Scoping Study of National Level Institutional Arrangements for Health Related SDGs Implementation and Monitoring in Ethiopia

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List of Acronyms and Abbreviations

ACHEST	African Center for Global Health and Social Transformation
MDGs	Millennium Development Goals
GTP	Growth and Transformation Plan
SDGs	Sustainable Development Goals
GDP	Gross Domestic Product
CSA	Central Statistical Agency
NPC	National Planning Commission
FDRE	Federal Democratic Republic of Ethiopia
MoFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
IDRC	International Development Research Center
HSTP	Health Sector Transformation Plan
HSDP	Health Sector Development Plan
MMR	Maternal Mortality Ratio
IMR	Infant Mortality Rate
UNDP	United Nations Development Program
ESDP	Education Sector Development Plan
USAID	United States Agency for International Development

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Executive Summary

Ethiopia has achieved six of the eight MDGs and did a visioning exercise for setting goals and targets that could be taken during 2016-2030. It contributed for the formulation of SDGs and the 2063 African Union Agenda. The main purpose of this assessment is to assess adaptation/implementation status of health related SDGS in Ethiopia. Both desk review and key informant interview were used for this scoping study.

The assessment indicated that the commitment of the government of Ethiopia for the successful implementation of SDGs is high and it ensured ownership by incorporating in its growth and transformation plan; different sectors including health have their own five years plan which is devolved into regional states and districts for its implementation. The government has given priority for six goals (Goals 1, 2, 3, 5, 9 and 14) and conducted Voluntary National Reviews (VNRs) on SDGs of Ethiopia in which achievements in the past one year and a half related to these goals is documented.

The main lessons drawn from the 2017 VNRs include availability of pro-poor and pro-growth and development, decentralized administrative system with power devolution coupled with institutional and organizational arrangement for effective implementation of SDGs as integral part of GTP II to realize the principle of "Leaving No One Behind" and the 2017 Analytical Theme "Eradication of Poverty and Promoting Prosperity in a changing world" under the Ethiopian realities. On the other hand the main challenges include climate change induced drought with negative impacts on the economy and human capacity, declining market prices of major Ethiopia's export commodities in international market, lack of commitment on the part of the international community in mobilizing financial resource for implementation of SDGs, particularly for infrastructure financing, and global unpredictability of peace and security which can affect aid, loan and foreign direct investment flows. Moreover, the country is doing well in achieving the SDGs.

Addressing the challenges requires more integrated and coordinated national effort and strong and effective global partnership. In conclusion, based on its experience on achieving MDGs and its track record of performance in implementing SDGs in the past one year and a half, Ethiopia is going well in achieving health related SDGs.

We recommend that awareness creation should be sustained to the grass root level using different channels, to implement the planned capacity assessment up to the lower level of administration, availability of a clear guideline on the roles and responsibilities of stakeholders, to define the role of academia, health policy research institutes, professional associations and the Ethiopian academy of science in the implementation of SDG targets, there should also be a mechanism to attract more funding for the implementation of SDG targets in Ethiopia, the disaggregation of data sources used for M&E of SDG targets should also be strengthened. The HMIS data should also be strengthened to the level that it can be disaggregated by elderlies, people with disabilities and the marginalized group to leave no one behind.

1. Introduction

1.1. Country Context

Ethiopia is the second populous country next to Nigeria with estimated population of 94.35 million (47,364,009 males and 46,986,992 females) on July 1, 2017[1]. About 75,265,000 of the population were living in rural areas while another 19,086,000 were living in urban areas of Ethiopia in 2017. The population of the Ethiopia has been growing by 2.56% per annum. The country is very young population whereby over 43% of the population was aged less than 15 years of age. The country has been striving to bring about changes in many spheres of its citizen lives in the last couple of decades. In this regard the attainment of most targets of the Millennium Development Goals (MDGs) has been witnessed. These achievement have helped the country in gaining replicable development experiences that have, in turn, informed the recognition of future opportunities that led the government to get fully committed in endorsing the 2030 Agenda for Sustainable Development with full sense of national ownership to implement its goals (SDGs) as integral part of its national development plan, the Second Five years Growth and Transformation Plan (GTP II)[2].

The Ethiopian GTP II is prepared and being implemented based on past development outcomes combined with the motivating and mobilizing power of GTP I[3]. It is built on sectoral policies, strategies and program, and lessons learnt from the implementation of GTP1; as well as by taking account global and regional economic situations that have direct and indirect bearings on the country's economy. With overarching objective of realizing Ethiopia's vision of becoming a lower middle income country by 2025, GTP aims to achieve an annual average real Gross Domestic Product (GDP) growth rate of 11% within stable macroeconomic environment while at the same time pursuing aggressive measures towards rapid industrialization and structural transformation[4]. With regards to the health sector, the general objective is to ensure the benefits of the societies through provision of equity, accessible and quality health services, enhance

[1] Federal Democratic Repulic of Ethiopia. Central Statistical Agency (CSA). Population Projection of Ethiopia for All Regions At Wereda Level from 2014 – 2017. Addis Ababa; CSA, 2013.
[2] Federal Democratic Republic of Ethiopia (FDRE), National Plan Commission (NPC). The 2017 voluntary reviews of SDGs of Ethiopia: Government commitments, national ownership and performance trends. Addis Ababa; NPC, 2017.
[3] Federal Democratic Republic of Ethiopia (FDRE), Ministry of Finance and Economic Development (MOFED). The Federal Democratic Republic of Ethiopia Growth and Transformation Plan (GTP I) 2010/11-2014/15). Addis Ababa; MOFED, 2010.
[4] Federal Democratic Republic of Ethiopia (FDRE), National Plan Commission (NPC). The Second Growth and Transformation Plan (GTP II) (2015/16-2019/20). Addis Ababa; NPC, 2015.

awareness and ownership of the health services and create enabling environment for societies to prevent communicable and non-communicable diseases. In addition, the health sector plan includes building of efficient health system in order to improve maternal, child and youth health, quality health development, disease prevention and expanding health care and emergency medical treatment, and enhance awareness for healthy living habits among the communities.

1.2. Background and Rationale of the Project

This particular scoping exercise is coordinated and commissioned by the African Center for Global Health and Social Transformation (ACHEST) – an African non-governmental independent "Think-Tank" – with support from the International Development Research Center (IDRC) Canada. ACHEST is undertaking this exercise to study the various national-level institutional arrangements for SDGs implementation and monitoring across Eastern and Southern Africa, and the results of the study are aimed at providing indispensable future investment guidance to the African Region Health Think Thank Initiative. Being a multi-country study, the scoping exercise is conducted in Ethiopia, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe.

1.3. Objectives of the Scoping Exercise

The questions this particular scoping exercise is aiming to address include assessing the pattern of roll out and domestication of the SDGs by the countries in east and southern Africa, including the preparation they made for implementation of the goals. Based on this, the specific objectives of the exercise are to:

- Establish to what extent the SDG have been introduced and adopted in national, health and health related sector plans;
- Determine the extent of SDGs' inclusiveness of disciplines cross-cutting nature across sectors; and
- Articulate the extent of adoption of common national and sectoral reporting frameworks in the implementation of SDGs.

1.4. Genesis of the SDGs

The SDGs are frameworks for development plan with 17 goals and 169 targets (built on the earlier eight MDGs) the world has agreed to implement within 15 years (by 2030) in order to eradicate extreme poverty. They focus on areas of: people, prosperity, peace, partnership, and the planet, and claim to address the root causes of poverty and the universal need for development that would be applicable for all countries, whereas the previous MDGs were intended for action in developing countries only.

The 17 goals of the SDGs that are aimed to be achieved by 2030 are:

1. No poverty;
2. No hunger;
3. Good health;
4. Quality education;
5. Gender equality;
6. Clean water and sanitation;
7. Renewable energy;
8. Good jobs and economic growth;
9. Innovation and infrastructure;
10. Reduced inequality;
11. Sustainable cities and communities;
12. Responsible consumption;
13. Climate action;
14. Life below water;
15. Life on land;
16. Peace and justice; and
17. Partnership for goals.

The particular goals and targets that are relevant for the health sector are shown in table 1.1 below. The health related SDG (SDG3) has many targets. In addition, health is also framed as contributor to and beneficiary of sustainable development, and as such: it is linked directly to SDG1, SDG2, SDG4, SDG5, SDG6, SDG16; and indirectly linked to SDG7, SDG10, SDG11, SDG12, SDG13.

Table 1.1 - Health Sector and Related SDGs[5]

	Goal	Goal
Health SDG	SDG3	*Ensure healthy lives and promote well-being for all at all ages*
SDGs Directly Linked to Health	SDG1	*End poverty in all its forms everywhere*
	SDG2	*End hunger, achieve food security and improved nutrition and promote sustainable agriculture*
	SDG4	*Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all*
	SDG5	*Achieve gender equality and empower all women and girls*
	SDG6	*Ensure availability and sustainable management of water and sanitation for all*
	SDG16	*Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels*
SDGs Indirectly Linked to Health	SDG7	*Ensure access to affordable, reliable, sustainable and modern energy for all*
	SDG10	*Reduce inequality within and among countries*
	SDG11	*Make cities and human settlements inclusive, safe, resilient and sustainable*
	SDG12	*Ensure sustainable consumption and production patterns*
	SDG13	*Take urgent action to combat climate change and its impact*

[5] Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN.3/2017/2).

2. National Context for SDGs

2.1. Framework for SDGs

Ethiopia is implementing SDGs within the framework of GTP II, and the health sector framework for the realization of GTP II is the Health Sector Transformation Plan (HSTP) which builds upon the successes and challenges of the successive HSDPs (HSDP I to HSDP IV) that are implemented over the last 20 years (1998 – 2017) [6]. The HSTP has three key features: quality and equity; universal health coverage and transformation, and sets out four pillars of excellence which are believed to help the sector to achieve its mission and vision that include: 1. Excellence in health service delivery; 2. Excellence in quality improvement and assurance; 3. Excellence in leadership and governance; and 4. Excellence in health system capacity. With the ultimate purpose of improving the health status of the Ethiopian population in an equitable manner, the major impact level targets for the HSTP include: reducing by 2020 of Maternal Mortality Ratio (MMR) to 199/100,000 live births, as well as reducing under five, infant, and neonatal mortality rates to 30, 20, and 10 per 1,000 live births respectively.

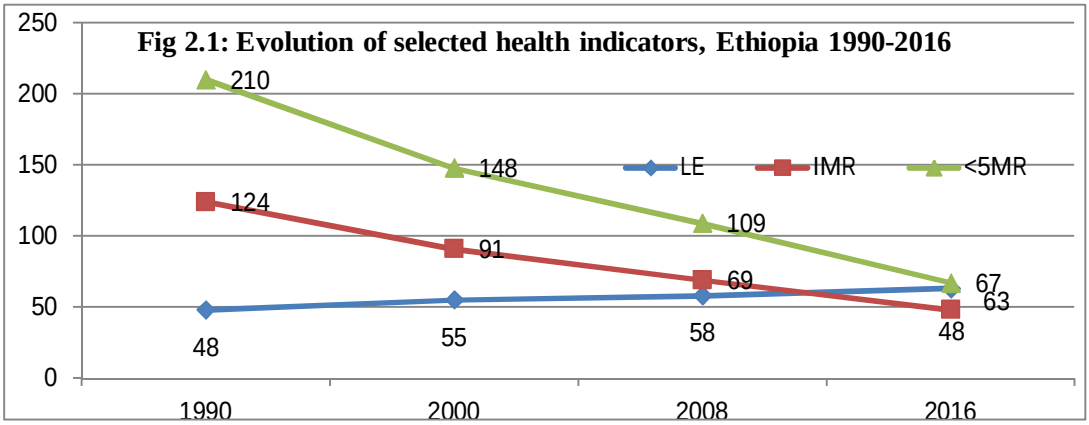
In addition to being part of GTP II (the country's overall development framework), the HSTP is the first phase of the "Envisioning Ethiopia's path towards universal health coverage through strengthening primary health care"[7]. With the vision of achieving health outcomes that commensurate with lower-middle income country by 2025 and middle-middle-income country by 2035; the envisioning document is intended to set directions for further development and further analysis as an indicative framework of investment plans which would lay out further input for development of the health sector, and operational plans that would link the planned health sector outputs, outcome targets and resource requirements.

[6] Federal Democratic Republic of Ethiopia (FDRE), Ministry of Health. Health Sector Transformation Plan (HSTP) 2015/15 – 2019/20 (2008-2012 EFY). Addis Ababa; FMOH, 2015.
[7] Federal Democratic Republic of Ethiopia (FDRE), Ministry of Health. Envisioning Ethiopia's path towards universal health coverage through strengthening primary health care. Addis Ababa; FMOH, 2015.

2.2. Progress in SDGs Related Performance

2.2.1. Ensuring health lives and promoting well-being

Even though Ethiopia has registered major achievements in that it attained most MDGs ahead of time, its health status remained quite low because of the very low benchmarks it started with. MDG4 target was achieved three years ahead by reducing under-five mortality by 67%, one of the highest in priority countries[8]. Neonatal deaths showed no reduction, in fact increased as proportion of IMR and close to 120,000 newborns die annually. The burden is highest in rural with 25-45 neonatal deaths in 1st 24 hours, 3/4 in 1st week[9]. The neonatal mortality in Ethiopia could be even higher as 84% of births occur at home leading to underreporting. In most parts of the country neonatal and peri-natal mortality are stigmatizing and hence less reported[10].



2.2.2. Ending hunger and poverty

Ethiopia has registered substantial decline in the proportion of people living below the poverty line but remains one of the poorest countries in the world with a per capita income of $470 in 2015 and ranking 173 out of 186 countries on UNDP (2015) Human Development Index[11]. The economy experienced strong and broad based growth, averaging 10.8% per year between 2003/04 and 2013/14 compared to the regional average of 5.0%. Annual average income per capita increased from US$377 in 2009/2010 to US$691 by 2014/15. The proportion of the

[8] USAID. Acting on the Call: Ending Preventable Child and Maternal Deaths - Key Facts. 2014.
[9] Yared Amare et al. Newborn care seeking practices in Central and Southern Ethiopia and implications for community based programming. *Ethiop J Health Dev* 2013; 27(1): 3—7.
[10] Federal Democratic Republic of Ethiopia (FDRE. Central statistical Agency (CSA). Ethiopia: Demographic and health survey 2016. Addis Ababa; CSA, 2017.
[11] Tafirenyika M. The Changing face of Ethiopia. *African Renewal* 2015; 29 (2): 4-5.

population living below the national poverty line fell from 38.7% in 2003/4 to 29.6% in 2010/11[12]. Nevertheless, the country's economy lingered also remained one of the poorest countries in the world with GDP per capita income of US$550 for 2014/15) that is substantially lower than the regional average, and the absolute number of the poor (about 25 million) remained largely unchanged over the past fifteen years[13].

The country also continued to suffer from frequent drought-based emergencies but, even more importantly, levels of malnutrition in children and women even in good years were still extremely high. Thus underlying chronic malnutrition is exacerbated by 'acute nutritional emergency'. Rising food prices had a significant and adverse effect on malnutrition and under-five mortality in spite of a greater share of agriculture in gross domestic product[14].

2.2.3. Ensuring inclusive and equitable quality education

Among the main goals of the Ethiopian Education Sector Development Program (ESDP)[15] include: improving access to quality primary education in order to make sure that all children, youth and adults acquire the competencies, skills and values that enable them to participate fully in the development of Ethiopia; and sustaining equitable access to quality secondary education services as the basis and bridge to the demand of the economy for middle- and higher-level human resources. Accordingly, with the supply of 32,048 primary and 2,333 secondary schools, the achievements of the ESDP IV (2009/10-2014/15) implementation indicate Gross Enrolment Rate (GER) for pre-primary 34% in 2013/14. As of 2013/14, the Net Intake Ratio (NIR) was 106% (102% for girls and 109% for boys) compared to the target of 100%, and, since 1996, the number of primary schools has risen from 11,000 to 32,048 and student enrolment at this level has grown from less than 3 million to over 18 million within the same time frame.

[12] Federal Democratic Republic of Ethiopia (FDRE), National Plan Commission (NPC). The Second Growth and Transformation Plan (GTP II) (2015/16-2019/20). Addis Ababa; NPC, 2015.
[13] UNDP. National Human Development Report 2014, ETHIOPIA: Accelerating Inclusive Growth for Sustainable Human Development in Ethiopia. 2015, Addis Ababa.
[14] Lee S et al. Food Prices and Population Health in Developing Countries: An Investigation of the Effects of the Food Crisis Using a Panel Analysis. ADB Economics Working Paper Series, Asian Development Bank, 2013, Manila.
[15] Federal Democratic Republic of Ethiopia. Ministry of Education. Education Sector Development Program V (ESDP V) 2008 - 2012 E.C. 2015/16 - 2019/20 G.C. Addis Ababa; FMOE, 2015.

Gender equity in secondary education has greatly improved with parity indices reaching 0.94 and 0.85 respectively in 2013/14, from 0.80 and 0.46 in 2009/10. The overall GER and NER in second cycle stand at 64% (63% for girls and 65% for boys) and 50% (50% for girls and 49% for boys) respectively in 2013/14. Furthermore, approximately 10.2 million illiterate adults (53%), of which 42% are female, have participated in year one and 7.2 million (35% of the 20.4 million population of illiterate adults) have graduated from year two within the National Adult Education Strategy implemented through ESDP IV.

2.2.4. Gender equality and empowerment of women and girls

Women comprise approximately 65% of the informal sector and provide 60% of the total agricultural labor. In addition, they perform a key role in maintaining and managing the household through their responsibilities for reproductive activities such as food preparations, health and hygiene and children care. In spite of their key roles in Ethiopian economy and household welfare, women experience persistent inequality and discrimination. Women are culturally regarded as inferior to men and are marginalized by hazy legal rights and male biased institutions and markets which ignore the needs of women farmers.

Ethiopia had one of the highest maternal mortality globally despite the significant decrease (69%) from the 1990 level. Utilization of maternal healthcare services remained low. The government has, in the National Reproductive Health Strategy, identified low rate of institutional delivery as a priority area and targeted to increase it to 60% by 2015[16]. However, even in 2016, only 26% delivered in health facilities[17] and the cesarean section rate of 1% was much lower than the recommended 5% threshold even though Bayou et al. (2016)[18] report higher figures in some settings.

Nevertheless, maternal health care uptake has shown modest increase during the past decade – ANC coverage has reached 62%, skilled attended delivery 28% (facility delivery being 26%),

[16] Hagos S, et al. Utilization of institutional delivery service at Wukro and Butajira districts in the Northern and South Central Ethiopia. *BMC Pregnancy and Childbirth* 2014, 14:178.
[17] Federal Democratic Republic of Ethiopia (FDRE. Central statistical Agency (CSA). Ethiopia: Demographic and health survey 2016. Addis Ababa; CSA, 2017.
[18] Bayou YT, Mashalla YJS, Thupayagale-Tshweneagae G. Patterns of caesarean-section delivery in Addis Ababa, Ethiopia. *Afr J Prm Health Care Fam Med* 2016;8(2), a953.

and PNC 16.5%. Overall, 36% of currently married women are using a method of family planning[19]. Maternal mortality ratio also declined sharply by 69% between 1990 and 2012, registering the 4th highest among the 24 priority countries[20] but still amounted to 11,000 deaths in 2015[21]. The increases in maternal care and the decrease in matenal mortality could be, to some degree, associated to the health extension program.

2.2.5. Availability and sustainable management of water supply & sanitation

Ethiopia adopted, in 2001, a National Water Strategy aimed at providing safe and sufficient water supply and adequate sanitation services to the population. A Water, Sanitation and Hygiene (WASH) movement was also launched in 2004 for a concerted effort involving a large number of partners. However, in spite of major increases and Ethiopia being classified among the top 10 countries that have achieved the highest reduction of open defecation since 1990 (WHO, 2012) coverage by improved water and sanitation facilities remained relatively low[22]. In 2015 only 67% and 42% of the population was covered by improved water and sanitation respectively[23].

More recently (according to EDHS 2016)[24], about two-thirds (65%) of households in Ethiopia obtain their drinking water from an improved source. The most common (88%) source of drinking water in urban areas is piped water. In rural areas, the most common sources of drinking water are public tap or standpipe (19%), a tube well or borehole (13%) and a protected spring (14%). With regards to toilet or latrine facilities, 6% of households in the country use an improved and not shared toilet or latrine facility another 9% of households (35% in urban and 2% in rural areas use facilities that would be considered improved if they were not shared by two or more households. Half of households in urban areas (50%) use an unimproved toilet facility, compared with 94% of households in rural areas. Overall, 32% of households have no toilet facility at all; they are almost exclusively rural, accounting for 39% of rural households.

[19] Federal Democratic Republic of Ethiopia (FDRE. Central statistical Agency (CSA). Ethiopia: Demographic and health survey 2016. Addis Ababa; CSA, 2017.
[20] USAID. Acting on the Call: Ending Preventable Child and Maternal Deaths - Key Facts. 2014.
[21] Inter Agency Group (IAG). Maternal mortality in 1990-2015: Ethiopia. WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group (IAG), 2015.
[22] WHO. The World Conference on Social Determinants of Health: Summary Report. Geneva; WHO, 2012.
[23] WHO. World Health Statistics 2015. Geneva; WHO, 2015.
[24] Federal Democratic Republic of Ethiopia (FDRE. Central statistical Agency (CSA). Ethiopia: Demographic and health survey 2016. Addis Ababa; CSA, 2017.

3. Study Objectives

3.1. General Objective

The general objective of this scoping study is to assess the adaptation/implementation status of health related sustainable development goals in Ethiopia.

3.2. Specific Objectives

Specifically, the study aims at:

- Establishing to what extent the SDGs have been introduced and adopted in national and health and health related sector plans in Ethiopia
- Determine to what extent has the interdisciplinary nature of SDG been inclusive and cross cutting?
- Articulate to what extent are the common national and sectoral reporting frameworks been adopted?

4. Methodology

4.1. Coordination of the Scoping Exercise

This SDGs scoping exercise is coordinated at regional level by the African Center for Global Health and Social Transformation (ACHEST) for assessment in – Eastern and Southern African countries. In Ethiopia, the Ethiopian Public Health Association (EPHA) has taken the role of representing delegates and supporting the assessment at national level.

4.2. Method of Data Collection

The major approaches used in conducting the scoping exercise in the Ethiopian situation include:

- Desk review (literature review) of publications, reports, and other documents that are relevant to SDGs implementation in the country;
- Consultations and/or key informant interviews with policy makers, implementers, SDGs coordinating authorities, and institutions that have relevant to the implementation of the initiative; and
- Analysis of the data collected for articulating the issues outlined in the objectives of the exercise as well as for coming up with conclusions and recommendations that are of policy relevance both at national and regional levels.

5. Findings

5.1. Actors and Stakeholders

Among the major stakeholders being involved in the Health related SDGs planning and implementation process include:

1. Ministry of Health and Regional Health Bureaus of Ethiopia;
2. National Planning Commission of Ethiopia;
3. Central Statistical Agency and Vital Events Registration;
4. Academic institutions such as Addis Ababa University, Gondar University, Jimma University; The Ethiopian Universities Research Centers Network which is hosted by Ethiopian Public Health Association;
5. Bilateral institutions such as DFID and USAID;
6. CSOs and NGOs such as CCRDA, Network of People Living with HIV/AIDS (NPLHIV), FGAE, Association of Persons with Disabilities;
7. Multilateral institutions and UN systems such as World Bank, WHO, UNICEF, UNFPA, UNAIDS;
8. Professional associations such as Ethiopian Economic Association, Ethiopian Medical Association, Ethiopian Pediatrics Association, Ethiopian Public Health Association, Ethiopian Society of Obstetrics and Gynecology among others; and
9. Ethiopian Academy of Sciences.

The private sector in health practitioners have also been represented in many forums through their associations such as the Medical Association for Physicians in Private Practice in Ethiopia (MAPP-E).

5.2. Implementation Status

5.2.1. How is Ethiopia prepared to roll out and domesticate the health SDGs?

Ethiopia was already committed to inculcate the basic goals of SDGs within GTP II. In addition, it had prepared the “Addis Ababa Action Agenda” as a basis for the launching of the SDGs with a 2016-2030 timeline. The agenda included a narrative document and indicator matrix with a timeline of 2016-2030, and also the African Union (AU)’s 2063 agenda. The agenda highlights national ownership as the most important element in the process.

At national level, the SDGs are rolled out within the framework of GTP II, and the visioning exercise and the HSTP are the health sector roadmap for the goals. Administrative reports, national surveys, program specific activity reports are the components of the GTP monitoring matrix. There was also an envisioning exercise which has been put in place before even the SDGs were endorsed by heads of state in September 2015. The target year for the envisioning exercise was fixed to be the year 2035 and described in detail in the MOH quarterly bulletin[25]. The visioning exercise document was a result of a committee established to identify strategic areas in six areas within the health sector that include: empowering the community to play a significant role in the health sector; strengthening primary health care units within the wider health sector context; ensuring a robust human resources for health development that commensurate with socio-economic development of the country as Lower Middle Income Country (LMIC) by 2025 and Middle Middle Income Country (MMIC) by 2035; engaging the private sector and Civil Society Organizations (CSOs) in support of the MOH's vision; developing sustainable financing mechanisms necessary to achieve a better health outcome; and developing institutional capacity within the ministry, regional health bureaus, and related agencies to be responsive to changing economic, social, environmental, technical, and epidemiologic context[26].

5.2.2. How has Ethiopia domesticated and prepared for SDG implementation?

The owner of the SDGs implementation and monitoring process is the National Planning Commission (NPC). There have been several advocacy and promotion activities since 2015/16 to create awareness about SDGs. There are activities started with UNDP (along the promotion/popularization of SDGs) that include: radio programs for promotion; mobile applications (to be disseminated to the public); translations of the initiative and activities for the implementation into regional languages and broadcasts through local radios.

There was a global meeting in New York in July 2017 where countries have presented their implementation performance report since the launching of the initiative. Ethiopia has also

[25] Admasu K, Tamire A, Tsegaye S. Envisioning the future of the health sector: An update. *Quarterly Bulletin of the Ministry of Health* 2014; 3-12.

[26] Federal Democratic Republic of Ethiopia (FDRE), Ministry of Health. Envisioning Ethiopia's path towards universal health coverage through strengthening primary health care. Addis Ababa; FMOH, 2015.

presented its own report at the meeting. The report from Ethiopia has been earlier discussed among community groups, Civil Society Organizations (CSOs), public and private sector institutions, government and opposition political parties, as well as development partners. There were 16 consultative meetings with these stakeholders to discuss and enrich the report as well as to popularize and promote the SDGs.

At present the NPC is working to address the comments given on the report at the New York presentation. Data are being disaggregated to include the elderly, the disabled, and those socially excluded based on the principle of "no one should be left behind" (in terms of how they are treated in indicators being reported). Studies are also being commissioned and undertaken to elaborate the needs assessment for the SDGs and to develop a 15 years national plan towards achieving them.

5.2.3. Mapping of coordination and implementation mechanisms

Globally it is the UN Economic and Social Council that follows the implementation of the SDGS globally. At national level in Ethiopia, it is the National Planning Commission that follows and monitors the implementation of SDGs, as it is the entity that follows the strategic plans of every sector in the country. The Monitoring and Evaluation Bureau within the NPC monitors the whole initiative and the performance of all sectors every six months. Cross-cutting issues that involve many sectors (including climate, gender) have national steering committees. The other indicators dealing with specific activities are given to the specific sectors.

The health sector has its own mechanism for monitoring its development plan that is already in built in the system during its 20 years implementation of the HSDP. The health sector joint steering committee is responsible for coordinating this activity. The committee is composed of leaders in the health sector including state ministers of health, directors of different directorates in the ministry of health, director generals of research institutes under the auspices of the federal ministry of health and regional health bureau heads. The joint steering committee has an annual review meeting (ARM) with health services providing entities as well as all development partners to monitor and evaluate activities related to SDGs stipulated in the HSTP. Moreover, the FMOH also has a joint consultative forum with development partners. The Joint Core

Coordinating Committee (JCCC), chaired by the Head of Planning and Programming Department of FMOH, will act as the technical secretariat of the Central Joint Steering Committee (CJSC) which is responsible for coordinating the support of development partners in the implementation, monitoring and evaluation of health related SDGs. When it comes to Civil Service Organizations (CSOs) the Consortium of Christian Relief Development Associations (CCRDA) is coordinating CSOs/Faith Based Organizations (FBOs) in its health partnership forum. However, the FMOH does not seem to have a specific unit or secretariat to coordinate all of these committees in the ministry of health or elsewhere in other government organizations or to specifically follow the implementation of SDGs. It is the cabinet that follows the implementation in each sector, and the central coordination is through the NPC.

5.2.4. M&E frameworks both at national level and at Sector

The Ethiopian Central Statistics Agency (CSA) is the main information source for monitoring and evaluation framework for the SDGs. In addition, data from sectors are used. There are standing committees within the House of People's Representatives (Parliament) to whom every sector reports its activities on annual basis, and GTP II is one of the most important meeting at the meetings of the National Parliament. As such, members of parliament were among those represented at the initial consultative meetings conducted by the NPC to enrich the planning process for the SDGs.

With regards to generation of reliable data to monitor and evaluate the progress of SDGs implementation, the FMOH collaborates with the CSA in generating reliable data sources such as the Ethiopian Demographic and Health Survey (EDHS) and the welfare monitoring survey. It also conducts surveys through its research wing, the Ethiopian Public Health Institute (EPHI). Currently an effort is being made towards supporting local Health and Demographic Surveillance Systems (HDSS) to continuously generate health and demographic outcomes in the country. Moreover, the newly initiated vital events registration system in the country will continuously update the burden of diseases in the country, if the required technical and financial support is rendered to it.

Evaluation of six indicators (including those of health) has been recently made to formatively assess the status of the SDGs implementation process. The specific goals that were reviewed

include: Goal 1 (ending poverty in all forms everywhere); Goal 2 (ending hunger, achieving food securing and improved nutrition); Goal 3 (ensuring healthy lives and promoting well-being at all ages); Goal 5 (achieving gender equality and empowering all women and girls); Goal 9 (building resilient infrastructure and promoting inclusive and sustainable industrialization and innovation); and Goal 14 (conserving and sustainably using oceans, seas and marine resources)[27].

The review of the health sector SDG (3) during the evaluation mentioned above has involved assessment of government policy directions, details of sector performance, reduction of maternal mortality, performance of health care services and nutrition, prevention and control of communicable diseases (HIV/AIDS, tuberculosis, malaria), teen age fertility, implementation mechanisms for ensuring health life and well-being. It has also briefly outlined the challenges identified and the lessons learnt as a result of the evaluation. Accordingly, the highlights of the evaluation of the health sector have been summarized in table 5.1 below.

Table 5.1 – Formative Evaluation of Health Sector SDG[28, 29]

Review Parameter	Review Highlights
Government policy directions	- Constitution has articles with enabling provisions that link the government's responsibility in ensuring access to health services by the country's population. - There are also health policies, strategies and programs that derive from the constitution.
Details of performance	- Success by the sector in implementing the Health Sector Development Program (HSDP) and the training and deployment of the Health Extension Workers (HEW). - Expansion of primary health care facilities. - Remarkable achievement in child health MDGs.
Reducing maternal mortality	- Increase in trained midwives, labor and delivery-care coverage - MMR reduced to 412 by 2015/16
Health care services and nutrition	- Under-5 mortality rate increased from 64 deaths per 1,000 live births in 2014/15 to 67 in 2016. - Infant mortality decreased from 28 deaths per 1,000 live births in 2014/15 to 48 in 2016. - Stunting of children under five decreased from 40% in 2014/15 to 38.4% in 2015/16. - Wasting of children under five increased from 9% in 2014/15 to 9.9% in 2015/2016.
HIV/AIDS	- New incidence of HIV infection was down to 0.03% in 2015/16.
Tuberculosis	- TB detection rate reached 61.3% in 2015/16. - Patients that received and completed treatment for TB reached 92% in 2015/16.

[27] Federal Democratic Republic of Ethiopia (FDRE), National Plan Commission (NPC). The 2017 voluntary reviews of SDGs of Ethiopia: Government commitments, national ownership and performance trends. Addis Ababa; NPC, 2017.
[28] Federal Democratic Republic of Ethiopia (FDRE), National Plan Commission (NPC). The 2017 voluntary reviews of SDGs of Ethiopia: Government commitments, national ownership and performance trends. Addis Ababa; NPC, 2017.
[29] Federal Democratic Republic of Ethiopia (FDRE. Central statistical Agency (CSA). Ethiopia: Demographic and health survey 2016. Addis Ababa; CSA, 2017.

Malaria	- Malaria incidence reduced from 22 per 1000 in 2014/16 to 21 per 1000 in 2015/16.

Among the challenges raised in the review include the adverse effect on the health sector posed by epidemics as well as drought and food shortage caused by climate change. The stress on the health sector by trans-border migration was also another challenge identified. On the other hand, the experiences in deploying HEWs and women health development army volunteers were the positive lessons learnt from the health sector SDG formative assessment.

5.2.5. Resource allocation

There are no resources specifically earmarked for the SDGs implementation. All the ministries use their allocated budget to execute the activities within their respective domain. The five years resources requirements for GTP II have been estimated, and the needs assessment for the SDGs has been initiated. In principle, the SDGs implementation at national level is expects to get resources in terms of development assistance, even though this is not forthcoming as expected due to many unforeseen situations at global level.

The FMOH has established the SDG Performance Fund by renaming the already existing MDGs Performance Fund. Support for the fund mainly comes from bilateral and multilateral partners through channel II.

5.2.6. Planning process at national and sector levels

Overall, the planning process for the SDGs is the responsibility of the NPC, and with regards to the health sector, the process is integrated within the activities of the Planning and Resource Mobilization Directorate of the FMOH.

In terms of projections for the planning process, the NPC considers the national rate of economic growth. Accordingly, the country is assumed to have nearly 11% growth that is well above the 7% recommended for low income countries. Therefore, it is hoped that it will achieve the SDGs as planned, if it keeps its momentum in terms of rate of economic growth.

5.2.7. Extent of inclusiveness of the overall process

The SDGs planning, implementation, and monitoring process is said to be inclusive in terms of involving the government, private sector, community representatives, CSOs, NGOs, and development partners. It is also expected to engage academic institutions in studies required for the needs assessment and monitoring. Research institutions as well as the Ethiopian Academy of Sciences are already being involved in parts of the formative assessment and promotional aspects of the process.

5.2.8. The Health Policy Research Institutes in Ethiopia and their roles on SDGs

The Ethiopian Public Health Association (EPHA) has been involved in health policy research and it has also consistently been advocating on pertinent public health issues such as HIV/AIDS, TB, Malaria, substance abuse and road traffic accident among others. EPHA has been instrumental in the formation of Ethiopian Universities Research Centers Network (EURCN) which created by public universities has been hosting the Health and Demographic Surveillance System (HDSS). Data from HDSS has been used to inform policy on population dynamics, burden of diseases, gender, health seeking and utilization in ecological diversified parts of the country.

The Ethiopian Academy of Sciences (EAS) which is established recently has been commissioned to undertake health policy researches. It is a nonprofit and non-governmental organization established to promote a culture of scientific inquiry and creativity and the pursuit of excellence and scholarship in the sciences among Ethiopians. Its fellows, associate and honorary fellows have made outstanding contributions to the expanding knowledge in their respective fields. It has also been advocating on pertinent public health issues in the country. Among its activities are: providing a series of public lectures on various issues; undertaking consensus studies; organizing conferences and workshops; recognizing excellence; and providing platforms where the scientific publications of Ethiopian scholars are made accessible to the public.

6. Discussion

The main actors of SDGs are government sector ministries, CSOs, NGOs, the academia, professional associations, bilateral and multi-lateral organizations. The National Planning commission is coordinating SDGs while the sector ministries are responsible for implementing it. The planning directorate of Ministry of Health has various coordinating mechanisms to engage government sectors, CSOs and bilateral and multi-lateral organization for successful implementation of SDG 3. Though there are efforts to encourage the private sector for the successful implementation of SDG targets from the outset of its inception it should be enhanced to ensure ownership of SDGs by the wider community. Efforts should be sustained to include associations of people with disabilities, elderlies and marginalized groups.

However, the role of think tanks such as Ethiopian Academy of Science, Ethiopian Network of Universities Research Center and professional associations and the academia has been given less emphasis in any of the documents we reviewed and our key informants did not give enough detail on their roles. These think tanks could be engaged in generating evidence for monitoring and evaluating targets related SDGs. They could also be used in advocacy and promotion of SDGs related issues. Furthermore, they can be involved in the capacity building of the human resources that will be involved in the implementation of SDGs. The Ethiopian Network of Universities Research Centers is a consortium of Ethiopian Public Universities hosting Health and Demographic Surveillance Systems (HDSS). There are now seven HDSSs in Ethiopia which are members of this network and located in different parts of the country. Such a network can provide reliable data for evaluating maternal and child health programs, gender related issues, burden of diseases and inequalities in health service seeking behavior and utilization among different communities in Ethiopia among others. There is also a wide pool of researchers and academicians some of whom involved as research advisory council members of the Federal Ministry of Health. The Ethiopian academy of Sciences (EAS) has also a monthly public lecture on pertinent issues by experienced scholars in different specialty areas. EAS could prepare one of the public lectures on SDGs to create awareness for the wider public. Such institutes could be

used as think tank in our country. The government of Ethiopia should immediately start dialogue to closely work with the above mentioned health policy research institutions.

Ethiopia inculcated the basic goals of SDGs within GTP II which showed the commitment of the government to own it. In addition, it had prepared the "Addis Ababa Action Agenda" as a basis for the launching of the SDGs with a 2016-2030 timeline which also included a narrative document and indicator matrix and also the African Union (AU)'s 2063 agenda. At national level, the SDGs are rolled out within the framework of GTP II, and the envisioning exercise and the HSTP are the health sector roadmap for the goals. The envision exercise identified empowering the community to play a significant role in the health sector; strengthening primary health care units within the wider health sector context; ensuring a robust human resources for health development; engaging the private sector and Civil Society Organizations (CSOs) in support of the MOH's vision; developing sustainable financing mechanisms necessary to achieve a better health outcome; and developing institutional capacity within the ministry, regional health bureaus, and related agencies to be responsive to changing economic, social, environmental, technical, and epidemiologic context.

The owner of SDGs implementation and monitoring is the NPC which made advocacies and promotion activities to create awareness with UNDP that include radio programs; mobile applications; translations of the initiative and activities for the implementation into regional languages. Ethiopia presented its report at the meeting in New York in July 2017. The report was discussed among community groups, CSOs, public and private sector institutions, government and opposition political parties, as well as development partners in 16 consultative meetings to enrich, popularize and promote SDGs. The NPC is working to address the comments received during the New York meeting to disaggregate data for the elderly, the disabled, and socially excluded based on the principle of "no one should be left behind". Needs assessment is commissioned and undertaken to elaborate SDGs and develop a 15 years national plan to achieve targets which could be considered as sign of commitment to sustain efforts to achieve targets.

The NPC monitors and evaluates the implementation of SDGs, as it is mandated to follow the strategic plans of every sector in the country. The M&E Bureau within the NPC monitors the

whole initiative and the performance of all sectors every six months. Cross-cutting issues that involve many sectors (including climate, gender) have national steering committees. The other indicators dealing with specific activities are given to the specific sectors. Development partners assist the government in their comparative advantages. Data generated by CSA, VERA and EURCN and HMIS will be used to monitor and evaluate targets of SDGs. The research wing of MOH has also been conducting studies.

There is no specific budget allocated for the implementation of targets set for SDGs though all development efforts are budgeted. All development partners need to share their plans to the sector where they want to engage in and the budget assigned by development partners will be used for activities for sectors' growth and transformation plan. Money has been pooled from development partners. However, the contribution of the private sector for the implementation of activities related to SDGs is insignificant. The Ethiopian government is not able to allocate the required budget for the implementation of SDGs. Its effort will be more hampered in situations of droughts in which case some of the budget could be re-allocated for the emergency situation.

The planning process for the SDGs is the responsibility of the NPC while it is the responsibility of the Planning and Resource Mobilization Directorate of the FMOH in the health sector. The NPC considers the national rate of economic growth which is assumed to have nearly 11% growth that is well above the 7% recommended for low income countries.

The SDGs planning, implementation, and monitoring process is said to be inclusive in terms of involving the government, private sector, community representatives, CSOs, NGOs, and development partners. However, the engagement of the academic institutions was only limited to the conduct of some of the formative assessments needed for monitoring and evaluation. Research institutions (under the auspices of MOH and beyond) as well as the Ethiopian Academy of Sciences should be approached to act as think tank group for the implementation of SDGs in Ethiopia. The private sector in health services has very limited role in the implementation of SDGs in Ethiopia which has to be strengthened. The Medical Association of Physicians in Private Practice in Ethiopia (MAPP-E) could be involved in promotion of SDGs in the private setting and the generation of valuable data from the private health sector.

Ethiopia is doing well in adapting and implementing the health related SDGs. SDG 3 is well on track by involving all partners; and other directly and indirectly related SDGs health are doing well according the recent National Voluntary Review done by the National Planning Commission of Ethiopia. However, there are challenges that need to be addressed for the effective implementation of GTP II in which SDGs are incorporated. The main challenges observed during the last one year and a half implementation of SDGs in Ethiopia were:

1. The severe drought caused by climate change during the 2015/16 turned 10.2 million people to be aid dependent to survive, which lead to re-allocation of resources from development works to food aid. The drought also lingered through the 2016/17 in some regions of the country which lead over 7.8 million people to remain on food aid. The response made to alleviate the drought impact competed with the resources for development;
2. In the 2015/16, revenue from export items and therefore foreign currency based revenue decreased due to the slowdown of international economy that caused commodity prices to decline. The export destinations got fewer and fewer , exacerbating the situation in Ethiopia's case has been that Ethiopia's export items are not diversified and are mostly agricultural produces; and
3. Rent-seeking behavior and lack of good governance all of which adversely impacted implementation capacity. They hindered and retarded implementation of social and economic services although different reform programs are put in place to minimize their negative impact.

All of the SDGs have been integrated with ten of the priority areas of the GTP II. All SDGs targets which reflect the objective reality in Ethiopia have also been integrated with GTP II. Those SDGs targets that may not match the objective realities are being identified. Ethiopia has deployed existing institutional and organizational arrangements as well as human resources and no new and/or parallel efforts have been made to implement SDGs.

The Ethiopian government indicated its commitment for the success of SDGs in its policy framework and institutional arrangement. The legal provision has also been witnessed in the

constitution and other bylaws. The government did not have special arrangement to implement SDGs alone; it rather has incorporated all of them in its national growth and transformation plans (GTP II) which indicates its commitment to own SDGs. The government has a pro-policy which is in line with the international commitment of leaving no one behind. The recent National Voluntary Assessment indicated the performance trends of SDGs in the past one year and a half. Early performance trends on the principle "Leaving No one Behind", on the 2017 Thematic Analysis: "Eradicating Poverty and Promoting Prosperity" and on the six sets of sustainable development goals for the 2017 in-depth review of SDGs, which include Goals I, 2, 3, 5, 9 and 14 have been assessed and the findings included in the 2017 VNRs report on SDGs of Ethiopia.

With regards to ensuring healthy lives and promoting well-being for all at all ages in Ethiopia, it has been proclaimed in the constitution of the FDRE that the Government has the obligation to allocate ever increasing resources to provide to the public health, education and other social services. The national health sector policy, strategy, plan and program of the Government have therefore, emanated from this constitutional provision and they are focusing on preventive rather than curative health services to address critical issues and problems of the health sector in Ethiopia. With the main objective of ensuring easy access to and quality of basic health services for all Ethiopian citizens, the Ethiopian Government has made massive investment in expanding health infrastructure and building the human capital in the health sector. Health Extension Program has been operational and rolled out to all rural and urban areas of the country for effective implementation of the national health sector policy by deploying about thirty eight thousand trained health extension workers. Accordingly, the national health services coverage reached 98 % through expanding health institutions, training and deploying sufficient human resources and increasing health service accessibility. Maternal and infants health has improved significantly with reduced maternal mortality rate per100,000 live births to 420 in 2014/15 while that of under five child mortality rate declined to 64/1000 live births in the same period. Incidences & spread of communicable diseases have been restrained and life expectancy has shown tremendous progress. Healthy and productive labor force is thus availed for the economy to maintain its accelerated pace and achieve the goal of eradicating poverty in all its forms by 2030.

7. Lessons Learnt Conclusions and Recommendations

The Ethiopian government has achieved six of the eight MDG targets and there a lot of lessons learned from this effort. Though declining there were better commitment of the international community to fund MDGs. The lessons learned on how to secure development partnership should be sustained and there should also be lessons learned to increase the capacity of the country to cover the budget from own funding mechanism.

In conclusion, the Ethiopian government aligned SDGs in its growth and transformation plan. It owned SDGs. Legal and policy frameworks are put in place for the successful implementation of SDG targets. The government in its recent national voluntary review has identified priorities that should be accomplished in the era of the second government growth and transformation plan (GTP II). The Ethiopian government planned attaining the status of lower middle income country in 2025 and that of middle income country by 2035 for which attainment of SDGs is considered as a key strategy. Devolution of power and resource has been the key characteristics of the government which is useful for the successful implementation of SDGs in Ethiopia.

Monitoring and evaluation mechanisms for the successful implementation of SDGS have been put in place, the planning departments of each sector is responsible for conducting it. The planning directorate of MOH is responsible to monitor and evaluate SDG 3. The planning commission will compile data generated by Central Statistical Agency, administrative records, and special surveys commission to conduct the success of SDGs in the country. The issue of data quality, especially those generated from administrative records is worth considering for which the MOH of Ethiopia considered data revolution as one of the key strategic issues that has been done in the HSTP II era.

Key informant interviewees indicated that the challenges mentioned need to be considered critically for the success of SDGs. However all of the challenges might not be addressed by the government of Ethiopia alone. Stakeholders should play their role in addressing these challenges. The country did not have all the required resources such as finance for infrastructure development for which the engagement of development partners is instrumental.

The international community needs to revitalize its commitment in mobilizing financial resource for implementation of SDGs, particularly for health sector infrastructure financing and global unpredictability of peace and security which affect aid, loan and foreign direct investment flows. Addressing the challenges requires more integrated and coordinated national effort and strong and effective global partnership.

The following recommendations are proposed:

- The awareness creation should be sustained to the grass root level using different channels;
- The planned capacity assessment should be done up to the lower level of administration. Findings of the assessment should be taken into action;
- There should be a clear guideline on the roles and responsibilities of stakeholders;
- The role of academia, health policy research institutes, professional associations and the Ethiopian academy of science in the implementation of SDG targets should be clearly defined;
- There should also be a mechanism to attract more funding for the implementation of SDG targets in Ethiopia; and
- The data sources used for M&E of SDG targets should be strengthened. The HMIS data should also be strengthened to the level that it can be disaggregated by elderlies, people with disabilities and the marginalized group to leave no one behind.

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Annexes

Annex 1 - Stakeholder Mapping

Sector	Actor – State actors	Non-state actors	Role of Non-state a tors
Health	• **Ministry of health** • **Other ministries** • **Housing, water, environment, sanitation** • **planning,** • **finance,** • **devolution** • **Justice,** • **Ministry of Labour and gender** • **Key gvt bodies** • **Gvt Agencies (Commissions, Authorities, Bureau** • **Population Council** • ***No national population council – can be mentioned as weakness in the assessment***	**CSOs/CBOs** **Academia, Research institutions, devt partners** **Private sector** **Think Tanks** ***USAID – Abt*** ***DFID*** ***World Bank*** ***UNICEF/WHO*** ***UNFPA/UNAIDS*** ***CCRDA*** ***FGAE*** ***EPHA/EPA/ESOG*** ***JSI/SPH- Urban Health***	**Implementation** **Advocates and lobbying** **Coordination** **Financing** **M&E**

Annex 2 – Performance of SDGs reviewed in Ethiopia[30]

SDGs	SDG-Targets' Indicators	Baseline (2014/15)	Performance (2015/16)	Planned targets (2016/17			
				2016/17	2017/18	2018/19	2019/20
SDG1	Ending Poverty						
	National Poverty headcount (%)	23.4					16.70
	Share of poverty oriented sectors' expenditure in total Gvt Expenditure (%)	66	67	72	72	71	88
	The Share of pro-poor sectors' expenditure (%)	12.3	12.9	13.5	14.1	14.8	15.4
	Gvt's expenditure for institutions benefiting women , the poor, vulnerable (Share in GDP in %)	17.3	18.4	19.3	20.2	21.4	22.6
	No. of beneficiary (50% of females) from safety net based social security services (millions)	1.2	1.54	0.81	0.90	0.98	1.01
	No. of beneficiary (the disabled) from physical rehabilitation services (thousand)	236.19	78.74	70.00	75.00	80.00	85.00
	No of households who received second degree rural land entitlement license (millions)	0.33	0.33	1.40	1.60	1.80	1.30
	No. of male family heads	0.26	0.27	1.12	1.28	1.44	1.04
	No. of female family heads	0.07	0.06	0.28	0.32	0.36	0.26
	Disaster presentation strategy-prepared/not-prepared	prepared	prepared	prepared	prepared	prepared	prepared
SDG2	End Hunger						
	Major foods crop production (in mlns of quintals)	270.08	267	319	346	375	406
	Average productivity of major food crops (Qt/ht)	21.05	19.0	25	27	29	31

[30] Source: National Planning Commission, FDRE. The 2017 Voluntary National Reviews on SDGs of Ethiopia: Government Commitments, National Ownership and Performance Trends; 2017, Addis Ababa, Ethiopia

	No. of households (farmers) who obtained general agricultural extension services ('000)	13950	15735	16406	17038	17692	18237
	No. of households (farmers) who obtained improved agricultural extension services ('000)	14014	14549	15105	15685	16287	16776
	Total No. of Male headed rural households who received agricultural extension services ('000)	8343	8594	8852	9118	9392	9674
	Total No. of female headed rural households who received agricultural extension services ('000)	4253	4466	4689	4924	5170	5325
	Total No. of rural youth (agriculturalists) who received agricultural extension services ('000)	1418	1489	1564	1643	1725	1777
	Total No. of pastoralists who received extension services ('000)	690	718	755	794	826	858
	Total No. of Male pastoralists who received extension services ('000)	414	427	449	472	487	502
	Total No. of female pastoralists who received extension services ('000)	207	218	229	241	254	267
	Total No. of youth pastoralists who received extension services ('000)	69	73	77	81	85	89
	Total No. of agro-pastoralists who received extension services ('000)	450	420	487	507	527	547
	Quantity of compost utilized (in metric tons)	1025231	752282	1355868	1559248	1793135	2062106
	Quantity of improved seeds supplied ('000 Qt)	1874	2617	2795	3052	3296	3560
	Areas covered by soil and water conservation	20170	1062	1168	1284	1412	2134

	structures in community watersheds ('000 ht)						
	Extent of GHG (CO_2) removed using biological methods from community watersheds (mln mt CO2e)	-	5	6	6	7	8
	Land developed through medium scale modern irrigation schemes (mln hectares)	2.35	3.0	3	4	4	4
	Meat production ('000 tons)	1321	1990	1652	1805	1966	2103
	Milk production (cow, camel, goat) (in mln liters)	5304	4467	5938	6610	7051	9418
SDG3	Healthy lives and well-being						
	MMR per 100,000 LB	420	412				199
	Deliveries attended by skilled health personnel (%)	60	72.7	72	78	84	90
	Under five mortality per 1000 live births	64	67				30
	Neonatal mortality per 1000 live births	28	29				10
	Under-5 stunting rate (%)	40	38.4				26
	Under-5 wasting rate (%)	9	9.9				4.9
	HIV/AIDS incidence rate (%)	0.03	0.03				0.01
	Detection rate of all forms of TB (%)	61	61.3	81	83	85	87
	Incidence of newly contracting hepatitis B (in '000)	21.63	23.2				
	No. of people in need of treatment for priority lowland diseases (millions)	75	66.6				14.9
	Mortality rate of heart diseases, cancer, diabetes and respiratory infections	476	287				
	Death rate from traffic accidents (per 10, 000)	60	63				27
	Mothers utilizing modern FPMs (%)	40.4	35.3				50
	Teenage (adolescent) fertility rate per 1000		12				

	Critical health coverage (%)	96	98				100
	No. of people with health insurance coverage (per 1000)	72	125				
	No. of health professional per 1000 population		0.84	1.2	1.3	1.5	1.6
	Kebeles (lowest administrative units in Ethiopia) that implemented health extension program (%)	92	93				100
SDG5	Gender Equality						
	Full-fledged implementation of Women Policy and Women Development Package and Youth Policy and Youth Developmental Package	Women Policy & Development Package prepared and put under implementation					
	Full-fledged implementation of national and sectoral development policies and programs, proclamations (eg.Education, Health policies and programs, family law)	Policy formulated and laws promulgated					
	No. of women trained on different professions (millions)	1.13	1.89	2.40	2.88	3.37	3.87
	No. of women benefited from vocational adult educational programs (Millions)	2.97	2.35	3.66	4.98	6.29	7.60
	No. of institutions/organizations that institutionalized women's affairs	8	69	19	20	21	22
	No. of structures in higher education institutions that provide counseling services for female students	31	111	119	127	135	143
	No. of hostels (boarding schools) established and strengthened	10	16	24	26	28	30
	Percent of women at parliament	38.8	38.8				50

	Decision making role of women at the federal executive bodies (%)	9.2		34	36	38	40
	Laws and regulations issued to ensure access to female reproductive health data and education	Procedure rolled out and under implementation					
	No. of women who received land use right	8647118	9492772	12086907	14681042	17275177	19869312
	Availability and usage of legislation backing women's equal right to land ownership and use	Women policy was produced and is under implementation					
	Monitoring mechanisms to ensure effective usage of budget allocated to enhance women's equality	Monitoring Mechanisms rolled out					
SDG9	Build infrastructure, promote industrialization and foster innovation						
	Areas 5 KM further away from all weather roads (%)	36.6	35.8				13.5
	Supply of passenger seats per flight distance (in billion Kms)	32	39.9				68
	Value added growth in MSE(%)	3.8	2.5	21.3	22.60	23.00	23.50
	Share of medium and large industries' products in GDP(%)	3.8	4.4	4.4	4.8	5.3	5.9
	Share of MSE products in GDP (%)	1.1	1	1.3	1.4	1.6	1.8
	Value added growth in manufacturing industries (%)	15.8	18.4				21.9
	Value added growth in medium and large industries (%)	23.1	22.9	21.3	21.8	22.6	23.4
	Mobile service penetration (%)	43.9	49	68.2	79.4	90	100
	Number of mobile service users ('000)	40,000	45963	65465	78197	90930	103662
	Construction of AA light Rail (34km) (%)	80	100				
	Construction of AA-Meiso_Dewole Raile (%)	86.5	99.2				
SDG1	Conserve and						

4	sustainably use the water resources for sustainable development						
	Medium and large irrigation study and design (ha)		71291				
	Medium and large irrigation development (ha		39785				
	Value added of sherry products (GDP share %)	0.1	0.1				
	Production of Fisheries (tons)		48386	55158			
SDG 17	International partnership for sustainable Development						
	Share of GDP of total revenue (%)	15.4	16	16.4	17.4	18.4	19.7
	The share of tax revenue in GDP (%)	12.7	12.5	14	15.2	15.9	17.2
	The share of foreign aid in GDP (%)	1	0.9	0.8	0.7	0.6	0.5
	The share of FDI, foreign aid and south-south cooperation aid in total government budget (%)	21	24				
	Share of budget deficit in GDP (%)	1.9	2.4	2.8	2.8	3	3
	Customs-Tariff (average rate (%))	17.5	17.5				
	No. of clusters of factories built in Industrial parks	19	52				
	Internet Services Users (Millions)	9.6	13.6	25.3	37.9	47.0	56.0
	Broad band internet service users (Millions)	1.6	4.9	16.4	24.1	31.6	39.1
	Share of export (commodities +service) in GDP (%)	9.4	8	15.5	15.7	18.1	20.6
	Methods to harmonize Sustainable Development with Development Policy	National Development plan harmonized with Sustainable Development					
	Competence to produce SDG Review – Reports	The SDG M&E system rolled					

	utilizing SDG-performance M&E formats	out					
	Adopting national SDG performance Indicators compatible with SDGs and with standard statistics principles	Plan and M&E Policy Matrix for the plan compatible with SDGs prepared					
	Adoption of Statistics-law compatible with national Statistics principles	Statistics law in effect already					
	Statistics plan supported by budget	National Statistics Strategy prepared					
	National population census at least once every 10 years	Population census conducted in 1983/84, 1994/95, 2007 and will be conducted in 2018					
	Infants that received birth certificates	Official issuance of birth certificates started in August 2016					