The United States Global Health Initiative

Ethiopia Global Health Initiative Strategy

FINAL APPROVED

The U.S. Ethiopia GHI Team

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Guide to Acronyms

ANC	Antenatal Care
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
B/CEmONC	Basic and Comprehensive Emergency Obstetric and Neonatal Care
BPR	Business Process Reengineering
CCMF	Community Case Management of Fever
CDC	United States Centers for Disease Control and Prevention
COP	Country Operational Plan
DHS	Demographic and Health Survey
DSS	Demographic Surveillance Site
EHNRI	Ethiopia Health and Nutrition Research Institute
EmONC	Emergency Obstetric and Neonatal Care
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
FP	Family Planning
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GOE	Government of Ethiopia
HCT	HIV Counseling and Testing
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
HP	Health Post
HSDP	Health Sector Development Plan
ICCM	Integrated Community Case Management
IEC/BCC	Information and Education Communication/Behavior Change Communication
IFHP	Integrated Family Health Program
IPFSMIS	Integrated Pharmaceutical Fund & Supply Management Information System
IMNCI	Integrated Management of Newborn and Childhood Illnesses
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multi-drug Resistant Tuberculosis
MIS	Malaria Indicator Survey
MNCH	Maternal, Neonatal and Child Health
MOFED	Ministry of Finance and Economic Development
MOP	Malaria Operational Plan
MOH	Ministry of Health
NGO	Non-governmental Organization
OP	Operational Plan
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund & Supply Agency
PIMS	Pharmaceutical Information Master System
PLMP	Pharmaceutical Logistics Master Plan
PLHIV or PLWHA	Persons Living with HIV/AIDS

PMI	President's Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
SI	Strategic Information
TB	Tuberculosis
TBD	To Be Determined
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

1. Rationale and Vision for the Global Health Initiative (GHI) in Ethiopia

Building upon the priorities of the Government of Ethiopia (GOE) and the successes of the United States Government (USG) health program to date, the GHI comes at a particularly opportune time for Ethiopia. Coinciding with the launch of the GHI, the GOE has embarked on a new Health Sector Development Program IV (HSDP IV) for 2011 to 2015, which includes new and updated strategic approaches for HIV/AIDS, Tuberculosis (TB), malaria, maternal child health/family planning (MCH/FP), infectious diseases, non-infectious diseases, mental health and health systems strengthening (HSS). Although the GOE has made tremendous progress in the past five years to improve access for millions of Ethiopians to basic health care services, the GOE is particularly concerned over relatively slow progress in achieving Millennium Development Goal (MDG) 5. The GOE has made addressing Ethiopia's persistent and unacceptably high levels of maternal and neonatal mortality its top priority. Under GHI, the USG will therefore prioritize reduction of maternal, neonatal, and child mortality and apply key GHI principles including "smart" integration and coordination, a woman- and girl-centered approach, health systems strengthening, a strong focus on monitoring and evaluation (M&E) and a robust country led approach to find more efficient and effective ways of delivering evidence-based assistance. This accelerated strategy focusing on maternal, newborn and under five mortality reduction will build on the robust program that the USG is currently supporting.

In addition, the USG will continue support to scaling up HIV/AIDS prevention, treatment, and care through the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) and increasing its coverage of high impact malaria interventions through the President's Malaria Initiative (PMI), as well as other existing USG bilateral health programs including those focused on TB. The extraordinary reach of USG-supported programs across Ethiopia as well as its close engagement with the Ministry of Health (MOH), non-governmental organizations (NGOs) and the private sector, provides a unique and promising opportunity to effectively reduce maternal, neonatal, and child mortality in a manner that is fully country-owned and sustainable.

Therefore, the vision for the GHI strategy, as articulated in the country results framework, is to further collaborate with the GOE and other local partners, including NGOs and the private sector, to improve the health status of Ethiopians and specifically the most vulnerable groups of mothers, newborn and children under five. In this vision, GHI/Ethiopia will contribute both to the ambitious GOE goals and the overall GHI goals of reduction in maternal mortality and child mortality by 2015. Utilization of quality health care services will be improved by increasing access to high impact evidence-based integrated health services, improving specific health-seeking behaviors, and improving specific components of the health system that will have the greatest impact on morbidity and mortality outcomes. Reduction of maternal, neonatal, and child mortality is being prioritized in this strategy as these are the top priorities of the GOE and because the USG health team is convinced that it can successfully apply a "whole of USG approach" to these public health issues. Improved effectiveness and efficiencies will be realized through:

- Enhanced support to local and existing well-performing partners;
- Increased integration in planning and implementation of USG-supported activities;
- Improved coordination with other bilateral and multilateral partners;
- Support of systems strengthening across all health programs;
- Increased linkages with other sector programs and "wrap-around" opportunities including, but not limited to, agriculture, education, Feed the Future, and Democracy and Governance;

- A strengthened M&E component with a focus on a GHI Learning Agenda.

2. Background on the Ethiopia Context and Challenges Affecting Health

As Africa's second most-populous country, Ethiopia has a large, predominantly rural, and impoverished population with poor access to safe water, housing, sanitation, food, and health services (see Table 1). These factors result in a high incidence of communicable diseases including TB, malaria, respiratory infections, diarrheal diseases, and nutritional deficiencies. HIV prevalence is highest in urban and transport-corridor settings, being largely driven by lack of awareness, mobility, and high-risk behavior in most-at-risk populations. A high fertility rate and low contraceptive prevalence contribute to an annual population growth rate of 2.6%, one of the highest in the world. The proportion of women using modern family planning methods is on the rise. In 2000 only 6% of women were using modern family planning methods as compared to 32% in 2009. However, high fertility and lack of access to quality services result in high rates of maternal and neonatal mortality. Nearly half a million children under five die every year and, of this number, 120,000 die in the first month of life. Although there has been steady reduction, Ethiopia has one of the world's highest rates of maternal deaths and disabilities in the world at 673 for every 100,000 live births. Over 90% of women in need of a caesarian section are unable to access this service; 19,000 women die from childbirth-related causes every year and it is estimated that over 50,000 women currently suffer from obstetric fistula. Maternal mortality causes include post-partum hemorrhage, infection, eclampsia and obstructed labor. Neonatal mortality causes include asphyxia, sepsis, and prematurity. Neonatal deaths account for 30% of under-five mortality, followed by respiratory infections, diarrheal diseases, and malaria (WHO 2006). Ethiopia also has the 7th highest TB burden in the world with 314,000 cases per year, approximately 20% of whom are also HIV-infected, and 3,000 multi-drug resistant TB (MDR-TB) cases per year (WHO 2008). An additional at-risk population is Ethiopia's 122,000 refugees currently placed in eight formal camps; the numbers of urban refugees is also continuing to grow. Finally, the delivery of health services is seriously undermined by a severe health workforce crisis with health worker density varying from 0.24 to 2.7 per 1,000 population in rural and urban areas, respectively and high attrition of health workers undermining efforts to scale-up their training and deployment.

3. GOE Response

Ethiopia has an overarching "Growth and Transformation Plan" that guides development. The GOE has taken an active role in addressing the country's health challenges. This includes a doubling of the treasury budget for health over the past five years. Because of the increase in development assistance including the Global Fund and PEPFAR, as well as the GOE budget to the health sector, the annual per capita expenditure on health has increased from $7.1 in 2004/5 to $16.1 in 2007/8[1], although this is still well below the World Health Organization's (WHO) recommended $34 per capita. The contribution of the GOE to HSDP IV will increase from $249 million in 2009/10 to $298 million in 2014/15; the 2009/10 contribution is 4.4% of the total national budget.

[1] 4th National Health Accounts; Federal Ministry of Health; April 2010 (2007/2008).

Table 1. Key Health and Population Indicators in Ethiopia

Indicator		Source
Population (2008)	77,812,236	*Projection from 2007 Census*
Proportion of population living in rural areas	84%	*2007 Census*
Per capita income	$232 USD	*2010 National 5 Year Growth Transformation Plan, MOFED*
Life expectancy	55.2 years	*2008 World Bank Development Indicators*
Fertility rate	5.32	*2008 World Bank Development Indicators*
Contraceptive prevalence rate	14% 32%	*2005 DHS* *Last 10K survey 2009 (Oromiya, Amhara, SNNP, Tigrai)*
Unmet need for family planning	34%	*2005 DHS*
Maternal mortality rate	673/100,000 births	*2005 DHS*
Proportion of deliveries assisted by skilled birth attendant	18.4%	*2008/9 MOH Health and Health Indicator Report*
Proportion of health facilities meeting minimum emergency obstetrical and neonatal care (EmONC) standards	11%	*2009 National Emergency Obstetric and Newborn Care Baseline Assessment (MOH, UNICEF, WHO)*
Cesarean section rate	0.6%	*2005 DHS*
Neonatal mortality rate	39/1,000 births	*2009 WHO*
Infant mortality rate	77/1,000 live births	*2005 DHS*
Under-five mortality rate	123/1,000 live births	*2005 DHS*
Stunting	38%	*EHNRI National Nutrition Program baseline 2010*
Orphans and Vulnerable Children	5.4 million (900,000 from HIV/AIDS)	*2010 FHAPCO Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS*
Fully immunized children < 1year	65.5%	*2008/9 MOH Health and Health Indicator Report*
TB incidence (all forms)	378/100,000	*2007 WHO*
Malaria mortality rate	1.9% among inpatients with malaria (5.6% of all inpatients)	*2008/9 MOH Health and Health Indicator Report*
HIV prevalence	2.3% (urban 7.7%; rural 0.9%)	*2007 FHAPCO*
Male circumcision prevalence	93%	*2005 DHS*
PLHIV	1.2 million (60% urban; 40% rural)	*2007 FHAPCO*
PLHIV on treatment	186,154 (62% coverage)	*2010 PEPFAR Semi-Annual Progress Report*
PMTCT coverage (% HIV+ women who receive ARVs)	17%	*2010 FMOH*
Health cadres : population **Doctors** **Health officers** **Nurses** **Midwives** **Health extension workers**	 1 : 36,710 1 : 48,451 1 : 3,928 1 : 57,350 1 : 2,514	*2008/9 MOH Health and Health Indicator Report*
Health posts	14,192	*MOH Annual Performance Report, 2010*

Health centers **Hospitals (public & private)**	2,147 (current); 3,300 (planned) 195	*2008/9 MOH Health and Health Indicator Report*

Many national policies and strategies are in place including the Population Policy, Policy on Women, Policy and Strategy for the Prevention and Control of HIV/AIDS, the Drug Policy, and strategies addressing child survival, nutrition, malaria prevention and control, and reproductive health.

As part of the GOE's recent Business Process Reengineering (BPR) to fundamentally rethink and radically redesign business processes to increase performance outcomes, Ethiopia has increasingly decentralized oversight and management of its public health system to the Regional Health Bureau (RHB) level. Several new institutions were created out of the BPR, including a new regulatory authority and public health institute. The GOE undertook civil service reform to implement BPR in the health sector to establish customer-focused institutions, rapidly scale up health services and enhance the quality of care.

Despite the GOE's tremendous efforts, major gaps still remain - weak health systems including serious health workforce shortages, management issues that cut across national, regional and district levels, poor quality of health services and a large unfunded gap in its estimated budget for achievement of HSDP IV goals -- all of which impact on reducing neonatal, under 5 and maternal mortality. The following are gaps worthy of highlighting:

- The BPR has changed the Ministry of Health (MOH) structure and direct responsibility of specific programs has shifted. While decentralization and reorganization under BPR provides important opportunities for evidence-based programming at the regional and district level, there is an overall need for strengthening in the areas of management, planning, technical and evidenced-based decision-making.

- It is a GOE priority to improve HRH. This involves expanding the number of doctors, midwives, and establishing a post graduate program on integrated emergency surgery for health officers, all of which are critical to reducing maternal mortality. Additional focus on human resource planning, development and management is necessary to ensure that these highly skilled and motivated staff will work and stay in the health sector to provide quality health services. Specific areas of focus include shortening medical education from six to four years by enrolling bachelor degree holders as new entrants, and improving the quality of health training, particularly for midwives, which includes increasing the capacity of instructors, matching job skills to curricula, making greater use of information technology, and standardizing curricula and materials nationwide. The HRH strategy will require development of a costed implementation plan and reaching the ambitious training targets will require massive increases in the number of health worker training institutions and teaching faculty.

- Underpinning the health workforce initiatives and especially to address decreasing maternal and child mortality, there is a need to increase infrastructure and equipment; ensure essential drugs and commodities, including contraceptives, are available; and strengthen and expand blood banks. The execution of these plans is threatened by serious funding gaps.

- While the GOE articulates a strong commitment to engaging the private sector in order to increase access to health services, and while major health strategy documents mention the importance of

working with the private sector, an enabling environment, including clear policies and guidelines to foster real private sector involvement, is lacking. As a result, the private sector in Ethiopia remains underutilized and there are concerns regarding the quality of services provided by the private sector. The private health sector is an important source of health care for many people in Ethiopia, especially those in rapidly-growing urban areas and including the poor. Engaging the private sector to serve those who can and will pay for private health services and ensuring the quality of those services will free up public sector resources to serve those with the greatest need and expand access to critical primary health care services.

4. USG Health Program in Ethiopia

In addition to being the largest recipient of Global Funds, Ethiopia has been among the top recipients of USG health resources in the world with a total FY 2010 funding level of $400 million including PEPFAR, PMI, MCH, family planning, tuberculosis, food and nutrition, and water and sanitation programs. The USG had aligned its program with the current GOE Health Sector Development Program III (HSDP III) and has played an integral part in the development of the HSDP IV. In partnership with the GOE, NGOs and the private sector, the USG has a robust and comprehensive health program that has widespread coverage and many entry points for reaching its GHI targets. The USG Integrated Family Health Program (IFHP) currently supports the GOE's Health Extension Program (HEP) and reaches over 32 million people (40% of the Ethiopian population) in 300 districts in four regions. Through assistance to over 13,000 HEWs and thousands of community volunteers the USG supports the delivery of key MNCH services at the community level including expanded immunization, family planning, essential nutrition actions, integrated community case management (ICCM) of childhood illness, promotion of antenatal (ANC) and PMTCT services, and water and sanitation. This project has been instrumental in assisting the MOH develop and change national policies including use of antibiotics at the community level.

PEPFAR supports the continuum of HIV prevention, care (including TB), treatment and mitigation in all 9 regions and 2 city administration regions with integrated PMTCT in 1,103 hospitals and health centers where antenatal, maternal, and neonatal services are also being strengthened. Antiretroviral Therapy (ART) is provided at 146 hospitals, including all public hospitals, and 386 health centers; as of March 2010, 186,154 individuals were receiving ART. The large Orphans and Vulnerable Children (OVC) program that emphasizes family-centered approaches is reaching over 500,000 of the most vulnerable children in the country and is linking with USAID's Basic Education and Food for Peace Programs to provide a more comprehensive package to OVC. The USG has a long standing fistula program that is reaching 1,000 women and through a multi-sectoral approach is also supporting many activities that address gender based violence and changing harmful traditional practices like female genital mutilation. Ethiopia is a PMI focus country and is concentrating its program in the populous Oromiya Region (27 million people), where three quarters of the population is considered endemic for malaria transmission. PMI is providing long lasting insecticide treated nets (LLITNs), indoor residual spraying and Artemisinin-based Combination Therapies (ACT) to this population. PMI also provides overall policy and system support as well as training and communications materials to benefit the country as a whole.

In addition, the USG is investing significant resources in strengthening health systems to respond to public health threats by contributing to the MOH's commodity logistics, public health emergency management system, health management information systems, laboratory systems, human resources,

and health facility and laboratory infrastructure. The USG has been investing for years in health financing reforms that have resulted in health facility retention of fees, national health accounts surveys and current piloting of community and social insurance. The USG builds the capacity of public and private health science and social work educational institutions to deliver quality pre-service education by supporting curriculum and faculty development and renovation and equipping of educational institutions, labs and field sites. The USG also supports extensive in-service education for health professionals including medical doctors, health officers, nurses, lab and pharmacy technicians, case managers and kebele-oriented outreach workers. The USG has engaged the private sector in provision of counseling testing, TB/PMTCT services, is strengthening the capacity of private sector representative bodies and is working towards supporting DACA in establishing a licensing and accreditation process for private providers based on clinical and management quality standards.

The USG, through PEPFAR funding provides additional assistance to refugee populations and the uniformed services, which includes prisons, police and the military. Of all PEPFAR Country Teams, Ethiopia's has been the strongest supporter of prevention, treatment, and care programs with refugee populations. Through the Department of Defense and other partners, the USG has also provided significant support for prevention, care and treatment within the uniformed services.

Through GHI, the USG will also continue to increase the capacity of the GOE to deliver health services through existing mechanisms and including possibly through reimbursement to the GOE for agreed health expenditures.

The USG also brings other sector development programs including education, food security and livelihoods to address the underlying causes of poor health. The USG has had a strong history of "wrap-around" programs linking food assistance with OVC, HIV/AIDS treatment and care programs, as well as linking education with HIV/AIDS, water/sanitation, micronutrient supplementation and education for behavior change. Plans are underway to link several Feed the Future agricultural and pastoralists programs with the provision of health services in the most food insecure regions.

5. Country-led Five Year USG/GHI Strategy, Priorities and Targets

The current HSDP IV provides overall strategic direction and program priorities for Ethiopia's achievement of the MDGs. HSDP IV is a product of intensive and substantial consultations between the MOH and Development Partners. HSDP IV prioritizes maternal and child health (MCH), prevention of communicable diseases, and health systems strengthening (HSS). The major vehicle for the implementation of the HSDP IV is the Health Extension Program (HEP) that promotes primary health care at the community level. There has been considerable progress in rolling out HEP through strong GOE leadership and remarkable support from Development Partners including the USG. More than 32,000 health extension workers (HEWs) and 3,000 HEW supervisors have been trained and deployed with recent expansion to urban areas. The number of hospitals and health centers has quadrupled from 645 in 2004 to 2,884 by 2009; over the same period the number of health post increased almost five-fold. The HSDP IV prioritizes several on-going and new HSS initiatives including the Pharmaceutical Logistic Master Plan, the Laboratory Master Plan, the Health Management Information Reform Scale-up, Public Health Emergency Management, Health Sector Financing Reform and Health Insurance, and the

Human Resource for Health (HRH) strategy. The private sector is expanding with a larger network of service providers and will be an important complement to the public arena.

Woman- and Girl-centered Approach: Using a new approach to an ongoing activity, GHI will take a more comprehensive life cycle approach to addressing the health of women and girls and work across development sectors including education and food security. Through GHI, a number of USG programs will be linked including PEPFAR, FP/RH, MCH, and other sector programs including education, food security, and democracy and governance to promote women's active participation and leadership in the health arena as well as addressing issues around promoting girls' education, prevention of early marriage, delayed sexual debut, female genital cutting, and gender-based violence. FP/RH services will be expanded and integrated into HCT, PMTCT and HIV care and treatment programs. Utilization of ANC and PMTCT programs will be increased by improving quality of services and increasing community mobilization. The quality and utilization of labor and delivery services will be increased through pre-service training of midwives and emergency surgery officers, improving facilities and blood supply and ensuring that needed commodities and equipment are in place. In addition, new Feed the Future activities will focus on women as key agricultural producers with the objective of increasing their income and food supply.

Quality of health services:

GHI in Ethiopia supports a focus on the creation of a quality health system that satisfies the community's health care needs, delivering safe and optimum quality of health services in an integrated and user-friendly manner. The results framework is based on the evidence that increased utilization of quality high impact services supported by strong systems is necessary for reducing maternal, neonatal and child mortality and for decreasing incidence of key communicable diseases. Health service delivery in Ethiopia is characterized by an inadequate number of well trained health providers (particularly midwives, doctors and emergency surgical officers), limited health infrastructure, inadequate space, shortages of equipment and commodities at health facilities and weak health systems which results in low service utilization. Access to and demand for services is affected by geographical, financial and cultural barriers, poor care seeking behaviors, organizational and management issues that impact on effective referrals. Although the GOE has made tremendous progress in developing state-of-the-art health policies and expanding both its physical infrastructure and availability of HEWs in rural areas, utilization of key quality services such as antenatal care, PMTCT, labor and delivery remains particularly low. The objective of the GHI strategy is to increase the use of quality health services to reduce maternal, neonatal and child mortality with an emphasis on the continuum of care for mothers and children that follows a life cycle approach. This includes FP/RH services, ANC, PMTCT, providing BEMONC/CEMONC for labor and delivery services including resuscitation of newborns, promotion of kangaroo mother care, immediate initiation of breastfeeding, expansion of IMCI, expanding facilities and selected health cadres, HSS improvements, and behavioral change and demand creation to achieve population-level impact in use of services.

Progression towards the "Three Ones" will take place through USG participation in the Woreda Based Health Sector Planning. In addition, the USG will provide ongoing support to the rollout of HMIS and work with the GOE to harmonize reporting systems. The USG will also provide information on their investments in the health sector.

This section describes the Results Framework in Appendix 1 including draft indicators and new activities under GHI. It includes attention to GOE focus on certain critical programs, such as PMTCT, increased skilled attendants at delivery and increased TB case detection. A summary of potential GHI targets, GOE targets in HSDP IV, key strategies, and partners is included in Appendix 1.

Overarching USG Goal: Improved Health Status of Ethiopians

5. 1 GHI Goal: Decreased Neonatal, Under-five and Maternal Morbidity and Mortality and Reduced incidence of communicable diseases (HIV, TB and malaria)

The GHI strategy will directly support the GOE's HSDP IV priorities to reduce the very high maternal, neonatal and child deaths prevailing in Ethiopia. This is the GHI emphasis area for accelerated impact notwithstanding continued support for comprehensive HIV and AIDS, TB and malaria programs. The strategy will build on existing programs and apply key GHI principles that will accelerate achievement of selected targets. The two main development hypotheses are: a) "smart" integration of health programs both at the health facility and community levels will help increase efficiencies and effectiveness; and b) interventions to strengthen health systems will ensure sustainability of results. Given the large population coverage of the USG programs, GHI will allow the USG to significantly contribute to the following GOE targets that are related to this goal:

GOE Five-Year Targets:

- Reduced Maternal Mortality: 673 to 267/100,000 live births
- Reduced Under-Five Mortality: 123 to 67/1,000 live births
- Reduced Neonatal Mortality: 39 to 15/1000 live births
- Reduced HIV incidence by 50%
- Reduce mortality rate due to all forms of TB by 50%
- Reduce malaria morbidity and mortality by 50%

5.2 Intermediate Goal: Increased Utilization of Quality Health Services

The results framework is based on the evidence that increased utilization of quality high impact services supported by strong systems is necessary for reducing maternal, neonatal and child mortality and decrease the incidence of key infectious diseases. Health service delivery in Ethiopia is characterized by poor quality resulting in very low service utilization. Lack of well trained health providers (particularly midwives, doctors and emergency surgical officers); a very limited physical health infrastructure; inadequate space; shortages of equipment and commodities at health facilities; and weak health systems has resulted in low service utilization. Access to and demand for services is affected by geographical, financial and cultural barriers; poor care seeking behaviors; and organizational and management issues that impact on effective referrals. Although the GOE has made tremendous progress in developing state-of-the-art health policies and expanding both its physical infrastructure and availability of HEWs in rural areas, utilization of key quality services such as antenatal care, PMTCT, labor and delivery remains particularly low. The objective of the GHI strategy is to increase the use of quality health services to reduce maternal, neonatal and child mortality with an emphasis on the continuum of care for mothers and children that follows a life cycle approach. This includes FP/RH services, ANC, PMTCT, provision of BEmONC and CEmONC, labor and delivery services including resuscitation of

newborns, promotion of kangaroo mother care, immediate initiation of breastfeeding, expansion of IMCI, expanding facilities and selected health cadres, HSS improvements, and behavioral change to achieve population-level impact in use of services. (Examples of innovative GHI approaches are outlined in Section 6). GHI will allow the USG to significantly contribute to the following GOE five-year targets that are related to the intermediate goal:

GOE Five-Year Targets:

- Increased Contraceptive Prevalence: 32% to 65%
- Increased percentage of fully immunized children under 1 year: 66% to 90%
- Increased percentage of women who deliver with a skilled birth attendant: 18.4% to 60%
- Increased percentage of pregnant women and children under 5 who slept under LLITNs the previous night: 42% to 86%
- Increased percentage of HIV-positive women who receive ART to reduce MTCT: 25% to 67%
- Provision of ART to 484,966 people

5.3 Results Framework Pillars

The achievement of the goal and objective of the strategy is dependent on the combined success of three highly interdependent pillars: a) Improved access to health care services; b) Increased demand for health services; and c) Improved health systems. Specific investments in all three areas will accelerate achievement of the targets. The three pillars include key principles of the GHI, specifically a more integrated and coordinated approach both at the service supply and demand sides and an emphasis on systems strengthening to ensure sustainability. The Ethiopia team will develop an operational plan that will translate the results framework pillars into coordinated implementation by reviewing on-going programs across the pillars and formulating plans to enable synergy and efficient use of resources. To inform a better understanding of where agencies and programs are operating, a series of maps will be developed which build upon information already available with USAID MCH, PMI and PEPFAR programs. Building on regional presence through ongoing presence of USG partners, USAID health and other development programs, and frequent interagency site visits, the USG through PEPFAR COP 2011 funding will embed USG interagency teams within regional health bureaus or regional laboratories in two of the major regions (Oromiya and Amhara) that together represent more than half of the Ethiopian population. These initial placements will be monitored and evaluated, and if found to favorably impact local capacity building, will be expanded to two additional regions within a year.

Pillar I: Improved Access to Health Care Services

USG investments will support four sub-results: a) Increased availability of integrated MNCH services; b) Increased availability of prevention, care and treatment services for diseases of public health significance (e.g. HIV/AIDS, TB, malaria, respiratory infections, diarrheal diseases); c) Strengthened referral linkages; and d) Increased access to essential community-based services through the health extension program. Through Pillar I, evidenced based high impact interventions will be supported by the USG with an emphasis on quality and scaling-up the following illustrative activities:

1. Integrated FP/RH/HIV services will be provided in all USG supported sites and integrated into HCT, PMTCT, ARV services ;
2. Integrated Community Case Management (ICCM) of Illness including pneumonia, diarrhea and malaria-using multi-species Rapid Diagnostic Tests (RDTs) will be rolled out in all USG supported districts and health posts. ;
3. Integration of PMTCT, ANC and maternal, neonatal, and child health services, including nutrition, will be improved in all health facilities ;
4. Provision of quality HIV/AIDS care, treatment and support services including ART which will be increased from 62% to 80% of all those eligible for treatment, of whom the majority are women;
5. Community linkages to facilities will be improved in all HIV/AIDS, MCH, FP programs;
6. Labor and delivery services will be expanded and quality improved, including emergency obstetrical and neonatal services and pre-service training of midwives and emergency surgical officers will be supported;
7. LLITNs will be distributed to pregnant women and children under five and pre-service training for management of acute malaria and anemia in pregnant women will be supported and integrated into the Focused Antenatal Package. In addition IRS programs will be supported including pre-service training for extension workers, and all materials.
8. Strengthen the implementation of the TB three" I's" and support the scale up plan for MDR-TB.

GHI will allow the USG to significantly contribute to the following GOE five-year targets that are related to Pillar I:

GOE Five-Year Targets:

- Increased percentage of pregnant women receive at least one-ANC visit: 66% to 90 %
- Increased percentage of HIV-positive pregnant women and their infants who received ART to reduce the risk of MTCT: 8% to 62%
- Increased proportion of health centers (5% to 100%) and hospitals (51% to 100%) which meet the criteria for basic and comprehensive obstetric and neonatal services
- Increased percentage of households with at least one LLITN: 66% to 96%
- 100% of suspected malaria cases diagnosed with RDTs and/or microscopy within 24 hours of onset of fever
- Increase proportion of pregnant women and U5 children who slept under LLTN on previous night from 42.5% to 86% and from 41.2% to 86% respectively
- Increased proportion of children under 5 with pneumonia who received antibiotics at community level from health extension workers: 0 to 41%
- Increase TB case detection rate from 34% to 75%
- Increase TB cure rate from 67% to 85%

- Increase the proportion of PLWHAs screened for TB from 15% to 80%

Pillar II: Increased Demand for Health Services

USG investments will impact increased demand for health services through an emphasis on three sub-results: a) Increased appropriate healthy behaviors; b) Expanded health promotion; and c) Increased knowledge and improved attitude toward health seeking behaviors, including creation of an enabling environment through intermediate structures such as the workplace, family, church, and social groups. The USG will primarily seek to achieve these results through to the GOE's HEP. Which will serve as a primary vehicle for prevention, health promotion, behavioral change communication and basic curative care through effective implementation of the 16 basic packages The USG program will identify successful interventions at the community level that reinforce and expand positive health behaviors including community conversations, "child-to-child" school health programs, model families, and other behavior change activities, including supporting the efforts of the MOH in the establishment of women-centered health development teams at village level. The USG's focus on this Pillar II will include the following illustrative activities:

- Support the MOH at the national level to strengthen its capacity to develop innovative IEC/BCC strategies, harmonize tools, and develop consistent messages using interpersonal and mass media approaches;
- Standardize messages and roll out community-based approaches with a focus on reduction of harmful traditional practices including prevention of early marriage, delay in sexual debut, female genital cutting, and gender-based violence;
- Promote increased use of ANC and PMTCT services, birth preparedness and complication readiness, promotion of breastfeeding, kangaroo mother care, neonatal care, promotion of breastfeeding, and safe water use;
- Promote the community HEP with a focus on promotion of MNCH including water and sanitation, expanded immunization, the Essential Nutrition Action package of interventions (vitamin A, iodine, breastfeeding, appropriate complementary feeding, care of the sick child and women's nutrition), and positive living for PLWHA; and
- Support the establishment of women centered health development teams. A family-focused approach will be utilized that includes targeting elders to facilitate improved care seeking behavior. The HEW and community volunteers are critical in achieving this objective.

GHI will allow the USG to significantly contribute to the following GOE five-year targets that are related to Pillar II:

GOE Five-Year Targets:

- Increased percentage of sexually active women who have ever tested for HIV: (TBD)
- Increased percentage of pregnant women who can identify pregnancy danger signs: (TBD)
- Increased Couple Years of Protection: (TBD)Reduce the prevalence of anemia in women of childbearing age (15-49) from 27% to 12%

- Increased proportion pregnant women supplemented with Iron during their pregnancy from 10% to 86%
- Increased proportion of children under 5 years with fever seeking treatment within 24hours: 15% to 85%
- Increased number and percentage of women and children reached through targeted prevention programs: (TBD)
- Increased exclusive breastfeeding of infants to 6 months of age: 49% to 70%
- Decreased wasting prevalence among children under 5 from 11% to 3%; and stunting prevalence from 38% to 28%
- Increased proportion of infants of 6 -9 months introduced to complementary food & continuation of breastfeeding from 54% to 65%
- Increased proportion of children in the age group of 6-59 months given vitamin A supplements every 6 months from 94% to 96%
- Increased proportion Children 2-5 years receiving deworming every 6 months from 86% to 96 %
- Increased proportion of households using iodized salt from 4% to 95%.
- Increased proportion of model households graduated through HEP from 25.6% to 85%

Pillar III: Improved Health Systems

GHI investment will impact improvements in health systems through coordinated investments in the six health systems elements and across USG funding streams, specifically through: a) Strengthened HRH; b) Expanded health financing options; c) Strengthened strategic information (SI) for evidence-based decision making; d) Increased health commodity and essential drug security; e) Improved health infrastructure and laboratory systems for service delivery; and f) Strengthened policy, planning and governance.

The GHI will focus on the key elements of systems where the USG has a comparative advantage and will strengthen the functioning of the health care system to particularly address issues facing MNCH services. The USG will build on its work already underway through PEPFAR, PMI, MCH/FP, and other programs. In order to improve the utilization of quality health services in a sustainable manner, it is essential to ensure the efficient and rational allocation of human, financial, and other health resources.

Through GHI, the USG will support components of health systems strengthening identified below with some indicative indicators, further expanded under Appendix 1 :

3.1 Human Resources Development:

The USG team will support GHI principles by addressing key HRH bottlenecks. A particular focus will be on improving the supply and quality of midwives, currently less than 2,000. Building on existing partnerships, including direct-funding cooperative agreements with local universities, the GHI will also support capacity building for the training of other cadres that are essential for improving emergency maternal and neonatal services including health officers and doctors trained in emergency obstetric care.

Illustrative Interventions

- Support the implementation of the new GOE HRH strategy and focus on the pre-service training and retention of midwives, emergency surgery officers, anesthesia professional, and doctors to improve ANC, labor and delivery, and EmONC services;
- Support the GOE in testing and implementing strategies, including non-monetary incentive schemes, to improve health worker retention and maximize performance.
- Implement a new HRH project that will focus on policy, strengthening of educational institutions and faculty, retention, recruitment and deployment issues;
- Support the establishment/expansion of innovative technology assisted medical and health science strengthening program

3.2 Health Care Financing

The ultimate outcome is to ensure that adequate resources are mobilized from internal and external sources, there is equitable resource allocation, greater improvement in the resource absorptive capacity and decreased wastage of resources.

Illustrative Interventions:

- Support the consolidation of health care financing reforms through fee retention and use at the facility level as well as the expansion of private wings to generate hospital and practitioner revenues, training hospital CEOs in administrative and fiscal management
- Support the enhancement of wavier and exemption system
- Support the GOE in the establishment and implement expanding national health insurance l and community based health insurance

3.3 Health Management Information Systems

The USG will continue to support strengthening evidence-based decisions to address the critical health problems at all levels of the health system in support of HSDPIV. This includes such activities as support at all levels of the health system in the HMIS rollout, support for population-based demographic surveillance and surveys, the development of a new generation of field epidemiologists and public health leaders (health information technicians (HITs), masters training in M&E and biostatistics/health informatics and FLETP). With USG support, it is envisaged that the GOE will consolidate this into one health information system.

Illustrative Interventions:

- Support the development, consolidation and scaling up of the new Health Management Information system in all 9 regions and 2 city administrations the private sector and ensure the system will support the continuum of care;
- Support the generation and use of strategic information in the context of health systems strengthening
- Support the institutionalization of comprehensive M&E system at all levels

3.4 Pharmaceutical Supply and Services

The GHI strategy will allow for expanded support to the GOE Pharmaceutical Logistics Master Plan (PLMP). GHI will invest in infrastructure, training, technical assistance and transport support. Specifically, GHI will improve GOE ability to forecast, quantify, procure and distribute essential health commodities and pharmaceuticals.

Illustrative Interventions:

- Support the development of the new GOE Integrated Pharmaceutical Fund and Supply Management Information System (IPFSMIS)
- Support Pharmaceutical transportation, storage and inventory control system

3.5 Improved Health Infrastructure

The USG will contribute towards improvement of health infrastructure such as expansion of health facilities, upgrading of health centers to the primary hospitals, improve the quality of laboratory systems and support the MOH in the national blood transfusion service.

3.6 Policy and Governance/Improved regulatory system

The USG will support the strengthening of the regulatory systems which will promote safety in the delivery of health services, products and practices, improve professionalism amongst health workers, implement regulations concerning institutional solid and liquid wastes disposal.

Illustrative Interventions:

- USG will support establishing an enabling environment, including the establishment of clear policies and guidelines, for broadening private sector engagement and improving GOE stewardship and oversight of the private sector by supporting the licensing and accreditation of private providers.
- Support the MOH to assume management responsibility for the National Blood Transfusion Service from the Red Cross.

GHI will allow the USG to significantly contribute to the following GOE five-year targets that are related to Pillar III:

GOE Five-Year Targets:

- Increased number of new health workers trained including midwives, health officers and doctors trained in EmONC: (TBD)
- Increased percentage of facilities retaining user fees: (100%)
- Increased percentage of individuals covered by health insurance: (20%)
- Increased percentage of health facilities using new HMIS: (100%)
- Decrease procurement lead time from 240 days to 120 days
- Increased percentage of facilities without a stock-out of essential drugs in past 3 months: (TBD)
- Reduce % of stock waste out due to exp[iry from 8% to 2%
- Increased percentage of facilities with family folders: (TBD)

6. Approaches in Ethiopia that Demonstrate GHI Principles

Integrated Community Case Management (ICCM) of Childhood Illness

The GHI Strategy will support the MOH to implement its new policy on treating children with fever at the community level with antibiotics and effective anti-malarials. The new policy focuses on treating the leading causes of death in children -- pneumonia, diarrheal diseases and malaria -- through an integrated approach. **In a new activity**, the Integrated Family Health Project (IFHP) with both MCH and PMI funds will train approximately 13,000 HEWs in over 300 districts to use the new rapid diagnostic multi-specie test that will determine definitively if the fever is malaria or another infection. Based on this information, HEWs will be able to treat fever with more precision than has occurred in most other community-based programs. With the recent new guidance allowing HEWs to administer cotrimoxazole for pneumonia, the USG will develop new curricula, conduct training and increase MOH capacity to implement and supervise this new ICCM approach at the community level. As many children are not taken to health facilities for treatment, the important rollout of this innovative integrated program will contribute to significant reductions in under-five mortality over the next five years.

Coordination with UN 4+ on PMTCT, Maternal and Newborn Health

In a new activity, a collaboration agreement will be signed between the UN4+ (UNICEF, UNFPA, WHO,

UNAIDS, World Bank) and the USG - the lead technical partners for PMTCT- to expand and improve the quality of PMTCT services in Ethiopia. A major focus will be to improve the continuum of care for mothers that will include expanding reproductive care and family planning services, improving antenatal care, delivery and post partum care. The agreement will include both policy and norms setting with a major emphasis coordinating programs at local levels.

Coordination between the Global Health and Feed the Future Initiatives on Nutrition

USG will continue to use its existing health, agriculture, humanitarian assistance and livelihood sector platforms to maximize impact on nutrition. Both prevention and treatment of malnutrition will be the focus of the different interventions for an integrated response. In prevention, resources will be used to strengthen the promotion of essential nutrition actions with a strong focus on behavior change at both the community and health facility level under IFHP. Support to the National Community-based Management of Acute Malnutrition Program and monitoring system will be strengthened to ensure that adequate and comprehensive emergency response and treatment services are readily available.
Under the Feed the Future Initiative, nutrition is now an integral part of new agriculture and livestock programs including additional resources to strengthen nutritional monitoring. Given the presence of the IFHP program in the four most populous regions of Ethiopia, agriculture programs will coordinate with IFHP and use this platform to monitor the impact of value chain activities on the nutritional status of households. In addition, the new capacity building activity will include the training of change agents such as agriculture health extension workers on essential nutrition actions to maximize reach with nutrition messaging to communities.

Health Systems Strengthening: Human Resources for Health (HRH)

In a new activity, the USG team will support GHI principles by addressing key HRH bottlenecks to achieving MNCH goals. A particular focus will be on improving the supply and quality of midwives using a systems approach. Currently Ethiopia has fewer than 2,000 trained midwives; the GOE target is 7,200 by 2015. The USG will expand support to midwifery training through both MCH and PEPFAR programs and is establishing a new project specifically to address overall policy, strengthening of educational institutions and faculty, retention, recruitment and deployment issues. Building on existing partnerships, including direct-funding cooperative agreements with local universities, the GHI will also support capacity building for the training of other cadres that are essential for improving emergency maternal and neonatal services including health officers and doctors trained in emergency obstetric care.

Health Systems Strengthening: Commodity and Logistics Systems

In an ongoing but expanded activity, the GHI strategy will allow for expanded support to the GOE Pharmaceutical Logistics Master Plan (PLMP). Currently a central supply chain system for HIV/AIDS commodities is functioning at the central and regional levels. In the next five years, GHI will support the integration of other commodities for TB, malaria, laboratories and other essential medicines into one joint network. GHI will invest in infrastructure, training, technical assistance and transport support. Specifically, GHI will improve GOE ability to forecast pharmaceuticals based on consumption, undertake

proper quantification, make international procurements, improve the distribution network that spans across hospitals and health facilities; improve rational drug use, improve logistics reporting with implementation of the integrated Pharmaceutical Information Management System PIMS, and improve biohazardous waste management.

Health Systems Strengthening: Health Financing

In an ongoing activity, the USG has been the lead donor in helping the GOE develop and implement innovative financing approaches. Retention of fees at the facility level has been a cornerstone of USG's efforts and currently 86 hospitals and 1086 health centers are retaining fees that are used for improvements in quality of services. Under GHI, the USG will assist the GOE to increase its ability to improve resource mobilization and utilization. Given the large gaps in funding particularly for achieving MDG 5 and 6, GHI will assist the GOE rolling out community health insurance and expanding national health insurance, increase the sustainability of hospitals by opening private wings, outsourcing clinical services, and improve financial information for decision making by financing national health accounts, costing analyses and other financial surveys. The USG will also continue to support training for chief executive officers who are tasked to implement these reforms at the site level. PEPFAR, MCH and FP funding will be used to support this critical program.

Improving Monitoring and Evaluation: Human Resources

One of the legacies of GHI will to be to leave behind a critical mass of Ethiopian public health officials who generate and use appropriate data to drive decision-making at the federal, regional, and district level both in the public and private sectors. In an ongoing activity, the USG has been the lead partner in supporting the MOH to create new cadres for its public health workforce, including the introduction of 9,000 new GOE health information technicians (HITs), a new training program in field epidemiology modeled after CDC's Epidemic Intelligence Service that will create a new generation of field epidemiologists and public health leaders and Masters in M&E and biostatistics. The USG is also the main supporter of the new country-owned health management information system (HMIS) which will be largely operationalized by the HITs at facility level. In a new activity, the public health institute of Ethiopia, EHNRI, has recently embarked on establishing a USG-supported Public Health Emergency Management Center to use data from new and improved surveillance systems to respond to epidemics and public health threats as they emerge. These systems will be enhanced to monitor progress in achieving GHI goals.

Improving Monitoring and Evaluation: Data for Decision Making

In an ongoing but expanding activity, the USG is supporting MOH colleagues at the regional and health facility level to use HMIS data for program performance improvement; for example, in PMTCT performance to improve the uptake of pregnant women and HIV-exposed infants at the various stages of the complex cascade. This approach resulted in a 20% to 82% increase in HIV-positive pregnant women completing ARV prophylaxis, a decrease in the turnaround time for CD4 results for HIV-positive

pregnant women from one week to one day, and an increase in male partner testing at the time of delivery from 7% to 31% at various facilities. The USG is also supporting six local universities to conduct population-based demographic surveillance covering 100,000 households in the absence of any vital registration system in Ethiopia. This will prove invaluable in monitoring community events related to morbidity and mortality that go undetected within the health care system. All of these USG-supported systems will be available to be enhanced to monitor GHI performance and evaluate impact.

Fostering Country Ownership to Achieve Sustainability

True ownership is achieved when a country assumes responsibility and accountability for addressing its public health challenges. In addition to close and flexible alignment of USG-supported programs with national plans and priorities, country ownership is also enhanced through giving local partners the opportunity to have a greater say in decision-making in how USG programs plan and utilize funds. Though the USG is not a signatory to Ethiopia's International Health Partnership+ or other local pooled-funding mechanisms, it does have programmatic direct funding agreements with a large number of local public and civil society partners through Cooperative Agreements to implement a wide range of programs. These ongoing and expanding agreements specify the collaborative relationship between the USG and the local partner and are closely monitored for progress. Examples of Ethiopian partners include the MOH, EHNRI, local universities, professional associations, and sub-agreements with regional health bureaus, all of whom are leading partners in the country for addressing maternal, neonatal, and child mortality. Efficiencies will also be achieved during GHI since these mechanisms have lower administrative costs and local partners are well-positioned to leverage USG funds with those of other development partners and the GOE's own funds.

7. Monitoring and Evaluation (M&E)

The results framework for the GHI seeks to decrease neonatal, under-five and maternal mortality through a three-pillared strategy. While the GHI team will utilize the cross-cutting indicators to be developed by headquarters, it will report on selected country-level indicators from existing GOE systems as much as possible. Where there are gaps, the USG will utilize implementing partner service statistics to monitor progress on the building blocks of the results framework. The 2010 Demographic Health Survey-Plus (DHS+) will collect population-based data in late 2010 and will serve as the primary baseline information, including neonatal, under- five, and maternal mortality levels. The next DHS+ will be conducted in 2015 and will serve as the best source of data for comparison purposes to measure the impact of GHI on a range of morbidity and mortality outcomes following at least five years of implementation. Shorter-term impact measurements will be considered through making use of USG-supported demographic surveillance sites (DSS) and special studies in partnership with EHNRI.

The HMIS will serve as the primary source of information for most of the indicators related to service utilization and the USG will continue to support the MOH to roll-out its system and maximize use of data for decision making. Specific surveillance systems under the leadership of EHNRI will also be utilized for selected indicators, such as HIV, TB, malaria, nutrition, and vaccine-preventable diseases. The M&E framework for GHI will follow the pillars and building blocks of the GHI Results Framework.

The M&E framework for GHI will follow the pillars and building blocks of the GHI results framework. The HSDP IV serves as a preliminary but important guide to align GHI indicators with those of the MOH and key HSDP IV indicators and targets indicated in Section 5. The success or failure of GHI is contingent on a number of critical assumptions, including continued MOH commitment and sustained leadership, continuation of USG, Global fund and other donor resources at projected levels and GOE commitment to expand and improve the quality and retention of health workers.

8. The GHI Learning Agenda

The following outline some preliminary ideas on the learning agenda to be considered in Ethiopia, recognizing the need to consult the GOE and further within the USG team. The basis for the Learning Agenda is the GOE's Health Strategic Development Plan IV. The USG/E GHI Team will focus on several components that can demonstrate how GHI can be applied as a model for improving USG efficiency and effectiveness. These include:

1. HSDP IV strategic objective 13: Improve Human Capital and Leadership

2. The MOH efforts to reduce maternal/neonatal mortality

3. HSDP IV strategic objective 4: Maximize Resource Utilization

The following broad learning agenda areas require further technical assistance consultations and streamlining.

1) HEALTH WORKFORCE PRODUCTION AND RETENTION

PROBLEM STATEMENT: Ethiopia is one of 57 countries considered to have a health workforce crisis. The crisis in Ethiopia is characterized by an absolute lack of trained health workers, an imbalance over the number of different HW cadres, a severe "brain drain" of health workers to more developed countries that offer better compensation, and a poorly motivated health workforce.

The HSDP-IV is attempting to address the health needs of the population and increase access to health services through a highly-integrated approach. An ambitious plan to increase the number of health service providers is underway. In 2009, the GOE made forays into civil service reform by implementing Business Process Reengineering (BPR) in the health sector to establish customer-focused institutions, rapid scaling up of health services and enhancing the quality of care in order to improve the health status of the Ethiopian people. The BPR identified eight core processes:

- Health Care Delivery
- Public Health Emergency Management
- Research and Technology Transfer
- Pharmaceutical Supply
- Resource Mobilization and Health Insurance
- Health and Health Related Services and Product Regulation
- Health Infrastructure, Expansion and Rehabilitation

- Policy, Planning, Monitoring and Evaluation.

In addition five support processes were designed: Human Resources Development and Management; Procurement, Finance, and General Service; Program-Based Audit; Public Relations; and Legal Services. The Human Resources for Health (HRH) five year strategic plan is under development and is a high priority for the MOH. The learning agenda will help to inform the HRH strategy

The learning agenda will address some of the following questions and could be comprised of survey and pilot schemes. The USG and its implementing partners also employ a large number of Ethiopian health workers so we would also look internally to see how best the USG can support the GOE through our own human resources practices (e.g. secondments, internal compensation strategies, etc.)

The USG has identified the following topics that warrant further exploration:

- Effective strategies, including non-monetary ones, that the GOE can employ to improve the retention and maximize performance of the trained health service providers within the HRH strategy. Implement a pilot that develops and evaluates innovative strategies to retain a particular cadre of health workers.
- Explore the possibilities and the potential of engaging the private sector and civil society to assist the GOE with retention issues.
- Evaluate how the GOE can increase production of new HWs, e.g. medical doctors and recruit and retain instructors, while at the same time maintaining quality of education. Explore the impact of the new problem-based learning approach on preparation for clinical service upon graduation.
- Evaluate the linkages between system investments and health impact (see more on Sarah's example)

2) **MATERNAL HEALTH**

The roll-out of the Health Extension Worker Program (HEP) provides opportunities to better link communities and health facilities. Health Extension Workers (HEWs) are primarily women. Thus building on one of the principles embodied within GHI, a women- and girl- centered approach, possible learning agenda topics could include:

- Explore the role of HEWs in bridging a link between community and facilities to increase demand for maternal health services (e.g. FP, ANC). Evaluate the range of maternal health services that can be effectively delivered by HEWs in the communities.
- Assess facility-based deliveries to identify factors that have been instrumental in women's attendance, particularly for those delivering in a facility for the first time.
- Explore best practices in rapid scale-up and delivery of Emergency Obstetric and Newborn Care (EmONC)
- Evaluate impact of facility-based training for HEWs encompassing labor and delivery rotations

3) INCREASING RESOURCES EFFECTIVENESS AND EFFICIENCY – resources and financing in general

At the Joint Assessment of National Health Strategies (JANS) Conference held from July 12-14, 2010 in Addis Ababa, the GOE stressed the importance of aligning the various donor financial systems to the GOE financial system by supporting the HSDP-IV with one plan, one budget and one reporting

system. The Ministry of Health (MOH) has taken some initial steps to address barriers to achieving this by conducting a costing of the HSDP-IV by using Marginal Budgeting for Bottlenecks (MBB), which will estimate the extra efforts and resources needed to reach the MDGs. The most significant constraints against rapid scale up of health interventions are the prevailing inadequacy and inefficiency in the allocation of health resources.

There are currently three channels of funding in the health sector in addition to the Technical Assistance Pooled Fund (managed by UNICEF), the MDG Performance Fund (initially supported by GAVI and managed by FMOH), channel two earmarked funding managed by the MOH (e.g. Global Fund) and channel three which includes the USG who funds the GOE through a series of Cooperative Agreements to specific institutions for project-related activities. The GOE preferred modes of funding are mainly block grants to woredas and the MDG Performance Fund (pooled fund). However, there has been poor subscription to these modes by many development partners and the GOE has developed procedures that will realize the 'financing of one-plan' concept. The USG will need to justify its approach to funding the health sector and align itself with the procedures.

Health Care Financing and Health insurance: USAID has been involved for over 10 years in supporting the GOE in developing sound health care financing policy changes. Recently the Ethiopian Parliament has ratified a new health insurance bill. There is a planned evaluation in mid 2011 on the overall impact of revenue retention at health facilities. Questions that could be explored:

- How can we build on the new financing arrangements in the Ethiopian health sector to strengthen efficiency?
- How do we assess the capacity of the public sector [health sector] to improve resource utilization, in terms of different financing mechanisms?
- CDC has provided direct funding to the MOH, EHNRI, and other local government and non-governmental institutions for nearly 10 years now. What can be learned from these experiences and how can such USG direct funding mechanisms be further utilized to foster country ownership? Can increased regional support build the fiscal and administrative capacity of regional governments and health bureaus?

NEXT STEPS:

- Hold a discussion with relevant people in the US and Ethiopia to further develop these potential learning agenda topics and decide to top priorities.
- Define a process of further developing these themes.
- Identify technical assistance needs.

9. Engagement with Government, Civil Society and Other Stakeholders

The implementation of GHI in Ethiopia will be coordinated with the GOE and in consultation with other donors and stakeholders, including civil society, professional associations and the private sector. The USG PEPFAR interagency team will broaden its scope and will coordinate and implement GHI efforts with the GOE through standing bi-monthly meetings with the Minister of Health, his Director Generals,

through continued participation in the GOE-donor forums set up under HSDP IV , MOH TWGs, and through active participation in the MOH's Annual Review Meeting (ARM) and other planning and review meetings at the national, regional and district level. In addition, the USG will encourage and actively participate in regular meetings of GOE-led TWGs such as the national SI Advisory Committee, PMTCT and Safe Motherhood TWGs. GHI/Ethiopia will coordinate with other donors, the Country Coordinating Mechanism for GFATM, and participate in meetings of the Donor's Forum, Health Providers Network and other relevant forums. Increased efforts will be made to harmonize USG health sector activities with the GFATM in order to maximize investments and increase efficiencies including documenting alignment of GFATM and USG activities and updating the current MOU.

Within a decentralized system, the regions are key players. The USG will closely liaise with Regional Health Bureaus and support planning, management and supervisory functions through the deployment of embedded teams or through targeted secondment of technical advisors. In order to strengthen partner coordination at regional levels, partner catchment area meetings are an important venue to exchange ideas and plans so that efficiencies can be maximized.

10. Implementation Arrangements

The GHI in Ethiopia will be guided by the overall direction of the US Ambassador or his or her designee. The Ambassador will have responsibility for ensuring that the GHI strategy is being carried out according to the GHI principles and that the USG team is working through a whole of government approach. The Ambassador will sign all relevant documents including the Strategy that will officially be submitted to Washington, DC.

The GHI Planning Lead(s) will serve a convening function, bringing together USG agencies working in health, and serve a secretariat function to ensure that GHI documentation is complete, annual progress results and reports are captured and reported as per requirements. The governance structure will build on the current monthly PEPFAR Executive Council which is chaired by the Ambassador or his designee and is attended by senior USG agency representatives, rename this the GHI Executive Council and redefine the terms of reference to better reflect GHI. In order to support the acceleration goal, current PEPFAR TWGs or other more appropriate forums will be examined as to how there functions might better support the identified priority areas and programs within the GHI strategy. In order to maximize USG investments in cross cutting development programs, the GHI Planning Lead(s) will also convene, from time to time, broader USG meetings in order to explore greater efficiencies and effectiveness.

The components of this strategy have been developed by the USG interagency team. Once approved, and following guidance from Washington, this team will jointly develop an overall implementation plan that will operationalize the strategy. The GHI/Ethiopia Team will develop guiding principles on how the agencies will share input into design and planning of activities and programs. Each agency will take responsibility for its respective leadership areas, as identified in the GHI guidance, and ensure that an inclusive process is followed for planning and implementing programmatic priorities. Such a process is

expected to maximize integration and coordination. The GHI team will review the overall program focus and budget but individual agencies will be responsible for overseeing their own budgets. The agencies together will be responsible for collecting and reporting of all results.

Appendix 1: Summary Table of GHI Targets and Strategies

Overarching GHI Principles:
Country ownership
Woman- and girl-centered approach
Strategic coordination/integration
Strengthen and leverage partner engagement
Health systems strengthening
Metrics/monitoring/evaluation
Research and innovation

	BASELINE INFO		**STRATEGY**	**KEY PARTNERS**
GHI Targets	**Baseline info/country-specific GHI target**	**Relevant Key National Priorities/Initiatives**	**Key Priority Actions Likely to Have Largest Impact**	
HIV/AIDS: Support the prevention of more than 12 million new infections; Support care for more than 12 million people, including 5 million orphans and vulnerable children Provide direct support for more than 4 million people on treatment;	New HIV infections/year - Current estimate: 130,000 - Target: 65,000 Number in care: - Current: 944,497 - 2012 Target: 1,073,956	From the GOE's Health Sector Development Plan IV (2010): • Build a multisectoral response to HIV and AIDS epidemic • Reduce incidence by 50% • Provide PMTCT to 85% of mother-infant pairs • Provide ART to 95% of eligible persons • Reduce socio-economic impacts of HIV on OVCs and people living with HIV/AIDS • Strengthen the generation and use of strategic information	• Focus comprehensive prevention in peri-urban, urban, transport corridor settings, esp with most at risk populations • Expand coverage with biomedical prevention (blood supply, universal precautions, male circumcision, syndromic management of STIs, earlier HIV/AIDs treatment) • Increase PMTCT coverage with more effective regimens • Strengthen integration of HIV prevention, care, treatment into routine health services • Improve quality of services • Strengthen involvement of civil society and the private sector • Strengthen retention of health workforce and task shifting • Strengthen implementation of the HMIS and the Health Network Model; health	Ministry of Health (MOH), Federal HIV/AIDS Prevention and Coordination Office (HAPCO), Ethiopian Health and Nutrition Research Institute (EHNRI), PFSA, Regional HAPCOs and Health Bureaus (RHBs), Global Fund, Ethiopian Public Health Association (EPHA), Ethiopian Society of Obstetricians and Gynecologists (ESOG), Ethiopian Medical Assoc (EMA), Ethiopian Nursing Assoc (ENA), Ethiopian

	Number in treatment: - Current: 186,154 - 2012 Target:300,150		insurance; supply chain and laboratory systems	Pubic Health Laboratory Assoc, Partnership for Supply Chain Management Systems (SCMS), Ministry of National Defense, Federal Police, WHO, UNAIDS, Addis Ababa University and the Ethiopian public university system, OSSA, Management Sciences for Health, Columbia U/ICAP, I-TECH/U Washington, JHU-Bloomberg, JHU-CCP, U Cal-San Diego, Tulane University
TB Save approximately 1.3 million lives by treating a minimum of 2.6 million new TB cases and 57,200 multi-drug resistant (MDR) cases of TB, contributing to a 50% reduction in TB deaths and disease burden.	Current Estimate: All forms of TBs 295,305 or 1881/100,000 Prevalence: WHO estimates 130,555 smear+ cases or 168 cases/100,000 Target prevalence: Decrease from 560 to 156 cases/100,000 % treated with DOTS:90% coverage of districts (not patients) Target new case	From the GOE's Health Sector Development Plan IV (2010): • Increase TB Case Detection Rate from 34% to 75% • Increase TB treatment success rate from 84% to 90% • Increase TB Treatment Cure Rate from 67% to 85% • Decrease proportion of MDR TB cases among new smear positive TB cases from 1.6% to 0.5%	• Develop one USG TB plan • Strengthen NTCP to monitor performance, including implementation of the three "I's" • Improve TB screening among HIV positives and HIV testing in TB patients • ART linkages for TB/HIV patients • Improve and expand TB diagnostic services at facility and regional lab level, including culture and drug sensitivity testing • Strengthen HMIS, and TB, HIV, MDR surveillance • Support the MDR-TB management scale up plan • Expand infection control • Private sector support • Development of IEC/BCC materials and targeted distribution to the following	MOH, EHNRI, PFSA, RHBs, WHO, TBCAP, Global Fund, CU/ICAP, I-TECH/UW, JHU, UCSD, Management Sciences for Health, Partners in Appropriate Technology for Health, Abt Associates

	treatment rate: 90% Current Rx success rate: 84% Target MDRTB cases treated: Increase 2nd line treatment from 13% to 100% of notified cases Source: Draft TB Strategic Plan	• Increase Proportion of PLHIVs screened for TB from 15% to 80% • Reduce TB-HIV co-infection rates from 24% to 10%	population (school, prison, military barrack, refugees, monastery, public transport service area (especially on infection control) and community etc. • Training of HWs and HEWs	
Malaria: Halve the burden of malaria for 450 million people, representing 70% of the at-risk population in Africa.	Refer to MOP11 indicators. Estimate of new malaria infections annually is 5 million, which correspond to a slide positivity rate of 25% of all fever episodes. Target by 2014: 1. Increase % of fever cases that are lab tested and confirmed from 22% to 80%; 2. Reduce malaria slide/RDT positivity rate from 25% to 12%. 3. Reduce malaria deaths from 5.6% to <2.8% of all-cause inpatient deaths Sources: MOH 2009	From the GOE's Health Sector Development Plan IV (2010): Reduce malaria morbidity and mortality by 50%. • 100% of households in target areas have, on average, two LLINs; • 90% coverage of indoor residual spraying (IRS) in IRS-target areas; • Universal population access to diagnostic services; • 80% LLIN utilization; • Strengthen operational program M&E and implement operational research	• Integrate malaria prevention with other GHI programs and through multilateral coordination • Strengthen health systems and workforces • Ensure woman-centered approach for malaria • Support for malaria laboratory diagnosis and bednet hang-up campaigns; • Community-level IEC/BCC	MOH, EHNRI, RHBs, Academy for Educational Development, CU/ICAP

	Health			
Maternal Health: Reduce maternal mortality by 30% across assisted countries.	Current estimate: Maternal mortality rate: 673 per 100,000 live births Target: 471 per 100,000 live births (TBD but this is if GHI/Ethiopia adopts the GHI target of 30% reduction	From the GOE's Health Sector Development Plan IV (2010): • Decrease maternal mortality ratio from 673 per 100,000 live births to 267 • Decrease teenage pregnancy from 17% to 5% • Increase Focused ANC 1+ visits from 66% to 90% and ANC 4+ from 31% to 86% • Increase Delivery Service attended by skilled birth attendants from 18% to 60% • Increase postnatal care service from 34% to 78%	• Support the Health Extension Program (HEP) to deliver family planning (FP) and clean delivery services in community • Improve access to quality ANC and maternity and neonatal services to create community demand • Support health facilities to meet criteria for emergency obstetrical and neonatal services • Blood transfusion services • Train and retain more midwives, doctors, and emergency surgeons • Prevent harmful traditional practices (HTP), including early marriage and GBV) and integration of FP programs; community leader etc involvement • Fistula Prevention, Care, and Repair Projects • Improve quality of health services at private clinics • HIV, TB and malaria services • HMIS to monitor ANC and maternal events • Demographic surveillance and maternal morbidity, mortality audits	MOH, RHBs, UNICEF UNFPA, Jhpiego, ESOG, Integrated Family Health Program, CU/ICAP, UW/ITECH, JHU-Bloomberg, Red Cross
Child Health: Reduce under-five mortality rates by 35% across assisted countries.	Current estimate: 123 deaths/1,000 live births Target: 80 deaths/1,000 live births	From the GOE's Health Sector Development Plan IV (2010): • Decrease under-five mortality from 101 to 68 per 1000 live births • Decrease infant mortality ratio from 77 per 1000 live births to 31 • Increase Penta 3, Measles, Full, Rota Virus and	• Expand prevention through infant nutrition, ORT, immunization through HEP • Support introduction of pneumococcal and rotavirus vaccines • Support HEP and health facilities to roll out Integrated Management of Newborn and Childhood Illnesses (IMNCI) • Support for improved water and sanitation at household level (safe water vessel) through HEP • Emergency obstetric and neonatal services	MOH,WHO, EHNRI, RHBs, Peace Corps, UNICEF, Project Concern International, Population Council, UNHCR, Development Associates, World Learning, International Orthodox Christian Charities, Catholic Relief Services, IRC,

		Pneumococcal immunization coverage from 82%, 76.6%, 65.6%, 0%, and 0%, respectively to 90% • Increase proportion of management of asphyxiated newborns and neonatal sepsis from 7% to 75% , from 25% to 74% respectively • Roll out integrated community case management (ICCM) of common childhood illnesses in all health posts and increase IMNCI service coverage in health centers and hospital to 100% from 52% and 62% respectively • Increase proportion of under 5 children with pneumonia who received antibiotics at community level from Health Extension Workers from 0 to 41%	to prevent and manage neonatal asphyxia through the Helping Babies Breathe Initiative • Public health emergency management to detect outbreaks, e.g., measles, pertussis, diarrheal disease • HIV/AIDS, malaria, and TB services	PATH, Pact, ChildFund, OSSA, Samaritan's Purse, AED, Fintrac, Save the Children, Salesian Mission, FHI, ICAP, I-TECH, UCSD, JHU, MSH, ANECCA
Nutrition: Reduce child undernutrition by 30% across assisted food-insecure countries in conjunction with the President's Feed the Future Initiative.	Current estimate: 38% and 46% of under-five are underweight , stunted, respectively Target: TBD but HSDP IV is 27% for underweight and 37% for stunted	From the GOE's Health Sector Development Plan IV (2010): • Decrease wasting in children under-five from 11% to 3%; and stunting from 46% to 37% • Increase proportion of newborns breastfed within one hour of birth from 69% to 92% • Increase proportion of	• Nutrition behavioral change communication at HH and community levels • In-service training for health workers and in pre-and in-service training and supportive supervision of Health Extension Workers (HEWs) and women's groups at community level . • Improve sustainable access to safe water, hygiene and sanitation • Support to FMOH for updating nutritional guidelines and training materials • Enhancing Integrated Life and Livelihood	MOH, EHNRI, RHBs, UNICEF, Care, Save the Children, World Food Program, Food for the Hungry

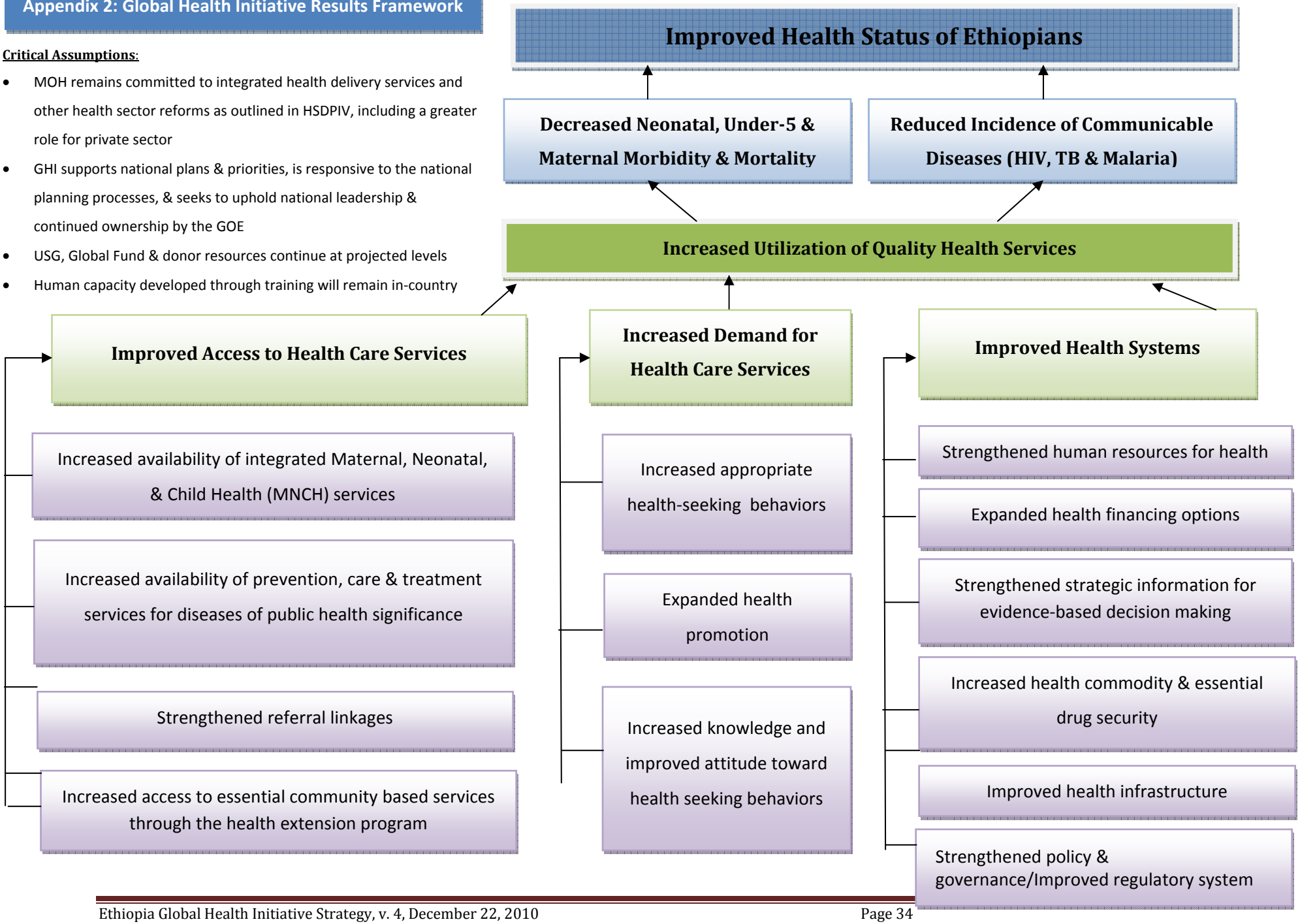
		exclusive breast feeding 0-6 months from 49% to 70 % • Increase proportion of infants 6 -9 months introduced to complementary food & continued breastfeeding from 54% to 84% • Increase proportion of under 5 children managed for severe malnutrition from 65% to 95% • Achieving cure rate > 75%, defaulter rate < 15% and mortality rate < 5% in TFP (both Inpatient care and OTP). • Increase proportion Children 6-59 months given vitamin A every 6 months to 100% • Increase proportion Children 2-5 years dewormed every 6 months to 100 % • Reduce prevalence of anemia in women of childbearing age(15-49) from 27% to 15% • Increase proportion pregnant women supplemented with Iron during pregnancy from 19% to 86% • Increase proportion of households using iodized salt from 4% to 95%	Saving Responses for Vulnerable Conflict Affected Populations in Borena Zone, Oromiya and Liben Zones Enhance the **Technical Assistance** directly or through partners including: • Nutrition Assessment & Counseling Support to Hospitals (NACS) in **all regions**. • NACS to Health Centers/Community Based Nutrition (CBN) programs in **emerging regions**. • Strengthen referral/linkage to and from hospitals/health centers to CBN programs. • Micronutrient Interventions (IEC/BCC, fortification and supplementation) • Provide Technical Assistance in developing policy, programs, guidelines, institutional capacity • HMIS to monitor % under nourished • Support EHNRI to enhance nutritional surveillance	

Family Planning and Reproductive Health: Prevent 54 million unintended pregnancies; Reach a modern contraceptive prevalence rate of 35% across assisted countries, reflecting an average 2% annual increase by 2014; Reduce from 24 to 20 percent the proportion of women aged 18 – 24 who have their first birth before age 18.	Current estimate of contraceptive prevalence: 14% (DHS) or 32% (Last 10K report) Target contraceptive prevalence: 65% Adolescent pregnancy: 17% Target: 5%	From the GOE's Health Sector Development Plan IV (2010): Improve health of mothers, neonates, children, adolescent and youth. • Increase family planning service (CPR) from 32% to 65% • Reduce teenage pregnancy from 17% to 5% • Unmet need for FP from 34% to 10% • Increase adolescent and youth friendly reproductive health services in 100% of hospitals and health centers	• Support of HEP and community mobilization to provide services • Support FMOH to improve M&E of FP results by strengthening capacity at lower levels for M&E for Implanon insertion • Fistula Prevention, Care, and Repair Projects • Prevention of Harmful traditional practices (HTP), including early marriage and GBV) and integration of FP programs; community leader etc involvement • Contraceptive Procurement and building an integrated health logistics system. • Integrate FP with PMTCT and other HIV services • HMIS to track uptake and by commodity used • Linkage to FP services for HIV infected women to prevent unplanned pregnancies • Cervical cancer screening and management	MOH, RHBs, UNFPA, Population Services International, Population Council

Appendix 2: Global Health Initiative Results Framework

Critical Assumptions:

- MOH remains committed to integrated health delivery services and other health sector reforms as outlined in HSDPIV, including a greater role for private sector
- GHI supports national plans & priorities, is responsive to the national planning processes, & seeks to uphold national leadership & continued ownership by the GOE
- USG, Global Fund & donor resources continue at projected levels
- Human capacity developed through training will remain in-country



Macro level factors such as, poverty, education, food security, gender inequality & infrastructure contribute to improved