Health Sector Transformation Plan

HSTP II

2020/21-2024/25

(2013 EFY - 2017 EFY)

January 2021

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Ethiopia has implemented the first Health Sector Transformation Plan (HSTP-I) from 2015/16 to 2019/20, during which significant achievements were registered in improving the health of our population and increasing access to and utilization of health services. Health outcome indicators have shown improvement, with a remarkable reduction in morbidity and mortality from major communicable diseases such as HIV, tuberculosis and malaria. Maternal and child health has also improved that resulted in saving the lives of millions of women and children.

Despite significant improvements, however, mortality and morbidity from communicable diseases and maternal and child health conditions are still high. The prevalence of non-communicable diseases (NCDs) and injuries are on the rise creating a triple burden

of diseases for the health system. There is a high disparity in service utilization and health outcomes socio-economic groups. The quality of health care is still sub-optimal. The health system is also challenged by emerging pandemics such as COVID-19.

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among people in different geographical areas and

The second health sector transformation plan (HSTP II) is the sector's five years strategic plan from 2020/21-24/25. It aims at improving the health of our population through the realization of accelerating progress towards Universal Health Coverage (UHC), protecting people from emergencies, creating Woreda transformation and making the health system responsive to people's needs and expectations. To measure progress towards these objectives, HSTP-II has set ambitious but realistic targets that are aligned with national and international targets such as the Sustainable Development Goals (SDGs). The plan has identified 14 key strategic directions that define the major strategic areas and initiatives of the strategic period.

The plan aspires to achieve UHC through expanding access to service and improving the provision of quality and equitable comprehensive health services at all levels. We will expand health services based on the recently revised Essential Health Services Package (EHSP), through which different services and high impact interventions will be made available for each respective level of care. Reproductive, Maternal, Newborn, Child, Adolescent and Youth health will continue to be the major focus areas. We will continue to strengthen the prevention and control of major communicable diseases such as HIV, Tuberculosis and Malaria. As NCDs and mental health problems are becoming public health concerns, we will give a special focus on the prevention and control of NCDs and mental health problems, mainly through integrating these services with the primary health care system. The health extension program (HEP) will be revitalized based on the newly revised HEP roadmap and we will implementnew health post arrangement, comprehensive health posts, where more essential health services will be expanded to make services more accessible to the population.

To protect the population from emergencies, we will focus on strengthening our public health emergency management system and work towards building a resilient health system. The plan also focuses on strengthening health investment areas such as medicines, information health workforce, health infrastructure, digital health and

innovations in health. The plan also emphasizes on strengthening multi-sectoral collaborative approach through which we can tackle the social determinants of health. Engaging the private sector in health is also identified as a major strategic area.

We have identified five priority areas/transformation agendas, which will be the top priority issues of the sector. It includes Quality and Equity of health Services, Information Revolution, Motivated, Competent and Compassionate Health workforce (MCC), Health Financing and Leadership.

The first priority area, i.e, quality and equity aspires to improve the provision of quality and equitable services to the population. A national quality and equity strategy will be developed and implemented. Equity and quality will be mainstreamed in all our health programs and regular measurement and improvement will be done. The information revolution will continue to be the priority in HSTP-II. Availability and use of quality data are key for informed evidence
based decision-making in the sector. The sector will focus on improving the production and use of quality of data, with a special focus on improving the routine health management information system (HMIS). As a key priority area, the sector will focus on creating a motivated, competent and compassionate health workforce, which will be one of the key inputs to provide quality and responsive health service. To accelerate progress towards UHC by protecting our people from financial hardship, health financing will be one of the priority areas. The sector will work towards sustainable health financing by implementing different health financing interventions such as insurance schemes, rigorous resource mobilization and different innovative financing mechanisms. The fifth priority area is leadership, which will play a pivotal role in policy and strategy development, creating and strengthening transparency and accountability in the health system, promote

coordination and inter-sectoral collaboration and overall guidance of the health system.

The HSTP-II builds on the successes and challenges of the first HSTP. I believe Ethiopia will continue the already started successes, reverse the challenges that hinder the health system and transform the health system in improving the health status of the population as outlined in the plan.

The objectives of the plan can be successful through the dedication of health workers, the continued political commitment, collaboration and concerted effort of all stakeholders. I hope that our collaborative efforts with the community, CSOs, development partners, donors, academia, associations and other stakeholders will continue to transform the health sector and achieve the ambitious targets set in the plan. Looking forward to working with you all towards the successful implementation of HSTP-II.

Lia Tadesse
Minister of health,
Federal Democratic Republic of Ethiopia

LIST OF ACRONYMS

AHRI Armauer Hansen Research Institute
AIDS Acquired Immunodeficiency Syndrome
ALOS Average Length of Stay
AMR Ant-Microbial Resistance
ANC Antenatal care
ANC4 Antenatal care fourth visit
APR Annual performance report
APTS Auditable Pharmaceutical Transaction and Service
ARM Annual Review Meeting
ART Antiretroviral Therapy
ARV Antiretroviral
BEmOC Basic Emergency Obstetric Care
CASH Clean and Safe Health Facilities
CBHI Community Based Health Insurance
CEmOC Comprehensive Emergency Obstetric Care
COC Certificate of Competence
COVID-19 Corona Virus Disease-19
CPD Continued Professional Development

CPR Contraceptive Prevalence Rate

CRC Compassionate Respectful and Caring

CRVS Civil Registration and Vital Statistics

CSA Central Statistical Agency

CSC Community Scorecard

CSO Civil Society Organization

DALYs Disability Adjusted Life Years

DHIS2 District Health Information System

DMAT Disaster Management Assistant Team

DPCD Disease Prevention and Control Directorate

DQA Data Quality Assessment

DR TB Drug resistance Tuberculosis

ECD Early Childhood Development

eCHIS Electronic Community Health Information System

EDHS Ethiopia Demographic and Health Survey

EFDA Ethiopia Food and Drug Authority

EFY Ethiopian Fiscal Year

EHAQ Ethiopian Hospitals Alliance for Quality

EHIA Ethiopia Health Insurance Agency

EHRIG Ethiopian Hospital Reform Implementation Guideline

EHSP Essential Health Services Package

EHSTG Ethiopian Hospital Services Transformation Guideline

EmONC Emergency Obstetric and Neonatal Care

ENBC Essential new-born care

EOC Emergency Operations Center

EPAQ Ethiopian Primary Health Care Alliance for quality

EPHI Ethiopian Public Health Institute

EPHIA Ethiopia Population Based HIV Impact Assessment

EPI Expanded Program on Immunization

EPSA Ethiopia Pharmaceutical Supply Agency

EPTB extra pulmonary tuberculosis

ETB Ethiopian Birr

FMOH Federal Ministry of Health

FP family planning

GBD Global Burden of Disease

GBV Gender Based Violence

GDP Gross Domestic Product

GGE General Government Expenditure

GGHE General Government Health Expenditure

GGI Good Governance Index

GII Gender Inequality Index

GMP Growth Monitoring and Promotion

GTP Growth and Transformation Plan

HALE Healthy Life Expectancy

HAPCO HIV/AIDS Prevention and Control Office

HBV Hepatitis B Virus

HCF Healthcare Financing

HCI Human Capital Index

HCMIS Health commodity Management Information System

HCs Health Centers
HCV Hepatitis C Virus
HDI Human Development Index
HDSS Health and Demographic Surveillance System
HEHD Hygiene and Environmental Health Directorate
HEP Health Extension Program
HEPHD Health Extension and Primary Health Directorate
HERQA Higher Education Relevance and Quality Agency
HEW Health Extension Workers
HF Health Facility
HHM Health Harmonization Manual
HiAP Health in All Policies
HIS Health Information System
HIT Health Information Technician
HITD Health Information Technology Directorate
HIV Human Immunodeficiency Virus
HMIS Health Management Information System
HP Health Post
HPV Human Papilloma Virus
HRD Human Resource Directorate
HRH Human Resource for Health
HRIS Human Resources Information System
HSTP Health Sector Transformation System
HSTQ Health Service Transformation in Quality
HTA Health Technology Assessment
ICMNCI Integrated Community Case Management of Newborn & Childhood Illness
ICT Information Communication Technology
ICU Intensive Care Unit
IDP Internally Displaced People
IHR International Health Regulation
IMNCI Integrated Management of Neonatal and Child Illness

IMR Infant Mortality Rate
INVEA Immigration, Nationality and Vital Event Agency
IR Information Revolution
JCCC Joint Core Coordinating Committee
JCF Joint Consultative Forum
JRM Joint Review Mission
JSC Joint Steering Committee
KM Knowledge Management
KMC Kangaroo Mother Care
KPI Key Performance Indicators
KPP Key and Priority Populations
LAN Local Area Network
LIP Leadership Incubation Program
LLINs Long-Lasting Insecticidal Net
LMIS Logistic Management Information System
LQAS Lot Quality Assurance Sampling
M&E Monitoring and Evaluation
MCC Motivated, Competent and Compassionate
MCH Maternal and Child Health

MCV Measles Containing Vaccine

MDG Millennium Development Goals

MFR Master Facility Registry

MHM Menstrual Hygiene Management

MMR Maternal Mortality Ratio

MNH Maternal & Newborn Health

MOE Ministry of Education

MOH Ministry Of Health

MPDSR Maternal and Perinatal Death Surveillance and Response

MSWT Multi-Sectoral Woreda Transformation

MTCT Maternal to Child Transmission

MTR Mid-Term Reviews

NAPHS National Action Plan for Health Security

NCDI Non-Communicable Diseases and Injuries

NCoD National Classification of Disease

NGO Non-Governmental Organizations

NHA National Health Account

NHDD National Health Data dictionary

NICU Neonatal Intensive Care Unit

NNMR Neonatal Mortality Rate

NNP National Nutrition Programme

NNT Neonatal Tetanus

NTD Neglected Tropical Diseases

ODF Open Defecation Free

OHT OneHealth Tool

OOP Out of Pocket

OPD Out Patient Department

ORS Oral Rehydration Salt

PCD Partnership and Cooperation Directorate

PHC Primary Health Care

PHCU Primary Health Care Unit

PHEM Public Health Emergency Management

PLHIV People Living with HIV

PMT Performance Monitoring Team

PMTCT Prevention of Mother to Child Transmission of HIV

PNC Postnatal Care

PPP Public-Private Partnership

QI Quality Improvement

QUALY Quality-Adjusted Life-Year

RDQA Routine Data Quality Assessment

RDT Rapid Diagnostic Test

RED Reach Every District

RHBs Regional Health Bureau

RHD Rheumatic Heart Disease

RIS Regulatory Information System

RMNCAYH Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health

RMNCH Reproductive, Maternal, Neonatal and Child Health

RRT Rapid Response Team

SALTS Saving Life Through Safe Surgery

SARA Service Availability and Readiness Assessment

SDGs Sustainable Development Goals
SHI Social Health Insurance
SPA Service Provision Assessment
SPM Strategic Planning and Management
SRH Sexual and Reproductive Health
STH Soil Transmitted Helminthiasis
STI Sexually Transmitted Infections
SUD Substance Use Disorders
SWOT Strengths, Weaknesses, Opportunities and Threats
TB Tuberculosis
TF Total Fertility
TFC Treatment Follow up Centers
TFR Total Fertility Rate
THE Total Health Expenditure
TICs Treatment Initiating Centers
TVET Technical Vocational Educational Training
U5MR Under 5 Mortality Rate
UHC Universal Health Coverage
USD United States Dollar
VLBW Very Low Birth Weight
VMMC Voluntary Medical Male Circumcision
VPN Virtual Private Network
VSD Very Sever Disease
WASH Water, Sanitation and Hygiene
WBHSP Woreda Based Health Sector Plan
WDG Women Development Group
WHO World Health Organization
WoHo Woreda Health Office
ZHD Zonal Health Department

EXECUTIVE SUMMARY

This is the second Health Sector Transformation Plan (HSTP-II) covering the period between Ethiopian fiscal years 2013 and 2017 (July 2020–June 2025). HSTP-II was developed as the first part of a 10-year health sector plan. It was prepared based on an in-depth situational analysis and performance evaluation of HSTP-I; it takes into consideration the country's global commitments and aligns with its overall macro-economic development framework.

HSTP-I (July 2015–June 2020) achieved significant achievements despite ongoing challenges, such as internal conflicts leading to population displacement and the COVID-19 pandemic.

The HSTP-I period was marked by encouraging improvements in life expectancy at birth. This included notable reductions in maternal mortality (decreased 676 deaths per 100,000 live births in 2011 to 401 in 2017). In addition, under-5 mortality and infant mortality per 1000 live births decreased from 123 and 77 in 2005 to 59 and 47, respectively, in 2019. However, over the years, there have been no significant reductions in neonatal mortality (33 deaths per 1,000 live births in 2019).

Morbidity and mortality from common communicable diseases, including malaria, HIV, tuberculosis (TB), and vaccine preventable diseases, declined dramatically during HSTP-I. However, the same period witnessed a substantial rise in the prevalence of non-communicable diseases. Although the burden of neglected tropical diseases (NTDs) is decreasing, the proportion of people affected remains considerable.

In terms of disease risk factors, there has been a relatively high level of reduction in unsafe sex behaviour.

The prevalence of stunting, underweight, and wasting have also diminished from 51% to 37%, from 33% to 21%, and from 12% to 7% respectively, between 2005 and 2019.However, risks from water, sanitation, and hygiene (WASH) and dietary factors, alcohol use, and high blood glucose level showed a lower rate of reduction.

The performance of major health programs has improved, as seen by an increase in the utilization of certain health services. For instance, in 2019, 41% of married Ethiopian women were using contraception compared to just 27% in 2011 and 35% in 2016 (the unmet need remains considerably high at 22%). Antenatal care visit 1 (ANC1) coverage also improved from 62% in 2016 to 74% in 2019, although only 43% of pregnant women had four or more visits. Skilled birth delivery has increased from 28% in 2016 to 50% in 2019. The mean availability of tracer items for basic emergency obstetrical care (BEMOC) stands at more than 85% for hospitals, 74% for health centers (HCs) and 55% for higher-level clinics. Access to safe abortion services and post-abortion care has also expanded. In terms of child health, in 2019, the proportion of children receiving three doses of pentavalent vaccine and all basic vaccines reached 61% and 43%, respectively.

There has also been impressive progress in prevention and control of major communicable diseases. Ethiopia is on track to achieve one of the three targets of the Global End TB Strategy; TB incidence has declined by 21% from the

2015 estimate (as compared to a targeted decline of 20%). TB case notification has been improving, with a detection rate of 71% in 2019/20. TB treatment success and cure rates also reached 95% and 80%, respectively in 2019/20. There has also been progress towards achieving two of the 90-90-90 targets for HIV: 90% of people who know their status were on ART, with 91% achieving viral supersession. Furthermore, in 2019/20, 91% of eligible mothers received services for antiretroviral therapy and prevention of mother-to-child transmission were available in 84% of public health facilities. Malaria control initiatives have been on track. Between 2015 and 2019, malaria deaths dropped from 3.6 to 0.3 per 100,000 among populations at risk. Malaria case incidence has dropped from 5.2 million in 2015 to under 1.6 million in 2019/20.

Several interventions have been implemented to enhance financial risk protection in accessing essential health services. These include provision of high-impact interventions free of charge through an exemption program; subsidization of more than 80% of the cost of care in public health facilities; implementation of community-based health insurance (CBHI) schemes; and full subsidization of the very poor through fee waivers for both health services and CBHI premiums. A revised health care financing strategy was developed within the framework of achieving the goal of universal health coverage.

To address the social and environmental determinants of health, the Government of Ethiopia has taken steps to strengthen engagement with key local and international sectors and stakeholders, for example in the nutrition and WASH programs. There have been multi-sectoral collaborative activities and interventions to improve the status of food security and nutrition, including the high-level government commitment platform, - the “Seqota” Declaration to end child under-nutrition by 2030. The government implemented major strategic initiatives to improve hygiene and environmental health, such as- urban sanitation, scale up of community-led and school-led total sanitation and hygiene, sanitation marketing, and actions to build adaptation and resilience to climate change into the health sector.

The three-tier health system—primary, secondary and tertiary—continues to be the backbone of health service delivery. The primary health care infrastructure has expand enormously, with potential coverage reaching more than 90% in 2019. The Health Extension Program continues to make significant contributions towards improved health indicators in the country. In the second- and third-tier facilities, implementation of strategic initiatives and reforms has strengthened pre-hospital and hospital clinical care. Overall, outpatient attendance rate increased from 0.27 to 0.9 per capita per year between 2000 and 2019.

In 2019, the Essential Health Service Package (EHSP) was revised and endorsed with emphasis on service availability, accessibility, acceptability, and affordability. The 1993 Health Policy has undergone revision and is currently being finalized. Based on the HSTP-I M&E (monitoring and evaluation) framework, the health information system was strengthened to generate data to the monitor the performance and various components of the plan.

An effective leadership and governance system further strengthened the legal and regulatory framework for the implementation of HSTP-I. In addition, stakeholder engagement and partnership with the health sector was strengthened through such platforms as the Joint Steering Committee meetings with Regional Health

Bureaus, the Executive Committee Meetings with agencies; and the regular meetings of the Joint Consultative Forum and the Joint Core Coordinating Committee.

Four transformation agendas were implemented during HSTP-I: 1) Woreda Transformation, 2) Information Revolution, 3) Transformation in Quality & Equity, and 4) Compassionate, Respectful, and Caring Health Workers. Leadership at all levels prioritized and closely monitored these agendas; and the agendas were successful in mobilizing resources and strengthening health sector's efforts to achieve the positive results described above.

HSTP-II aims to build on the successes of the HSTP-I period, incorporating the lessons from its implementation. HSTP-II is aligned with the country's overall macro-economic development framework. The plan was developed in a consultation with the National Plan and Development Commission by employing Strategic Planning and Management tool, and using an inclusive and active participatory process led by the health sector. The process included iterative gathering of feedback during which different versions of the Plan were shared with a wide range of stakeholders, including government sectors and agencies, regional health bureaus, academia, professional associations, the private sector, civil service organizations, and development partners.

The overall objective of HSTP-II is to improve the health status of the population –by accelerating progress towards universal health coverage, protecting populations during health emergencies, transforming woredas, and improving the health system's responsiveness.

HSTP-II has targets to measure its objectives and performance that are developed by considering baseline, national and international standards and anticipated resources. For instance, HSTP-II has set ambitious targets to reduce the maternal mortality rate to 279 per 100,000 live births and to reduce under-5 and neonatal mortalities to 44 and 21 per 1,000 live births, respectively. In terms of service uptake, targets include increasing skilled delivery attendance to 76%, coverage of ANC 4 to 81%, and coverage of pentavalent (3), TB detection rate and ART coverage to 90%, 81%, and 95%, respectively. The list of all indicators with the corresponding targets appears in the "Targets" section.

The Government of Ethiopia developed 14 strategic directions, along with their major activities, to achieve the targets laid out in HTSP-II:

- Enhance provision of equitable and quality comprehensive health service
- Improve health emergency and disaster risk management
- Ensure community engagement and ownership
- Improve access to pharmaceuticals and medical devices and their rational and proper use
- Improve regulatory systems
- Improve human resource development and management
- Enhance informed decision-making and innovations
- Improve health financing
- Strengthen governance and leadership
- Improve health infrastructure
- Enhance digital health technology
- Improve traditional medicine
- Enhance health in all policies and strategies
- Enhance private engagement in the heath sector

Five priority issues were identified as part of the transformation agenda for HSTP-II. Key interventions will be implemented to address these priority issues to transform the health system and to achieve health for all. The transformation agenda are:

1. Quality and Equity: Ensuring equity in delivery of quality health services by creating high-performing primary health care units, ensuring active engagement of the community in service delivery, and continually improving clinical care outcomes.
2. Information revolution: Significantly improving methods and practices for collecting, analyzing, presenting, using, and disseminating information that can influence decisions.
3. Motivated, competent, and compassionate health workforce:- Ensuring equitable distribution and availability of an adequate number and skill mix of health workers who are motivated, competent, and

compassionate to provide quality health services.

4. Health financing: Reforming public financial management and health financing to improve efficiency and accountability, while pursuing the agenda of sustainable domestic resource mobilization for health. 5. Leadership: Enhancing leadership and governance mechanisms at all levels of the health system to drive attainment of the national strategic objectives through activities to ensure alignment and harmonization, thereby creating an enabling environment for the translation of plans into results.

The overall costing for HSTP-II implementation was computed using OneHealth Tool (OHT), a tool based on the WHO's six health system building blocks framework. Accordingly, U.S. dollars $21.88 billion and $ 27.55 billion at base and high-case scenario respectively is required for the five years to be covered in the plan, while the available financial resources during that period are projected at $18.7 billion, $19.7 billion, and $21.9 billion for low-, medium-, and high-case scenarios, respectively.

HSTP-II will be cascaded to all levels of the health system, and will be translated into annual operational plans using the woreda-based health sector annual plan. Its implementation will be regularly monitored using the agreed monitoring framework in a coordinated manner.

Chapter 1

INTRODUCTION

Ethiopia has accomplished the second growth and transformation plan (GTP-II, June 2015 – June 2020), marked by several positive results and achievements. However, this period was also marred by internal conflicts, resulting in large displacement of populations and creating additional burden to the health system. In addition, the COVID-19 pandemic posed a clear threat to ongoing reforms and relatively strong economic growth, with wide-ranging, serious impacts across the country. Nevertheless, the country has still managed to achieve impressive progress in transforming the socioeconomic status of its people.

The first Health Sector Transformation Plan (HSTP-I) was the health chapter of the GTP-II and the first phase of the "Envisioning Ethiopia's Path towards Universal Health Coverage through Strengthening Primary Health Care by 2035." The performance of HSTP-I has been critically reviewed through annual performance reviews and ad hoc assessments, including routine Health Information Management System (HMIS)

assessments, mid-term reviews, Joint Review Mission reports, and various population- and facility-based surveys.

These reviews show that Ethiopia has achieved the goals of the GTP despite the challenges mentioned above. These achievements were made possible due to the implementation of high-impact interventions, primarily through flagship community-based programs such as the Health Extension Program (HEP). Through the implementation of the four Transformation Agendas (1. Woreda Transformation, 2. Information Revolution, 3. Transformation in Quality & Equity, and 4. Compassionate, Respectful, and Caring Health Workers), the health sector has developed momentum to address critical health system bottlenecks. The health sector has also ardently advocated for multi-sectoral collaboration to address the social determinants of health. However, the COVID-19 pandemic caused an important setback and threatened to unwind these gains and achievements.

The second Health Sector Transformation Plan (HSTP-II) is the next five-year national health sector strategic plan, which covers the period between 2013–2017 Ethiopian fiscal years (July 2020–June 2025). During this strategic period, the sector envisions building on the successes and consolidating the gains of HSTP-I to build a resilient, sustainable, high-quality, equity-based health system. Thus, the preparation of HSTP-II was informed by in-depth situational analysis of the performance of the health sector during HSTP-I. The plan also took into account the nation's long-term socioeconomic strategic directions and priorities, the global situation and country's commitments to sustainable development goals, and the dynamics of social determinants of health.

The Ministry of Health (MOH) and Regional Health Bureaus (RHBs) used an active participatory process to develop the HSTP-II. The health sector first identified the nation's long-term strategic goals in consultation with the National Plan and Development Commission, using the Strategic Planning and Management tool. A series of consultations were held with the private sector, academia, professional associations, other government sectors and development partners. These consultations were instrumental in developing a comprehensive plan and ensuring commitment and shared vision among all stakeholders, and the resulting feedback was incorporated in the plan.

HSTP-II's objectives and strategic directions were developed based on the situational analysis of the HSTP-I; and the baseline and targets were developed using data from recent surveys and in consultation with program experts. Costing and target setting was developed using a OneHealth tool designed to inform national strategic health planning in low- and middle-income countries by linking strategic objectives and targets of health programs to the required investments in health systems.

The six chapters that follow give a comprehensive overview of HSTP-II. Chapter 2 covers the country context; Chapter 3 describes the situation analysis; Chapter 4 outlines the objectives, targets, and strategic directions of HSTP-II; Chapter 5 details the costing and financial gap analysis; Chapter 6 describes the implementation arrangement; and Chapter 7 covers the monitoring and evaluation (M&E) plan.

Chapter 2

COUNTRY CONTEXT

Geography

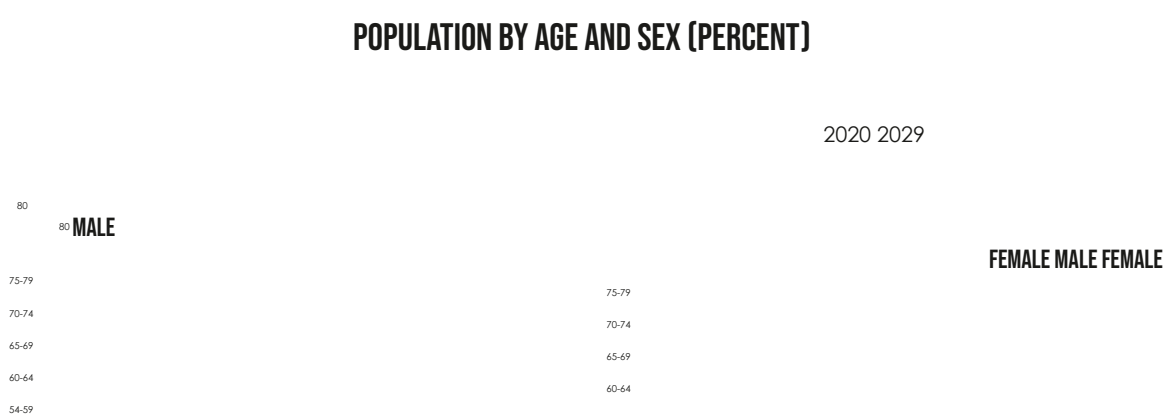
Ethiopia is located in the North-Eastern part of Africa, also known as the Horn of Africa. It is bordered by Sudan and South Sudan on the west, Eritrea and Djibouti on the northeast, Somalia on the East and Southeast, and Kenya on the south. Ethiopia lies between the Equator and Tropic of Cancer, between the 30°N and 150°N Latitude and 330° E and 480° E longitude.

The country occupies an area of 1.1 million km^2 and water bodies occupy 7,444 km^2. Ethiopia is a country with rich geographical diversity that includes rugged mountains, flat-topped plateaus, deep gorges, and river valleys. Over the ages, erosion, volcanic eruptions and tectonic movements have contributed to the nation's diverse topography. More than half of the geographic area of the country lies 1,500 m above sea level. The highest altitude is at Ras Dashen (4,620 m above sea level) and the lowest altitude is at Danakil (Dallol) Depression (148 m below sea level).

Demographic Profile

With a population of about 101 million in 2020, Ethiopia is the second most populous country of Africa and ranks 12th in the world. Ethiopia is the home to various ethnicities, with more than 80 different spoken languages. The country is characterized by rapid population growth (2.6%), young age structure, and a high dependency ratio, with a high rural-urban differential. Ethiopia has a high total fertility rate of 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000 in 2016. The average household size is 4.6. By 2024, the population is projected to reach 109.5 million (Central Statistics Agency, Juy 2013) and will reach 122.3 million by 2030 (See Figure 1 below).

Children under age 15 years and individuals in the age group of 15-65 years account for 47% and 49% of the population, respectively. Only 4% of the population is above the age of 65 years. The sex ratio between males and females is almost equal, and women of reproductive age constitute about 23% of the population. Nearly 80% of the population lives in rural areas mainly depend on subsistence agriculture (Central Statistics Agency, Juy 2013).



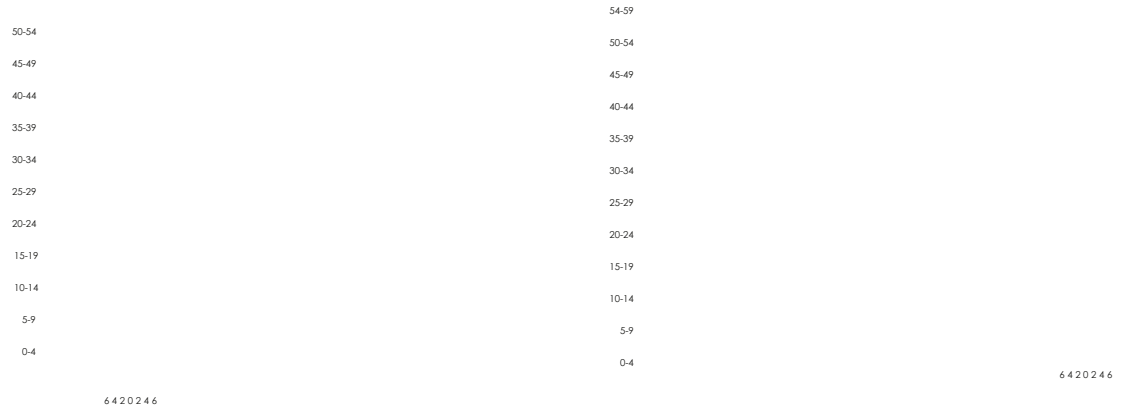


Figure 1. Ethiopian population by age and sex (percent)

Demographic shift/dividend

Ethiopia's population age structure has the potential to yield demographic dividends since the majority of the population is young. However, harnessing this dividend will depend on the country's ability to scale up human capital investments and address existing inequalities. With enhanced efforts to reduce health and education inequalities between urban and rural areas and among regional states, Ethiopia can benefit from accelerated economic growth and improve citizens' quality of life. Strategic investments in health, education, economic policy, and governance will be crucial to achieve substantial gains from the demographic dividend.

Socioeconomic situation

Ethiopia is engaged in rapid, comprehensive development activities to transition from poverty to sustainable, reliable growth and prosperity. Since 1991, the country has implemented several macroeconomic policies, including a market-based and agriculture-led industrialization. The government has introduced initiatives to ensure successful transformation from an agrarian to industry-led economy. The country has registered commendable achievements on Millennium Development Goals (MDGs) mainly in reducing poverty head count, achieving universal primary education, narrowing gender disparities in primary education, reducing child and neonatal mortality, and combating HIV, TB, and malaria.

Ethiopia is a low-income country with a gross domestic product (GDP) per capita (current US$) of $772 in 2018, up from about $340 in 2010. It is one of the fastest-growing economies in Africa, experiencing an average annual growth of about 10% between 2004 and 2014. The main contributors to the economic growth are agriculture, industry, and service sectors. According to Ethiopia's poverty assessment report, household poverty rate has diminished remarkably, by around 20%, between 2011 and 2016 (World Bank 2019). However, despite its significant economic growth, the country remains one of the world's poorest.

Women's empowerment has been an important feature of Ethiopia's economic reform. The Ethiopian Constitution recognizes the principle of equality of access to economic opportunities, employment, and property ownership for women. According to a report by the Central Statistical Agency (CSA), the national income inequality coefficient increased from 0.298 in 2010/11 to 0.328 in 2015/16.

Between 2000 and 2017, Ethiopia's Human Development Index value increased from 0.283 to 0.463, an increase of 63.5%. However, it remains below the average of 0.504. According to the 2019 World Bank report, Ethiopia's Human Capital Index is 0.38, making Ethiopia 135th of 157 countries (The World Bank, 2019).

The road coverage has increased by six-folds compared to 1990, with total road length reaching 105,000 kms. Under the Universal Rural Road Access Program, about 10,765 rural kebeles are now connected, creating better access to health care for millions of mothers and children. Connectivity via modern communication devices has improved tremendously, with 32 million mobile phone subscribers, which expands opportunities for digital health.

Humanitarian impact and needs

Ethiopia is prone to natural and manmade shocks and stresses. The country experiences cyclical hazards that affect households, infrastructure, and system resilience. The periodic occurrence of regular outbreaks such as measles, yellow fever, and cholera poses a challenge to the health system, and the global COVID-19 pandemic has further tested the health system's resilience. In 2020, an estimated 8.4 million needed humanitarian assistance (UNOCHA, 2020). Of these, women and children are disproportionately affected. For the health sector specifically, 5.9 million people are estimated to have humanitarian needs, including 1.2 million women and girls needing family planning and maternal health services. Among internally displaced people (IDPs), unmet need for health services for pre-existing and new disease conditions, physical and mental trauma, and sexual and gender-based violence (GBV) remains high. IDPs put additional pressure on local health systems, straining the health care work force and stocks of medicines and other essential supplies.

Position of the health sector in the country context

Population health is both the means and outcome of development. A healthy population is an engine for economic growth. Investment in health can reduce poverty and catalyse wider cycle of economic growth. Investment in health is also an outcome, as good economic status of a nation allocates more resource to keeping their people healthy. The latter depends on the country's policies and strategies for safeguarding health.

The Ethiopian health sector, alongside other sectors, is playing its part as a means of economic growth. The contribution of the sector towards national socioeconomic development is critical, as equitable human development well-being relies on the health status and well-being of individuals and communities. Investing in health is an investment in current and future generations, and towards sustainable development. Health is also a measure of inclusive growth that should be commensurate with economic development. Otherwise, economic growth without equitable social development may not be sustainable. The health sector should therefore be viewed as a conduit to development, and as a means to ensuring social justice and sustainable economic development.

Chapter 3

PERFORMANCE OF HEALTH SECTOR TRANSFORMATION PLAN I – SITUATION ANALYSIS

This section provides a comprehensive overview of the progress made in achieving the Ethiopian health sector's goals and objectives. The section also presents some of the key lessons from the implementation of HSTP-I, including strengths, weaknesses, opportunities, and threats (SWOT) and stakeholder analysis of the Ethiopian health system. The Ethiopian health system framework (Figure 2), adapted from the WHO African region framework, is used to analyze and structure the situation analysis.

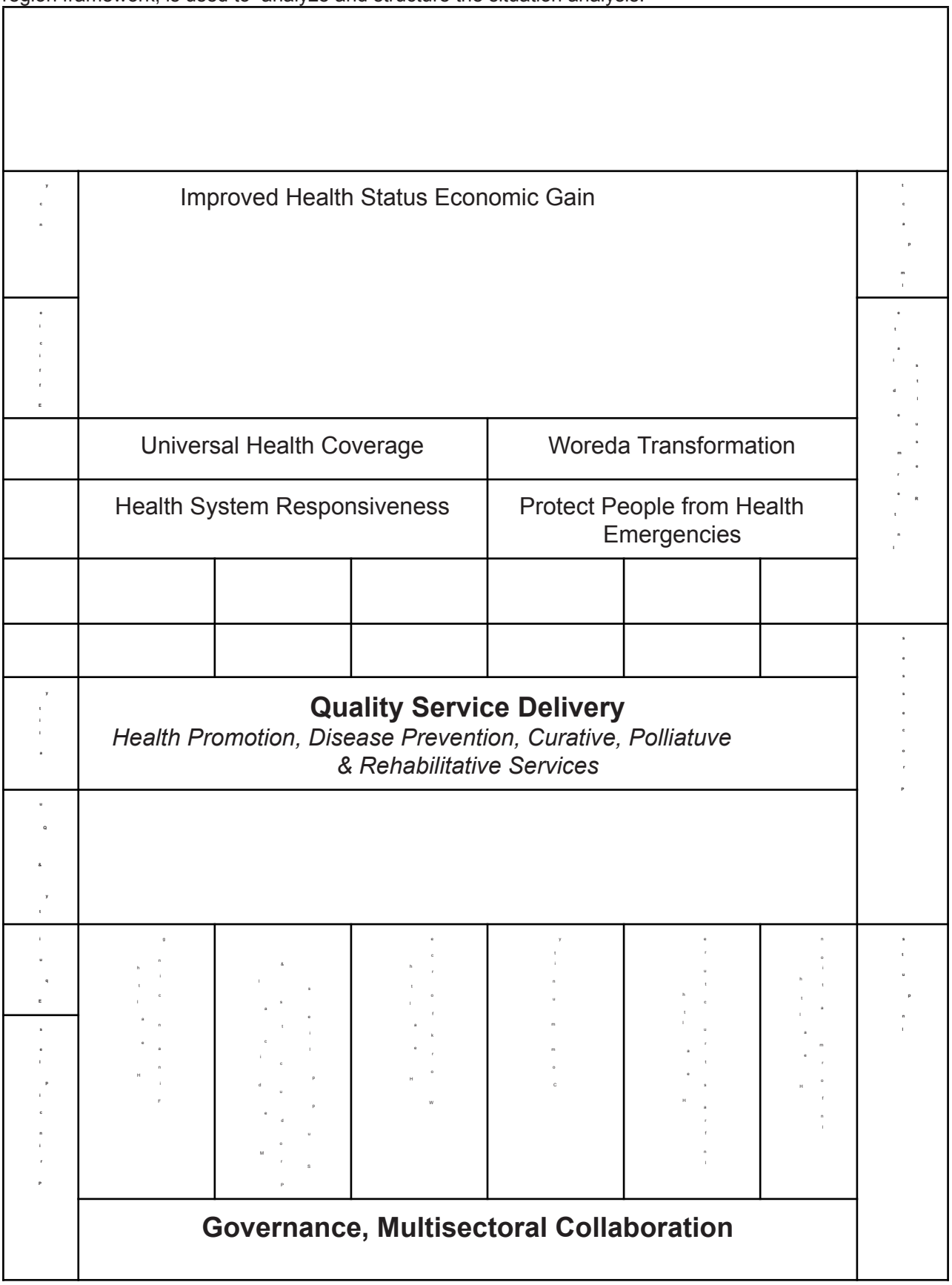


Figure 2. Ethiopia's health system framework (adapted from the WHO African regional framework)

Overall, while HSTP-I was successful on some fronts, the performance on certain domains in the health system framework, as measured by key performance indicators from its M&E framework, was in general sub-optimal. Table 1 summarizes the baseline, targets, and achievements of HSTP-I on key performance indicators. Details on specific topics are presented in subsequent sub-sections.

Table 1. Summary of performance for HSTP-I key performance indicators

Health status	Life expectancy at birth (in years)	64	69 65.5
	Maternal morality ratio	420	199 401
	Under five mortality (per 1,000 live births)	64	30 59
	Infant mortality (per 1,000 live births)	44	20 47
	Neonatal morality (per 1,000 live births)	28	10 33
Status of Priority Health Programs	Health System Investments Stunting (under five years old)	40	26 37
	Wasting (under five years old)	9	4.9 7
	HIV incidence rate (per 1,000)	0.03	0.25 0.16
	TB incidence rate (per 100,000)	224	156 151
	TB mortality rate (per 100,000)	32	17 22
	Malaria death rate (per 100,000)	0.6	0.32
	Contraceptive prevalence rate	42	55% 41%
	Unmet need for FP	24	10% 22%
	ANC (at least four visits)	95%	43%
	Skilled birth attendance	90%	50%
	Postnatal care coverage	95%	34%
	Still birth rate (per 1000 live births)	18	10 15
	CS rate as proportion of births	2.2	8 4
	ART to prevent MTCT of HIV	59%	95% 91%
	Three doses of pentavalent immunization	98%	61%
	Exclusive breast feeding at six months	72%	59%
	ART coverage – Adult >=15 years	82%	90%
	75.8% TB case detection rate	61%	87% 71%
	TB treatment success rate	92%	95% 95%
	Proportion of women screened for cervical Ca	0.6%	20% 5%
	% of HHs with safe water source	35%	28%
Health Security	OPD attendance per capita	0.48	2 0.9
	Average length of stay	4.3	5 days 4.5 days
	Health emergency risk management		

Proportion of emergency affected people provided rehabilitation	36% 95% 84%
Proportion of epidemics controlled	NA 85% 80%
Health workers per 1,000 population	0.84 1.6 1.74
Proportion of Woredas with CBHI	15% 80% 70%
OOP as a proportion of THE	33.7% 15% 31% %
of HCs with BEmONC	56% 100% 74% % of
hospitals with CEmONC	83% 100% 85%
Essential medicines availability at PHC	90% 100% 48%
Report completeness	72% 90% 89%

3.1 HEALTH STATUS AND ECONOMIC GAINS

3.1.1 The state of healthy life

Life expectancy at birth increased from 58 years in 2007 to 65.5 years in 2017, with an annual rate of increase ranging from 1.98% in 2007 to 0.7% in 2016. Despite encouraging improvements in life expectancy at birth, premature death and suboptimal quality of life still constitute major health and development challenges in Ethiopia. Although health-adjusted life expectancy at birth (57.5 years) is above the average for low-income countries (54.9 years), it is still lower than the global average (63.3 years) and that of low- to middle-income countries (59 years).

3.1.2 Major causes of mortality and morbidity

Ethiopia is currently facing triple burden of diseases (communicable and non-communicable diseases or NCDs, mental health, and injuries) that affects all age groups, with a disproportionately higher burden among children and women in their reproductive age. In 2019, 58% of disability adjusted life years (DALYs) were due to maternal and neonatal conditions, communicable diseases, and malnutrition (Figure 3). Over the past two decades, the share of NCDs has increased from 17% to 35%.

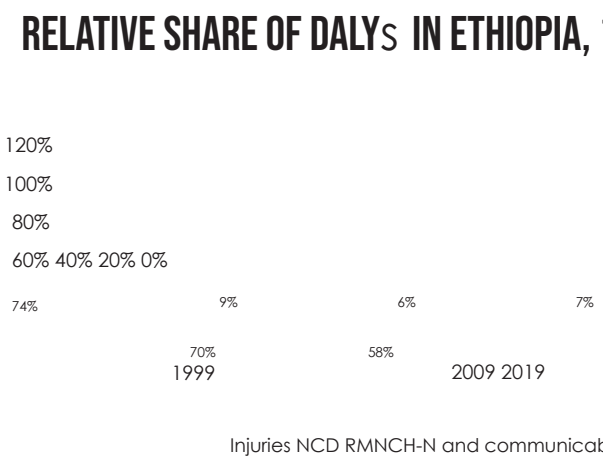


Figure 3. Relative share of categories of diseases for DALYs lost in Ethiopia, 1999-2019

Ethiopia has documented notable achievements in improving the health status of women and children in the last two decades. Between 1990 and 2015, child deaths have diminished by two-thirds. The under-5 mortality rate decreased from 123 per 1,000 live births in 2005 to 59 in 2019. Similarly, the infant mortality rate decreased from 77 per 1,000 live births to 47 in 2019. However, maternal and neonatal mortalities remain high. The decline in maternal mortality declined was modest: from 871 deaths per 100,000 livebirths

in 2000 to 401 in 2017. Similarly, neonatal mortality declined modestly, from 39 deaths per 1,000 livebirths in 2000 to 33 in 2019. **(Figure 4)**

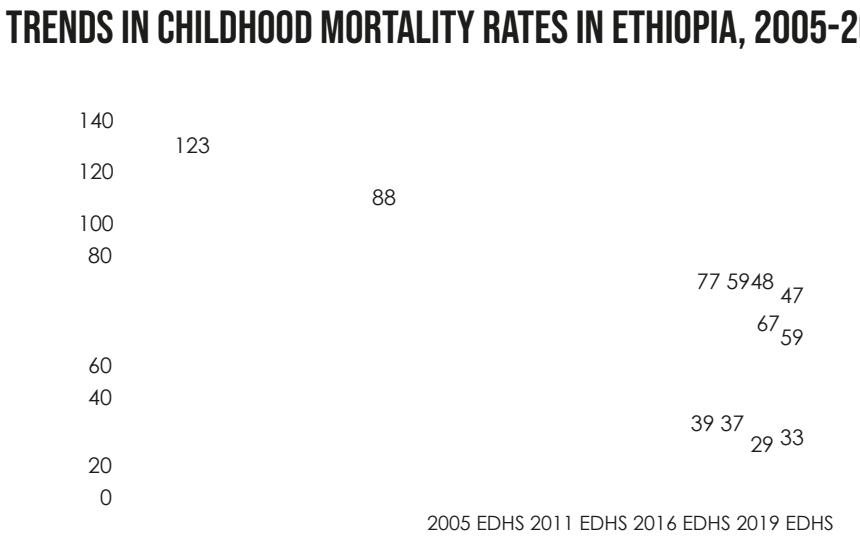


Figure 4.

Trends in childhood mortality rates, 2005 – 2019

In the last two decades, morbidity and mortality from common communicable diseases such as HIV, drug susceptible TB and vaccine preventable diseases like measles has decreased, including during the HSTP-I period. Due to the lack of comparable data, it has been difficult to measure the impact on mortality from NCDs. However, data from the Global Burden of Disease (2019) suggests that an increasing trend in the proportion of deaths is attributable to NCDs (Institute for Health Metrics and Evaluation, 2019).

Injuries, accidents, and mental health problems are becoming growing concerns. The 2016 Ethiopia Demographic and Health Survey (EDHS) showed that 3% of households reported having at least one member who was injured or killed in the 12 months before the survey (CSA [Ethiopia] and ICF Macro [USA], 2016). As per WHO estimates, road traffic accidents caused 27 deaths per 100,000 population in 2016 (WHO, 2018). The burden of neglected tropical diseases (NTD) is decreasing, even though a considerable number of people in Ethiopia are still affected. In 2017, NTDs caused 547,599 DALYs annually (1.4% of the total DALYs lost from any cause), and 3 deaths per 100,000 population, accounting for 0.6% of the total deaths in the country in the same year.

3.1.3 Economic gain

The Ethiopian government has made significant investments to improve the health outcomes of its population. The country reaped cascading benefits from its investments up to now, in terms of the improved health of millions of Ethiopians. At the same time, the country's macro-economy has improved rapidly, achieving a yearly per capita growth of more than 8% and elevating many out of poverty. As population health improved, school attendance increased dramatically. Control of major infectious diseases like HIV/AIDS and malaria has increased productivity, as better health leads to increased worker capacity, lower rates of absenteeism, and less workforce turnover. During the same time, life expectancy increased, which

led to increased incomes and encouraged people to save more for retirement—which in turn boosted the economy-wide capital available for increased investment.

Nevertheless, further investment is critical to sustain these gains and improve access to services and quality of care. A study found that in 2015 there were 8 million avoidable premature deaths due to lack of access to quality care, leading to $6 trillion in annual economic loss (Harvard Medical School, 2018). Inadequate access to high-quality health care results in significant mortality and imposes a macroeconomic burden that is inequitably distributed, with the largest relative burden falling on low-income countries like Ethiopia. It is estimated that COVID-19 will shave 2.9 percentage points off this fiscal year's economic growth in Ethiopia.

Poor-quality care can also lead to important waste and inefficiency. Health-care waste includes the overuse of unnecessary care or ineffective approaches, medical errors, unsafe care, incoordination of care, misuse (including inappropriate hospital admissions and bypassing), fraud, and abuse.

The World Health Report (2010) estimated that about 20-40% of all health sector resources are wasted and highlighted leading sources of inefficiency (WHO, 2010). According to a study done in public health facilities in Ethiopia, the average number of outpatient equivalent visits per clinical staff per day in primary hospitals was 2.54

in 2016. This is slightly lower than output production found among health centers in Ethiopia, at 3.7 outpatient equivalent visits per clinical staff per day (Peter Berman, 2016). The average pure technical efficiency score among the inefficient primary, secondary, and tertiary hospitals and health centers were 68%, 66%, 61%, and 79%, respectively, implying that on average, these same facilities could reduce their inputs by 32%, 44%, 39%, and 21%, without reducing outputs. Those efficiency reports indicate some areas where improvements in resource allocation and use improve the efficiency of health services.

3.2 THE STATUS OF HEALTH SYSTEM PERFORMANCE

3.2.1 Progress towards universal health coverage

As a signatory to the Alma Ata Declaration and UN political declaration on universal health coverage (UHC) UHC, Ethiopia is committed to achieving UHC through primary health care (PHC). This has led to growing investment in expanding health services, infrastructure, and health workforce. As a result, although access to primary health coverage has potentially increased from 50.7% in 2000 to more than 90% in 2019, the UHC service coverage index remains at 43%. Additionally, outpatient attendance rate has increased from 0.27 to 0.9 per capita per year during the same period (MOH, 2019).

With respect to financial risk protection, according to the National Health Account (NHA)-7, out-of-pocket (OOP) spending on health remains high at 31% of Total Health Expenditure (THE) in 2016/17, with a significant proportion of households (4.2%) facing catastrophic health expenses (Ministry of Health of Ethiopia, 2019).

3.2.2 Healthy lifestyle and practices

In Ethiopia, behavioral risk factors including malnutrition, dietary risks, unsafe sex, alcohol use, and tobacco use constitute five of the top 10 risk factors contributing to the most DALYs lost. Lifestyle-related risk factors for chronic diseases tend to be more prevalent in the younger age groups, resulting in higher premature mortality compared to the developed world (Ethiopian Public Health Association (EPHA), 2012). Sedentary lifestyles are common among adolescents (Mohammed OY, 2020). Almost half of patients with cardiovascular diseases have sub-optimal knowledge about cardiovascular risk factors (Negesa LB, 2020). Modification of lifestyle and health-related behaviors remains low overall. According to the 2019 National Assessment of the HEP, only half of rural households adopted healthy behaviors related to family health, disease prevention and control, and hygiene and environmental sanitation (Teklu AM, 2020).

3.2.3 Demand for health services

In Ethiopia, use of health services is low, especially among rural dwellers, socioeconomically deprived groups

such as pastoralist communities, and those without formal education (Alene M, 2019). Numerous factors combine to limit service use. Misperceptions regarding the causes, outcomes, and remedies of diseases contribute to low health-seeking behavior. Diverse sociocultural beliefs and practices also greatly influences decisions regarding use of health facilities. Facility-related factors such as poor client satisfaction and disrespectful treatment, low trust in the health service provided, poor geographical accessibility, stock outs of medical supplies and equipment, lack of cleanliness at facilities, and long waiting times limit use of health services. General low health system literacy, where a community is not fully aware of available services at different system levels, also contributes to the low demand and utilization of health services.

3.2.4 Health security, health system resilience, and lessons from the COVID-19 pandemic

In the Joint External Evaluation conducted in 2016 by MOH and WHO using the International Health Regulations (IHR) framework, Ethiopia scored 2.6 out of a possible 4 points (highest scores for national legislation and policy, and lowest score for chemical and radiation events).

Overall, public health emergency management in Ethiopia has been effective, including outbreak investigations and timely responses. During the period of the HSTP-I, rehabilitation services were provided to 84% of people affected by public health emergencies. The proportion of epidemics controlled within acceptable mortality rates also increased from 40% in 2015/16 to 80% in 2017/18. In terms of laboratory confirmation of outbreaks, the performance has remained consistently above 80% between 2015 and 2018. However, certain challenges remain, such as limited surveillance capacity at the lower levels, poor functionality of emergency operations centers (EOCs), poor documentation of rumors and a limited verification system, suboptimal laboratory-based surveillance, inadequate emergency funds, inadequate preparedness for pandemics such as COVID-19, and conflicts that lead to many internally displaced people (IDPs).

The COVID-19 pandemic offered a number of lessons on the need to continue investing in and improving public health to build a resilient health system. The experience points these priority needs:-

- **Improve emergency health management:** Strengthen the public health emergency management (PHEM) system at all levels of the health system. Decentralization of PHEM functions is critical for timely detection and containment of outbreaks and emergencies. Operationalizing PHEM at all levels will requires identification of a dedicated PHEM team with strong linkages to a robust community surveillance system. Strengthening of everyday preparedness and integration of clinical and public health response at each level is crucial.
- **Establish an emergency funding source:** To respond to the need for additional flexible funds to respond to emergencies, a contingency fund should be established. In addition, a pre-defined financial, human, infrastructure, and supplies mobilization scheme should be considered to cover acute periods of such emergencies.
- **Develop an emergency supply plan:** Prior planning to manage stocks of the medicines, supplies, and medical devices needed to maintain essential and pandemic health services at each level of health care is critical. This should take into consideration possible supply and transport disruptions during a pandemic.
- **Strengthen governance:** Strong leadership and governance are paramount for an effective response. This should include multi-sectoral coordination mechanisms, at national and local levels, among government ministries, competent authorities, nongovernmental organizations, and non-state actors involved in preparedness and response activities. Health care leaders should implement actions to strengthen health sector coordination and communication mechanisms with preparedness, response and recovery partners (e.g., national emergency management and other government agencies, and the health care sector at subnational and local levels).
- **International solidarity:** The COVID-19 pandemic has underlined the need for global solidarity. No country can tackle the pandemic and overcome its economic and social impact alone.

3.2.5 Health system responsiveness

HSTP-I launched many interventions to improve patient satisfaction in the care provided. Improved satisfaction will lead better trust and care uptake. The agenda for compassionate, respectful, and caring CRC) health workers was launched as a transformation agenda under HSTP-I, and a movement was created around it. Unfortunately, measuring CRC is difficult since it is an emerging area, and there were no indicators to assess progress. Measuring clients' satisfaction to evaluate quality of care has not been found useful in many other low- and middle-income countries. Satisfaction is generally measured using other aspects of care like accessibility, costs, health status, expectations, immediate outcomes of care, and gratitude.

According to WHO-AFRO report, the health system's score for responsiveness and satisfaction in Ethiopia is 0.52, which is slightly above the average for the African region (0.47). Access to social support has the highest score, at 1.0. Other aspects, such as autonomy, prompt attention, and choice of care provider have lower scoring: 0.25, 0.27, and 0.31, respectively (WHO Regional Office for Africa, 2018). Contributing factors for the low scores include long waiting time, lack of clean toilets, lack of privacy in examination rooms, absence of directions and communications on post-visit care, lack of laboratory and radiologic services, and other facility characteristics. Health workers' lack of respect for patient privacy is a common main reason for low satisfaction with outpatient services (Fufa BD, 2019). By contrast, good communication and attitude from health staff improve client satisfaction (Kumsa A, 2016).

3.3 SERVICE DELIVERY

Ethiopia has made significant efforts to make high-quality essential health services available, accessible, acceptable, and affordable to the community. In 2005, the first essential health services package (EHSP) was defined. It included a set of health promotion, disease prevention, curative, and rehabilitative services. This was revised in 2019 to include 1,019 interventions that are now included in the EHSP.

3.3.1 Service delivery platforms of the health sector

Health services are provided by a network of health facilities arranged in a three-tier health care delivery model. (Please refer to the section on implementation for further details). The status of these service delivery platforms is described below.

3.3.1.1 Primary Health Care/Health Extension Program

Primary Health care units (PHCUs (17,550 health posts and 3,735 health centers) are the main source of primary care services, especially for rural communities in Ethiopia. The Health Extension Program, or HEP, provides a package of 18 primary care packages for family health, health promotion and disease prevention, hygiene, and environmental sanitation. Findings from the 2019 national HEP assessment suggest that the program has contributed to improvements in health indicators, especially family health. HEP has helped to reduce maternal and child mortality by increasing service utilization among mothers (MERQ Consultancy, 2020). Nevertheless, PHC facilities continue to face challenges such as lack of access to basic amenities (water, electricity, communication equipment, and sanitation facilities), shortage of skilled and committed leadership, high staff attrition, and low staff motivation and competencies.

The national assessment of the HEP also identified a number of areas for improvement. Priority areas include expanding the HEP service package to meet the ever-growing needs of the community, addressing gaps in quality of care provided by health extension workers (HEWs), revising the number and mix of health professionals, strengthening HEP infrastructure to allow the provision of more comprehensive and improved services, improving the functionality of community structures and its engagement, strengthening HEP leadership, and revising information system to allow effective monitoring and evaluation of the program. Also, the current HEP service packages, delivery modalities, and service delivery points were found to be inadequate, leading to marginalization of males and youth.

3.3.1.2 Hospital-based services

Hospital-based services are provided by 353 hospitals that are categorized into primary, general, and specialized hospitals. During HSTP-I, actions were undertaken to strengthen pre-hospital and hospital-based clinical care services—for example, purchasing over 3,000 ambulances, building community capacity in first aid, rolling out wide-scale basic emergency care training and assembling disaster medical assistant teams (DMATs) nationally and in all regions. Provision of specialized clinical care services at intensive care units (ICUs) was another major initiative. There are currently 53 ICUs all over the country and the ICU mortality rate stands at 29.4%. To improve emergency care, two more trauma centers and four more burn care centers were established during HSTP-I. Private hospitals also prove services to the population.

However, numerous continuing challenges persist: poor coordination and referral linkages, inefficient facility management and weak accountability, weak ambulance management system, low staffing in and client satisfaction, and a need for more ICUs and ICU equipment—among others. In addition, rehabilitative and palliative care services were limited, as were specialty and subspecialty clinical services.

3.3.2 Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health (RMNCAYH)

3.3.2.1 Family Planning

Family planning services are available in almost all public health facilities in Ethiopia, ranging from 99% in health centers to more than 93% in general and referral hospitals. About 82% of private health facilities also provide family planning services (FMOH and EPHI, 2018). In 2019, 41% of married Ethiopian women were using contraception, compared to just 29% in 2011 and 36% in 2016. In terms of method mix, the share of long-acting/permanent method users has increased in the past six years, from 17.9% in 2014 to 35.5% in 2019 (PMA 2019). These proportions are far below the targets for 2020(55% for contraceptive prevalence rate). In addition, there is still a high unmet need (22% in 2016, compared to a target of 10%) (EDHS 2016). There is also significant variation in total fertility rate, desired family size, and contraceptive prevalence among regions and different socioeconomic groups. In addition, there was consistent decline in percentage of women who were counseled on three key aspects of their chosen method; told about other methods, counseled on side effects, and counselled on what to do if side effects occur since 2015 (PMA 2019).

Younger women are having sex later, getting married later, having births later and starting contraceptive use earlier than older women. On average, rural women give birth to two children before starting contraception for the first time, while urban women start contraception after their first birth (PMA 2019).

3.3.2.2 Maternal, Neonatal and Child Health

Coverage of reproductive, maternal, neonatal, and child health services (RMNCH) increased during HSTP-I. ANC1 coverage improved from 28% in 2005 to 74% in 2019 (EPHI and ICF, 2019). However, only 43% of pregnant women had four or more visits, and only 20% of women started ANC visit at the recommended time. Only 50% of women delivered in a health facility in 2019. Quality of care also remains a concern. For instance, only 10.6% of mothers received iron for 90 days or more during their pregnancy. In addition, only 14% of expected deliveries took place in functioning emergency obstetric and neonatal care (EMONC) facilities. The rate of caesarean delivery remains low at 4%, with large regional disparities (ranging from 25% in Addis Ababa to less than 1% in Afar and Somali). Coverage of PNC remains low despite marginal increase from 17% in 2016 to 34% in 2019 (EPHI and ICF, 2019). According to SARA 2018, 75% of hospitals, and no health centers provided comprehensive EMONC services. Mean availability of tracer items for basic emergency obstetric care was more than 85% for all the three types of hospitals, 74% for health

centers, and 55% for higher-level clinics. Efforts have been made during the period of HSTP-I to expand access to safe abortion and post-abortion care.

Despite the encouraging reduction in under-5 mortality rate, it is still estimated that 189,000 under-five children die from preventable childhood diseases every year with more than half happening during their neonatal period. Many more children suffer illnesses and face long-term disabilities due to complications of neonatal and childhood diseases. Neonatal disorders, diarrhoea and lower respiratory infections remain the major killers of under-five children contributing for 40.7%, 13.2% and 10.3% of total deaths respectively. Injury, measles, and malaria are also major killers of under five children (Institute for Health Metrics and Evaluation, 2019) . Malnutrition remains to be a major contributor to child mortality contributing for nearly half of under-5 deaths.

The progress of Ethiopia in preventing childhood deaths has been less successful in the prevention of neonatal mortality. The proportion of neonatal deaths from the total under-five deaths increased from 43% in 1990 to 55% in 2019 (EPHI and ICF, 2019). In addition, equivalent numbers of stillbirths occur, representing a “silent epidemic”. Close to half of stillbirths occur during the process of labour and delivery. More than 80% of all newborn deaths are caused by preventable and treatable conditions. Congenital anomalies are also becoming notable contributors to neonatal mortality, morbidity and disability. Generally, half of neonatal deaths occur in the first day of life, and some three quarters of all neonatal deaths occur within the first week of life.

Despite increasing accessibility of services, uneven distribution of health resources, sub-optimal quality of care, low child health care seeking behaviour of communities, low coverage of Kangaroo mother care (KMC) services, and shortage of essential health commodities and equipment at service delivery points remain to be key challenges contributing to high rates of neonatal mortality.

3.3.2.3 Immunization

In 2019, coverage with three doses of pentavalent vaccine and all basic vaccines among children under 1 year of age reached 61% and 44%, respectively. However, about 19% of children had no vaccination at all. There is also high vaccination dropout rate with a national dropout of 13% from pentavalent 1 to measles, with high regional variation. Factors in low immunization coverage include inadequate cold chain infrastructure, data inconsistency among different reports, inadequate service delivery and behavioral change communication, and sub-optimal overall management of the Extended Program on Immunization.

3.3.2.4 Adolescent and youth health

Adolescents and youth constitute 42% of the population in Ethiopia (Central Statistics Agency, Juy 2013). However, about 20% of adolescent girls aged 15-19 years are anemic and underweight. Most young people in Ethiopia lack comprehensive knowledge on sexual and reproductive health (SRH), often engaging in risky behavior. Wide urban-rural disparities in comprehensive knowledge about HIV and HIV testing persist. About 37% of girls and 43% of boys aged 15-19 year consume alcohol. About 57% of boys also chew Khat. Despite high prevalence of health problems and risk factors among adolescents and youth, access to and utilization of health services is limited; and health education and life skills trainings for youth are often fragmented.

3.3.3 Prevention and control of major diseases

3.3.3.1 HIV/AIDS

Progress towards the 2020 90-90-90 targets for HIV was suboptimal for the first 90 with only 78.5% of estimated people living with HIV (PLHIV) knowing their HIV status. Achievements were better for the second and third 90’s: 90% of PLHIVs who know their status were on ART and 91% of those on ART had viral suppression (MOH, 2019/20). About 90% of the annual incident HIV infections in children under 15 are still due to mother-to-child transmission (13.4%, according to UNAIDS 2019). In 2019, among the estimated HIV-positive mothers that need ART for prevention of mother-to-child transmission (PMTCT), 74% received antiretroviral therapy (ART). PMTCT service is available in 84% of public health facilities, but only in 5% of private facilities (SARA 2018). In 2019, 64% of HIV-exposed infants born to HIV-positive women received

virological testing for HIV; but proportion of infants born to HIV-positive mothers who received antiretroviral prophylaxis is low, and requires further effort. Major challenges and gaps in Ethiopia's response to the HIV epidemic include suboptimal HIV case finding, especially in pediatric and adolescent age groups and in key and priority populations; and gaps on overall quality of services for prevention, diagnosis, care, and treatment.

3.3.3.2 Tuberculosis and Leprosy Prevention and Control services

Ethiopia is on track to achieving one of the three targets of the global End TB Strategy: TB incidence has declined by 21% from the 2015 estimate (was against a target of 20%). However, progress in reducing TB mortality was only 15% (target was 35%) under HSTP-I. As there is no nationally representative estimate of the catastrophic costs for TB-affected households, the status of progress on the third milestone is not known.

TB case notification has been improving, with a detection rate of 71%. In 2019/20, TB treatment success and cure rates also reached 95% and 80%, respectively (MOH, 2019). According to the mid-term review of the national TB and Leprosy strategy in 2018, among health facilities having TB smear microscopy, 74% participated in external quality assurance (EQA) schemes and the concordance rate was 96%. According to SARA 2018, 50% and 39% of health facilities (excluding health posts) offered TB diagnosis by sputum smear microscopy examination and clinical symptoms, respectively. Multi-drug-resistant (MDR) TB is a public health concern as the number of cases increase in Ethiopia. Since 2009, a cumulative of 4,906 drug-resistant TB (DR TB) patients were detected and enrolled on second-line drug treatment. As of 2019, there are 59 DR TB treatment initiative centers, and more than 700 treatment follow-up centers providing DR TB treatment services.

The prevalence of leprosy has sharply declined, from 20 per 10,000 population in 1983 to 0.34 per 10,000 population in 2018/19. The number of leprosy cases detected in 2011 Ethiopian Fiscal Year (EFY) (2018/19) was higher than the number detected in the last two years. A total of 3,383 new leprosy cases were detected in 2018/19, mainly from Oromia and Amhara regions (MOH, 2019).

Increasing case detection, addressing MDR TB, accelerating response to TB/HIV, increasing financing to close resource gaps, and intensifying research and innovations remain some of the main priorities for prevention and control of TB and leprosy.

3.3.3.3 Malaria Prevention and Control Services

In the past five years, mortality and morbidity from malaria has declined dramatically. Between 2015 and 2019, malaria deaths dropped from 3.6 to 0.3 per 100,000 population at risk, and malaria case incidence dropped from 5.2 million in 2015 to less than 1 million in 2019. In 2017/18, a malaria elimination program was launched, with activities carried out in 239-targeted woredas. The government has started a sub-national elimination program to comprehensively interrupt local transmission of the disease by 2030.

The 2019 World Malaria Report indicated that Ethiopia is on track for a 40% reduction in incidence and mortality by 2020. However, high-level resistance of malaria vectors to insecticides, sub-optimal usage of interventions by target communities, complacency in maintaining the momentum, delay in implementing the national case management guidelines, and shortage of complete and timely data for evidence-based decision-making are remaining challenges that need close attention.

3.3.3.4 Hepatitis C Virus and Hepatitis B Virus

Most patients in Ethiopia (85% to 95%) do not know their hepatitis B or C infection status and fewer than 5% access treatment. The hepatitis prevention and control program remains under-resourced, which accentuates the challenges of access to diagnosis, treatment, and preventive measures. In addition, low coverage of hepatitis vaccine for newborn babies, the high cost of diagnostics, stock outs of pharmaceuticals, the slow scale up of diagnosis and treatment services are among the major challenges for the program.

3.3.3.5 Non-Communicable Diseases and Injuries

In Ethiopia, the most common cancers among adults include breast cancer (30.2%) and cervical cancer (13.4%). About two-thirds of reported annual cancer deaths occur among women. The main reasons for high

cancer mortality include low awareness of cancer signs and symptoms, inadequate screening and early detection and treatment services, and inadequate diagnostic and treatment facilities.

In 2015, about 16% of the population is hypertensive, with higher prevalence among urban (22%) than those rural dwellers (13%). In addition, the prevalence of rheumatic heart disease was 17 per 1000 children and young adults aged 4-24 years. Diabetes, asthma, chronic kidney disease, and eye diseases are among the major NCDs affecting Ethiopians (NCDI Commission, 2018) .

Despite the increasing burden of NCDs, available health services are very limited. The 2018 SARA assessment revealed that only 36%, 49%, 53% and 9% of health facilities, excluding health posts, offered diagnosis and treatment for diabetes, cardiovascular diseases, chronic respiratory diseases, and cervical cancer, respectively. Overall readiness score for these services is very low, ranging from 18% for chronic respiratory disease diagnosis/management to 51% for cervical cancer diagnosis (FMOH and EPHI, 2018).

3.3.3.6 Mental Health

In 2019, about 26% of health facilities had integrated mental health services into their general health services. The mental health bed-to-population ratio stands at less than 1%. Inpatient child and adolescent mental health care are almost nonexistent, and there is only one mental health rehabilitation center in the country. Forensic psychiatry service is provided in Amanuel Hospital, which has limited beds for this purpose. There is also a significant treatment gap for priority mental health illnesses. Lack of sustainable availability and unaffordability of psychopharmaceutic agents and limited psychosocial interventions are the other challenges that remain unaddressed.

3.3.3.7 Neglected Tropical Diseases

During the HSTP-I period, there were major interventions that targeted NTDs: regular mass drug administration to all people at risk of morbidity and/or infection; and intensified disease management within the primary health care system. This led to remarkable progress towards control and elimination of targeted NTDs. Guinea worm transmission was interrupted in 10 woredas; currently only one endemic woreda is left in Gambela Region. Intensified implementation of trachoma control program enabled 610,000 cases (88% of the TT backlog) to be cleared during HSTP-I period. Coverage with preventive therapeutic coverage for trachoma reached 85% in 2018. Preventive chemotherapy for onchocerciasis, soil transmitted helminths, schistosomiasis, and lymphatic filariasis reached 100%, 95%, 85%, and 94% coverage, respectively. In addition, morbidity and disability management for lymphedema & hydrocele improved, and the number of intensified treatment centers for leishmaniasis increased from 19 in 2016 to 28 in 2019. Inadequate WASH integration, population movement in investment corridors, lack of scientific evidence on human-animal interface in Guinea worm transmission, insufficient scientific evidence for Leishmaniasis control program, and declines in both domestic and international financing for NTD prevention and control are among the major continuing challenges.

3.3.4 Health promotion

Health promotion has been central to all policies and strategies in Ethiopia. During HSTP-I, the health sector focused on promoting multi-sectoral actions on nutrition and WASH.

3.3.4.1 Nutrition

Ethiopia has one of the highest rates of malnutrition in sub-Saharan Africa, and faces high rates of acute and chronic malnutrition and micronutrient deficiencies. Between 2005 and 2019, the prevalence of stunting decreased from 51% to 37%; underweight declined from 33% to 21%; and wasting decreased from 12% to 7%. The prevalence of anemia in children aged 6 to 59 months, and in women in the reproductive age group, were 57% and 24%, respectively.

During HSTP-I, considerable efforts were made to improve food security and nutrition. Multi-sectoral collaborative interventions were implemented with the objectives of improving nutritional status of children and women. In 2015, the government launched a major collaborative platform, a high-level government commitment called Seqota Declaration, to end child under-nutrition by 2030, and this intervention is continuing. In addition, the health sector also implemented nutrition interventions, including micronutrient supplementation, deworming, screening and growth monitoring, and management of malnutrition.

Despite national commitment and continued efforts, several cross-cutting issues remain. These include missed opportunities to integrate nutrition into the health sector, introduce nutrition-sensitive RMNCH interventions, and mainstream multi-sectoral nutrition programs into other sectors; along with frequent changes of National Nutrition Program implementing sectors officials at all levels, inadequate capacity of HEWs, and weak supply chain systems.

3.3.4.2 Water, sanitation, and Hygiene

During HSTP-I, three major strategic initiatives were implemented under hygiene and environmental health program: rollout of an urban sanitation strategy; scale- up of community- and school-led total sanitation; and hygiene, sanitation marketing, and building adaptation for resilience to climate change in the health sector. Since 2015, more than 370 woredas have established at least one sanitation marketing center from the target of 500 for HSTP-I. According to Joint Monitoring Program (JMP) 2019 estimates, coverage with improved sanitation facilities in Ethiopia is only 14% (7% basic and 7% limited), which is very slow compared to the HSTP-I target of 82% coverage. Similarly, only 14% of drinking water from point of collection was free from contamination (WHO and UNICEF, 2019). According to the 2019 National Assessment of the Health Extension Program, only 11% of rural households have proper solid waste collection and disposal practices, and only 10.8% were practicing proper liquid waste management. This achievement is far lower than the HSTP-I target of 40%. According to the same report, the proportion of households using water treatment and safe storage was 28% (versus the HSTP-I target of 35%) (Teklu AM, 2020).

Sanitation in schools and health facilities is also a major problem in Ethiopia: 40% of schools have unimproved latrines; only 6% of schools have basic hand-washing facilities with soap; and 18% have limited services (WHO and UNICEF, 2019). According to 2017 baseline survey on menstrual hygiene management in Ethiopia, 50.9% of girls reported that they discuss menstruation with their close friends, 24% with their sisters, and 16.3% with their mothers (MOH and UNICEF, 2017).

During the first phase of the One WASH national program (2015-2019), a total of 1,920 health facilities obtained water supply schemes and 3,109 health facilities obtained access to latrine facilities. The HSTP-I target for health institutions with gender and disability sensitive full WASH packages is 60%. However, only 34% of health facilities have an improved water source in the facility premises. Besides two third (61%) of facilities have access to an improved sanitation facility in the premises and 52% health facilities had safe disposal of infectious wastes according to the 2018 service availability and readiness assessment (OWNP, 2019).

Low coverage of sanitation facilities at schools and health facilities, poor household-level hygiene and sanitation, poor community attitudes and behavior regarding hygiene and environmental health, poor regulation of unhygienic practices, and weak coordination among different sectors remain in need of improvement.

3.4 THE STATE OF EQUITY IN THE ETHIOPIAN HEALTH SYSTEM

Despite efforts to reduce regional disparities, inequitable distribution of health outcomes and health services continues across different segments of the population. Health indicators vary significantly by region, place of residence, gender, disability status, education, and socioeconomic status. In general, urban residents,

literates, and wealthier segments of society enjoy better health outcomes compared to others (Firew Tekle Bobo, 2017).

3.4.1 Geographic disparities in health

Regional variations in health indicators are dominant in Ethiopia, caused by multiple factors such as gender norms and harmful traditional practices, low economic and educational status, low access to basic utilities, poor road communication networks, and food insecurity. Recognizing these challenges, the government has given special attention to addressing equity by designing and implementing initiatives that provide special support to relatively disadvantaged regions.

Results of the 2019 Mini EDHS show that although there have been improvements, inequalities persist. However, health disparities are still unacceptably wide across different segments of the population and across regions and the urban-rural divide, calling for innovative solutions to address the root causes (EPHI and ICF, 2019). As shown in Figure 5, the probability of dying during the early childhood period (per 1000 live births) is considerably higher in some regions compared to others.

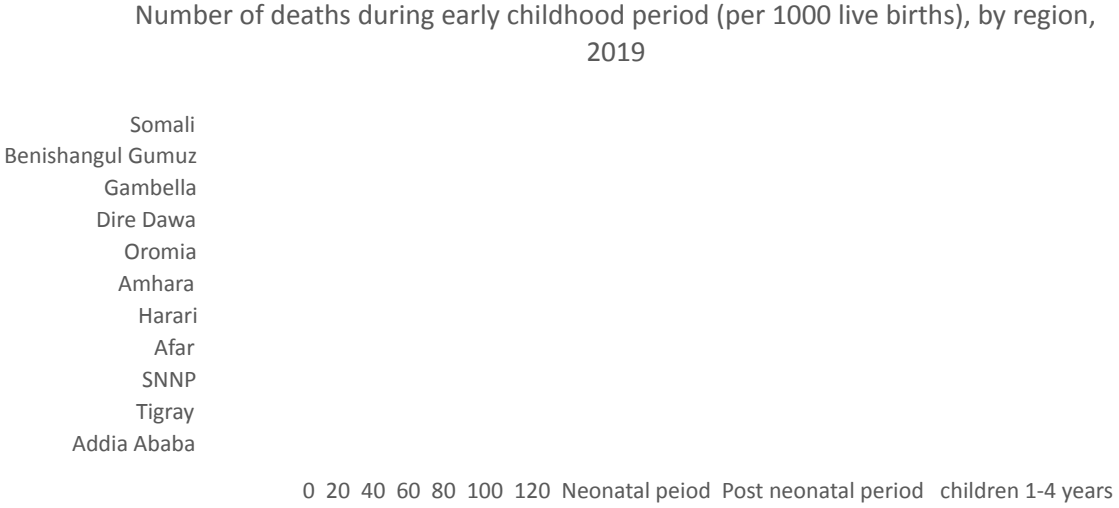


Figure 5. The probability of early childhood deaths by time of death and regions, 2019

The results of the 2019 mini-DHS showed that coverage with RMNCH services is consistently lower in rural areas and special support regions as compared to that in urban areas and non-special support regions. The widest urban-rural disparity in maternal health service utilization occurred in health facility delivery. The use of modern family planning methods varies significantly across regions. In 2019, the contraceptive prevalence rate (CPR) (modern methods) ranged from 3.4% in Somali Region to 49.5% in Amhara. Vaccination with all basic vaccines varied from 18.2% in Somali Region to 73.0% in Tigray and 83.3% in Addis Ababa. In 2019,

the under-5 mortality rate was 59 deaths per 1,000 live births, ranging from 26 in Addis Ababa to 101 in Somali.

Similarly, utilization of RMNCH services largely varied by educational status and wealth quintiles. Individuals and households with higher educational status and in the higher and highest wealth quintiles had consistently better health service utilization indicators compared to their less educated and poorer counterparts (Firew Tekle Bobo, 2017) (Figure 6).

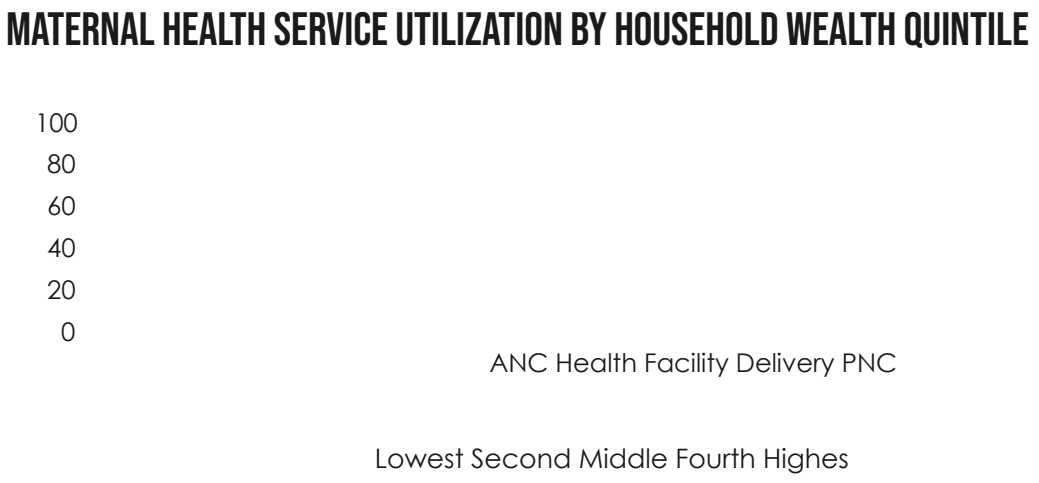


Figure 6. Maternal health service utilization by household wealth quintile

Overall, there are pressing needs to address geographic and regional disparities in health services access, utilization, and outcomes. Major challenges include inconsistency in priorities, limited contextualization of health service delivery systems, low community awareness and utilization of available services, mal-distribution and wrong placement of health workers, and inadequate infrastructure. Addressing these challenges will require context-specific, innovative solutions to tackle the root causes.

3.4.2 Gender disparities in health

The last five years saw progress in gender mainstreaming and women's empowerment in the health sector. Activities implemented include promoting empowerment of females in the health workforce, developing manuals on gender and orienting the health workforce, conducting gender analyses and gender audits in some regions and agencies, and building the capacity of selected health facilities on provision of services for survivors of gender-based violence (GBV). Moreover, a one-stop shopping center for GBV response at federal and regional levels was established and made functional for GBV survivors.

However, efforts to address gender disparities in health is still in its early stages. Gender-disaggregated data from the routine health information system, population-based surveys, including the EDHS, and model-based estimations show that women in general have a longer life expectancy than men do. However, women tend to receive health services less frequently than their male counterparts, possibly compromising their quality of life. In Ethiopia, gender disparities in health service utilization may be linked to the women's limited decision-making power at the household level. Factors such as needing permission to visit a health facility, obtaining money for treatment, distance to a health facility, and unwillingness to go to a health facility alone are important barriers to women's health service utilization.

Among the major challenges in the addressing gender disparities in health are limited enforcement of existing laws and policies on the rights of women and girls, limited capacity among health care workers in designing and implementing gender-responsive health services, and limited capacity for providing comprehensive, multi-sectoral services to survivors of sexual GBV.

3.4.3 Socioeconomic disparities

Despite national initiatives to address financial barriers (fee waiver system for the poorest of the poor, fee exemption for selected essential PHC services, and community-based health insurance, or CBHI, with premium subsidy for indigents), socioeconomic disparities in health service utilization are very wide, even for services that do not require user fees, including RMNCH services (Firew Tekle Bobo, 2017).

3.5 HEALTH SYSTEM INPUTS

3.5.1 Health Workforce

Increasing access to compassionate, respectful, and caring health workers was one of the transformation agendas of HSTP-I, and the government sought to increase the availability of health workers. In 2018, health worker density was estimated at 1.0 per 1,000 population (considerably lower than 4.5 per 1000 population standard proposed by WHO to achieve UHC). The inadequate skill mix of health professionals is another issue; there is a relatively high number of nurses but a shortage of medical doctors, midwives, anesthetists, pharmacists, and medical laboratory technologists. To address this, MOH and the MOE have committed to scaling up health professional training in public and private universities and colleges.

Key initiatives implemented during HSTP-I include upgrading HEWs and expansion of medical residency (specialization) and nursing specialty trainings and scale up midwifery and anesthesia professional trainings. The Ethiopian Residency Matching Program for 22 medical specialty programs enrolls an average of 1,050 residents per year in 13 public universities; 3,150 residents were in training in 2019. The nursing specialty training program was started with categories for neonatal, emergency and critical care, operating room, pediatric and surgical nursing. However, it fell short of meeting the target with only 1,113 enrolled and 771 graduated in 2019 against a target of 11,780 specialty nurses.

To improve the quality of health professional education, the Higher Education Relevance and Quality Agency (HERQA) is working actively to accredit private health education institutions. A Certificate of Competence (COC) program was developed based on Ethiopian occupational standard, serving as a criterion for licensing graduates of technical vocational education training-level trainees. MOH also implemented a National Licensing Examination for first-degree graduates of seven health care types to measure their competencies and issue license accordingly. To address the need for continuous professional development, MOH developed and approved the national continued professional development (CPD) implementation guidelines, followed by identification and accreditation of CPD provider institutions. The CPD program is expected to become a requirement for re-licensing of health workers.

In 2009, the MOH introduced the Human Resources Information System (HRIS) to facilitate routine data collection and management. However, the system has not been fully functional at various levels, and has failed to produce comprehensive national HR information. During the HSTP-I period, the MOH took actions to strengthen the HRIS.

High staff turnover has been a persistent challenge for the health sector. To motivate and retain health staff, MOH developed a new incentive package for health workers that is allocated based on pre-identified exposure level of risk. Interventions need to continue during HSTP-II to build and sustain a competent, motivated, and compassionate health workforce, with adequate number and skill mix. Moreover, human resource management has to be further improved to retain a motivated health workforce.

3.5.2 Medical products and supplies

The HSTP-I mid-term review (2018) documented relatively high availability of program medicines, successful integration of vaccines supply management into the Integrated Pharmaceuticals Logistics System, reduction of pharmaceuticals wastage, and establishment of electronic supply management system at the central Ethiopian Pharmaceutical Supply Agency (EPSA) and its hubs. According to a WHO African Region report, Ethiopia had a health product score[1] of 0.51, which was slightly higher than the regional average of 0.48.

With the need to shift from product-oriented to patient-oriented services, several initiatives were carried out during HSTP-I, including rollout of auditable pharmaceutical transactions and service (APTS) in 200 health facilities, introduction of clinical pharmacy and drug information services, and increased emphasis on anti-microbial resistance (AMR).

However, several challenges remain. For instance, a recent essential tracer medicines availability survey indicates that nationally, 21.8% of hospitals and health centers fulfilled more than 80% of the storage conditions. Hospitals demonstrated better performance, fulfilling more than 80% of storage conditions versus only 18.9% of health centers

and 4.6% of health posts. Comparison of data between 2015 and 2018 surveys showed that the percentage of hospitals that met at least 80% of the storage conditions has increased from 43.0% in 2015 to 71.4%, whereas the storage availability declined from 63.0% to 44.6% in health centers. Progress on plans to reduce pharmaceuticals wastage rate to less than 2% and increase the contribution of local manufacturers in supplying EPSA to 60% are far behind 2020 targets, but there is a challenge in last-mile delivery of medical supplies. There are also challenges in procurement, maintenance, and inventory management of medical equipment, along with a gap in testing the efficacy of generic drugs produced in Ethiopia, due to lack of bioequivalence centers.

The blood safety program has shown improvement in geographical coverage of the population/ hospitals accessing safe blood services from 90% to 100% in 5 years. Thus, through a network of the blood bank sites, safe blood and blood products have been made available to 420 health facilities across the country. Total units of blood collected per annum increased from 121,960 in 2015 to 288,966 unit in 2019/20, mainly provided by voluntary blood donors (99.5%). Despite this significant increase in the amount of blood collected, there is a profound lack of production and utilization of blood products.

To ensure safety and efficacy of traditional medicines, efforts are underway to strengthen research on and production of quality-assured traditional medicine in Ethiopia.

1. A score composed of indicators that include readiness of diagnostics and essential medicines, density of pharmacy professionals, and rate of blood donation

In the HSTP-II period, actions including proper quantification and forecasting, reduced procurement lead-time should continue to ensure an uninterrupted supply of quality-assured medicines and supplies, to avoid stockouts and ensure timely access to essential medicines and health products.

3.5.3 Health infrastructure

By the end of 2011 EFY (2018/19),17,550 HPs, 3,735 health centers and 353 hospitals were available; and 425 health posts, 96 health centers, and 107 hospitals were under construction in Ethiopia. In addition, during HSTP-I, special purpose facilities, including warehouses, trauma centers, mini blood banks and laboratory infrastructures were constructed.

The SARA 2018 survey assessed availability of seven basic amenity tracer items.[2] These were found only in 1% of the 764 health facilities assessed. The mean availability of tracer items for all facilities assessed was 39%, with referral hospitals scoring the highest and health posts the lowest (30%). Current administrative reports, however, show that water and electricity are available in 59% and 76% of health facilities, respectively.

In terms of the network infrastructure system (Health Net), as of September 2019, about 1,636 health facilities are connected with a cabled virtual private network (VPN) and 1,944 sites are connected with wireless 3G option. An additional 25 health facilities with no cabled VPN or Wireless 3G options are connected with customized options.

As per the 2018 WHO Africa Regional report, the health infrastructure index[3] in Ethiopia (is 0.46 (higher than the regional average of 0.39). However, high inflation of construction materials, security problems in some regions, lack of finance and cash flow for capital projects, inefficiency of some contractors, and capacity gaps at regional and lower levels continue to challenge the development of the health infrastructure.

In HSTP-II period, there should be a continued focus on upgrading, maintaining and equipping of health facilities, in addition to construction of primary hospitals and other medical infrastructure projects.

3.5.4 Health financing

During HSTP-I, a number of measures were undertaken to enhance health financing and improve the coverage and quality of health services. To mobilize resources for health and protect people from financial hardship, the government implemented several interventions including-provision of a fee waiver for high-impact interventions through an exemptions program; subsidization of more

than 80% of the cost of care in government health facilities; implementation of CBHI schemes; and full subsidization for the very poor through fee waivers both for health services and CBHI premiums.

In the 7th round NHA (2016/17), Ethiopia's total health expenditure was estimated at 72 billion ETB ($3.1 billion), accounting for 4.2% of the country's GDP. The total health expenditure has grown steadily since 1995/96, and grew by 45% from 49.6 billion birr in 2013/14 to 72.1 billion birr in 2016/17. However, this growth was 15% in real terms after adjusting for inflation (Ministry of Health of Ethiopia, 2019). Furthermore, the share of GDP is lower than the expected average of 5% for low-income countries, and well below the global average of 9.2%. The share of government contribution for total health expenditure was 32% in 2016/17—only slightly higher than the 30% contribution in 2013/14. Expenditure on health as a share of total government expenditure increased from 7.6% in 2013/14 to 8.1% in 2016/17. This figure is lower than the low-income country average government health expenditure (8.7%). Average health expenditure per capita is $33, as compared to a regional average of $38 (World Bank, 2016). Although the government allocates 60-70% of total budget to pro-poor sectors, allocations to health fall well short of the Abuja Declaration target or WHO's recommended $86 per capita spent to deliver UHC.

Major financial challenges include low government budget allocation to health, inefficient resource utilization, lack of a strategic purchasing and performance-based financing mechanism, ineffective processes for the selection and financing of the poor absent social health insurance (SHI), and low coverage of the informal sector through the ongoing CBHI scheme.

2 Water, electricity, sanitation facilities, emergency transport, consultation room, computer with internet, and communication equipment 3 Composite of amenities, equipment and HF to population coverage and readiness

3.5.5 Health information

During HSTP-I, the indicators selected to monitor progress did not align with the burden of disease and had an unbalanced mix. Most performance indicators were not measured, due to lack of appropriate data source and inability to conduct the required surveys and assessments.

During the HSTP-I period, the government developed health information systems policy documents and guidelines, and established and staffed health information technology structures at different levels. During this period, 1,588 facilities were connected with copper-wired VPN, and 1,806 facilities with 3G wireless networks. E-health architecture has been designed and implemented, but a large part of the information revolution road map activities remains unimplemented (MOH, 2019).

With regard to data quality, report completeness improved from 72% in 2015 to 89% in 2019 (MOH, 2019). Data consistency also improved, leading to reduced discrepancy between the data from routine information system and data in surveys. Various platforms were put in place to strengthen key decision-making, including performance monitoring teams (PMTs), review meetings, a Joint Steering Committee (JSC), and planning forums. The MOH also began engaging local universities in capacity building and mentorship program.

The DHIS2 platform was customized and fully scaled up with user-friendly data use features. Other service recording systems for logistics, regulatory system, and other functions were also introduced. An electronic Community Health Information System (echoes) application was developed and implemented in 1250 in rural health posts; and several other applications are in development including a Master Facility Registry, a web-based HRIS, and a National Health Data Dictionary (MOH, 2019).

Regarding public health surveillance information system, 23 reportable diseases, including maternal and perinatal death surveillance and response, are reported through the disease surveillance system. A national database center was created at EPHI to handle the Public Health Emergency Management (PHEM) information system.

Vital events and civil registration systems are operational, but the coverage is low; and current practices for vital event registration needs improvement, especially at health-facility and community levels.

Despite interventions to strengthen health information systems, there are persisted gaps, including limited human resources HIS, inadequate functionality of PMTs at all levels, poor documentation, inadequate implementation of data quality assurance, and limited coverage of VPN-Health Net, LAN, electricity, and computers. Implementation of an electronic medical records began, but its functionality and scale up is very much limited.

To strengthen knowledge management, a strategic plan and road map (2016-2020) has been developed. In addition, knowledge management (KM) structures are established at EPHI and AHRI. However, lack of functional coordination mechanism and absence of a systematic/institutional management of knowledge assets limit the ability to create value and meet the tactical and strategic requirements.

A number of studies took place during the HSTP-I period, including EDHS 2016, mini-DHS 2019, review mission/ mid-term reviews, the Malaria Indicator Survey, Data Quality Review (DQA), SARA, and others. The Ethiopian Public Health Institute (EPHI) and Armature Hansen Research Institute (AHRI) also conducted research on health sector topics. In 2019, a total of 119 operational, biomedical, and clinical studies were conducted on infectious and non-infectious diseases, health system, nutrition and traditional medicines. However, most findings from research and technical reports are not synthesized for use in decision-making, indicating weaknesses in research coordination and knowledge management.

3.5.6 Community engagement

Community engagement has been a primary principle and strategy for achieving the strategic objectives of HSTP-I. The Women Development Army (WDA) served as a primary community engagement platform at the grassroots level. WDA has been scaled up to almost universal coverage in agrarian settings and partial coverage in urban settings. In pastoralist settings, social mobilization committees serve as community engagement platforms. There have been interventions to build the capacity of WDAs through competency-based trainings, with nearly half a million WDA leaders trained (MOH, 2019).

However, in recent years, the functionality of these structures has shown signs of decline. According to the 2019 National HEP Assessment, WDA leaders did not demonstrate model behaviors. Major challenges in community engagement strategies include low capacity and acceptability among WDA leaders and low acceptance by community members. Overdependence on the WDA structure has resulted in underutilization of other community resources, including those of men, religious leaders, and traditional leaders.

3.6 LEADERSHIP, GOVERNANCE AND MULTI-SECTORAL COLLABORATION

3.6.1 Leadership and governance

Legal and regulatory system: A strong regulatory system is paramount to ensure the safety and quality of health and health-related products and services. During HSTP-I, efforts were undertaken to strengthen the regulatory system for food, medicine, traditional medicines, equipment and supplies, health professional, and health and health-related facilities. As of 2020, about 4,353 medicines and 4,448 medical devices were registered. Although there is a good inspection system in place, it needs to be further strengthened. Though not optimal, consignment and post-market surveillance testing was performed for food, medicines, and medical devices. Health care facility standards were developed and routine inspection of public and private

health care facilities took place. A number of proclamations, regulations, and legal frameworks were developed and implemented during the HSTP-I period, including a tobacco control proclamation, directives on national medicine use, food and pharmaceutical sampling, food registration, and alcohol advertisement. However, there is a need to harmonize and strengthen the enforcement of all regulatory frameworks.

Stakeholder engagement and partnership: As a coordination platform with RHBs, the MOH holds regular Joint Steering Committee (JSC) meetings every two months, and Executive Committee Meetings take place with agencies every two weeks. These platforms support the health sector by regularly reviewing and monitoring the performance against set targets and helping to make timely decisions. Joint Consultative Forum (JCF) meetings are held regularly between MOH and donors. The Joint Core Coordinating Committee (JCCC) meetings between MOH and developing partners address technical and operational issues. The Ministry has also been working closely with private organizations and professional associations and has ensured their engagement in planning, review meetings, supportive supervision, and other health activities.

Accountability: The Ministry has developed a scorecard system to improve the accountability of the health system by enabling communities to measure the performance of health facilities and provide feedback. Currently, the scorecard system is in use in more than 600 woredas. Despite these initiatives, there is a recognized need to further strengthen accountability framework at each level during HSTP-II period.

Leadership capacity building: The Ministry has been working towards improving the capacity of health sector leaders. The Leadership Incubation Program (LIP) was started in 2019 with the goal of producing future leaders—a positive initiative that should continue.

Health policy: During HSTP-I, the 1993 health policy was revised to respond to current sociodemographic, epidemiologic, and economic changes in Ethiopia. The revision also took into account the government's vision of becoming a middle-income country and the national commitment to UHC and the SDGs. The policy document has undergone a series of consultations and will be submitted to the Council of Ministers for final ratification.

Health sector planning: Under the leadership of MOH and RHBs, and in line with the country's GTP II, the HSTP-I was developed with the aim of transforming the health system and ensure equitable, quality, resilient, sustainable health services to all segments of the population. Guided by the principles of "one plan, one budget, and one report" in the health sector, annual woreda-based health sector plans (WBHSP) are prepared through top-down and bottom-up approaches. The WBHSPs have contributed to the alignment and harmonization of systems for planning, budgeting, resource allocation, prioritization, tracking, and reporting. This has increased capacity for planning and is expected to help staff to focus on the results of activities. Challenges include weak resource mapping, misalignment of the timing with the government budget ratification schedule, and poor utilization of plans for budget negotiations at sub-national level, resulting in disproportionate budgeting for health.

3.6.2 Multi-sectoral collaboration

Health is multi-factorial and requires strong multi-sectoral collaboration. However, by design, governments operate in sectoral silos. Despite national policy statements and coordination platforms, when it comes to delivering a truly prioritized set of interventions at the grassroots level, much remains to be done to translate the policy statements into action.

To engage effectively with other sectors, the Ministry has initiated the concept of multi-Sectoral Woreda Transformation concept, comprising 11 line ministries. A pilot implementation took place at Gimbichu Woreda, but there needs to be further action.

3.7 SWOT ANALYSIS

A strengths, weaknesses, opportunities, and threats (SWOT) analysis was performed to inform preparation of the HSTP-II. Its objective is to identify the factors that are likely to influence the performance of the health sector and broadly classify them into internal factors (strengths & weaknesses) and external factors (opportunities & threats). The table below shows the results of the SWOT analysis.

▪ Good coordination and governance mechanism, especially at Federal and Regional levels ▪ Improved service availability and accessibility, particularly to PHC ▪ Presence of Community-based health extension program and community engagement platforms ▪ Initiation and implementation of national quality improvement initiatives and learning collaborative platforms ▪ Increased availability of ambulance services ▪ Improving health facility management system (governing board/management committee) ▪ Engagement of CSOs such as professional associations and stakeholders in the health system ▪ Strong diseases surveillance system ▪ Establishment of national and regional Disaster Medical Assistant Team (DMAT) ▪ Initiation and implementation of health care financing reforms (such as fee retention, private wing, service fee revision) ▪ Community Based Health Insurance ▪ Increased community contribution (for infrastructure, service improvement and ambulance procurement) ▪ Regular and participatory review mechanism in place ▪ Improved data storage, better and improved reporting and data availability supported with ICT infrastructure ▪ Availability of national and international donors for supporting the public health sector	▪ Sub-optimal quality of health services ▪ Low public trust and satisfactions on the health service and health system ▪ Disparity in health care utilization among the population by factors such as geography, residence, level of education, wealth and other equity parameters ▪ Poorly coordinated referral system at all levels ▪ Lack of organized pre-hospital services (with universal access call number and dispatch center) ▪ Poor planning of human resource for health which resulted in scarcity of staff for some cadres and unbalanced mix of staff ▪ Inadequate competency and skill, low motivation and satisfaction of the health work force ▪ High staff turnover including the leadership and absence of retention mechanism ▪ Lack of streamlined scope-based work ▪ Inadequate pharmaceutical supply chain management system resulting in shortage of supplies, high wastage rate, and unsafe disposal of non-usable items ▪ Inadequate implementation of rational medicine use ▪ Weak maintenance of medical equipment ▪ Lack of system for safe & environment friendly decommissioning and disposal of non-usable medical equipment ▪ Fragmented and weak implementation of health care financing ▪ Lack of standard cost of health service ▪ Inefficient utilization of resources ▪ Inadequate implementation of CBHI in pastoral regions ▪ Challenges in financial utilization and liquidation at all levels ▪ Sub-optimal public-private partnership and weak inter-sectoral collaborative efforts ▪ Sub-optimal accountability at all levels of the health system ▪ Limited awareness and leadership capacity ▪ Sub-optimal uniformity in regulatory practices at public and private health and health related institutions ▪ Lack of independent regulatory body ▪ Conflict of interest between regulatory and other sectors ▪ Poor data quality in terms of consistency and timeliness ▪ Lack of standardized electronic medical record (EMR) system in public health facilities ▪ Low utilization of evidence for decision making

▪ Economic growth and presence of strong government structure ▪ Positive government attention to global commitments, such as SDGs ▪ Strong political will to advocate for women leadership ▪ Global PHC/UHC movement ▪ Presence of community engagement mechanism in developmental activities including health (disease prevention movements, ambulance purchase) ▪ Global advocacy for timely emergency and trauma care ▪ Presence of favorable cultural and traditional self-help practices in the community	▪ High adult illiteracy rate, especially among women ▪ Poor health literacy and health system literacy ▪ Low economic status of the population (poverty, high unemployment) ▪ Increasing risk factors, unhealthy lifestyle and harmful practices ▪ Inadequate information on social determinants and other health related activities ▪ Community fatigue in some activities such as HDA ▪ Inadequate political commitment to support health sector in some regions and Woredas

▪ Increase in community demand for high quality of health care ▪ Improving engagement of stakeholders (CSO and Professional associations) in improving quality of care ▪ Improved government commitment to PPP ▪ Increased number of health professionals' training institutions (public and private sectors) and programs ▪ Engagement of local universities in HIS and knowledge generation ▪ High political commitment to support the expansion and building of health infrastructure ▪ Improved road accessibility and transportation facilities ▪ Establishment of third-party insurance for Road Traffic Accident ▪ Improved education enrolment, particularly girl's education ▪ Increased number of new graduate health workers (availability) ▪ Implementation of various reforms in the country ▪ Presence of scientifically proven and globally accepted health technologies ▪ Advancements in technology both globally and locally, improving internet availability, access to various media outlet and Social Networks	▪ Increasing manmade and natural disasters, and emergence and re-emergence of disease epidemics ▪ Proliferation and/or weakly controlled promotion of processed foods ▪ Low government expenditure on health ▪ Delayed government decision to implement Social Health Insurance ▪ Appointment of public health facility management by political affiliation, not by merit, in local governments ▪ Weak inter-sectoral collaboration ▪ Lack of consistency in implementation of gender mainstreaming ▪ Weak law enforcements and regulatory mechanisms ▪ Weak/poor infrastructure such as road, water supply, ICT, electricity ▪ Inadequately managed urbanization and industrialization ▪ Compromised quality of pre service training ▪ Increasing brain drain (to other sectors and abroad) ▪ Limited incentive mechanism for private sector investment in health services and products ▪ The effect of global economy (rising cost of pharmaceuticals, supplies etc.) ▪ Porous border, increasing number of refugees, instability of neighboring countries and internal political instability ▪ Inadequate aid effectiveness and Low predictability of funding ▪ Climate change, global warming

3.8 STAKEHOLDER ANALYSIS

Stakeholders are key players in the health sector, and understanding their needs is crucial to the success of HSTP-II. The table below shows the key stakeholders whose needs and interests should be taken into consideration during HSTP-II implementation.

Community	Participation, engagement Ownership Service utilization Healthy life style	Access to health information and service, empowerment, Quality of health care Stewardship	Dissatisfaction Opting for unsafe alternatives Underutilization	Community mobilization, ensure participation Quality and equitable service and information

Parliaments, Prime Minister's Office, Council of Ministers, Regional Governments	Ratification of Policies, proclamations etc. Resource allocation	Implementation of proclamations, Policies etc. Equity & quality Plans & Reports	Administrative measures Organizational restructuring Influence on budget allocation	Put in place strong M&E system and comprehensive capacity building mechanisms
Line Ministries (Water, Finance, Labor, Women's Affairs, Agriculture, etc.)	Inter-sectoral collaboration Consider health in all policies and strategies	Evidence-based plan & reports Effective and efficient use of resources & coordination Technical support	Fragmentation Dissatisfaction Considering health as low priority	Collaboration Transparency Advocacy
Health professional training institutes	Knowledgeable, skilled and ethical health professionals trained	Technical, policy support, guidance	Curriculum revision	Policy and leadership support
Development Partners	Harmonized and aligned Participation More financing Technical support	Financial system accountable and transparent Involved in planning, implementation and M&E	Fragmentation High transaction cost Inefficiencies	Government leadership Transparency Efficient resource use Build financial management capacity
NGOs, CSOs, and professional associations	Harmonization & alignment Participation, resource & TA Participate in licensing and accreditation Promote professional code of conduct	Involvement in planning, implementation and M&E Participation	Dissatisfaction Fragmentation Scale down Withdrawal	Transparency, Advocacy Capacity building Financial support
Diaspora and Private for-profit entities	Quality of care; Client oriented; Knowledge and technology transfer	Enabling environment for their engagement	Mistrust Rent seeking	Transparency Accountability Dialogue
Civil servants	Commitment, Participation CPD	Conducive environment Transparency Incentive	Dissatisfaction Unproductive Attrition	Motivation Involvement

3.9 SUMMARY OF LESSONS FROM HSTP-I IMPLEMENTATION

Community ownership

The Ethiopian health sector is well known for its strong community health program through initiatives such as the health extension program (HEP). The HEP delivers cost effective basic services to all Ethiopians, mainly women and children. HEP is underpinned by the core principle of community ownership, which empowers communities to manage health problems specific to their communities, thus enabling them to safeguard their own health. The HEP 15-year roadmap was finalized during the HSTP period.

However, during the implementation of HSTP-I, the link between primary healthcare units and HEP began showing signs of slowdown. This was caused by several factors, including inadequate support from political leadership, dissatisfaction and fatigue among HEWs, sub-optimal facility readiness, and community demands that surpassed the scope of the services provided at health posts. The epidemiologic transition also posed new challenges to the health system, in particular the rise in NCD burden. Community-based activities by HEWs, including household visits, have declined in recent years. Further, the implementation of the strategy for generating grassroots community faced such challenges as low literacy, slow progress in community training (level-I training), limited supportive supervision, and lack of incentives, recognition, or appreciations of volunteers.

Leadership and coordination

As mentioned previously (see "Stakeholder engagement and partnership"), the MOH held regular JSC meetings with RHBs, agencies, donors, and developing partners to track program performance, work out technical and operational issues, and coordinate health sector's multi-sectoral, multi-level activities. However, high turnover of leadership at all levels has affected the overall implementation, monitoring, and evaluation of the health sector plan. Also, introduction of new strategies without sufficient consideration of local contexts has sometimes delayed implementation. Delays were compounded by weak institutional capacities, low ownership and governance mechanisms, and suboptimal integration of vertical and horizontal components.

Health services quality and equity

To address the quality arm of the HSTP-I agenda, the National Quality Strategy (NQS) was developed. It focuses on ensuring reliable, excellent clinical care, protecting patients, staff, and attendants from harm, and improving the efficiency of the delivery of care, while increasing access, equity, and dignity of care for Ethiopians. NQS prioritized five major areas: RMNCH, nutrition, communicable diseases, NCDs, clinical services, and surgical services.

Accordingly, a number of service and/or program specific quality improvement initiatives were developed and implemented. However, a range of problems undermined implementation, including lack of coordination at national and subnational level, weak accountability mechanisms, sub-optimal quality measurement data and tools, weak information use culture, shortage of a wide range of service inputs (including finance, competent and compassionate workforce, medical supplies and public health infrastructure). Community preference for higher-level care (secondary and tertiary) and lack of integration across service components along the continuum of care (such as poor referral and follow-ups services) contribute to the challenges.

Despite intensive ongoing to address the equity gaps, disparities remain in delivery and coverage of high-quality health services, persisting across domains of geography, age, gender, and disability. These disparities, in turn, contribute to inequities in use of health services, health outcomes, and population-level impacts.

Public Health Emergencies Management

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

Ethiopia has built a public health management system at national and subnational levels to coordinate and strengthen all efforts to improve the preparedness of the health sector, and to prevent or reduce the public health consequences of outbreaks of diseases. Core capacities to prevent, detect, respond to, and mitigate public health emergencies have improved. The country has responded to the COVID-19 pandemic in a coordinated and organized manner using the "whole of government" approach. The health sector has played remarkable and commendable role in the overall preparedness and response to the COVID-19 pandemic.

Despite these successes, a number of challenges to health security persist, as detailed in section 3.2.4. Continuing weaknesses in systems for emergency operations, care, prevention, and financing, combined with the emergence of new and emerging infections such as COVID-19 and conflicts leading to many internally displaced persons (IDPs), still stand in the way of building a resilient health system.

Chapter 4

HEALTH SECTOR TRANSFORMATION PLAN II: OBJECTIVES, TARGETS, AND STRATEGIC DIRECTIONS

4.1 VISION

To see a healthy, productive and prosperous society

4.2 MISSION:

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

4.3 VALUES

- Community first
- Integrity, loyalty, honesty
- Transparency, accountability, and confidentiality
- Impartiality
- Respect for law
- Being a role model
- Collaboration
- Professionalism
- Change/innovation
- Compassion

4.4 OBJECTIVES

HSTP-II's objectives are operationally defined as high-level result statements, equivalent to goals that lead to achievement of the vision for the sector. The targets described in section 4.5 will be used to measure achievements under these objectives.

The overarching objective of HSTP-II is to improve the health status of the population by realizing these four objectives:

1. Accelerate progress towards universal health coverage
2. Protect people from health emergencies
3. Woreda transformation
4. Improve health system responsiveness

Improve health status of the population

This overall objective entails strengthening the health system to ensure that people live longer, healthier lives by reducing the causes of premature deaths, including maternal and childhood health conditions, unhealthy lifestyles, and accidents; expanding access to high-quality health care for all; and ameliorating the effects of social determinants of health. It focuses on enabling all people to have a long life and a good quality of life. In addition, the objective embraces the inclusion of all segments of the population, irrespective of gender, age groups, places of residence, geographical areas, level of economic status, education, or other equity dimensions. It aspires to the goal of never leaving anyone behind.

The four pillars for improving the population health status are described as follows.

1. Accelerate progress towards universal health coverage

This objective focuses on accelerating the progress towards full coverage of essential health services and protecting people from financial hardship, including those in currently underserved populations. Building upon the long-term achievements of the health sector and aligning with SDG3, HSTP-II aspires to attain UHC through increasing effective coverage of essential health services by 2030.

This objective ensures the achievement of the following three components of UHC to all population subgroups:

- Essential service availability: The Government of Ethiopia revised its essential health service packages (EHSP) in 2019. HSTP-II intends to ensure that all components of care and all essential interventions are available at each service delivery level, mainly at the primary health care level, with an acceptable level of quality.
- Essential service coverage: HSTP-II intends to ensure that all individuals and communities receive the services they need. Effective coverage combines three essential components of health care

interventions: need, utilization, and quality.

- Financial risk protection: This is a key component of UHC, which is defined as access to all needed quality health services without being exposed to financial hardship. HSTP-II intends to ensure that the EHSP service components are accessible, and that they are used by community members without causing financial hardship to service users.

2. Protect people from health emergencies

This objective refers to improving health security by protecting the public from the impact of public and medical (routine) health emergencies caused by human-made and natural disasters, conflicts, recurrent and unexpected disease outbreaks and epidemics, accidents, emergencies due to infectious or non-infectious causes, and new health threats. It also includes safeguarding the public from cross-border health problems and ensuring the health security of the population. Essentially, this objective refers to increasing health system resilience.

Public health emergency services mainly focus on preparedness, prevention, detection, management, and recovery from all public health emergencies. Medical emergencies include any medical problems that could cause death or permanent injury if not treated quickly. These emergencies can arise due to infectious or non-infectious disease conditions, or due to trauma, that requires stabilization and immediate medical care. Preparing for such emergencies entails establishing and implementing emergency, trauma, and intensive care medical services. Protecting the public from both public health and medical emergencies requires the capacity and resources to ensure preparedness, prevention, early detection, and response. It also entails post-emergency assessment, interventions, and documentation of lessons from the emergency events.

3. Woreda transformation

Woreda transformation is developed as an objective of HSTP-II considering the role of individuals, families and communities in promoting health and wellbeing. Households are considered as the center of gravity to address the challenges of families and tap potentials of the community for inclusive and sustainable development. Therefore, transformed households highly contribute to the nation's growth and development efforts of ending poverty and hunger and promote health & wellbeing. Transforming households in a given Woreda results in a transformed

Woreda, where the environmental, social, economic and other dimensions of development are improved. Such holistic development approach that focuses on household impact will result in better health and well-being by addressing the social determinants of health. Transforming Woredas require community participation, engagement, empowerment and ownership. It also requires a multi-sectoral collaborative effort to address development issues and social determinants of health. The health sector will contribute towards a multi-sectoral Woreda transformation.

The measurement of this objective will be based on two dimensions: Multi-Sectoral Woreda Transformation and sector-specific Woreda transformation.

Multi sectoral Woreda Transformation (MSWT): This focuses on holistic development at the community level, which can be addressed by integrated multi sectoral interventions. The health sector will contribute towards such multi-sectoral development. It will be measured using MSWT performance measures, which will be based on indicators in the following key areas of development:

- Livelihood related indicators (food security, income level of households and other economic measurements)
- Lifestyle indicators (Including household physical condition, household utilities (such as water, latrine, energy…), use of technologies (access to information etc…)
- Literacy indicators (adult literacy, girls' education and other education indicators)
- Life expectancy and related indicators (Health impact indicators)

Sector-specific Woreda Transformation: The health sector will work in close collaboration with relevant sectors and contribute towards holistic MSWT. The health-sector specific Woreda transformation mainly focuses on strengthening and transforming district health systems through improving key health system investments and implementing high-impact health interventions mainly at household and primary health care

levels. It will focus on creating model households, model kebeles and high performing primary health units (PHCUs) through a meaningful community engagement and a transformed Woreda leadership. It also focus on implementation of Woreda management standards, reforms and implementation of health-financing strategies to reduce financial risks to the community. The health-specific Woreda transformation will be measured on indicators that includes the following key attributes:

- Creation of model households and model kebeles
- Creation of high performing primary health care units (PHCUs)
- Implementation and high coverage of health insurance mechanisms such as CBHI
- Creation of a resilient Woreda management
- Enhanced community participation and engagement in health

4. Improve health system responsiveness

Health system responsiveness refers to the level to which health services respond to the needs and expectations of targeted individuals and communities. This objective focused on respecting and responding to preferences and values of individuals and communities during health service provision, ensuring that beneficiaries' values dictate health service delivery processes. Responsiveness focuses not on the system responds to health needs—which shows up in health outcomes—but on how the system performs relative to non-health aspects, meeting or not meeting clients' expectations of how they should be treated by providers of prevention, care, or other services.

Health system responsiveness includes respecting dignity, privacy, non-discrimination, autonomy, confidentiality, and clear communication; and includes a focus on users focus: choice of provider, short wait times, respect for clients' voice and values, affordability, and ease of use. Achieving this objective will improve clients' and communities' satisfaction and trust, which will in turn improve service uptake and recommendation of services to others.

4.5 TARGETS

HSTP-II targets are set by considering baseline, previous trends, burden of disease, national and international standards, efficacy of technologies, anticipated availability of resources, and other concerns, using the OneHealth tool and wider consultation with experts. The targets are set for the year 2017 EFY (2024/25). The performance of HSTP-II will be measured against these targets:

General

1. Increased life expectancy at birth from 65.5 to 68
2. Increased UHC index from 0.43 to 0.58
3. Increased proportion of clients satisfied during their last health care visit (Client satisfaction rate) from 46% to 75%

Reproductive, maternal, neonatal, child, adolescent and youth health and nutrition

4. Decrease the maternal mortality rate (MMR) from 401 per 100,000 live births to 279 5. Decrease under-5 mortality from 59 per 1,000 live births to 44 per 1,000 live births 6. Decrease infant mortality from 47 per 1,000 live births to 36 per 1,000 live births
7. Decrease neonatal mortality from 33 per 1,000 live births to 21 per 1,000 live births 8. Increase CPR from 41% to 50%

9. Increase proportion of pregnant women with four or more ANC visits from 43% to 81% 10. Increase deliveries attended by skilled health personnel from 50% to 76%
11. Increase Cesarean Section Rate from 4% to 8%
12. Decrease still birth rate (per 1,000) from 15 to 14
13. Increase Proportion of newborns with neonatal sepsis/Very Sever Disease (VSD) who received treatment from 30% to 45%
14. Increase coverage of early postnatal care (PNC) within 2 days from 34% to 76%
15. Increase proportion of asphyxiated newborns resuscitated and surviving from 11% to 50% 16. Increase proportion of under five children with pneumonia who received antibiotics from 48% to 69% 17. Increase proportion of under five children with diarrhea who were treated with ORS and Zinc from 44% to 67% 18. Increase pentavalent 3 coverage from 61% to 85%
19. Increase second dose of measles containing vaccine (MCV2) measles coverage from 50% to 80% 20. Increase full vaccination coverage from 44% to 75%
21. Reduce mother to child transmission rate of HIV from 13.4% to less than 5%
22. Decrease teenage pregnancy rate from 12.5% to 7%
23. Decrease stunting prevalence in children aged less than 5 years from 37% to 25%
24. Decrease wasting prevalence in children aged less than 5 years from 7% to 5%

Disease prevention and control

25. Increase proportion of PLHIV who know their HIV status from 79% to 95%
26. Increase percentage of PLHIV who know their status and receives ART (ART coverage from those who know their status) from 90% to 95%
27. Increase percentage of people receiving antiretroviral therapy with viral suppression from 91% to 95% 28. Increase TB detection rate from 71% to 81%
29. Increase TB treatment success rate from 95% to 96%
30. Increase number of DR TB cases detected from 720 to 1,365
31. Reduce grade II disability among new cases of leprosy from 15% to 5%
32. Reduce malaria mortality rate from 0.3/100,000 population at risk to 0.2
33. Reduce incidence of malaria from 28 per 1,000 population at risk to 8 per 1,000
34. Reduce risk of premature mortality from Major Non-Communicable Diseases from 18% to 14% 35. Increase the proportion of women 30-49 years screened for cervical cancer from 5% to 40% 36. Decrease mortality rate from all types of injuries (per 100,000 population) from 79 to 67 37. Increase proportion of hypertensive adults diagnosed and know their status from 40% to 60%

38. Increase proportion of hypertensive adults whose blood pressure is controlled from 26% to 60% 39. Increase proportion of DM patients whose blood sugar level is controlled from 24% to 60% 40. Increase treatment coverage of severe mental health disorders (Depression from 5% to 30%; Substance Use Disorders (SUD) from 1% to 20%)
41. Increase cataract Surgical Rate (Per 1,000,000 population) from 720 to 1500
42. Increase proportion of Trachoma endemic Woredas with Trachomatous Inflammation Follicular (T.F) to < 5% among 1 to 9 years old children from 26% to 77%

Health extension program

43. Increase proportion of Model households from 18% to 50%
44. Increase proportion of health centers and primary hospitals providing emergency surgical care from 1.3% to 19%
45. Increase proportion of high performing Primary Health Care Units (PHCUs) from 5% to 35% 46. Increase proportion of health posts providing comprehensive health services from 0 to 12%

Hygiene and environmental health

47. Proportion of households having basic sanitation facilities from 20% to 60%
48. Increase proportion of kebeles declared open defecation-free (ODF) from 40% to 80% 49. Increase proportion of households having hand washing facilities at the premises with soap and water from 8% to 58%

Medical services

50. Increase outpatient attendance per capita from 1.0 to 1.75
51. Increase bed occupancy rate from 41.9% to 75%
52. Increase proportion of patients with positive experience of care from 33% to 54%
53. Decrease institutional mortality rate from 2.2% to 1.5%
54. Increase percentage of blood component production from total collection from 23.3% to 65% 55. Increase ambulance response rate to 90%

Public health emergency management

56. Increase Health Security Index score from 0.63 to 0.78
57. Proportion of epidemics controlled within the standard of mortality from 80% to 100%

Health system investments (financing, pharmaceuticals & supply, information, leadership, regulatory, human resources, and infrastructure)

58. Decrease out-of-pocket expenditure as a share of total health expenditure from 31% to 25% 59. Increase general government health expenditure (GGHE) as a share of general government expenditure (GGE) from 8.07% to 10%
60. Increase total health expenditure per capita (US$) from 33 to 42.2
61. Decrease incidence of catastrophic health spending from 2.1% to 1.8%
62. Increase proportion of eligible households enrolled in community-based health insurance from 49 % to 80% 63. Increase proportion of eligible civil servant/employees covered by social health insurance (SHI) from 0 to 100% 64. Increase availability of essential medicines at health facility level from 79.2% to 90% 65. Increase proportion of health facilities that meet data verification factor within 10% for selected indicators to 95%
66. Increase proportion of births notified (from total births) from 35% to 80%
67. Increase proportion of deaths notified (from total deaths) from 3.4% to 35%
68. Increase information use index from 52% to 85%
69. Proportion of primary health care facilities implementing Community Scorecard from 61% to 90% 70. Decrease the prevalence of unsafe and illegal food products in the market from 40% to 30% 71. Decrease percentage of substandard and falsified medicine in the market from 8.6% to 6% 72. Increase health workers density per 1,000 population from 1.0 to 2.3
73. Decrease Health care workers attrition rate from 6.2% to 4.5%
74. Increase proportion of health facilities (health centers and hospitals) with basic amenities (Improved water supply from 59% to 90%, electricity from 76% to 100%, improved latrine from 61% to 86%, basic health care waste-management services from 16% to 50%).
75. Increase number of new/improved technology (diagnostics, therapeutics, tools, or vaccines) transferred from 1 to 6
76. Increase proportion of health facilities implementing compulsory Ethiopian health facility standard from 53% to 80%

4.6 STRATEGIC DIRECTIONS

The strategic plan for HSTP-II identifies 14 strategic directions that are detailed below.

1. Enhance provision of equitable and quality comprehensive health services
2. Improve health emergency and disaster risk management
3. Ensure community engagement and ownership
4. Improve access to pharmaceuticals and medical devices and their rational and proper use 5. Improve regulatory systems

6. Improve human resource development and management
7. Enhance informed decision making and innovations
8. Improve health financing
9. Strengthen governance and leadership
10. Improve health infrastructure
11. Enhance digital health technology
12. Improve traditional medicine
13. Ensure integration of health in all policies and strategies
14. Enhance private engagement in the heath sector

Description and Major Initiatives of the Strategic Directions

4.6.1.Enhance Provision of Equitable, Quality Comprehensive Health Services

Description:

This direction focuses on provision of health promotion, disease prevention, curative, rehabilitative, and palliative care services in an equitable manner and at the highest possible quality. These comprehensive services deal with the triple burden of diseases (disease, mental health, and injury), and are meant to meet the population's ever-growing needs for health services, resulting in healthy and productive society. The strategy emphasizes not only reducing common communicable diseases, but also the alarmingly increasing rate of NCDs and injuries.

Taking in to account the national PHC approach that views PHCs as a foundation of the health system, a full spectrum of services will be provided based on the recently revised EHSP, in an integrated manner across all level of health care delivery system. Increasing demand for and provision of the EHSP to the general population and vulnerable groups is the critical step in ensuring Ethiopia's progress towards UHC. Decentralization of more essential health services to the comprehensive health posts, and integration of HEP packages to all primary-level health facilities, will play critical role in this regard.

Health services provision will consider the following key interventions/activities: Demand creation (through behaviour change communication, or BCC, advocacy, social mobilization), provision of services through different modalities (static, outreach, mobile…), uninterrupted supply of essential commodities, referral linkage, and service integration when appropriate, which can apply for most programs stated below.

4.6.1.1. Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health-Nutrition

These program areas encompass health services provided by organizing services in a continuum of care through the course of life cycle including adolescent health, preconception and pregnancy care, childbirth, child health, and nutrition services. The RMNCAYH-N package contains seven major program areas: 1) family planning and reproductive health, 2) maternal health, 3) prevention of maternal to child transmission of HIV, 4) neonatal and child health, 5) immunization, 6) adolescent and youth health, and 7) nutrition. The main strategies and major activities are described in each of the program areas below.

Family Planning and Reproductive Health

Major strategic initiatives

- Increase demand for quality contraceptive service through BCC and other demand creation interventions
- Universal access to quality and comprehensive rights-based family planning information and services at all levels of health care delivery system, with emphasis to post-pregnancy family planning services

- Expand family planning and sexual and reproductive health services to workplaces, private health facilities, people with special needs, universities and colleges, and in humanitarian settings
- Improve access to screening and management for SRH and medical problems, such as cervical cancer, infertility, sexually transmitted infections (STIs)
- Strengthen Prevention and management of GBV and child marriage
- Expand access to quality comprehensive abortion care services

Maternal, Neonatal, and Child Health

Major strategic initiatives

- Provide quality and equitable antenatal, labor, delivery, and postnatal care services, mainly through introduction of at least one ultrasound service for all pregnant women before 24 weeks of gestation, expansion of maternity waiting rooms, implementation of 24 hours stay after delivery and improving community engagement in making transport available
- Improve access to comprehensive emergency maternal and newborn care through expansion of OR blocks, equipping and staffing of health facilities
- Improve referral network for women and New-born babies during complications, in a way that can access comprehensive services in 30 minutes
- Strengthen maternal and perinatal death surveillance and response system
- Strengthen prevention and management of obstetric fistula and pelvic organ prolapse ▪

Strengthen and expand advanced neonatal care, NICU and Essential New-born Care (ENBC)

services

- Strengthen & expansion of services for low birth weight and preterm babies including kangaroo mother care (KMC)
- Strengthen PMTCT
- Strengthen and expand contextualized integrated community case management of new-born & childhood illness and quality Integrated management of newborn and childhood illnesses services
- Introduce and scale up early childhood development (ECD) implementation through a multi-sectoral collaboration approach

Immunization

Major strategic initiatives

- Design and implement innovative strategies to build demand, community participation and BCC (Build trust, confidence, and resilient demand for immunization services)
- Improve effective coverage of routine immunization to achieve Universal Immunization through data-driven and evidence based strategies such as implementation of intensified outreach strategies, Reach Every District/Child (RED/C) approach, vaccination of missed children during school entry, expansion of services (such as HPV) and others
- Strengthen vaccine supply chain (planning, forecasting, quantification, CCE) in order to implement effective vaccine management strategies at all levels
- Enhance and sustain the accelerated vaccine-preventable diseases (polio, measles, MNT) control, elimination and eradication initiatives
- Introduce and rapidly scale up (achieve high coverage and geographic reach) new vaccines into the

immunization program (HepB birth dose, Yellow Fever, Meningitis A, Measles and Rubella (MR) etc…)

- Strengthen the second year of life (2YL) immunization service delivery
- Strengthen immunization integration with other Health services to ensure access and avoid Missed Opportunity for Vaccination (MOV)
- Strengthen surveillance, detection, and communication for vaccine-preventable diseases and adverse events following immunization, to rapidly detect and respond to outbreaks, enhance immunization safety, improve management of outbreaks, and diminish incidence of adverse events

Adolescent and Youth Health

Major strategic initiatives

- Expand provision of comprehensive sexual and reproductive health information, counseling, and services
  - Support and facilitate the introduction/adaptation, testing and scale up of high-impact, youth-focused, youth– friendly, and innovative interventions to improve effective and person-centered care
  - Expand provision of comprehensive, sexual and reproductive health information, counseling and services; and access to psycho-social support for adolescents
  - Promotion of healthy behavior among adolescents (nutrition, physical activity, no tobacco, alcohol, or substance use)
  - Implement interventions to prevent, detect, and manage sexual and other forms of gender-based violence and harmful practices such as child and forced marriage
  - Implement parenting skill enhancement program and expand access to life skill training for adolescents and youth
- Strengthen the integration of adolescents and youth health with school health initiatives and programs

Nutrition

Major strategic initiatives:

- Enhance food and nutrition information, communication, coordination, and dissemination ▪ Scale up comprehensive integrated nutrition services(CINS) and First 1,000 Days initiative ▪ Implement infant feeding programs in all facilities such as Baby-Friendly Hospital Initiative

- Strengthen and scale up deworming and micro-nutrient supplementation (such as Vitamin A supplementation) to children, and women in need including pregnant and lactating women
- Strengthen and expand nutritional screening of children, pregnant and lactating women, and HIV-positive individuals and management of moderate and severe malnutrition
- Strengthen nutrition service delivery for communicable and non-communicable diseases
- Expand and scale up lessons from the Seqota declaration in collaboration with other sectors to end child undernutrition
- Strengthen multi-sectoral coordination linkage and nutrition coordination platform across food and nutrition policy implementing sectors

4.6.1.2. Prevention and Control of Communicable Diseases

Description

This strategic direction focuses on the prevention, control and management of major communicable diseases such as HIV, malaria, tuberculosis, leprosy, and hepatitis. The health system will focus on high-impact

interventions aimed at reducing the burden of these communicable diseases, and on on health promotion and disease prevention; and will strengthen screening, diagnosis, and treatment of communicable diseases.

HIV

Major strategic initiatives

- Intensify combination prevention interventions (structural, biomedical and behavioral) targeting key and priority populations and high incidence geographic localities
- Scale up pre-exposure prophylaxis for population groups at substantive risk and experiencing high levels of HIV incidence and strengthen post-exposure prophylaxis
- Strengthen case finding through targeted HIV testing, especially for key and priority populations, using innovative approaches (such as index case testing, partner notification, social network services and HIV self-test) and expand the service to health posts and community level.
- Implement Fast-Track Cities Initiative against HIV
- Strengthen implementation of ART regimen optimization & rollout of third-line ART

treatment ▪ Expand and strengthen viral load testing services

- Strengthen HIV prevention and control mainstreaming and social enablers that includes gender based violence prevention and mitigation, economic empowerment of women, elimination of stigma and discrimination, empowerment of communities to respond to the HIV program

Hepatitis

Major strategic initiatives

- Initiate and expand hepatitis testing and treatment service at hospitals and health centers, and also scale up viral load testing
- Strategize program implementation toward the elimination of viral Hepatitis by 2030
- Integrate viral hepatitis service into the existing HIV/SRH, TB, MNCH services, and create linkage between viral hepatitis services with blood safety and infection prevention activities

Tuberculosis and Leprosy

Major strategic initiatives

- Enhance implementation of integrated, patient-centered TB prevention and care (shift from a TB control to Ending the TB epidemic mode)
- Strengthen TB and leprosy case finding, contact tracing and screening services
- Strengthen TB/DR-TB diagnostic services, including sample referral network and access to a more sensitive screening tools such as chest X-Ray and GeneXpert
- Enhance provision of Community TB screening and treatment support services
- Engage private facilities in TB diagnosis and treatment services
- Strengthen and expand TB prevention therapy for HIV+ cases and household

contacts ▪ Strengthen and expand universal drug susceptibility testing services

- Strengthen and expand drug-resistant TB treatment initiating and follow up sites

- Strengthen and expand house-to-house screening, passive case finding and contact investigation of leprosy cases
- Capacity building of clinical and laboratory diagnosis, treatment and disability prevention of

Leprosy
- Strengthen rehabilitation services for people with a major disability

Malaria

Major strategic initiatives

- Strengthen malaria surveillance and epidemic response
- Accelerate activities supporting sub-national malaria elimination
- Strengthen malaria laboratory investigation through microscopic diagnosis and RDT
- Strengthen vector control activities through community interventions, targeted indoor residual spraying, larviciding, and maintaining universal coverage of long-lasting insecticidal nets (LLINs)
- Introduce long-acting anti-malaria drugs to prevent transmission of malaria among seasonal migrant workers
- Identify and implement potential safe disposal mechanisms for obsolete/expired chemicals and LLIN plastic covers

4.6.1.3. Prevention and Control of Neglected Tropical Diseases

Description:

This direction focuses on implementation of appropriate interventions to prevent and control neglected tropical diseases in Ethiopia, resulting in the elimination of many. It includes schistosomiasis, soil-transmitted helminthiasis, onchocerciasis, podoconiasis, lymphatic filariasis, leishmaniasis, trachoma, scabies, and snakebite. Through service integration, multi-sectoral approach and large-scale treatment campaigns, also known as mass drug administration, will be strengthened and continued in HSTP-II. Priority interventions include preventive chemotherapy, transmission control, WASH, innovative case management, prevention of zoonotic diseases, and vector ecology management. In addition, service integration, multi-sectoral approaches and large-scale treatment campaigns or mass drug administration will be strengthened.

Major strategic initiatives

- Advocate multi-sector engagement and promote community awareness and mobilization for NTD prevention and control
- Coordinate the implementation of WASH and NTD interventions at all levels
- Strengthen integrated environmental management including vector control

interventions
- Clear TT surgery backlog cases and build sustainable institutional

capacity
- Strengthen integrated mass drug administration and implement innovative case management interventions for NTDs
- Enhance veterinary public health interventions such as rabies vaccination for canines and rabies post-exposure prophylaxis
- Sustain guinea worm disease surveillance and eradication interventions

4.6.1.4. Prevention and Control of Non-Communicable Diseases and Mental Health Description

The priority NCD prevention and control interventions are targeted to the reduction of risk factors for the major non communicable diseases and promotion of healthy life style. In addition, reduction of premature mortality from NCDs is one of the focus areas of this strategic direction. Priority will be given to prevention of NCDs and injuries, treatment of childhood cancer, early treatment of breast cancer, basic palliative care, treatment of acute pharyngitis in children to prevent rheumatic fever, and implementation of high-priority multi-sectoral interventions.

Mental health is one of the top priorities in HSTP-II. Mental health promotion, prevention, and management of common mental health problems such as depression, bipolar disorder, and schizophrenia will be addressed through such interventions as advocacy, social mobilization, BCC, strengthening social support, capacity building, and expansion of access to medication, psychosocial interventions, and rehabilitation.

Non-Communicable Diseases

Major strategic initiatives

- Facilitate the development and enforcement of comprehensive policies and legislations to address the rising burden of unhealthy diet and khat consumption
- Establish a multi-sectoral coordination mechanism for prevention and control of NCDs and their risk factors
- Implement awareness-raising programs on NCDs and risk factors for the general public, at workplaces and schools
- Enforce the implementation of regulations on tobacco and alcohol
- Promote institutionalization of interventions on the reduction of exposure to environmental and occupational risk factors for NCDs
- Scale up programs for primordial, primary and secondary prevention of Rheumatic heart disease
- Expand implementation of interventions on NCDs and risk factor to primary health care through task shifting, task sharing, and improved referral networks
- Support health facilities to fulfill minimum standards to deliver screening, diagnosis, treatment, and care services for NCDs and risk factors

Mental Health

Major strategic initiatives

- Facilitate the development of mental health legislation to protect the rights of people with mental health conditions
- Strengthen integration and coordination of mental health care implementation and scale up at each level of the health system
- Conduct advocacy, social mobilization and SBC interventions to create public awareness on mental health and mental illnesses
- Establish a National Institute of Mental Health
- Introduce and strengthen promotion and preventive mental health services in schools, work places, health facilities, religious, and traditional treatment settings

▪ Expand and strengthen prevention and rehabilitation interventions against substance use, suicide and self-harm ▪ Ensure availability of mental health services to vulnerable groups or special populations ▪ Expand access to rehabilitation services for substance abuse

• Ensure a dependable and affordable supply of essential medicines and diagnostic technologies for mental health and access to psychosocial care at community level

4.6.1.5. Hygiene and Environmental Health

Description

This strategic element focuses on addressing environmental determinants of health and thereby promoting health, preventing diseases and other conditions, and improving the quality of health services. It encompasses implementation of multi-dimensional interventions to ensure adequate and safe sanitation; personal hygiene; water safety and quality; food hygiene and safety; indoor air quality; healthy living environment; occupational health safety; and liquid and solid waste management. It also includes contributing to building climate-resilient health system and WASH in institutions, including health care facilities, and during emergencies that require coordinated actions by various sectors. The interventions will take place at various levels and settings, including at household, community, health care facilities, and other institutions; and in rural, urban, and pastoral areas.

Major strategic initiatives

- End open defecation practice through tailored social and behavior change communication coupled with advocating the needed enabling environment
- Ensure access to quality and affordable sanitation and hygiene products and services through sustainable market-based system
- Design and promote wide range of inclusive and contextually tailored hygiene, sanitation and environmental health technology options
- Improve availability and proper utilization of basic sanitation service at household and community level through intensive demand creation and tailored behavior change approaches
- Improve proper solid and liquid waste management at household level through regular promotion and targeted social and behavior change communication
- Improve household food hygiene and safety practice from farm to fork
- Ensure safe drinking water through promotion of different household water treatment and safe storage options ▪ Improve water source quality and safety through strong water quality monitoring and surveillance system

- Ensure sustainable hand hygiene practice, face washing and oral hygiene practices through social and behavior change approaches
- Strengthen Menstrual Hygiene practice through culturally tailored social and behavioral change communication coupled with increasing access to safe and affordable products
- Reduce indoor air pollution through promotion of safe, smokeless energy source options. ▪ Ensure inclusive water, sanitation and hygiene services in all health facilities
- Strengthen Infection prevention and control interventions in health facilities
- Promote water, sanitation and hygiene services and practices in schools and workplaces ▪ Improve occupational health and safety through regular promotion and

monitoring

- Promote environmental pollution prevention
- Improve resilience of the health system towards climate change and reduce the health system's contribution for climate change
- Strengthen hygiene and environmental health institutional arrangement and implementation capacity ▪

Strengthen multi sectorial integration and coordination for hygiene and Environmental Health

interventions

4.6.1.6. Health Extension and Primary Health Care

Description

This program encompasses two platforms for delivering PHC services to accelerate progress towards UHC: the HEP, and service delivery at health centers. In this strategic period, the Health Extension Program (HEP) will continue to be an effective program for community participation and an effective service delivery platform to reach individuals, families, and communities with a comprehensive package of PHC services. The program will scale up implementation of the HEP optimization roadmap to address evolving community needs for quality health services and fully embrace emerging public health challenges. During the strategic period, creating model households, model kebeles and high functioning primary health care units will be given priority. Activities will be contextualized to fit urban, agrarian, and pastoralist settings through the development and implementation of detailed agrarian and pastoralist HEP implementation guides and an Urban Health Strategy. Guided by the HEP Optimization Roadmap, community quality improvement systems and health post level reforms will also be implemented in this strategic period. This program also focuses on improving PHCUs' readiness to provide quality care to their catchment population. Therefore, activities will include enhancing PHC management capacity to provide support and oversight to both the clinical and community based activities; improving quality and expanding package of services; implementing reforms and collaborative learning platforms; expanding surgical services at the health centers; ensuring strong PHCU linkage, and strengthening multi-sectoral collaboration.

Major strategic Initiatives

- Develop HEP implementation strategies to guide the implementation of the HEP optimization

roadmap ▪ Test and scale up major features of the HEP optimization roadmap

- Expand services provided through the HEP to meet UHC requirements and community needs
- Devise and implement strategies to a more inclusive HEP service provision (such as women, men, children, and youth)
- Redefine and standardize HEP service packages and restructure service delivery

platforms ▪ Implement reforms and standards to ensure quality health services at PHCU

level

- Enhance the implementation of collaborative platforms including the Ethiopian Primary Health Care Alliance for Quality, twinning partnerships, and catchment area mentoring

- Strengthen and expand family health team approach in urban settings, and mobile health team approach for pastoralist and semi-pastoralist settings
- Accelerate creation of model kebeles and high-performing primary health care

units. ▪ Improve the capacity of the woreda health system leadership

- Develop and implement innovative SBCC interventions fitting the changing needs and contexts at community and facility levels

- Increase access to health information and services at schools, youth centers, and other public institutions
- Introduce emergency obstetric and surgical care services at selected health centers

4.6.1.7. Medical Services

Description

During HSTP-II, the sector aspires to create a medical system offering comprehensive medical services, including pre-facility care. These services receive support to provide safe, effective, efficient, equitably accessible, and internationally acceptable care by designing and implementing a range of strategic interventions. This strategic direction includes clinical services, emergency and critical care, quality of health services, blood transfusion services, laboratory, and diagnostic services.

For clinical services the emphasis will continue to be on standardizing diagnostic treatment, curative, rehabilitation, and palliative services in health. Standardized, strengthened clinical care leadership, innovative financing in health facilities, improved surgical and anaesthesia care availability and accessibility, improved rehabilitative service accessibility and quality of care, medical tourism, and introduction and scale up of I-CARE will also be priority strategic areas.

The emergency care system includes services that range from scene care to facility care with an appropriate referral and communication to maintain continuum of care. The system provides an integrated platform for delivering accessible, quality, time-sensitive health care services across the life course. Establishing and strengthening emergency, trauma, and intensive care medical services is essential for ensuring timely care for the acutely ill and injured. Besides meeting the everyday health needs of the population, a well-organized, prepared, and resilient emergency care system has the capacity to maintain essential acute care delivery throughout a mass event, limiting direct mortality, and avoiding secondary mortality altogether. During emergencies that require a public health response, links will be made with the national PHEM system to respond in a coordinated and integrated manner.

Blood transfusion is a life-saving intervention that involves mobilization, recruitment and selection of blood donors, use of appropriate blood collection procedure, processing and testing of blood units and cold-chain maintained storage and transportation, issuing and transportation of safe blood units to health facilities. It also includes compatibility testing and administration to patients. To meet the ever-increasing demand for quality blood and blood products, the program will implement strengthening volunteer blood donation program, expanding blood banks across the country and consolidation of key blood transfusion service functions, strengthening coordination of blood transfusion service, strengthening quality management system to the level of accreditation, and appropriate use of blood and blood products in health facilities.

Regarding laboratory service, the health sector will continue to improve access to quality laboratory service through laboratory capacity building, quality assurance programs, infrastructure development and maintenance and expansion of basic and advanced lab services at health facilities. Moreover, the program will implement a laboratory quality management system, a step-wise accreditation process, preventive and curative equipment maintenance, and a laboratory information system.

Clinical Services

Major strategic initiatives

- Improve health service availability and readiness based on the EHSP
- Implement specialty and subspecialty roadmap
- Expand and improve accessibility of services such as high quality surgical and anesthesia care, ophthalmology service, basic dental service, dermatology service, basic mental care, and other specialty

services

- Expand tertiary medical care (specialty and sub-specialty programs)
- Develop and implement national medical tourism strategic plan
- Improve and standardize health facility Leadership and Governance and build clinical governance

capacity ▪ Implement Teaching Hospital Improvement Program

- Implement health technology (telemedicine, telepathology, tele-radiology, robotic surgery, 3-D printing for prostatic supplies)
- Strengthen home-based clinical care
- Strengthen accessibility and quality of rehabilitative and palliative care, including pain

management ▪ Implement geriatric care service

- Intensify clinical auditing and mentorship
- Establish and implement tissue and organ transplantation program
- Develop and implement cancer registry

Pre-Facility, Emergency, Trauma, and Critical Care Services

Major strategic initiatives

- Advocate for emergency care systems, trauma and critical care
- Expand and strengthen community first aid response
- Standardize and strengthen basic, advanced ambulance and prehospital services
- Create surge capacity for responding to emergencies and building resilience at all level ▪

Expand and strengthen basic and advanced critical care services, trauma, poisoning and burn

care ▪ Standardize liaison and referral system

- Institutionalize continuous system design and quality improvement in the acute care continuum

Blood Transfusion Services

Major strategic initiatives

- Strengthen centralized coordination of blood transfusion services and use of blood and blood products ▪

Advocate and build awareness to increase total blood collection from voluntary non-remunerated blood

donors ▪ Strengthen blood donor recruitment and management, including post-donation counseling service

- Strengthen quality-assured testing for transfusion-transmissible infections, blood grouping, compatibility testing, and component production and transport of blood
- Promote the safe and appropriate use of blood and blood products at the clinical interface and

strengthening

hemo-vigilance program

- Accredit national and regional blood banks with African Society of Blood Transfusion

Services ▪ Introduce newer blood transfusion technologies and products

Laboratory and Other Diagnostic Services

Major strategic initiatives

- Strengthen the implementation of laboratory quality management system and stepwise laboratories quality improvement process towards accreditation to ISO 15189 or 17025 standards
- Establish a national proficiency testing/EQA production center and expand as needed
- Improve availability of national and regional lab infrastructures including bio-security and Biosafety Level Three capacity at the national level
- Improve accessibility of essential diagnostic service and enhance specimen referral linkages and networks, including backup services
- Improve and strengthen access and quality to pathology services
- Improve and strengthen Imaging services including nuclear medicine
- Standardize laboratories testing capacity at each tier of the health care delivery

system ▪ Introduce and expand auditable laboratory services in hospitals and beyond

- Strengthen national capacity for the evaluation and validation of laboratory technology methods and

reagents ▪ Establish national genomics and bioinformatics center

4.6.1.8. Prevention and Containment of Anti-Microbial Resistance (AMR) Description

Evidences have shown that Antimicrobial Resistance (AMR) is becoming a global health and development threat. AMR is found not only among pathogens that cause common bacterial infections, but also in diseases such as TB, HIV, Malaria and fungal infections. AMR leads to prolonged illness, longer hospital stays, higher medical costs and increased mortality. It also threatens to undermine the effectiveness of health programs and reduce public confidence.

AMR is becoming a public health threat to Ethiopia. According to the national AMR surveillance reports (2018 and 2019), drug resistance surveillance of anti TB and HIV drugs and other studies, resistance was found to be high among common micro-organism, mycobacteria and HIV. The major drivers are believed to be overuse and misuse of antimicrobials including irrational prescribing, dispensing, poor patient adherence and self-medication with antimicrobials. Ethiopia has developed and been implementing national strategy of AMR Prevention and Containment (2015-2020) in alignment with global action plan. Even though a national AMR surveillance plan is developed, and AMR Surveillance system is established, challenges remain. Only nine hospitals currently provide DST. Awareness is low and inappropriate use of drugs is common.

This direction aims at strengthening actions to the prevention and containment of the spread of the ever-increasing AMR as a public health threat. During HSTP-II, the ministry will strengthen priority actions towards prevention of AMR by improving the availability of safe, effective and quality assured antimicrobials and promoting its effective use. The ministry will engage a wide range of actors such as the agriculture and food industry, the pharmaceutical industry, NGOs, CSOs, the private sector and other stakeholders to synergize efforts towards AMR prevention and containment.

Major strategic initiatives

- Improve awareness and understanding of antimicrobial resistance through effective communication, education and training. Strengthen AMR training in Continuous Professional Development and pre-service training
- Strengthen knowledge and evidence through surveillance and research
- Optimize the use of antimicrobials and ensure optimal prescribing, dispensing and use.

- Improve access to quality antimicrobials and laboratory commodities and initiate DST in public and private hospitals
- Strengthen leadership, ownership, and commitment for implementation of AMR prevention and containment activities at national, regional/city administration, and health facility level
- Improve infection prevention and contain the spread of resistant microorganisms across human and animal communities and health care settings through individual and environmental sanitation, hygiene, and infection prevention measures

4.6.1.9. Quality in Health Care

Description:

High-quality health care a health system that: ensures universal health coverage built on quality of care; standardizes and implements evidence-based interventions that demonstrate continual improvement; ensures that all people with chronic conditions are able to minimize the condition's impact on the quality of their lives; fosters a culture, system, and practices that reduce harm to patients, seeks a benchmark against similar systems that are delivering best performance; emphasizes continuous learning and knowledge management for improvement; and engages communities.

Building on the gains made, and addressing major health care quality challenges, HSTP-II will focus on cultivating competent and companionate health care providers who offer service that are safe, evidence-based, timely, people centered, and clearly communicated. Interventions will engage both clients and communities to optimize services and improve of care outcomes. Quality monitoring will focus on outcomes of care, community trust in services, and effective coverage and competency of care.

Major strategic initiatives

- Develop and implement national health care quality and patient safety strategy
- Institutionalize a concept of health care quality and practice at all levels
- Establish a National Health Care Quality Council
- Standardize and strengthen health care quality structures and their functions
- Reform, redefine, and standardize scopes and functions of health facilities
- Establish and strengthen collaborative, high-quality learning platforms
- Decentralize and share/shift tasks to minimize facility crowding and to maximize efficient utilization of specialized service providers
- Develop and implement a support package for public and private health facilities for

accreditation ▪ Establish quality improvement hubs

- Strengthen regular quality of care measurement and improvement

4.6.1.10. Equity in Health Service

Description

Equity reduces disparities between geographic areas and groups with underlying social advantage/disadvantage (women, youth, children, the uneducated, the poor, and people with disabilities) in provision of quality health service. Achieving universal health coverage, access to essential health care services and affordable essential medicines and vaccines for all assumes the achievement of universal

equity. This principle focuses on ensuring that all Ethiopians, no matter their geography, gender, age, wealth, education or disability status, are able attain the same high levels of health outcomes and access to essential services. Equitable accessibility to high-quality health services will lead to improvements in the health of the population, especially high-priority vulnerable groups, including mothers and new-borns, the elderly, and other vulnerable groups. HSTP-II is committed to working across the following dimensions of health equity in Ethiopia:

- Access to and uptake of health care: Ethiopia will continue to scale up access to essential health care and ensure that all members of society have equal access to essential health services: for example, by reducing physical barriers, distance, price, and socio- cultural barriers.
- Difference in health status (or outcomes) such as life expectancy, mortality, and nutritional status can occur not only due to differences in health service access and uptake, but also to a wider social, economic, and environmental determinant (the wider determinants of health), pointing to the critical importance of addressing the underlying structural determinants of health.

Major strategic initiatives

- Mainstream and institutionalize health care equity concept and practice across programs and strategies at all levels
- Conduct continuous, regular health equity analysis and disseminate the findings for intervention and policy decisions
- Implement alternative and contextualized health service delivery modalities (mobile, outreach) and community engagement platforms to better reach mobile, hard-to-reach and special need communities
- Provide targeted technical and financial support to strengthen health planning, implementation, and health systems capacity to areas with the lowest capabilities
- Explore financial modalities to target populations with the greatest health needs in low-performing areas and among the most vulnerable groups, and incentivize stronger performance
- Enhance health workers retention and motivation mechanisms for geographic and climate hardship areas and mobile communities
- Ensure high-quality health services tailored to address disparities in access based on socioeconomic, geographic, gender, demographic, and special needs

4.6.2.Improve Public Health Emergency and Disaster Management Description

This strategic direction focuses on public health emergency and disaster management and includes all elements of this process: effective and timely anticipation, prevention, early detection, rapid response, control, recovery, and mitigation of any public health emergency crises with direct or indirect impacts on the health, social, economic, and political well-being of communities and society in general well-being. The range of threats to public health faced by countries worldwide is broad and highly diverse and includes infectious disease outbreaks, food and water contamination, chemical and radiation contamination, natural and technological hazards, wars and other societal conflicts, and the health consequences of climate change.

The health sector requires solid capacity, strong coordination, and relationships with other sectors to implement a spectrum of public health emergency risk management measures at the community, regional, national, and international levels. The HSTP-II period will focus on strengthening the capacity for preparedness, detection, prevention, response and recovery to all public health emergencies and disasters. An integrated approach to public health emergency management and clinical emergency care reduces the impact of public health emergencies. The result of this strategic direction is minimization of the occurrence and consequences of public health emergencies and disasters.

Major strategic initiatives

- Develop and implement public health emergency management strategy that will address public health threats and build a resilient health system

- Strengthen health sector and public health emergency multi-sectoral coordination, collaboration, and partnership
  - Strengthen regular risk assessment, profiling (hazard, vulnerability, and capacity analysis), risk communication and early warning system
  - Strengthen and sustain the International Health Regulation core capacity through implementing and monitoring multi-sectoral National Action Plan for Health Security
  - Increase the capacity of woredas for emergency preparedness and management
  - Strengthen Emergency Operations Centers at national and subnational levels
  - Ensure the availability of adequate and trained surge capacity for PHE response(Disaster Medical Assistant Team (DMAT)/Emergency Medical Teams including Rapid Response Teams (RRTs) at all levels
  - Ensure continuity of essential health service during and after disasters
  - Improve the capacity to forecast, detection, prepared and respond to public health emergencies, and to learn and improve after emergency experiences, maintaining the course towards long-term goals
  - Build the capacities required to create a resilient health system to promptly respond, recovered and rehabilitate in the context of health emergencies
  - Ensure availability and functionality of adequate isolation, quarantine, and treatment centers at identified and designated point of entries
  - Ensure that adequate regulatory measures are in place at point of entries to prevent importation of communicable diseases
  - Mobilize the resources required to adequately fund emergency preparedness, emergency response operations, and recovery
  - Coordinate and strengthen implementation of diseases and health events that are targeted for elimination/ eradication

4.6.3.Enhance Community Engagement, Empowerment, and Ownership Description

This strategic direction focuses on ensuring active participation and engagement of the community in planning, implementation, monitoring and evaluation of health and health related activities. It is about enabling communities to increase control over their lives through creating health literacy and decision power. Re-designing, testing, and implementing a package of alternative approaches tailored to address emerging challenges to the existing community engagement strategies will be a key milestone in this strategic period to advance community engagement and ownership and accelerate the progress towards UHC. The expected result of this direction is to achieve a community with improved health behaviour, health outcomes, and improved accountability.

Major strategic initiatives

- Design and implement multi-sectoral coordination approaches at all levels to create model households, keels, schools and communities.
- Design and implement interventions to increase health literacy and health system literacy

- Design, test, and scale up alternative community engagement options for the HEP and health service delivery and introduce innovative motivation mechanisms for community volunteers
- Introduce new and strengthen existing social accountability mechanisms such as community scorecard , town hall meetings; and increase participation of the community in health facility governing boards to enhance accountability and transparency of the health system to the public
- Evaluate, refine, and implement competency-based training for community-level structure representatives and model households
- Introduce and implement “self-care” initiatives
- Design and implement approaches to enhance community resource contribution
- Apply human-centered design and other frameworks to foster social innovation in designing novel solutions tailored to prevailing people’s desires and local contexts
- Use existing community potentials and indigenous resources such as associations, faith-based, and communi ty-based organizations as platforms for engaging communities in health
- Cultivate and incubate local community-led innovations for local health problems

4.6.4. Improve Access to Pharmaceuticals and Medical Devices and Their Rational and Proper Use

Description

This strategic direction focuses on strengthening the pharmaceutical supply chain, pharmacy services, and medical device management systems to ensure uninterrupted availability and accessibility of safe, effective, and affordable medicines and medical devices that are needed to address the health problems of the community and ensure that they are used rationally and properly. This strategic direction also addresses reduction of pharmaceutical wastage and strengthening of systematic and environmentally friendly disposal of expired and damaged pharmaceuticals and non-functional medical devices. The direction additionally includes development and implementation of strategies that strengthen local manufacturing of medicines and medical devices, and standardization of procedures for procurement and management of medical devices.

Major strategic initiatives

- Strengthen Strategic Procurement System through the introduction of e-procurement, establishment of international and regional pooled procurement, and long-term fixed price procurement mechanisms
- Develop medicine selection, pricing and reimbursement strategy
- Establish Central Order Management System
- Develop and implement demand-based forecasting and supply planning
- Establish market shaping strategies for pharmaceuticals and medical devices
- Optimize good warehousing, inventory, fleet and distribution practice
- Establish end-to-end data visibility for the supply management of medicines and medical devices such as implementation of track and trace system
- Establish and implement track and trace system for medicines and medical devices across the supply chain

- Strengthen medical device management system such as standardization of medical device, maintenance workshops, refurbishment centers , maintenance referral system and disposal
- Implement reverse logistics at health facilities and pharmacy retail outlets that extends to households
- Develop and implement strategies to reduce medicine wastage and to implement pharmaceuticals waste

management and medical devices decommissioning

- Strengthen capacity for local manufacturing of medicines and medical devices
- Establish National Medicine and Poison Information Center
- Strengthen the prevention and containment of antimicrobial resistance
- Strengthen implementation of auditable pharmaceutical transactions and services
- Strengthen clinical pharmacy and drug information services
- Revise the National Medicine Policy
- Strengthen integration of modern and traditional medicine
- Introduce audit-and-feedback and accountability system at all levels

4.6.5.Improve Regulatory Systems

Description

This strategic direction seeks to protect the public from health risks that arise from poor and substandard products and services. It focuses on ensuring the safety, quality, efficacy, and proper use of medicines; performance of medical devices; safety of food; quality of health and health-related services against standards; competence of health professionals; and regulation of tobacco and alcohol. It also includes the implementation of digital regulation systems to establish an effective, transparent, and accountable system that ensures adherence by all state and non-state actors to national health regulatory standards and legal frameworks. Engagement of all stakeholders such as industry, academia, communities and consumers will be a mainstay of this strategic direction. The Ministry engages professional associations in the process of licensing health professionals (such as developing exams, participating in the examination process) within this strategic period and aspires towards transferring this task afterwards. The MOH will work towards establishment of a semi-autonomous regulatory system for health facility regulation.

Major strategic initiatives

Regulation of Food, Medicines, Equipment, and Other Health Products

- Build and maintain adequate quality control systems, infrastructures, and laboratories (including Min-laborato ries at each entry and exit port)
- Control food adulteration and develop a rapid alert system for health products
- Strengthen registration capacity, introduce product- and risk-based auditing pre- and post-licensing inspection, improve post-shipment (consignment) and post-marketing surveillance, and enforce quality control tests of products
- Strengthen pharmaco-vigilance and vaccine safety and improve interface with clinical surveillance ▪

Establish a regulatory system for safety and quality of blood, blood products, human tissues, and

organs ▪ Establish Regulatory Center of Excellence to provide service, training, and research

- Standardize, register, and regulate the safety and efficacy of traditional medicine and practice

Regulation of Health Professionals and Health and Health-Related Facilities

- Regulation of health professionals and traditional medicine practitioners (professional ethics and code of conduct)
- Regulation of health and health-related facilities, both public and private (enforcing adherence to the

Ethiopian health facility minimum standard)

- Competency assessment of all graduates before joining the health workforce
- Introduce and scale up clinical audits to ensure quality of practice in health facilities
- Engage private health care facility associations in health regulatory system

4.6.6.Improve Human Resource Development and Management Description

This direction entails human resources planning, development and management (training, capacity building, recruitment, deployment, performance management, and motivation) to ensure the presence of motivated, competent, compassionate and committed health professionals in adequate numbers and skill mix. It focuses on improving the quality of pre-service training and continuous professional development, and will emphasize promotion of ethics and professionalism in pre-service education and in-service training programs. The human resource management aspect of this direction focuses on need-based training, recruitment, deployment, performance management, and motivation. It also includes leadership development, with attention to the involvement of women in leadership positions. Generally, this direction requires multi-faceted interventions, from recruiting students with the drive and motivation to be health professionals, to continuously engaging health science students to consider being a health professional and inspiring practicing health professionals to demonstrate commitment to their country and its people, and to care for their patients.

Major strategic initiatives

- Strengthen system of compassionate, competent, and motivated health workforce through quality pre-service education, improved retention and motivation mechanism, continuous professional development (CPD) integrated with professional re-licensing
- Strengthen health facility-based education and training in the health system, and also make health facilities conducive to health science training
- Enhance demand driven-health workforce forecasting, planning, and development
- Establish health professionals council and engagement of health care workers
- Integrate academic activities, service provision, and research functions at teaching hospitals
- Redesign health workforce intake approaches through joint education-health planning and integration mechanisms
- Develop and implement strategies to enhance health workforce safety
- Shift HEW career levels to a level IV and above, and improve career structure of the health workforce in general
- Ensure the distribution and availability of health workforce to health facilities with adequate number and appropriate professional and gender mix in an equitable manner
- Establish National Health Workforce Accounts and national Health Workforce Observatory
- Conduct provider competency assessment survey on a yearly basis
- Empower women in the health work force by creating conducive environment at workplace, and ensuring their representation at all levels

4.6.7.Enhance Informed Decision-Making and Innovation Description

This strategic direction focuses on generation of quality evidence, research, and innovations, building a culture of evidence-based decision-making, and developing and using technology (new and/or improved tools). It also promotes use of data from routine and non-routine data sources, including new research supported with appropriate information communication technology (ICT), and using an established HIS governance framework. The program aims at improving evidence generation and use from numerous sources, including census, civil registration, and vital statistics; as well as surveys, surveillance, routine information systems, researches, and monitoring and evaluation systems. It also focuses on continuously improving the availability and quality of data, building capacity in data use core competencies, bridging the gap between data users and data producers, strengthening organizational data demand and use platforms, documentation and communication of data demand and use successes, data access and sharing, security, and data warehousing. It also includes institutionalizing a knowledge management system.

This strategic direction also addresses the process of ideation, evaluation, selection, development, and implementation of new or improved products, services, or programs to improve health outcomes. Health innovation identifies new or improved health policies, systems, products, and technologies, and services and delivery methods that improve people's health and well-being.

Major strategic initiatives

- Improve the ownership and quality of health sector woreda-based planning
- Strengthen and expand, as needed, all health management information system and surveillance systems
- Improve quality of data through a national movement to prevent data falsification; implement comprehensive data quality assurance and auditing; improve demand for quality data
- Strengthen culture of information use at all levels (nurturing leadership role in championing information use, capacity building, accountability mechanism, advanced data analytics, data use forums/platforms)
- Create structures and forums (Research Council) that identifies research needs, coordinates the process, and translates evidence to policy
- Mainstream HIS training in all health professional training curricula
- Establish and enhance knowledge management system at all levels
- Strengthen biomedical research to develop and test diagnostics, therapeutics and vaccines
- Strengthen birth and death notification for Civil Registration and Vital Statistics system and system for documenting cause of death
- Strengthen health information system governance
- Strengthen health biotechnology research and use of biotechnology products
- Strengthen short term and long term medical research trainings
- Establish system for technology transfer for production of vaccine and diagnostic

materials ▪ Design and expand innovation labs

- Establish and strengthen a system for technology transfer for vaccines and diagnostics

production ▪ Strengthen biomedical research to develop and test diagnostics, therapeutics, and

vaccines ▪ Establish incubation centers for health innovations

- Establish and strengthen Health Research Council

4.6.8.Improve Health Financing

Description

This strategic direction is about ensuring adequate and sustainable financing to realize Ethiopia's progress towards "Universal Health Coverage through strengthening Primary Health Care" without financial hardship for citizens. This strategy requires mobilizing adequate and sustainable financial resources, pooling of resource and risk, purchasing, and paying for health services and improving health system efficiency. It will also include improving accountability and transparency in management and utilization of financial resources. This strategic direction will ensure a transition to more sustainable financing for health through gradual replacement of resources from external to domestic sources.

This strategic direction can be realized through devising new implementation modalities and governance arrangements. The strategy will employ current local and global opportunities that take advantage of the dynamisms of the health sector to transform supply- and demand-side health financing mechanisms.

Major strategic initiatives

- Design and implement innovative resource mobilization, mainly for domestic resources, by revising user fees to reflect cost of care and advocating, through continuous dialogues and negotiation, to increase government allocation to health
- Reform the role of MOH in health financing to improve mobilization and allocation of resources based on priorities of health programs
- Implement mandatory health insurance, social health insurance system, review premiums based on actual cost of care (not user fees), tailor benefit packages and premiums, and establish higher-level pooling
- Strengthen health facility revenue generation and effective utilization: recover full cost of services from either patients or an entity that pays on their behalf, establish pre-negotiated rate for all of user fee exempted services, introduce user fee to cover curative health services at HP level
- Design and implement performance linked strategies to improve efficiency and effectiveness (performance-based financing and results-based financing)
- Design and implement strategies for efficient utilization of existing resources and capacity by investing on high-impact, cost-effective interventions, strengthening different financial resource tracking systems and conducting regular financial audits

4.6.9.Enhance Leadership and Governance

Description

This direction is about ensuring an accountable, transparent leadership and governance system for effective implementation of strategies. It addresses public accountability on resource management and optimal health service provision; and includes designing and implementing sound regulation mechanisms, building effective teams, and institutionalizing appropriate implementation mechanisms and platforms.

The components include transparency, accountability, responsiveness, effectiveness and efficiency, participatory, consensus building, equitable and inclusiveness, and adherence to the rule of law. Strategic initiatives incorporate the views of minorities, minimize corruption, and include the voices of the vulnerable in decision-making and implementation of decisions.

Major strategic initiatives

- Build leadership capacity through leadership incubation programs, CPD (such as leadership management governance) for leaders, and twinning
- Mainstream gender in all health programs and operations, and empower women by ensuring their representation at all levels

- Promote merit-based assignment of health facility leaders alongside gender equity goals ▪ Redesign, reorganize, and implement institutional structures and management systems to embrace dynamism ▪ Revitalize harmonization and alignment for health (one plan, one budget, and one report principles) ▪

Standardize and institutionalize grievance handling and monitoring mechanisms at all levels ▪ Strengthen partnership and coordination among public sectors, private for profit, CSOs, and NGOs ▪ Design and implement legal frameworks (proclamation, regulations, directives and guidelines) ▪ Implement incentive and accountability mechanisms in the health sector

- Design and implement transparent resource allocation mechanism

4.6.10. Improve Health Infrastructure

Description

This strategic direction aims at improving access to health facilities that are well equipped and furnished, and ensures that existing and new health institutions meet minimum standards. It encompasses developing standard construction designs; building health institutions; and expanding, renovating, and maintaining health and health-related facilities. It also includes equipping, furnishing health institutions, providing utilities (such as water, electricity, sanitation facilities), and ICT infrastructure, and enforcing construction quality standards.

Major strategic initiatives

- Prepare design of health facilities that suits health service demand considering environmental, climate and geographic factors
- Construction, expansion (such as operating room blocks in health centers), rehabilitation (of sub-standard health facilities), maintenance, and renovation of health and health-related facilities to meet national standards
- Upgrade and/or construct health posts located in kebeles far from catchment health centers for provision of comprehensive PHC services
- Establish medical equipment maintenance centers and strengthen their capacity and functionality
- Introduce standard procedures for preventive maintenance of health and health-related facilities, equipment, and furniture
- Accelerate the expansion of utilities (water, electricity, ICT infrastructure) for health institutions

4.6.11. Enhance Digital Health Technology

Description

Digital technologies provide concrete opportunities to tackle health system challenges, and thereby offer the potential to enhance the coverage and quality of health practices and services. This strategic direction includes four major components: 1) Digitization targeted to clients, 2) health workers, 3) health system managers, and 4) health data services.

The range of uses for digital technologies in supporting health systems is wide, and these technologies continue to evolve. Digital health technologies and interventions should be linked to the broader digital health architecture. All digital health systems should be developed by applying interaction design methods to make them user-friendly.

Major strategic initiatives

- Keep the national eHealth architecture and interoperability framework up to date
- Develop standards and guidelines for selection, development and use of digital health

solutions ▪ Strengthen digitization of routine and non-routine data collection, management,

analysis and use ▪ Develop digital solutions for health worker decision support on prioritized

health services ▪ Develop digital solutions to provide capacity building for health workers

- Digitize digital health interventions for clients that improve client-provider interaction and increase health literacy
- Digitize and implement individual-level data recording system
- Strengthen ICT infrastructure at all levels of the health system
- Establish data warehouse

4.6.12. Improve Traditional Medicine

Description

This strategic direction refers to the registration, licensing, research, production, use, and integration of traditional medicine and traditional medical practices. Traditional medicine and practices are directly or indirectly related to protection of societal health, equitable distribution of public health care services, the right to exercise a profession, intellectual property rights, biodiversity conservation, and protection and promotion of indigenous knowledge and culture. This direction promotes public health by ensuring the safety, efficacy, and quality of locally produced traditional medicines and standardizing and regulating the practices of traditional healers.

Major strategic initiatives

- Develop and implement an inclusive and integrated policy framework and legislation for traditional medicines and practices
- Improve conservation and documentation of medicinal plants, traditional medicine knowledge, and practices
- Promote intellectual property rights, registration of indigenous knowledge rights, and market authorization of traditional remedies
- Promote research and development of traditional medicines, including clinical trials, and engage academia and research institutions
- Create incentive package for large scale production of scientifically validated traditional medicines in industries
- Establish incubation center for laboratory formulation of traditional medicines and increase laboratory scale formulation of scientifically validated traditional medicines
- Build capacity of traditional healers, tertiary level researchers, and the workforce involved in the production and supply management of traditional medicines
- Implement preparatory activities towards integration of traditional medicine into primary health care

4.6.13. Health in All Policies

Description

Health in All Policies (HIAP) is a systematic approach for considering the health implications of decisions of public policies across all sectors. It anticipates the synergistic effects of public policies, and prevents and mitigates harmful health effects ensuing from policies to advance population health. It advances the accountability of policymakers for health impacts through efficient, effective multi-sectoral actions; and emphasizes the need to be vigilant to prevent any unintended consequences of public policies on determinants of health, well-being, and the health system. By

promoting healthy practices across all sectors, HIAP fosters inclusive, sustainable development and helps

address the social determinants of health, reduce multi-sectoral risk factors, and promote health and well-being.

Major Strategic Initiatives

- Utilize Multi-sectoral Woreda Transformation platform to enhance planning, budgeting, execution, and monitoring and evaluation of multi-sectoral development interventions in pilot Woredas to bring about the four L's (Livelihood, Lifestyle, Literacy and Longevity)
- Advocate for the inclusion of health and health-related perspectives in all relevant sectorial policies and regulation
- Advocate for allocation of sector-specific budget line for social determinants of health initiatives
- Scan existing policies and strategies from all sectors and identify priority collaborative areas for multi-sectoral engagement
- Conduct joint planning, monitoring, and evaluation of multi-sectoral actions, including evidence generation and use
- Develop and a implement legal framework and implementation arrangement for effective implementation of multi-sectoral actions
- Formulate lessons from existing multi-sectoral initiatives such as the One WASH program, Seqota Declaration, and multi-sectorial woreda transformation, and scale these up more broadly
- Promote environmental impact assessment to mitigate health impacts of huge projects

4.6.14. Enhance Private-Sector Engagement in Health

Description: This strategic direction is about a deliberate and systematic collaboration of government and the private sector to move national health priorities forward, beyond individual interventions and programs. It aims to improve the engagement of the private sector in improving access and quality of health services, and to increase their engagement in a comprehensive range of health-related activities, from service delivery to supply forecasting to management to health systems strengthening. This direction includes the engagement of both private for-profit and private nonprofit institutions.

A sub-element of the engagement arrangement, partnership with the private sector, could strengthen health service delivery, improving the quality, quantity, and affordability of essential health inputs by facilitating local manufacturing of pharmaceuticals and medical devices. This partnership also increases production of skilled health human resources; mobilizes additional resources for the health sector; and contributes to meet the increase demand for access and utilization of health care.

Major strategic initiatives

- Review and revitalize the policy framework and strategies to enhance public-private engagement in health
- Create an enabling environment for public-private partnerships (PPP) for health, including establishment of transparency, accountability, and responsiveness within the partnership modalities
- Create an enabling environment for private sector to engage in health promotion, disease prevention, curative, rehabilitative, and palliative care
- Engage the private sector in the development of competent health force, production, and distribution of medical products and supplies, planning, implementation and monitoring and evaluation of the health system
- Strengthen mutual accountability system between government and private health sectors
- Introduce PPP arrangement in selected areas of health services
- Build a medical city in Addis Ababa

4.7 PRIORITIES /TRANSFORMATION AGENDAS OF HSTP-II

From the 14 strategic directions, the health sector has identified the top key priorities or health sector transformation agendas based on the major challenges identified in the situational analysis. These are investment areas that form the foundation of our health system, and if successfully implemented, they will transform the health sector and enable it to provide competent care that results in better health for all. Accordingly, the following are the priorities/
focus areas of HSTP-II.

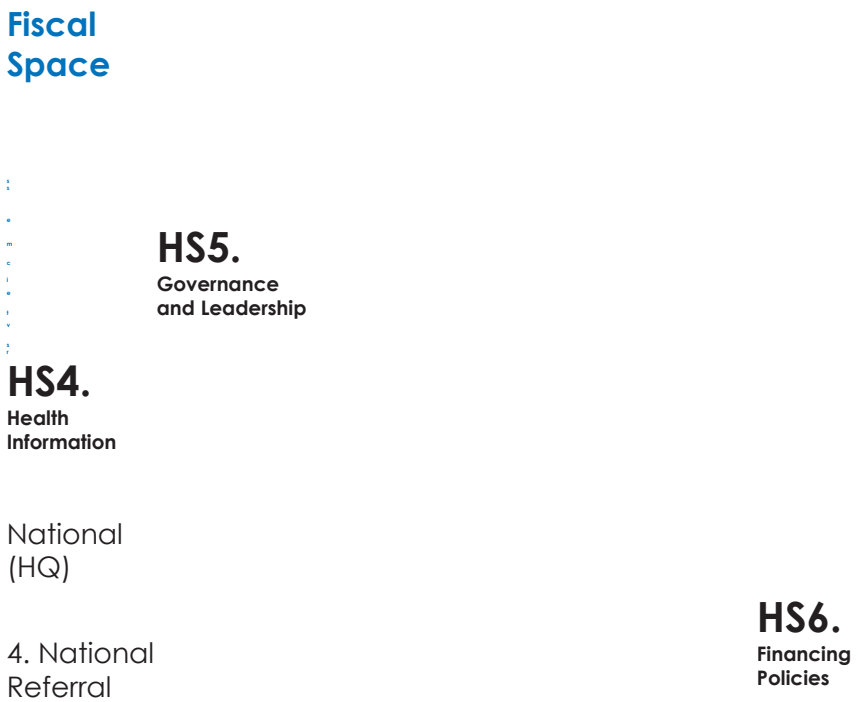
Quality and equity	*This transformation agenda refers to ensuring delivery of quality health care (reliable, patient-centered and efficient) to all in need in an equitable and timely manner. It is about ensuring availability of the best care to all, so that the quality of care provided does not differ by any personal characteristics including age, gender, socioeconomic status or place of residence, or disability status. Improving quality of care requires broad solution space that addresses both the demand for quality of care by the community, and the care itself. Only a few methods have been used up to now to improve the demand side. People with high expectation demand quality of care and vice versa. Some of the interventions are described here, but more innovative approaches are needed. Facilities should also design accountability mechanisms to redress poor quality of care, and should be transparent to inform people about the level of care provided. In addition, HSTP-II will address the supply side by emphasizing quality of care. Activities will include regular monitoring of the state of equity at all levels of the health sector implementation of tailored interventions, such as redesigning mode of service delivery, incentive packages and others, to reinforce quality of care.*
Information Revolution	*The overall goal of the information revolution is to improve the capability of the health system to generate and use high-quality data for evidence-based decision-making and advance towards better health systems performance. The information revolution is not only about changing the techniques of data and information management; it is also about bringing fundamental cultural and attitudinal change regarding perceived value and practical use of information. HSTP-II, efforts will focus on three pillars of the information revolution: transforming a culture of high-quality data use; digitization of the health information system (HIS); and improving HIS governance.*
Motivated, Competent and Compassionate (MCC) health workforce	*This priority area/transformation agenda refers to ensuring availability of an adequate number and mix of quality health workforce that are Motivated, Competent and Compassionate (MCC) to provide quality health service. Creating motivated, competent and compassionate health workforce depends on several but inter-related factors. These include well-regulated, high-quality pre-service education, in-service training, and CPD to build the required number of well-qualified professionals and managers; fair recruitment, selection, orientation, and placement; and creation of an enabling work environment with clear roles and responsibilities, equitable remuneration packages, and performance support (supportive supervision and timely feedback) through strong human resources management policy and practices.*
Health financing	*Transformation in health financing is about reforming the financing and management system of the health system so as to mobilize sufficient, sustainable health finance and improve efficiency. High out-of-pocket expenditure, catastrophic expenditure, and inefficient allocation and utilization of resources are major challenges to achieving universal health care coverage. HSTP-II will address these finance-related barriers through these major interventions: proactively mobilizing adequate resources from domestic and international sources, reforming resource allocation & prioritization, optimizing the health insurance system, forming public-private partnership, reforming cost recovery mechanisms, implementing performance-based financing, and designing and implementing strategies for efficient use of resources and capacities.*
Leadership	*Transformation in leadership is about enhancing the leadership and governance system at all levels of the health system to drive attainment of the strategic objectives. Lack of clear accountability, transparency, shared vision, evidence-based decisions, regulation, and coordination are some of the leadership and governance challenges of the sector. Leadership is a crucial pillar of a health system and exerts direct influence on the performance of health systems. Translation of plans to results will require leadership at all levels of the health system functions well. HSTP-II will implement these major interventions to transform leadership: redesigning & restructuring the health system, institutionalizing accountability mechanisms, strengthening clinical governance, ensuring regulatory system autonomy, strengthening stakeholder engagement and partnership, building leadership capacity at all levels, and incorporating the Health in All Policies approach throughout the government.*

Chapter 5

COSTING AND FINANCING

5.1 COSTING

Costing and financing of HSTP-II is computed using OneHealth Tool (OHT) (Figure 7). This tool is built on six health system building blocks, drawing upon the WHO health system framework that includes the health workforce, infrastructure, logistics and supply chain, health information system, health systems financing, and leadership and governance. OHT is a policy projection-modeling tool that allows users to create short- and medium-term plans for scaling up health services. It is used for health planning, costing and budgeting with a focus on integrating planning and financial space analysis. The tool is also organized into three components: health systems, health services delivery, and impact module.



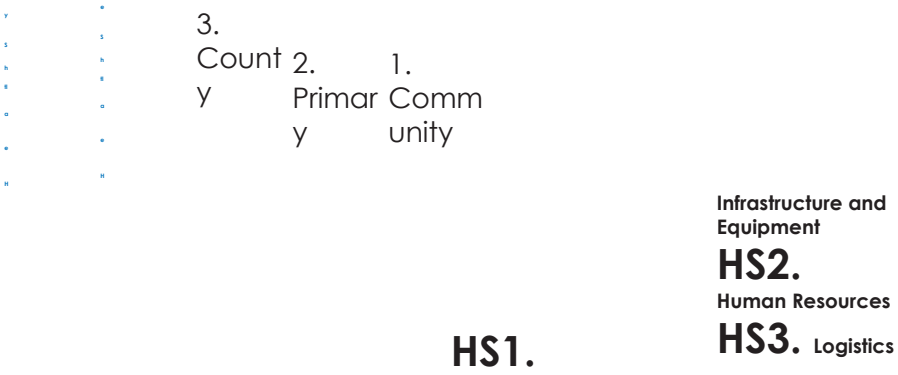


Figure 7. OneHealth Tool Framework

Where there are financial limitations, the tool facilitates a process of prioritization and/or scenarios with more realistic levels of ambition for developing the plan.

The OneHealth tool uses a modular approach; the user can either decide to use only one module (e.g., Malaria or Human Resources) independently, and/or can make use of other modules in sequential order. Once the user selects which interventions s/he intends to focus, s/he then allocates these into different modules. Subsequently, the disease modules are defined. This flexible approach allows variation between the structures of vertical disease programs in countries

OneHealth tool is based on Spectrum, which is a Windows-based system of integrated policy models. The integration builds on DemProj, which is used to create the population projections that support many of the calculations in the other components, such as FamPlan, the AIDS Impact Model, and the Lives Saved Tool.

The assessment of costing and financial feasibility is integrated into the planning process. In addition to this investment are linked to results in terms of system outputs and predicted health outcomes and impacts. The cost estimate is based on:

1. The best accessed information on disease profiles
2. Official figures for base year population demographics
3. Assumptions that all available facilities are functioning
4. Assuming that the required staff is in place
5. National protocols and expert opinions are used for clinical practices
6. Expansion targets are set to meet the standards as based on population figures and other criteria

5.1.1. Assumptions: Base and High Scenario

Targets were estimated using available baseline evidences from surveys such as EDHS, SARA; estimates and projections; researches; routine HMIS data, and expert opinion as a last option. Inputs for the tool were completed through iterative consultative workshops with program experts and relevant stakeholders. Lists of high-impact interventions in each program area were identified and prioritized prior to entry to the OneHealth tool for costing and target setting. Considering this, the tool generated cost and targets on two scenarios: base case scenario and high case scenario. Base case scenario considers existing interventions and similar investments to estimate targets and cost. The high case scenario additional investment such as expansion of infrastructure and increases high-impact intervention coverage to estimate impact level targets and cost. The base case scenario achieves the targets set in HSTP-II with a minimum cost and lower health outcomes, while the high-case scenario has relatively higher targets and better health outcomes (Table 2).

Some of the major impact indicators based on the estimated cost are shown below. For example, in base case scenario, maternal mortality ratio (MMR) will decline from 401 to 279 and 220 per 100,000 live births in 2024, in base case and high case scenario, respectively.. To achieve MMR SDG target of 140 per 100,000 live births, we have to use the high case scenario, which requires increasing the coverage of high-impact

interventions and mobilization of sufficient resources (Figure 8). Similarly, under 5-mortality rate will decline from 59 in 2019 to 44 and 36 per 1,000 live births in 2024 in base case and high case scenarios, respectively (Figure 9).

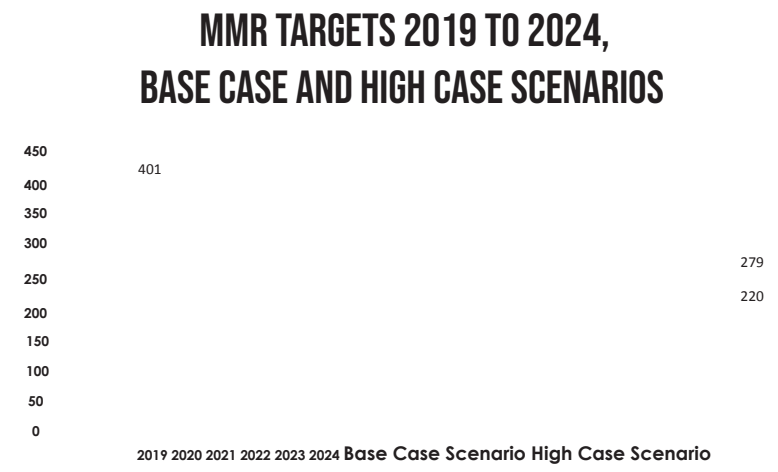


Figure 8. Maternal Mortality Ratio targets (per 100,000 live births): Base and high case scenarios

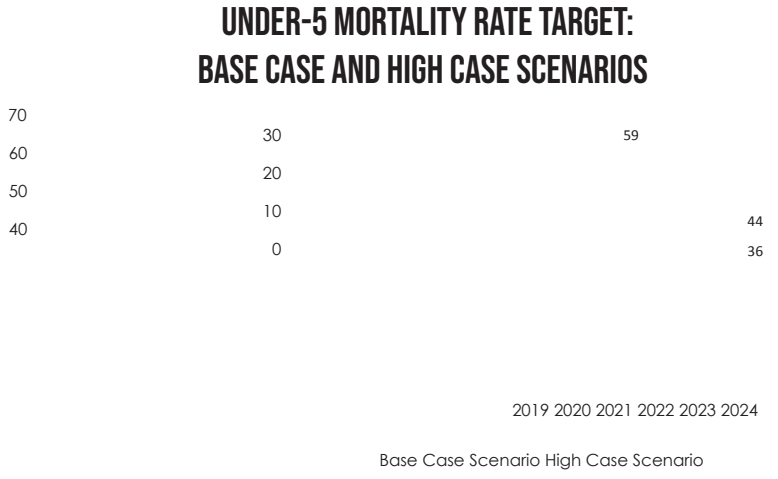


Figure 9. Under-5 mortality rate targets (per 1,000 live births): Base case and high case scenarios

Table 2. Basic Assumptions of Costing for Base and High Case Scenarios

Targets for impact and outcome indicators	Life expectancy	Increase from 65.5 years	68 years	69 years
	MMR - Reduces from	Reduce from 401	To 279 per 100,000 LB	To 220 per100,000 LB
	Neonatal Mortality Reduces from	Reduce from 33	To 21 per 1,000 live births	To 15 per1,000 live births
	Infant mortality	Reduce from 47	To 36 per 1,000 live births	To 30 per 1,000 live births
	Under five mortality	Reduce from 59	To 44 per 1,000 live births	To 36 per 1,000 live births

	TFR	Reduce from 4.6	3.23	3
	CPR	Increase from 41%	50%	54%
	Intervention/service coverage	Targets set to help achieve the health status of the population	Relatively Smaller	Higher than base case
Inputs				
	Supply	Adjusted with the services planned for base case		Increases for covering targets
	Infrastructure	Infrastructure to population ratio		
		▪ HP is 1:5,000 pop (rural)		
		▪ HP (2nd Generation construction and renovation)	Reach to 1000	Reach to 12,121
		▪ HC is 1:20,000 pop (rural) and 1: 40,000 pop (urban)	Reach to 3884	Reach to 4889
		▪ Primary Hospital is 1:100,000 pop (rural)	Reach to 500	Reach to 1,275
		▪ Gen Hospital is 1:1-1,500,000 pop (total)	Reach to 109	Maintain at 109
		▪ Specialized Hospital is 1:5,000,000 pop (total)	Remains at 15	Maintain at 15

5.1.2. HSTP-II Cost Estimates: Base and High Case scenarios

The total cost estimation for the base and high case scenarios is $21.88 billion and $27.54 billion, respectively, for the next five years. The biggest cost difference between base and high case scenarios is observed in infrastructure and pharmaceutical supply.

5.1.2.1. Cost Estimation: Base case Scenario

The total cost estimation for the base case scenarios is $21.88 billion for the next five years. Out of the total cost of the base scenario, 50% ($10.87 billion) is costed for procurement of medicine & medical equipment, 19 % ($4.26 Billion) for human resource development and management, 13% ($2.77 billion) for health infrastructure (construction, rehabilitation and maintenance of health facilities, equipment and furniture, ICT materials, vehicle), and 8% ($1.67 billion) for health service programme management cost which includes short-term trainings, supervision, advocacy, and other program-specific costs, in the base case scenario (Table 3, Figure 10).

Table 3. HSTP-II Summary Cost - Base Case Scenario (USD in '000)

Health Service (Program Management)	355,688	319,578	342,277	342,739	316,010	1,676,292	8%
Medicines, commodities, and	1,658,31	1,879,40	2,303,52	2,343,42	2,685,52	10,870,19	50%

supplies	8	7	3	1	7	6	
Human Resources	748,470	796,532	849,321	905,336	964,745	4,264,403	19%
Health Infrastructure	553,592	554,608	553,843	555,165	554,583	2,771,791	13%
Health Care Financing	40,461	18,098	44,652	21,418	22,453	147,082	1%
Health Information Systems	222,095	232,320	238,862	238,333	234,306	1,165,916	5%
Regulatory	63,219	66,246	71,610	74,907	77,487	353,470	2%
Governance	113,724	110,191	125,294	138,542	149,634	637,385	3%
Grand Total	3,755,568	3,976,979	4,529,383	4,619,860	5,004,745	21,886,536	100 %



Figure 10. Percentage share of the various components of HSS to base case costing

Out of the total cost allocated for program cost, which is $1.67 billion, the highest proportion (17%) is allocated for each Health Extension Program (HEP), (12.2%) for diagnostic management, 11.9% for immunization, and 8.7% quality of health services, and 7.8% for maternal, new-born, adolescent and reproductive health.

The health system, as per the OneHealth tool, includes human resource, infrastructure, logistics supply management, health financing, HIS, research and technology, regulatory activities, and other governance-related activities. The total cost allocated for the health system is $20.21 billion. The highest proportion is for medicines, commodities supplies and logistics management (53.8%), followed by human resources (21.1%) and infrastructure (13.7%) (Table 4, Table 5).

Table 4. HSTP-II Cost - Base Case Scenario by program and health system building blocks (USD in '000)

Health Service (Program Management)						
Maternal, Newborn, Adolescent and Reproductive Health	22,183	30,673	26,139	26,565	25,319	130,878
Child Health	1,261	891	738	499	396	3,785

Immunization	32,409	38,707	45,086	39,042	44,434	199,679
Nutrition	18,381	17,124	16,500	15,773	15,185	82,964
Hygiene and Environmental Health	15,087	14,788	14,733	14,542	14,504	73,654
HIV/AIDS	5,228	5,146	5,396	5,725	6,863	28,358
TB and Leprosy	17,879	15,925	16,568	17,522	17,291	85,184
Malaria	11,510	5,289	8,349	15,049	6,322	46,519
Non-communicable diseases	8,730	3,588	5,153	3,048	6,781	27,301
Mental, neurological, and substance use disorders	195	270	171	186	239	1,061
Neglected Tropical Diseases (NTD)	23,261	24,077	22,210	22,210	22,190	113,948
Clinical Services	13,196	13,161	12,936	13,157	12,677	65,127
Injury Prevention; Emergency and Critical Care	49,472	18,024	18,039	18,226	18,309	122,070
Diagnostic Services	33,948	38,037	40,255	43,703	48,278	204,221
Blood Safety	4,067	3,326	3,635	3,987	4,089	19,105
Health Extension Program (HEP)	64,960	57,690	65,526	64,135	32,806	285,117
Hepatitis	1,831	211	211	213	258	2,724
Quality of Health Services	25,018	25,116	32,325	30,822	32,295	145,576
Equity of Health Services	5,967	6,087	5,971	5,669	5,554	29,248
Gender	1,106	1,446	2,337	2,664	2,220	9,774
Total program costs (management)	355,688	319,578	342,277	342,739	316,010	1,676,292
Health Systems	0	0	0	0	0	0
Human Resources	748,470	796,532	849,321	905,336	964,745	4,264,403
Health Infrastructure	553,592	554,608	553,843	555,165	554,583	2,771,791
Medicines, commodities, supplies and Logistics Management	1,658,318	1,879,407	2,303,523	2,343,421	2,685,527	10,870,196
Health Financing	40,461	18,098	44,652	21,418	22,453	147,082
Health Information & Innovation	155,467	162,624	167,203	166,833	164,015	816,141
Health technology	66,629	69,696	71,658	71,500	70,292	349,775
Regulatory activities	63,219	66,246	71,610	74,907	77,487	353,470
Other Governance activities	113,724	110,191	125,294	138,542	149,634	637,385
Total Health Systems	3,399,880	3,657,401	4,187,106	4,277,122	4,688,735	20,210,244

Table 5. HSTP-II Cost - Base Case Scenario by HSTP-II strategic Directions (USD in '000)

Enhance equitable and quality comprehensive health service	1,962,274	2,153,853	2,605,838	2,646,575	2,958,474	12,327,013	56%
Improve health emergency and disaster risk management	19,028	20,660	22,429	24,349	25,923	112,389	1%
Ensure community engagement and ownership	90,713	84,385	94,551	104,700	115,837	490,187	2%
Strengthen pharmaceutical and medical equipment supply management	51,732	45,133	39,962	39,585	43,063	219,475	1%
Improve regulatory systems	63,219	66,246	71,610	74,907	77,487	353,470	2%
Improve human resource development and management	748,470	796,532	849,321	905,336	964,745	4,264,403	19%
Enhance informed decision making (information and Innovation)	155,467	162,624	167,203	166,833	164,015	816,141	4%
Enhance health financing	40,461	18,098	44,652	21,418	22,453	147,082	1%
Strengthen governance and leadership	1,106	1,446	2,337	2,664	2,220	9,774	0%
Improve health infrastructure	553,592	554,608	553,843	555,165	554,583	2,771,791	13%
Enhance digital health	66,629	69,696	71,658	71,500	70,292	349,775	2%
Improve traditional medicine	996	1,281	2,069	2,364	1,957	8,667	0%
Health in all policies and strategies	996	1,281	2,069	2,364	1,957	8,667	0%
Enhance private engagement in the sector	885	1,138	1,839	2,101	1,740	7,702	0%
Total	3,755,568	3,976,979	4,529,383	4,619,860	5,004,745	21,886,536	100 %

Regarding the share allocated for strategic directions, the highest cost allocation for the strategic direction “improve access to equitable and quality health services,” “improve human resource management,” and “improve health infrastructure” accounts for 56%, 19%, and 13% respectively (Table 5).

5.1.2.2. Cost Estimation: High case Scenario

The total cost estimation for the high case scenarios is $27.55 billion for the next five years. As indicated in table 6 below, in the high case scenario, 45% of the total cost ($12.32 billion) is for procurement of medicines/commodities and supplies, 22% ($6.10 billion) for health infrastructure, 16% ($4.33 billion) for human resources development and 9% ($2.47 billion) for health services program management (Table 6, Figure 11).

Table 6. HSTP-II Summary Cost - High Case Scenario (USD in '000)

Health Service (Program Management)	481,149	498,404	504,227	498,064	493,455	2,475,300	9%
Medicines, commodities, supplies and logistics management	1,740,683	2,094,279	2,609,319	2,731,768	3,147,656	12,323,705	45%
Human Resources	754,814	809,683	869,702	933,482	964,745	4,332,426	16%
Health Infrastructure	1,197,576	1,304,019	1,230,803	1,236,197	1,131,502	6,100,095	22%
Health Care Financing	40,461	18,098	44,652	21,418	22,453	147,082	1%
Health Information and innovations	222,095	232,320	238,862	238,333	234,306	1,165,916	4%
Regulatory	63,219	66,246	71,610	74,907	77,487	353,470	1%
Governance	114,222	111,361	127,322	141,621	153,972	648,497	2%
Grand Total	4614220	5134409	5696496	5875790	6225577	27546493	100 %

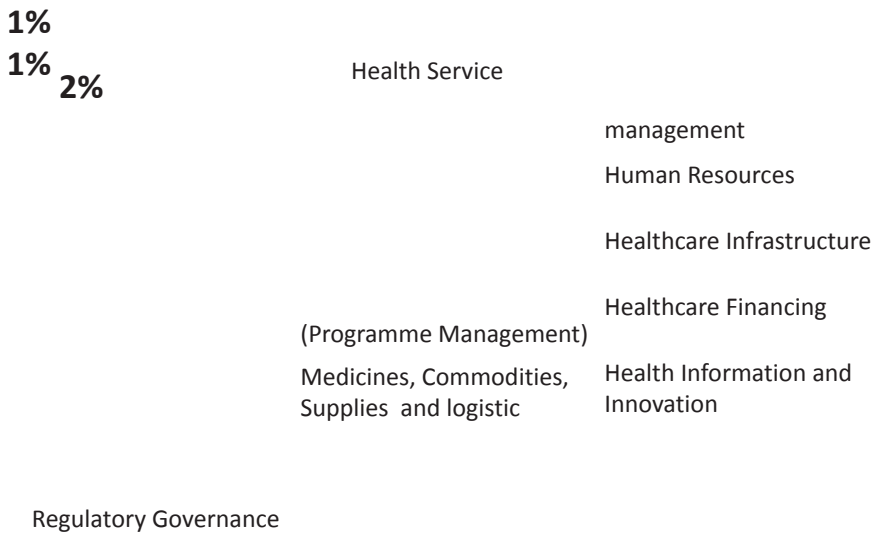


Figure 11. Percentage share of the various components of HSS with a high case scenario costing

From the total cost in high case scenario, program management cost accounts for 9% ($2.47 billion), and the other health system related cost accounts for 91% ($25.07 billion). From the program management cost, the highest proportion is costed for nutrition (22.3%) followed by diagnostic management (14%), and Health Extension Program (11.5%) . Regarding health system cost in high case scenario, the highest proportion is costed for Medicines, commodities, supplies and logistics management (49.2%) followed by infrastructure (24.3%) (Table 7).

Table 7. HSTP-II Cost - High Case Scenario by program and health system building blocks (USD in '000)

Maternal, Newborn, Adolescent and Reproductive Health	22,183	30,673	26,139	26,565	25,319	130,878
Child Health	1,261	891	738	499	396	3,785
Immunization	32,409	38,707	45,086	39,042	44,434	199,679
Nutrition	112,381	111,124	110,500	109,773	109,185	552,964
Hygiene and Environmental Health	15,087	14,788	14,733	14,542	14,504	73,654
HIV/AIDS	5,228	5,146	5,396	5,725	6,863	28,358
TB and Leprosy	17,879	15,925	16,568	17,522	17,291	85,184
Malaria	11,510	5,289	8,349	15,049	6,322	46,519
Non-communicable diseases	8,730	3,588	5,153	3,048	6,781	27,301
Mental, neurological, and substance use disorders	195	270	171	186	239	1,061
Neglected Tropical Diseases (NTD)	23,261	24,077	22,210	22,210	22,190	113,948
Clinical Services	13,196	13,161	12,936	13,157	12,677	65,127
Injury Prevention; Emergency and Critical Care	39,459	40,180	40,037	40,063	40,540	200,280
Diagnostic Services	56,096	64,459	68,786	71,409	84,801	345,552
Blood Safety	4,067	3,326	3,635	3,987	4,089	19,105
Health Extension Program (HEP)	64,960	57,690	65,526	64,135	32,806	285,117
Hepatitis	1,831	211	211	213	258	2,724
Quality of Health Services	44,344	61,364	49,745	42,604	56,986	255,043
Equity of Health Services	5,967	6,087	5,971	5,669	5,554	29,248
Gender	1,106	1,446	2,337	2,664	2,220	9,774
Total program costs	481,149	498,404	504,227	498,064	493,455	2,475,300
Health Systems	0	0	0	0	0	0
Human Resources	754,814	809,683	869,702	933,482	964,745	4,332,42

						6
Health Infrastructure	1,197,576	1,304,019	1,230,803	1,236,197	1,131,502	6,100,095
Medicines, commodities, supplies and logistics management	1,740,683	2,094,279	2,609,319	2,731,768	3,147,656	12,323,705
Health Financing	40,461	18,098	44,652	21,418	22,453	147,082
Health Information & Innovation	155,467	162,624	167,203	166,833	164,015	816,141
Health technology	66,629	69,696	71,658	71,500	70,292	349,775
Regulatory activities	63,219	66,246	71,610	74,907	77,487	353,470
Other Governance activities	114,222	111,361	127,322	141,621	153,972	648,497
Grand Total	4,614,220	5,134,409	5,696,496	5,875,790	6,225,577	27,546,493

Regarding the share allocated for strategic directions in high case scenario, the highest cost allocation is for the strategic directions "improve access to equitable and quality health services," "improve health infrastructure," and "improve human resource management," accounting for 52%, 22.1% and 15.9% respectively.

Recurrent and Capital Cost: Base case and High Case Scenario

The total recurrent cost in base case and high case scenarios is $20.45 billion and 422.9 billion, respectively. Regarding capital cost, the total in base case scenario is $1.39 billion and in the high case scenario$4.63 billion. In base case scenario, recurrent cost accounts for 93.6% and capital cost accounts for 6.4%. In High case scenario, recurrent cost accounts for 83.2% and capital cost accounts for 17.1% (Table 8).

Table 8. Recurrent and Capital Cost: Base Case and High Case Scenarios (USD in '000)

	Base case Scenario			**High case Scenario**		
2020/21	3,516,781	238,788	3,755,568	3,724,308	889,912	4,614,220
2021/22	3,687,167	289,813	3,976,979	4,082,522	1,051,887	5,134,409
2022/23	4,240,614	288,769	4,529,383	4,739,707	956,789	5,696,496
2023/24	4,330,602	289,258	4,619,860	4,944,157	931,633	5,875,790
2024/25	4,717,244	287,501	5,004,745	5,423,133	802,444	6,225,577
TOTAL	20,492,408	1,394,128	21,886,536	22,913,827	4,632,666	27,546,493

Cost by Service Delivery Levels: Base case and High Case Scenario

The total cost is also estimated by service delivery levels in the two scenarios. Out of the total estimated cost, 58.8% ($12.86 billion) in base case and 59% ($16.26 billion) in high case is allocated for the PHCU (household/community level, Health Post, Health Center, and Primary Hospital level interventions). At secondary and tertiary level of care (general and specialized hospitals), the total estimated cost is $6.79 billion (31%) and $7.6 billion (27.6%) in base case and high case scenarios respectively. In addition, the remaining cost is allocated for national and sub-national level program support such as for trainings, workshops, and supportive supervision is estimated and described in Table 9 and Table 10.

Table 9. HSTP Summary Cost by Service Delivery Levels of Base Case Scenario (USD in '000)

1	Primary Health Care Unit (PHCU)						
1.1	Household / Community	172,892	198,609	309,037	288,101	332,020	1,300,659
1.2	Health Post	169,449	166,221	277,840	201,900	252,540	1,067,949
1.3	Health Center / Primary Hospital	1,642,394	1,867,408	2,112,484	2,296,530	2,575,954	10,494,771
	PHCU total	1,984,735	2,232,237	2,699,361	2,786,531	3,160,515	12,863,379
1	Hospital (General & Specialized)	1,250,263	1,283,608	1,372,985	1,406,366	1,479,266	6,792,487
2	National program	561,624	530,162	556,499	555,754	532,197	2,736,235
	Grand Total	3,755,568	3,976,979	4,529,383	4,619,860	5,004,745	21,886,536