage their health and well-being. By 2040, noncommunicable diseases are projected to account for almost 70% of the country’s disease burden, up from 17% in 1990. About 16% of the population is hypertensive, with higher prevalence among urban dwellers (22%) than among rural dwellers (13%). Especially worrying is that most noncommunicable disease deaths in Ethiopia, as elsewhere, are premature (before age 70).¹⁵ About 5% of the adult population smokes.¹⁶ The proportion of overweight and obesity among women increased from 3% in 2000 to 8% in 2016.¹⁷ Addressing lifestyle issues has become central to controlling the noncommunicable disease burden.

Ethiopia also lags in sanitation coverage. According to the 2019 Joint Monitoring Programme report,¹⁸ 45% of Ethiopia's urban population and 68% of its rural population use unimproved sanitation facilities, with 5% in urban and 27% in rural communities practising open defecation. In addition, capacity to manage environmental threats, including air and water pollution, is hampered by limited availability of financial and human resources.

The Health Extension Programme provides an important link between the health system and communities. However, in recent years, it has shown signs of slowing down due to several factors: inadequate support from political leadership, dissatisfaction and fatigue of health extension workers and suboptimal facility readiness, including lack of basic amenities and availability of essential commodities. In addition, demand from communities has surpassed the scope of the services provided at health posts. The Organized Community Movement at the Grass-Root Level Strategy has faced a variety of challenges emanating from several factors, including low literacy, slow progress of community training (level-I training), limited supportive supervision, lack of incentives and lack of recognition or appreciation of volunteers.





Recurring health emergencies

Ethiopia is prone to frequent natural and human-made disasters and public health emergencies. Among the natural disasters, droughts are historically common, severely affecting the rain-fed agriculture and aggravating food insecurities. Flash floods and riverine flooding are common in parts of the country, leading to outbreaks of waterborne and vector-borne disease outbreaks.¹⁹ In addition, outbreaks of measles, cholera, meningococcal meningitis and yellow fever are commonly reported. Prevailing reforms in the political sphere and long-suppressed ethnic differences often express violently, leading to rising tensions, mass population displacements and sometimes serious humanitarian crises. In 2020, 1.8 million Ethiopians (50.1% of whom were women and girls and 49.9% men and boys) were internally displaced as a result of conflict, drought or flooding, and 1 million returning internally displaced persons required humanitarian assistance.¹⁰

Antimicrobial resistance also poses a threat to health security. The antimicrobial resistance surveillance programme has registered alarming levels of drug resistance in many pathogens of critical public health significance. The National Strategy for the Prevention and Containment of Antimicrobial Resistance, now in its third edition, adopts the One Health approach to address human health, animal health and environment risks.

Limited intersector collaboration

Health is multidimensional and multifactored. Addressing the determinants of health is a shared responsibility that requires a multisector approach. For example, as the COVID-19 pandemic has shown, responding to an outbreak requires strong collaboration among the sectors for public health, food safety, veterinary medicine, emergency management, international borders, ports, airports, ground crossings, customs, trade, agriculture industry and transportation. And it requires active community engagement and consideration for dominant sociocultural and religious beliefs.

To tackle the social determinants of health, the Ministry of Health initiated Multisectoral Collaboration and Woreda Transformation, consisting of 11 sector ministries.²⁰ While there are many notable initiatives of cross-sector collaboration such as this, the full potential of intersector collaboration remains underachieved. There is no mechanism to coordinate whole-of-government and whole-of-society responses to address health risks. Further work is needed to harness the benefits of strong alliances with other sectors.





3.

A SHARED VISION FOR HEALTH

Ethiopia is a founding member of the United Nations. It has always enjoyed a rich and evolving partnership with the United Nations system on a vast array of issues within the health, development, peace and security and humanitarian spheres.

In 2015, the Government ratified the 2030 Agenda for Sustainable Development. The SDGs have been mainstreamed, aligned with the Second Growth and Transformation Plan 2015/16–2019/20 and the recently launched Ten-Year Perspective Development Plan.

The Ten-Year Perspective Development Plan specifies “quality and universal accessibility of social services and infrastructure” as one of its overarching development objectives. It recognizes the importance of improving education and health outcomes in achieving the vision to make Ethiopia an “African beacon of prosperity”.

The Health Sector Transformation Plan II outlines the strategic framework for the health sector (Fig. 1). Its overall objective is to improve the health status of the population by accelerating progress towards universal health coverage; protecting people from health emergencies; woreda transformation; and improving health system responsiveness. It details five transformation agendas: (i) transformation in equity and quality of health service delivery; (ii) information revolution; (iii) transformation in health workforce; (iv) transformation in financing; and (v) transformation in leadership.

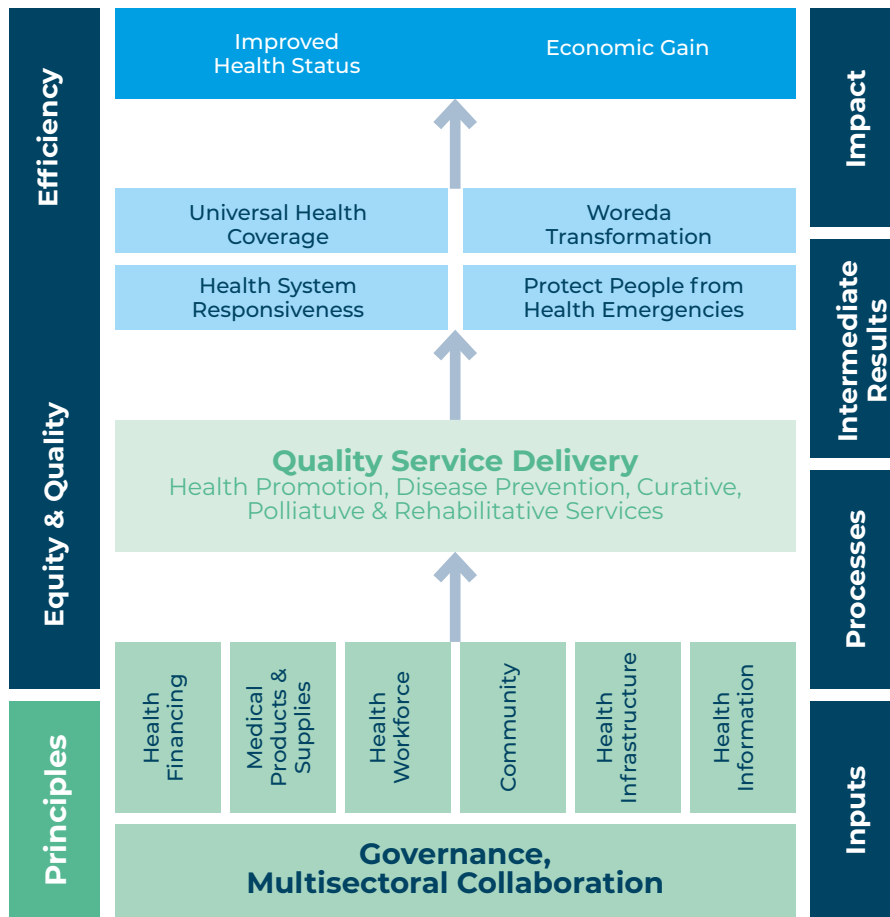


Vision:

To see a healthy, productive and prosperous society

Mission:

To promote the health and wellbeing of the society through providing and regulating a comprehensive package of health services of the highest possible quality in an equitable manner



Source: Health Sector Transformation Plan II.



Alignment with the impact framework of the Thirteenth General Programme of Work

Universal health coverage

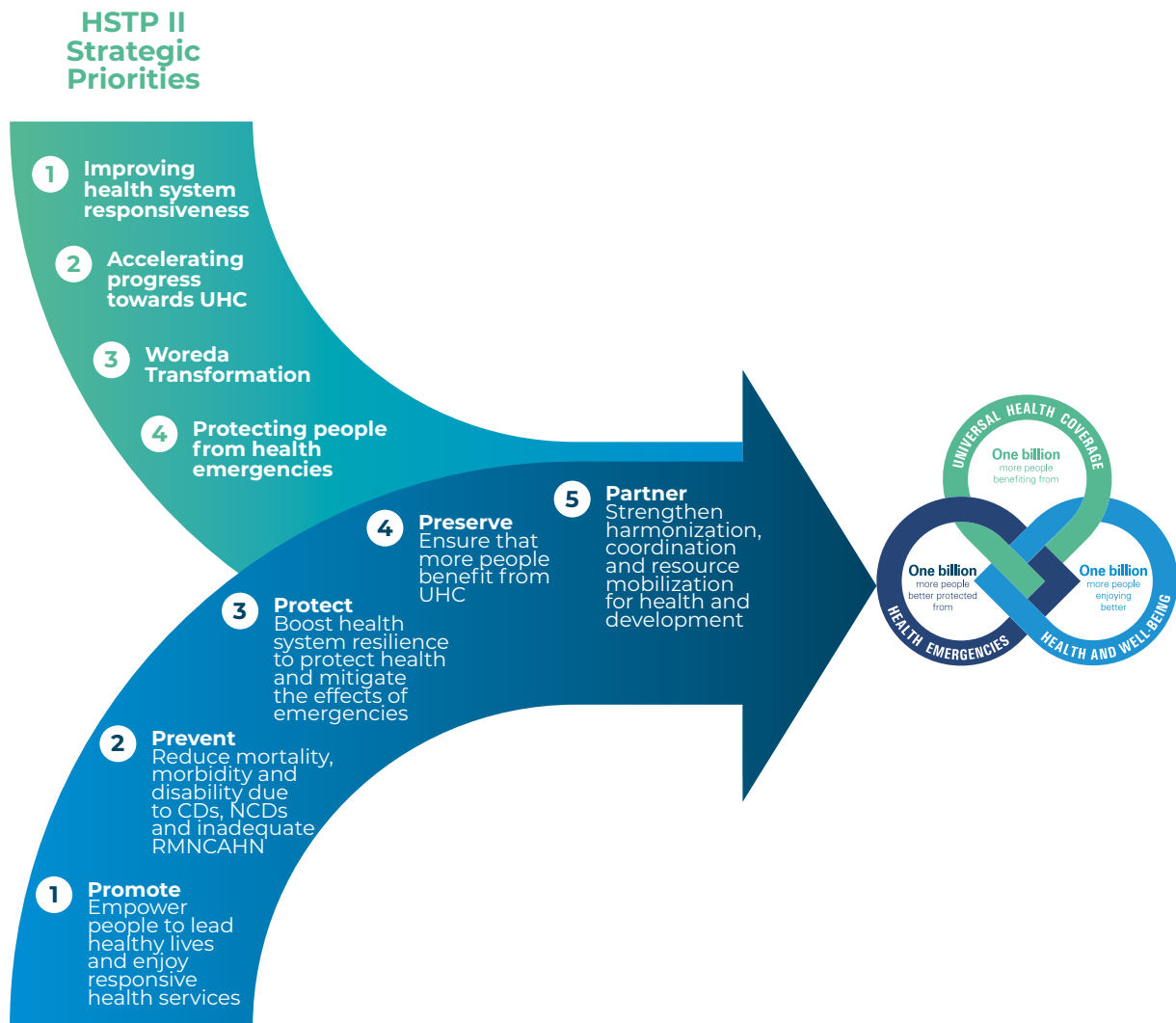
Ethiopia is exploring mechanisms to extend coverage of health services and financial protection to its population, with a commitment to achieving universal health coverage by 2030 through the adoption of innovative approaches to health care issues, including equity and citizen engagement. However, the country faces multiple challenges to improving efficiency and quality across health issues. Low expenditure on health and human resources is a bottleneck at all levels. To improve the current situation, one of the overarching objectives of the Health Sector Transformation Plan II is accelerating progress towards universal health coverage.

Emergency preparedness and response

Ethiopia is prone to multiple human-made and natural emergencies and outbreaks, including natural disasters such as cyclic floods and droughts. These disasters trigger outbreaks of communicable diseases (mainly waterborne and vector-borne diseases), as well as malnutrition and injuries. They also seriously affect the health of the population and overall national economic development. Within the 2019 Global Health Security Index, Ethiopia scored 40.6 and ranked 84th of 195 countries.²¹ To strengthen health system preparedness and resilience, the Health Sector Transformation Plan II specifies protecting people from emergencies as one of its strategic priorities.

Promoting a healthier population

Ethiopia is facing a triple burden of diseases, characterized by an increase in the morbidity and mortality due to noncommunicable diseases (including mental health) and injuries. There is urgent need to address the sociocultural, economic, commercial and environmental determinants of health, including the promotion of healthier lifestyles. An overarching objective of the Health Sector Transformation Plan II is to create a responsive health system with increased local ownership and social accountability through the transformation of woredas.



**CCS
Priorities**

Note:
 HSTP=Health Sector Transformation Plan;
 GPW=General Programme of Work;
 UHC=universal health coverage.

WHO will work together with the Government to help operationalize the Health Sector Transformation Plan II and its vision and continue to work towards the SDGs and other international commitments. This will be achieved through five strategic priorities that are aligned with its Thirteenth General Programme of Work and that complement the Government’s development priorities (Fig. 2).

4. ETHIOPIA–WHO COOPERATION FOR HEALTH AND DEVELOPMENT

The overarching goal of WHO's support to Ethiopia is to ensure that all Ethiopians, regardless of their age, gender and socioeconomic and ethnocultural backgrounds, have the opportunity to lead healthy and productive lives in a healthy environment, including through timely and equitable access to quality and affordable health services.

Fig 3. Strategic priorities



These priorities emerged through a series of discussions with the Ministry of Health and stakeholders. They are based on critical analysis of the country's needs and WHO's comparative advantage in addressing those needs. The CCS spells out WHO's jointly agreed priorities and their alignment with the national context and needs, specifically the health and development agenda, as well as opportunities for collaboration and interaction between various partners and stakeholders.

Strategic priority 1

Promote: Empower people to lead healthy lives and enjoy responsive health services

The Health Sector Transformation Plan II 2020/21–2024/25 aspires to create a society in which Ethiopians have the means to lead healthy and productive lives and have a health system in which they feel respected, valued and empowered in all of their interactions. This approach requires a significant reorientation of the current system, from a disease- and service-oriented system to a health- and people-oriented system.

The next five years are a critical time for shifting the health paradigm towards empowering people to lead healthy lives. WHO will support the Government in reorienting its health approach in a way that respects people and puts them at the centre—that is, WHO consciously adopts the perspectives of individuals, families and communities and sees them as participants as well as beneficiaries of a trusted health system that responds to their needs and preferences in humane and holistic ways.

WHO will provide help towards the establishment of a national health promotion approach that supports people in leading healthy lives and leverages laws and policies to promote healthy lifestyles.

The following actions will support these goals:

- Support the implementation and monitoring of a comprehensive nutrition programme to address the double burden of stunting and obesity and accelerate progress towards the goals in the Seqota Declaration through coordinated multisector efforts, including smart investments to innovate and find localized solutions.
- Support the adoption of healthy lifestyles with the involvement of individuals and communities as equal partners in the planning, developing and monitoring of their care. Maximize opportunities to create healthy environments, address modifiable risk factors and determinants of health, implement comprehensive school health services and eliminate harmful traditional practices.
- Accelerate progress in achieving tobacco-free societies by supporting the full implementation of evidence-based measures to reduce tobacco use and exposure to tobacco smoke.



- Adopt a people-centred approach to increase the responsiveness of health services, including those related to mental health, neurologic and substance-use problems through early detection and management of acute and chronic conditions. And proactively address the risk factors.
- Improve the capacity of the health sector to deliver services on gender-based violence and violence against child survivors and guide the development of policy and practices to enhance prevention.
- Strengthen health sector capacities in promoting safe WASH and in strengthening health resilience to climate change, including threats arising from air pollution and changing patterns of vector- food- and water-borne diseases.
- Enhance the capacity of a core constituency drawn from the executive and legislative branches of the Government, lawyers, journalists, road safety advocates and civil society to address the issue of road traffic injuries as a major public health concern.

Strategic priority 2

Prevent: Reduce mortality, morbidity and disability due to communicable diseases, noncommunicable diseases and inadequate reproductive, maternal, newborn, child and adolescent health and nutrition

The Government is taking many steps to minimize death and illness from ailments for which well-proven and cost-effective interventions exist. For instance, the country's Expanded Programme on Immunization provides free immunization to children, adolescents and women for recommended vaccines; diagnosis and treatment are provided free for tuberculosis, malaria, HIV, AIDS, rabies and neglected tropical diseases, such as filariasis, schistosomiasis and leprosy. Maternal, neonatal, infant and child health have been strengthened in recent years with the adoption of the Early Essential Newborn Care and Essential Intra-partum and Newborn Care packages and other measures. While these efforts have saved many lives, too many people continue to suffer because they do not have sufficient access to the well-proven, immediate-impact interventions. Many of these people live in geographically isolated areas, are members of vulnerable populations or are otherwise socially or economically disadvantaged. This is particularly true for noncommunicable diseases (NCDs) where access to preventive, curative, rehabilitative and palliative services remains limited.

WHO will support the Government to fast-track interventions that have high and immediate impact on saving lives and avoiding disease so that by the end of this CCS, these interventions become accessible, acceptable and affordable to all who can benefit from them. WHO will focus on supporting the development, implementation and tracking of scale-up strategies that aim for universal coverage, with priority to the high-risk groups, vulnerable populations and the socially or economically disadvantaged groups.

The following actions will support these goals:

- Accelerate progress towards the targeted elimination of tuberculosis, the AIDS epidemic, malaria and viral hepatitis by supporting implementation of evidence-based policy options and innovations using primary health care approaches. Provide technical support to prevent new infections, raise awareness and improve diagnosis, and strengthen the continuum of care. This will also include monitoring and assessment of epidemiological and programmatic trends.
- Intensify the control and treatment of neglected tropical diseases with new and integrated approaches to diagnosis, bringing the point-of-care tool closer to people and advocating new tools for vector control and management.
- Strengthen implementation of reproductive, maternal, neonatal, child and adolescent health policies with a special focus on geographically isolated and disadvantaged areas by providing technical support to identify effective interventions to reduce the maternal, neonatal and under-5 mortality rates by improving timely and responsive access to skilled care. Support meaningful engagement of adolescent and youth in health and wellbeing.
- Expand population coverage under the national vaccination programme by supporting strategies to make vaccines available where and when needed and by creating demand for immunization, including for the COVID-19 vaccines.
- Support the reorientation of health services towards patient-centred care that not only detects and manages acute and chronic diseases, NCDs, surgical care and eye health, but also proactively addresses risk factors and prevents complications. Build capacities across the care continuum, from promotive to rehabilitative and palliative care.





Strategic priority 3

Protect: Boost health system resilience to protect health and mitigate the effects of emergencies

Ethiopia has made major gains in preparing for and responding to natural and human-made disasters and public health emergencies. Climate change has escalated the frequency and intensity of extreme weather events in the country, resulting in frequent droughts and flooding. In addition, ethnocultural uprisings frequently result in tensions, mass population displacement and sometimes serious humanitarian crises. After each disaster, the Government strives to “build back better” with more responsive and resilient health systems and increase the preparedness of the communities.

To tackle natural environmental threats, the Government has taken several initiatives, including the establishment of the Public Health Emergency Management Center. Its role is to coordinate and assist all efforts to improve the preparedness of the health sector to prevent or reduce the public health consequences of outbreaks of diseases, including malnutrition, natural disasters, industrial or technological accidents, displacement of populations, civil unrest, conflicts or acts of terrorism and any other emergency or disaster situations.²² In response to the COVID-19 pandemic, the Ministry of Health and the Ethiopian Public Health Institute acted swiftly to develop an emergency preparedness and response plan. Timely efforts were taken to strengthen the surveillance system and the laboratory and response capacities to contain and mitigate further transmissions.²³

WHO strategic support over the next five years will sustain and augment preparedness against disasters, environmental threats and emerging infections.

The following actions will support these goals:

- Support the Government in consolidating a comprehensive emergency response, including support on strengthening disaster risk management and humanitarian response for health by building generic capacities for preparedness, response and recovery. Provide technical assistance to strengthen the core capacities needed for the functional implementation of the International Health Regulations (2005).
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- Co-lead the national Health Cluster response in emergency situations following natural and human-induced disasters and support the Ministry of Health and the Ethiopian Public Health Institute in the planning, implementation and coordination of disaster risk management initiatives.
- Strengthen links among risk assessments of public health events and emergencies, risk communication and public health laboratory and response systems for timely and informed decision-making.
- Support the emergency care system as the first point of contact for timely and equitable access to care for the injured, including first aid, prehospital care, facility-based emergency unit care, and early critical care and operative care as needed.
- Support the development of a skilled workforce for surveillance, risk assessment and response through expansion of the Field Epidemiology Training Programme network and the emergency medical teams.
- Improve access to safe water and food by providing technical support for water and sanitation safety planning as well as developing the capacities of food inspectors and coordinating bodies that regulate food safety.





Strategic priority 4

Preserve: Ensure that more people benefit from universal health coverage

As a signatory to the Alma-Ata Declaration and the United Nations Political Declaration on universal health coverage, Ethiopia is committed to achieving universal health coverage through the strengthening of primary health care. Since the mid-1970s, Ethiopia has been implementing the primary health care approach to achieve disease prevention and control. The flagship Health Extension Programme was implemented in 2003 to deliver cost-effective basic services to all Ethiopians free of charge. This has improved the utilization of health services by linking communities and health facilities, particularly health centres. Despite consistent implementation of these approaches, the overall service coverage for Ethiopia (at 34.3%) is substantially lower than the SDG target of 80% by 2030,²⁴ and concerns regarding the poor quality of health services remain prevalent. Additionally, out-of-pocket spending remains considerably high.²⁵

An important limitation is the level of decentralization with fragmented lines of accountability, management authority, information flows and financing. To mitigate much of this, the Ministry of Health has deemed woreda transformation as one of its strategic objectives. A transformed woreda will have the capacity and resources to effectively plan and implement health system investments and high-impact health interventions. It will also have the capability to meaningfully engage the community to meet its health and development needs.

The next five years will create opportunity to build up the capacity of national, regional and local institutions for a coordinated approach to health service delivery through joint ownership, unified management and financing and enhanced social accountability. WHO will support the Ministry of Health and the regional health bureaus to build a sustainable health system that is responsive to the differentiated local health needs.





The following actions will support these goals:

- Improve governance and accountability at all levels to enhance the quality, safety, gender-responsiveness and equity of health services through a focus on strengthening primary health care. Build up the capacity of national, regional, zonal and woreda-level institutions on participatory planning, efficient management of resources, effective implementation and monitoring of the chosen interventions, better service delivery and, ultimately, better health outcomes.
 - Support woreda transformation and strengthened local stewardship for health to implement equitable and differentiated service delivery models and governance approaches, including collaboration with the non-health sector to strengthen health promotion and counteract the social and environmental determinants of health.
 - Support efficient and effective regulatory capacity, procurement and management of supplies and logistics for vaccines, modern and traditional medicines and ancillaries, including work on combating falsified medical products. Continue to build up local capacity for the production of pharmaceuticals for increased self-reliance. Promote the rationale use of medicines to address antimicrobial resistance.
 - Ensure protection from catastrophic health expenditures by supporting the expansion and efficiency of the national health insurance schemes and introduction of innovative health systems financing mechanisms.
 - Ensure equitable health workforce distribution and capacity by guiding workforce planning and incentive systems and institutionalizing of competency-based pre-service and in-service training of health workers to optimize their capacity and motivation.
 - Promote evidence-informed policymaking and planning in support of achieving national and global targets by supporting the development of a health information system and an integrated and resilient health information, analysis, planning and research-based approach.
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Strategic priority 5

Partner: Strengthen harmonization, coordination and resource mobilization for health and development

The Government of Ethiopia recognizes that multisector action is crucial for health and well-being. It acknowledges that working beyond the health sector is important to address the complex challenges faced in the efforts to improve health and well-being and to reduce inequities and promote rights-based approaches to programming. The efforts must include collaboration with all relevant stakeholders. Close collaboration with other government sectors and commissions must include education, labour, social affairs, human rights commissions, justice (law enforcement, legislation), agriculture, science, technology, information, social media, women, children and youth affairs, regional state governments and others, including nongovernmental organizations, civil society organizations, religious groups, people's organizations, patient groups, consumer advocacy groups, professional associations, medical societies and academia.

Throughout the CCS cycle, WHO will help the Government determine these opportunities and work with other sectors to develop and implement health-relevant policies, regulations and interventions. WHO will also support the acceleration of health sector interventions that help achieve non-health goals.

The following actions will support these goals:

- Promote multisector approaches to address the social, environmental and economic determinants of health.
- Work with civil society groups and academia to take significant roles in the implementation of health actions and generating evidence to inform decision-making.
- Encourage synergies between the public and private health sectors to ensure universal applicability of clinical and public health standards, guidelines and procedures, and explore mechanisms for increased engagement of private health sector care delivery.
- Advocate for greater regional cooperation and cross-border collaboration for emergency preparedness and response, and equitable access to health services.
- Diversify partnerships for leveraging resources and capacities to support the Government through the United Nations family to contribute to the outcomes of the United Nations Sustainable Development Cooperation Framework.
- Promote the African Union's African Sustainable Development Agenda 2020–2063.

Beyond the United Nations, WHO also has a strong and growing partnership with the African Union and its various organs, such as the Africa Centres for Disease Control and Prevention (Africa CDC), the Pan-African Parliament and the African Union Development Agency. There have been several memoranda of understanding between WHO and these institutions in the past few years to guide their strategic continental partnerships. These are operationalized by way of joint biennial technical workplans on areas of mutual interest.

There is strong collaboration between the WHO Regional Office for Africa and the Africa CDC for continental activities on emergency outbreaks and health security. There is scope to develop distinct bilateral relations between the WHO Ethiopia Country Office and the Africa CDC, given that both are located in Addis Ababa. This relationship would jointly support the Government of Ethiopia in tackling the multiple and simultaneous health emergencies the country regularly faces. This could be formalized by way of establishing communication channels with the Africa CDC for frequent exchange of information and requests for support. It would also enable the sharing of technical and financial resources as well as operational capacity to jointly support Ethiopia.

WHO's work with the African Union Commission spans both noncommunicable and communicable diseases as well as across the health system functions. There are frequent country consultations on continental frameworks, strategies and other normative documents. The WHO Liaison Office to the African Union and the UN Economic Commission for Africa should continue to involve relevant WHO Ethiopia Country Office colleagues to provide critical country perspectives for these continental normative documents.

Finally, in the context of the African Union reforms, the regional economic communities on the continent are to have a growing role in the implementation of decisions made by the African Union Heads of State. There are eight African Union-recognized regional economic communities on the continent, one being the Inter-Governmental Authority on Development (IGAD), which spans the Horn of Africa and includes countries from two WHO regions: Africa and the Eastern Mediterranean. WHO Ethiopia is the steward for relations with IGAD. There is potential to establish formal relations with IGAD through a memorandum of understanding to highlight the critical areas of support that WHO can provide. This sub-regional partnership can be further enhanced by developing a joint technical workplan on WHO's support to IGAD.

5. IMPLEMENTING THE AGENDA— ONE RELEVANT, RESPONSIVE AND ACCOUNTABLE WHO

5.1 How we will work as One WHO and as part of the United Nations family

WHO's unique strength lies in the combined expertise of its three organizational levels: country, region and global. WHO's comparative strength is its global platform; reputation as an impartial convener of a range of partners; stewardship of global standards, frameworks and conventions; role as a trusted and authoritative source of health information; and technical and policy expertise.

The country office is the day-to-day entry point to WHO expertise. In supporting the Ministry of Health, the WHO Ethiopia Country Office aims to be a dynamic place with competitive organizational capabilities and for competent technical experts interested in delivering evidence-informed and innovative solutions that will benefit all Ethiopians. The country office will pursue an integrated approach with dialogues and complementarities across programmes, disciplines and sectors. As a learning organization, WHO is committed to ensure that its staff members regularly update their skills and repurpose as necessary to remain a relevant and valued partner.



Table 2. Implementation support for the Country Cooperation Strategy priorities from WHO

WHO's key contributions		
Country Office	Regional Office	Headquarters
<p>Strengthening the national capacity to detect, diagnose, treat and manage noncommunicable diseases and risk factors within the national health system; emphasis on primary health care to ensure universal health coverage and reduce gender and health equity gaps.</p> <p>Supporting health financing reforms that embrace a social health insurance model.</p>	<p>Boosting the country office capacity to assist in adapting and strengthening health information systems to collect disaggregated data to track disease-related mortality, morbidity, risk factors and health inequities and guide future policymaking.</p> <p>Adapting global tools to the regional context to improve health system governance, including institutional, legal, regulatory and societal frameworks, and coordinating with regional partners to speed up universal health coverage.</p>	<p>Developing guidance and support for improving equitable access to basic technologies and essential medicines, including generic drugs for noncommunicable diseases.</p> <p>Generating international best practices and developing guidance to support Member States in initiating multisector policy dialogue and capacity- building for effective development and implementation of intersector actions and Health in All Policies for universal health coverage.</p>

As a specialized agency of the United Nations, WHO Ethiopia is part of the largest UN Country Team in the world with strong links to regional bodies. This team works to implement the United Nations Sustainable Development Cooperation Framework (2020–2025), which presents the shared objectives of the United Nations system, the areas in which it intends to support the Government of Ethiopia and its people and the expected outcomes of its cooperation.²⁶ The Cooperation Framework is implemented through joint, multiyear workplans in a limited number of areas representing strategic, multidimensional issues that the United Nations pursues collectively. The WHO CCS complements the Cooperation Framework (Fig. 4). In this regard, to reach UNSDCF targets and goals, WHO will explore joint programming opportunities with other UN agencies.



Fig 4. UN Sustainable Development Cooperation Framework 2020–2025 outcomes and partnership

Alignment with the Ten-Year Perspective Plan and SDGs:

<p>1 PEOPLE</p> <p>All people in Ethiopia enjoy the rights and capabilities to realize their potential in equality and with dignity.</p>	<p>1. Quality economic growth. 2. Productivity and competitiveness. 3. Institutional transformation. 5. Equitable participation of women and youth.</p>	
<p>2 DEMOCRACY, JUSTICE & PEACE</p> <p>All people in Ethiopia live in a cohesive, just, inclusive and democratic society.</p>	<p>3. Institutional transformation. 5. Equitable participation of women and youth.</p>	
<p>3 PROSPERITY</p> <p>All people in Ethiopia benefit from an inclusive, resilient and sustainable economy.</p>	<p>1. Quality economic growth. 2. Productivity and competitiveness. 4. Private sector's leadership in the economy.</p>	
<p>4 ENVIRONMENTAL PROTECTION & CLIMATE CHANGE</p> <p>All people in Ethiopia live in a society resilient to environmental risks and adapted to climate change.</p>	<p>6. Climate resilient green economy.</p>	

The Cooperation Framework outcomes have been developed based on theories of change methodology. To achieve desired results under the outcomes, the United Nations will work together to achieve the desired changes. WHO is committed in three of the four outcomes, which detail its contribution in the Cooperation Framework in nine outputs (1.1, 1.2, 1.3, 1.4, 3.1, 3.2, 3.3, 3.4 and 4.3). WHO will continue to implement the WHO CCS and take the initiative to build partnerships among the United Nations Country Team members and with others to contribute to the Cooperation Framework's outcomes and outputs. To ensure complementarity with the Cooperation Framework, the WHO CCS has the same timeline.

Collaboration with the United Nations system at the country level

The United Nations Sustainable Development Cooperation Framework is the most important instrument for planning and implementing United Nations activities at the country level in support of the 2030 Agenda for Sustainable Development. The Cooperation Framework guides the country programme cycle of United Nations agencies at the country level. WHO is part of the United Nations Country Team and recognizes the Cooperation Framework as the main instrument for coordinating efforts. The CCS elaborates the strategic health priorities for WHO, while working together on issues beyond the health sector. It supports implementation of Cooperation Framework-defined health priorities.

5.2 Delivering on the WHO agenda

This CCS aims to support implementation of the Thirteenth General Programme of Work at the country level and the monitoring of results. It focuses on WHO's comparative advantage, organizational resources and expertise to assure public health impact. In implementing the strategic agenda, WHO will emphasize the following means of implementation.

Means of implementation

Technical and policy advice

Leveraging WHO's global, regional and country resources, this CCS will use integrated approaches to strengthen health system responsiveness and resilience. The focus will be on ensuring that WHO support to Ethiopia is sustainable and focused on long-term, gender-responsive solutions, with the principle of leaving no one behind.

Technical cooperation between WHO and the Government will focus on strengthening individual and institutional capacity and providing technical assistance. WHO programmes will be delivered through national frameworks, with regional and global tools adapted to the national context.

Continuing professional development for country office staff and Ministry of Health colleagues will continue to ensure that staff have the required skills and competencies to address and respond to health issues.

Strengthening data demand and use

Recognizing the need for accurate, timely, reliable and usable data to respond to health needs and informed planning for preparedness and prevention, WHO will continue to advocate and support the systematic and transparent appraisal of evidence as an input for policymaking.

Technical cooperation between WHO and the Government will focus on strengthening the availability of quality data and evidence for use by the national and local governments. WHO will continue to support sustainable approaches to strengthening routine health information and disease surveillance systems, including civil registration and vital statistics. This includes support for periodic surveys, web-based tools and reporting systems and establishing a nationwide system to link intersectoral databases.

PHC as a foundation for strengthening health systems

PHC is as a core component of effective, equitable, sustainable and resilient health systems. It addresses the majority of a person's health needs throughout their lifetime. This includes physical, mental and social well-being. PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care.

WHO will support accelerated actions towards universal access to primary health care through the design and implementation of integrated people-centred delivery models focused on local and woreda levels, that provide comprehensive health services, including health promotion, disease prevention, curative care, rehabilitative and palliative care, while ensuring effective referral systems. WHO will also provide guidance to promote active participation of all people, especially women, in the processes of developing and implementing policy and improving health and health care.

Adopt a gender-, equity- and rights-based approach


Key to achieving the health-related SDGs with the objective of leaving no one behind are the efforts to prevent avoidable and unacceptably high inequities in health outcomes in Ethiopia. In response, WHO will prioritize the mainstreaming of gender-, equity- and human rights-based approaches and social determinants across all areas of technical support.

WHO will provide guidance on the integration of sustainable approaches that advance health equity, promote and protect human rights, are gender responsive and address social determinants for different technical programmes and institutional approaches. WHO will also help promote disaggregated data analysis and health inequality monitoring for responsive actions.

Strengthening partnerships and multisector collaboration

The success of the implementation of this CCS will be contingent upon the ability to engage with sectors beyond health, including other United Nations agencies and development partners. In line with the United Nations Sustainable Development Cooperation Framework, to accelerate progress towards the SDGs, WHO will assist the Ministry of Health to advocate for whole-of-government and whole-of-society approaches. WHO will leverage existing platforms, such as the Development Assistance Group, the Joint Consultative Forum, the Joint Core Coordinating Committee and the thematic technical working groups, to coordinate across sectors and partners and collaborate on addressing health risks that exist beyond the health sector.





WHO will continue to work closely with development partners, including other United Nations agencies, and other multilateral and bilateral partners. Joint work will be guided by the SDGs, the Ten-Year Perspective Development Plan, the Health Sector Transformation Plan II, the United Nations Sustainable Development Cooperation Framework 2020–2025 and the WHO Thirteenth General Programme of Work. WHO will also collaborate with partners on the regular reporting of achievements against agreed indicators.

In addition to maintaining its current funding stream, WHO will seek to expand its donor base to mobilize additional funds by engaging in joint programming with other UN agencies, work through the health cluster partners to mobilize resources and harmonize actions in coordination with other relevant clusters such as WASH and nutrition.

Strategic communications

Effective, integrated and coordinated communications are integral to achieving WHO's goal of building a healthier future and delivering on its mission to promote good health, keep the world safe and serve the vulnerable populations.²⁷

WHO will continue to enhance its communication framework to meet the growing need for information, advice and guidance for its audiences. The communications will also foster increased visibility of WHO health messages and adaptation of technical recommendations within the local context.

Risk mitigations

Risk mitigation measures are critical to foresee and counter changes in global health priorities and the financial landscape. For instance, the decision to progressively ramp down the Global Polio Eradication Initiative-funded human resources and their integration into other health programmes will have implications for WHO's technical and financial support. In the face of such changes, WHO must be able to develop new risk management capabilities. This should include the ability to delimit the appetite for risk taking, detect both new potential risks and weaknesses in controls and decide on the appropriate approach to risk management. This will include promotion of transparency and management of corporate-level risk, within the framework of WHO's ethical principles.

6.

ACCOUNTABILITY FRAMEWORK: TRACKING PROGRESS IN A LEARNING ORGANIZATION

The CCS will support the implementation of the Thirteenth General Programme of Work's triple billion targets, based on national strategic priorities identified in consultation with the Ministry of Health and other development partners. The CCS will be more strategically focused on results, with targets and milestones based on outcome indicators to achieve impact, in line with longer-term goals, such as the health-related SDGs.

The CCS serves as the basis for all of WHO's strategic cooperation work with the Government of Ethiopia. It provides the basis for the WHO Country Support Plans and indicates the role of all three levels of the Organization (global, regional and country) in contributing towards the priority outcomes and targets defined at the country level.

At a strategic level, monitoring will be based on a systematic assessment of progress towards the achievement of results, notably towards the targets of the Health Sector Transformation Plan 2020/21–2024/25 and the SDGs. Each of the health-related SDGs can be mapped to one of the CCS strategic priorities, and tracking progress will call attention to areas lagging and needing accelerated support. A mid-term evaluation will be conducted to determine the progress towards the SDGs and national targets as well as towards the achievement of the five cross-cutting CCS strategic priorities.

Operationally, the CCS will be implemented through biennial workplans, which will include objectives, activities and deliverables in line with the CCS framework. These are linked to WHO's internal organizational performance monitoring framework, the basis of which are the organizational outputs formulated in WHO's General Programme of Work. An annual midterm review will take place after the first year of each biennium, and a more comprehensive programme budget performance assessment will take place following the close of the biennium.

As a learning organization, WHO will use the results of monitoring and evaluation to take corrective action to address underperformance or to inform a strategic scaling up of activities to achieve the desired results, as well as to provide instructive experience that guides the next planning cycle.



Table 3. Thirteenth General Programme of Work impact framework indicators at baseline

Policy area WHO GPW13—1 billion / universal health coverage						
Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
1. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease or other noncommunicable diseases	20% relative reduction in premature mortality (age 30–70 years) from noncommunicable diseases through prevention and treatment	18.3% (2016)	1.1	SDG 3.4.1	Survey (WHO Report; 2-3 years)	Premature mortality from major non-communicable disease
2. Proportion of women of reproductive age (15–49 years) whose family planning needs are met with modern methods	Increase the proportion of women of reproductive age (15–49 years) whose family planning needs are met with modern methods to 66%	62.3% (2018)	1.1	SDG 3.7.1	EDHS	Contraceptive Prevalence Rate
3. Tuberculosis incidence per 100 000 population	Reduce by 27% the number of new TB cases per 100 000 population	164 (2017)	1.1	SDG 3.3.2	Program Specific Survey/ EDHS	TB case detection rate
4. Maternal mortality ratio	Reduce the global maternal mortality ratio by 30%	353 (2015)	1.1	SDG	EDHS	Maternal Mortality Rate per 100,000 live birth
5. Number of new HIV infections per 1000 uninfected population, by sex, age and key populations	Reduce number of new HIV infections per 1000 uninfected population by sex, age and key populations by 73%	0.17 (2017)	1.1	SDG 3.3.1	Survey/ EDHS	Proportion of PLHIV who know their HIV status
6. Age-standardized prevalence of raised blood pressure among persons older than 18 years (defined as systolic blood pressure >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure	20% relative reduction in the prevalence of raised blood pressure	30.3% (2015)	1.1	WHA 66.10	Survey/ STEPS	Proportion of hypertensive adults diagnosed for HPN and know their status
7. Health worker density and distribution	Increase health workforce density, with improved distribution	1 physician per 10 000 8.4 nurses per 10 000 (2017)	1.1	SDG 3.c.1	HRIS/HMIS	Health workers density per 1,000 population

Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
8. Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access among the general and the most disadvantaged populations)	Increase coverage of essential health services (universal health coverage Service Coverage of Index*)	39 (2015)	1.1	SDG 3.8.1	HMIS, DHIS, EHIA	UHC index
9. Proportion of births attended by skilled health personnel	Reduce the global maternal mortality ratio by 30% (proportion of births attended by skilled health personnel (%))	27.7% (2016)	1.1	SDG 3.1.2	HMIS/EDHS	Proportion of deliveries attended by skilled health personnel
10. Under-5 mortality rate	Reduce the preventable deaths of newborn (neonatal mortality rate) and children younger than 5 years (under-5 mortality rate) by 17% and 30%, respectively	58.5/28.9 (2017)	1.1	SDG 3.2.1	EDHS/ MiniDHS	Under 5 Mortality Rate per 1,000 Live Birth
11. Neonatal mortality rate	Reduce the preventable deaths of newborn (neonatal mortality rate) by 17%	28.9% (2017)	1.1	SDG 3.2.2	EDHS/ MiniDHS	Neonatal Mortality Rate per 1,000 Live Birth
12. Proportion of the target population covered by all vaccines in the national programme	Increase coverage of second dose of measles vaccine to 85%	44% (2017)	1.1	SDG 3.b.1	EDHS	Fully immunized children coverage

Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
13. Number of people requiring interventions against neglected tropical diseases	Reduce by 400 million the number of people requiring interventions	69 802 693 (2017)	1.1	SDG 3.3.5	NTD Survey	Proportion of Trachoma endemic woredas with Trachomatous Inflammation Follicular (T.F) to < 5% among 1 to 9 years old children
14. Malaria incidence per 1000 population	Reduce malaria case incidence by 50%	37.37 (2017)	1.1	SDG 3.3.3	HMIS	Malaria incidence rate (per 1000 population at risk)
15. Proportion of population with large household expenditure on health as a share of household expenditure or income services	Stop the rise in percentage of people suffering financial hardship (defined as out-of-pocket spending of total exceeding ability to pay) in accessing health	31% (2016)	1.2	SDG 3.8.2	NHA	Out of pocket expenditure as a share of total health expenditure
16. Proportion of health facilities that have a core of relevant essential medicines, available and affordable on a sustainable basis	Increase the availability of essential medicines set for primary health care, including those free of charge, to 80%	79.2% (2018)	1.3	SDG 3.b.3	SARA/HMIS	Availability of essential medicines by level of health care



Policy area WHO GPW13—1 billion / universal health coverage

Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
1. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Decrease the proportion of ever-partnered women and girls aged 15–49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15%	-	3.1	SDG 5.2.1	HMIS	Proportion of health facilities providing comprehensive care to survivors of GBV/SV
2. Death rate due to road traffic injuries (per 100 000 population)	Reduce the number of global deaths and injuries from road traffic accidents by 20%	26.7% (2016)	3.1	SDG 3.6.1	HMIS	Mortality rate from all type of injuries per 100,000 population
3. Proportion of population using (a) safely managed sanitation services and (b) handwashing facilities with soap and water	Provide access to safely managed sanitation services for 800 million more people	1.02% (2015)	3.1	SDG 6.2.1	Survey/ EDHS	Proportion of households having basic sanitation facilities
4. Prevalence of stunting (height-for-age ≤ 2 standard deviation from the median value of the WHO Child Growth Standards) among children younger than 5 years	Reduce the number of stunted children younger than 5 years by 30%	38.4% (2016)	1.1	SDG 2.2.1	EDHS/ MiniDHS	Stunting prevalence in children aged less than 5 years (%)
5. Prevalence of malnutrition (weight-for-height ≥ 2 or ≤ 2 standard deviations from the median value of the WHO Child Growth Standards) among children younger than 5 years (wasting)	Reduce the prevalence of wasting among children younger than 5 years to less than 5%	9.9% (2016)	1.1	SDG 2.2.1	EDHS/ MiniDHS	Wasting prevalence in children aged less than 5 years (%)
6. Age-standardized prevalence of current tobacco use among persons aged 15 years and older	25% relative reduction in prevalence of current tobacco use in persons aged 15 years and older	4.4% (2016)	1.1	SDG 3.a.1	STEPS Survey	Prevalence of current tobacco use in persons aged 15+ years (HSTPII M&E)

Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
7. Harmful use of alcohol, defined according to the national context as per capita consumption (aged 15 years and older) for a calendar year in litres of pure alcohol	7% relative reduction in the harmful use of alcohol as appropriate, within the national context	2.85 litre per capita (2016)	3.2	SDG 3.5.2	STEPS Survey	Prevalence of harmful use of alcohol in persons aged 15+ years

Policy area WHO GPW 13—1 billion / Health emergencies

Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
1. International Health Regulations capacity and health emergency preparedness (percentage of attributes of 13 core capacities that have been attained at a specific point in time)	Increase in the International Health Regulations capacities of Member States	79.11% (2017)	2.1	SDG 3.d.1	PHEM	Health Security Index
2. Vaccine coverage of at-risk groups for epidemic- or pandemic-prone diseases	Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza	X	2.2	WHE	WHO GHO	-
3. Number of cases of poliomyelitis caused by wild poliovirus	Eradicate poliomyelitis to zero cases caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines to stop outbreaks caused by vaccine-derived poliovirus	0 (2017)	2.2	WHA 68.3	PHEM	-

Indicator	2023 Milestone GPW13 or CCS	Country baseline	GPW-13	SDG or World Health Assembly	Data Source	HSTP II Indicator
4. Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population	Reduce the number of deaths, missing persons and persons affected by disasters per 100 000 population	0 (2013)	2.3	SDG 1.5.1	PHEM/Health Security Index	-
5. Proportion of vulnerable people in fragile settings provided with essential health services	Increase the number of vulnerable people in fragile settings provided with essential health services to at least 80%	-	2.3	WHE	PHEM/Health Security Index	-

Financing the strategic priorities

The proposed CCS financing is closely linked to the WHO Country Support Plan, which translates the CCS priorities in WHO-led support for its country work. The five-year budget estimate is detailed in the following table.

Table 4. Five-year Country Cooperation Strategy budget

Strategic priority	Estimated budget required (A)	Anticipated funding (B)	Anticipated funding gap (C)
Promote: Empower people to lead healthy lives and enjoy responsive health service	US\$ 8 250 000	US\$1 250 000	US\$7 000 000
Prevent: Reduce mortality, morbidity and disability due to communicable diseases, non-communicable diseases and inadequate reproductive, maternal, newborn, child, adolescent health and nutrition	US\$ 25 000 000	US\$ 12 500 000	US\$ 12 500 000
Protect: Boost health systems resilience to protect health and mitigate effects of emergencies	US\$ 31 250 000	US\$ 17 500 000	US\$ 15 000 000
Preserve: Ensure more people benefit from universal health coverage	US\$ 10 000 000	US\$ 5 500 000	US\$ 4 500 000
Partner: Strengthened harmonization, coordination and resource mobilization for health and development	US\$ 5 000 000	US\$ 1 250 000	US\$ 3 750 000
TOTAL	US\$ 79 500 000	US\$ 38 000 000	US\$ 41 500 000

(A) Planning and technical networks should devise and use a consistent methodology to define the budget, including main planned activities across all three WHO levels, scale of the problem and historical costs.

(B) Based on historical funding and anticipated funding from donors in priority areas. The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. More details at SDG 3.8.1 metadata source, <https://unstats.un.org/sdgs/metadata/>.

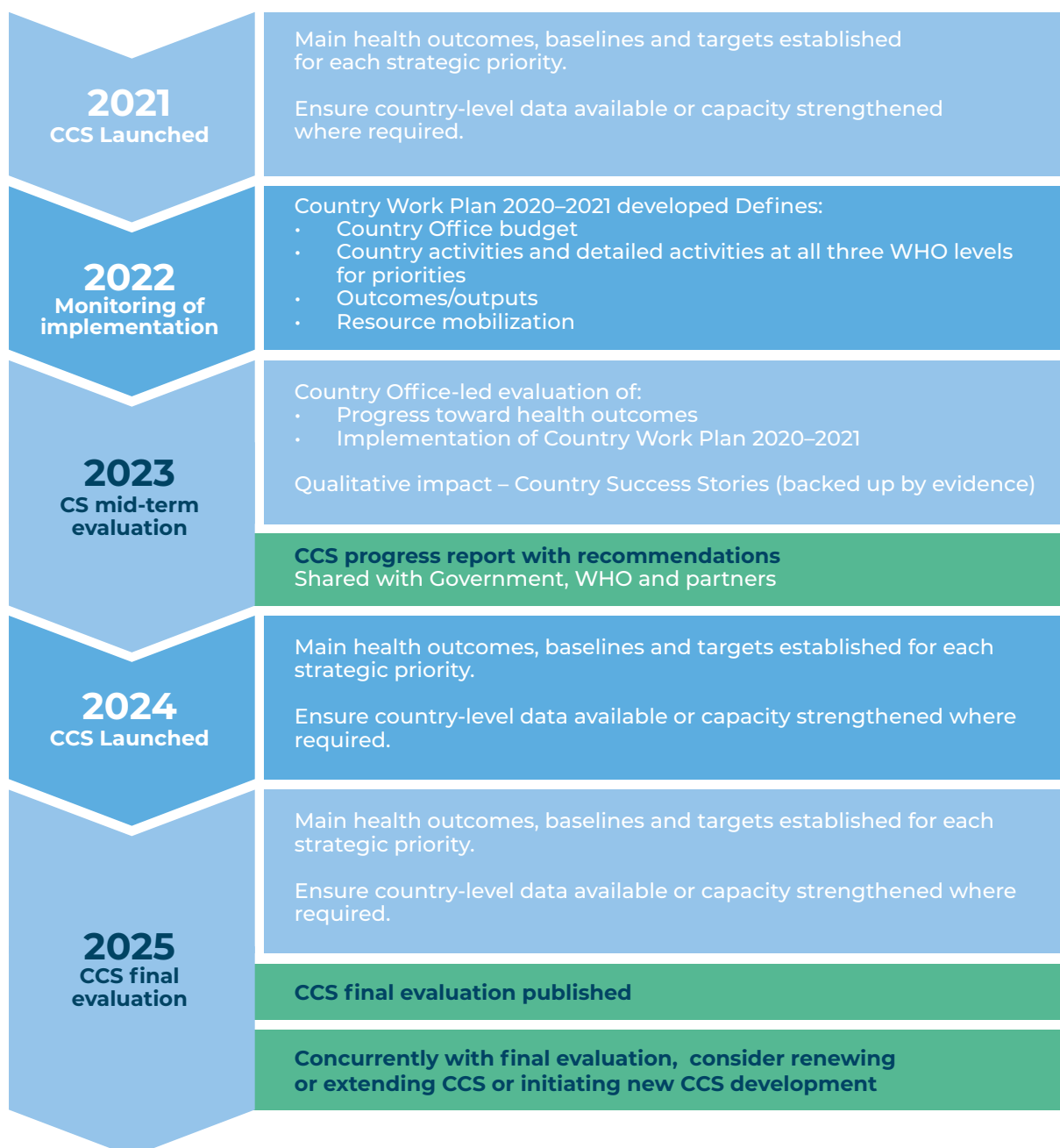
(C) A minus B. The funding gap serves as the basis for the country resource mobilization plan.

To deliver on the CCS priorities, WCO has identified that it needs US\$ 79.5 million, which will come from both assessed contributions and voluntary contributions. This represents an increase of 13% over the five-year period when compared to the approved base Programme Budget for 2020–2021.

The resource mobilization strategy will therefore seek to improve the quality of funding, with a view to increased predictability and flexibility, and streamline the management of funds. The strategy will focus on meeting our partners' expectations in exchange for their contributions, with a clear emphasis on delivery and results that is complemented by professional and consistent donor relationship management and visibility, creating a virtuous circle of confidence.

7. MONITORING AND EVALUATION

KEY MILESTONES, APPROACH & ACTIVITIES



While CCS monitoring is the responsibility of the WHO Country Office, it will be done in collaboration with the Government, health partners, and involve all three levels of the Organization to encourage joint ownership of results.



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