World Health Organization

Country Cooperation Strategy

at a glance

Ethiopia

http:// www.who.int/countries/en/

WHO region	Africa
World Bank income group	Low-income
Child health	
Infants exclusively breastfed for the first six months of life (%) (2011)	52.0
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016)	77
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	64.8 (Both sexes) 66.8 (Female) 62.8 (Male)
Population (in thousands) total (2015)	99390.8
% Population under 15 (2015)	41.4
% Population over 60 (2015)	5.2
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2011)	30.7
Literacy rate among adults aged >= 15 years (%) (2007-2012)	39
Gender Inequality Index rank (2014)	129
Human Development Index rank (2014)	174
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	4.88
Private expenditure on health as a percentage of total expenditure on health (2014)	41.29
General government expenditure on health as a percentage of total government expenditure (2014)	15.75
Physicians density (per 1000 population) (2009)	0.025
Nursing and midwifery personnel density (per 1000 population) (2009)	0.252
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2016)	27.6 [21.7-35.2]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2016)	58.4 [46.6-72.8]
Maternal mortality ratio (per 100 000 live births) (2015)	353 [247 - 567]
Births attended by skilled health personnel (%) (2016)	27.7
Public health and environment	
Population using safely managed sanitation services (%) (2015)	4 (Rural)
Population using safely managed drinking water services (%) (2015)	11 (Total) 38 (Urban) 4 (Rural)

Sources of data:
Global Health Observatory May 2017
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

Ethiopia has made tremendous achievement in economic, political and social spheres. Health, as part of the environment and social services, has recorded success marked by the increased estimated healthy life expectancy at birth to 64.8 years in 2016 from as low as 45 years in 1990. The health status of the country's population indicates that about 80% of diseases are attributable to preventable conditions related to infectious diseases, malnutrition; and personal and environmental hygiene. However, Ethiopia is displaying decreasing trend of these conditions through the effective performance of health extension programs. The adult HIV prevalence is 1.1% in 2016, more in female than male. The HIV infection among 15-24 age groups has significantly reduced from 12.4% in 2001 to 1.7% in 2014 - suggesting a decline of HIV incidence. The prevalence of TB in Ethiopia is estimated to be 200 with incidence of 207 per 100, 000 populations. The health of women, neonates and children are areas of major concern including gender-based violence and harmful traditional practices. Ethiopia has reduced the under-five mortality rate from 166 per 1,000 live births in 2000 to 59 per 1,000 live births in 2015; Neonatal mortality rate declined by 42% between 1990 and 2013 to 28/1000 live births in 2013. New vaccines, like pneumococcal, rotavirus and human papillomavirus vaccines were introduced into the routine immunization programme. There is great improvement in maternal mortality rate between 1990 and 2013, Ethiopia achieved a 70% reduction in maternal mortality ratio; from 1400 per 100,000 live births in 1990 to 420 per 100,000 live births in 2013; a decline of 5% per annum. The country achieved MDG 4 - under-five mortality- two years prior to the target year and demonstrated notable progress towards MDGs 5 and 6 targets. Non-communicable diseases (NCD) and its related risk factors are growing in the country with high morbidity and mortality. In 2014 deaths from NCD account for 40% of all deaths. Injuries following road traffic accidents and harmful consumption of alcohol and tobacco showing increasing trends. Ethiopia ratified the WHO FCTC on 21st January 2014. Ethiopia has faced repeated disease outbreaks like acute watery diarrhea, measles, meningitis, yellow fever and dengue. There have also been natural crises like the El Nino and La Nina phenomena, droughts and floods with health consequences. In all cases government led a robust response with the support of partners. Investing in resilient national systems in the context of humanitarian-development nexus is the way to a sustainable future.

HEALTH POLICIES AND SYSTEMS

The right to health for every Ethiopian has been guaranteed by the 1995 Constitution of the Federal Democratic Republic of Ethiopia (FDRE), which stipulates the obligation of the state to issue policy and allocate ever increasing resources to provide public health services to all Ethiopians. The Federal Ministry of Health (FMOH) of Ethiopia availed a comprehensive well-articulated health sector strategic plan (HSDP IV 2010 - 2015) to guide the health programs aligned with the national Growth and Transformation Plan I (GTP I) that was effective in attaining the national goals and MDG targets.

The ministry has also developed 20 years of visioning Ethiopia towards the path of universal health coverage (2015 – 2035). This document directs the pace of transitioning to low-middle income country by 2025 and to middle-middle income country by 2035. The current Health Sector Transformation Plan (HSTP), extrapolated from the GPT II, covers a five year period from July 2016 to June 2020 and is well aligned with SDGs3 and health related SDGs and targets that also influence the performance of health determinants.

Ethiopia follows a decentralized health care system; development of the preventive, promotive and curative health care delivery by public, private for profit and not-for profit players in the health sector. The Ethiopian health care delivery, organized in to three tier-system, puts the health extension program, the innovative community-based service delivery (health development army), as a center of focus for the provision of primary health care services to the broad masses. Primary health care (PHC) potential coverage stands at 90%, reaching most of the rural areas in the country. The growing countrywide network of healthcare facilities has enhanced access to health services. The rapid expansion of both private-for-profit and not for-profit health facilities accounts for about 11% of health service coverage and this has enhanced public-private-partnerships in health.

COOPERATION FOR HEALTH

Ethiopia enjoys unprecedented support from bilateral and multilateral donors and partners. The health partners are governed through the Health, Population and Nutrition (HPN) partners' forum. Partners' contributions represent 49.9% of the health sector expenditure (NHA 2014), while the household contribution is 33.7 % and the government is at 15%. WHO Country Office Ethiopia actively participates in all planning, implementing, monitoring and evaluating of health sector development and humanitarian programs in the country. In 2009, the Government and a number of IHP+ partners signed a Joint Financing Arrangement (JFA) to commit resource to a pooled funding mechanism managed by the Federal Ministry of Health. The JFA was called the MDG Pooled Fund (MDG PF) and rechristened SDG pooled fund in 2016. The MDG/SDG PF covers all program areas where there is a funding gap; so far it has mostly covered the procurement of public goods required to facilitate health service delivery at lower levels. The United Nations Development Assistance Framework (UNDAF), 2012-2015, was successfully implemented. A new UNDAF, 2016 – 2020, in support of the five-year national development plan – Growth and Transformation Plan II (GTP II) is being implemented. The current UNDAF was developed within the Delivery as One (DaO) framework to ensure a harmonized, coherent and more effective approach of UN's contribution to the implementation of the GTPII. The current WHO Country Cooperation Strategy (2016- 2020) is aligned with the HSTP, the SDGs and the UNDAF.

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2016–2020)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
STRATEGIC PRIORITY 1: Reduced mortality, morbidity, and disability due to communicable and non-communicable diseases	• Strengthening national efforts in ending HIV/AIDS and tuberculosis and eliminating Viral Hepatitis, malaria and neglected tropical diseases • Strengthening NCD preventive, promotive and case management interventions • Scaling-up of climate resilient Water Safety System
STRATEGIC PRIORITY 2: Reduced maternal, new-born and child morbidity and mortality and improved Sexual and Reproductive Health (SRH) rights and utilization	• Increasing access to high quality and utilization of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) interventions • Expanding access to immunization services and control of vaccines preventable diseases • Supporting improved capacity for integration and coordination of comprehensive facility and community based nutrition service including school based nutrition package
STRATEGIC PRIORITY 3: improve access to quality and equitable health services in ensuring universal health coverage	• Strengthening the national health system for quality health services • Improving access to safe, effective, quality and affordable medicines and health technology including blood transfusion services including strengthening regulatory systems.
STRATEGIC PRIORITY 4: Resilient systems for emergency risk and crisis management	• Enhancing preparedness for public health emergency; • Strengthening disease surveillance systems at national and subnational levels; • Strengthening Public health emergency response system and the public health emergency risk communication
STRATEGIC PRIORITY 5 : Strengthened partnerships for harmonization, coordination and resource mobilization for health and development	• Strengthening coordination and information sharing with bilateral and multilateral agencies, and non-state actors (professional associations, public-private partnership, and civil societies) • Strengthening external relations, resource mobilization and strategic communication • Partnership with health sector for strengthening the multi-sectoral collaboration on social determinants of health, mainstreaming gender, equity and human rights in health and development including initiatives for women health rights projects

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