SUPPORT STILL NEEDED

ETHIOPIA:
HEALTH PROGRESS & DONOR ASSISTANCE

RESULTS
the power to end poverty

CONTENTS

EXECUTIVE SUMMARY 03

GOOD PROGRESS TOWARDS THE MDGS 04
LEAVE NO-ONE BEHIND 05
UNDERNUTRITION, A BARRIER TO PROGRESS 06
THE ROLE OF UK AID 07
FINANCING HEALTH 08

RECOMMENDATIONS 09
DELEGATION ITINERARY 10
ACRONYMS & REFERENCES 11

In October 2015 a cross-party delegation of three UK parliamentarians visited Ethiopia to gain insight into how the country is addressing their major health challenges. The delegation was organised by RESULTS UK and followed a similar parliamentary delegation in 2013. The trip had a particular focus on improvements in nutrition and child health, coupled with looking at how substantial investment in health system strengthening has led to the successful achievement of Millennium Development Goal 4 (To reduce by two-thirds, between 1990 and 2015, the under-five mortality rate). The delegation also examined the impact of UK support to Ethiopia on these key issues through various bilateral and multilateral channels.

This publication is part of the RESULTS Nutrition series, which aims to highlight the serious negative impact that undernutrition has on development progress around the world:

- **What Works for Nutrition? Stories of Success from Vietnam, Uganda, and Kenya. 2015**
- **Who Pays for Progress? The Role of Domestic Resource Mobilisation and Development Assistance in Financing Health. 2015 (Kenya)**
- **Undernutrition in the land of rice. 2014 (Cambodia)**
- **Nutrition Advocacy in Zambia. 2014**
- **You can't study if you're hungry. 2014 (Tanzania)**
- **Nutrition Aid Architecture: How Could Improvements in Financing Mechanisms Galvanise the Global Effort? 2014**
- **Proposed Nutrition Goals, Targets & Indicators for the Post-2015 Development Agenda. (RESULTS & others) 2015**
- **Call to Action: Nutrition in the Post-2015 Development Agenda. (RESULTS & others) 2015**
- **Increasing the UK's contribution to tackling malnutrition: Review and Recommendations. (RESULTS & others) 2015**

They are available on our website: results.org.uk/about-us/publications

RESULTS UK grants permission to share, copy, cite extracts from, and reproduce this publication for non-commercial purposes.

EXECUTIVE SUMMARY

In October 2015 a delegation of UK parliamentarians visited Ethiopia to gain an insight into how the country is addressing challenges in child health and nutrition. The main findings were as follows:

ETHIOPIA HAS MADE GOOD PROGRESS TOWARDS THE MDGS THROUGH INTERNAL EFFORTS & DONOR SUPPORT

Ethiopia – the world's 15th poorest country - has made more progress on the MDGs than almost any other developing country. It achieved MDG4, to reduce child mortality, three years ahead of the deadline. The under-five mortality rate was cut by 67% between 1990 and 2012. Ethiopia is a positive example of how poverty can be reduced through strong political leadership and good collaboration between the state and donor partners. Despite this progress, in absolute terms, Ethiopia still has the sixth highest number of under-five deaths in the world. Hundreds of thousands more suffer chronic malnutrition. The main challenge is that while national statistics show good progress, this progress has been uneven. Some regions and population groups are being left behind.

◆ UNDERNUTRITION IS A BARRIER TO PROGRESS

Progress in all development areas is hindered by high rates of undernutrition. More than 44% of children under the age of five are stunted while 10% are wasted. Reducing undernutrition is needed for economic growth to reach its full potential, as malnutrition costs Ethiopia around 16% of its Gross Domestic Product per annum. The Government of Ethiopia (GoE) has recognised this as a major development challenge and is implementing policies to address undernutrition. In July 2015, it launched the Seqota strategy, an ambitious National Nutrition Plan for 2016 to 2020.

The GoE has to tackle both medium term and urgent needs. The medium term priority is to address the undernutrition that affects large numbers of the population. Each year around 24 million people are short of food in certain months. They suffer from micronutrient deficiencies, which affect their health and well being. There needs to be a stronger response to provide essential minerals and vitamins. A multi-sectoral response is needed, through nutrition-sensitive agriculture, food fortification, nutrition education, water and hygiene. A nutrition response based in the Prime Minister's office would strengthen a cross-ministry approach.

Today the GoE also faces an urgent threat from the failure of rains affected by the global El Niño phenomenon. This will need an urgent effort from donors and the state to improve food security through provision of food aid or cash transfers to the affected population. Currently 8.2 million people are known to be affected but this number may climb to as many as 12 million people by early 2016.

◆ THE ROLE OF UK AID

UK assistance through its bilateral programme is significant. The UK has provided over £300 million since 2010 to support Ethiopia's progress towards the health MDGs. Most of this goes to a pooled fund for primary health care. The delegates found the work of DFID to be highly impressive and to have contributed significantly to the success of Ethiopia in meeting its health challenges.

All DFID country offices worldwide are currently writing plans for the next five years. In Ethiopia, one scenario being considered is to reduce assistance to health, and end it by 2020. Based on the strongly positive impact of UK Aid, it is highly worrying the UK would no longer support the health sector. It would have a detrimental impact on health services in Ethiopia, and also send the wrong message to other donors and African governments which are working hard to improve their health services.

UK assistance is also delivered to health through multilateral agencies such as Gavi, the Vaccines Alliance, and the Global Fund to Fight AIDS, TB and Malaria (GFATM). These are effective global bodies that deliver core funding to tackle health challenges. DFID is a global leader in its support for these agencies, which is commendable. But funding to these agencies cannot be 'tied' to certain countries. The UK therefore cannot cut bilateral aid to health in Ethiopia and expect the global funds to make up that funding through their sources.

◆ FINANCING HEALTH

Ethiopia has made commendable progress towards the MDGs partly because of strong government leadership. Political direction has been excellent and this was reinforced recently with a GoE commitment to end undernutrition by 2030. The financial commitment has been less impressive, understandable given that Ethiopia is still one of the poorest countries in the world. The GoE only spends $25 per capitai on health, far below the WHO recommended figure of $64 required for a minimum package of health services in a developing country. The budget percentage that is allocated to health has remained stable for the last six years and some donors are calling for it to increase. Around 40% of total spending on health falls on citizens themselves through user fees or out of pocket expenditure. Significantly more financial resources from donors and the GoE are required to meet the health needs of the country. Donors and the GoE should invest more in efforts to increase Domestic Resources for Health.

GOOD PROGRESS TOWARDS THE MILLENIUM DEVELOPMENT GOALS (MDGS)

Visiting Ethiopia towards the end of 2015 meant assessing a country virtually at the end of the 15 year MDG period. A major priority of the MDGs, a set of 8 targets to be achieved between the years 2000 and 2015, was the reduction of extreme poverty and improvements in three sets of health indicators.

Ethiopia, the world's 15th poorest country, has made more progress on the MDGs than almost any other developing country[ii]. The country achieved MDG4 – to reduce child mortality by two thirds, three years ahead of the deadline. The under-five mortality rate has been reduced by 67%, from 204 deaths to 68, per 1000 live births, between 1990 and 2012. Ethiopia is a good example for other countries, showing that poverty can be reduced and children's lives saved when there is strong political leadership and good collaboration between the state and donor partners, even in a low-income country.

Ethiopia has also made impressive progress towards MDG5 (to reduce by three quarters the maternal mortality ratio) and towards MDG6 (to combat HIV/AIDS, malaria and other diseases). The country has been able to achieve this through revitalising the concept of primary health care, implementing a nationwide programme of Health Extension Workers (HEWs) which are fundamental to the delivery of preventative health care in even the most rural areas of Ethiopia.

Our delegation was able to visit many aspects of this primary health programme including health centres and health posts in urban and rural areas, village health workers, and volunteer families in model villages. While a health centre serves up to 25,000 people, a health post is a small building that serves a local community of approximately 5000. Since over 80% of Ethiopia's population lives in rural areas health posts are particularly important for bringing health services closer to previously neglected areas. In the last seven years the number of health centres has risen from 600 to 3,500, and there are now around 15,000 health posts.

Most of the world's poorest nations have a significant shortage of trained health personnel and this has always been true of Ethiopia. But since 2003, the Government has recruited and trained a large pool of primary health workers, HEWs. There are now 38,000 of these, almost all young women, chosen to represent and serve their local community with an emphasis on mothers and children. Health workers deliver a set of 16 basic health interventions such as immunisation, family planning, sanitation education and growth monitoring.

LEAVE NO-ONE BEHIND

Just two days before we left for Ethiopia, 192 world leaders signed off the next phase of global development efforts – the Sustainable Development Goals. This new set of Global Goals aims to see the elimination of extreme poverty by 2030. A crucial aspect of the new goals is that they must apply to all sectors and people, in all countries – not just the urban, or easily reached. Development progress should be across all wealth quintiles, and inequality reduced.

Although Ethiopia has made excellent progress with national averages this progress has been uneven. For example, the infant mortality rate (IMR) in the capital has been reduced to 53 deaths per 1000, but in more remote provinces, such as Benishangui, the IMR is as high as 169. Reducing inequality and reaching the poorest needs to be the major challenge of the

> Ethiopia remains one of the world's poorest countries, with around 25 million people living in extreme poverty. In the last five years, with UK support, Ethiopia has reduced child mortality by a quarter, put four million more children in primary school and protected almost eight million people from needing humanitarian food aid.
>
> **GRANT SHAPPS, MINISTER FOR INTERNATIONAL DEVELOPMENT, 4 NOVEMBER 2015**

UNDERNUTRITION, A BARRIER TO PROGRESS

"We are extremely concerned about the impact of the current drought on the food security situation in Ethiopia….In October, the Government of Ethiopia announced that about 8.2 million people are in need of emergency food aid, up from the 4.5 million estimated in August….Britain has acted quickly by providing emergency support for 2.6 million people.

BARONESS VERMA IN THE UK HOUSE OF LORDS, 18 NOVEMBER 2015

Nutrition is a crucial driver of development progress in all areas. Undernutrition contributes to around 45% of all child deaths globally. For millions of children the consequences of undernutrition are lifelong and irreversible: poor school outcomes, hindered productivity, and lower earnings. Thus, malnutrition impacts both individuals and nations as a whole. Ethiopia loses an estimated 16% of GDP due to undernutrition[iii].

Our delegation learnt about two issues relating to food security and undernutrition, the ongoing need and the immediate need. The ongoing need is the structural undernutrition that still affects large numbers of the population. Every year, around 24 million people are short of food in certain 'hungry months' before the new harvest comes in. More than 6 million children (40% of all under-fives) are stunted and unable to reach their potential. Micronutrient deficiencies, also known as 'hidden hunger', are widespread amongst such populations. Even where children have enough staple food for most of the year, their non-diverse diets lack essential minerals and vitamins, and this adversely affects their growth and development.

Our delegation visited health posts where development partners such as the Micronutrient Initiative (MI) support the Government in its efforts to tackle vitamin and mineral deficiencies among women and children. We were told that 38% of children in Ethiopia are deficient in vitamin A, and 17% of women are anaemic. Health Extension Workers are being trained to provide vitamin A supplementation to children under the age of five years, and therapeutic zinc to treat diarrhoea which can be fatal. Various technical agencies provide capacity strengthening to the Government and we were pleased to learn that one new technical assistance project, – the Nutrition Technical Assistance Mechanism (N-TEAM), - has just been co-funded by the UK and Canada.

A shortage of zinc supplements at the health posts was a significant barrier to the provision of zinc, and we heard that this was due to supply problems from a bulk supplier in India. (a very large order was placed, but this meant all the zinc arrived at once. By the time the stocks arrived in rural health posts much of the zinc was past its expiry date). The Ministry of Health will have to work on an improved purchase system of inputs (for example, smaller consignments and more frequent purchases). It should also encourage local production of essential drugs and inputs.

In addition to the longer term nutrition interventions, a more immediate need alarmed the delegation. This year (2015), the El Niño effect, a global cyclical weather pattern, has had a highly negative effect on rainfall in large part of the country[iv]. The failure of the belg rains in spring and the kirempt rains in July has caused crop failure and consequent food shortages. This will lead to a slow-onset emergency, with livestock already dying in some areas. The Government estimates that around 8.2 million people have been affected. Other agencies, however, said the figure may be around 10 million, and could even affect 15 million people by early 2016.

According to the UN 'Ethiopia Humanitarian Country Team', $237 million is needed to pre-position food supplies for the first quarter of 2016. DFID has agreed to release $45 million (£30m) for this intervention which is an important step, but much more will be needed from the donor community. The Ethiopian Government will need to show great urgency and transparency to tackle the situation. This particularly strong El Niño is also causing drought and hunger in other countries (such as Malawi and Zambia) and thus brings added urgency to global efforts to tackle climate change.

Regular growth monitoring is an important role for Health Extension Workers

UK SUPPORT TO HEALTH AND NUTRITION

"I was impressed to see the efforts made to collect data, even in rural areas. On the walls of every health post we saw charts tracking nutritional targets, and the degree of success in the battle against diseases such as Malaria. I recognise from my own work on Breast Cancer in Scotland, the motivation and pride felt by Health Workers seeing improvements in their population. But there are still significant challenges in registering births and deaths

DR PHILIPPA WHITFORD

Through meetings with the Minister of Health, health service providers and Ethiopian civil society, the delegation of UK parliamentarians explored how the UK has supported Ethiopia in their successful accomplishment of the health MDGs. Development in the poorest countries will not be achieved through aid alone, however aid will continue to be a significant driver of development. A careful combination of aid and domestic financing will help countries address health challenges, and move towards middle-income status. In the health sector, aid from the UK has been extremely important. Dr Kebede Worku, State Minister of Health explained that DFID has been a strong partner for many years and "What has been valuable has not only been the amount of funding, but the partnership and the funding model".

The UK provides the vast majority of its funding directly into the MDG Performance Fund (MDGPF), a pooled fund in partnership with other donors such as the World Bank, UN agencies and other European countries. This is a sector budget support scheme that means the health ministry can work with one unitary plan, budget and monitoring system. There is a close and beneficial relationship between ministry staff and health staff from DFID and other donors.

The UK has provided over £300 million between 2011 and 2015 in bilateral programmes to accelerate Ethiopia's progress towards the health MDGs. The main component of this is over £50 million a year which goes to the MDGPF. This substantial funding in recent years is available due to the UK successfully moving towards and achieving the UN target of giving 0.7% of GNI to international development. If other countries were to also meet this target the eradication of global poverty could be achieved much quicker.

DFID is one of the leading donor nations supporting nutrition programmes. Prior to 2013 only a very small proportion of UK aid went to nutrition. However, since the Nutrition for Growth conference in London in 2013, co-hosted by the UK Government, this proportion has steadily grown. It is hoped that both Ethiopia and the UK will send their Prime Ministers to the next Nutrition for Growth Summit in Rio de Janeiro, Brazil, during the 2016 Olympics, to make ambitious pledges for tackling malnutrition in all forms, and ensuring no one is left behind.

The UK is also a global leader supporting major global funds and networks that contribute a huge amount to improving child health. Examples of these are Gavi, the Vaccines Alliance, the Global Fund to Fight AIDS, TB and Malaria (GFATM) and, on a smaller scale, the Scaling Up Nutrition (SUN) movement. DFID's bilateral programmes in 28 priority countries interact strategically with these global funds that work across a large number of developing countries. The delegation heard that DFID is considering phasing out the bilateral health programme in Ethiopia over the next five years. We consider that withdrawing support from one of Africa's most successful health programmes would greatly endanger the progress made, and leave a large hole in the funding required to strengthen the rest of the Ethiopian health system.

Doctor Philippa Whitford MP and the delegates discuss the use of Iron and Folic Acid to reduce anaemia

FINANCING HEALTH

The new Seqota Declaration inspires us all to engage more strategically. With this initiative the government reaffirms its commitment to end undernutrition in Ethiopia by 2030

HENOCK GEZAHEGN (MI)

Even tiny out-of-pocket charges can drastically reduce the use of needed services. This is both unjust and unnecessary

JIM KIM, WORLD BANK PRESIDENT.[viii]

Strong political leadership and the commitment of Government has been imperative in Ethiopia's progress towards meeting the health MDGs. Our delegation heard that donors have confidence investing in Ethiopia as levels of financial inefficiencies, or corruption, are low. Planning is detailed and plans are followed through. Political direction has been excellent and this was reinforced recently with the publication of the Seqota Declaration where the Government has committed to ending under-nutrition by 2030.

A concern however is that the Seqota Declaration is so far uncosted. In other respects, too, financial commitment could be improved. The Government only spends $25 per capita[vi] on health, far below the WHO recommended figure of $64 required to achieve a minimum package of health services in a developing country, let alone the recommended $84 needed to move towards Universal Health Coverage. Of total expenditure on health across the country the Government only contributes one fifth, while the main proportions are contributed by donors or by citizens themselves purchasing medicines or paying health user fees. The budget percentage that is allocated to health has remained stable for the last six years, while some donor nations would like to see this increase.

This situation is not unique to Ethiopia of course. In research done by RESULTS in Kenya in 2015 a similar situation was found – 45% of the Kenyan health budget is contributed by donors (and even more of the nutrition budget)[vii]. The research found that economic growth could be boosted with greater investment in health, and that both donors and the state should increase their spending on health to achieve this. Economists have shown that spending on simple nutrition programmes for infants in the first two years of life gives a return-on-investment higher than almost any other development intervention.

Ethiopia does devote a large proportion of government spending to social programmes such as education, health and agriculture. The challenge is that the total resources available are still so low, in what is still an extremely poor country. Efforts should be made to increase the total pot of funds available for health, both from external sources (donors) and from internal sources. The UK should encourage other donor nations to increase their support to health in Ethiopia. Another way to raise the total funding available is to increase Domestic Resource Mobilisation (DRM), recognising that the economy is growing at around 10% a year.

Improving DRM was one of the main themes of the Financing for Development conference held in Addis Ababa in July 2015. Both donors and the Government of Ethiopia are keen to increase DRM and one way to do this is by improving tax collection. In Ethiopia, DFID as well as other donors have increased their support to improving the effectiveness of revenue systems. This was evident in the launch of the Addis Ababa Tax Initiative during the conference in July. Another way in which Ethiopia could increase resources available for health, and promote equity, is by implementing a pooled Social Health Insurance scheme. This should cover, through tax revenue, the contributions of the poorest members of society, so that the burden of paying user fees can be reduced.

State Minister of Health Dr Kebede Worku with delegates Lord Sheikh and Jonathan Oates.

RECOMMENDATIONS

FOR DFID

◆ CONTINUE TO SUPPORT THE HEALTH SECTOR

The support given by DFID to health in Ethiopia has been substantial, strategic and significant to improving health outcomes and saving lives. The delegation heard that DIFD is considering winding down its support to the health sector in the next five years, partly so as to free up more funds to support other priorities such as private sector development. DFID is recommended not to withdraw from the health sector. A five year period would be too rapid and would result in a significant drop in available funds for health and nutrition. DFID withdrawing from the health sector would break a highly successful partnership and would give a very negative message to other donors.

◆ CONTINUE TO SUPPORT MULTI-LATERAL FUNDS BUT THESE CANNOT REPLACE BILATERAL FUNDS

DFID contributions to global funds such as Gavi, the Vaccine Alliance, and The Global Fund to fight AIDS, TB and Malaria have been crucial over the last decade. The UK is to be commended for global leadership supporting these organisations. However these agencies work globally and donor countries cannot earmark their contributions to specific recipient countries. Some stakeholders in Ethiopia suggested that the UK could reduce bilateral funding for the health sector in Ethiopia but this would be offset by UK funds via multilaterals. It is recommended that DFID continue the current substantial support to these Global Funds. But by doing so the UK could not claim that funding multilaterals would make up for significant cuts to the bilateral programme.

◆ FACILITATE THE ENGAGEMENT OF UK PRIVATE SECTOR IN THE LOCAL PRODUCTION OF INPUTS

The fact that nutrition interventions such as zinc, iron and folic acid and Ready-to-Use Therapeutic Foods such as Plumpy'Nut are produced abroad is a weakness for Ethiopia. There is potential for the UK private sector to assist in the move towards local production, thus bringing savings in costs, currency and efficiency. DFID should include a feasibility study of national production of health-assisting products in its Private Enterprise Programme.

FOR GOVERNMENT OF ETHIOPIA (GOE)

◆ URGENTLY SEEK FUNDING TO COPE WITH CURRENT FOOD INSECURITY

The GoE is to be commended for the excellent progress in primary health care since 2000 and for their reduction in infant mortality rates. However these gains are threatened by the relative failure of the rains in 2015. The GoE need to move in an urgent and transparent way to acknowledge the scale of the problem and source internal and external funds to ensure lives are not lost.

◆ INCREASE DOMESTIC RESOURCES FOR HEALTH AND REDUCE THE BURDEN OF USER FEES.

According to figures received, of Total Health Expenditure in Ethiopia the GoE currently contributes about 20%, donors 40% and 'Out-of-pocket spending' 40%, making the Government responsible for only one fifth of health expenditure. The GoE should make efforts to improve domestic resource mobilisation to raise more income for health. The UK can assist by encouraging other donors to increase their support for health in Ethiopia, and by providing technical assistance to tax collection systems to improve DRM.

◆ MOVE TO REDUCE HEALTH USER FEES OVER THE NEXT FIVE YEARS

Global evidence from the WHO has proven that health user fees cause ill people to delay health-seeking behaviour. User fees are prejudicial to the poor and are inefficient to collect. The GoE should instigate sustainable and equitable ways of phasing out fees for health services as the point of delivery.

FOR ALL STAKEHOLDERS

◆ WORK WITHIN THE STRUCTURES THAT EXIST TO ADDRESS BOTH SHORT-TERM & MEDIUM TERM PRIORITIES

All agencies are encouraged to keep up the excellent progress so far on the MDGs while prioritising the major challenge of the next 15 years – to leave no-one behind. The GoE should be assisted to prioritise "reaching the final fifth", the bottom quintile. Stakeholders should balance support to short-term needs such as the current failure of the rains, and to long-term 'hidden hunger' caused by ongoing micronutrient deficiencies which lead to stunting today and huge economic and social costs in the future. Investing in nutrition and health now will bring significant economic benefit in the future, as the country moves towards the ambition of Middle Income status by 2025.

ITINERARY

MONDAY 28 SEPTEMBER
ADDIS ABABA

- Briefing with the **FCO**
- Meeting: **Dr Pierre Mpele**, WHO Representative to Ethiopia.
- Dinner with **Cat Evans**, Deputy Ambassador to Ethiopia and **Angela Spilsbury,** Senior Health Adviser, DFID

TUESDAY 29 SEPTEMBER
OROMIA

- Visit to **Bole Health Centre**
- Visit to **Salam Health Centre**
- Visit to **Debrezeit Health Centre**
  Facilitated by Ministry of Health and WHO

WEDNESDAY 30 SEPTEMBER
HAWASSA / OROMIA

- Visit to **Wondo Health Clinic**
- Meeting with **health extension workers**
- Visit to **Tula Health Centre**
  Facilitated by Ministry of Health and WHO
- Dinner with staff from **UNICEF**

THURSDAY 1 NOVEMBER
SEBETA / ADDIS

- Visit to **Teffik Health Centre**
- Visit to **Bonde Health Post**
- Visit to **local households and meetings with community elders**
  Facilitated by Micronutrient Initiative
- Meeting with **DFID Health Team**
  Jyoti Tewari, Senior Human Development Adviser,
  Angela Spilsbury, Senior Health Adviser and
  Casan Mohammed, Consultant
- Dinner with **Dr Abdul Adish**, Deputy Africa Director & Africa Nutrition Advisor, and
  Henock Gezahegn, Country Director, Micronutrient Initiative

FRIDAY 2 NOVEMBER
ADDIS ABABA

- Meeting with **Dr Kebede Worku**, State Minister of Health
- Meeting with **Dr Ephream Tekle**, Director Maternal and Child Health;
  Dr Helina, Immunisation Programme Manager;
  Dr Liya, Nutrition Programme Manager, and
  Dr Biara, Child Health Programme Manager,
  all from the Ministry of Health
- Meeting with **Immunisation Inter-agency Coordination Committee** including representatives from UNICEF, DFID, WHO, Government of Ethiopia, Rotary and JSI.
- Meeting with representatives of **International NGOs & networks working in Ethiopia**
- Meeting with representatives of **National NGOs & networks working in Ethiopia**

ACRONYMS

FCO	Foreign and Commonwealth Office (UK)
DFID	Department for International Development
Gavi	Gavi, The Vaccine Alliance
GFATM	The Global Fund to Fight AIDS, Tuberculosis & Malaria. Often shown as The Global Fund
GoE	Government of Ethiopia
JSI	John Snow, Inc
MDGs	Millennium Development Goals
MDGPF	MDG Performance Fund
MoH	Ministry of Health
MI	Micronutrient Initiative
WHO	World Health Organisation
SDGs	Sustainable Development Goals

REFERENCES

i *http://data.worldbank.org/indicator/SH.XPD.PCAP*

ii *Towards a healthier Ethiopia. WHO, June 2015*

iii *The Cost of Hunger in Africa: Results from Ethiopia http://www.costofhungerafrica.com 2012*

iv *https://www.oxfam.org/en/research/entering-uncharted-waters-el-nino-and-threat-food-security 2015*

v *https://www.humanitarianresponse.info/en/operations/ethiopia 10 November 2015*

vi *http://data.worldbank.org/indicator/SH.XPD.PCAP*

vii *Who Pays for Progress? RESULTS (UK) & KANCO (Kenya); July 2015*

viii *Dr Jim Kim, Speech at World Health Assembly, 2013*

PHOTO CREDITS:

Cover | PP06 | 07 **Zacharias Abubeker**

PP04-05 | 08 **Steve Lewis - RESULTS UK**

WE WOULD LIKE TO THANK ALL THOSE WHO MET WITH US AND ARRANGED VISITS

DELEGATES & STAFF NAMES

Lord Sheikh | Conservative member of the House of Lords and business leader.
Dr Philippa Whitford | SNP MP for Central Ayrshire and party Spokesperson for Health. (Dr Whitford is also a practicing surgeon)
Lord Jonathan Oates | Until recently Chief of Staff of the Deputy Prime Minister. Recently appointed as Liberal Democrat peer in the House of Lords

Steve Lewis | Head of Policy Advocacy, RESULTS UK
Jim Calverley | Parliamentary Advocacy Officer (Child Health)
Laura Kerr | Policy Advocacy Officer (Child Health)

RESULTS UK

This report was produced by RESULTS UK, a non-profit advocacy organisation that aims to generate the public and political will to end hunger and poverty. The focus of RESULTS' work is on educating and empowering people – be they ordinary citizens or key decision-makers – to bring about policy changes that will improve the lives of the world's poorest people. Our advocacy focuses on areas we believe have the most potential to make a difference. We have a track record of expertise in education, microfinance, global health and nutrition issues.

RESULTS collaborates with MPs and other high level 'champions' and also has a network of volunteers around the UK: grassroots advocates who work together in local groups to become powerful advocates for change. We support people to build their understanding of poverty issues and what they can do about them. Our approach has proven to be effective and powerful, yielding significant results which have brought closer an end to poverty. RESULTS carries out strategic advocacy, media and public awareness raising campaigns at national and international levels.

RESULTS UK collaborates with RESULTS organisations in the USA, Japan, Canada, Australia, South Korea and Mexico to achieve our advocacy objectives, and we work closely with allied NGOs in Africa, Asia and Europe through the ACTION Global Health Partnership.

+44 (0) 20 7793 3970 | **info@results.org.uk** | **www.results.org.uk**

THE ACTION GLOBAL HEALTH PARTNERSHIP

RESULTS UK is a member of ACTION – a global partnership of advocacy organisations working to change policy and mobilise resources to fight diseases of poverty and to improve equitable access to health services. ACTION was founded in 2004 as a partnership of civil society advocacy organisations with the shared mission of mobilising new resources to respond to TB globally. Since then, ACTION has expanded its advocacy efforts to include the promotion of child survival. Within the child survival area ACTION has a particular focus on highlighting the importance of undernutrition for infant development and supporting the benefits of immunisation.

www.action.org | **@ACTION_tweets** | **info@action.org**

RESULTS UK Head Office, 31-33 Bondway, London, United Kingdom, SW8 1SJ
+44 (0)207 793 3970 | www.results.org.uk | facebook.com/results.uk | twitter@resultsuk