INTERNATIONAL SUPPORT

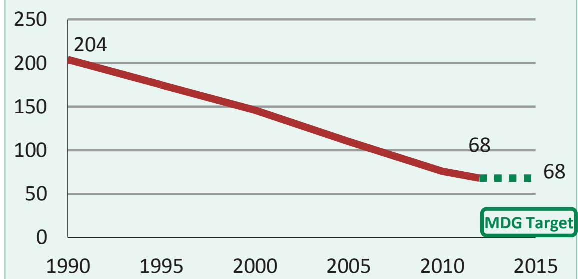
Time to invest in Health

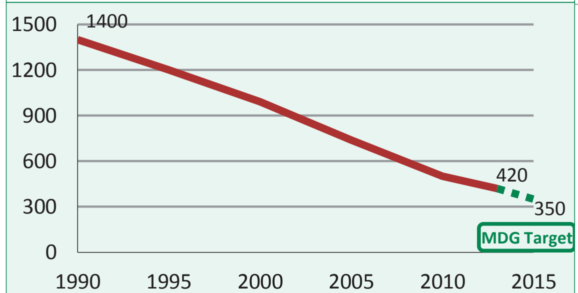
The Health sector in Ethiopia has registered a remarkable progress throughout the last two decades. This paper begins by highlighting the improvements achieved in the core areas; Maternal and Newborn Health, Child Health, Communicable Diseases, Non-communicable Diseases and Health Systems. The following section shows how these successful results were based on the effective policies undertaken by the Ministry of Health. None of the above would have been possible had it not been for the financial support of the international partners. Therefore, the third section looks at the funding of the sector drawing the attention to the limited per capita donor support. In view of the framework presented, the closing remarks call for further investment in order to fill in the current gaps and accomplish the desired high quality health service in Ethiopia.

A STORY OF SUCCESS. PERFORMANCE INDICATORS

Maternal and Newborn Health

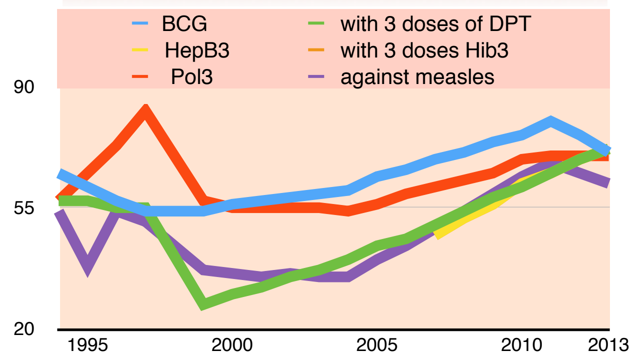
Improving the health of mothers and newborns was among the main priorities of HSDP IV. Number of high impact and cost effective initiatives were applied during EFY 2007 focusing mainly on increasing service utilization for Maternal, Neonatal and Child Health (MNCH) services. According to the 2014 World Health Statistics Report, Ethiopia has achieved MDG 4 target three years earlier by reducing under-five mortality by 67% from the 1990 estimate. The UN Inter Agency Group's 2013 mortality estimate reported that Ethiopia's under-five, infant and neonatal mortality rates were 68, 44 and 28 per 1000 live births respectively. The major causes of under-five mortality, based on the 2014 WHO/CHERG estimates for Ethiopia, are acute respiratory infection (ARI) (18%), diarrhea (9%), premature births (11%), sepsis (9%), birth asphyxia (14%), meningitis (6%), injury (6%), measles (3%) and others (21%). Malnutrition underlies nearly 50% of under-five deaths. According to UN estimates, Ethiopia has so far reduced maternal mortality by 69% from the 1990s estimate with annual reduction rate of 5% or more. According to the latest UN estimate, the proportion of mothers dying per 100,000 live births has declined from 1400 in 1990 to 420 in 2013.

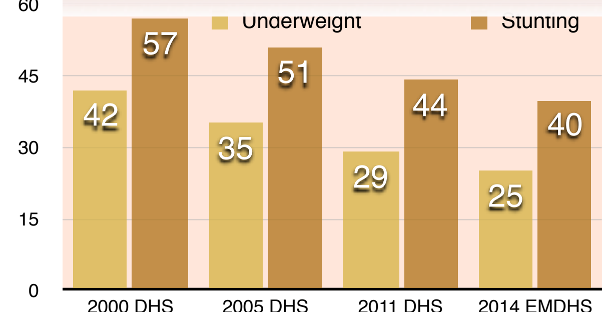




Child Health

The achievements in child health are mostly attributable to large scale implementation of promotive, preventive and curative primary health care interventions alongside a positive trend of socioeconomic changes. These include: IMNCI/ICCM (currently being provided in more than 2500 health centers and 12,000 health posts); prevention and management of malaria (with 65% of under 5 children sleeping under insecticide treated nets (ITN) with indoor residual spray (IRS) reaching 47% of houses in endemic areas in 2011); community based nutrition programs and establishment of Neonatal Intensive Care Units. The dramatic increase in immunization coverage has also significantly decreased fatalities associated with vaccine preventable diseases. Currently, Ethiopia is providing 10 antigens targeting major killer diseases during childhood. Four new vaccines (PCV 10, Rota and Penta) were introduced since 2007 in addition to the already existing six traditional antigens. The introduction of these new vaccines coupled with ICCM programs and expansion of the Health Extension Program is expected to further lower childhood morbidity and mortality due to pneumonia and diarrhea.

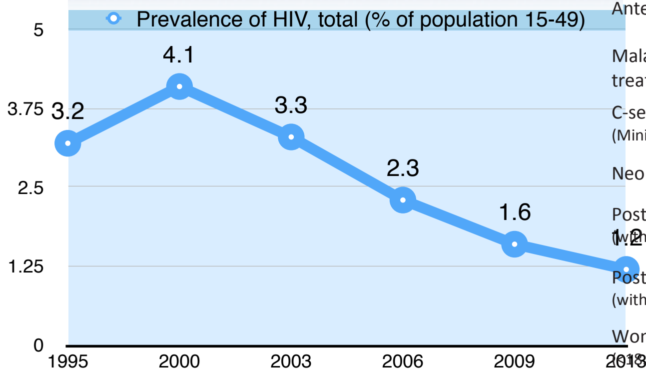




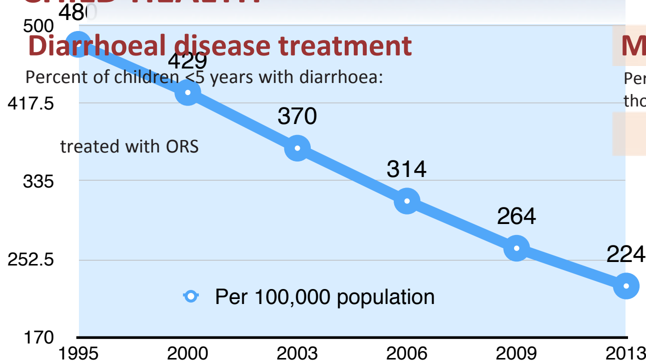
*Data was obtained from the World Bank and WHO databases updated by the MiniDHS 2014

Communicable Diseases

Prevalence of HIV

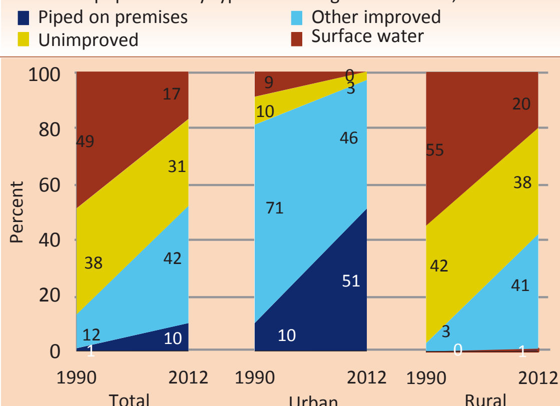


Prevalence of Tuberculosis



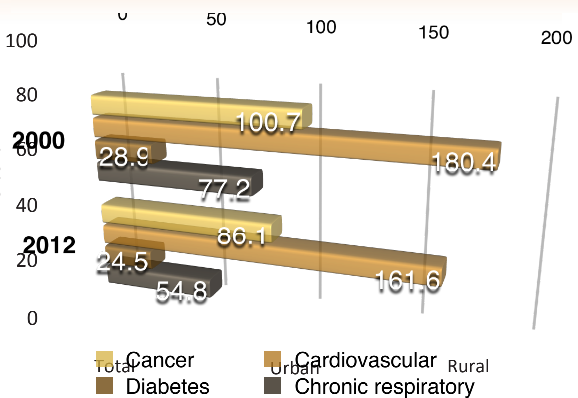
According to the HIV related estimates and projections for Ethiopia (FMOH/EPHI, 2012), the adult HIV prevalence is estimated at 1.2% (0.8% in males and 1.6% in females) and the adult HIV incidence stood at 0.03% in 2014. This indicates that Ethiopia has achieved the MDG target of halting and reversing the epidemic well ahead of time by reducing HIV new infection by 90% and mortality by more than 50% among adults in the last decade. Ethiopia is one of the few sub-Saharan African countries with a“rapid decline” of HIV burden, with a reduction by 50% of new HIV infections among children between 2009 and 2012 (UNAIDS report 2013). Annual rate of AIDS related deaths has declined from 106,761 deaths in 2002 to 41,451 in 2012. According to WHO's 2014 Global TB report, Ethiopia has achieved all the three targets set for tuberculosis prevention and control. Mortality and prevalence due to Tuberculosis has declined by more than 50% and incidence rate is falling significantly. Ethiopia has shown a remarkable progress in achieving malaria related MDG targets evidenced by reduced prevalence and death rates associated with malaria as well as an increase in the proportion of population in malaria prone areas using effective malaria prevention and treatment measures.

Noncommunicable Diseases & Other



Deaths by NCDs

per 100.000 people

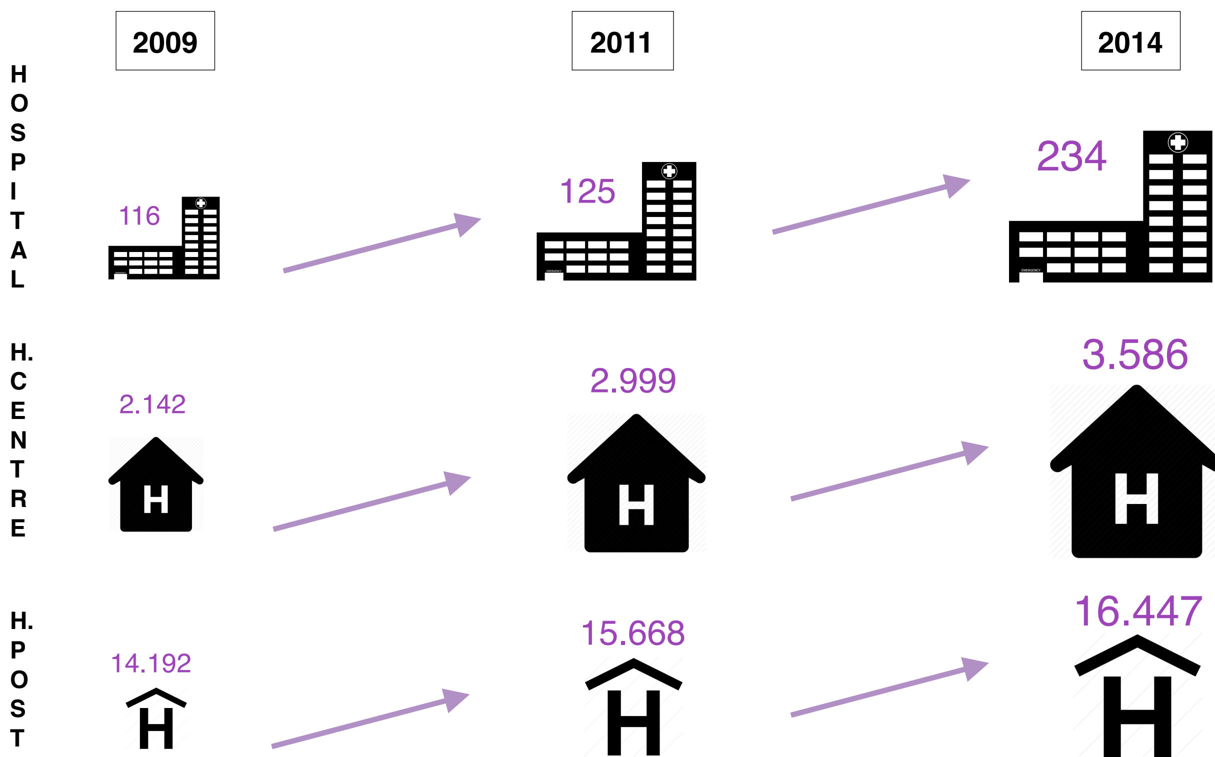


In accordance with the 2011 UN political declaration on NCDs the FMOH has developed and launched the national NCD prevention and control strategy. EFY 2007, the government started conducting nationwide stepwise survey to determine the magnitude of NCD risk factors and selected NCDs in the country. Ethiopia is also a signatory of the Framework Convention on Tobacco Control (FCTC) and following the proclamation by the Peoples Representative of the FDRE on tobacco use, FMOH developed an implementation/execution guideline. Tigray regional state parliament has ratified the guideline and started implementation while other regions are on process. As part of the effort to fight cancer, a total of 22,818 women aged 30-49 undergone cervical cancer screening; out of whom 2,801(12.3%) had signs of the disease.

A STORY OF SUCCESS 2

Health systems

INFRASTRUCTURE



The chart above highlights the tremendous progress that Ethiopia has made from the supply side. As a matter of fact, one Hospital used to give coverage to 688.748 populations in 2009. As of today, such indicator has increased to a ratio of 1:384.615 people. Likewise accessibility to primary health care facilities have spiked. In 2009 one health centre and one health post had a target population of 37.299 and 5.630 people respectively. Nowadays, one health centre and one health post provide services to 25.097 and 5.472 people respectively. Furthermore, According to preliminary Ethiopian Service Provision Assessment (ESPA+), about half of health facilities have regular electricity or has functional generator with fuel. About 88-100% of hospitals (public & private), 84% higher clinics, 61% lower clinics, 57% health centers and 29% of health posts have regular power sources. Over three-quarters of all health facilities (public and private) have an improved water source in their facility, including 71% of health centers and 49% of health posts.

BLOOD SAFETY

The National Blood Transfusion Service (NBTS) reversion from the Red Cross to the government health care service delivery has recently been completed. Its mission is to ensure the availability of safe and adequate blood to all patients in need. In 2013, the number of regional blood banks increased from 12 to 25 with a total of 30 mobile teams collecting blood from the communities on a daily basis. These banks are located to supply to all health facilities within 150-200 km radius of their catchment areas. Currently 52% of health facilities receive products from NBTS.

PHARMACEUTICAL SUPPLY

PFSA aims to increase the availability of quality pharmaceuticals (drugs, medical equipment and medical supplies for prevention, diagnosis and treatment) at an affordable price by ensuring adequate supply to health facilities in a sustainable manner. The agency aims to achieve improved rational drug use and a significant reduction in pharmaceutical wastage. The expected outcome is ensuring adequate availability of the right pharmaceuticals at the right place and at the right time in the right condition, being also properly used by patients and clients

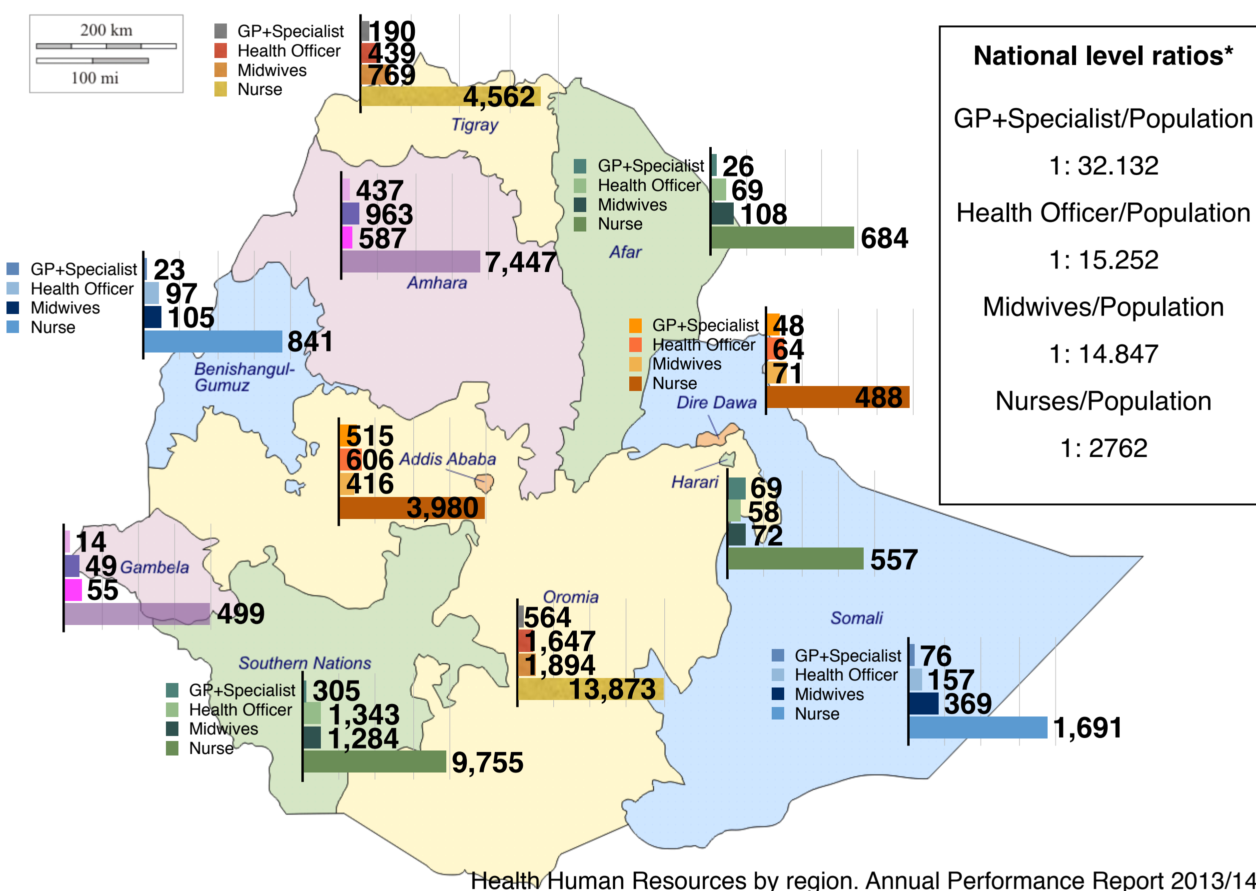
specialised training. Furthermore, one of the major initiatives designed by the FMOH in 2008 was to improve the provision of emergency obstetric care and surgical services at primary hospital level where a gynaecologist or surgeon are not available. The Integrated Emergency Surgery and Obstetric Training was thus started as a three years master's program for health officers (HO) in five universities aimed at reducing maternal mortality related to pregnancy and child birth. Likewise, the FMOH launched the accelerated midwifery training program and the plan to staff each HC with two midwives. In 2014, 1.219 midwifery graduates were deployed to health facilities. Anaesthesia , ambulance service and emergency care/paramedics training has also been given adequate attention.

OTHER POLICIES

- ★ Open Defecation Free Kebeles
- ★ Productive Safety Net Program
- ★ Enhancement of National Laboratory System
- ★ Health Information Technology Initiative
- ★ Distribution of Insecticide Treated Bed Nets
- ★ Indoors Residual Sprays
- ★ Global Initiative on blindness prevention and control
- ★ Prevention and Control of Neglected Tropical Diseases
- ★ Integrated Disease Surveillance (IDSR)
- ★ The National Policy on Women
- ★ The National Mental Health Strategy
- ★ Public Health Emergency Management

HUMAN RESOURCES FOR HEALTH

Still far from the physician to population ratio recommended by WHO (1:10.000), Ethiopia is devising strategies to increase the number of graduates in the coming years. In 2014, 3.583 new students were enrolled in 27 public medical schools, making the total medical students on training 14.290. The New Medical Education Initiative has been implemented in 13 medical schools. The Ministry is also signing agreements with private hospitals abroad for further specialized training. The map below shows the current status quo by region. Achieving the current numbers has been a consequence of policy endeavors and increases in the number of health professionals across all regions. As an illustration, in 2009 there used to be one GP +Specialist per 56.013 people. In 2009 a health officer and a midwife provided services to 25.709 and 39.758 populations respectively. The density significantly increased for nurses, as the ratio to population in 2009 was 1:3.012.



Health Human Resources by region. Annual Performance Report 2013/14

*Indicators that need population data have been adjusted based on Central Statistical Agency 2014 census result

LEADERSHIP, MANAGEMENT AND GOVERNANCE

The Government of Ethiopia (GoE) implemented the Business Process Re-engineering (BPR) in the health sector in order to establish customer focused institutions, rapidly scale up health services and enhance the quality of care, as part of the civil services' reform programs (HSDP IV, 2010). The BPR has changed the FMOH structure, and has shifted direct responsibility of specific programs. With the BPR, Ethiopia has increasingly decentralized oversight and management of its public health system to the Regional Health Bureau (RHB) level. The existing structure at the FMOH facilitates federalization/decentralization as it enables the federal level structure to examine the effectiveness, efficiency, equity and sustainability of health services and engagement of local stakeholders through dialogue on these issues using various forums like the Joint Core Coordinating Committee (JCCC), review meetings, community forums etc.

A STORY OF EFFORT. POLICIES

The overall achievements summarized above are not a result of coincidence or luck. Conversely, they reflect the thorough effort led by the Health Sector authorities in Ethiopia. Within the next two pages, this paper includes some of the most relevant policies contributing to the positive trends observed in the key indicators. Furthermore, the map opening this paper and the one closing this section capture the expansion of the health infrastructure and human resources respectively. Hence, both are also an illustration of the commitment to improve the delivery of health services in Ethiopia.

THE HEALTH EXTENSION PROGRAM. Implementation of the Health Development Army

HEP is an innovative strategy to deliver preventive and promotive services and selected high impact curative interventions at community level. It brings community participation through creation of awareness, behavioral change, and community organization and mobilization. It also improves the utilization of health services by bridging the gap between the community and health facilities through the deployment of Heath Extension Workers (34.800 currently operating). In this context, a major initiative is the implementation of the Health Development Army. HDA refers to an organized movement of the community through participatory learning and action meetings. It consists of health development teams that comprise up to 30 households residing in the same neighborhood. The health development team is further divided into smaller groups of six members, commonly referred as one-to-five networks. Using the HDA, HEWs are propagating healthy behaviors throughout the country and bringing improvements in the areas of maternal health, hygiene and sanitation. HEWs' engagement as full-time government-salaried civil servants is key to HEP's early success and long-term sustainability.

THINKING STRATEGICALLY. The "one plan, one budget and one report" formula

Seeking to harmonize efforts, simplify administrative procedures and improve effectiveness, the "One plan, one budget and one report" strategy governs the health policy in Ethiopia. The overall idea is that all stakeholders' plans and budgets should be reflected in one strategic plan which is then broken down into annual plans. Implementation is then monitored using an agreed set of indicators and reporting formats. These principles have translated into the coordinated preparation of the Health Sector Development Plan (HSDP) which sets the global objectives to be pursued in a 5 years term (the HSTP has just been released). Then, annual plans that incorporate regional and woreda needs, further specify the actions to be taken and the targets to achieve. The "one budget" principle has resulted in the establishment of the MDG Performance Fund (currently called SDG pooled fund) which is the hallmark towards reaching an agreement for full one-budget framework in the health sector of Ethiopia. Finally, annual reports are produced evaluating the progress fulfilled. The Health Management Information System is the tool attempting to track reliable data on key indicators.

OTHER POLICIES

- ★ Open Defecation Free Kebeles
- ★ Productive Safety Net Program
- ★ Enhancement of National Laboratory System
- ★ Health Information Technology Initiative
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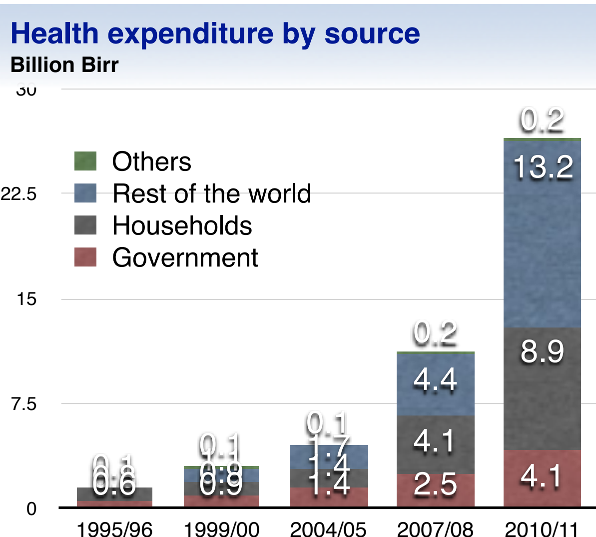
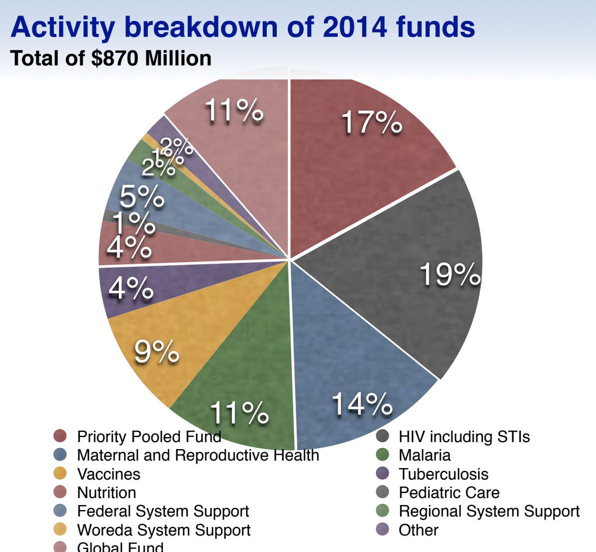
- ★ Integrated Disease Surveillance (IDSR)
- ★ The National Policy on Women
- ★ The National Mental Health Strategy
- ★ Public Health Emergency Management

All the above has been supported by a long lasting partnership with international donors. This section examines the current funding sources for the Health sector in Ethiopia. Collecting one of the lowest per capita expenditures in Africa, the success story of the Health sector shows the fruitful collaboration with all stakeholders. It is precisely this efficient management that encouraged donors to create the MDG pooled fund. Its flexibility and strengthening of the Ministry's systems, makes this source the preferred channel for prospective funding.



National Health Accounts

NHA is a globally recognized and accepted resource tracking methodology for the health sector. The fifth round in Ethiopia finds that the contributions of all major financers increased reaching a total of 26.5 Billion Birr in 2011. Despite this absolute raise, per capita spending on health in 2007/08 was only $16.1, far less than the WHO's recommended $34 in 2001, revised to $60 by 2015. In per capita terms, both government allocation and external assistance lags behind most African countries. The 6th round of the Health Accounts exercise is currently being conducted by the Ministry.



Resource Tracking Exercise

The annual resource mapping exercise captures 4 levels of information about all health programs; who is the funder and implementer, the activity the money is spent on, the geographical area and the breakdown of the costs. The graph on the left provides a picture of how the $870 million committed funds for 2014 are intended to be spent. Already 17% stems from the Priority Pooled fund and 11% from the Global Fund both analyzed below. The exercise also finds that almost 60% of the funds are managed by the FMoH showing the trust from international donors on the government's capacity.

Towards Sectoral Budget Support. The Priority Pooled Fund

The demonstrated diligence of the Federal Ministry of Health is earning the progressive transition towards sectoral budget support formulas. Increasingly, international donors are joining their financial support to Channel 2 modalities among which the following are to be underlined:

The Millennium Development Goal Performance Fund: the MDG PF is a pooled funding mechanism managed by the FMOH using GOE procedures. It provides flexible resources to secure additional funding to accomplish Health Sector Development Plan objectives. The MDG PF covers all program areas where there is a funding gap, with the exception of salaries or wages. However, in the past five years the MDG PF has covered mostly the procurement of public goods required to facilitate the health service delivery at the lower levels.

The Global Fund: it mobilizes and invests nearly US$4 billion a year to support programs run by local experts in more than 140 countries. As a partnership between governments, civil society, the private sector and people affected by the diseases, the Global Fund is accelerating the end of AIDS, TB and malaria as epidemics. As it is based on a country ownership principle, the Global Fund is endorsing Ethiopia's capacity to manage international funding.

A STORY OF SUCCESS, EFFORT AND COLLABORATION. WAY FORWARD

This paper has summarized the merits of the Health Sector in Ethiopia for the last two decades. The Federal Ministry of Health is committed to pursue this promising evolution. Consequently, the challenge ahead is to achieve the Health Sector of a middle income economy within the next ten years. This section, evaluates the existing gap separating Ethiopia from the aforementioned objective. This step up will require further funding as shown below. Hence, we continue by presenting the strategy to mobilize the necessary resources. From each of the sources, we explain the rationale underlying the current request for support. Additionally, mechanisms to grant sustainability and long term autonomy are emphasized, as a middle income economy health sector would mainly be based on such financing. For the credentials accredited by the Ethiopian Health Sector in the last decade and the vision for the future, **it is time to invest in Health**.

Estimating the gap

There is no list of standards that defines the Health Sector of a middle income economy. However, the table below shows the gap on a selection of key indicators separating Ethiopia from the level registered by the average of lower-middle and middle income economies. In order to provide a more contextualized framework, the third column specifies the best score out of three middle income African countries. Numbers in red illustrate whenever a gap is present.

Indicator	Ethiopia	Zambia/Nigeria/Ghana		Lower-Middle		Middle income	
Maternal Mortality Ratio	420	280	(140)	240	(180)	170	(250)
Total fertility rate	4.1	3,9	(0,2)	2,9	(1,2)	2,3	(1,8)
Under five mortality rate	64.4	78.4		59	(5,4)	43,4	(21)
Skilled birth attendance	15	68,4	(53,4)	58,9	(43,4)	71,5	(56,5)
Antenatal Care	40	86,6	(46,6)	—		—	
Neonatal Mortality Rate	27.5	29.3		27,1	(0,4)	20,3	(7,2)
Contraceptiv prevalence	40	34.3		51,1	(11,1)	65,9	(25,9)
Immunisation measles	62	89	(27)	75,8	(13,8)	83,3	(21,3)
Immunisation Pol3	70	91	(21)	76,3	(6,3)	83,4	(13,4)
Immunisation DPT	72	90	(18)	75,5	(3,5)	82,9	(10,9)
Malnutrition under 5	44.2	36	(7,8)	35,2	(9)	24,5	(19,7)
Wasting under 5	9	10		12.48		8,4	(0,6)
Prevalence of HIV	1.2	1.3		0,6	(0,6)	—	
Prevalence tuberculosis	224	92	(132)	236		173	(51)
Life expectancy at birth	62.9	60.9		66,2	(3,3)	70	(7,1)
Improved sanitation	23.6	42,8	(19,2)	47,5	(23,9)	60,2	(36,6)
Improved water	51.5	87,2	(35,7)	88	(36,5)	90,2	(38,7)
Physician/Population	0.025	0,39	(0,36)	0,78	(0,75)	1,31	(1,28)
Nurses and midwives	0.3	1,6	(1,3)	1,78	(1,48)	2,23	(1,93)
Health expenditure pc	17.5	96,1	(78,6)	86,25	(68,7)	261,68	(244,1)

Most recent figures from World Bank Data

From the financial perspective, the HSTP has computed the funding required to achieve the targets set for the coming five years. In the base case scenario shown below, 36% of the total cost (5.5 Billion USD) is for human resource development and management; 25% (3.9 Billion USD) is for medicines, commodities and supplies; and 24% (3.7 Billion USD) is for health infrastructure which includes construction, rehabilitation and maintenance of health facilities, equipment and furniture, ICT materials, vehicle (capital and running cost); 6% (967 Million USD) is for program cost which includes short term trainings, supervision, advocacy, and other program specific costs, and 5% (859 Million USD) for health care financing.

HSTP Summary Cost - Base Case Scenario (USD in '000)

Cost area	2015/16	2016/17	2017/18	2018/19	2019/20	Total
Health service (program management)	220,832	214,782	212,715	170,561	147,957	**966,847**
Medicines, commodities and supplies	638,308	828,818	730,742	788,429	918,461	**3,904,758**
Logistics supply management	33,265	33,419	36,211	33,318	35,714	**171,927**
Human Resources	707,290	899,218	1,098,823	1,306,265	1,521,865	**5,533,461**
Human infrastructure	919,590	802,681	801,902	693,381	520,963	**3,738,517**
Health Care Financing	152,281	170,795	168,469	180,762	184,327	**856,634**
Health Information Systems	55,578	55,486	55,483	55,483	55,483	**277,513**
Regulatory	27,704	31,525	34,207	37,536	40,610	**171,582**
Governance	1,155	1,191	1,227	1,259	341	**5,173**
Total	**2,756,003**	**3,037,915**	**3,139,779**	**3,266,994**	**3,425,721**	**15,626,412**

HSTP (FMOH) 2015

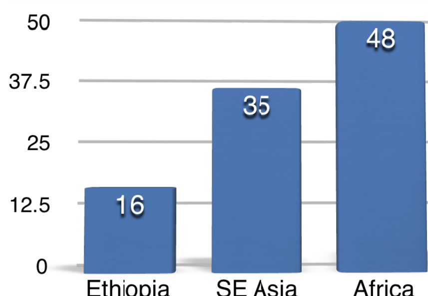
This cost estimate was done with the One Health Tool and is based on:

1. The best accessed information on disease profiles
2. Used official figures for base year population demographics
3. Assumed that all available facilities are functioning
4. Assumed that the minimum required staffs are 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

Prospective funding sources

Filling the gap outlined above would entail improving health care service, an expansion of the infrastructure and a considerable increase in the health professionals. Consequently, the next level for Ethiopian Health sector will require further funding. The Federal Ministry of Health has devised the following resource mobilization strategy to obtain the necessary investment. It is based on the principles of long-run sustainability and short term kick-start.

Government expenditure on Health as percent of Total Health Expenditure



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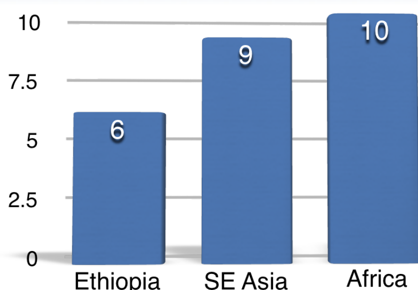


WHO 2011 and ENHA V

Government Budget Allocation

Government expenditure in Ethiopia lags behind regional parameters. The targeted progress on the sector will need an increased financial commitment from this domestic source. A forward estimation exercise conducted by MOFED found that raising the government expenditure up to 15% of the Budget would bring about remarkable achievements. As a matter of fact, if the aforementioned figure was set, in 2025 the health per capita expenditure would be $38 ceteris paribus. Given that the rest of financial sources would presumably increase as a result of the current efforts, Ethiopia should be close to reach the $60 per capita health expenditure recommended by WHO. Just to name two African examples, Ghana devoted 12% of the Government Budget to health in 2011 and 2012. Zambia has consistently spent 16% of the national funds on Health for the last 5 years. The constraints faced by each country are different but Ethiopia should no longer remain at the lower bound of Africa as far as government expenditure is concerned.

Households expenditure. Insurance Policies

According to the V Round of the National Health Accounts, National Health Expenditure increased by 138 percent between 2007/08 and 2010/11. Most of the increment came from households whose contributions grew by 116 percent. In fact, households finance 34 percent of the Ethiopian health sector. However, they are burdened by high out-of-pocket costs that usually are incurred at time of sickness. Consequently, the ongoing health insurance initiative is timely and commendable.

- Community-Based Health Insurance (CBHI): targeted for the informal sector, CBHI intends to cover more than 83 percent of the population. It is currently at the pilot implementation stage that began in 13 selected districts (with 1.45 million people) in the four biggest regions: Amhara, SNNPR, Tigray, and Oromia. (we need to include an evaluation of the initiative up to date, showing how it is contributing to sustainability and also include a projection)

- Social Health Insurance (SHI): SHI is a mandatory health insurance program that will be implemented for categories of formal sector employees. It will be financed from payroll/pension contributions made by the employer and the employee, based on a fixed percentage of the income. The main goals of SHI are to improve access to care by reducing out-of-pocket spending, increase utilisation of health facilities, improve quality of care by increasing resources for health facilities and enhancing accountability, and mobilise additional resources for the health sector through collection of contributions/premiums.

Domestic philanthropies

A healthy society will ultimately revert in higher demand for products as greater disposable income would be available. Successful entrepreneurs in Ethiopia will be called to contribute at this historical moment for the Health Sector. The FMoH will advocate mechanisms to foster Corporate Social Responsibility. Moreover, strategies to articulate recognition to those companies supporting the sector should be developed.

Private investment opportunities

According to the regulations, investing on health carries important commercial benefits. It is expected that this strategy will also play a key role on the expansion of infrastructures and the improvement of private wing outsourcing. Private wing has been designed to increase health workers' motivation and reduce attrition of highly qualified medical doctors. Besides, it provides alternative choices of health care for clients, mobilizes additional resources to improve quality of services in the non-private wing sections.

Innovative Financing

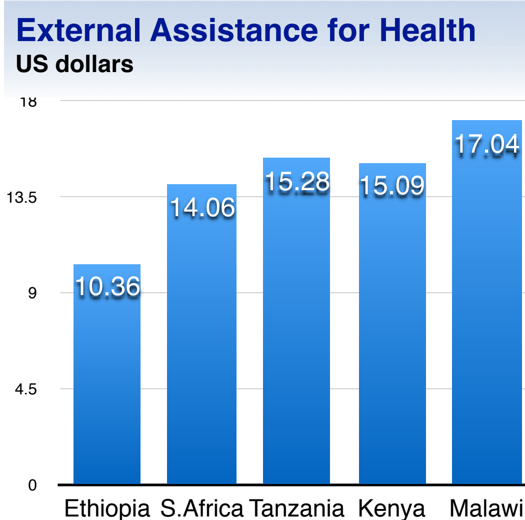
One of the major health financing flagship initiatives is the introducing of innovative financing mechanisms. Within the first two years the feasibility of innovative financing will be explored and if found feasible, implementation is expected to happen after the midterms of the HSTP. The implementation of the innovative financing is expected to contribute to reducing the financing gap. The FMOH is currently focusing on exploring the feasibility of an Airline levy and a Tourism levy.

Efficiency gains

Mainly focusing on procurement, human resources productivity and supply management. The sector will continue to take advantage of bulk procurement that enhance value for money in the next five years. The sector will explore and implement human resource productivity enhancing interventions to ensure that available human resources produce more services than they currently do. The distribution of and management of health commodities will be strengthened to ensure that they are distributed on time, and wastage rates are reduced.

International Partners

Even though Ethiopia is sometimes perceived as overfunded by development partners, the reality is that it receives much less than many other countries in per capita terms. It is precisely for this reason that increasing the international support is crucial at this point. While all the above sustainable sources consolidate, the pursuit of the objectives for the sector calls for a financial push from international partners. The FMoH intends to reach agreements with the existing donors to increase their contribution with a determined time horizon. Those countries who are not participating yet, will also be needed in this process.



Existing international partners | Foreign private institutions | Domestic philanthropies | Government allocation | Efficiency gains

KICK START → SUSTAINABILITY

New international partners | Innovative financing | Private investment opportunities | Insurance mechanisms