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MINISTRY OF HEALTH-ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!

National Health Equity Strategic Plan

2020/21-2024/25

December, 2020
Addis Ababa

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2020/21-2024/25

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Foreword

Ethiopia has implemented successive Health Sector Development Plans (HSDPs) in four phases (1997 – 2015 GC). During these periods a country has achieved various health related Millennium Development Goals (MDGs) and its targets. Hence, there was an accelerated expansion of Primary Health Care (PHC) facilities, massive training and development of lower and midlevel health workforce, training and deployment of lower and midlevel health workforce, improving access to essential medicines and enhancement of community engagement and ownership. To sustain the achievements of MDGs by aligning with global Sustainable Development Goals (SDGs) AND Envisioning Ethiopia's path towards Universal Health coverage (UHC) through strengthening PHC, the Health Sesctor Transformation Plan (HSTP I, 2015/16 – 2020 GC) was developed and implemented. During these periods, the country has made remarkable achievements in major health outcomes.

Despite encouraging results, the country still has high rates of morbidity and morality from preventable causes. Also, there is a dispartity in access, coverage and quality of high impact interventions among regions, zones, woredas and health facilities. Besides, the disparity is common among diffenet segments of the population. To address these disparities, the Ministry of Helath (MoH) has established Health Systems Strengthening Special Support Directorate (HSSSSD) during 2009 GC. The directorate aimed a addressing geographical inequalities by implementing health system strengthening internventions tailored to the four developing regions. These efforts were expanded to low-performing areas and pastoralist zones of agrarian regions during HSTP I. In order to implement the Equity and Quality transformation agenda depicted in the HSTP I, the Equity Plans of Action (2016-2020 GC) was developed and implemented. As a result of these interventions there are improvements in implementation capacity of the regions, access to health care, essesntial medical supplies and health management Information System. Moreover, human resuources for health development and capacity building including Health Extension Program Strategy adaptations for the pastoralist communities were performed.

However, social determinants of health continued to hinder the path towards addressing health inequity and socio-cultural attitudes that threaten health and wellbeing of the population. There is also an inadequate incentive for service providers.

Cognizant of these, the MoH planned to address health inequity by meeting the targets in SDG-3, SDG-10 and National HSTP II. For the implementations in assuring the UHC focusing on access to quality essential health –care services and access to safe, effective, quality and affordable essential medicines and vaccines for all including financial risk protection stipulates the importance of addressing inequality. In these regards the dimensions of inequity that has to be addressed includes geography, gender, age wealth, education and disability status. Indeed, the focus of addressing avoidable health inequalities requires a shift in the status quo to drive improvements at national scale over improvements at national scale over the next five years. Thus, the National Health Equity Strategic plan is a vital instrument to guide our investment towards ensuring health equity.

The National Health Equity Strategic Plan in line with HSTP-II, has set ambitious goals to improve health equity gaps through addressing acess, coverage and utilization of essential health services, improve quality of health care services, and enhance the implementation capacity of the health systems to attain the theme of UHC ‘no one should left behind by 2030’

The government of Ethiopia has strong political, professional and technical commitment to address the aforementioned startifier of health inequity. Furthermore a comperehensive and integrated investment among stakeholders is crucial to reduce and prevent health inequity.

Finally, I am confident with the unwavering political commitment of our government, strong multisectorial approach, commitment of donors, development partners, civic society organizations, universalities, public private partnership, engagement and ownership of the community and the steadfast commitments of our health workers, we will achieve the goals and targets of this strategic plan.

Lia Tadesse (Dr.)
Minister, Minstry of Health
Federal Democratic Republic of Ethiopia

Acknowledgments

The preparation of this strategic plan wouldn't have been successful without the continued commitment of different stakeholders. On behalf of Ministry of Health (MoH), I would like to whole-heartedly extend heartfelt thanks and appreciation to all institutions and individuals who participated in the development of National Health Equity Strategic Plan (2020/21-2024/25).

My special recognition and appreciation also goes to the following development partners who provided technical and financial support during the development of this strategic plan, DFID, WHO, UNICEF, Save the Children, AMRFF Health Africa, Transform HDRS, JSI-I 10K. Engender Health, Emory University and JSI- UIH.

Lastly, I would like to confirm the Ministry's commitment to implement this strategic document to realize the ambitious targets and goals depicted in the document.

Dereje Duguma (MD, MIH)
State Minister, Ministry of Health
Federal Democratic Republic of Ethiopia

Key message from the director

Ethiopia has made strong commitments to advance health equity. The country has put health equity as a priority transformation agenda in the HSTP II that aspires to promote "qual access to essential health services, equal utilization for equal need, and equal quality of care for all".

Over the past decade, the directorate has implemented various interventions focusing on health system strengthening tailored to the context of developing regions, pastorialist and low performing zones. As a result, the health service disparities among the regions interms of access and utilization in key maternal and child health outcomes are being narrowed.

Even if there were promising achievements in health status of the population, there is a huge disparity in levels of achievement among regions, between rural and urban, among socioeconomic status and the types of services delivered. In fact, addressing health and health care disparities is vital not only from a health equity standpoint, but also for enhancing health more broadly in achieving improvements in overall quality of care and health of the population.

The development of this strategic document followed a series of consultative meetings by engaging the relevant stakeholders, excutive and management committees, Joint Steering committee, regional health bureaus, development partners, professional associations and house of people's representatives. To this end, the strategic objectives in the document as a baseline are formatted from the past five year's equity plan for action performance.

The strategy focused on the improving accessibility of health facilities, leadership and governance, building resilent health system, engaging all stakeholders and community, inclusion of equity in all national goals and targets. A comprehensive and integrated approach through evidence based decision making that is directed at the areas with greatest need, including most marginalized and disadvantaged populations in particular, minimizing the disparities in key health outcomes will be implemented.

Gemu Tiru Bati (BSc, MPH)
Director, Health System Strengthening Special Support Directorate

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Acronym/Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APTS	Auditable Pharmaceutical Transaction System
ARI	Acute Respiratory Illness
BCC	Behavioural Change Communication
BPR	Business Process Reengineering
CBHI	Community Based Health Insurance
CDC	Communicable Disease Control
CHIS	Community health information system
CPD	Continuing professional development
CSOs	Civil Society Organizations
DFID	Department for International Development
DHIS2	District Health Information System
EDHS	Ethiopian Demographic and Health Survey
DRS	Developing Regional States
DTC	Drug and Therapeutic committee
EMDHS	Ethiopian Mini Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EMR	Electronic Medical Record
EPHI	Ethiopian Public Health Institute
EPI	Expanded Program on Immunization
EPSA	Ethiopian Pharmaceuticals Supply Agency
FDRE	Federal Democratic Republic of Ethiopia
FGC	Female Genital Cutting
FDA	Food and Drug Authority
FHPCO	Federal HIV prevention and control office
GDP	Gross Domestic Product
GIS	Geographic Information System
GOE	Government of Ethiopia
GTP	Growth and Transformation Plan
HCMIS	Health community management information system

HDA	Health Development Army
HEP	Health Extension Program
HEWs	Health Extension Workers
HIS	Health Information System
HMIS	Health Information Management System
HPF	Health Pool Fund
HRH	Human Resource for Health
HRIS	Human resource information system
HSDP	Health Sector Development Program
HSS	Health System Strengthening
HSSSSD	Health Systems Strengthening Special Support Directorate
HSTP II	Health Sector Transformation Plan II
ICT	Information Communication and Technology
IEC	Information Education Communication
IMR	Infant Mortality Rate
IPLS	Integrated Pharmaceutical Logistic Management system
ISS	Integrated Supportive Supervision
JSC	Joint Steering Committee
JSI	John Snow Ink
LB	Live Births
LIS	Laboratory information system
LMG	Leadership Management and Governance
LMIC	Lower Middle Income Countries
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio

MNCH	Maternal, Neonatal , and Child Health
MoH	Ministry of Health
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
NHA	National Health Accounts
NMR	Neonatal Mortality Rate
OOP	Out of Pocket
OPD	Out-patient Department
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PNC	Post Natal Care
RDF	Revolving Drug Fund
RHBs	Regional Health Bureaus
RMNCAYH	Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendants
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SRH	Sexual and Reproductive Health
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WBP	Woreda Based Planning
WHO	World Health Organization
WoHO	Woreda Health Office

Executive Summary

Ethiopia is the second most populous country of Africa with a population of 102,850,793 million having growth rate of 2.6% in 2020 and ranks 12th in the world. The country is home to various ethnicities, with more than 80 different spoken languages. The life expectancy of Ethiopia reached 65.3 years (67.3 and 63.7 years for females & males respectively) in the year 2016.

Health services in Ethiopia have shown improvement in the past three decades; according to EDHS MMR declined from 871 (2000) to 401 (2017) per 100,000 live births; a reduction of 54%. Similarly, under five children mortality and infant mortality declined from 166 to 59 and from 97 to 47 in 2000 and 2019, respectively. Also, neonatal mortality has declined from 49(2000) to 29 in 2016. However, it showed increment from 29 to 33 in 2019.

The contraceptive prevalence rate (CPR) for currently married women age 15-49 years in Ethiopia is 41.4 %, in 2019. According to mini EDHS 2019, the coverage of ANC4+ increased from 31.8% (2016) to 43.0% (2019). However, the regional disparity indicates 56.5% and 63.9% for Tigray, 11.8% and 11.1% for Somali in 2016 and 2019, respectively. The highest improvement in ANC_4 services was gained in Amhara and Oromia, 19.3% and 18.4% respectively, while Gambella region experienced a reduction of -11.6%[1]. The skilled birth attendance increased from 27.7% (EDHS2016) to 49.8% (mini EDHS 2019), an increase of 22.1%.

According to Mini EDHS 2019, the proportion of surviving infants who received a third dose of pentavalent vaccine before their first birthday was 61% with Addis Abeba recording the highest (93.1%) and the lowest in Afar with (25.9%). The full immunization coverage has increased steadily from 14.30% in 2000 to 43.19% in 2019. Also, the prevalence of stunting decreased from 58% (2000) to 37% in 2019, an average decline of more than one percent per year. On the other hand, the prevalence of wasting showed insignificant change during the same periods (a decline from 10% in 2016 and to 7% in 2019).

Despite progress made in narrowing

1 Stat Compiler

inter-regional health disparities, the rate of change has been slow due to inconsistent focus and follows up to regions. Such disparities persist in the face of a number of on-going and inter-related challenges with the most critical being inadequate financing and associated high out of pocket expenditure for health services, poor health planning and healthcare worker capacity. Other challenges include a lack of last mile drug delivery in the developing regions, the need to address a wide range of socio-cultural beliefs that contribute to behaviours that undermine health and limit health-seeking behaviour and service utilization. In addition, lowland parts of Ethiopia also experience annual cyclical drought resulting in post drought crisis such as poverty, reduced food security, population's displacement and public health emergencies. International investment also tends to be emergency oriented, allowing inadequate time and investment to address the underlying contributing factors.

Therefore, the health sector with stakeholders has prepared the National Health Equity Strategic Plan(NHESP), in line with HSTP II, setting ambitious goals to narrow the health equity gaps especially those related to (gender, age, wealth, education, residence, geography, and people with special needs).The NHESP also aims to expand essential health services coverage and utilization, improve quality of healthcare services, emergency preparedness and enhance the implementation capacity of the health sector at all levels of the health system.

Vision: To see all Ethiopians receiving the highest possible quality health care services in an equitable manner

General Objective: To narrow the existing inequities in health care services in terms of access, uptake, quality including contributing towards addressing the social determinants of health by the end of 2025.

Pillars of Health Equity

- Excellence in Access and Uptake to Essential Health Service Packages
- Excellence in Leadership and Governance
- Excellence in Evidence Generation and Knowledge Management

Strategic Directions

- Enhance provision of equitable and quality comprehensive health service delivery
- Improve accessibility of health facilities in all regions
- Community Engagement and Empowerment
- Resilient health system, emergency management and one health approach
- Improve Health Commodity Supply Chain and Logistics Management
- Enhance Leadership, Management and Governance
- Health Equity in all policies, strategies and program
- Improve research and evidence based decision making
- Enhance Health Financing

The plan will be cascaded to all levels and will be translated into annual operational plans using the Woreda-based health sector annual plan. Its implementation will be regularly monitored using the agreed monitoring system in a coordinated manner.

Costing: The total cost estimated to implement the strategy is 26,984,704,475 (Twenty six billion nine hundred eighty four million seven hundred four thousand four hundred seventy five ETB).

The major cost drivers for this strategy are,

- Construction of health facilities and equipping it with basic amenities (water, electricity and sanitation facilities),
- Design and implement interventions that address social determinant of health,
- Design and implement Maternal, neonatal, child health , adolescent, youth and nutrition projects and,
- Strengthen emergency preparedness, management and mitigation of public health emergencies

1 Introduction

1.1 Background

Ethiopia has transformed from a country of low health profile to an exemplary nation with better health services and outcomes in sub-Saharan Africa through its innovative primary health care programmes over the last three decades. However, while the nation has scored impressive reduction in morbidity and mortality, and narrowed disparities in access to primary health care(PHC), there is persisting regional and intra-regional disparities in major health outcomes and impact indicators, pointing to the critical importance of better targeting populations with the poorest health. Only by addressing these equity challenges that Ethiopia will be able to fulfil its vision of achieving universal health coverage (UHC) by 2030.

There is ample evidence that social determinants of health including education, employment status, income, gender, ethnicity and religion have a marked influence on health. In the country there are wide disparities in the health status of the population linked to an individual's geographical location, place of residence (urban/rural), social status, income, ethnicity, gender, people with special needs and environmental conditions. Even though robust data is not currently available, it is likely that some particularly vulnerable population groups such as street children, people with special needs particularly those in congregate settings, single-headed households, mobile populations and commercial sex workers face enormous challenges in accessing appropriate essential health services leading to poorer health outcomes than the general population.

A large number of factors continue to undermine progress to close the equity gaps including insufficient human resources for health (HRH), poor healthcare infrastructure, inadequate financial allocations, weak leadership capacity, poor planning and execution and weak delivery of drugs and medical supplies systems just to mention a few. In addition, non-health sector factors like wider social determinants of health and socio-cultural attitudes that threaten health and wellbeing of women and girls fuelled by weak multisectoral approach and incentives to facilitate the system to prioritize the most vulnerable population groups and communities in the country.

Health inequities are unfair and could be reduced by the right mix of government strategies. The factors that make up the root causes of health inequities are diverse, complex, evolving, and interdependent in nature. It is important to understand the underlying causes and conditions of health inequities to inform the complex and effective interventions aiming to promote health equity across all segments of the Ethiopian population through implementing targeted programs for the most vulnerable and disadvantaged, narrowing the performance gap between the highest and lowest population subgroups and interventions that address the general populations.

The development of this strategy is a result of frequent consultative meetings with all relevant key stakeholders including executive and management committees in the ministry, regional health bureaus, development partners, professional Associations and house of people's representatives (social, agriculture, climate change and pastoral standing committees). The strategic objectives are formulated from the last five years performance of equity plan of action by evaluating what has been achieved and the persisting gaps for future engagement in order to implement a comprehensive approach to addressing health related factors including different contextual factors around determinants of health contributing to health inequities.

1.2 Descriptions of Health Equity

The World Health Organization (WHO) defines health equity as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification" such as disability status. The term health equity implies that every person no matter how their status is, should have a fair and equal opportunity to attain their full health potential.

In line with the WHO equity framework, this National Health Equity Strategy is committed to working across three broad dimensions of health equity:

As national contexts we will consider Equal access to essential health service, equal utilization for equal need, and equal quality of care for all which is horizontal equity. Vertical equity which is financial equity, which means peoples has to pay according to affordability in a way that it will not create financial impoverishment

Access to healthcare: Ethiopia continues to scale-up access to essential healthcare as per 2019 Revised Essential Health Service Packages to ensure all members of society have equal access to at least basic health services such as reducing physical barriers, distance, price, and other socio- cultural barriers.

Uptake of healthcare services: National Health Equity Strategy focuses on increasing the quality of health services through ensuring all clients have the opportunity for motivated, compassionate and respectful care.

Difference in health status (or outcomes): Difference in health status (or outcomes)

such as life expectancy, mortality and nutritional status can occur not only because of differences in access and uptake to health service, but also because of the wider social, economic and environmental determinants; pointing to the critical importance of addressing the social determinants of health. Thus, the strategy focuses on addressing major social determinants of health in collaboration with all relevant stakeholders.

1.3 Historical perspective of Health Equity

The 1946 WHO Constitution proclaimed that "the highest standards of health should be within reach of all, without distinction of race, religion, and political belief, economic or social condition". Two years later, in 1948, the United Nations adopted the Universal Declaration of Human Rights (UDHR) which set a standard by which the human rights activities of all nations, rich and poor alike were to be measured[2,3]. It states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family. It also states that "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" [4]

The concept of health equity was strongly endorsed by the participants in the WHO Conference on Primary Health Care in Alma-Ata in 1978. The launch of "Health for All" (HFA) campaign, implicitly made health equity a priority for all countries[5]. The Alma- Ata Declaration viewed health as part of and an impetus for development, with every social sector needing to collaborate in the production and maintenance of "health for all." The Alma-Ata Declaration highlighted the inequality between the developed and the developing countries and termed it politically, socially, and economically unacceptable[6]. Astana 2018 renewed these commitments and further outlined the importance of strengthening primary health care for the achievement of Universal Health Coverage.

Equity in health was also a cornerstone of the Millennium Development Goals (MDGs). The countdown to Equity working group established to determine how countries were advancing on health equity in relation to the MDGs collected and analysed country data and provided key indicators to monitor reproductive, maternal, new-born, and child health across different dimensions of equity[7].

In 2005, World Health Organization established the Commission on Social Determinants of Health (CSDH) to address the social, economic, environmental, commercial and political factors contributing to ill health and health inequities, and to draw the attention of government agencies and policy makers to the social determinants of health[8]. The CSDH 2008 report of the recommendations include:-to improve populations living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action[9]. The World Federation of Public Health Associations (WFPHA) produced the Addis Ababa Declaration on Global Health Equity (World Congress on Public Health 2012), during the 13th World Congress on Public Health, held in Addis Ababa, Ethiopia with a theme of 'A call to act on closing some of the critical gaps in global health and well-being'

The 2030 Development Agenda concept of "leaving no one behind" implies that equity is at the heart of the Sustainable

2 UN General Assembly, (1948) Universal Declaration of Human Rights; 217 A (III)
3 World Health Organization (1946) Constitution of the World Health Organization
4 US Dep Health Hum Service (1980) Promoting health/ preventing disease: Objectives for the nation, Washington DC: Public Health Service
5 World Health Organization (2010) World Health Report 2010, Geneva: WHO.
6 Fee E, Brown TM (2015) a return to the social justice spirit of Alma-Ata. Am J Public Health, 105: 1096-1097.
7 Countdown to 2015 (2014) Maternal, new born & child survival. Equity analyses and profiles. Geneva: Countdown to 2015.
8 Commission on Social Determinants of Health (CSDH) (2008) Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva, WHO.
9 World Bank Group (2006) World Development Report. Washington, DC: World Bank.

Development Goals (SDGs). Of the 17 SDGs, Goal 3 "*Ensure healthy lives and promote wellbeing for all at all ages*", of which target 3.8 states that achieving universal health coverage and goal 10 *"reducing inequalities within and among countries"* are directly linked to equity.

Nationally Health is human and constitutional right for every citizen as highlighted in with regard to this HSTP I addressed equity as one of the transformation agenda over the last five years & during the same period Equity plan of Action developed and implemented in four developing regions and selected low performing zones of Agrarian regions. During HSTP II Equity will continue positioned as one of the transformation agenda to ensure healthy lives and wellbeing for all at all ages in Ethiopia.

1.4 Health Equity Stratifiers

1.4.1 Geography Disparity

Ethiopia is a country with rich geographical diversity. It consists of rugged mountains, flat-topped plateaus, deep gorges and river valleys. Ethiopia is home for agrarian, pastoralist & urban communities with all types of weather conditions. More than half of the geographic area of the country lies 1,500 m above sea level. The altitude ranges from highest at Ras Dashen (4,620 m above sea level) and lowest at Danakil Depression (148 m below sea level).

Health geography recognizes the importance of context, setting and spatial scale from global to local in determining health outcomes. The issues facing health and health care are complex and multidimensional requiring, a multidisciplinary approach to finding solutions and to ensure that research provides relevant, high quality evidence to inform health policy. Partnerships among health specialists, geographers and others can help sustain innovative approaches to solving complex problems and ultimately reduce inequities[10].

There is compelling evidence of geographically driven poverty; the geographic characteristics of the residence alone can lock people into poverty[11] .This can led to several anti-poverty interventions to use geographical targeting to achieve their objectives[12]. The household surveys conducted in different countries have shown how modern input prices are higher and adoption rates of improved technologies, agricultural yields, commercial surpluses, and both non-farm and overall incomes are lower in more isolated areas[13]. Evidence also shows that areas with limited infrastructure connectivity are less likely to receive food aid[14].

Perhaps a less explored factor contributing to worse outcomes related to limited service delivery in more remote and hard-to-reach localities. A study using data from 21,000 interviews in 17 African countries show how remoteness is strongly related to access to and satisfaction with public services in rural Africa[15]. Recent evidence from Ethiopia, suggests that more connected areas are in terms of infrastructure less vulnerable to weather shocks[16].

10 Health geography: supporting public health policy and planningTrevor J.B. Dummer, 2008
11 Kraay & McKenzie, 2014
12 Baker & Grosh, 1994; Bigman & Fofack, 2000
13 Christiaensen, Demery, & Paternostro, 2003; Damania et al., 2017; Deichmann, Shilpi, & Vakis, 2009; Jacoby & Minten, 2009
14 Briggs 2018
15 Brinkerhoff, Wetterberg, and Wibbels 2018
16 Hill & Fuje, 2016; Hirvonen, Sohnesen, & Bundervoet, 2020; Nakamura, Bundervoet, & Nuru, 2020

Geographical barriers significantly reduce the performance of basic health services, for example, lower health services as seen with Infants protected from Neonatal Tetanus at birth by regions ranging from 56% in Somali region to 100% in Addis Ababa, Ethiopia[17]. Similarly, 97% of urban households have access to an improved source of drinking water, as compared with only 57% of rural households. About 93% of urban households have access to electricity while only 8% for rural households[18] highlighting avoidable inequalities in Ethiopia.

1.4.2 Demographic Disparity

Ethiopia is the second most populous country in Africa with a population of 102,850,793 with a growth rate estimated at 2.6% in 2020 and ranks 12th in the world (CSA). The country is home to various ethnicities, with more than 80 different spoken languages. Ethiopia is characterized by young population, higher dependency ratio with children under 15 accounting for 47%, 15 - 64 age group representing 48% of the total population, and individuals aged 65 and older only 4% while women of reproductive age accounts to 23% of the population (EDHS 2016). The male to female ratio is almost equal, and the country has the highest total fertility rate of 4.6, urban areas 2.3 and rural areas 5.2 (EDHS 2016). The highest population (80%) in Ethiopia resides in rural areas, mainly due to subsistence agriculture (CSA 2007 projection).

According to Ethiopia Multiple Deprivations Study 2018, 88 per cent of children have been exposed to multiple deprivations. This implies that children in Ethiopia need to be protected by adults and treated equally considering they are not independent and do not have a formally recognised voice.

Ethiopia life expectancy reached 65.5 in 2016 (63.7 for males and 67 years for females in 2016, which rose from 52 years (2000) representing 30% increase in a decade and half time (WHO life table)

17 DHIS2 2011 EFY
18 EDHS 2016

1.4.3 Gender Disparity

Gender refers to the socially constructed characteristics of women and men such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed[19].Gender equity in health refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce[20].

Even though there is general political will and commitment to address gender inequality, gender mainstreaming and empowerment in the health sector over the last decades has been suboptimal. This is due to limited capacity to implement community-based interventions targeting gender using a more holistic and practical approach.

Gender bias exists across and within health occupations. Gendered nature of health work is not accurately described, thus, women's contributions to health systems continue to be unsupported, under-valued or not recognized at all. Adult women (58%) are more likely than adult men (7 %) to collect drinking water. In Rural households, adult women are more than eight times as likely as adult men to fetch the water for the household (68 % versus 8 %). Female children under age 15 are more than two times as likely as male children of the same age to collect drinking water (10 % versus 4 %)[21].

Among the major challenges in addressing gender disparities in health are limited enforcement of existing 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 multi-sectoral services to survivors of sexual GBV.

Traditional attitudes, beliefs and practices that reinforce harmful gender roles contribute to constrain women's participation in social development including health. Harmful traditional practices, including female genital mutilations (national prevalence rate of 65.2%) and child marriage disproportionately affect rural women and girls. Despite the existing gender disparities in health, currently it is inadequately understood or there is no well-organized disaggregated data to highlight the discrepancies adequately.

Despite increased attention to human resources in health, the lack of research dedicated to documenting its gendered nature and in assessing interventions that redress gender inequalities must urgently be rectified. We should have Systems thinking to mainstreaming gender into health workforce planning, development and management at all levels of the health sector[22].

19 https://www.who.int/gender-equity-rights/knowledge/glossary/en/
20 https://www.who.int/gender-equity-rights/knowledge/glossary/en/
21 EDHS-2016
22 EDHS-2016

1.4.4 Socio Economic Disparity

Differences in socioeconomic status, whether measured by income, educational achievement, or occupation, are associated with large disparities in health status. Health is unevenly distributed across socioeconomic status. Persons of lower income, education, or occupational status experience less access to health services, health seeking behavior and health service utilization than do their better-off counterparts[23]. In addition, lowland parts of Ethiopia also experience annual cyclical drought and resulting post drought crisis such as poverty, reduced food security, displaced populations and disease outbreaks. International investment also tends to be emergency oriented, allowing inadequate time and investment in addressing the underlying health system challenges and focusing on the overall health system strengthening.

Ethiopia is engaged in rapid and comprehensive development activities to transition from poverty to sustainable and reliable growth and prosperity. The country had registered commendable achievements on Millennium Development Goals (MDGs) mainly in reducing poverty headcount, achieving universal primary education and narrowing gender disparities in primary education. Equity analysis of key maternal and child health (MCH) and nutrition indicators from Mini EDHS 2019 report show that the wealthiest and those highly educated consistently benefitted more from the health interventions. On the other hand, the regional variations are quite high, Addis Ababa being the region that mostly benefited region, however there are considerable inconsistencies from one cycle of DHS to another in almost all regions.

Although the pro-rural and pro-poor policy will still be relevant going forward it is important to consider the socio-cultural appropriateness of the health service delivery strategies at regional and sub-regional levels in order to effectively close the inequality gaps. Rapid urbanization is underway across the country, with mobile populations likely to pose new health sector challenges and inequalities which requiring tailored adaptive health service delivery designs[24].

Education in urban areas is better than in rural areas with

57% of rural women having no formal education compared with 16% of urban women. The urban-rural difference is more pronounced at the secondary or higher levels of education. For example, only 1% of women in rural areas have more than a secondary level education, compared with 21% of urban women. Despite cultural and traditional context variations Education is an important factor influencing an individual's attitudes and opportunities towards health service uptake and health seeking behaviour. From Ethiopian Mini EDHS data, it is evidenced that individuals with educational status of more than secondary level are more likely to use health services than their counterparts with highest wealth quintile are using health service of any kind compared to lowest quintile. Educational attainment also varies by wealth quintile. Seventy four percent of women in the lowest wealth quintile have no education, as compared with only 19% of women in the highest quintile. Similarly, less than 1% of women in the lowest wealth quintile have more than a secondary education, compared with 18% of those in the highest quintile.

23 Fiscella K, Williams DR. Health disparities based on socioeconomic inequities: implications for urban health care. Acad Med. 2004 Dec; 79(12):1139-47. Doi: 10.1097/00001888-200412000-00004. PMID: 15563647.

24 Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key Indicators. Rockville, Maryland, USA: EPHI and ICF.

1.4.5 People with special needs

Persons with disabilities are faced with a range of barriers when they seek healthcare. Strategies are required to overcome these different barriers in order to achieve UHC and the fulfilment of rights. People with disabilities are a diverse group, and people with different impairment types may be particularly vulnerable to certain types of barriers to accessing services. Barriers will also vary in different geographic and cultural settings and in different policy environments. A barrier that is perhaps conceptually straightforward arises from limited physical access to healthcare facilities. Obstacles can make it difficult to gain entry into the facility, but also to move through elevators or doorways into treatment rooms, or use the bathrooms. Having accessible/adaptable furniture or equipment is also an important consideration. If these are not available, people with disabilities may not be examined, or not to the same standards as others. For example, a pregnant physically disabled woman may not be able to get onto a bed for antenatal checks easily or may not feel safe. Lack of accessible transport, or lack of nearby facilities, may also limit people with disabilities' access to health services. Women and girls with disabilities are at particular risk of violence and abuse, but it should be noted that men and boys with disabilities are also at risk[25].

Health equity can be classified as vertical and horizontal health equity. Horizontal Health Equity: when different groups of people with the same needs are treated the same and vertical health equity: when people with different needs are treated differently according to their health needs. For example, the needs of disabled and non-disabled people are not the same, the measure of health equity should not be parity of usage: it should be the extent to which health services meet complex medical and rehabilitation needs of persons with disabilities, i.e. is vertical health equity. For example, the analyses of the World Health Surveys in the *World Report on Disability* showed that both men and women with disabilities were significantly more likely to report needing healthcare services but not receiving them, (women: 5.8% versus 3.7%; men: 5.8% versus 4.1%). A Canadian study found that adults with disabilities aged 20-64 years had three times the level of unmet healthcare needs as adults without disabilities[26].

To achieve health equity, access to health care is a vital prerequisite. Access to health is not just about physical access to a healthcare facility but also covers factors such as quality, affordability and acceptability of services[27].

There is a lack of information on the availability of health services accessible to persons with disabilities in accordance with their need, interest and disability types.

25 Ortoleva, S. and H. Lewis. Forgotten sisters: a report on violence against women with disabilities: an overview of its nature, scope, causes and consequences. 2012 [cited 2018 24/04]; Available from: http://lsr.nellco.org/nusl_faculty/166

26 McColl, M.A., A. Jarzynowska, and S.E.D. Shortt, Unmet health care needs of people with disabilities: population level evidence. Disability & Society, 2010. 25(2): p. 205-218.

27 Peters, D.H., et al., Poverty and access to health care in developing countries. Ann N Y Acad Sci, 2008. 1136: p. 161-71]

2

Situational analysis on State of Health Equity

2.1 Multisectoral collaboration

Global commitments promote the need for multisectoral collaboration. However, by design, governments operate in sectoral silos. Despite national policy statements and coordination Platforms, when it comes to the delivery of a truly prioritized set of interventions at the grassroot level, much remains to be done to translate the policy statements into action. The Government of Ethiopia (GOE) through its National One WaSH programme, Seqota Declaration Initiative and Multi-sectoral Woreda transformation (MSWT) are changing the status quo by developing a cross-sectoral one plan, one budget, and one report.

In order to tackle the structural social determinants of health, the GOE through line ministers undertake different developmental interventions with an aim to change the livelihoods ofthe community, mainly focusing on developing regional states since 2009 G.C. under a federal special support board that was led by the Deputy Prime minister. On top of that the ministry initiated the concept of Multi-sectoral Woreda transformation (MSWT) that consisted of 11 line ministries and a pilot implementation was started at Oromia regional state, Gimbichu Woreda.

Through lessons learnt from multisectoral platform corrective measures on challenges faced during implementation and scale at large for promising practices will be undertaken during National Health Equity Strategy implementation.

2.2 Summary on the main progress to date for Health Equity (Lessons learned from Equity action plan I)

In line with HSTP I Equity Plan of Action 2016-2020 developed and mainly focused on health system building blocks and community engagement interventions were implemented in four developing regions and selected low performing zones of Agrarian regions.

The Ministry has demonstrated a strong commitment to tackling persistent challenges of health inequities between regions. So far, various efforts have been made to strengthen health systems and in introducing community-based health insurance in implementing woredas to the vulnerable groups against catastrophic health expenditures.

The pastoralist HEP strategy was developed and implemented to improve the Health Extension Program.

Improvement in leadership, management and governance skills at all levels, including RHBs, ZHD, WoHO, Health facility management members through health Leadership Management andGovernance (LMG) training and continuous coaching and mentorship at work place have increased health leadership competency and commitment to the improvement in key performance indicators.

The technical assistance from the MOH has contributed to creating an improved work climate and responsive management at regional, zonal, woreda and health facilities in pastoralist regions and selected low performing zones.

To increase access to health services, matching based health center construction, health facility expansion, equipping facilities with basic amenities such as solar power, building residential houses for health worker deployed in hard-to-reach health facilities, expansion of EPSA hubs, blood bank, operation room, ambulance and vehicle distribution.

The National health equity plan of action and health systems interventions have contributed in narrowing the intra & inter-regional disparities as highlighted in the Mini EDHS 2019 report, though it needs greater effort and engagement of government, communities and development partners to fully achieve their stated objectives.

Besides hard work and commitment to address geographic disparities of health, the national health equity plan needs focus and equal attention to work on other dimensions of inequities and wider social determinants of health.

While progress has been made in closing inter-regional health disparities, the rate of change has been slower than expected and efforts to address social determinants of health have been insufficient. Such disparities persist in the face of a number of ongoing and inter-related challenges, the most critical of which include inadequate financing and associated high out of pocket expenditure for health services, poor health planning and healthcare worker capacity, and a poor last mile drug delivery in the developing regions. The wide range of socio-cultural beliefs like adolescent pregnancy, FGC, discriminatory healthcare provider behaviours that undermine health and limit health-seeking behaviour and service utilization also affect health equity.

The Ministry's effort to address health equity was limited to specific regions and missed major health equity stratifiers beyond geographic inequities. Considering this fact, a comprehensive health equity strategic plan that covers all regions and incorporates major health equity stratifiers has been developed and will be implemented over the coming 5 years.

2.3 Health Equity status in health care System

In analysing the state of equity in the health care service, a list of major indicators were identified and were reviewed across seven equity stratifiers; geography, education, wealth, gender, age, residence and marital status. The major data sources were EDHS, SARA, SPA and Routine HMIS and other global datasets. Additionally, various references were reviewed as necessary.

2.3.1 Health Service delivery

Morbidity and Mortality

There were 559,997 deaths in Ethiopia in 2019, of which 317,818 were male (57 %), representing 520 per 100,000 people. Crude death rates for broad groups of causes; Communicable, maternal, neonatal, and nutritional diseases records 297,055, non-communicable disease and injuries records 219,284 and 43,658 respectively. According to the Global Burden of Disease (GBD) 2019 results neonatal disorders, diarrheal diseases, lower respiratory tract diseases and HIV are the top causes of death[28].

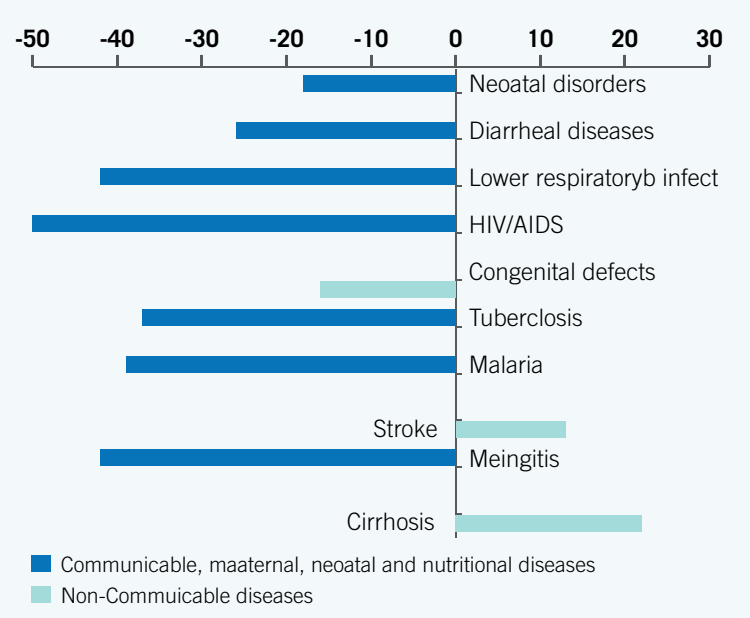

Figure 1: Top 10 causes of death and disability (DALYs) in 2019 and percent change 2009–2019, all ages combined

28 http://www.healthdata.org/ethiopia

The top ten causes of disability adjusted life years (DALY) lost in Ethiopia are Neonatal disorders, diarrheal diseases, lower respiratory diseases, tuberculosis, stroke, HIV/AIDS, ischemic heart disease, cirrhosis, diabetes and congenital defects in a declining order.

Neglected tropical diseases and malaria which have been among the top causes of DALYs and Year life lose (YLL) have declined and are no more the top causes of morbidity and mortality. However, the top ten causes of morbidity include malaria as the 8th (males and children) and 9th (females) cause of morbidity in Ethiopia; but still it is not among the list of top causes of mortality[29].

The top health risks that lead to death and disability are malnutrition, air pollution, water and sanitation problems and unsafe sex.

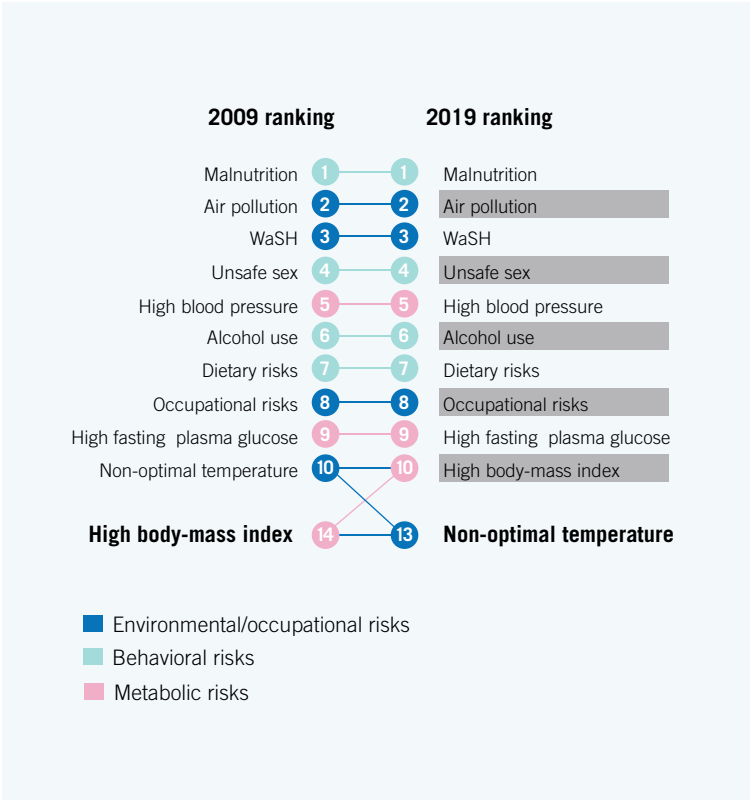

Figure 2: Top 10 risks contributing to total number of DALYs in 2019 and percentage change 2009–2019, all ages combined

Maternal Mortality Ratio has declined from 871 (2000) to 401 (2017) per 100,000 live births; a reduction of more than 54% in nearly a decade and half. Similarly, under-five mortality has declined from 166 in 2000 to 59 per 1000 live births, infant mortality has declined from 97 per 1000 live births in 2000 to 47 in 2019, and neonatal mortality has declined from 49 in 2000 to 29 per 1000 live births in 2016 but slightly increased to 33 in 2019[30],[31],[32].

Looking at under-five mortality across gender; which was 173 per 1000 thousand for males and 159 per 1000 for females that has declined to 81 and 52 per 1000 for males and females respectively.

A review of the mortality indicators by residence shows that neonatal, infant and under-five mortality were all slightly higher in the urban set-up in 2000 than the rural set-up. However, the progress in the past decades shows relatively a better decline in the urban set up for both neonatal and under-five mortality, while it is almost similar for infant mortality though there are improvements in both rural and urban settings. In 2016, only neonatal mortality in urban areas was lower than those in rural, but both infant and under-five mortality were higher in urban settings.

Regarding regional variations; the inequities in neonatal mortality ranges from 68 and 42 per 1,000 in Tigray and Dire Dawa in 2000 respectively. However, in 2016 the Tigray region managed to reduce neonatal mortality to 34 deaths per 1,000. Variations in neonatal mortality ranged from 18 and 47 per 1,000 in the Addis Ababa and Amhara region, respectively.

29 http://www.healthdata.org/ethiopia

30 EHDS 2000
31 EDHS 2016
32 EDHS 2019

Infant mortality ranged from 81 in Addis Ababa to 129 in Afar in 2000. Based on the 2016 EDHS, the infant mortality ratio declined to 81 per 1,000 live births in Afar and 28 in Addis Ababa. The highest improvement in infant mortality was recorded in the Gambella and Tigray regions, where it reduced to 67 and 61 deaths per 1,000.

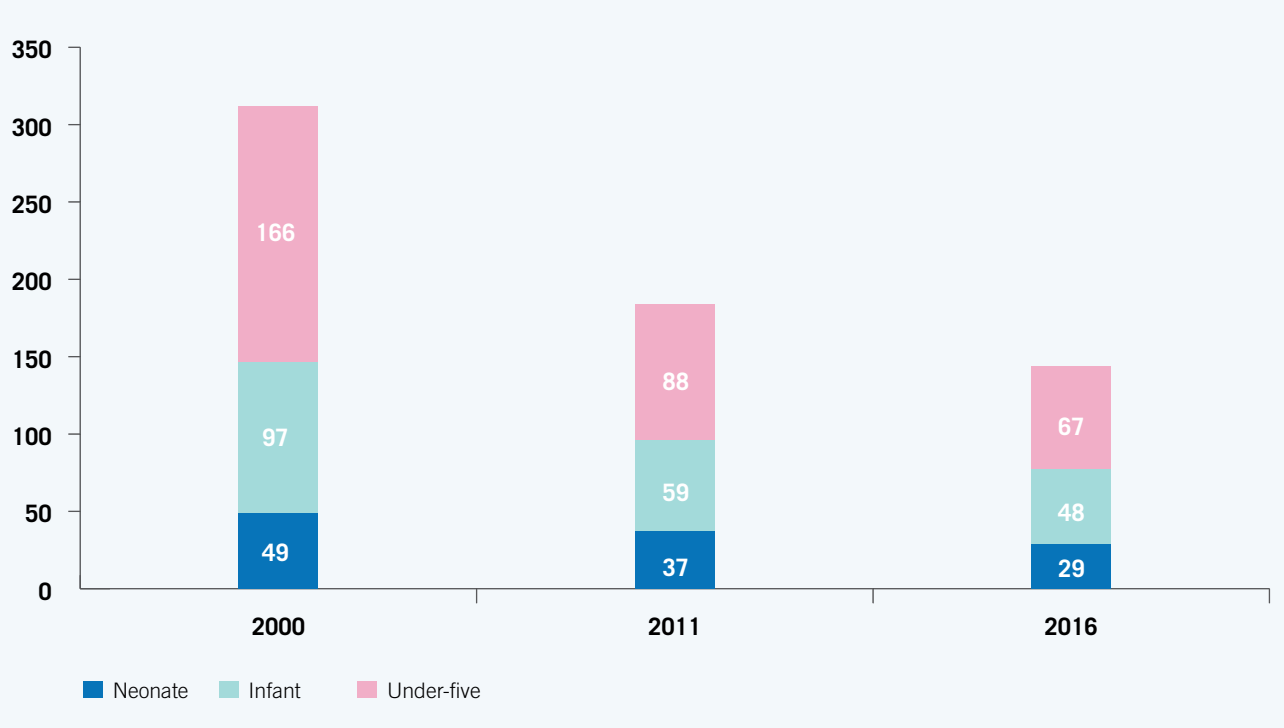

Figure 3: Neonatal, infant and under five mortality trends (EDHS 2000, 2011, 2016)

A review of neonatal, infant and under-five mortality between 2000 and 2016 showed that mortality was very high among children born to adolescent mothers. Neonatal mortality among adolescent mothers which was 85 per 1,000 in the year 2000, reduced to 47 per 1,000 in 2016. Similarly, under-five mortality was 225 per 1,000 in 2000 thousand and declined to 93 per thousand in 2016.

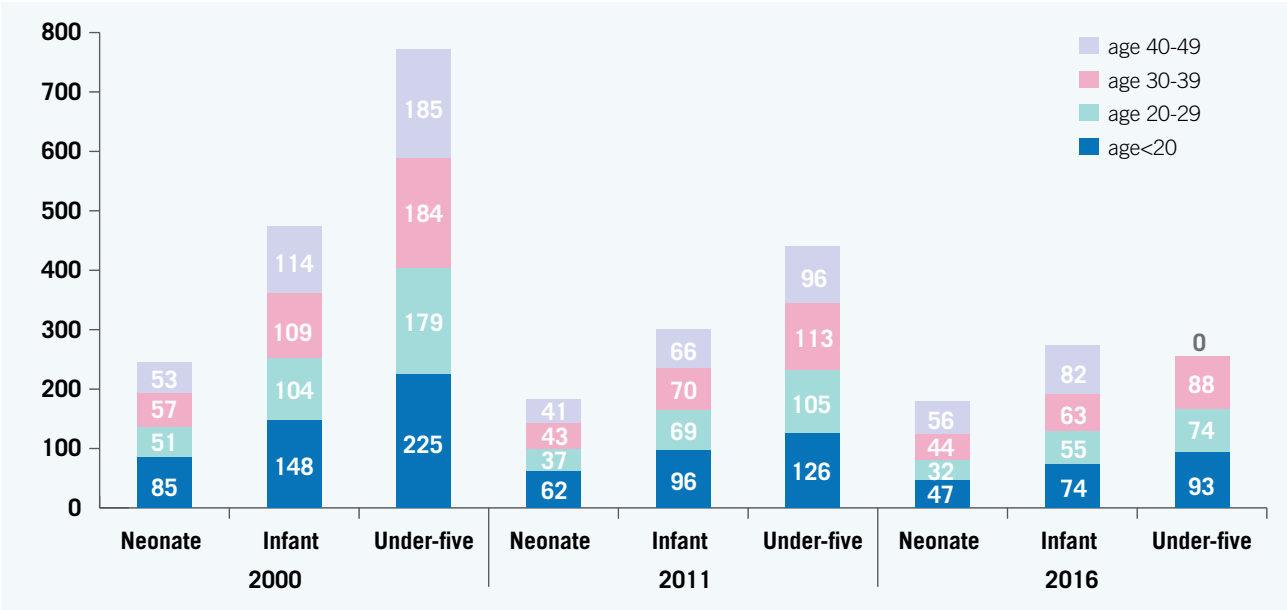

Figure 4: Neonatal, infant and under five mortality trends (EDHS 2000, 2011, 2016) disaggregated by maternal age

Maternal Health Services

The Maternal, Neonatal and Child Health (MNCH) services in Ethiopia has shown improvement in the past two decades, despite the growing disparities across rural and urban areas and geographic regions.

Contraceptive Prevalence Rate

The contraceptive prevalence rate (CPR) for married women aged 15-49 in Ethiopia is 41.4%. The CPR ranges from 3.4% in Somali to 49.5% in Amhara and 49.9% in the Addis Ababa region. Urban women are much more likely than their rural counterparts to use any method of contraception; i.e. 50% in urban and 38% in rural.[33]

Contraceptive use increases with women's level of education and household wealth. Fifty- eight percent (58%) of women with higher than secondary education used any contraceptive method on 2016 compared with 32% of women with no education. Likewise, 28% of women in the lowest wealth quintile used any contraceptive method compared to 53% of women in the highest quintile. Women with no living children (28%) and those with five or more children (32%) are the least likely to use any method of contraception compared with those who have 1-2 children (54%) or 3-4 children (44%).[34]

33 EMDHS 2019
34 Mini EDHS 2019

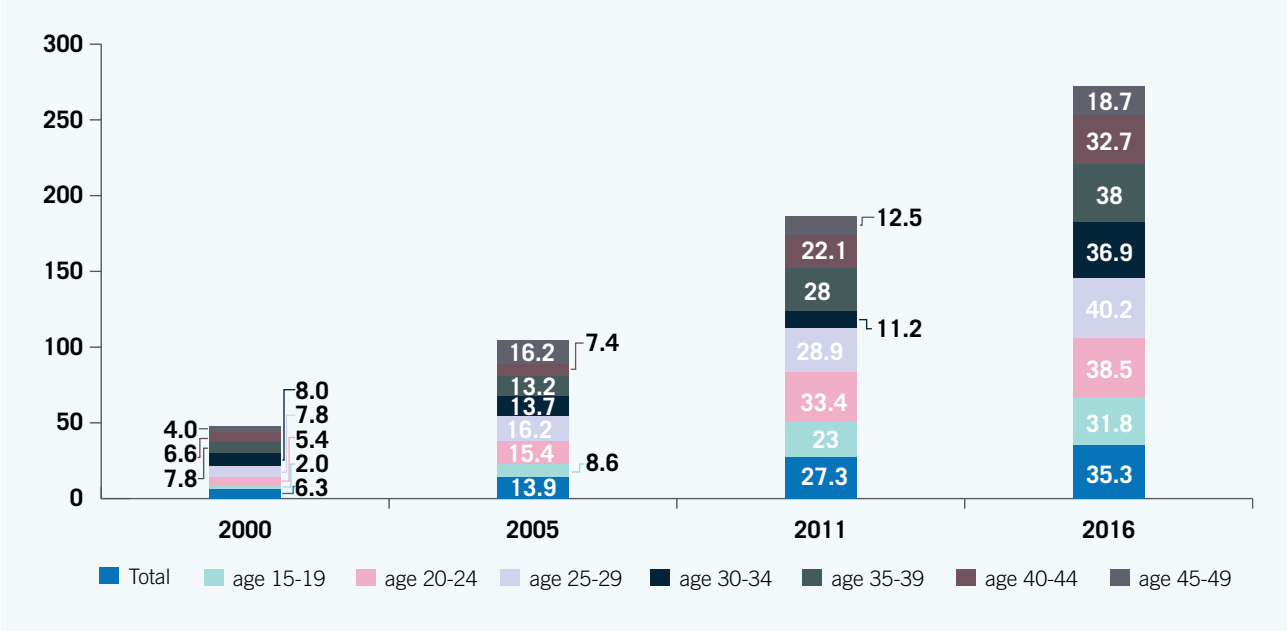

Figure 5: Trend of contraceptive utilization across different ages in Ethiopia, 2000-2016 (EDHS)

Figure 5 shows that the current use of any modern contraceptives by married women differs across age. In 2005 and 2011, married women in the age range of 20 to 29 used modern contraceptives more than women in any other age bracket. However, contraceptive use among adolescents increased dramatically in 2011 (nearly 3-fold from 2005) and continued to increase in 2019. Addressing the variations across age groups requires ensuring access to quality comprehensive contraceptive services of choice.

Antenatal Care

The 2019 EMDHS results show that 74% of women who gave birth in the 5 years preceding the survey received ANC from a skilled provider at least once for their last pregnancy. Forty-three percent (43%) of women had four or more ANC visits for their most recent live birth. Women who attended ANC at least 4 times (ANC4+) during pregnancy have increased from 31.8% in 2016 to 43.0% in 2019. However, there were regional disparities, with women attending 4 or more ANC services increasing from 56.5% to 63.9% in the Tigray region between 2016 and 2019 compared to a decline in attendance from 11.8% to 11.1% in the Somali over the same period. The highest improvement in ANC4 services was gained in Amhara and Oromia, which recorded 19.3% and 18.4% gain respectively. The Gambella region, by contrast, recorded a reduction of 11.6% in ANC4 service use during the same period.

Urban women were more likely than rural women to receive ANC from a skilled provider (85% and 70%, respectively) and to have four or more ANC visits (59% and 37%, respectively). ANC services uptake also varies by women's educational status; among women with no education, 62% obtained ANC services from a skilled provider and 32% received four or more ANC visits compared with 100% and 79%, respectively, of women with more than a secondary education more likely to receive ANC from a skilled provider. The use of ANC services provided by a skilled provider and proper number of ANC visits also increased steadily with household wealth.[35]

35 Mini EDHS 2019

Birth Attended by Skilled Health Personnel:

Skilled birth attendance has increased from 27.7% in 2016 to 49.8% in 2019, an increment of 22.1% in four years. Addis-Ababa and Somali are the highest and lowest performing regions with 95.7% and 26.0% respectively in 2019. Improvements in skilled birth attendance were noted at Benishangul Gumuz, Amhara and Oromia regions, which recorded a gain of 36.3%, 28% and 24% respectively. The lowest improvement in skilled birth attendance was noted in the Somali region (6%). Significant rural and urban differences in skilled birth attendance were observed between 2016 and 2019. In 2016 around 80% of birth in urban areas were attended by a skilled birth attendant while only 21% of births in rural areas were attended by skilled birth attendant.

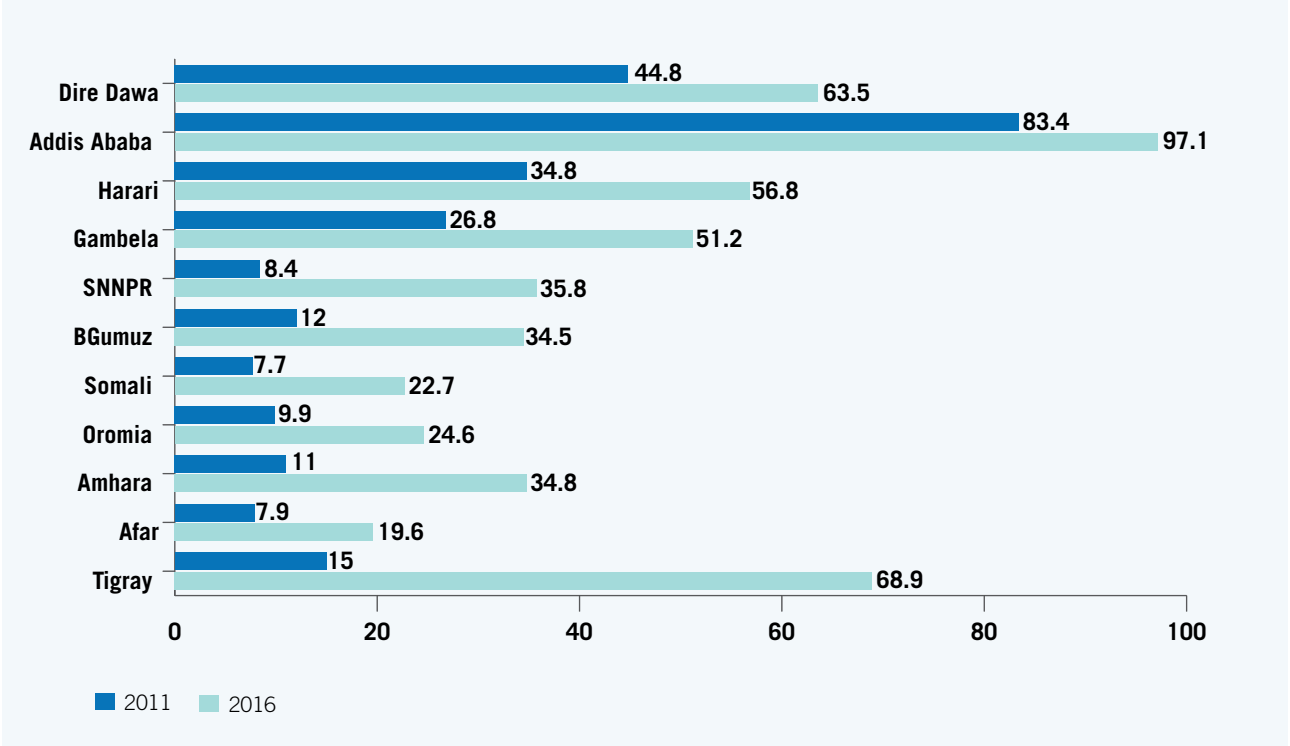

Figure 6: Trends of Skilled birth attendant (EDHS 2011 & 2016)

Based on the data from the SARA survey 2018[36], only 46% of facilities provided BEmONC services; 85% of hospitals, 74% of HCs and 55% of higher clinics provided BEmONC services. Marked variations existed across regions and facilities with only 60% of facilities providing these services.

36 SARA 2017

Immunization Service

The proportion of surviving infants who receive a third dose of pentavalent vaccine before their first birthday was 61% nationally, with the highest recorded in Addis Ababa 93.1%, and the lowest performance observed in Afar 25.9%. Full immunization coverage has increased steadily from 14.30% in 2000 to 43.19% in 2019. Over time EPI coverage has improved both for rural and urban communities.

Among children aged 12-23 months, vaccination coverage declined as the birth order increased - from 47% for first order births to 29% for sixth or higher order births. Children in rural areas (65%) were more likely to receive all basic vaccinations than children in urban areas (35%) (EDHS 2016).

The regional variation in immunization coverage of all basic vaccinations was highest in Addis Ababa (89%) and lowest in Afar (15%). Children were more likely to receive all basic vaccinations if their mothers had more than secondary education (65%), than if their mothers had only a primary education (46%) or no education (34%). Children in households with the highest wealth quintile (65%) were more likely to receive all basic vaccinations than those in the lowest wealth quintile households (25%)[37].

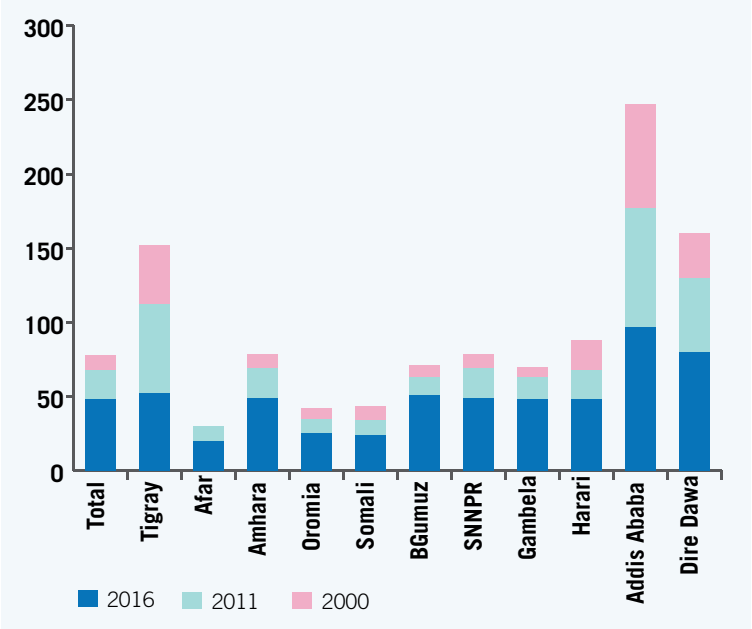

Figure 7: Trends of EPI by regions (EDHS 2000- 2016)

Child Nutrition

The prevalence of stunting has decreased considerably from 58% in 2000 to 37% in 2019 nationwide. While the prevalence of wasting declined only marginally over the same time period, i.e. from 23% 2000 to 7%. The prevalence of underweight has consistently decreased from 41% in 2000 to 21% in 2019 over the last two decades.

Child malnutrition is associated with childbirth size and maternal malnutrition. Children who are smaller at birth are more likely to be stunted, wasted and underweight than children who are normal or larger at birth. Likewise, whose mothers are thin (with BMI less than 18.5) are more likely to be stunted, wasted, or underweight than children whose mothers have a normal BMI, or whose mothers are overweight or obese.

Stunting, underweight, and wasting prevalence is higher among children in rural areas than those in urban areas. Amhara, Benishangul-Gumuz, Afar, and Dire Dawa are most highly affected by child stunting (41-46%), whereas wasting imposes the heaviest burden in Somali, Afar, and Gambela, with rates of 23%, 18%, and 14%, respectively. The proportions of children who are stunted and underweight decline with increasing mother's education and increasing household wealth.[38]

37 EMDHS 2019

38 EDHS2016

Communicable Diseases Prevention and Control

Human Immune Virus (HIV)

The Prevalence of HIV among the general population decreased from 1.4% in 2005 to 0.9% in 2016 (by 0.5%). The proportion of women and men who have been tested for HIV was twice as high in urban areas (36% for women and 33% for men) while in rural areas it was 15% for both women and men. HIV testing coverage was highest in Dire Dawa (39% for women and 36% for men) and lowest in Somali (9% for women and 8% for men). HIV testing coverage tends to increase with rising levels of education in Ethiopia. For example, coverage for women with no education was at 14% while among women with more than secondary education it was 44%. Among men, the HIV testing coverage varied from 13% for those with no education to 39% among men with more than secondary education levels (EDHS 2016).

Even though there was a decrease from 5.5% in 2005 to 2.9% (2016) representing a 2.6 percent point decrease, the prevalence of HIV among the urban residents is still high. According to EDHS 2016, HIV prevalence among the general population is high in Gambella with 4.8%, Addis-Ababa 3.4%, Dire-Dawa 2.5% and Harari 2.4% in descending order.

Table 1: HIV prevalence among general population disaggregated by region EDHS 2016[39]

Characteristic	HIV prevalence among general population
Tigray	1.2 (CI: 0.6 – 1.7)
Afar	1.4 (CI: 0.4 – 2.5)
Amhara	1.2 (CI: 0.6 – 1.8)
Oromia	0.7 (CI: 0.3 – 1.1)
Somali	0.0 (CI: 0.0 – 0.1)
B/Gumuz	1.0 (CI: 0.3 – 1.6)
SNNPR	0.4 (CI: 0.1 – 0.6)
Gambela	4.8 (CI: 3.0 – 6.5)
Harari	2.4 (CI: 1.4 – 3.5)
Addis Ababa	3.4 (CI: 2.6 – 4.2)
Dire Dawa	2.5 (CI: 1.5 – 3.5)

The three 90's:- From a total estimated 669,236 PLHIVs in Ethiopia, 526,690 (78.7%) of them know their HIV status (the first 90s' is 78.7%) and the second 90 target is 90%. The national performance of the third target to be 91.4%[40] .Tigray, Harari and Addis Ababa achieved a target of the second 90%.[40]

Currently on ART: The 2019 HIV related estimates and projections for Ethiopia show that the estimated number of people living with HIV is 669,236 (among which 255,689 are male and 413,547 are females). Of these, 625,007 (93.4%) were adults and 44,229 (6.6%) were children under 15 years of age. In 2019/2020 (2012 Ethiopian fiscal *Year (*EFY), 474,124 (70.8%) PLHIVs were receiving Antiretroviral Therapy (ART). In the year 2019/2020 PLHIVs who were on ART increased by 6,355 from the 2018/2019 (2011 EFY). Even though the number of PLHIVs receiving ART has increased over time, the proportion of PLHIVs who are receiving ART has decreased (72% in 2018/2019 (2011 EFY) compared with 70.8% in 2019/2020), which might *be due to* changes in the number of estimated PLHIVs or COVID 19 pandemic. Disaggregated by age, from the total estimated adult PLHIVs, 73.1% were receiving ART while only 39.4% of children under 15 years of age were receiving *ART.* There is an inequity in *ART* service provision among adults and *children.*

Regarding regional performance on ART service provision, the 2019/2020 suggests that Somali and *Afar* regions have the lowest performance with *ART* coverage at 25% and 39% *respectively.* Harari (86.2%), Addis Ababa *(85.9%)* and Tigray (*75.9%)* regions *had* a better *ART* coverage performance

39 Stat compiler
40 ARM 2020 report

compared with the other regions. In all regions, ART coverage among children under 15 years of age is less than 50%, except in Harari (75.3%) and Addis Ababa (55.5%). In the Somali and Afar regions, only 8.1% and 9.9% of Children under 15 years of age were receiving ART. This shows that there is a huge disparity in ART coverage among children when compared with *adults* and developing regions performing less when compared with other regions.

In EDHS 2016, 69% of women and 84% of men knew where to obtain an HIV test, and 40% women and 43% men had ever been tested for HIV and received the test results. The proportion of respondents who had never been tested for HIV was highest among women and men aged 15- *19 (75%* and 80%, respectively) compared with 46% of women *and 41%* of men aged 25-59 who had never been tested for HIV. Among women, knowledge of where to obtain HIV test services was much higher in urban areas (92%) *than* rural areas (63%).

Tuberculosis

Tuberculosis **(**TB) case detection rate was more than 100% in four regional states (Gambella, Harari, Addis Ababa, Dire Dawa) in 2017 and 2019, whereas lowest in Benishangul Gumuz (48% and 49% in 2017 and 2019 respectively) and Somali regional state (44% and 43% in 2018 and 2019 respectively). TB treatment success rate was lowest in the Gambella region at 88% in 2019. The region also had the lowest TB cure rate in 2019, together with the Somali region (Gambella had 35% cure rate while Somali had 75%).

Outpatient per capita

Nationally the average number of outpatient visits per person per year was 0.9 ranging from 0.21 in the Somali region to 1.83 in Tigray region. The 2009-2014 data in the African region indicates the average number of outpatient visits per capita in Ethiopia is only 0.2 visits compared to the 3.5 in Mauritius.

The 2014 National Health Account provides evidence that there is only a slight variation in outpatient service utilization rates between males and females, and between rural and urban areas. However, the rate of utilization show considerable variations when the survey data are disaggregated by region. It shows also that use of health facilities for outpatient services also varied across place of residence and wealth quintiles. For instance, individuals in urban areas who sought outpatient care were more than seven times more likely to use private hospitals than those in rural areas.

Government health facilities were used by a larger proportion of individuals in the poorest wealth quintile (75.9%) than those in the richest quintile (67.8%). Individuals in the richest quintile seem more likely to use outpatient care provided by private health facilities (27.2%) than do those in the poorest quintile (20.7%).

2.3.2 Human Resources for Health

The SDGs recommend a minimum health worker density of 4.45 doctors, nurses and midwives to deliver basic health services to meet the universal health coverage goal. Africa had a health worker density of 2.2 per 1000 population which is nearly half of the recommended density for UHC. Ethiopia's health worker density is 1 per 1000 population which is even lower than continental average . The three regions with the highest nurse to population ratio are Addis Ababa city Administration, Gambella and Benishangul-gumuz regional states with ratio of 20.3, 15.6 and 12.6 per 10,000 population respectively. Regions with the lowest nurse to population ratio are Afar (2.3 per 10,000) and Somali (3.4 per 10,000).

In 2019/2020, there are 273,601 health workforces employed in public health facilities, among which 181,872 (66.5%) are health professionals and the remaining 91,723 (33.5%) are administrative/supportive staff. As indicated in the figure below, among health professionals, the top three professional categories are Nurses, Health Extension workers and Midwifery that account for 59,063 (21.59%), 41,826 (15%) and 18,336 (7%) respectively. The total private sector health workforce in Ethiopia is estimated at about 60,000 personnel. Overall, the staffing standards per public health facilities and all professional mix are not met.

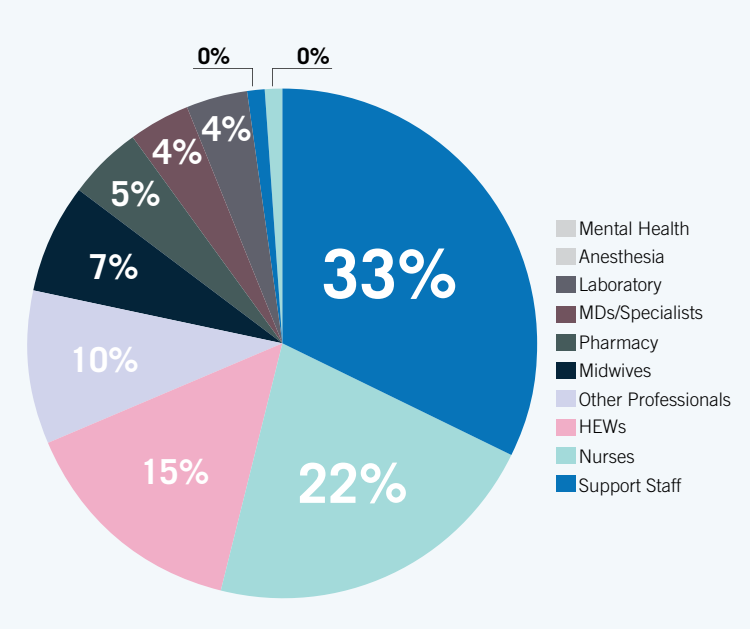

Figure 8: Number and percent of health workers by category (2019/2020 (2012 EFY))

The highest health workforce to population ratio is observed in Addis Ababa followed by Dire- dawa City Administrations & Harari region. By professional categories, there is better equity among regional states in terms of the distribution of health extension workers (HEWs). There are high disparities among regions in the availability of specialist medical doctors and a range of other health cadres, including general practitioners, despite some of these health workers being available on the market.

Health professional density is one of the criteria set by the WHO to measure health sector staffing. The ratio of medical doctors (GP+ Specialist) per populations is nearly 7:10,000 in Addis Ababa compared to 0.24 in the Afar region, which translates to one medical doctor (GP+ Specialist), serving 41,400 population. In Addis Ababa, one medical doctor serves around 1,567 population.

2.3.3 Health Infrastructure

The physical work environment often influences (positively or negatively) the mind-set of the service providers and their efficiency and ability to innovate in delivering expanded services. There is a visible gap ranging from site selection to the level of quality of construction of facilities. The construction design of existing health facilities in Ethiopia did not consider new and emerging disease patterns, which imposes stresses on the existing/ routine health services.

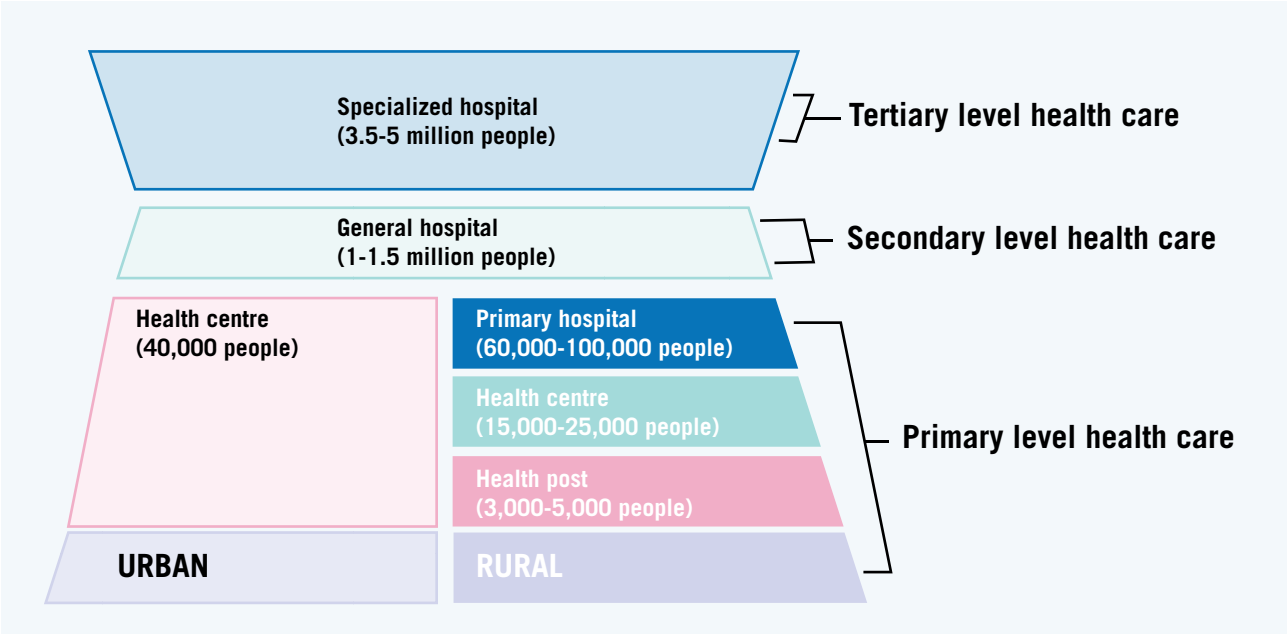

Figure 9: The Ethiopian health care tier system people)

Health posts:

In the past 5 years, 1,103 new health posts (HP) were constructed, making a cumulative number of 17,975. Of which 17,550 are functional, 425 HP are under-construction. The majority of health posts 308 (72.5%) under construction are from Somali region.[41]

Table 2: Number of functional and under construction Health Posts by Region, 2019/2020 (EFY 2012)

Regions	Number of HPs in EFY, 2012		
	Functional	Under construction	Total
Tigray	743	0	743
Afar	338	6	344
Amhara	3565	0	3565
Oromia	7090	0	7090
Somali	1214	96	1310
B/Gumz	419	5	424
SNNPR	3975	308	4283
Gambella	142	10	152
Harari	28	0	28
Dire Dewa	36	0	36
Total	17550	425	17975

Health Centers:

The *number* of functional *health centers* (HCs) *has* increased *from* 3,586 in 2007 *to* 3,735 in 2012, 96 HCs are currently *under* construction.

Table 3: Number of functional and under construction health centres by region 2019/2020 (2012 EFY)

Regions	Number of Health Center in EFY, 2012		
	Functional	Under construction	Total
Tigray	226	3	229
Afar	96	1	97
Amhara	861	7	868
Oromia	1,405	18	1423
Somali	208	18	226
B/Gumz	58	14	72
SNNPR	731	34	765
Gambella	29	0	29
Harari	8	1	9
Addis Ababa	98	0	98
Dire Dewa	15	0	15
Total	3,735	96	3831

Public Hospitals:

In 2012 EFY, the total number of functional public hospitals were 353 and 107 hospitals were under construction.

41 Health & Health related indicator 2020

Table 4: Number of functional and under construction Hospitals by region 2012

Regions	Functional	Under construction	Total
Tigray	41	4	45
Afar	7	0	7
Amhara	82	20	102
Oromia	104	39	143
Somali	12	6	18
B/Gumz	6	2	8
SNNPR	79	34	113
Gambella	5	0	5
Harari	2	0	2
Addis Ababa	13	1	14
Dire Dewa	2	1	3
National	353	107	460

According to the SARA 2018 report, availability of basic amenities across health facilities was greater among urban facilities than rural health facilities for all items except for emergency transport (62% compared with 69 % of rural facilities).

Among regions, Addis Ababa has the highest mean availability of basic amenities, which had 6 tracer items out of 7 basic amenities evaluated, improved water source (100%), communication equipment (89 %), and computers with internet (33%). Around 15% of health facilities in Addis Ababa had all the 7 items evaluated. The lowest mean availability of basic amenities tracer items was found in SNNPR; which has at least 2 tracer items out of 7 basic amenities.

2.3.4 Pharmaceutical Supply

Access to essential medicines is a critical component of UHC. However, availability of essential medicines in health facilities, excluding health posts, is only 28%; ranging *from 15%* in Gambella *to 54% in Dire* Dawa. None of the health facilities have all the 24 essential medicines. On average health facilities have 7 out of 24 essential medicines. Availability of essential medicines in government health facilities was 12 out of 24 and *those* managed by others, *only* 2 from 24 essential medicines tracer *items.*

Concerning facility type, on average the facilities which have the highest number of essential medicine tracer items from the total of 24 were referral hospitals (21), followed by general hospitals (19), primary care hospitals (19), and health centers (12), higher clinics *(5),* medium clinics (2) and lower clinics (1).

2.3.5 Health Financing

In 2001, African Union heads of state pledged to allocate at least 15% of their annual expenditure to health under the Abuja Declaration[42]. Fifteen years later, most African governments have increased the proportion of total public expenditure allocated to health, with an average of 76% of health expenditure being financed from domestic resources in 2014. The average level of per capita public spending on health has also risen from about US$70 in the early 2000s to more than US$160 in 2014[43].

In Ethiopia, Since 2010/11, domestic government spending on health per capita tripled to reach US$10.6 in 2016/17 which is a 5.3% increment per year on average, from US$28.7 in 2013/14 to US$33.2 in 2016/17. This figure is still far below the US$86 per capita spending estimated to be required to make essential health care services available in low-income countries. Total health expenditure (THE) as a percentage of GDP remained stable over the reporting period, with a

42 https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1

43 World Health Organization. Public financing for health in Africa: from Abuja to the SDGs. World Health Organization; 2016.

slight decrease in 2016/17 to 4.2%. This is still a considerable improvement compared to the late 2000s share, when it stood at 3.8% of GDP. Expenditure on health as a share of total government expenditure increased from 7.6% in 2013/14 to 8.1% in 2016/17. The low-income country's average government health expenditure as a proportion of total government expenditure is 8.7%, which is a little over Ethiopia's figure.

The total nominal health expenditure values increased by 45%; driven by government spending on health between 2013/14 and 2016/17. Total health spending during 2016/17 was ETB 72.1 billion (US$3.1 billion), a 45% increment in nominal terms from ETB 49.6 billion (US$2.5 billion) in 2013/14. Government expenditure accounted for 32% of total health spending and the nominal value of health spending increased remarkably, from ETB 14.7 billion to ETB23.7 billion between 2013/14 and 2016/17. External funding accounted for 35% of total health spending. Out-of-pocket (OOP) spending on health represented 31% of total health expenditure (THE) in 2016/17, considerably higher than the global recommended target of 20%. Over 87% of total health spending was allocated to recurrent expenditure in 2016/17, while the remaining 12% went to capital and capital-related health expenditure.[44]

Health Insurance

Health insurance benefits should be equitable, not necessarily equal. The concept of equity is most often applied to health outcomes, in terms of addressing the burden of disease borne by onegroup compared to another (REF). The solution to these inequities often involves assessing the distribution of health determinants and allocating resources accordingly. Therefore, the achievement of equitable health access will be effective through community ownership and engagement, ensuring a good governance system, and raising public awareness about health services. Nationally the Community Based Health Insurance/CBHI/ Enrolment rate reached 770 functional woreda is 50% while further compared with the total eligible population the coverage is 38%.

According to the 7th National Health Account (NHA) report, the burden of out-of-pocket (OOP) spending is still significant (31%), implying the need and importance of the health insurance program in the country.

Table 5: Membership coverage disaggregated by regions 2020

Region	Eligible	Enrolled			
		Paying	Indigents	Total	%
Tigray	832,090	375,756	108,003	483,762	58%
Amhara	4,208,004	2,047,714	481,412	2,529,124	60%
Oromia	6,263,752	2,047,281	679,438	2,726,719	44%
Sidama	294635	42426	18313	60739	21%
SNNP	1,951,168	809,413	112,367	921,769	47%
B/Gumuz	87,841	27,032	6,816	33,848	39%
Hareri	33,641	6,708	3909	10,617	32%
Afar	9,114	3,209	800	4009	44%
Addis Ababa	292,695	137,942	49,371	187,313	64%
Total	**13,926,049**	**5,484,860**	**1,457,140**	**6,941,989**	**50%**

2.3.6 Digital Transformation (information revolution)

Digital technology is the cornerstone to reach the local population to narrow the gaps in health information and evidence –based decision making process. The 'digital transformation of health services' is viewed as an important and influential process that is already exercising a substantial impact on health systems and is undoubtedly set to fundamentally alter the future of health systems. Just as banking, retail or travel now occur in a fully digital world without the 'e' prefix; this revolution will arrive in health systems. However, the impact of digitalization goes beyond the platforms and mechanisms through which patients interact with health services. The proliferation of health related smart phone applications, the quantified self-movement (a form self-knowledge through self-measurements of physiological variables) and the use of big data that draws upon health and lifestyle information all have a profound impact to shape the health of current and future generations outside the parameters of health care delivery.

The WHO classifies 'digital technologies (Digital technology as per WHO framework)' used for health and health services into four distinct categories:

- Interventions for clients
- Interventions for health care providers
- Interventions for health system or resource management
- Interventions for data services
- Commonly held aspiration is that:

'Now that digital technologies have provided almost full interconnectivity among all humans, they should be used to meet key challenges to ensure that health is created and that it spreads to reach every person on earth' Jimenez-Marroquin, Deber and Jadad.7

2.2 SWOT Analysis in Health System Equity

STRENGTHS	WEAKNESS
Service Delivery	
• Access is improved particularly to PHC and health service expanded to rural areas • Slight improvements in Service utilization • Health outcomes improved • Availability of ambulance services is increased • Regulatory system is improved	• Low quality health services • Huge disparity in terms of health status and utilization among the population across various equity dimensions (Urban/rural, Agrarian/pastoralist, women/men…etc.) • Low satisfaction of patients and staffs on health services • Lack of standard cost of health service • Sub optimal public and private partnership; lack of uniformity in regulatory practices • Poor awareness and misconceptions about the burden and consequences of NCDs, among the policy makers, health professionals and the general public • Fragmented structure and lack of fully autonomous health regulatory body • Poor community mobilization in the health sector • Low determination and support on regulatory initiatives
Health workforce • Increased number of professional associations • Rapid increase in human resources for health • New initiatives such as Continuing professional development (CPD) including leadership programs	**Health workforce** • Weak planning of human resources for health; manifested by scarcity and unbalanced mix of health workers. • Decreased motivation and competency of the health workforce. • High staff turnover and absence of retention mechanism • No dedicated professional career structure for some professions
HMIS • Availability of evidence and data improved • Fully scaled up DHIS2 leading to improved HMIS • Integrated Supportive supervision and inspection • Regular and participatory review mechanism in practice	**HMIS** • Poor data storage, sharing, analysis and low utilization of evidence for decision making • Poor data quality including completeness and timeliness of reporting • There is no standardized electronic medical record (EMR) in the public health facilities. • Lack of comprehensiveness in quality and equity oriented indicators • Lack of standardized national level information systems including emergency care, laboratory services. • Weak feedback and follow up system on routine reports and monitoring and evaluation findings,

STRENGTHS	WEAKNESS
Supplies and Logistics • Improved supply of medical equipment • The existence of a structure in the management of pharmaceutical logistic system (EPSA)	**Supplies and Logistics** • Poor logistics and pharmaceutical supply management system including lack of capacity for quantification, long procurement time and weak distribution system • Lack of rational use medical equipment, pharmaceuticals and laboratory supplies • Lack of medical device management policy and inadequate medical equipment maintenance workshops • Lack of national health technology assessment system
Budgeting • Health care financing reform (such as fee retention, private wing, service fee revision, etc) • Implementation of the community health insurance system. • Improved resource mobilization (MDG PF, HPF…); RDF capital is improving **Community** • The existence of an organized community structure (Women development army) • Improved awareness of the public on health and wellbeing • Increased demand for quality health services • Scale up of the health extension program **Leadership** • Strengthened health facilities' governing board/management committee • Program management is improving • High commitment of public leadership to improve health service • Improved engagement of stakeholders	**Health Care financing** • Inadequate budget allocation • Fragmented and weak implementation of health care financing and constraints in raising local revenue • Low capacity of financial utilization by the system at all levels • High out of pocket expenditure **Leadership** • The appointment of managers for public health facilities is done through political affiliation rather than merit based • Poor coordination and harmonization within the MoH and agencies • Lack of accountability at all levels of the health system • Lack of streamlining assignments among managers and staff • High turn-over of leadership • Limited awareness and leadership capacity • Conflict of interest between regulatory and other sectors **Community** • Poor health literacy and health system literacy • Harmful traditional practice are still barriers to the delivery and utilization of essential health services • Community fatigue in some activities such as Health development army(HAD)

OPPORTUNITIES	THREATS
• Determination and political commitment • Health is among global as well as national priority agenda Positive government attention (availability of favorable policy, strategy and plans) • Improved access to various media outlets and Social Network. • Financial and technical support different partners and donors • Improved advancements in technology • Improved implementation of various reforms in the country • Presence of favorable cultural and traditional self-help practices in the community • Expansion of health professionals training institutions (public and private sectors) • Improved community engagement in the development and social sectors • Growing role of the private sector on health, • Improving mobile and telecom infrastructures • Improved literacy rate, particularly girl's education • Industrialization (local production of drugs and equipment, local manufacturers of food, etc.) • Promotion of women to leadership position in the health sector • Presence of global and national attention towards addressing gender issues	• Emergence and re-emergence of disease epidemics/ & pandemics • Increasing burden of non-communicable diseases, and injuries • A significant proportion of the community being below the poverty line • High population growth and high unemployment rate in the country • Increased manmade and natural disasters • Political instability including increased conflict and security threats that hinder service provision • Instability of neighboring countries and having a porous border • High adult illiteracy rate, especially women illiteracy • Wide spread of harmful health practices including gender disparities • Increased brain drain to wealthy countries • Lack of good quality data from other sectors; like vital events registration; household income status; access to electricity and water supply. • Low coverage of the important infrastructure such as road, water supply, and electricity • Poor technology infrastructure and use in the country • Potential global economic crisis following COVID-19 (rising cost of pharmaceuticals, supplies etc) • Low predictability of funding, Dependence on donor fund, and poor aid effectiveness • Weak multi-sectoral coordination mechanism • Proliferation and unregulated promotion of industrial/ commercial processed foods and unhealthy lifestyle • Poor quality of pre-service education in health science college/medical schools • Rural to urban migration, unemployment and waste management following growing urbanization.

2.3 Stakeholder analysis

Stakeholders are key to address health inequity in the country. The level of their contribution at different level may vary. It is crucial to map and engage in implementation of the strategy to narrow the health disparities according to their level of influence.

Table 6: Summery of key stakeholders

	STAKEHOLDER	BEHAVIORS WE DESIRE	THEIR NEEDS	RESISTANCE ISSUES	INSTITUTIONAL RESPONSE
1	Community	Participation, engagement Ownership Service utilization and Healthy life style	Access to health information and service, empowerment, affordable cost, Quality of health service in equitable manner	Dissatisfaction, Opting for unsafe alternatives health care and underutilization of services	Community mobilization, ensure participation, Access to information quality and equitable health service
2	Parliaments, Prime Minister's Office, Council of Ministers, Regional Governments	Ratification of Policies, proclamations, directives and Resource allocation	Implementation of proclamations, policies, ensured equity & quality health service delivery, quality Plans & Reports, cultivating culture of accountability	Administrative measures Organizational restructuring Influence on budget allocation	Put in place strong monitoring & evaluation system and comprehensive equity health service implementation in the country
3	Agencies (EPHI, EPSA, AHRI, NBBS, EHIA, EPSA, FHAPCO, FDA)	Availing medical commodity, emergency preparedness and responses, availing safe blood and financial protection for all corner of the country in equitable manner, ensuring quality and equitable services through regulations and evidence based generation for informed decision making	Coordination, joint planning, implementation and M&E	Mal distribution of medical commodity, increasing emergency related problems, inadequate blood supply, increasing out pocket expenditure for health service, poor quality of health services and leading to preventable & premature death	Mobilize resources and allocation budget for medical commodity, create resilient emergency management system, mobilize volunteer blood donations and universal coverage for health insurance(CBHI&SHI)

	STAKEHOLDER	BEHAVIORS WE DESIRE	THEIR NEEDS	RESISTANCE ISSUES	INSTITUTIONAL RESPONSE
4	All relevant line Ministries	Inter-sectoral collaboration Mainstream health and equity in all policies, strategies and programs	Evidence-based plan & reports Effective and efficient use of resources & coordination Technical support	Fragmentation Dissatisfaction Considering health as low priority and giving less attention	Advocacy Collaboration, coordination Transparency
5	Regional president office and Regional sectors bureau	Implementation of equity health strategies, resource allocation , multi sectorial coordination, M&E	Equitable and quality health care service,	Poor health service delivery, fragmented resource mapping	Advocacy, coordination, and M&E
6	Donors, UN agencies, Implementing partners, NGOs, CSOs, and professional associations	Harmonization & alignment, Participation, resource mobilization &Technical Advisors, Participate in licensing and accreditation, Promote professional code of conduct, support in evidence generation	Involvement in planning, implementation and M&E Participation	Dissatisfaction Fragmentation Scale down Withdrawal	Advocacy ,transparency, coordination, capacity building financial support and M&E

3

Health Equity Strategic Plan

3.1 Vision

To see all Ethiopians receiving the highest possible quality health care service in an equitable manner

3.2 Mission

To ensure health equity by increasing access and utilization of health service through strengthening health system, collaboration and evidence-based decision making.

3.3 Values

- Community first
- Integrity, loyalty, honesty
- Transparency, accountability and confidentiality
- Impartiality
- Inclusiveness
- Respecting Law
- Collaboration and integration
- Innovation

3.4 Guiding Principles

The equity strategic plan considers the following shared values and ethical standards:

- **Fairness:** Provision of quality and equitable services will be emphasized through ensuring that all services reach all populations based on their health need and irrespective of sex, income, geography, age, residence and education.
- **People-centered and Integrated services**: is an approach to care that consciously adopts the perspectives of individuals, families and communities, and considers them as stakeholders as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways.
- **Collaboration:** Basically, equity is a cross cutting issue which needs collaboration and coordination with different sectors and departments. One of key principles of this strategic plan is to maximize the successes and avoid duplication of efforts. Also, existing partnerships will be valued and sustained.
- **Evidence-based interventions:** The data generation will be promoted to design appropriate interventions to minimize the disparity of equitable health services.An equity measurement dashboard will be in place to monitor the progress of the strategic plan.
- **Innovations:** Strengthening technology expansion, adaptation and promotion of the innovative strategies based on the context.

3.5 Objective

3.5.1 General Objective

The aim of this strategic plan is to narrow the current health inequity gaps in terms of access, uptake, and quality and contribute to addressing the social determinants of health by the end of 2025.

3.5.2 Specific objectives

- To improve access to healthcare by reducing physical, price and socio-cultural barriers
- To increase the uptake of healthcare service
- To reduce the difference in health status (or outcomes)
- To integrate the concept of equity throughout all dimensions of quality improvement tools, health care operation and health care practices

3.6 Pillars of Health Equity and Strategic directions

3.6.1 Pillars of Health Equity

3.6.1.1 Excellence in Access and Uptake to Essential Health Service Packages

Client centered and responsive service delivery is a vital element of any health system. Service delivery is a fundamental input to population health status, along with other factors, including social determinants of health. In any well-functioning health system, the network of service delivery should have the following key characteristics.

1. Comprehensiveness

A comprehensive range of health services is provided according to the needs of the target population which includes promotive, preventive, curative, palliative and rehabilitative health services.

2. Accessibility

Services shall be sustainably accessible with no undue barriers of financial hardship, language, culture, age, sex, disability, physical structure, psychological or geography factors, among others.. Health services shall be closely available to the people, with a routine point of entry to the service across the continuum of care. Services can be provided at home, community, school, youth centre, workplace, congregate settings, or in the health facilities as appropriate.

3. Coverage

Service delivery is designed to serve all people in a defined target population including the sick and the healthy, without considering income and social status.

4. Continuity

Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle including emergency conditions.

5. Quality

Health services shall be provided with the highest possible quality in an effective and safe manner, centred on the patient's needs and given in a timely fashion as well.

6. Person-centeredness

Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable to them. There is participation from the target population in service delivery design and assessment. Therefore, people are partners and clients in their own health care.

7. Coordination

Primary health care units should be efficiently coordinated across the types of provider and care levels of service delivery for both routine and emergency management. Moreover, the patient's primary care provider facilitates the route through the needed services and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors and stakeholders.

8. Accountability and efficiency

Health services need to be well managed to achieve the core elements with a minimum wastage of resources. Health managers at different levels of the sectors should be accountable to achieve planned objectives, overall performance and results.

3.6.1.2 Excellence in Leadership and Governance

This theme refers to evidence-based policy formulation and planning; implementation; effective monitoring and evaluation, motivation and partnerships that integrate all health systems building blocks to achieve results. It incorporates Equitable and effective resource allocation, Leadership development within the sector and the community, including community engagement platform, with the concept of community empowerment, and partnership and coordination.

3.6.1.3 Excellence in Evidence Generation and Knowledge Management

Evidence Generation and Knowledge Management is a process of creating, capturing, storing, retrieving, sharing, and managing knowledge and effectively using it for informed decision making. Health equity at outcome level refers to coverage of high impact intervention disaggregated by relevant equity dimensions. Difference and ratio as well as concentration curve in relation to health service utilization to measure inequality by place of residence (urban/rural), between two extreme groups of wealth status (top and bottom wealth quintiles) and level of education, and gender selected high impact indicators will be used as tracer of outcome and impact level inequalities for the health sector.

Equitable accessibility to high quality health services will then lead to improvements in the health of the population with particular emphasis to vulnerable groups including:

- Mothers
- Neonates
- Children (with emphasis to street children and orphans)
- Adolescents and youth (in and out of school, recreational place and workplace at mega projects and industries)
- Persons with disability
- Elderly and
- Congregate setting and other vulnerable groups.

3.7 Targeted Initiatives or Core interventions to address health equity

Addressing socio economic inequity

- Access to social and community based health insurance
- Covering health expenditure for the indigent peoples by government
- Expand the implementation of Family health team in urban setting
- Implement School Health, WaSH programme, industrial parks and development corridors and Nutrition Policy
- Establish mechanism to address communities in Industrial Park and Development Corridors
- Improve household income level through multi sectoral approach

Disparities due to Level of education

- Improve health and health system literacy
- Create awareness through health extension program and other community based platforms
- Expand implementation of tailored Social and Behavioural Change Communication (SBCC)
- Implement adult education in collaboration with education sector and other stakeholders

Geographic Disparities

- Improve accessibility of essential health service packages and equipping health facilities with basic utilities in pocket and geographically in accessible areas
- Promoting healthy lifestyle
- Healthy City Programme (involving the entire community including local government in designing spaces that encourage walking and cycling)
- Tailored health service delivery modality

Gender Disparities

- Empowering women to leadership
- Improve women targeted interventions
- Create and enforce legislation that promotes gender equity and avoids discrimination
- Strengthen gender mainstreaming by creating and financing a gender equity unit
- Increase investment in reproductive health services and programmes for building the universal coverage and reproductive health rights
- Strengthen in investing on formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies
- Addressing people with special need and congregate setting (refugee, IDP, geriatric centre, prison, etc) with tailored health service approach

Demographic disparities

- Early Childhood development strategy implementation
- Adolescent and youth health strategy implementation
- Healthy aging strategy implementation
- Mainstream Life course approach
- Encourage to scale up people with special need friendly health facilities and services
- Implement RH strategy

3.8 Strategic Directions Addressing Health Equity among General Population

The detailed situational analysis, bottleneck and root causes, have created a strong foundation and evidence for designing effective interventions to address historic inequities in health outcomes and social determinants of health in the Ethiopia. The agenda of universal health coverage and ensuring that services are equally accessible, affordable and socially or individually acceptable define the direction the country's health care systemis moving.

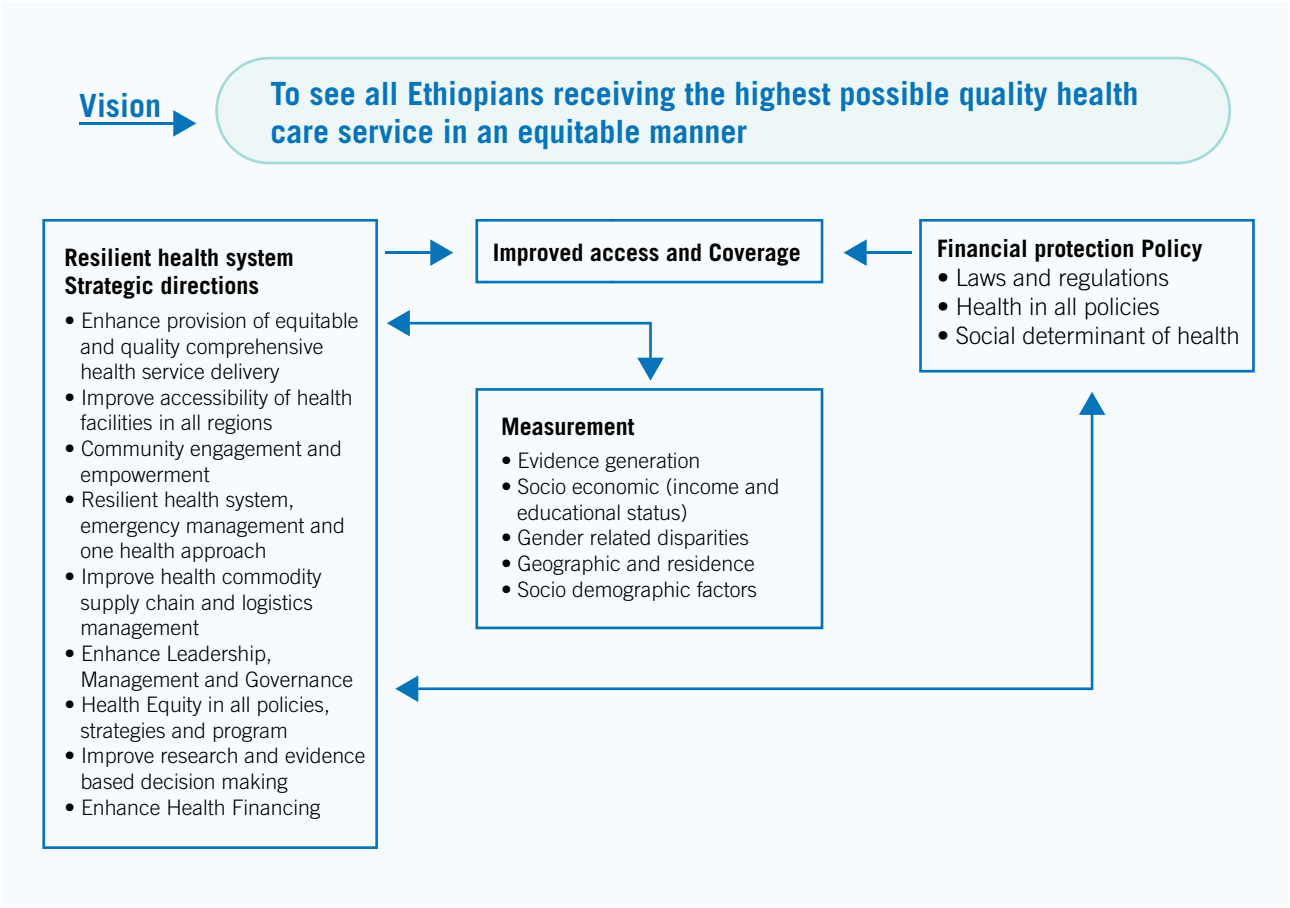

Figure 10: Strategic framework for health equity

The performance monitoring framework is structured in such a way to guide the translation of the strategy into measurable results. The strategic initiatives that have emanated from the strategy will be decoded into a set of high priority core interventions. There is a chain of interdependent results from the general objective at a higher level, through strategic initiatives, core interventions and performance measures. This will also help to track the progress of the implementation. The strategic objectives also emanated from the identified gaps of the health equity dimensions.

Strategic Directions

- Enhance provision of equitable and quality comprehensive health service delivery
- Improve accessibility of health facilities in all regions
- Community engagement and empowerment
- Resilient health system, emergency management and one health approach
- Improve health commodity supply chain and logistics management
- Enhance Leadership, Management and Governance
- Health Equity in all policies, strategies and program
- Improve research and evidence based decision making
- Enhance Health Financing

Strategic Direction 1: Improve access and quality of health service provision

The focus of this strategic direction is to improve access to and quality of health services in the country by implementing high impact interventions of maternal, newborn, child health, adolescents and youth health, nutrition, hygiene and sanitation, communicable and non-communicable diseases, emergency and clinical services. Indeed, the health problem of Ethiopia is related to inaccessibility of essential health services, lower health literacy, harmful traditional practices and unhealthy lifestyles. Consequently, health problems related to poor hygiene and environmental sanitation, malnutrition, low economic status and emerging and re-emerging communicable diseases are prevalent. Non-communicable diseases and injuries/ accidents are also becoming a major health problem, leaving the country facing a triple burden of diseases (communicable, non-communicable and injuries). The burden is different across access and quality parameters, inter and intra-regional distribution, with agro-ecological zones of urban and rural areas, and people with special needs. In order to tackle these challenges tailored health service delivery with emphasis to health promotion, disease prevention, curative and rehabilitative care by providing the service in an equitable and quality manner is crucial.

Initiatives or Core Interventions

Maternal, New-born, Child Health, Adolescent and Youth, and Nutrition

- Strengthen reproductive health, maternal, new born, child, adolescent and youth focused and nutrition services
- Enhance implementation of routine immunization improvement initiative minimizing the immunization gap
- Implementing and Strengthen and further expand Case Management of New-born & Childhood Illness (ICMNCI)

Diseases Prevention and Control

- Strengthens STIs prevention and control, strengthens implementation of ART service.
- During the period of 2021-2025, combination HIV prevention interventions will be implemented in the three incidence levels of woredas (high, medium and low incidence woredas), need based ART/PMTCT service expansion
- Enhance implementation of integrated, people-centered TB prevention and care equitable service framework
- Strengthen and expand drug resistance treatment and follow up sites
- Implement tailored TB detection and treatment approach for urban and pastoralist communities
- Ensure universal access to malaria prevention, diagnosis and treatment
- Enhance integrated Neglected Tropical Diseases (NTD) prevention, treatment and case management
- Strengthen and expand integrated prevention and control NCDs and mental health services into the government sectors, Strengthen health systems for NCD and mental health prevention and control across all levels of the health sector
- diagnosis, following up and treatment of NCD risks and treatment of established cases in an integrated manner

Hygiene and Environmental Health

- Strengthen and expand sanitation marketing by engaging mainly micro and small- scale enterprises
- Ensure access to adequate and inclusive sanitation services in health facilities disaggregated by sex
- Promote access to adequate and inclusive sanitation services disaggregated by sex in all institutions
- Promote access to menstrual hygiene management services in all institutions
- Design inclusive sanitation and hygiene behavioural change approach
- Improve hygiene, safety and environmental health program

Health Extension Program

- Implement HEP optimization road map in tailored manner
- Strengthen and expand mobile health for pastoralist/semi-pastoralist
- Design and disseminate tailored SBCC Strategy on essential and community health services for different target groups

Strategic Direction 2: Improve accessibility of Health Facilities in all Regions

The accessibility of health facilities will be carried out in areas where no health facilities exist and in places where people travel long distances to access health care. Construction of new facilities will be the responsibility of each region matched with MoH funds based on need and equity.

Initiatives or Core interventions

- Mapping and planning of health facilities to reach all segment of population
- Address health infrastructure and basic amenities (water, electricity, communication technologies,) needs of health facilities for the provision of quality health services
- Construction of Health facilities by matching basis(223 primary hospitals by standards of 1: 100,000 population ,1336 Health centres 1:20,000 population, operation room, blood bank, health facilities utilities, Regional laboratory and EPSA hub
- Ensure staffing of positions by appropriate skill mix(qualified health professionals) through regulatory and other measures including training of pharmacist, laboratory technologist and HIT

Strategic Direction 3: Engaging and Empowering Community

Community participation is the basic principle of Primary Health Care. In the coming five years regions will work to fully engage communities through community engagement platforms, health extension programs, health insurance and other effective social mobilization strategies in the planning, implementation, and evaluation of initiatives. A good deal of community representation will be ensured on the health facility board and community forum. A well-researched communication strategy will be adopted and developed to facilitate this big endeavor.

Initiatives or Core interventions

- Engaging community based civic organization
- Participating individuals on their health seeking behaviour changes & empowering women to choose their need
- Design and implement interventions to increase health literacy and health system literacy
- Design, test, and scale-up alternative & context tailored community engagement options
- Introduce new and strengthen mechanisms such as community scorecard primed to enhance accountability of the health system to the public
- Evaluate, refine and implement competency based training for community level structure representatives and model household
- Test and introduce innovative motivation mechanism for community volunteers
- Strengthen the engagement of communities in decision making processes such as board members in health facilities
- Design and implement approaches to enhance community resource contribution
- Engage school community members to reach households with health message
- Use existing community potentials and indigenous resources such as associations, faith based and community based organizations as platforms for engaging communities in health
- Implement contextualized community engagement strategies in pastoralist, geographically hard to reach and vulnerable populations across the nation (such as IDPs, refugees)
- Engage formal and informal community organizations in ensuring good governance practices

Strategic Direction 4: Resilient health system, emergency management and one health approach

The health impacts of recent global infectious disease outbreaks and other disasters have demonstrated the importance of strengthening public health systems to better protect communities from naturally occurring and human-caused threats.

Ethiopia has built a public health management system at national and subnational levels 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. The core capacities to prevent, detect, respond and mitigate to public health emergencies have been improving. As part of reaching all population segment and ensuring equity the country tried to reach populations in pastoralist communities, IDPs, Congregates Settings and Urban Slums. Despite all the challenges related to health security, suboptimal multi-stercoral collaboration, lack of surveillance structure at lower levels, poor functionality of EOCs, poor documentation of rumors and verification system, suboptimal laboratory-based surveillance, inadequate emergency fund, emergence of global pandemics such as COVID-19, conflicts leading to many internally displaced people (IDPs) that must be given emphasis in the future.

The national health system should be resilient enough in terms of preparedness, early detection, prevention, response and recovery, and transforming effectively to any health emergencies as a result of manmade and natural calamities. Especially the developing regions, pastoralist and selected low performing zones of agrarian regions are more prone to natural disasters like flooding, internal displacement, drought and outbreaks of communicable diseases. This system will strengthen existing PHEM structures at all levels. Strengthen the human, animal, and environmental interface for ensuring national health security (one health approach). The management and response team will periodically meet to discuss routine surveillance reports and agenda related to emergency preparedness. The emergency preparedness and response committee will report to the concerned bodies on a regular basis.

Initiatives or Core interventions

- Strengthen Community based surveillance system (CBS)
- Enhance routine sentinel and facility surveillance system at all levels integrate with e-CHIS and DHIS2
- Strengthen health sector and multi-sectoral coordination mechanisms (one health approach)
- Strengthen hazard, vulnerability, and capacity analysis (VRAM), risk communication and early warning system
- Improve emergency logistics and fund for emergency preparedness, response and recovery at all levels of the health system
- Develop and updated national health emergency Roster
- Strengthen emergency preparedness response plan (EPRP)
- Strengthen Emergency Operations Center (EOC) and Disaster Medical Assistant Team (DMAT)/Emergency Medical Teams.
- Strengthen Referral linkages with laboratory systems and networks for prevention, detection, and readiness for response to potential epidemic/pandemic threats
- Develop and implement strategies for post trauma management such as psycho-social support to emergency victims
- Ensure availability of adequate isolation, quarantine and treatment centers at identified and designated point of entries

Strategic Direction 5: Improve health commodities supply chain and logistics management

Uninterrupted pharmaceutical supplies and availability of quality medical equipment are essential input to successful provision of quality care. To ensure this, a comprehensive supply improvement plan is in place to address the bottlenecks identified. The working relationship will be strengthened between regional health bureaus and EPSA to implement APTS and IPLS. The Drug and Therapeutic committee (DTC) will be enhanced to oversee the overall performance of the supply chain management of the regions. Optimizing good warehousing and distribution practice is also crucial. Accountability framework will be designed and implemented to ensure availability of medical commodities at all levels of the health system.

Initiatives or Core interventions

- Optimize good warehousing and distribution practice
- Institutionalize robust information systems to ensure end-to end data visibility for the supply management of medicines and medical devices across the supply chain.
- Strengthen private and other stakeholders' engagement in areas of supply chain and medical devices management
- Strengthen medical device maintenance workshops, refurbishment centres and maintenance referral system
- Implement reverse logistics within health facilities and pharmacy retail outlets that extends to households
- Promote the rational use of medicines by healthcare professionals and the public
- Strengthen the prevention and containment of Antimicrobial Resistance (AMR)
- Strengthen Drug and Therapeutic committee (DTC)
- Strengthen implementation of Auditable Pharmaceutical Transactions and Services (APTS)
- Strengthen clinical pharmacy and drug information services
- Strengthening community pharmacy
- Strengthening the implementation of IPLS

Strategic Direction 6: Enhance leadership, Management and Governance

The focus of this strategy is to make universal health coverage a reality through robust transformative health leadership as a pivotal role. In the lifespan of this strategic plan, different effective strategies will be put in place to enhance the continuity of committed leadership that will work to ensure community ownership and active participation of health projects and interventions. Capacity building activities will be organized to improve the leadership and managerial skills of the health workforce. Efforts will be made to make the system and health workforce accountable based on health equity measures.

Initiatives or Core interventions

- Build leadership capacity through different mechanisms like Leadership Incubation Programs and project based leadership, management and governance training at all levels
- Promote merit-based/competent professionals assignment of health sector
- Design and implement transparent resource mobilization and allocation mechanism
- Prepare guideline/standard to ensure accountability and transparency at all level
- Empower women interms of education, economy in leadership and decision making
- Institutionalize grievance handling, conflict resolution and monitoring mechanism
- Design and implement innovative mechanisms to improve social accountability
- Strengthen partnership among public sectors, private for profit, CSOs and NGOs
- Design and implement incentive package and accountability mechanisms
- Ensure the implementation of good governance principles at all level
- Strengthen participation and inclusion of special need communities
- Design and implement interventions to reduce corruption

Strategic Direction 7: Health Equity in all policies, strategies and programs

Health in All Policies (HiAP) is a systematic approach of considering the health implications of decisions of public policies across all sectors. It anticipates synergistic effect of public policies, prevent and mitigate harmful health effects in order to advance population health. It advances accountability of policymakers for health impacts through efficient and effective multi-sectoral actions. It emphasizes the need to be watchful of the consequences of public policies on determinants of health, well-being and health system. HiAP fosters inclusive and sustainable development and helps in addressing the social determinants of health, reducing multi-sectoral risk factors, and promoting health and well-being through promoting healthy practices across all sectors.

Equity is a cross-cutting issue that must be implemented across all policies, strategies and programs. During the strategic implementation life span the ministry along with key stakeholders advocate and work on to ensure the mainstreaming of health equity agendas in all policies, strategies and programs based on the identified gaps.

Health and health equity are values in their own right, and are also important prerequisites for achieving many other societal goals. Many of the determinants of health and health inequities in populations have social, environmental, and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies in all sectors and at different levels of governance can have a significant impact on population health and health equity.

Initiatives or Core interventions

- Advocate and review the inclusion of health equity agenda in all policies, strategies and programs
- Ensure implementation of equity concepts and practice across all levels of the health system
- Develop equity index dashboard and update regularly to monitor health equity status
- Conduct continuous and regular health equity analysis and disseminate the findings for intervention and policy decision
- Implement alternative health service delivery modalities (such as mobile health, mobile clinic, private engagement and application of technologies) to reach mobile, hard-to-reach and special need communities.
- Provide need based technical and financial support to strengthen health planning, implementation and health systems capacity
- Enhance multi-sectoral coordination among line ministries and other relevant sectors at all levels through joint planning, monitoring and evaluation.

Strategic direction 8: Public-private partnership

Public-Private Partnership (PPP), a subset within the engagement arrangement, with the private sector could strengthen the health service delivery through improving the quality, quantity and affordability of essential health inputs by facilitating local manufacturing of pharmaceuticals and medical devices. It also increases production of skilled health human resources; mobilize additional resources for the health sector; and, contribute to meet the increase demand for access and utilization of health care.

The government will facilitate the private sector's usual engagement in the expansion of health infrastructure, local production of pharmaceuticals, and medical devices, as well as training and continuing development for health professionals.

Initiatives or Core interventions

- Strengthen and Implement Public Private Partnership (PPP) projects in clinical and non-clinical services

Strategic Direction 9: Enhance Health Financing

Financial risk protection is one of the essential components of universal health coverage. Health care financing strategy and policy has a significant role in addressing health inequity arising due to high out of pocket expenditure to minimize financial catastrophe. To ensure financial sustainability there is a need for innovative revenue generation, increasing budget allocation by government, active engagement of the community, creating awareness at different levels, engaging all donors and developmental partners and building the capacity of those on driving seats and their associates to properly manage the finance.

Accountability will be ensured through participatory joint planning and review, strengthening of the facility-community and WoHO governing board, and regular financial auditing. In addition, partnership with development partners and private institutions to synergize the effort of resource mobilization should be strengthened.

Initiatives or Core interventions

- Mobilize adequate resources through existing and innovative approaches from domestic and external sources.
- Develop and implement strategies to increase government budget allocation for health
- Initiate and scale up social health insurance
- Expand and strengthen Community Based Health Insurance (CBHI) and Provide cover for all indigent.
- Review premiums for CBHI with a view to increasing the costs to create a more sustainable model
- Conduct regular financial audit, risk assessment and strengthen different financial resource tracking systems
- Strengthen coordination platform to improve health care financing
- Strengthen health facility revenue generation and effective utilization
- Standardize health service fee setting process across regions context and level of care
- Introduce user fee to cover curative health services at HP level
- Design and implement performance linked strategies to improve efficiency and effectiveness (performance based financing and result based financing) and conduct performance audit

- Increase health sector's/ organizational capacity for health financing at all administrative, management and service delivery levels

Strategic Direction 10: Improve research and evidence based decision making

The progress and success of any endeavour can be tracked by monitoring, evaluation and learning systems in place. The return on investment is gauged by the system put in place to track the progress timely and efficiently through proper documentation of vital statistics at woreda level engaging the community, HEWs and other stakeholders by strengthening health management information systems. The ministry works closely with the region to implement the information revolution strategy and to ensure a culture of using evidence for decision making is enhanced at all levels of the health system. Regular participatory data quality assurance practice will be internalized.

Initiatives or Core interventions

- Enhance implementation of "one plan", "one budget" and "one report" approach at all levels of the health system
- Strengthen the routine health information system through digitalization (DHIS2, LIS, HCMIS, LMIS, CHIS, HRIS)
- Implement data quality improvement, assurance and auditing
- Enhance research activities and synthesise evidence based information to contribute for policy program practice improvements
- Regularly conduct household, community and facility-based surveys through collaborating with international and local universities and research organizations
- Enhance knowledge management unit at all health system levels
- Strengthen birth and death notification for civil registration and vital statistics (CRVS) system.
- Design the suitable mobile community health information system (Manual and electronic)
- Strengthen monitoring and evaluation

4

Implementation Modality

4.1 The implementation arrangement

The National Health Equity strategic plan will have the following implementation modality. Arrangement of organizational structure from national to the facility level is crucial for implementation of the strategic plan (Figure 11).

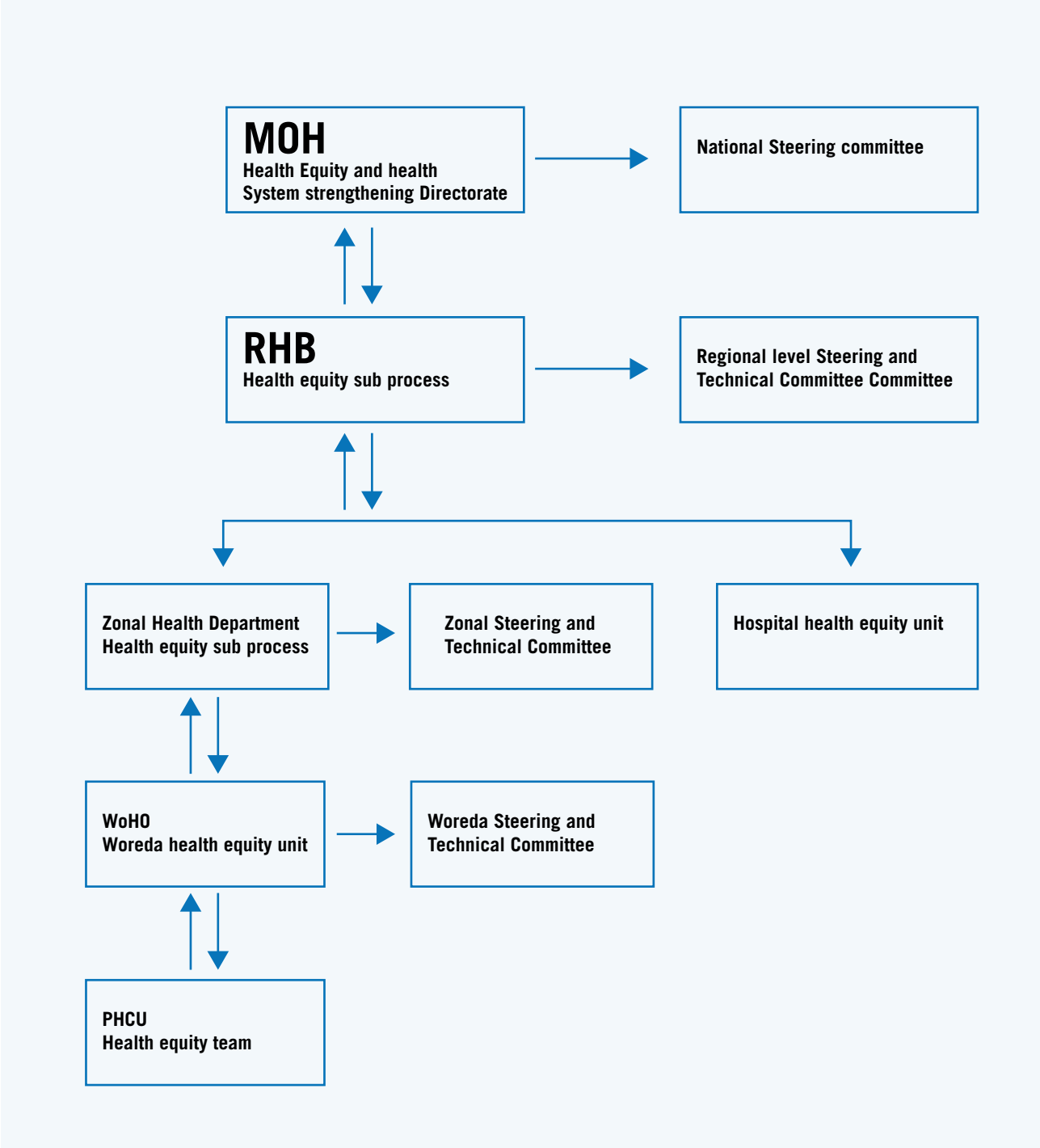

Figure 11: Implementation Modality

Federal Level Steering Committee

The members of the steering committee at federal level will include MoH minister and state ministers, directorates, Agencies, donors and development partners. The steering committee is responsible to follow up and evaluate the overall implementation of the equity plan at national level. The steering committee is expected to conduct regular meetings on a quarterly basis to ensure the planned activities are being carried out.

The members of the technical committee at Federal level will include MoH Agencies (EPSA, EPHI, NHIA, FDA, AHRI, NBB, FHAPCO and directorates in the ministry. Health Equity and System Strengthening Directorate will take the leading and coordination role, UN Agencies, Partners, and representatives are also the members of the steering committee. The technical committee is responsible to closely monitor and evaluate the overall implementation of the equity plan at national level. They will play an advisory role by providing guidance in implementing the equity plan. The technical committee is expected to conduct regular meetings on a monthly basis.

The members of the steering committee at Regional level includes RHB, Universities found in the region, Health Science Colleges and implementing partners at regional level. The steering committee is responsible to follow up and evaluate the overall implementation of the equity plan at regional level. The steering committee is expected to conduct regular meetings on a quarterly basis.

The members of the technical committee at regional level includes agencies (EPSA hub, Regional public health institute, Health Insurance branch, Regional regulatory, RBB, and RHAPCO), Health Equity and System Strengthening unit, UN Agencies and Partners and representatives from the members of steering committee. The technical committee is responsible to closely monitor and evaluate the overall implementation of the equity plan at regional level. They will play an advisory role in implementing the equity plan. The technical committee is expected to conduct regular meetings on a monthly basis.

The steering committee and the technical committee are also expected to be established at zonal and woreda levels and they have similar roles and responsibilities similar to that of regional committees tailored to regional context.

4.2 Implementation strategies

The implementation strategies of equity aim at facilitating the implementation of the strategy by relevant stakeholders. The main implementation strategies identified for this equity strategic plan implementation are:-

4.2.1 Leadership and governance

Ample of evidence and observations from supportive supervisions, inspections and assessment reports shows there is weak accountability and regulation of procedures related to health service provision; strengthening the leadership and governance structures and proper implementation of its practices will spearhead the package of interventions to be implemented. There is also strong evidence that a robust leadership and management system are essential for the efficiency and effectiveness of any program and project implementations planned among the other five health system building blocks.

The national initiative to ensure good governance and leadership in service provision to address the public complaints and health inequity will be used as a springboard to ignite and accelerate the good governance initiative implementation. To follow and monitor functionality of facilities involvement of administrative structures at all levels, an exemplary intervention to strengthen sense of ownership and meticulous follow up is crucial.

4.2.2 Launching and Advocacy of the plan

Engaging stakeholders is one of the key practices of good governance. Thus, the strategic plan will be launched and advocated in the presence of all stakeholders at the federal level. The launching of the plan is also expected to be cascaded to regional, city administration, zonal, woreda and primary health care unit levels.

4.2.3 Signing agreements with regions and city administrations

Implementation of the initiatives in the project span depends on the full engagement at all levels. Regional presidents, city administration mayors and office heads of other line bureaus play critical roles in realization of the plan. Moreover, building consensus and gaining commitment from regional stakeholders is crucial to achieve the targets. Accordingly, an agreement will be signed between the ministry of health and respective regional and city administration health bureaus outlining the roles and contribution of each stakeholder that will be supported by an accountability framework.

4.2.4 Preparation of region specific equity strategy and cascading

The issue of health service inequity varies from region to region and the plan prepared at national level does not fit for the actual contexts of each region. Thus, every region is expected to customize this strategic plan to its context to address the health inequities within that region. The implementation of this national five years strategic plan is aimed at improvement of health of all peoples in all regional state and city administrations. Once an agreement is reached on the content and modality of implementation on the proposed strategies and core interventions, specific activities will be designed and outputs will be determined. The strategic plan will be dissected into an annual plan by the Ministry of Health and regional health bureau jointly with deliverables and measuring indicators.

Though regions have differences in context and depth, there are considerable similarities of underlying causes. Hence, implementation of the proposed core activities needs to be tailored to the context of the specific areas. Annual targets will also be set based on the current health profile of the locality.

4.2.5 Preparation and Ignition

The implementation of this plan requires the leadership and managerial readiness, commitment and sensitization of stakeholders. The health Equity and system strengthening directorate will play the leading role in the federal level. In order to coordinate the implementation at regional and sub-regional level, the regions are expected to establish/ strengthen similar units. The regional team/unit coordinates the zonal and district level technical assistance. The unit with the woreda level technical assistants sensitizes PHCU and local structures for the implementation of the proposed interventions.

In order to bring everlasting change in the health service equity across the country, ensuring the availability of leadership and change agents who are mentally prepared to be exemplary and selfless is one of the primary inputs. After having such attitudinal change, equipping leaders with the appropriate set of managerial and leadership skills will enable them to expedite their inspiration for bringing improvement. However, such motivated and skilled leaders can only operate in a system whereby the basic amenities such as supplies and infrastructure are fulfilled. Though ensuring the availability of such inputs is the responsibility of these leaders, national

support to lift up the regions with supplies, infrastructure (basic and enabling) and human resources is mandatory. Needless to mention the importance of proper and good governance, placing procedures to monitor the progress of the plan and evaluate its impact plays incredible role in ensuring accountability and measurability of achievement

4.2.6 Infrastructure and facilities readiness

Once the engine of the health system; human resources, is made available having the set of appropriate skills and mix, further components like pharmaceutical supplies, infrastructure, information system and health financing need to be addressed to ensure the proper running of the health service. Though, it is hard to put logical and time series based sequencing of interventions, the seamless availability of these inputs will be ensured metered with the need of each implementation unit.

4.2.7 Multi- sectoral collaboration

To ensure health service equity and quality, multi sectoral collaboration has a crucial role. To mention some, accessing roads, water supply and electricity to health facilities are first of all the priorities. Besides having healthy and productive citizens, securing every household and individuals with food supplies and nutrition is an unforgettable task. Empowering women and young girls through education is also crucial to avoid the underlying causes of malnutrition, poor educational performance and poverty vicious circle. So, the involvement and engagement of concerned stakeholders is mandatory at each level.

The national health equity strategy considers reaching all rounded personal, social, environmental, economic, and political for improved health service uptake and outcome. This entails collective actions by wide-ranging actors outside the health sector, such as education, environment, agriculture, housing and infrastructure, and water, within the ecological framework of health determinants. Engaging these sectors involve the coordination different stakeholders within the public sector, private sector, non-government agencies, civil services and community-level organizations.

4.3 Role and Responsibilities of Stakeholders

During the implementation of this strategic plan, several stakeholders will have a role to play, and the success of the proposed initiatives depends on the proper delivery of these responsibilities by each stakeholder. The roles and responsibilities of key stakeholders are stated below:

4.3.1 Ministry of Health

- Launch and introduces the equity strategic plan to the regions and sign memorandum with regions
- Support regions on building the capacity at each level for implementation
- Capacitate the Health Equity and System Strengthening directorate and regional delivery unit for effective and efficient implementation of the plan
- Mobilize funding for program implementation in the areas where there is inequity
- Recruit and deploy technical assistants who can support at regions, zones and districts
- Support the construction of health facilities and required basic infrastructures
- Strengthens multi sectoral engagement and collaboration
- Facilitate annual plan preparation from the strategic plan and its implementation
- Follow and support monitoring and evaluation of the strategic plan implementation

4.3.2 Health Equity & System Strengthening Directorate

- Coordinate the preparation and ignition stage of the strategic implementation through advocacy
- Support implementation of health equity concepts and practices at all levels of the health system
- Support and follow up the cascading of national equity strategic plan for all regions
- Support regions to work on building the capacity at each level for implementation.
- Support the establishment of tailored community health information system
- Coordinate monitoring and evaluation of the strategic plan implementation

4.3.3 Agencies

- Implement/scale up Integrated pharmaceutical Logistic system (IPLS) (with close support from EPSA) at all region
- Support for drug/revolving drug fund during Planning, budget allocation to address the health equity
- Support and strengthening of the implement of community based health insurance
- Ensure implementation of national food safety policy, proclamation, regulation, guidelines, and standards in collaboration with other sectors.
- Scale up research for evidence based decision making at all level
- Support the regional blood banks in Supplying and distributing blood and blood product at all levels in equitable manner

4.3.4 Regional Health Bureau

- Develop the region specific equity strategic plan and cascade on annual bases
- Lead the implementation of the whole strategic plan in the region
- Build capacity to zones and woredas for efficient and effective implementation
- Support zones and woredas where there is inequity with funding for program implementation
- Recruit and deploy the required human resource to staff facilities and health institutions
- Create community and health sector forum to monitor functionality of facilities
- Work with all relevant sectors and stakeholders in the region
- Conduct regular monitoring and evaluation
- Establish and run HCF, Social and community based health insurance

4.3.5 Zonal Health Department

- Developing the Zonal specific equity strategic plan and cascade on annual bases
- Ensure the implementation of the whole strategic plan in the zone
- Build capacity to woredas for efficient and effective implementation
- Work with all relevant sectors and stakeholders in the zone
- Conduct regular monitoring and evaluation
- Follow up the performance of HCF and community based health insurance

4.3.6 Woreda Health Offices

- Prepare woreda level equity strategic plan and cascade on annual bases.
- Implement HEP road map
- Strengthen community engagement platforms
- Support and strengthen the implementation of equity plan at the PHCU level
- Regularly monitor and evaluate the implementation of the plan in the woreda health offices and PHCU
- Work closely with all sectors and stakeholders at woreda level

4.3.7 Health facilities

- Prepare health facility level tailored equity plan and cascade on annual bases
- Follow implementation of plan
- Implement HEP road map through health center to health post linkage
- Strengthen community engagement platforms
- Avail all essential health services for all people regardless of their status.

5 Monitoring and Evaluation

The monitoring and evaluation plan is to describe the framework and implementation process of national health equity strategic plan through the generation and use of quality data for evidence informed decision making in a coordinated and harmonized manner.

5.1 The main purposes of Monitoring and Evaluation:

- To guide and track implementation progress of national health equity strategic plan
- To assess the performance of the national health equity strategic in accordance with agreed targets
- To determine and describe the data collection, processing, analysis and use of data for decision making
- To determine and describe the indicators for national health equity strategic plan
- To describe the performance review process for national health equity strategic plan
- To describe platforms and ways of data dissemination and communication

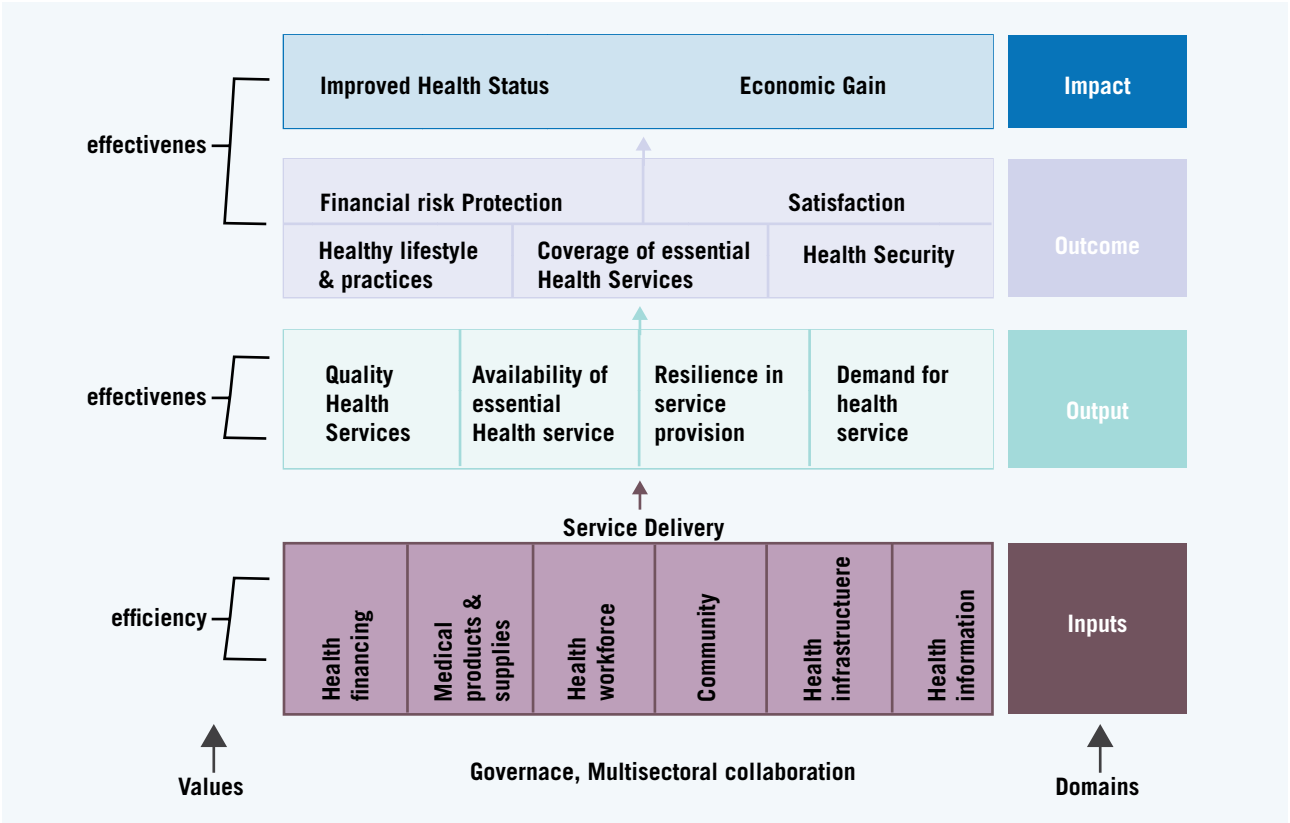

Figure 12: Monitoring and Evaluation Framework

5.2 Monitoring and Evaluation coordination mechanism

Strong monitoring, support and evaluation framework is a pillar for ensuring health service equity through establishing regular follow up mechanisms in place. Implementation of monitoring support and evaluation framework helps to assess the implementation status of the project measuring its output, outcome and Impact results. To ensure the implementation status of NHESP and, the following key practice evidence based decision interventions will be put in place,

- Integrated Supportive supervision and Inspection
- Implementing reforms
- Timely regular performance reviews
  - Annual and biannual reviews of operational plan
  - Baseline, Midterm Final review of the strategic plan
  - Evidence generation through research

Key Health equity performance indicators

Table 7: Key Health Equity Performance Indicators

Health System Building Blocks	Core indicators	Type of Indicator	Level of Disaggregation								Source of Data			Frequency Data collection and reporting		
			Age Group	Region (Geography)	Education	Disability	Residence (urban/ rural)	Gender	Wealth	Religion	DHIS 2	EDHS	Other surveys	Frequency of reporting	Level of Data collection	Level of reporting
Service Delivery	Skilled Birth Attendance	Outcome	x	x	x	x	x		x		x	x		Monthly	Facility	All level
	Contraceptive acceptance rate	Outcome	x	x	x	x	x		x	X	x	x		Monthly	Facility	All level
															Facility	All level
	ANC 4 coverage	Outcome	x	x	x	X	x		x		x	x		Monthly	Facility	All level
	Penta 3 coverage	Outcome		x	x		x		x		x	x		Monthly	Facility	All level
	EPI Dropout rate (Penta 1-MCV2)	Outcome		x	x		x		x		x	x		Monthly	Facility	All level
	Proportion of Fully Vaccinated children	Outcome		x	x		x		x		x	x		Monthly	Facility	All level
	Prevalence of Stunting in children aged less than 5 years	Impact		x	x	x	x	x	x	x		x	x	2-5 years	Facility/Community	All level
	Prevalence of Wasting in children aged less than 5 years	Impact		x	x	x	x	x	x	X		x	x	2-5 years	Facility/Community	All level
	Proportion of people Current on ART	Outcome	x	x	x	x	X	X	x		x			Monthly	Facility	All level
	TB detection rate	Outcome	x	x	x	x	x		x		x			Quarterly	Facility	All level
	Malaria mortality rate per 1000 population at risk	Impact	x	x	x	x	x		x		x			Monthly	Facility	All level
	OPD attendance Per capita	Output	x	x	x	x	x	X	x		x			Monthly	Facility	All level
	EHCRIG Reform performance status	Outcome		X			X				x			Quarterly	Facility	All level

Health System Building Blocks	Core indicators	Type of Indicator	Level of Disaggregation								Source of Data			Frequency Data collection and reporting		
			Age Group	Region (Geography)	Education	Disability	Residence (urban/ rural)	Gender	Wealth	Religion	DHIS 2	EDHS	Other surveys	Frequency of reporting	Level of Data collection	Level of reporting
Service Delivery	House Holds with basic sanitation facilities	Outcome		X	x		x		x		x	x		Quarterly	Facility	All level
	Proportion urban individuals getting service by family health team (FHT)	Output	x	X	x	x		x			x			Monthly	Facility/Community	All level
	Number of pastoralist woredas providing the mobile health team services for hard to reach sites	Input		X										Monthly	Facility/Community	All level
Health Infrastructure	Ratio of facilities with basic amenities (water, electricity, sanitation facilities and ICT network) between rural and urban	Input		X			X						SARA	2-3 years	woreda	All level
	Primary Hospital coverage per 100,000 population	Input		X			X				x			Annual	woreda	All level
Human Resource for Health	Health workers density per 1000 population	Input		X			x				x	x		Annual	woreda	All level
Public health emergency management	Proportion of epidemics controlled within acceptable mortality rate	Outcome		X			X				x			Monthly	Facility	All level
	Availability of essential drugs by Rural and Urban facilities	Input		X			X				x			Monthly	Facility	All level

Health System Building Blocks	Core indicators	Type of Indicator	Level of Disaggregation								Source of Data		Frequency Data collection and reporting		
			Age Group	Region (Geography)	Education	Disability	Residence (urban/ rural)	Gender	Wealth	Religion	DHIS 2	EDHS	Other surveys	Frequency of reporting	Level of Data collection	Level of reporting
Health Information System	Proportion of Health Posts implemented e-CHIS	Output		X			X							Quarterly	Facility/Community	All level
Health Care Financing	Proportion of eligible households enrolled in CBHI,	Input		X	x		x		x		x			Annually	Facility/Community	All level
	General government expenditure on health (GGHE) as a share of total general government expenditure (GGE)	Input		X			X						admin	Annually	woreda	All level
Leadership and Governance	Proportion of women in leadership positions	Input		X	x		X						admin	Annual	Facility/woreda	All level
	Number of Primary Health Care Facilities implemented Community Score Card	Input		X			X				x			Quarterly	Facility	All level
	Proportion of Model households on HEP packages	Outcome		X	x		X		x		x			Quarterly	Facility	All level
	Proportion of kebeles with functional community engagement platforms	Input		X			X							Annul	Community/Facility	All level
	Prevalence of FGM	Impact	x	X	x		x		x	X			x	Unspecified	Community	All level
	Percentage of Age 15-19 begun child bearing	Impact	x	x	x		x		x	X			x	Unspecified	Community	All level

5.3 Target Setting

Table 8: National Health Equity Strategy Targets

S/N	Indicators	National base line	National target	Base line of the region with lowest performance	Target set for lowest performance
1	Contraceptive acceptance rate	41%	50%	3%	24%
2	ANC 4 coverage	43%		23%	44.50%
3	Skilled Birth Attendance	48%	76%	29%	53%
4	Penta 3 coverage	61%	95%	25.90%	90%
5	EPI Dropout rate (Penta 1-MCV2)	13%		28%	10%
6	Fully Vaccinated	43%	69%	18.20%	39.70%
7	Prevalence of Stunting in children aged less than 5 years	37%	25%	48.70%	25%
8	Prevalence of Wasting in children aged less than 5 years	7%	5%	13.90%	5%
9	Ratio of "Coverage of currently on ART" between pediatrics (<15) and Adults (>15)			0.54	0.80
10	TB detection rate	69%	81%	46%	75%
11	Malaria mortality rate per 100,000 population at risk	0.3	0.1	3.55	0.3
12	Ratio of OPD attendance Per capita between male and female			0.89	0.92
13	EHCRIG reform performance status	70%	90%	48%	83%
14	Proportion of households having basic sanitation facilities	20%	60%		50%
15	Proportion urban individuals getting service by family health team (FHT)	NA	50%		25%
16	Number of pastoralist woredas providing the mobile health team services for hard to reach sites			49	74
17	Ratio of facilities with basic amenities (water, electricity, sanitation facilities and ICT network) between rural and urban			0.62	0.9
18	Primary Hospital coverage per 100,000 population	0.29	0.6		0.5
19	Health workers density per 1000 population	1	2.3		1.5
20	Proportion of epidemics controlled within acceptable mortality rate	80%	100%		80%
21	Availability of essential drugs by Rural and Urban facilities	NA	0.90		0.9
22	Proportion of Health Posts implemented e-CHIS			0%	50%
23	Proportion of eligible households enrolled in Community Based Health Insurance	49%	80%	32%	57%
24	General government expenditure on health (GGHE) as a share of total general government expenditure (GGE)	8.07%	12%		10%
25	Proportion of women in leadership positions			NA	50%
26	Proportion of model households on HEP packages	18%	72%		50%
27	Proportion of kebeles with functional community engagement platforms	NA	100%	NA	100%
28	Prevalence of FGM	65.2%		98.5%	78.8%
29	Percentage of Age 15-19 begun child bearing	13%		23.4%	18.7%

6 Costing

6.1 National Health Equity Strategy Costing

Table 9: National Health Equity Strategy Costing

Strategic direction	Initiatives and core interventions	2020/21	2022	2023	2024	2024/25	Total	Remark
1. Enhance provision of equitable and quality comprehensive health service	Design and implement Maternal, neonatal , child health , adolescent, youth and nutrition projects in selected low performing regions, zones and woredas	152,000,000	152,000,000	152,000,000	152,000,000	152,000,000	760,000,000	Currently we have 460 public hospital , 3831 health centers including those under construction,
	Design and implement interventions that address social determinant of health in selected low performing regions, zones and woredas	172,000,000	172,000,000	172,000,000	172,000,000	172,000,000	860,000,000	
	Design and implement communicable and non-communicable diseases intervention that will reduce premature preventable mortality in selected low performing regions, zones and woredas	76,000,000	76,000,000	76,000,000	76,000,000	76,000,000	380,000,000	
2. Improve accessibility of health facilities in all regions	Construction of Health facilities by matching (867 primary hospitals to achieve 85% in 10 years by standards of 1: 100,000 population ,1336 Health centers 1:20,000 Pop. ,OR centers , blood bank, health facilities utilities(water supply for 27 facilities, PV solar for 91 facilities), Regional laboratory (204 primary hospitals to be constructed in five years) and 168 Health Post		5,804,287,232	5,804,287,232	5,804,287,232	5,804,287,232	23,217,148,928	
3. Empowering and engaging community	Implement community engagement interventions	121,000,000	121,000,000	121,000,000	121,000,000	121,000,000	605,000,000.00	
4. Enhance resilient Public Health Emergency Management system	Strengthen emergency preparedness, management and mitigation of public health emergencies	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000	750,000,000.00	

Strategic direction	Initiatives and core interventions	2020/21	2022	2023	2024	2024/25	Total	Remark
5. Improve supply chain and logistics management	APTS expansion (capacity building and renovation)		35,000,000	35,000,000	35,000,000	35,000,000	140,000,000	
6. Enhance leadership, Management and Governance	Implement leadership management and governance including leadership incubation program (LIP);Regional zonal woreda and health facility management members	23,317,895	23,317,895	23,317,895	23,317,895	23,317,895	116,589,475	
7. Health Equity in all policies, strategies and program	National health equity strategy development and launching	2,586,844.00					2,586,844.00	
8. Improve research and evidence for informed decision making	Conduct operational plan, supportive supervision, and performance reviews	18,543,040	18,543,040	18,543,040	18,543,040	18,543,040	92,715,200.00	
	Conduct baseline, midterm and end line survey including operational research	4,000,000		8,000,000		10,000,000	22,000,000	
9. Enhance resource mobilization health care financing and synergy	Strengthen the implementation of health care financing and Health insurance	5,123,000	7,531,028	8,500,000	8,500,000	9,010,000	38,664,028	
Total		**765,983,935**	**10,368,391,963**	**10,377,360,935**	**10,369,360,935**	**10,379,870,935**	**26,984,704,475**	