Dr. Tedros - Director-General of the World Health Organization, with staff of WCO ETHIOPIA during his first visit in June 2017, Addis Ababa, ETHIOPIA (Photo Credit: WHO ETHIOPIA)
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“This report documents the 2017 work of the WHO country team for ETHIOPIA – the focus and achievements of the country team made possible by the extraordinary support of the WHO Regional Office for Africa and WHO headquarters. In 2017, the work of WHO in Ethiopia was organized around THREE investment pillars – (1) responding to health emergencies, (2) building resilient health system, and (3) reforming WHO for effectiveness – in the context of such core principles of the Agenda 2030 as leave no one behind, working across sectors, and whole of government and whole of society approaches”

Organizing the work of WHO around the three investment pillars was in pursuit of the “Africa Health Transformation Programme 2015 - 2020: A vision for Universal Health Coverage” (AHTP) and “the transformation agenda of the world health organization Secretariat in the African region, 2015 - 2020” (TA) launched by Dr. Matshidiso Moeti, the Regional Director for Africa, in 2015.¹ Both the AHTP and the TA are founded on the WHO 12th General Programme of Work, 2014-2019 (GPW 12).² The AHTP articulated five strategic priority areas for WHO investment in the African region: (i) improving health security by tackling epidemic-prone diseases, emergencies and new health threats; (ii) driving progress towards equity and universal health coverage through health systems strengthening; (iii) pursuing the post-2015 development agenda while ensuring that the MDGs are completed; (iv) tackling the social and economic determinants of health; and (v) building a responsive and results-driven WHO secretariat.³

Towards investment pillar (1) which addresses AHTP strategic priority area (i), WHO in 2017: deployed resources towards control of ongoing public health emergencies; undertook root cause analysis of the cyclical public health emergencies in Ethiopia, concluding that breaking the humanitarian vicious cycle in Ethiopia required the adoption of new way of working in the context of the humanitarian-development nexus; and adapted the WHO health emergency strategy to the Ethiopian context with focus on three results pillars: RESULT PILLAR 1, prevention of public health incidents – through reducing risks/vulnerabilities by frontloading development investments in priority areas informed by risk/vulnerability maps; RESULT PILLAR 2, preparation for public health

¹ Dr. Matshidiso Moeti had in 2015, launched the AHTP as “the strategic framework that will guide WHO’s contribution to the emerging sustainable development platform in Africa…a vision for health and development that aims to address the unacceptable inequalities and inequities that have kept our region lagging far behind others in terms of health indices and enjoyment of the highest attainable standard of life.” The launch of the AHTP was preceded in the same year by the launch of the TA whose goal is to engender the emergence of “…a regional health organization that is foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately resourced and equipped to deliver on its mandate; an organization that meets the needs and expectations of its stakeholders.”

² GPW 12 is WHO’s global strategic plan for health

incidents through building shock responsive regional health systems (prepared systems) with capacity for early detection of public health incidents and rapid deployment and scale-up of life saving resources and interventions; and RESULT PILLAR 3, protection of life during public health incidents through responding rapidly by activating and operationalizing the prepared systems.

Pursuant to investment pillar (2) which addresses AHTP strategic priorities areas (ii), (iii) and (iv), WHO in 2017 invested in: developing shock responsive regional health systems in disease epidemic prone areas; mainstreaming water-centered development (resilient WASH); strengthening public health emergency management system; generating strategic information for health policies and strategies; and strengthening national health systems towards universal health coverage including investments in enhancing access to essential medicines and technologies, strengthening initiative on local pharmaceutical manufacturing, strengthening immunization systems, controlling communicable and non-communicable diseases, promoting health along the life course, mainstreaming equity, gender equality and human rights in health and integration of health into the Ethiopia-Kenya “cross-border integrated programme for sustainable peace and socio-economic transformation.”

WHO initiatives in its investment pillar (3) which addresses AHTP strategic priority area (v) were guided by feedback from stakeholders during consultations towards the development of the country cooperation strategy in 2016. In 2017 therefore, WHO invested in programmatic reforms that consisted of: initiatives towards enhancing WHO capacity for health emergency preparedness and response; finishing the unfinished business of polio eradication; and shifting WHO health development investments towards outcome/impact levels. WHO also invested in management reforms that included initiatives towards: strengthening accountability for results and resources; strengthening risk management and compliance; enhancing transparency and equity in human resource management; fostering transparency in procurement of goods and services; enhancing resource mobilization and external communication capacities; and strengthening WHO field presence for enhanced impact.

The ongoing work of the WHO in Ethiopia around the three investment pillars will continue in 2018; it will be fully aligned with the 13th General Programme of Work (GPW 13) led by Dr. Tedros Adhanom Ghebreyesus, the WHO Director General, with a strategic focus on accounting for outcome and impact.

"WHO in the African Region is committed to working with its Member States and partners to deliver results that transform the health of all Africa's people through universal health coverage for achieving the Sustainable Development Goals (SDGs)"

Dr. Mathidiso MOETI
WHO Regional Director for Africa

(On the 67th session WHO Regional Committee for Africa)
Victoria Falls, Zimbabwe
August 2017

Dr. Akpaka A. KALU
WHO Representative in ETHIOPIA
February 2018
INTRODUCTION
In 2017, Ethiopia struggled with the consequences of La Niña-induced drought in the southern and southeastern parts of the country with no time to recover from the 2016 El Niño-induced drought. Ethiopia in 2017 therefore experienced dire humanitarian situations: population displacements among pastoralist communities in search of water and fodder for their animals; loss of animals and other livelihoods; outbreak of moderate and severe acute malnutrition; epidemic of communicable diseases including acute watery diarrhea (AWD), measles, hepatitis A, dengue fever, and guinea worm disease (GWD). The drought-induced internally displaced persons (IDP) crisis was compounded by conflict-induced IDPs in 2017.

Consequently, WHO in 2017 focused on responding to the prevailing public health emergencies without losing sight of the need to continue priority health development investments like: enhancing access to essential medicines and technologies; advancing the initiative for strengthening local pharmaceutical manufacturing; strengthening immunization systems; controlling communicable and non-communicable diseases; promoting health along the life course; and mainstreaming equity, gender equality and human rights in health. Also WHO in 2017 invested in organizational reform in line with the TA; WHO invested in strengthening its capacities and systems towards enhanced delivery and accounting for strategic results.

Thus the work of WHO in Ethiopia during 2017 was organized around three investment pillars: (1) responding to health emergencies; (2) building resilient health systems; and (3) reforming WHO for effectiveness. Towards WHO commitments in Ethiopia along these three investment pillars, cognizance was taken of the imperatives of the sustainable development goals (SDGs) and the core principles of Agenda 2030 such as leave no one behind, working across sectors, and whole of government and whole of society approaches. In 2017 therefore, WHO actively engaged within and outside the UN development system, partnering with other organizations including non-health sectors like the ministry of industries and the ministry of water resources.

The sections that follow are organized along the three investment pillars of the work of the WHO in Ethiopia in 2017. They document progress made in planned investments under each pillar. Finally, the section on future perspectives defines the ways forward in 2018 and beyond.

Partnerships with various stakeholders is appropriately acknowledged in the section on WHO’s partners in ETHIOPIA.
Partnerships with various stakeholders is appropriately acknowledged in the section on WHO’s partners in Ethiopia.

PROGRESS IN INVESTMENT PILLAR

THE WORK OF WHO IN ETHIOPIA DURING 2017

INVESTMENT PILLAR 1
RESPONDING TO HEALTH EMERGENCIES

INVESTMENT PILLAR 2
BUILDING RESILIENT HEALTH SYSTEM

INVESTMENT PILLAR 3
REFORMING WHO FOR INCREASED EFFECTIVENESS

AFRICA HEALTH TRANSFORMATION PROGRAMME, 2015 - 2020
THE TRANSFORMATION AGENDA OF THE WHO SECRETARIAT IN THE AFRICAN REGION, 2015 - 2020
WHO TWELFTH GENERAL PROGRAMME OF WORK, 2014-2019
RESPONDING TO HEALTH EMERGENCIES

PHOTO 03: WHO IN ACTION: Case management officer providing mentorship to CTC monitors – August 2017
(Photocredit: WHO ETHIOPIA / Tseday Zerayacob)
Degahadi Kebele, Siti Zone - Somali Regional State, ETHIOPIA
In 2017, WHO responded to several health emergencies:

- **AWD outbreak in Somali, Afar, Amhara, Tigray, SNNP, Benishangul Gumuz, Dire Dawa, Addis Ababa and Oromia regions.** Over 48,000 AWD cases and about 887 deaths were reported in 2017; 74% of the cases and 85% of the deaths were reported in the Ethiopia Somali Region. After initial lag in response, deployment of WHO surge capacity in April 2017 resulted in reduction of the daily number of AWD cases from over 700 per day in March 2017, to 7 per day by August 2017.

- **Guinea worm disease outbreak in Gambella region.** Fifteen confirmed cases of guinea worm disease (GWD) and 1,570 suspected cases were reported. WHO coordinated the task force established to manage the epidemic. Interventions included: effective management of cases; isolation of suspected cases for follow up, and contact tracing of exposed individuals; cross border surveillance; entry point screening (48,827 people were screened); active case searches; and awareness creation in the affected region including in the five refugee camps hosting about 370,000 – all the 466 community outreach agents in the camps were also trained on GWD surveillance.

- **Other communicable diseases outbreaks in various parts of the country.** A total of 4,011 cases of measles were reported throughout 2017. In September 2017, Hepatitis A outbreak was confirmed in Dollo zone of Somali region. And in December 2017, dengue fever outbreak was confirmed in Somali region and Dire Dawa city. Throughout the year, a total of 158,862 cases of scabies were reported from Oromia and Amhara regions.

- **Severe acute malnutrition outbreak:** A total of 343,000 severe acute malnutrition (SAM) cases were treated nationwide; about 26% of the cases were treated in Somali region.

- **Drought and conflict-induced internally displaced persons (IDPs) crisis:** Access to primary health services for drought-induced IDPs in Somali region was ably managed by the regional government including deployment of available medical supplies and health workers to the IDP camps. In the last quarter of 2017, violent conflicts were reported at the border between Oromia and Somali regions resulting in more than 800,000 IDPs in a population already vulnerable from drought and its aftermath. An assessment revealed compromised access to primary health care services as well as non-food items (NFIs), shelter and food among the IDPs.

Based on the WHO Emergency response framework (ERF), the AWD and SAM outbreaks were the basis of the multiple classification and reclassification of the Ethiopia health emergency in 2017 – it
was classified as protracted level 3 by the end of the year. Also in 2017, countries were graded on 3 priority levels based on their vulnerability to the risks of outbreaks – priority 1 countries being the most at risk. Ethiopia was classified among the eight priority 1 countries and the appropriate WHO health emergencies Country Business Model (CBM) was adopted, detailing the key human resource (HR) capacities required by the country for effective health emergency response in Ethiopia. There is ongoing recruitment to fill the positions.

1.1: RESPONDING TO THE 2017 HEALTH EMERGENCIES IN ETHIOPIA

The WHO ERF defines the role of the WHO under the incident management system (IMS) as: leadership and partner coordination; information and planning; health operations and technical expertise; operations support and logistics; and finance and administration. The 2017 response was framed around these functions.

1.1.1 Leadership and partner coordination

By March 2017 the number of AWD cases reported in the Ethiopia Somali region spiked. Consequently, the WHO internal grading of the Ethiopia epidemic was raised for the first time from level 2 to level 3. The Incident Management (IM) System was activated at regional, zonal and district levels in Somali region. Massive deployment of WHO resources ensued: release of WHO Contingency funds for emergencies (CFE) amounting to USD 2.7 million; provision of logistics and supplies including vehicles, case management protocols, medicals kits containing oral rehydration salts, intravenous fluids, essential drugs and rapid diagnostic kits; and deployment of a rapid response team consisting of experts in disease surveillance, case management, water, sanitation and hygiene (WASH), nutrition, risk communication, administration and logistics.

Part of the IM system was the setting up of health emergency command posts at all levels along 6 pillars: surveillance; leadership and coordination; WASH; social mobilization; case management; and logistics. WHO co-led the commands posts, deploying the multidisciplinary team that guided all response activities and supporting partners for enhanced synergy and efficiency of investments. A health services availabilities and readiness assessment (HERAMS) was supported with the aim of mapping availability of health resources in the region for their possible deployment towards revitalization and improvement of the regional health system.

Health cluster coordination was strengthened at national and regional levels. Health Partners rallied together and collaboratively developed the “Who, Where and doing What” (3Ws) scheme for effective management and coordination of response activities in order to avoid duplication or orphaning of any aspect of the response. In collaboration with Health Cluster Partners, WHO also supported: the Meher rain assessment; IDP response assessment; and the preparation and/or updating of the 2017 humanitarian response document (HRD).
1.1.2 Information and planning

The information and planning component of the response consisted of investments to: enhance evidence-based humanitarian response in each of the nine regions that reported AWD, malnutrition and other reportable diseases in 2017; and develop and operationalize system for information management and use.

Investments for enhancing evidence-based humanitarian response

Specific WHO investments towards enhanced evidence-based response focused on: strengthening early detection and containment systems:

- Deployment of a network of 22 surveillance officers at the peak of the AWD outbreak in Somali Region – one surveillance officer and driver per hotspot district reporting to one surveillance officer per zone;
- Implementation of community-based surveillance including field investigation of notified cases, water quality and other risk factor monitoring in high priority areas, and surging of diagnostic and case management capacities at the local level in order to achieve outbreak containment;
- Training of relevant health workers on: surveillance and response especially at district, health facility, and community levels; data management; quality of care monitoring and improvement; online 4Ws (Who, Where, What and When) tool for reporting on partners activities (39 staff of various NGOs were trained with the support of iMAP);
- Technical support in the areas of active case reporting of AWD and other outbreak diseases;
- Establishment of functional multi-disciplinary rapid response team (RRTs) at different administrative levels – a total of 58 RRT members were trained in collaboration with the Ethiopian Public Health Institute (EPHI) and the US Centres for Disease Control and Prevention (US CDC).

The RRTs were drawn from national and regional PHEM offices (Epidemiologists/Public health specialists), Hospitals (physicians), Public health laboratories (Laboratory technologists), Bureau of Livestock and Fisheries (Veterinarians) and Bureau of Environmental Protection (Environmental specialists).

**Investments in developing and operationalizing system for information management and use**

Technical assistance was provided on the establishment of an integrated electronic surveillance system including data base at national and sub national levels. The system consisted of the following:

- Public Health Emergency Operation Centre (PHEOC) that served as the platform for daily partnership coordination and information sharing;
- System for real-time data reporting and updating, and alerts and monitoring of public health events;
- System for daily and weekly transmission of data from the regional PHEOC to the WHO country office as well as a system for data analysis and feedback from WHO country office to the team on the ground (Regions and Zones) including channelling summary update to the senior management/incident management team, as well as to OCHA, the health cluster, the Ethiopia humanitarian country team (EHCT), the country AWD working group and bilaterally to partners.

**1.1.3 Health operations and technical expertise**

Health operations actions started in March 2017 with the deployment of the AWD response surge team of about 150 persons in the Ethiopia Somali Region. Other actions were: development and implementation of a 30 day plan; development and implementation of a 90 day plan – a plan envisaged to dovetail into an extension of the WHO response beyond AWD to health systems focused response starting 1st August 2017.

The specific areas of focus of the operations were: strengthening the capacity management of AWD case treatment centers; strengthening inpatient management of SAM cases with medical complications (SAM/MC); enhancing capacity for infection prevention and control (IPC) in AWD case treatment centers/units (CTCs/CTUs) and nutritional rehabilitation centers (RCS); enhancing WASH response to the AWD outbreak; enhancing capacity for risk communication; and enhancing access to health services among IDPs.
Strengthening the capacity of AWD case treatment centers

A total of 156 CTCs/CTUs were supported in Somali region, and 231 CTCs/CTUs in other regions. WHO support to the case management of AWDs included the supply of 28 drugs modules, 28 renewable supplies modules, 18 complete central kits, 40 complete community kits, 6 complete hardware, 120 complete investigation kits, and 16 complete laboratory kits. WHO also trained a total of 1,811 health workers on AWD case management and recruited and deployed a total of 74 case management mentors to enhance quality of care.

Strengthening inpatient management of SAM cases with medical complications

Strengthening inpatient management of SAM/MC started with a quality of care assessment of the RCs in collaboration with the emergency nutrition cluster. Subsequently a total of 33 RCs for SAM/MC were set up (See FIGURE 1).

To enhance national capacity for the management of SAM/MC, WHO recruited 6 international and national medical nutritionists. Also 18 former CTC mentors were repurposed and trained to serve as SC mentors. Specific interventions in the RCs by the WHO team included: development of Algorithm for the management of SAM cases with AWD; training of 130 health care providers serving in the 33 RCs on the management of complicated SAM cases; and weekly/biweekly mentorship for RC staff on the management of SAM/MC. Between September and December 2017, a total of 800 SAM/MC cases were managed in the 33 SCs. WHO support in the RCs resulted in steady rise in the proportion of admitted SAM cases discharged to the outpatient.

Enhancing capacity for infection prevention and control in CTCs and RCs

Infection prevention and control (IPC) was mainstreamed in the Ethiopia Somali region as a result of: the large number of cases of AWD and SAM/MC; and the large number of CTCs and RCs. Specific IPC support in the CTCs and RCs included: IPC supportive visits to RCs; and capacity building including supplies and training, and mentorship on IPC /antimicrobial stewardship, and on Clean and Safe Hospital (CASH) initiative.
Enhancing WASH response to the AWD outbreak
In collaboration with the WASH cluster, WHO in 2017 provided the following WASH support in response to the AWD outbreak in various parts of the country: assessment of potential risk factors of AWD outbreak in hot spot areas of Addis Ababa, Amhara, Oromia, Somali, Tigray and Dire Dawa regions – in these regions, the focus was on holy water sites, investment farms, and water sources for domestic use in affected communities; development of response plans based on identified risk factors; advocacy workshop on risk mitigation in high risk regions, targeting over 500 participants including religious leaders, prominent elders, regional health bureaus heads and renowned persons; provision of emergency and rapid water quality test kits; training of 275 water and health professionals on water quality monitoring and surveillance including bacteriological water quality testing, sanitary survey/risk factors assessment, hygiene promotion, and coordination; development of health promotion and community engagement strategies, key messages targeting general public and affected communities and IEC materials; and training of media personnel and health extension workers on risk factors and risk mitigation as part of capacity building for strengthening community engagement and social mobilization.

Enhancing capacity for risk communication
In collaboration with the regional health bureaus, WHO supported risk communication and community engagement initiatives including: risk assessment of suspected dengue fever outbreak in affected areas; assessment of dengue fever knowledge, awareness, health seeking behavior and prevention practices; vulnerability assessments, risk mapping, and contingency planning for each disease outbreak.

Enhancing access to health services among IDPs
Towards access to health services among drought-induced IDPs, WHO in the early part of 2017 supplemented the response of the Somali regional health bureau with
medical supplies and allocated emergency health cluster funds to UNOPS to enable logistical support to health workers deployed from other regions.

Concerning the conflict-induced IDPs, WHO in 2017 supported enhanced access to health services through: supply of drugs and medical supplies; training of human resources; and allocation of funds and supplies through the health cluster to enable NGOs operate 32 health and nutrition mobile clinics in Oromia and Somali regions.

- Training of 47 officers involved in the management of mobile health teams on "Minimum Initial Service Package (MISP) for Reproductive Health in crisis Situations" – the trained officers were placed among the IDPs with the responsibility of integrating comprehensive sexual reproductive health services into primary health care at the IDP camps as well as manage the consequence of sexual violence; and

- Integration of Maternal Death Surveillance and Response (MDSR) into the overall Public Health Emergency Management (PHEM) system including Basic PHEM training of 320 surveillance focal persons in Oromia region aimed at strengthening Early warning system, epidemic preparedness, and response.

1.1.4 Operations support and logistics

A major part of the 2017 health emergency response was operations support and logistics especially: transport fleet management; procurement of goods and services; and information technology (IT) services.

**Transport fleet management**

The 2017 health emergency response operations was supported with a vehicle fleet size of 71 WHO vehicles complimented by 151 rented vehicles. In order to ensure professional management of this huge fleet, WHO deployed two staff: a Logistics specialist; and a Fleet Manager both of whom operated from Jijiga in the Somali area where the outbreak was most acute. In addition, WHO put in place an operational plan for transportation of zonal teams.

**Procurement services**

In response to the 2017 AWD emergency in the country, WHO supported Somali region procurement and distribution of medicines and supplies valued at USD 260,000: SAM kits for 15 RCs; AWD medical and non-medical supplies, and nutrition and WASH items for 13 CTCs in 6 zones; and 50 Inter-Agency Emergency Health kits basic modules to selected health facilities in 11 zones.
IT services

WHO immediately deployed an ICT team of two experts as the response team resumed in the Ethiopia Somali Region. To enable “working and communicating on the go” at the onset of the emergency deployment, staff were supported with 62 Wi-Fi routers and 89 smart phones and monthly airtime. The Somali Regional Health Bureau (RHB) was also provided with two LCD projectors, a desktop computer and power stabilizer as part of WHO capacity strengthening to enable the RHB host the regular inter-cluster meetings for the AWD emergency coordination.

As the emergency response continued, WHO enhanced the capacity of its Somali operational hub with the following: plotting machine; fixed and Wi-Fi internet connection; and multiple knowledge management platforms for mobile data collection through ODK and sharing information on WHO Sharepoint.

1.1.5 Finance and administration

Financial resource mobilization activities included recruitment of a resource mobilization officer who spearheaded WHO engagement in promoting partnerships including regularly meetings with the leading donors in Ethiopia. A total of USD 11,436,000.00 was mobilized for the emergency response in 2017; the major funding sources were: AFRO; US Centers for Disease Control; OCHA Ethiopian Humanitarian Fund (EHF); and CFE. (See FIGURE 2) for the proportional breakdown.

Also WHO supported the preparation of a plan that mobilized a total of USD 27 million from the Ethiopia SDG pooled fund – this allocation was used by the government to support its own response efforts in 2017.

As part of the health emergency surge capacity, a robust administrative support team was deployed consisting of a team from the management support unit of the country office as well as specifically recruited temporary administrative staff. A human resource management team was deployed by WHO headquarters.

1.2: TOWARDS BREAKING ETHIOPIA’S HUMANITARIAN VICIOUS CYCLE – WORKING DIFFERENTLY

By mid-2017, Ethiopia was in the middle of a massive epidemic of AWD; this was accompanied by malnutrition especially in the Ethiopia Somali Region. Both public health events had been ongoing since 2015/2016 with regular upsurges (see FIGURE 3 for the AWD epidemiological graph).
In 1985, massive drought and consequent famine hit Ethiopia and the Horn of Africa. In 2011, another drought-induced famine occurred.

“Compared with 20 years before, there was a much better science available and a better understanding of the crises...But at the same time the frequency and intensity of the drivers of the emergencies was increasing....The international community must change the way it operates to meet the challenge of recurrent crises ... Long-term development work is best placed to respond to drought.”

Randolph Kent
A veteran of humanitarian work in the Horn of Africa
Director of the Humanitarian Futures Programme
Kings College London

A literature review showed that Ethiopia experiences cyclical complex humanitarian emergencies: recurrent drought with loss of animals, crops and livelihoods; drought-induced population displacements, malnutrition and outbreaks of AWD, other water-borne diseases, measles, viral hemorrhagic fevers and other climate sensitive diseases like malaria. It was found that the root cause of these emergencies in Ethiopia was development lag characterized by: disregard of strategic guidance on “long term development work in response to drought;” absence of strategies to wean off food aid dependent districts; and misalignment of development investments with risks, vulnerabilities and needs.

In spite of this strategic guidance, when in 2017, another drought struck the region, the nations and stakeholders in the Horn of Africa were unprepared – the risk factors had not been addressed; a total of 8.5 million people still needed food assistance in Ethiopia. And there had been no transitioning out of districts in need of food assistance – year after year for at least four years the same districts were repeatedly classified as priority 1 districts for food assistance6 (FIGURE 4). There had been no investment to enable the districts transition out of food dependency and become resilient.

6 From April 2009 to June 2017, 23 hotspots classifications were released.
The 2017 shocks overwhelmed the health system in Somali region as the major risk factors, limited access to safe water and hygiene facilities, had not been fully addressed through “long-term development investment.” Water, Sanitation and Hygiene (WASH) investments in Ethiopia were skewed to the Western parts of the country, areas with low risks for drought and AWD (See FIGURE 5). Expensive deployment of mobile health and nutrition services, redeployment of 500 health care workers from other regions and water trucking to the affected populations were resorted to in Somali region.

Based on the review of literature and available data, by mid-2017 it was concluded that without targeted development investments for risk factors mitigation, the cyclical public health emergencies in Ethiopia will continue with recurrent annual shocks; the annual AWD peak for instance will keep rising year on year. Also loss of crops, animals and livelihoods will continue even as the challenges of drought induced IDPs and poverty will remain perennial.

It became obvious therefore that breaking the humanitarian vicious cycle in Ethiopia required responders to work differently: adopting the new way of working (NWoW) in the context of the humanitarian-development nexus.

Humanitarian-development nexus entails co-investment by development and humanitarian actors through: collaborative definition of the development investments required to reduce risks and vulnerabilities, prevent humanitarian emergencies and/or reduce the humanitarian price tag; and frontloading the said development investments while continuing with evidence-based humanitarian response as community resilience is enhanced over time leading ultimately to at risk communities and households being weaned off and graduated from humanitarian dependency.
This calls for a New Way of Working (NWoW) to transcend humanitarian/development divides as defined in the World Humanitarian Summit (WHS) of May 2016.

NWoW is about doing things differently to improve the lives of the people affected by protracted crises; it is about bringing coherence between development, peace building and humanitarian response. The prerequisites for NWoW are: adoption of collective outcomes; multi-year planning; involvement of a multiplicity of partners through a whole of society approach; joint analysis; joined up planning; and effective leadership and coordination. Pursuant to the NWoW and with the aim of breaking the public health emergency vicious cycle, WHO in 2017 adopted three strategic results pillars.

In FIGURES 6, 7 and 8 are seen the deliverables and strategic actions that the WHO is committed to – implementation of the strategic actions started in 2017 and will be sustained through 2018.
FIGURE 07: DELIVERABLES and STRATEGIC ACTIONS for results PILLAR 2: BUILDING SHOCK RESPONSIVE HEALTH SYSTEM

DELIVERABLE 21: PUBLIC HEALTH EMERGENCY MANAGEMENT (PHEM) CAPACITY STRENGTHENING
- Standardizing coordination for public health emergencies; establishing emergency operation centers (EOCs);
- Strengthening partnership; enhancing integrated disease surveillance system;
- Supporting national data management systems

DELIVERABLE 22: "COMMUNITY TO HOSPITAL" REFERAL SYSTEMS DEVELOPMENT IN HIGH RISK AREAS
- Designating and strengthening capacities of isolation centers including human resource capacity strengthening; installing ambulance system with community call-in capacity; prepositioning of supplies & commodities; community liaisons & education

FIGURE 08: DELIVERABLES and STRATEGIC ACTIONS for results PILLAR 3: RESPONDING RAPIDLY BY ACTIVATING AND OPERATIONALIZING EXISTING SYSTEMS

DELIVERABLE 31: COORDINATION AND LEADERSHIP STRENGTHENING
- Operationalizing incident management system; developing, monitoring & evaluating response plans

DELIVERABLE 32: HUMAN RESOURCE CAPACITY STRENGTHENING
- Deploying rapid response team (RRT) and incident management team; training/retraining of RRTs and other health workers

DELIVERABLE 34: INFORMATION MANAGEMENT CAPACITY STRENGTHENING
- Enhancing health & nutrition surveillance & risk mapping in ongoing emergency; operationalizing EOCs

DELIVERABLE 33: OPERATIONS, SUPPLIES AND LOGISTICS CAPACITY STRENGTHENING
- Supplying medicines, equipment and materials; supporting transport logistics

RESULT PILLAR 3: PROTECTING LIVES DURING PUBLIC HEALTH EVENTS
DElIVERABLES AND STRATEGIC ACTIONS

RESULT PILLAR 2: PREPARING FOR PUBLIC HEALTH EVENTS
DElIVERABLES AND STRATEGIC ACTIONS

WHO COUNTRY OFFICE FOR ETHIOPIA | ANNUAL REPORT 2017
PROGRESS IN INVESTMENT PILLAR

THE WORK OF WHO IN ETHIOPIA DURING 2017

INVESTMENT PILLAR 1
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REFORMING WHO FOR INCREASED EFFECTIVENESS

AFRICA HEALTH TRANSFORMATION PROGRAMME, 2015 - 2020

THE TRANSFORMATION AGENDA OF THE WHO SECRETARIAT IN THE AFRICAN REGION, 2015 - 2020

WHO TWELFTH GENERAL PROGRAMME OF WORK, 2014-2019
BUILDING RESILIENT HEALTH SYSTEM

WHO IN ACTION: Community outreach session for health education supplemented with demonstration – June 2017

Photo Credit: WHO ETHIOPIA / Tseday Zerayacob
Koleji IDP Camp, Fafan Zone - Somali Regional State, ETHIOPIA
2. PROGRESS IN INVESTMENT PILLAR 2: BUILDING RESILIENT HEALTH SYSTEM

The following were prioritized in 2017: development of shock responsive regional health systems; mainstreaming water-centred development; strengthening the public health emergency management (PHEM) system; generating strategic information for policies and strategies; strengthening health systems towards universal health coverage (UHC) including investments in communicable diseases control, control of non-communicable diseases, promoting health along the life course and integrating health into the Ethiopia-Kenya “cross-border integrated programme for sustainable peace and socio-economic transformation.”

2.1: DEVELOPING SHOCK RESPONSIVE REGIONAL HEALTH SYSTEM

As part of the strategies towards breaking the humanitarian vicious cycle in Ethiopia, WHO in 2017 defined the concept of a shock responsive regional health system as a health system “with autonomous capacity to scale up during emergencies and scale down when the shock recedes” – a scalable health system consisting of the following:

- “Community to hospital” referral system in high risk zones including: human resources capacity strengthening at priority hospitals/health centres; operationalization of ambulance system with community call-in capacity in each priority hospital/health centre; optimizing supply management system in the priority hospitals/health centres; and facilitating community liaison and education in targeted communities;
- Strengthened public health laboratory capacity in each region aimed at enhancing prompt diagnosis and containment of communicable disease outbreak;
- Functional national surge capacity or roster of experts for health and nutritional emergencies including database and annual refresher training of national capacities in the priority skill areas;
- Functional centre for health and nutrition emergency training at diploma/certificate level;
- Empowered regional universities serving as extensions of WHO core capacity for the provision of public health emergency management capacity building, monitoring and evaluation support to the various regions.

In 2017, the concept “shock responsive regional health system” was appropriated by the Federal Ministry of Health. As part of the implementation of the “community to hospital” referral system, WHO supported the ministry to deploy a DFID grant of USD 6,742,800.00 for developing health isolation sites in 58 disease epidemic hotspots in 2017. There is ongoing resource mobilization for the full development of the shock responsive regional health system in Ethiopia.

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5 Already 56 hospitals covering all regions have been designated as communicable diseases management centers.
2.2: MAINSTREAMING WATER-CENTERED DEVELOPMENT OR RESILIENT WASH

The major risk factors for public health emergencies in Ethiopia are recurrent drought and the consequent loss of livelihoods, and outbreak of acute malnutrition and communicable diseases including water-borne diseases.

Therefore, investments towards breaking Ethiopia’s humanitarian vicious cycle must be centered on the provision of water to those in need – water for domestic use, and for watering animals, growing fodder and development of other water-centered economic activities among the pastoralist communities.

As part of effort towards durable solutions, WHO in 2017 defined and commenced advocacy for water-centered development – the use of population-based water provision as an entry point to community development founded on two strategic principles: evidence-based identification of the most vulnerable based on clear demographic stratification and geographic stratification criteria; and targeting the most vulnerable with a combination of humanitarian and development investments with clear “exit strategy and exit point,” enabling the most vulnerable live above the poverty line and subsequently undergo positive socio-economic transition where they live and work.

The provision of deep water boreholes is envisaged as part of this socio-economic transformation in the drought-prone/pastoralist areas of Ethiopia; this is expected to result in seven outcomes/impacts (The theory of change is seen in FIGURE 09).

Towards water-centered development, WHO in collaboration with the UNHC, UNAIDS, and UNICEF embarked on advocacy with the Ethiopia Development Assistance Group (DAG) and the Minister for Water Resources. WHO also commissioned the development of an investment case on water-centered development in the Ethiopia Somali region. The advocacy resulted in a planned 2018 high level forum on development in Ethiopia.

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*Exit strategy and exit point* being the definition of success in the targeted investment.
the drought-prone areas of Ethiopia.

2.3: STRENGTHENING PUBLIC HEALTH EMERGENCY MANAGEMENT SYSTEM

As a country that has faced and is facing protracted and recurrent public health emergencies, strengthening readiness through building a resilient public health surveillance system is both strategic and auspicious in Ethiopia. Consequently, in 2009, Ethiopia set up the Public Health Emergency (PHEM) System as a platform for anticipating, preventing, preparing for, detecting, responding to, controlling and facilitating recovery from consequences of public health threats.

By mid-2017 it had become obvious that although PHEM structure exists in each region, its functionality remained suboptimal and variable at all levels. The challenges included: sub-optimal architecture in many regions and zones; inadequate numbers and quality of health workforce and rapid response teams at district level; delays in real-time availability and use of surveillance data for decision making; and suboptimal laboratory capacity for effective and timely outbreak investigation and response. It was also noted by mid-2017 that implementation of disease surveillance in Ethiopia depended largely on the WHO polio surveillance officers, a dwindling resource in Ethiopia as polio ramp down progresses – in January 2017, WHO reduced the number of polio surveillance officers from 137 to 20, severely constricting the PHEM system capacity for disease surveillance and response.

Consequently, by mid-2017, WHO developed and commenced implementation of strategies for the acute response and recovery phases of the then ongoing health emergency response – the recovery phase focused on increasing resilience of the health system (See FIGURE 10) with the aim of strengthening and maximizing the PHEM system; enabling PHEM managers at all levels to become “the first to know, first to respond and first to communicate” on any health emergency or rumor. Implementation started 1st August 2017 with focus on:

- Integration of all public health surveillance systems into the PHEM at regional, zonal and woreda levels including: harmonizing AFP surveillance activities with IDSR activities as well as with outbreak detection, investigation, response and evaluation; and development of a detailed action plan for capacity building for resilient health surveillance system;
- Capacity strengthening for PHEM officers on public health surveillance at regional, zonal and district levels including training, and on-job competencies upgrading;
- Prepositioning of and provision of relevant equipment, logistics, and supplies (Rapid Diagnostic Kits, Diarrheal Disease Kits, Laboratory reagents and vaccine-preventable diseases supplementary supplies (cold-chain, emergency vaccines);
- Capacity strengthening for regional public health laboratories for early diagnosis and containment of diseases of public health importance;
- Capacity strengthening for vulnerability risk assessment and mapping at all levels, capacities required for sustainable generation of accurate information on health risks useful for development of more accurate preparedness plans;
- Capacity enhancement for use of intelligence including events based surveillance, gathering and investigation of rumours through contact with various community structures including Health Extension Workers and Health Development Army; media monitoring to pick up unusual events; use of hotlines for information collection during outbreaks; triangulating rumours with the support of partners working in districts, tracking, mapping and investigating rumours to verify them;
- Data management capacity strengthening including development of a 'national interoperable electronic reporting systems;' and
- Enhancing synergy between animal and human health surveillance of epidemic prone zoonotic diseases.

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2.4: GENERATING STRATEGIC INFORMATION FOR POLICIES AND STRATEGIES

WHO's commitment to the generation of strategic information for health policies and strategies is evident in the various operational/implementation researches ongoing in Ethiopia during 2017. These are detailed in a table presented within the annexes section (pages 49 and 50) which describes WHO supported research projects ongoing in ETHIOPIA.

2.5: STRENGTHENING NATIONAL HEALTH SYSTEMS TOWARDS UHC

Some WHO health development investments in 2017 towards UHC were in the following areas: enhancing access to essential medicines; strengthening local pharmaceutical manufacturing; strengthening national immunization systems; enhancing
communicable disease control systems; strengthening non-communicable disease control systems; promoting health along the life course; integrating equity, gender equality and human rights in health programming; and integration of health in the Ethiopia-Kenya cross border initiative.

2.5.1. Enhancing access to essential medicines and technologies

In 2017, WHO provided support to the national health system towards enhancing access to quality, affordable and rational use of medicine and health technologies with specific focus on:

- Provision of strategic information and evidence for systems strengthening as well as capacity strengthening for essential medicines and technologies management including: assessment of availability and price of NCD medicines and health technology; assessment of medicine pricing and reimbursement and technical capacity building including training on medicine pricing and reimbursement – these assessments enabled MOH and its agencies to identify strengths, gaps and recommendations for improvement.
- Review and advocacy for narcotic drugs and psychotropic substances access and control;
- Development of antimicrobial resistance (AMR) stewardship guidelines;
- Technical assistance for blood transfusion services including in the: development of strategic plan (2015/16 to 2019/20); implementation of a blood safety information system; building of capacity for increased Voluntary Donor Pool and Blood Collection through training on donor recruitment, development and use of the medical assessment guideline and retention of blood donors, development of national Hemovigilance policy and safe blood administration guidelines, and enhancement of quality management system for blood transfusion services.

2.5.2. Strengthening local pharmaceutical manufacturing initiative

Ethiopia’s local pharmaceutical manufacturing initiative is guided by the Multi-sectoral National Strategy and Plan of Action for Pharmaceutical Manufacturing Development in Ethiopia (NSPA-Pharma) 2015-2025; the collaborating partners are: WHO; the Federal Ministry of Health; the Federal Ministry of Industry; and other stakeholders. Specific WHO investments in 2017 towards enhanced local manufacturing of pharmaceuticals in Ethiopia included the following:

- Assessment of 9 pharmaceutical manufacturers to align them with the Good Manufacturing Practice (GMP) standards – the assessment generated Corrective Action Preventive Action (CAPA) plan aimed at ensuring that their production processes and products consistently meet quality of standards;
- Study on prioritization exercise on essential medicines for local production;
- Feasibility study on the possibility of deploying entecavir, a locally manufactured product, for mass treatment of Hepatitis B in Ethiopia;
Development of Application Program Interface (API) manufacturing Road map;

Feasibility study on the possibility of manufacturing APIs in Ethiopia.

2.5.3. Strengthening Immunization Systems

The ongoing support of WHO and partners in strengthening Ethiopia’s immunization systems and control of vaccine preventable diseases resulted in the following in 2017:

- Sustaining polio eradication and commencing polio ramp-down. Ethiopia reported the last wild polio virus (WPV) on January 2014. Three years down the line, WHO in 2017 supported Ethiopia’s polio free documentation which was accepted by the Africa Regional Certification Commission (ARCC) in June 2017. Remedial actions for sustaining the polio free status were recommended by the ARCC and are being implemented. Such actions constitute one part of the unfinished business of polio eradication. The other part is implementation of the polio endgame strategic plan (2013-2018) with Polio legacy and transition planning as a key objective – the strategic plan is also being implemented with the support of WHO and other partners. Ethiopia is one of the 16 countries with large polio assets and prioritized for the first phase of Polio transition planning. In 2017, a five year transition plan (2018-2022) was developed and resource mobilization activities are planned. Also in 2017, a total of 28 driver posts were abolished. Eighteen new driver posts competed for by the 28 affected drivers. By the end of 2016 a polio contract with UNOPS for human resource and logistical support to polio eradication activities was terminated; the support of a total of 75 surveillance officers was lost. There is ongoing advocacy for government and partners to take over the polio eradication functions in a phased manner.

- Attainment of Acute Flaccid Paralysis (AFP) surveillance certification standard with a national NPAFP rate of 2.6, and stool adequacy rate of 92% (See figure 12). In furthermore of polio eradication, WHO in 2017 still supported polio supplemental immunization activities (SIAs) in high risk zones of Somali, Afar,
Gambella, Benshangul Gumuz, Amhara, Oromia, SNNP, and Tigray regions; administrative coverage of the first and second rounds of the SIAs were reported as 98.4% and 98.2% respectively while the coverage documented through the independent monitoring activities were 98% and 97.5% for the first and second rounds respectively. AFP surveillance in Ethiopia is exclusively supported by WHO in Ethiopia.

- Attainment of Maternal Neonatal Tetanus Elimination (MNTE); the declaration of Ethiopia as MNT-free followed a WHO-supported joint external validation mission in June 2017.

- Immunization data quality review to address the discrepancy between administrative coverage data and data from coverage surveys – discrepancy between the routine immunization administrative coverage in 2017 for Pentavalent vaccine dose-3, Measles and fully immunized child documented as 97.5%, 93.6%, and 91.2% respectively, and coverage data from the 2016 Ethiopia demographic and health survey (EDHS) documented as 53.2 % for Pentavalent vaccine dose-3; 54.3 % for Measles. The results were immunization coverage estimates and data improvement plans. Also in order to address the high number of unimmunized children in some regions, WHO supported many activities: EPI Mid-Level Management (MLM) training in Benshangul Gumuz region; and data Quality Self-assessment (DQS) in Amhara, Gambella, Oromia, and SNNP regional states; and measles SIAs.

- Reduction of risk of measles epidemic through measles SIAs conducted countrywide in the first quarter of 2017; it targeted children 6 months to 59 months in some regions and 6 months to 14 years of age in others; the targeting was guided by documented measles epidemiology in each of the regions. An administrative coverage of 96.3% was achieved.
PHOTO 07:
Commemoration of the World Polio Day 2017 in ETHIOPIA
THEME: “commending ETHIOPIA polio free status, sustaining the gain!”
24 October 2017
(Photo Credit: WHO ETHIOPIA / Selamawit Yilma)
Addis Ababa, ETHIOPIA

CLOCKWISE:
- Dr. Kalu, WHO Representative in ETHIOPIA, delivering an opening remarks
  “The polio free status of Ethiopia has been achieved; however, the country is at risk of polio importation because of cross-border movements of populations of six countries, being the most populous nation in the Horn of Africa Region with difficult topographies and hard to reach areas.
  I am confident that the country will continue to work hard to maintain its polio free status, and WHO will continue to support the government in strengthening routine immunization and disease surveillance to ensure protection of children through high quality immunization service and rapid detection of suspected cases for investigation.”
- Candle vigil event was part of the WPD commemoration
- Higher officials briefing the media
- Dr. Kalu greeting the former president of the FDRE (Girma W.Giorgis): on the WPD commemoration day

PHOTO 08:
Briefing the 30 visiting Rotarians from USA and Canada on polio eradication efforts in ETHIOPIA by Dr. Thomas from EPI team of WHO ETHIOPIA
31 October 2017
(Photo Credit: WHO ETHIOPIA / Selamawit Yilma)
Hilton Hotel - Addis Ababa, ETHIOPIA
2.5.4. Enhancing communicable disease control systems

Major investments in 2017 towards communicable diseases control were in the following areas: medicines efficacy surveys; disease risk mapping; supply of commodities; and human resource capacity strengthening.

Medicines efficacy surveys

In 2017, WHO supported the Ethiopian Public Health Institute in the monitoring of the efficacy of antimalarial drugs, HIV drug resistance surveys and TB drug resistance survey in all settings is ongoing which the results will inform policy change.

Programme reviews and planning

Review of HIV, TB and Malaria programs were supported in 2017 with the aim of assessing the progress of implementation of the respective programme strategic plans. WHO also contributed to the rapid external review of the national HIV/AIDS, TB and Malaria programs, a prerequisite for the successfully application of Ethiopia for a GFATM grant of USD 366.5 million in 2017.

Disease risk mapping

Technical and financial support was provided towards the mapping of trachoma in 30 districts of Somali Region of Ethiopia. The mapping provided evidence base for the planned launch of mass drug administration (MDA) for trachoma; the planned MDA will benefit about 5.5 million people.

Supply of commodities

WHO supported: procurement and supply of 3,500 patient treatment doses of anti-Leishmanial drugs (Sodium Stibogluconate and Paromomycine); procurement and supply of 23,375 individual diagnostic test kits for leishmaniasis; and donation (by GSK) and distribution of a total of 2,332,000 tablets of Albendazole used for MDA for elimination of Lymphatic Filariasis.

Human resource capacity strengthening

Several training programmes in support of communicable disease control were supported in 2017: 107 health workers trained on viral hepatitis screening, diagnosis, care and treatment; 62 health workers trained on integration of tuberculosis and maternal/child health (TBRMNCH) programs; 26 health workers sensitized on TB-HIV collaboration; 52 health workers trained on comprehensive tuberculosis management (TBL, TBHIV and MDR-TB); 500 health workers trained on maliariology; 75 health workers trained on comprehensive management of neglected tropical diseases; and training of 69 health workers (33 clinicians and M&E experts and 17 laboratory technicians) trained on management of visceral leishmaniasis (VL).
PHOTO 09:
Dr Tedros Adhanom - WHO Director General, Dr Akpaika Kalu - WHO Representative for ETHIOPIA and Dr Innocent Ntaganira - Head of WHO Liaison Office to the AU and ECA having side discussion during the African Leaders Malaria Alliance (ALMA) working dinner.
July 2017
(Photo Credit: WHO Liaison Office to the African Union)
Addis Ababa, ETHIOPIA

PHOTO 10:
Dr Matshidiso Moeti - WHO Regional Director for AFRICA, Prof. Yifru Berhane - Minister of Health (ETHIOPIA) and Dr Akpaika Kalu - WHO Representative for ETHIOPIA during the working launch session of the African Leaders Malaria Alliance (ALMA)
December 2017
(Photo Credit: WHO Liaison Office to the African Union)
Addis Ababa, ETHIOPIA
2.5.5. Strengthening non-communicable disease control systems

In 2017, WHO focused its non-communicable disease control investments on addressing the major risk factors of NCDs in Ethiopia: tobacco use; unhealthy diet; harmful use of alcohol; and physical inactivity.

- Generation of evidence used to develop the action plan for multi-sectorial response to NCDs: Global Adult Tobacco survey, a global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators; and National NCD STEPs survey using the WHO STEP-wise approach tools.

- Facilitating the mission of the United Nations Interagency Taskforce on NCDs. The mission recommended among others: conduct of a high level national summit on NCDs; development of an effective multi-sectorial coordination mechanism at the highest level of the government; increase of excise taxes on tobacco products and adoption of specific taxation for tobacco products; adoption of a whole of government, whole of society response to NCD prevention and control, focusing on health promoting urbanization based on SDG 11; development of sustainable financing framework for NCDs by mid-2019 based on the costing of the NCD action plan; and integration of cervical cancer screening within all sexual and reproductive health (SRH) clinics as a strategy for enhancing early diagnosis and management. Towards implementing these recommendations, the high level forum on NCDs is schedule to hold in March 2018 and would be co-hosted by the UN Resident Coordinator and the Federal Minister of Health.


2.5.6. Promoting health along the life course

WHO support in promoting health along the life course in 2017 included: development of the national roadmap for maternal and new born health (MNH) quality of care with technical guides and tools for Maternal and perinatal Death surveillance and Response (MPDSR); development of adolescent and youth health implementation standards and minimum service delivery package; development of standard tool for Quality health-care Services for adolescents; conduct of subnational perinatal death survey which contributed strategic information towards the development of the MPDSR technical guide, tools and training materials; introduction of MPDSR using the MDSR platform to ensure accountability and response to perinatal deaths – the maternal death surveillance and response (MDSR) had been ongoing since 2015; and training at all levels on MPDSR, Adolescent and Youth Health, Comprehensive Emergency Obstetrics and New-born Care (CEmONC), Family planning and National Quality Improvement based on the developed/reviewed guidelines and tools.

2.5.7. Mainstreaming equity, gender equality and human rights in health

In 2017, WHO contributed the following in building national capacity for integration of equity, gender equality and human rights into health programming:

- Production of info graphics materials on the integration of equity, gender and rights during health events around thematic topics like: tuberculosis; mental health; and cancer;
- Production and dissemination of training package for health response to gender-based violence/sexual violence (GBV/SV);
- Production and dissemination of a practical handbook for health workers on the translation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW);
- Training of universities and regional health bureaus on GBV/SV including distribution of GBV kits for collection of forensic clinical data, in support of the multi-sectoral response to GBV/SV;
- Facilitation of the ban on the medicalization of female genital mutilation in health sector – the ban by the Federal ministry of health came into effect in the year 2017;
- Establishment of a partnership between WHO and the Ethiopian Human Right Commission (EHRC) focused on monitoring the mainstreaming equity, gender and human rights in the work of the health sector;
- Development and implementation of a joint project on policy initiative for women health rights funded by the “delivering together for results fund” (DFR-F).

2.5.8. Integrating health interventions into the Ethiopia-Kenya “cross-border integrated programme for sustainable peace and socio-economic transformation”

The goal of the “Cross-border integrated programme for sustainable peace and socioeconomic transformation: Marsabit county, Kenya and Borana and Liben zones, Ethiopia” is “to transform the region into a prosperous, peaceful and resilient community through capacity building programmes and creation of alternative livelihoods and cross-border trade aimed at reducing poverty, inequality, low education levels and poor quality, inadequate access to basic health care and unemployment, especially among the youth; and sustainable and effective utilization of the resources of the region. WHO participated actively in the consultations that resulted in the signing of the programme by the authorities of the two countries on 17th February, 2017.

WHO’s focus was in ensuring the integration of appropriate health interventions in the programme. This was achieved as seen in output number 3, “improved education and health conditions in both regions,” and a health objectively verifiable indicator (OVI), “increase in Proportion of the target communities accessing quality healthcare services.” Implementation of the cross-border programme is ongoing on phases.
THE TRANSFORMATION AGENDA
OF THE WORLD HEALTH ORGANIZATION SECRETARIAT IN
THE AFRICAN REGION
2015 – 2020

It was launched by the Regional Director for Africa in February 2015. Its objective is to ensure that the WHO Secretariat in the African Region evolves into the primary leader in health development in Africa and is a reliable and effective protector of Africa’s health stock.

The Transformation Agenda has four focus areas: pro-results values, smart technical focus, responsive strategic operations and effective communications and partnerships. The managerial, programmatic and governance themes of the ongoing WHO global reform were factored into its development. It is not only a commitment to positive change in the Regional Office but also a programme for accelerating the implementation of WHO global reform within the Region, with each focus area closely aligned with specific outcomes of the WHO global reform programme.

The Transformation Agenda aims to be bold, ambitious and seeks to engender a regional health organization that is foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately resourced and equipped to deliver on its mandate. The Transformation Agenda also responds to increased expectations of Member States and regional and global stakeholders for a change in the way WHO does business in the African Region. There is anticipation of accelerated implementation and institutionalization of the WHO reform agenda as well as improvement in the effectiveness and efficiency of actions in line with the Organization’s mandate. Stakeholders want to see an appropriately resourced and equipped WHO that is responsive and effective in strengthening national health systems; coordinating disease prevention and control, including outbreak preparedness and response; and launching supranational actions in support of global health security.

Whilst it is a vision and a strategy for change aimed at facilitating the emergence of “the WHO that the staff and stakeholders want”, its success will depend on the commitment and cooperation of staff, Member States and partners.
THE WORK OF WHO IN ETHIOPIA DURING 2017

INVESTMENT PILLAR 1
RESPONDING TO HEALTH EMERGENCIES

INVESTMENT PILLAR 2
BUILDING RESILIENT HEALTH SYSTEM

INVESTMENT PILLAR 3
REFORMING WHO FOR INCREASED EFFECTIVENESS

AFRICA HEALTH TRANSFORMATION PROGRAMME, 2015 - 2020
THE TRANSFORMATION AGENDA OF THE WHO SECRETARIAT IN THE AFRICAN REGION, 2015 - 2020
WHO TWELFTH GENERAL PROGRAMME OF WORK, 2014-2019
WHO IN ACTION: Boots on the ground leading the overall emergency response operations – July 2017
(Photograph: WHO ETHIOPIA / Teddy Zerayacob)
Dembel, Sib Zone - Somali Regional State, ETHIOPIA
3. PROGRESS IN INVESTMENT PILLAR 3: REFORMING FOR EFFECTIVENESS

The goal of the Transformation Agenda of the World Health Organization secretariat in the African region, 2015-2020 is to engender the emergence of “...a regional health organization that is foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately resourced and equipped to deliver on its mandate; an organization that meets the needs and expectations of its stakeholders.” Pursuant to the TA, consultations were held in Ethiopia towards the development of the country cooperation strategy (CCS), 2016-2020. The consultations showed that health stakeholders expected WHO in Ethiopia to reprioritize its health investment portfolio and focus mainly on public health emergency management – stakeholders expect WHO to be on the ground serving as the “first to know, first to respond and first to communicate” on health emergencies in Ethiopia. In health development investments, stakeholders called on WHO to focus more on attributable results. A functional review of the WHO country office held in October 2017 elicited similar sentiments during its consultation with partners. All these point to the need for: programmatic reforms – a strategic refocusing of the work of WHO in Ethiopia; and management reforms – a shift of the management support of WHO operations towards effective delivery on the programmatic expectations of stakeholders, and transparent accounting for results and resources.

3.1: PROGRAMMATIC REFORMS

Through concerted advocacy by leadership and training of staff members, in 2017, WHO/Ethiopia started shifting its health development investments towards outcome/impact levels, away from input/output levels – investments in communicable diseases control, non-communicable diseases control, health systems strengthening, and promoting health along the life course. The result was the inclusion of outcome/impact level investments in many programme areas of the country office operational plan for the 2018/2019 period. The statutory semi-annual reviews of the operational plan in 2018 and 2019 will afford non-compliant programme areas the opportunity to align with the shift and support the country office commitment to contribute to and account for contributions to Ethiopia’s outcome/impact targets as demanded by GPW 13.

3.2: MANAGEMENT REFORMS

The management reform of WHO/Ethiopia in 2017 focused on: strengthening accountability for results and resources; strengthening risk management and compliance; enhancing transparency and equity in human resource management; fostering transparency in procurement of goods and services; enhancing resource mobilization and external communication capacities; and strengthening WHO field presence.

3.1.1. Strengthening accountability for results and resources

As a champion for the TA, the WHO Representative at every opportunity emphasized the centrality of accountability for results and resources in enhancing the trust of...
partners and in driving successful resource mobilization. This investment in mainstreaming pro-results values of the organizational was complimented by the following initiatives in 2017: adoption of key performance indicators (KPI) and KPI monitoring; implementation of EPI accountability performance framework; introduction of the programme management officer (PMO) network; and introduction of quarterly planning and review meetings and reporting.

**Adoption of KPIs and KPI monitoring and reporting**

As part of the implementation of the TA, WHO country offices were required in 2017 to select programmatic KPIs; like other country offices, WHO/Ethiopia adopted 20 KPIs (13 compulsory KPIs prescribed by the Regional Office for Africa and 7 country specific others). Earlier in 2016, managerial KPIs had been adopted. The programmatic and managerial KPIs are linked to the performance objectives of individual health programs and clusters in the country office; they were also linked to the performance objectives of individual staff members since mid-2017. Beginning in the third quarter of 2017, the country office submitted regular quarterly KPI reports to the Regional Office. Regular feedbacks were received. In 2018, the feedbacks would be the basis for ordering technical audits of poor performing programmes and programme clusters.

**Implementation of EPI accountability performance framework**

Ethiopia country office implemented the accountability performance framework for all EPI and Polio-funded staff effective April 2017 – the accountability framework is a systematic process of performance monitoring, evaluation, and feedback for both individuals and teams. It includes a suite of recognition mechanisms, rewards, and incentives for good performance and process for investigation and remediation (support and sanctions) of poor performance. It also involved regular integrated supportive supervision using open data kit (ODK) – online tools for monitoring performance against objectives (Online Dash Board) – and submission of data generated at site to a live server domiciled in the WHO Regional Office for Africa. Monthly feedbacks on performances were received from the regional office and this has helped enhance accountability of staff members. There is a plan to, in 2018, review implementation of the performance framework and expand its utilization by all programmes and clusters in the country office. That was why non-EPI programmes were supported to participate in the framework’s inception training in Ethiopia.

**Introduction of the PMO network**

Prior to 2017, the country office faced great problems in managing its programme budget and meeting deadlines for submission of donor reports. As part of the solution, in 2017, the PMO network was introduced in WHO/Ethiopia. The network consists of the following: two programme management officers; the technical programme clusters working in close collaboration with the management support team;
In 2017, the strategic focus of the work of the PMO network was on: enhancing financial planning and monitoring of the programme budget at national level; and improving completeness and timeliness of donor reporting. This resulted in: timely delivery of high quality report of the 2016-2017 programme budgets; timely completion of the 2018/2019 programme budget in the last quarter of 2017; and greatly enhanced completeness and timeliness of donor reporting in 2017.

In 2018, the work of the network will be further strengthened to focus on the following: incorporation into the PMO network, the finance, administrative or programme assistants assigned to the various programme clusters and regional hubs with a focus on mentoring them to undertake grant monitoring and enforce compliance with terms of donor agreements.

Introduction of quarterly planning and review meetings and reporting

Offline annual implementation plans by programmes/clusters with quarterly timelines started in 2017 with variable success. This offline planning will be strengthened and continued in 2018 and indeed extended to the various WHO regional teams in the country.

The review meetings served as platforms for peer review of the work of each programme and programme cluster.

3.1.2. Strengthening risk management and compliance

WHO/Ethiopia completed its risk register in 2017, defining the internal and external risks. Subsequently, the country office set up a risk and compliance management committee that oversees and audits the control system and deal with non-conformity, hidden risks and violations of WHO internal policies.

Further actions towards managing internal risks included enhanced information sharing and mentoring – fostering a well-informed team on organizational rules and control systems. Staff members were also supported to: comply with the mandatory eLearning courses including that on “management, accountability and leadership development;” and sign-off the declaration of interest form – by staff members with financial management and procurement responsibilities.

External risks in 2017 were associated with the WHO cash transfer mechanism (the direct financing cooperation or DFC) which allows the counterpart to adjust the timing of activities provided the country office is informed in advance – thus risk of delay in implementation of funded activities is high. Also the country office deals with significant number of DFCs per year. To reduce the risk associated with the management of DFCs, in many cases programme managers opted for direct implementation of activities – staff members undertaking to directly oversee the implementation of the said activity, including responsibility for financial management and accounting. Direct implementation
will be further expanded as WHO field presence is strengthened.

3.1.3. Enhancing transparency and equity in human resource management

The staffing levels for WHO Ethiopia as at December 31, 2017, stood at 290 with 48% of them holding fixed term/continuing appointment, and 52% holding short term/SSA contracts (See table 2). About 35% of all personnel were general staff and 65% professional staff (Among those with fixed term/continuing appointment, 43% were of general staff category, and 57% of professional staff category; among SSA contract holders, 27% were general staff and 73% professional staff). Of the 290 personnel in the country office at the end of 2017, only 15% were females with the majority (85%) being males (among those with fixed term/continuing appointments, 21% were females and 78% males; among SSA contract holders, 9% were females and 91% males).

At the end of 2017, there were 43 staff member separations (22 resignations, 11 abolitions, 4 retirements, 1 death, 5 position changes – 2 international appointments and 3 special service agreement (SSA) consultants assuming staff positions.) In support of the health emergency response, a total of 53 staff members were repurposed for epidemic response from other programmes and deployed for variable periods of time.

The human resources (HR) team in the country office paid specific attention to enhancing transparency and equity in the recruitment processes. A total of 70 selections were undertaken – 8 staff (TP/FT) and 62 SSA positions comprising of National officers and General Service staff. There was induction for 10 newly appointed staff (National and International); and induction for 60 international consultants with the support of AFRO and HQ.

<table>
<thead>
<tr>
<th>CLUSTER/PROGRAMME</th>
<th>PERSONNEL – FIXED TERM/CONTINUING CONTRACT</th>
<th>PERSONNEL – SHORT TERM CONTRACT (SSA)</th>
<th>TOTAL PERSONNEL</th>
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<tr>
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<td>FEMALE MALE TOTAL</td>
<td>FEMALE MALE TOTAL</td>
<td>FEMALE MALE TOTAL</td>
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<tr>
<td>General staff</td>
<td>14 44 60</td>
<td>3 36 41</td>
<td>19 82 101</td>
</tr>
<tr>
<td>Professional staff</td>
<td>13 66 79</td>
<td>11 99 110</td>
<td>24 155 189</td>
</tr>
<tr>
<td>TOTAL</td>
<td>29 110 139</td>
<td>14 137 151</td>
<td>43 247 290</td>
</tr>
<tr>
<td>Percent general staff by gender</td>
<td>27% 73%</td>
<td>7% 93%</td>
<td>14% 81%</td>
</tr>
<tr>
<td>Percent general staff by contract type</td>
<td>43%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Percent professional staff by gender</td>
<td>14% 84%</td>
<td>10% 90%</td>
<td>13% 87%</td>
</tr>
<tr>
<td>Percent professional staff by contract type</td>
<td>57%</td>
<td>73%</td>
<td></td>
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<tr>
<td>Percent of total personnel by gender</td>
<td>21% 79%</td>
<td>9% 91%</td>
<td>15% 85%</td>
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<tr>
<td>Percent of total personnel by contract type</td>
<td>48%</td>
<td>52%</td>
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3.1.4. Fostering transparency in the procurement of goods and services

Transparency in the procurement of goods and services in the country office was enhanced in 2017. A total of 325 procurement transactions were undertaken in 2017 with a total value of USD5.7 million – health emergency procurements amounted to USD 3.2 million (56% of all procurements in 2017).

Procurement transparency was further enhanced through piggy-bagging with UN sister agencies in sourcing goods from Suppliers that give the best of both quality and price – this is done as part of WHO collaboration in the procurement network coordinated through the UN joint Operations Management Team (OMT); the OMT maintains Long Term Agreement (LTAs) for a broad range of services and for goods.

3.1.5. Enhancing resource mobilization and external communication capacities

In mid-2017, the capacity of the country office for external relations and resource mobilization was strengthened with a support of a senior external relations and resource mobilization officer. Progress made included mobilization of a total of USD 11,436,000.00 for health emergency response.

Strengthening capacity for modern communication including news-making, infographics and dissemination of appropriate information would be a strategic investments in 2018.

3.1.6. Strengthening WHO field presence in ETHIOPIA

Strengthening WHO field presence was aimed at enhancing WHO capacity to deliver and account for the results of its work in each region. A strengthened WHO field presence was defined in 2017 to consist of:

- A functional WHO office in six hubs – Jijiga serving Somali, Dire-Dawa and Harari regions, Hawassa serving SNNPR, Gambella serving Gambella region, Mekelle serving Tigray and Afar regions, Bah Dir serving Amhara and Benshangul Gumuz regions, and Addis Ababa serving Oromia and Addis regions – each hub being equipped with appropriate human, financial and material resources.

- In situ Regional Coordinators – senior experts in health systems strengthening – operating out of the six hubs and with appropriate support staff. Each Regional Coordinator will be authorized to: serve as WHO team leader in the assigned region; represent WHO in the region; and manage and account for the assets and work of WHO in the assigned region.

- An appropriate compliment of technical staff including regional health cluster coordinator, under the technical and managerial leadership of the Regional Coordinator, supporting the work of WHO in health emergency preparedness and response, health systems strengthening, diseases control, and promotion of health along the life course – all of these in the context of implementation of the national health sector strategy.
Costed WHO annual implementation plan for each region aimed at making WHO investments in each region more predictable, while enhancing WHO accountability for results and resources - empowering Regional Coordinators to be the interlocutors of WHO investments in each region and recipients of funding or support request from regional stakeholders.

An effective “Coordinator of WHO field operations” in the country office empowered to serve as first line supervisor and backstop officer of the Regional Coordinators.

Pursuant to the above, in 2017, WHO field offices were secured in Jijiga, Bah Dir and Mekelle – the offices in Bah Dir and Mekelle being shared with UNICEF. Also some staff members were designated as Regional Coordinators in acting capacity. Recruitment of substantive Regional Coordinators would be undertaken in 2018 as well as the development of the hubs in the remaining three locations.
FUTURE PERSPECTIVES
In 2018, WHO/Ethiopia will maintain its focus on the three investment pillars: (1) responding to health emergencies; (2) building resilient health system, and (3) reforming WHO for effectiveness. This will be in the context of the 13th GPW, 2019 – 2023.

- **Investment pillar (1):** The major focus will be on implementing the country office strategy for health emergency encompassing the three results pillars of: prevention including use of measles vaccination coverage maps to define high risk areas for measles epidemic and undertake emergency vaccination campaigns; preparation including strengthening Ethiopia’s biosafety and biosecurity and preparedness for earthquakes and other vulnerabilities; and protection including strengthening the rapid response system in all regions.

- **Investment pillar (2):** The focus will remain on: building shock responsive regional health systems; continuing advocacy for mainstreaming water-centered development in the drought-prone areas; and generating strategic information for health policies and strategies. Other areas for focus in 2018 are: assessment of the quality of care of the health extension programme (HEP) to generate evidence for HEP review and planning; development of in-country training of medical specialists; policy analysis and support; health care financing; strengthening health management information system (HMIS); strengthening procurement supply management system; mid-term review of the health sector transformation plan; and strategic expansion of WHO health development investments – this involves revision of 2018/2019 operational plan by mid-2018 to in better align it with GPW 13, focusing more on investing for outcome/impact, shifting WHO investments towards the planned outcomes/impact targets of the national health sector transformation plan.

- **Investment pillar (3):** The following will receive major attention: implementation of the recommendations of the 2017 functional review of the work of WHO in Ethiopia; implementation of the recommendations of the planned 2018 comprehensive audit of WHO/Ethiopia; implementation of the 2017 DFC reviews; and strengthening WHO field presence.

Furthering improvement on the following will continue to be priority: strengthening accountability for results and resources; strengthening risk management and compliance; enhancing transparency and equity in human resource management; fostering transparency in procurement of goods and services; and enhancing resource mobilization and external communication capacities.
In 2017, WHO worked with many donors, technical and implementing partners; it was a win-win partnership that saved lives, supported the vulnerable, and strengthened systems – a valuable partnership indeed!
WHO’S PARTNERS IN ETHIOPIA

WHO IN ACTION: Humanitarian coordination team visiting a stabilization center – August 2017
(Photo Credit: WHO ETHIOPIA / Tesfay Teregebab)
Deghebour, Jarar Zone - Somali Regional State, ETHIOPIA
4. WHO’S PARTNERS IN ETHIOPIA

FEDERAL MINISTRY OF HEALTH AND REGIONAL HEALTH BUREAUS

OCHA

UNOPS

icddr,b

unicef

Gavi

National Philanthropic Trust

UNFPA

UNDP

THE WORLD BANK

Australian AID

CCRDA

GOARN

THE CARTER CENTER

AFRICA CDC

Public Health England
ANNEXES
## Annex 1: Acronyms

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<tr>
<td>AFRO</td>
<td>African Regional Office</td>
</tr>
<tr>
<td>API</td>
<td>Application Program Interface</td>
</tr>
<tr>
<td>ARCC</td>
<td>African Regional Certification Commission</td>
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<tr>
<td>AHTP</td>
<td>Africa Health Transformation Programme 2015-2020</td>
</tr>
<tr>
<td>AWD</td>
<td>Acute Watery Diarrhea</td>
</tr>
<tr>
<td>CAPA</td>
<td>Corrective Action Preventive Action</td>
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<tr>
<td>CASH</td>
<td>Clean and Safe Hospital</td>
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<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>CDC</td>
<td>United States Center of Disease Control</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
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<tr>
<td>CFE</td>
<td>Contingency Fund for Emergencies</td>
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<tr>
<td>CTC</td>
<td>Case Treatment Center</td>
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<tr>
<td>CV</td>
<td>Curriculum Vitae</td>
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<tr>
<td>DFC</td>
<td>Direct Fund Cooperation</td>
</tr>
<tr>
<td>EHRC</td>
<td>Ethiopian Human Rights Commission</td>
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<tr>
<td>EIC</td>
<td>Ethiopia Investment Commission</td>
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<tr>
<td>EmONC</td>
<td>Emergency Obstetrics and newborn Care</td>
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<tr>
<td>EPHI</td>
<td>Ethiopian Public Health Institute</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded program of Immunization</td>
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<tr>
<td>ETAT</td>
<td>Emergency Triage and Treatment</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture organization (United Nations)</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccine and Immunization</td>
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<tr>
<td>GMP</td>
<td>Good Manufacturing Practice</td>
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<tr>
<td>GPEI</td>
<td>Global Polio Eradication Initiative</td>
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<tr>
<td>GPW</td>
<td>General program of work</td>
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<tr>
<td>HES</td>
<td>Health Emergency Surveillance</td>
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<tr>
<td>HQ</td>
<td>Head Quarter</td>
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<tr>
<td>HR</td>
<td>Human Resource</td>
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<tr>
<td>HRPD</td>
<td>Human Resource Development</td>
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<tr>
<td>HSE</td>
<td>Health Security and Emergency</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced People</td>
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<tr>
<td>IMNCI</td>
<td>Integrated Management of Newborn and Childhood Illnesses</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention Control</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MPOSR</td>
<td>Maternal and Perinatal Death Surveillance and Response</td>
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<tr>
<td>NASPA-Pharma</td>
<td>National Strategic and Plan of Action for Pharmaceutical Manufacturing Development</td>
</tr>
<tr>
<td>NDRMC</td>
<td>National Disaster Risk Reduction &amp; Management Affairs</td>
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<tr>
<td>OCHA</td>
<td>Office of Coordination of Humanitarian Affairs</td>
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<tr>
<td>ODK</td>
<td>Open Data Kit</td>
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<tr>
<td>PHEM</td>
<td>Public Health Emergency Management</td>
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<td>RBEC</td>
<td>Regional Bioequivalence Centre</td>
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<tr>
<td>RMNCAH</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health</td>
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<tr>
<td>RRT</td>
<td>Rapid Response Team</td>
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<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<td>SC</td>
<td>Stabilization Center</td>
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<tr>
<td>SDG</td>
<td>Sustainable Developmental Goals</td>
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<td>SEA</td>
<td>Sexual Exploitation and abuse</td>
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<tr>
<td>SSA</td>
<td>Special Service Agreement</td>
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<tr>
<td>ToT</td>
<td>Training of the trainers</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nation Programme on HIV/AIDS</td>
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<tr>
<td>UNDAF</td>
<td>United Nation Development Assistance Framework</td>
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<tr>
<td>UNDP</td>
<td>United Nation Development Programme</td>
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<tr>
<td>UNSS</td>
<td>United Nation Safety and Security</td>
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<tr>
<td>UNECA</td>
<td>United Nation Economic Commission for Africa</td>
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<tr>
<td>UNHCT</td>
<td>United Nations Ethiopia Humanitarian Country Team</td>
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<tr>
<td>US</td>
<td>United States</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WASH</td>
<td>Water Sanitation and Hygiene</td>
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<tr>
<td>WCO</td>
<td>WHO Country Office</td>
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<td>WHO</td>
<td>World Health Organization</td>
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|                                                                         | To assess the effectiveness of integration, in terms of detection of TB and HIV associated TB among attendees at the RMNCH/PMTCT services and linking them to appropriate care and support. | Arsi Negele Woreda (district) in Oromiya region | Oromiya RHB, USAID/Challenge TB      |
| Baseline survey of Elimination targeted 239 districts: PHASE 1          | To assess the structural and human resources readiness of existing malaria program towards adopting malaria elimination efforts in selected geographic locations (woredas). | National (in elimination targeted 239 districts) | FMOH (NMCP), EPHI, WHO, ACIPH, CAHI, MACEPA, UNICEF and others |
| Baseline survey of Elimination targeted 239 districts: PHASE 2          | To assess the epidemiological stratification of malaria towards launching malaria elimination efforts in selected geographic locations (woredas). | National (in elimination targeted 239 districts) | FMOH (NMCP), EPHI, WHO, ACIPH, CAHI, MACEPA, UNICEF and others |
WCO ETHIOPIA staff renewing their commitment to end gender-based violence anywhere, anytime with a theme “end violence against women and girls!” – by joining the WHO HQ’s #orangetheworld movement of 16 days of activism against gender-based violence. 24 November 2017.

Photo Credit: WHO ETHIOPIA / Selamawit Yilma