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Health Sector Development Programme III

Annual Performance Report

EFY 2002 (2009/10)

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Annual Performance Report
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Acronyms

AHOTP	Accelerated Health Officers Training Program
AIDS	Acquired Immunodeficiency Syndrome
ALERT	All Africa Leprosy Rehabilitation and Training Center
ANC	Antenatal Care
ARI	Acute Respiratory Infections
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARV	Antiretroviral
AWD	Acute Watery Diarrhea
BCG	Bacille Calmette Guerin
BEOC	Basic Emergency Obstetric Care
BPR	Business Process Re-engineering
BSC	Balanced Score Card
CAR	Contraceptive Acceptance Rate
CBHI	Community Based Health Insurance
CBN	Community Based Nutrition
CDC	Center for Disease Control (USA)
CEO	Chief Executive Officer
CEOC	Comprehensive Emergency Obstetric Care
CHD	Child Health Days
CJSC	Central Joint Steering Committee
CLTS	Community Led Total Sanitation
CPAP	Country Program Action Plan
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CSRP	Civil Service Reform Program
CT	Computed Tomography
DACA	Drug Administration and Control Authority
DDT	Dichlorodiphenyltrichloroethane
DFID	Department For International Development
DHS	(Ethiopia) Demographic Health Survey
DOTS	Directly Observed Treatment – Short course
DPs	Development Partners
DPT	Diphtheria, Pertussis, and Tetanus vaccine
EDHS	Ethiopia Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHMI	Ethiopian Hospital Management Initiative
eHMIS	Electronic HMIS
EHNRI	Ethiopian Health and Nutrition Research Institute
EMA	Ethiopian Medical Association
EMR	Electronic Medical Records
EMS	Emergency medical system
EOS	Expanded Outreach Service
EPHA	Ethiopian Public Health Association
EQA	External Quality Assurance

Acronyms

EPI	Expanded Program on Immunization
ERCS	Ethiopian Red Cross Society
ERIA	Enhanced Routine Immunization Activities
ESOG	Ethiopian Society of Obstetricians and Gynecologists
ETB	Ethiopian Birr
FELTP	Field Epidemiology and Laboratory Training Program
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FP	Family Planning
GAIN	Global Alliance for Improved Nutrition
GC	Gregorian Calendar
GDP	Gross Domestic Product
GIS	Geographic Information System
GOE	Government of Ethiopia
GPs	General Practicioners
GTZ–AMESE	GTZ-Acces to Modern Energy Services Ethiopia
HAPCO	HIV/AIDS Prevention Control Office
HC	Health Center
HCT	HIV Counselling & Testing
HCF	Health Care Financing
HEP	Health Extension Program
HEW	Health Extension Worker
HF	Health Facility
HHM	HSDP Harmonization Manual
HIT	Health Information Technicians
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health Officer
HP	Health Post
HPDPGD	Health Promotion and Disease Prevention General Directorate
HPF	Health Pooled Fund
HPN	Health, Population and Nutrition Donor Group
HRD	Human Resource Development
HRH	Human Resource for Health
HRIS	Human Resource Information System
HS	Health Station
HSDP	Health Sector Development Program
ICASA	International Conference on AIDS and STDs in Africa
IDD	Iodine Deficiency Disorders
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education, Communication
IESO	Integrated Emergency Surgery Officer
IHP	International Health Partnership
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPFSMIS	Integrated Pharmaceuticals Fund and Supply Management Information System

Acronyms

IRS	Insecticide Residual Spraying
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Net
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
JANS	Joint Assessment of National Strategy
JCCC	Joint Core Coordinating Committee
JFA	Joint Financial Arrangement
JRM	Joint Review Missions
JSI	Joint Steering Commitee
LSI	Leadership in Strategic Information
MDG	Millennium Development Goals
MDR-TB	Multi-drug Resistant TB
MDT	Multi Drug Therapy
NHE	National Health Expenditures
MMC	Millennium Medical College
MMR	Maternal Mortality Ratio
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
MOU	Memorandum of Understanding
MOWR	Ministry of Water Resources
MRI	Magnetic Resonance Imaging
MTEF	Mid Term Expenditure Framework
NGO	Non-Governmental Organization
NAC	National Advisory Committee
NCB	National Competitive Bidding
NCDs	Non-communicable diseases
NCPB	National Committee for the Prevention of Blindness
NTDs	Neglected tropical diseases
NDL	National Drug List
NHA	National Health Account
NNP	National Nutrition Program
OPD	Outpatient Department
OPV	Oral Polio Vaccine
OR	Operations Research
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PBS	Protection of Basic Services
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
PHC	Primary Health Care
PHCU	Primary Health Care Units
PHEM	Public Health Emergency Management
PLWHA	People Living With HIV/AIDS
PMO	Prime Minister's Office

Acronyms

PMTCT	Prevention of Maternal to Child Transmission of HIV
PMUs	Project Management Units
PNC	Postnatal Care
POA	Plan of Action
PPP	Public Private Partnership
RBI	Research Based Initiative
RDF	Revolving Drug Fund
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
RRU	Revenue Retention and Utilization
RTK	Rapid Test Kit
RUTF	Ready to Use Therapeutic Feeding
SAFE	Surgery, Antibiotics, Facial cleanliness, and Environmental Improvement
SAM	Severe Acute Malnutrition
SD	Skilled Delivery
SHI	Social Health Insurance
SNNPR	Southern Nations, Nationalities and Peoples Region
SOP	Standard Operational Procedures
SSA	Sub Saharan África
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TLPC	Tuberculosis and Leprosy Prevention and Control
TOR	Terms of Reference
TOT	Training of Trainers
TVET	Technical and Vocational Education and Training Center
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USD	United States Dollar
VAS	Vitamin A Supplementation
VCHWs	Voluntary Community Health Workers
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

EXECUTIVE SUMMARY

Strengthening the health system and providing quality and equitable health care to all of its citizens remain a priority for the Government of Ethiopia and all stakeholders in the health sector. As a result, numerous initiatives were undertaken during the third Health Sector Development Programme (HSDP III) to achieve universal access to primary health care, notably through the implementation of the Health Extension Program and the accelerated expansion of health centers. This report highlights the major achievements and challenges of the health sector in EFY 2002 under five major sections: Leadership and Governance, Human Resources Development and Management, Essential Medical Products and Technologies, Service Delivery and Quality of Care, and Health Financing.

LEADERSHIP and GOVERNANCE

1 The Leadership and Governance section comprises of policy, planning and M&E, health facility reforms, operational research and technology transfer, public-private partnership, and the ethics programme. Various activities have been carried out, such as strengthening implementation capacity through provision of regular training on management skills to the leadership and top management at various levels of the health system, and undertaking performance evaluation, including the revision of the Ethics Guideline. The implementation of the Health Sector Reform Program has changed the features of the health service system and brought fundamental changes in its organizational structure, mode of operation and governance. The Federal Ministry of Health, Regions, Zones and Woredas have monitored the status of implementation of HSDP III in EFY 2002 through various monitoring and reporting mechanisms.

2 One of the major planning activities that were undertaken in EFY 2002 was the preparation of a sector-wide Woreda-based Core Plan for EFY 2003. The other major undertaking during the year was the development and finalization of the Fourth Health Sector Development Plan (HSDP IV) through continuous consultations made between the Ministry of Health and Development Partners (DPs).

3 The scaling up of the Health Management Information System (HMIS) has progressed, and overall 18,090 health professionals and 1,111 Supervisors have been trained; 64 hospitals (44 in EFY 2001) and 475 health centers (82 in EFY 2001) are currently implementing the reformed HMIS. The printing of around 15 million Family Folders is being processed and so far, around 2.5 million folders have been distributed to Tigray, Amhara, SNNP and Oromia regions.

4 The Health Center Reform Implementation Guideline has been prepared. Hospital Reform Implementation Guideline has also been completed, and based on the guideline several training manuals have been prepared. The implementation of the guideline on the organization and operation of private wings in government hospitals is underway.

5 The Research and Technology Transfer Sub Programme is being implemented starting with production of anti-rabies vaccine. In EFY 2002, operations researches were conducted in the areas of Nutrition, HIV/AIDS, TB, Malaria, traditional medicine and commodity tracking.

HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

6 In EFY 2002, a comprehensive Human Resource for Health (HRH) strategic plan up to EFY 2012 was finalized through the involvement of relevant stakeholders, development partners and international consultants. Though it is awaiting official endorsement, implementation of some of the major components has started already.

7 A total of 34,382 Rural HEWs were deployed up to the end of EFY 2002, which is above the HSDP III target, bringing the cumulative performance to 104.1%. Out of 3,990 Urban HEWs planned to be trained in EFY 2002, a total of 3401 HEWs were trained and deployed in six regions (85.2%), while in pastoral and semi-pastoral areas, out of the planned training of 1179 HEWs, 948 Health Extension Workers (HEWs) were trained, while 747 are still under training.

8 Through the Accelerated Health Officer Training Programme (AHOYP), the total number of both post basic and generic students who graduated up to August 2010 was 3,871 (71.3% of the total). In EFY 2002, 1,559 students (28.7% of the total) are under training and with their graduation AHOTP will be on target. Furthermore, 148 health officers had been enrolled at five Universities to pursue the Integrated Emergency Surgery Officer training programme.

ESSENTIAL MEDICAL PRODUCTS AND TECHNOLOGIES

This section comprises of medical products regulatory system including the necessary safety monitoring, legislation and enforcement mechanisms, and a pharmaceuticals supply and distribution system. The major achievements in EFY 2002 include:

9 Strengthened and sustainable regulatory activities have been performed through a decentralized regulatory system. The Proclamation on Food, Drugs and Health Care Facilities has been approved. The Model Proclamation that enables regions to prepare their own legal framework on inspection of food, drugs and health care facilities has been prepared and distributed to regions.

10 The Pharmaceuticals Supply Programme has progressed during EFY 2002. The Pharmaceutical Fund and Supply Agency (PFSA) carried out a number of activities with regard to forecasting, procurement, distribution, fleet management, warehouse infrastructure and capacity building. The most important achievements are related to a procurement package worth ETB 3.04 Billion, and direct distribution of drugs and supplies to health facilities on bi-monthly basis.

SERVICE DELIVERY AND QUALITY OF CARE

This section comprises of the services provided by the health system, notably the Health Extension Programme, Maternal and Child Health Services, Prevention and Control of Communicable Diseases and Health Infrastructure Expansion, Equipping and Rehabilitation.

11 In EFY 2002 the target was to train and graduate 7,422,664 model households; but the number of households that graduated in the year was 5,918,714 (80% of the annual target).

12 Out of the annual target of 4,468,873 new latrines in EFY 2002, a total of 2,596,031 households built latrines and the annual performance rate was 58.1%. The addition of the new latrines (2,596,031) constructed in EFY 2002 plus the baseline of 9,878,199 resulted in a cumulative total of 12,474,230 households with latrine, with a coverage of 73.7%, short of the 85% target set for the year in the Core Plan.

13 Implementation of the Maternal Health Program had mixed results. Antenatal care coverage increased from 67.7% in EFY 2001 to 71.4 % in EFY 2002 and clean and safe delivery service coverage (delivery service provided by HEWs) from 12.3% in EFY 2001 to 17.0% in EFY 2002, while contraceptive acceptance rate rose from 56.2% in EFY 2001 to 61.9% in EFY 2002. On the other hand, the percentage of deliveries attended by skilled health personnel declined from 18.4% in EFY 2001 to 16.8% in EFY 2002, while postnatal care coverage increased by 1.9 percent (36.2%) from its performance level in EFY 2001 (34.3%), exceeding the HSDP target of 31%.

14 There were upward trends in immunization coverage. DPT/Pentavalent 3 vaccine coverage increased from 77% in EFY 1998 to 86% in EFY 2002, measles vaccine coverage from 67% to 82%, and full immunization coverage from 55% to 72% in the same period. In the last year, there was an increase in immunization coverage, with Pentavalent 3 vaccine coverage increasing from 81.6% in EFY 2001 to 86.0% in EFY 2002, measles vaccine coverage from 76.6% to 82.4%, and full immunization coverage from 65.5% to 72.3%. At the end of EFY 2002, 1,267 Health Centers (HCs) were providing IMNCI, while 578 Woredas were providing Community Integrated Management of Neonatal & Childhood Illnesses (IMNCI) interventions.

15 Concerning Vitamin A Supplementation (VAS), out of the eligible population of 10.9 million children aged 6-59 months, 10.7 million were given the 1st dose of VAS and 9.9 million received the 2nd dose. The national VAS coverage, which was 95% on average (2 doses) in EFY 2001, increased in EFY 2002 to 98% for the 1st round and decreased to 83% for the 2nd round.

Out of the eligible population of 7.6 million 2-5 years old children, the deworming coverage in EFY 2001 which was 98% on average (2 doses) declined in EFY 2002 to 93% for the 1st round and 83% for the 2nd round.

16 The number of clients using HCT services increased substantially during the HSDP III period from 564,321 in EFY 1998 to 9,445,618 in EFY 2002. Despite the steep increase observed from 5,853,472 in EFY 2001 to 9,445,618 in EFY 2002 (+61.4%), the performance was short of the target set for the year, which was 12,591,468.

A total of 6,990 HIV-positive mothers received Prevention of Maternal to Child Transmission of HIV (PMTCT) prophylaxis in EFY 2002, a performance that is slightly above the achievement of EFY 2001 (6,466), but far below the target set for EFY 2002 (37,408): therefore, only 18.7% of the target was achieved in EFY 2002.

A steep increase was observed in the number of People Living with HIV/AIDS (PLWHA) ever enrolled in the ART program (from 39,489 in EFY 1998 to 473,772 in EFY 2002), ever-started ART (from 24,236 to 268,934 in the same period) and currently on ART (from 18,594 to 207,733 in the same period). The upward trend was consistent over time and it was confirmed in the last year: from 376,772 in EFY 2001 to 473,772 in EFY 2002 (+25.7%) for PLWHA ever enrolled in the ART program, from 208,784 to 268,934 (+28.8%) for those ever-started ART and from 152,472 to 207,733 (+ 36.2%) for those currently on ART.

17 According to the Core Plan, 18.5 million Insecticide Treated Nets (ITNs) were planned to be distributed to maintain ITN coverage at 100%; however, 13,060,282 were procured and are being distributed to regions. The cumulative number of ITNs distributed to regions increased from 22,177,419 in EFY 2001 to 35,237,701 in EFY 2002.

18 TB indicators were quite stable in EFY 2002 with respect to EFY 2001, with TB case detection rate being at 36%, TB treatment success rate at 84% and TB cure rate at 65%. Overall, slight upward fluctuations were observed during HSDP III, with an increase of the TB case detection rate from 30% in EFY 1998 to 36% in EFY 2002 (HSDP III target: 50%), TB treatment success rate from 76% to 84.0% (HSDP III target=85%), and TB cure rate from 62% to 65.2% in the same period. Therefore, TB case detection rate in Ethiopia is still far below HSDP III target, while the HSDP III target for TB treatment success rate has been almost achieved.

19 Concerning strengthening of the National Laboratory system, 550 laboratories have participated in the national and international quality control program conducted in EFY 2002. A total of 369 professional personnel have been given training on CD4, chemistry, haematology, malaria microscopy etc. Various types of manuals and job aids have been prepared and distributed to concerned institutions.

20 Concerning Public Health Emergency Management, surveillance and monitoring of 20 diseases and other hazards, have been conducted from Woreda to national levels.

21 There have been outbreaks of epidemic diseases; such as AWD, Measles, Meningitis and Malaria that have been contained through integrated and collaborative effort of the FMOH and Regions, and provision of the necessary drugs and medical supplies to regions affected by the epidemic.

22 Out of 15,842 planned for the year, 14,192 health posts were constructed at the end of EFY 2002, with a performance rate of 89.6%. The cumulative total of health posts equipped during HSDP III rose from 10,797 in EFY 2001 to 12,527 at the end of EFY 2002, which is 79.1% of the cumulative target of equipping 15,842 health posts. A total of 4,452 medical kits were distributed to health posts in urban centers, while in pastoral and semi pastoral areas, 496 health posts (41 in Afar, 106 in Benishangul Gumuz, 304 in Somali, and 45 in Gambella) were provided with adequate medical equipment and materials.

23 The target of HSDP III was to put 3,300 health centers in place by EFY 2002. The FMOH and the Regional Health Bureaus (RHBs) concluded an agreement at the ARM in 2007, whereby for every health center to be constructed by the FMOH, the RHB would have matched this by one health center to be constructed by the region, the so called 'matching health centers'. In addition, the FMOH would have supplied the medical equipment for all newly constructed health centers, both regional and federal. As per their agreement, the FMOH was committed to build 1,456 health centers, while the RHBs were expected to build 1,200 health centers. Accordingly, out of the 1,456 sites planned by the FMOH, 1,249 health centers were available or under construction, of which 848 were completed at the end of EFY 2002.

24 On the part of RHBs, the plan for EFY 2002 was to construct 1,200 matching health centers. Accordingly, 929 health centers were available or under construction, of which 626 were completed at the end of EFY 2002. The national EFY 2002 was 2,142 health centers available; in addition, the construction of 680 new health centers started in EFY 2002, thereby reaching the cumulative total of 2,822 health centers available plus under construction in EFY 2002, which is 85.5 % of the HSDP III target.

25 With respect to equipping health centers, medical equipments were procured for 2,299 existing and newly constructed health centers, and medical equipments for 1,700 health centers (73.9%) were re-packaged and delivered.

26 In EFY 2002, Regions have reported the construction of eight new hospitals, ongoing construction of 27 hospitals, and expansion or upgrading of nine hospitals.

27 Out of the construction of 16 blood banks, 100% of the work has been completed in Debre Markos and Metu, 95% in Debre Birhan, Goba, and Debre Tabor; 90% in Hawassa, Jimma, Harari, Chiro, Adama, Hossana, and Gambella and 85% in Assosa, Axum, Wolisso and Mekelle. The blood bank service run by the Ethiopian Red Cross Society is being transferred to the FMOH.

28 Concerning Outpatient (OPD) attendance, 0.29 OPD visit per capita was reported in EFY 2002; which was lower than in EFY 2001 (0.30) and much lower than the target set for HSDP III (0.66). Wide variations were observed across regions, ranging between 0.11 visits per capita in Gambella and 0.68 in Addis Ababa.

HEALTH FINANCING

29 A sustainable financing system is being developed as a result of the efforts made in the implementation of Resource Mobilization Strategies. The Health Care Financing (HCF) reform has been implemented at National, Regional, Woreda and Health Facility levels. Currently, a total of seven regions and two City Administrations are implementing the HCF reform. In other words, a total of 86 hospitals and 1,268 health centers have started the implementation of the HCF reform.

In order to provide more detailed guidance on the utilization of retained revenue, Guideline on Revenue Retention and Utilization for Quality Improvement has been developed. General National Health Account (NHA) studies and two surveys (Household and PLWHA) have also been finalized.

A proclamation which states the major aspects of the health insurance enriched by the feed backs from stakeholders was submitted for the Council of Ministers in the preceding year. During the current year, the proclamation was approved by the Council of Ministers and subsequently by the Parliament. This is a major milestone to proceed with the next steps in the implementation of SHI. A draft regulation which contains the details including the premium & benefit packages has also been prepared during the fiscal year. To pilot the Community-Based Health Insurance (CBHI), a design document showing the implementation process, an implementation manual and a draft directive have been prepared. CBHI Regional Feasibility Studies and Assessment have been conducted on institutional arrangement of CBHI schemes and sections at Woreda and Kebele levels of the respective four pilot regions (Tigray, Amhara, Oromia and SNNP).

30 The percentage share of the health budget from total budget was 10.4 % (10.1 % in EFY 2001). The percentage of regional block grant budget allocated to the health sector ranged from 4.4 % in Addis Ababa to 12.9 % in SNNPR and Oromia Region. The per capita allocation on health increased from ETB 38.03 in EFY 2001 to ETB 39.8 in EFY 2002. According to the fourth National Health Account, the total expenditure on health as percentage of GDP reached 4.5%, which is close to the WHO standard of 5%. The per capita health spending also increased substantially from 7.1 USD in 2004 / 05 to 16.1 USD in 2007 / 08. The per capita public expenditure on health had grown from ETB 26.00 in EFY 2001 to ETB 34.55 in EFY 2002.

31 Comparison between commitment and disbursement of donors' funds shows that 89% of the total amount committed was disbursed in EFY 2002, with a disbursement rate which was much higher than in EFY 2001 (55.4%). The gross amount of fund disbursed by DPs for the sector in EFY 2002 increased by 62% from the previous year (from USD 229,579,247 in EFY 2001 to USD 368,476,556 in EFY 2002).

CHALLENGES

32 Some of the major challenges encountered during implementation of the EFY 2002 Core Plan are as follows:

- Poorly functioning referral mechanisms;
- Shortage of medical doctors, midwives and anesthesiologists;
- Attrition of highly skilled professionals and high turnover of management staff;
- Limited capacity of human resources management at various levels;
- Shortage of qualified contractors willing to take contracts in remote sites;
- Serious shortage and fluctuating high prices of construction materials;
- Weak monitoring and follow-up capacity at regional and Woreda levels;
- Inadequate availability of resources compared to the health care needs;
- Inequitable distribution of funds among various priority health programmes;
- Poor progress in terms of adopting a common budgetary framework and reporting format by Development Partners;
- Slow response of many Development Partners to join the IHP Compact and JFA; and
- Inadequate capacity for fund liquidation, reporting and auditing.

The health care system has made good progress and ongoing efforts continue to produce encouraging results in some of the critical indicators. This is largely due to increasing focus on prevention-oriented interventions supported by strengthened treatment programmes with high coverage.

However, there is still more to be done. There are marked improvements in the MMR which have shown a decease from 871 deaths per 100,000 live births in 2000 (EDHS 2000) to 673 deaths per 100,000 live births in 2005 (EDHS 2005), with projections based on models estimating MMR in Ethiopia at 470 per 100,000 live births in 2008 (WHO 2010). Major problems are related to low percentage of deliveries attended by skilled health attendants (15.7%), low TB case detection rate (35.8% compared to the international standard of 70%) and very low PMTCT coverage of HIV positive mothers (8.3% of those eligible). Environmental health remains a challenge due to the wide variation in coverage of safe water and sanitation across the Regions.

ARM 2010 is the right forum to deliberate on these challenges and come up with relevant recommendations to solve these constraints.

CHAPTER I

INTRODUCTION

Introduction

Wide ranges of stakeholders are represented at the Annual Review Meeting; which is one of the major forums for monitoring and evaluation of progress in the implementation of the HSDP. The Performance Report for EFY 2002 is the fifth report prepared in the wake of the sector's HMIS reform. According to the approved Terms of Reffernce (TOR), one of the objectives of the Twelfth Annual Review Meeting is to review the progress made and the challenges encountered in the implementation of the EFY 2002 plan based on the review of the annual performance report for the year. The performance report is, therefore, one of the core agenda items at the ARM.

During the course of HSDP III, a number of efforts have been made to fulfill the objectives of the HMIS and the Monitoring & Evaluation component. A comprehensive and integrated Monitoring and Evaluation framework has been developed and strengthened; linkages between Woreda, regional and central levels have been established; joint steering committees have been revitalized; and ARM, Joint Review Missions (JRM) and Mid Term Review (MTR) of HSDP III have been successfully conducted. In addition, significant steps have been taken to strengthen the M&E system as a whole. Thus, at the end of HSDP III, there is a unified reporting format, a sector-wide annual performance report based on standardized set of indicators as well as a sector-wide Annual Core Plan.

Substantial progress has also been made in the achievement of the harmonization vision of operating through 'one-plan', 'one-budget' and 'one-report'. Despite these notable achievements, however, improving the quality of routinely collected data, developing data analysis and finding ways of translating the output of the information system into evidence-based decision making still remains a challenge for the health sector for the coming years. In this report:-

- The EFY 2002 performance of the sector has been assessed against the set of selected indicators;
- Highlights of performance against the Core Plan have been presented through the use of the national and regional level indicators;
- Trends of achievements have been analyzed;
- Regional comparisons have been made; and
- An overview of the health sector support system and a health sector financial report for EFY 2002 have been presented.

In the preparation of this report, attempts have been made to follow a uniform structure of presentation by indicating in each section the background, targets, performances, challenges and the way forward.

The main sources of data for compilation of this report are routine service and administrative data that are incorporated within the monitoring and evaluation framework of HSDP; including surveys and studies which have been undertaken by various stakeholder institutions and reports by FMOH programs and other central level institutions.

Similar to EFY 2001 population figures and population-based indicators for EFY 2002 have been estimated based on the 2007 census.

This report is made up of 7 sections, and contains 17 tables and 54 figures that clearly show progress, decline, comparison and trends over time in the implementation of HSDP III.

CHAPTER II

LEADERSHIP AND GOVERNANCE

Leadership and Governance

Under this sub program the target was to achieve strengthened implementation capacity at all levels by developing an effective, participatory planning and management system that is in line with the national and international goals. It also includes introducing health facility reforms, undertaking research that addresses the health problems of the country, establishing a monitoring and evaluation system for supporting evidence based decision making at all levels of the health system.

2.1 Policy, Planning, Monitoring and Evaluation

As part of harmonization and alignment, Policy, Planning and Monitoring and Evaluation is designed to address the need for informed decision-making based on an integrated and aligned planning, monitoring and evaluation system. This includes policy analysis of the sector, developing Woreda-based national strategic and annual planning, activity-based budget and monitoring and evaluation.

Planning: In 2003, the Fourth Health Sector Development Plan (2010 -2015) and the Woreda based health sector plans have been prepared in line with the principle of "one plan, one budget, and one report". This planning system has created a platform for joint planning by all stakeholders at all levels of the health system including health development partners.

A major undertaking in EFY 2002 was the development and finalization of the Fourth Health Sector Development Plan which will govern the sector's activities for the coming five years (2010 -2015). The zero draft of the document was developed by the Ministry of Health in consultation with the Regional Health Bureaus including the use of technical assistance from various stakeholders. The draft was reviewed at the Regional Steering Committee meetings and was shared with all health partners, CSOs and NGOs. The consultation process was enhanced using the Joint Assessment of National Strategy (JANS) tools and guidelines. Consultation workshops were organized with the participation of both international and local partners. The final document will be presented for purposes of familiarization at ARM 2010.

In tandem with the strategic planning, Woreda-based Core Plan for EFY 2003 has been finalized. Each Woreda has developed an annual and a strategic plan. Woreda plans have been aggregated and reconciled to develop the Federal and Regional Annual Core Plans and Comprehensive Plan. The annual planning process for EFY 2003 used the draft HSDP IV as an indicative health sector plan. Training on evidence-based planning has been provided to 160 professionals drawn from all regions and to 25 professional personnel drawn from partner organizations to facilitate the planning process, resource mapping and gap analysis was completed at the Federal level. Similar activities have been undertaken at Woreda level to capture resources from local governments, NGOs and other organizations in the one plan framework and this has been an important input for the development of HSDP IV.

In summary, the Fourth Health Sector Development Plan (2010-2015) and the EFY 2003 Evidence-Based Woreda-Based Annual Core Plan have been prepared with continuous consultation with stakeholders at all levels, improving on many aspects of the planning process based on experiences gained in previous years. The strategic and annual plan for EFY 2003, for the first time, is based on the Balanced Score Card.

Routine Data Collection and Aggregation: In EFY 2002, it was planned to implement the newly re-designed HMIS in all Regions and to train all health professionals working in the health system. Accordingly, the seven Regions of Dire Dawa, Harari, Benishangul-Gumuz, Gambella, Addis Ababa, Tigray and Afar Regions have scaled up the HMIS in their respective eligible health facilities. These Regions have hired the required health information technicians, performed the required renovation of their facilities and fulfilled the required equipments and furniture to facilitate the scale up.

Amhara, Oromia, SNNP and Somali Regions are at various stages of implementation. Amhara Region has implemented in 3 out of 10 zones; Oromia Region in 5 out of 18 Zones; SNNPR in 2 zones and 1 special woreda out of 14 zones and special woredas and Somali Region in 2 of 10 Zones. It is expected that these Regions will complete the scale up of the HMIS in EFY 2003.

To facilitate the implementation of the HMIS, the FMOH has distributed forms and registers worth of 20 million ETB to health facilities that have met the necessary pre-requisites for implementing the new HMIS. To enable the Woredas and Zones to lead and sustain the implementation process, supervisory level training for a period of three weeks was provided to 1111 professionals. These supervisors, along with mentors from FMOH and development partners, conducted 5 days training to 18,090 health professionals in 64 hospitals and 475 health centers, which are currently implementing the new HMIS.

Health facilities that have implemented the HMIS have shown significant improvement in the level of data quality. Encouraging results are being demonstrated not only in completeness and accuracy of reported data, but more importantly, on the level of data utilization and establishing links with the annual Woreda Plan.

In EFY 2003, the health extension supervisors training manual and implementation guideline have been completed. To ease the implementation of the Community Information System/ Family folder, a pilot study in two Woredas was conducted and finalized. Using the evidence from pilot studies, scale up procedures were finalized. Salient points that were determined from these experiences include procedures for numbering households, recording and updating folders, introduction of a Master Family Index and refining the tallying and reporting procedures. Parallel to this effort, the family folder was adapted for the Urban Health Extension Program. The adaptation included updating the training packages, and designing the non-communicable diseases component.

Currently, the printing of 15 million rural family folders is underway and around 2.5 million folders have been distributed to Tigray, Amhara, SNNP and Oromia Regions. It is expected that the HEW supervisors will start implementation by providing on-the-job training to health extension workers. At the end of the next fiscal year, most rural and urban households will have their own family folder.

Availing complete and timely reports was one of the focus areas for this year. An application, SmartCare eHMIS module, has been designed and piloted. This application enables electronic reporting, archiving and analysis. Currently, it has been implemented in all 26 health centers and the Addis Ababa Regional Health Bureau. For the first time ever the city health offices have the capacity to send timely and accurate electronic reports. Similarly, in Oromia region East Shewa Zone has successfully implemented eHMIS in 26 health centers, 2 hospitals and 16 Woreda Health Office and one city health office including the Oromia Regional Health Bureau. Furthermore, EHNRI with a development partner is piloting the National Disease Surveillance Information System (DSIS-SmartCare module) that will enable to send surveillance reports from

health facilities to the national public health emergency center at EHNRI. An innovative grid mapping/GIS has been adapted within the system enabling accurate identification of disease case reporting to within one square kilometer area, supporting accurate and informed decision making for epidemiological interventions. The system is capable of utilizing similar basic telecommunication infrastructure to send/ receive reports as the eHMIS module. Preparations are finalized to scale up the HMIS/PHEM reporting application to all Regions within the coming fiscal year.

Performance Monitoring and Coordination: As a priority activity of the FMOH, Regions, Zones and Woredas, the specific objective of Monitoring and Evaluation is to regularly monitor progress and achievements of HSDP in general, as well as improvements in service delivery, quality of care and financial performance in particular.

To strengthen the implementation of performance monitoring within the health system the Balanced Scorecard (BSC) has been selected as a measurement tool of choice for the health sector. The BSC is directly linked to the comprehensive annual plan at all levels. Guideline on training has been prepared and training has been given to 148 professional personnel and workers drawn from RHBs, FMoH and agencies accountable to the FMoH. Furthermore, in the effort to institutionalize the BSC, a delegation from the FMoH conducted an experience sharing visit to the Botswana Ministry of Health. Currently, FMOH is being supported by the BSC Institute of George Washington University.

The status of implementation of HSDP III in EFY 2002 has been monitored by the FMOH and Regions through various monitoring and reporting mechanisms. At FMOH level, monthly meetings have been conducted by General Directorates and Directorates to follow-up implementation of planned activities.

The monitoring implementation of EFY 2002-plan has been undertaken through bi-monthly meetings of the Joint Steering Committee (JSC) of the FMOH and RHBs and the weekly meetings of the Joint Core Coordinating Committee (JCCC).

In EFY 2002, the majority of RHBs have undertaken their annual and five years performance review meetings with Woredas and Zones based on Core Plan EFY 2002 and their respective HSDP III. During the meeting the strengths/enablers and challenges in their own respective regions discussed with their relevant stakeholders before the National Annual Review Meeting. The ARM was conducted in Dire Dawa City Administration in the presence of partners and other stakeholders representing Federal, Regional, Woreda and Community level Institutions and organizations.

The Joint FMOH-HPN Donors Group Consultative Forum continued playing useful role in addressing the coordination, harmonization, financing and monitoring issues at FMOH and Regional levels.

The Guideline and Evaluation Checklist on Integrated Supportive Supervision (ISS) has been revised. Training on the guideline and checklist was given to 50 professionals drawn from all core and support processes. However, national level integrated supportive supervision has not been carried out in EFY 2002 due to the revision of the work process.

Concerning submission of reports, bi-annual and annual performance reports was submitted to the Prime Minister's Office (PMO) and an annual PASDEP report was submitted to MOFED.

Preliminary assessment was completed in six regions (Amhara, Oromia, Tigray, SNNP, Gambella and Afar) to gather inputs to design a pilot Performance Based

Contracting (PBC) in Ethiopia. A TOR has been developed to establish a Technical Working Group composed of different stakeholders and a concept note that would facilitate the preparation of manuals and implementation guidelines is underway.

Evaluation: Five evaluation studies have been carried out in EFY 2002. The implementation status of HSDP III from EFY 1998 to EFY 2001 has been reviewed. The evaluation of the HMIS was undertaken in four pioneer regions (Harari, Dire Dawa, Benishangul Gumuz and Gambella) with an exploratory assessment of the available human resources for implementation of the HMIS at national level and an assessment focusing on the capacity and effectiveness of available information technology. Mid-term evaluation on implementation of the National Strategic Plan for Prevention of Blindness has been performed.

Three editions of Policy and Practice Quarterly Health Bulletin have been prepared in EFY 2002 and 4500 copies of the bulletin have been distributed to stakeholders.

Currently the HMIS implementation has gathered enough momentum though some zones and Woredas have problems to hire the required personnel and fulfill the pre-conditions set. It is expected that most of the lagging zones/Woredas will be able to overcome these challenges within the coming year.

Challenges

- Shortage of trained human resources, specifically high turnover at Regional and Woreda levels;
- Slow progress in HMIS scale up; and
- Slow progress in applying the one report principle.

Way forward

- Continuous capacity building; and
- Advocate for Harmonization and Alignment.

2.2 Health Facility Reform

Hospital Reform: The Ethiopian Hospital Management Initiative (EHMI) was launched in EFY 1998 by the FMOH. The major objective of this program is to enhance the management capacity of hospitals in Ethiopia using a system-based approach. To this end, significant amount of work has been done to develop guidelines for key areas of hospital management, preparation and implementation of Blue print document to roll out implementation; preparation and application of monitoring and evaluation tools; establishment of Hospital Management Boards and engagement in large-scale training of Directors and CEOs assigned to Federal and Regional hospitals.

In EFY 2002, an implementation guideline for hospital reform was finalized, printed and distributed to regional health bureaus and hospitals after a sensitization workshop was conducted in the presence of all the Regional Health Bureaus and selected hospitals in May 2010. Trainings were given on selected chapters of the hospital reform document to assist implementation of the hospital reform. Based on the implementation guideline trainings were provided, and most hospitals have started implementing the standards of the reform document.

To facilitate implementation of the reform process, first drafts of manuals and standard operational procedures (SOPs) have been prepared for infection prevention, quality management, nursing care and hospital governing boards. The first round of TOT has been given to 40 health workers on nursing care.

Supportive supervision was conducted to the RHBs and together with RHB to 25 hospitals in nine regions on problem identification and technical support to solve the problems. Special focus has been given to enable the hospitals in emerging regions to start implementing the standards.

All Federal Hospitals have provided training to reform implementation teams and have carried out monitoring activities on a weekly and monthly basis. Federal hospitals were closely followed and were assisted to implement the reform standards via a supportive supervision visit and monthly follow up meetings. As part of the reform, in order to support decision making and to create a forum for community participation, a governing board was established at Emmanuel, St. Peter, ALERT and St Paul hospitals.

Management Boards have been set up and have become operational in all hospitals in Oromia, Tigray and Amhara Regions. Similarly, governing boards have been established in almost all hospitals except few in the emerging regions.

Rehabilitation services: A study has been made to identify five hospitals (3 in Amhara and 2 in Addis abaa) suitable for starting rehabilitation service, and based on the results of the study, a draft "Guideline on Rehabilitation Services" has been prepared, including list of equipment required for provision of rehabilitation service in hospitals.

Private wing in public hospitals: As one component of retaining highly skilled professionals, especially specialists and general medical practitioners, government hospitals have started providing private wing service. Some regions like Oromia have started this service earlier, and the Federal Hospitals, Emmanuel, St. Paul, and ALERT Hospitals have started this service in EFY 2002. St. Peter Hospital had started the service but was not able to continue it due to inadequate number of patients utilizing the private wing service. Amhara Regional Health Bureau has finalized the preparation but not yet started the implementation.

Table 1: Number of Hospitals that have Started Implementing a Private Wing Service By Region (EFY2002)

Region/Level	Hospitals with Private Wing Service	
	Number	Percentage
Federal	3	60%
Tigray	9	75%
Amhara	0	0%
Oromia	5	16%
SNNPR	0	0%
Addis Ababa	2	40%

Blood Safety: Decision has been made to revert the functions of blood transfusion services from ERCS to FMOH. A committee jointly established from ERCS and the FMOH is managing the transition. Different subcommittees have also been established. A TOR and plan of action, as well as a transition strategy, have been finalized. Accordingly, draft organograms and job descriptions for the national and regional blood banks have been prepared. Close follow up was also done for the procurement of blood supplies and equipment. Training workshops on the "Appropriate Clinical Use of Blood for Doctors" and "Safe Bedside Practices for Nurses" have been conducted for a total of 73 doctors and nurses. Despite the transition of the blood transfusion service from ERCS to FMOH, ERCS will continue to collaborate with the FMOH to ensure an adequate and safe blood supply in all regions.

Emergency Medical System (EMS): As part of improving the response to emergency conditions arising from medical, obstetric, trauma and other conditions, a system of networked resources, capable of providing medical care at the scene of the emergency and on the way to health facilities where patients get definitive care, is needed. This requires the establishment of functional ambulance system in the country.

A national task force has been established to oversee the functions of the EMS. Organizational structure has been prepared and a guideline to establish EMS has also been developed. Different short-term trainings were given. Thirty three ambulances were procured and additional 56 are under process, of being procured two are already donated to the Addis Ababa Fire and Emergency Service and the remaining are waiting for the signing of the memorandum of understanding (MOU).

It is envisaged that ambulance services are to be established at Woreda levels in the districts and municipal ambulance services in cities and major towns. To this effect, MOU with roles and responsibilities of FMOH, RHBs and Woreda administrators has been prepared. Priority Woredas from respective regions are identified to start the ambulance services on the basis of criteria including maternal deaths, traumas, and remoteness.

Ambulances should be provided with the required personnel, supplies and equipment and hence procurement of supplies and equipment for ambulances is underway and paramedic-training curriculum has also been developed.

Referral System: To strengthen the referral system of the country, the FMoH has published a guideline for the implementation of referral network in Ethiopia for use by all relevant bodies. A technical working group has been established to undertake the remaining tasks such as developing a referral directory, standard operating procedures, and policies providing other related technical inputs.

Health Center Reform: To standardize the service delivery process across health centers, a reform implementation guideline for health centers was prepared by the FMOH and the first phase of implementation has started in 31 selected health centers in Addis Ababa, Amhara, Oromia and Tigray Regions.

2.3 Operational Research and Technology Transfer

Operational research (OR) was performed in the sector to identify and study priority public health concerns and produce evidence that would help decision-makers to improve the services and develop realistic health sector policies, strategies and practices. In EFY 2002, the following operational research studies have been conducted.

Nutrition: The primary objective of OR in this area is to increase the efficiency of interventions to prevent and treat nutritional disorders. The Ethiopian Health and Nutrition Research Institute (EHNRI) has set up a committee comprising of members drawn from various partner organizations to prioritize OR activities and complete arrangements to undertake those research activities in EFY 2003.

Preparatory arrangements necessary for conducting a National Nutrition Baseline Survey had been completed in EFY 2001. The baseline survey was envisaged to serve as a tool to gauge the implementation status of the National Nutrition Program. Collection and analysis of data have been completed and the first draft of the survey report has been prepared in EFY 2002. Studies have been made on Nutrition Communication Framework training needs vis-à-vis nutritionists, and curriculum assessment in different institutions of higher education. Human resources needs assessment on national level nutrition education has been carried out and the study report has been presented to the FMOH.

HIV/AIDS, TB and Malaria: In accordance with the plan to conduct HIV surveillance on pregnant mothers, blood samples have been collected from 115 HIV surveillance centers and data have been analyzed.

A research protocol on Early Warning Indicators of Resistance to ART drugs was approved, training was given to professional personnel drawn from the WHO, CDC, HAPCO and EHNRI, then data was collected. Threshold survey on drug resistance to HIV is being carried out. Study on indicators of immune response towards different antigens of TB has also been carried out.

A study on the potency of four chemicals (Malathion, DDT, Parametrin and Deltametrin) on mosquitoes has been done in six selected locations and the technical report has been prepared and distributed to concerned bodies. A research protocol on insecticidal property and utilization of insecticide treated nets has been prepared. A study on resistance to anti-malarial drugs has been done using molecular analysis and 70 samples have been tested. For the study on efficacy of Coartem, molecular analysis of ninety samples has been made and the study report has been distributed to the concerned authority.

A commodity tracking survey on supply, distribution and utilization of medical equipment and drugs has been conducted country wide during EFY 2002.

Challenges

Some of the challenges encountered during implementation include:

- non-functioning equipment which has hampered timely performance of the study on resistance to anti-malarial drugs; and
- the TB drug resistance survey could not be started due to ethical clearance problems on the part of a development partner.

Traditional Medicine: Research activities have been carried out by EHNRI to determine the efficacy of herbal extracts for the treatment of intestinal parasites. A chronic toxicity study has been made on one extract proving its efficacy and safety. The study on the preparation of anti-malarial drugs from selected herbs is still underway. A study has been carried out to prove the efficacy of herbs used by traditional practitioners to treat skin diseases of animals.

A research protocol for the study of bactericidal and anti-fungus effects of selected herbs has been prepared and presented to the Ethics Committee for approval. Another research protocol on the study of herbs used in the treatment of diabetes, hypertension and asthma, has been prepared and presented to the Ethics Committee for review. A study to identify the bactericidal effects of herbs on Leishmania parasites is also underway.

Technology Transfer: In EFY 2002, virus needed for the production of anti-rabies vaccine using sheep's brain has been secured from a development partner and training of one week duration has been given to two professional staff. Crude anti-rabies vaccine has been produced using this virus and the safety and efficacy of this vaccine is under study. Since this crude vaccine can be used for protecting dogs and other animals, work has been initiated to start production through agreement with the Debrezeit Veterinary Drugs and Vaccine Production Center.

In order to start, a joint venture in technology transfer with respect to the production of vaccines, drugs and bio-medical substances, an experience sharing visit has been made to Cuba and a Memorandum of Understanding has been signed with Cuban Institutes. Accordingly, a proposal to enable joint production of meningitis and Pentavalent DPT-Hep B-Hib vaccines has been prepared.

Surveillance on polio, measles, rubella, influenza and Rotaviruses was performed at national level by carrying out laboratory examinations on collected samples. Results were reported to the FMOH and the WHO.

2.4 Gender Mainstreaming

The goal of this sub-program is to strengthen the participation of women and increase their benefits through gender mainstreaming and capacity building measures.

The performance of key activities in EFY 2002 is described below.
BPR study on how to mainstream gender in the health sector has been completed and further refined by the Joint Forum of the Council of Directors and higher management. Female workers at FMOH Head Office, agencies and hospitals under the FMOH have discussed the result of the BPR study, decision has been made to implement the study results and, as a result, a new structure has been developed and is being implemented.

In order to mainstream gender issues into the health sector, training on gender has been given to 50 managers drawn from the Head Office of the FMOH and from agencies and hospitals under the FMOH. On the occasion of the International Women's Day, awareness raising education on the rights of women had been given to both men and women drawn from the head office, agencies and hospitals. In this connection, best practices from

national and external sources have been presented and discussed extensively. In addition, training on "Gender Analysis Tool" has been given to gender representatives and to heads/ experts of planning units.

Gender mainstreaming and women empowerment activities have been incorporated within the EFY 2003 plan and HSDP IV and major activities that are considered important for ensuring the participation and empowerment of women will be realized over time.

2.5 Public Relations

The performance status of key public relations activities in EFY 2002 is described below.

One hundred eighty seven radio and fifty six television reports have been presented with respect to implementation of the health sector policy and strategies and the benefits derived by families and communities from disease prevention activities.

As part of the new Hospital Reform, the official launching of the implementation of the Standard Blue Print in all hospitals was given broad media coverage. A total of 37 radio, 12 television programs and 10 newspaper columns have been used to popularize to the public and other health institutions, the best practices in the implementation of the Hospital Reform made by Emmanuel, Adama, Dire Dawa and Bishoftu Hospitals.

Concerning new H1N1 influenza and other epidemics, radio and television messages have been transmitted to raise the awareness of the community. With the aim of reducing the high maternal mortality in Ethiopia, forums for creating awareness on "Safe Motherhood" were prepared continuously during the whole of Tir in EFY 2002.

In collaboration with Walta Information Center, two panel discussions have been conducted in the presence of representatives from mass media, mass organizations (Women, Youth, Edir, Residents) and private health institutions. The discussion was aimed at popularizing the implementation of the reform process, including best practices and results. The discussion was screened through television programs.

Educational messages on rational drug use, professional ethics, proper provision of health care and the like are regularly aired through two radio stations (FM 98 and National Radio) and through articles published every fortnight in Addis Zemen Newspaper.

2.6 Legal Services

To support the BPR process within FMOH with legal frameworks and also to enable institutional change based on firm legal basis, the following key functions were performed in EFY 2002.

Preparations have been completed for organizing discussion on the draft proclamation on health care delivery and administration with concerned stakeholders. The proclamation on community health insurance has been approved by the Parliament. The proclamation on food, drugs and health care management and inspection has been promulgated by the Parliament, while re-establishment regulation on the inspection authority has been approved

by the Council of Ministers at the end of the year. Model draft proclamation to help regions prepare their own legal framework on food, drugs and health care management inspection has been prepared and sent to regions. Seven draft regulations ensuring implementation of the proclamation have been prepared and presented to different discussion forums to gather comments and suggestions. Draft establishment regulation of the St. Paul's Millennium Medical College and draft establishment regulation on the Ethiopian Mental Health Institute have been prepared during the year.

2.7 Public Private Partnership

A guideline for Public-Private Partnership (PPP) in health was produced and, circulated to relevant Directorates of the FMOH after incorporating feedbacks from different stakeholders. It will be finalized in the coming fiscal year. The FMOH continues to work with different professional associations since the advent of HSDP. The main tasks accomplished with these associations in EFY 2002 are described below.

The Ethiopian Public Health Association (EPHA) has performed, in collaboration with FMOH, several activities during EFY 2002. These include provision of technical and financial support to Health Promotion and Disease Prevention General Directorate (HPDPGD) and Regional Health Bureaus to undertake Communication Strategies and Leadership Training, and financial support for the safe motherhood campaign. In addition it has provided technical and financial support to the Drug Administration and Control Authority to promote "No Smoking Day", and participated in the Training Programme on Leadership in Strategic Information (LSI) for various categories of health workers.

EPHA has also coordinated a Field Epidemiology and Laboratory Training Program (FELTP), and provided training on hospital based TB prevention. Besides, it has also developed television spots and provided IEC materials on TB prevention.

Together with HPDPGD, EPHA has participated in the Standardization of a Model Manual for Family Services, in consultative meetings to develop the training manual on Newborn Care and the FP Counseling Guide for HEWs, and in the Implanon scale up initiative in North and South Wello Zones of the Amhara Regional State. Besides, it has collaborated in the production and dissemination of best practices for HEWs, and also in the Tobacco control initiatives.

Ethiopia will be hosting two upcoming international conferences: the International Conference on AIDS and STDs in Africa (ICASA) in 2011 and the 13th World Congress on Public Health in 2012. FMOH in collaboration with the EPHA has set up a Task Force to organize these two important conferences to be held in Addis Ababa.

The Ethiopian Medical Association (EMA), in collaboration with FMOH, has been implementing Research Based Incentive (RBI) project in four emerging regions (Afar, Benishangul Gumuz, Gambella, and Somali) since 2001, with the aim of contributing towards the mitigation of the crisis in Human Resources for Health (HRH). The main strategy of the project is to train physicians on Research Methodology and Proposal Writing and provide financial support to undertake research.

EMA has been implementing this project through its four branch offices, which are functionally connected to University research review panels and to individual researching

physicians who received standard training on "Health Research Methodology and Proposal Writing". A total of 38 physicians took the training and 32 of them are carrying out their research. Three physicians from Benishangul Gumuz and Somali Regional States have completed their research work and are among those who are selected to present their findings to the 46th Annual Medical Conference.

The Ethiopian Society of Obstetricians and Gynecologists (ESOG) has collaborated with the FMOH in EFY 2002 to launch the safe motherhood month in Ethiopia under the theme of "No Woman Should Die while Giving Life". A panel discussion of Ethiopian Professional Associations on Safe Motherhood in Ethiopia was conducted in January 2010 including a parade with the active involvement of ESOG. Development of training manual on Comprehensive Abortion Care for health workers in Ethiopia is underway. A training manual on care of survivors of sexual violence has been developed and process of disseminating the training manual countrywide is underway. Furthermore, several training programs on various topics have been implemented during EFY 2002.

One hundred and sixty one providers were trained on PMTCT in six rounds in collaboration with Addis Ababa RHB, while CEmONC training for health officers and GPs and BEmONC training for Health Officers were conducted in Oromia and Amhara Regions. With FMOH as a member, a project with a technical working group for introduction of magnesium sulphate for the Management of Severe Preeclampsia and Eclampsia in all hospitals in Ethiopia was formed and 55 gynecologists have been trained in May 2010.

One review meeting and regular supportive supervision on PMTCT service expansion in the Private Health Sector Project was conducted in collaboration with Addis Ababa City Administration.

The Ethiopian Radiographers' Association has also been working closely with FMOH, especially in revising job descriptions of Radiography Professionals. During the EFY 2002 the FMOH, in collaboration with the Radiographers' Association, has finalized the job descriptions for radiography professionals.

2.8 Ethics Programme

The target of this programme was to prepare and implement an Ethics Guideline incorporating basic ethical principles that correspond with the basic functions and duties of the institution. The performance of this sub-program in EFY 2002 is described below.

Two teaching modules related to the six behavioral characteristics and ethical decision-making have been prepared, by organizing awareness raising forums that foster development of institutional culture and enable management body and workers to provide ethically sound services.

Values and beliefs that have spread across work processes due to the BPR exercise have been brought together and reviewed in a way, which can foster institutional culture and also help to develop common outlook. In this respect, a working paper has been prepared showing the nature of the values and beliefs, prioritizing the need for such values as well as means of promoting their diffusion among workers.

One-day long training to raise awareness on ethics and the nature of corruption has been given to 32 workers drawn from different sections. The revised Ethics Guideline has been presented for discussion.

CHAPTER III

HUMAN RESOURCE MANAGEMENT AND DEVELOPMENT

Human Resource Management and Development

To develop and maintain a health workforce that is appropriately sized, skilled and distributed various activities have been implemented in EFY 2002. These include finalization of HRH strategic plan, provision of need-based training, deployment of the Human Resource Information System (HRIS) as well as development of the relevant HRH legal framework.

3.1 HRH Strategic Plan

In EFY 2002, a comprehensive HRH strategic plan up to EFY 2012 was developed with the involvement of relevant stakeholders, health development partners, and international consultants. It provides details on HRH planning, management, education, training and skilled development, legal framework as well as costing. Although the strategic plan is awaiting for the official endorsement by the executive, the implementation of some of the major components have been already began.

3.2 Training and Deployment

Health Extension Workers (HEWs)

The national target for EFY 2002 was to deploy a cumulative total of 33,033 rural Health Extension Workers (HEWs) in the country. However, a total of 34,382 HEWs were deployed up to the end of EFY 2002, which is above the HSDP III target, bringing the cumulative performance to 104.1%. The plan for EFY 2002 was to train and deploy 2,494 new HEWs; out of this target, 2,551 HEWs (102.3%) were newly trained and deployed during the year (Table 2). The annual performance was above the annual target in six regions (Afar, Amhara, Benishangul Gumuz, SNNPR, Harari and Dire Dawa), on target in Oromia and below target in the remaining regions.

Table 2: Training and Deployment of Rural HEWs by Region (EFY 2002)

Region	Cumulative number of HEWs trained and deployed in EFY 2001	Number of HEWs newly trained and deployed in EFY 2002	Cumulative number of HEWs trained and deployed in EFY 2002	Number of HEWs available at the end of EFY 2002	EFY 2002 target for number of HEWs newly trained and deployed	Annual Performance (%)	EFY 2002 target for cumulative number of HEWs trained and deployed	Cumulative Performance (%)
	(A)	*(B)*	*(C)= (A+B)*	*(D)*	*(E)*	*(F)= (B*100) /(E)*	*(G)*	*(H) =(C*100) /(G)*
Tigray	1,369	73	1,442	1202	361	20.2%	1620	89.0%
Afar	376	196	572	572	173	113.3%	548	104.4%
Amhara	7,012	330	7,342	6188	66	500.0%	6481	113.3%
Oromia	12,963	524	13,487	12875	524	100.0%	13,399	100.7%
Somali	1100	327	1,427	1427	820	39.9%	1920	74.3%
B. Gumuz	521	403	924	924	335	120.3%	834	110.8%
SNNPR	7,915	627	8,542	7238	180	348.3%	7672	111.3%
Gambella	457	0	457	429	-	-	457	100.0%
Harari	39	8	47	38	4	200.0%	36	130.6%
D. Dawa	79	63	142	102	31	203.2%	66	215.2%
TOTAL	31,831	2,551	34,382	30,995	2,494	102.3%	33,033	104.1%

There was a steady increase in the cumulative number of rural HEWs trained and deployed during HSDP III from 9,900 in EFY 1998 to 34,382 in EFY 2002, which was above the HSDP III target of 33,033 (Figure 1).

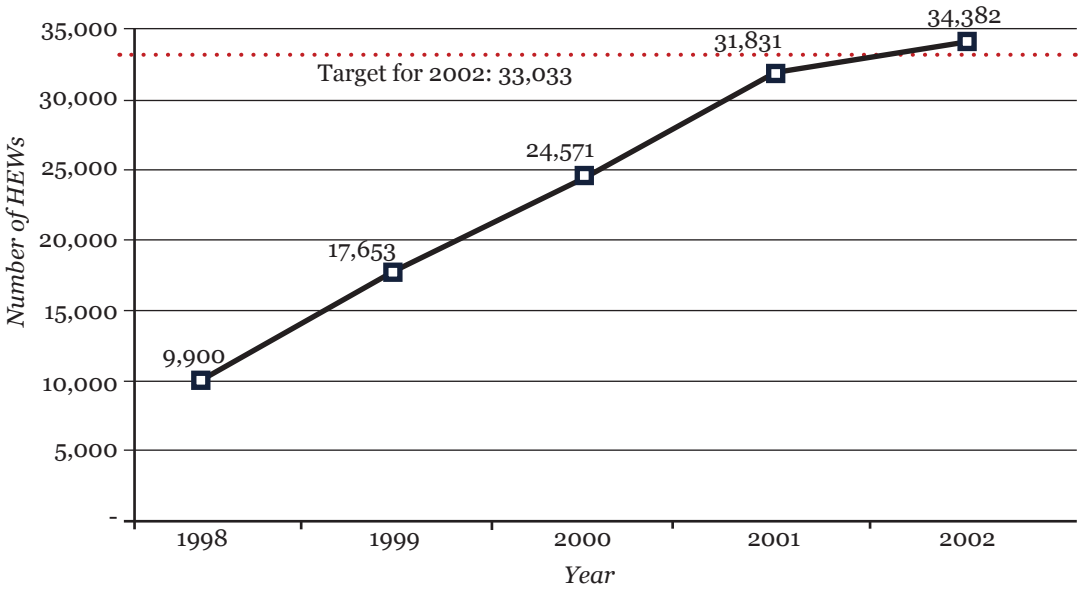

Figure 1: Trend in the Cumulative Number of HEWs Trained and Deployed in Health Posts (EFY 1998-2002)

Variations were observed across regions in the cumulative performance of rural HEWs being trained and deployed in EFY 2002, ranging between 74.3% in Somali Region and 215.2% in Dire Dawa. Tigray and Somali were the only two regions that did not achieve their regional target by the end of EFY 2002 (Figure 2).

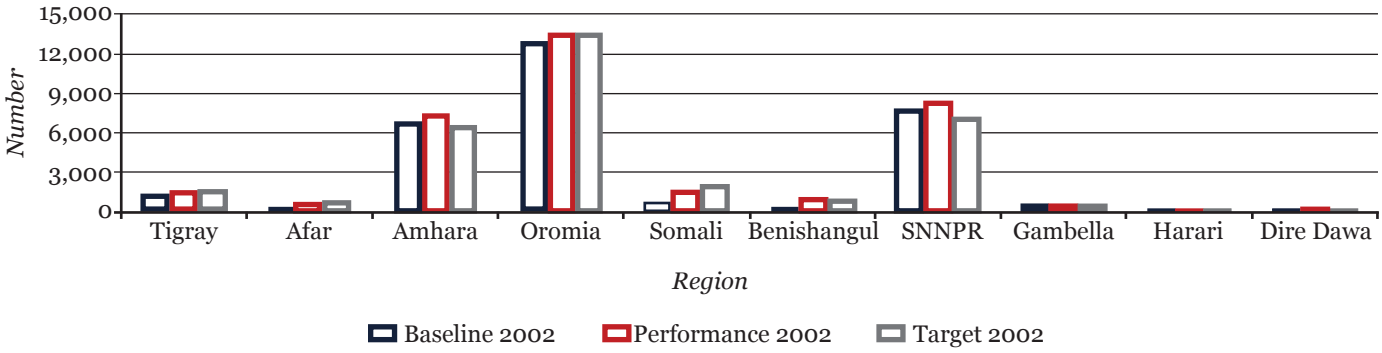

Figure 2: Comparison of Baseline, Performance and Target of the Cumulative Number of HEWs Trained and Deployed by Region (EFY 2002)

There were variations also in the annual performance of regions in terms of HEWs newly trained and deployed in EFY 2002 (Figure 3). Some regions performed above the annual target, these include Afar, Amhara, Benishangul Gumuz, SNNPR, Harari and Dire Dawa having trained and deployed additional HEWs to address attrition problems. New HEWs were not trained and deployed in Gambella Region. In SNNPR, 604 HEWs were still under training by the end of EFY 2002, but not yet deployed. Furthermore, the number of HEWs newly trained and deployed in Tigray (20.2%) and Somali (39.9 %) during EFY 2002 were below the target set for the year.

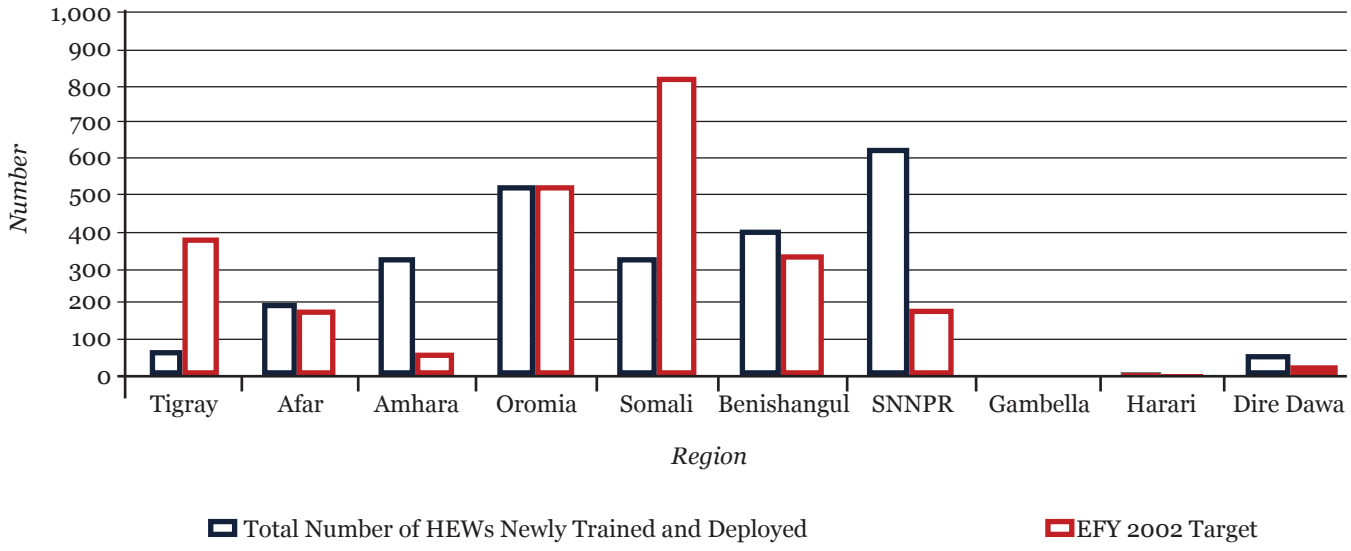

Figure 3: Comparison of Performance and Target of the Number of HEWs Newly Trained and Deployed by Region (EFY 2002)

More than 33,000 Health Extension Workers (HEWs) have already been trained and deployed across Ethiopia since 2002. They are playing an important role in delivering a wide range of community-based health promotion and disease prevention services. Since 2008 the FMOH has been working to upgrading the skill and knowledge of HEWs from the current level-III to IV according to the Ethiopian occupational standard. This will help the HEP to provide better quality service and address the high service needs of the community.

The core objectives of the upgrading program are to improve the extent and quality of HEP services, to fill gaps identified in previous level III HEP trainings, to improve the knowledge, skill and attitude of HEW, to make a significant contribution in achieving the health related Millennium Development Goals (MDGs) and to upgrade career of HEW. The level IV curriculum and Ethiopian Occupational Standard (EOS) was developed and endorsed by Federal Ministry of Education in 2008. Since 2009, the Open University UK (OU), in partnership with UNICEF and AMREF, is supporting the development of an innovative program of print-based blended learning resources to teach the theoretical components and to train HEWs on practical skills in local Health Centres and District hospitals. Over all 12 learning modules out of 13 have been prepared and planned to be completed by end of October 2010. Thirty five high level experts drawn from local universities have participated in the module write-up. The previous HEP packages and manuals have been revised in accordance with the level-IV HEP expected services. Six RHBs were selected to enroll 1,000 HEW by February 2011 and most of them recruited HEW to be upgraded to level IV which is equivalent to Diploma level.

Training and Deployment of Urban HEWs: HEP in urban areas started in EFY 2001 and was implemented in six regions in EFY 2002 (Table 3). Out of the planned 3,990 HEWs, a total of 3,401 HEWs were trained and deployed in six regions (85.2% of the target), with a performance ranging from 36.2% in SNNPR to more than 100% in Dire Dawa. The low performance in some regions was due to the inability to publish and dispatch training materials to regions on time and to the delay in giving TOT training for urban HEP supervisors.

Table 3: Training and Deployment of Urban HEWs by Region (EFY 2002)

Region	Overall Target	HEWs in EFY 2002		Annual Performance (%)
		Annual target	Total Trained and Deployed	
Tigray	352	352	221	62.8%
Amhara	991	634	462	72.9%
Oromia	1548	774	841	108.7%
SNNP	726	726	263	36.2%
Harari	40	40	59	147.5%
Dire Dawa	111	27	85	314.8%
Addis Ababa	1437	1437	1470	102.3%
Total	5205	3990	3401	85.2%

Provision of Training Materials and Guidelines: In accordance with the targets set for EFY 2002, 10,000 copies each of the 15 packages, the Health Education Manual, and the Urban HEP Implementation Manual were printed and distributed to regions. A reference book for HEWs was prepared and is being printed. Draft curriculum training guide and implementation manual were prepared for urban HEP supervisors.

Accelerated Health Officer Training Programme

The HRH plan in the EFY 2002 has focused on improving the availability and distribution of the health workforce and enhancing HRH management capacity. With the aims of improving the HRH availability and distribution in the country, the Ministry has been implementing some major initiatives. One of such initiatives is the Accelerated Health Officers Training Program (AHOTP), which was launched in November 2005 in 5 Universities and in 20 hospitals. The target set in HSDP III was to produce at least 5,000 health officers (both generic and post basic) in five years. At the end of the third year, a total of 5,430 students have been enrolled. The summary of those under training and those who graduated is shown in the following table.

Table 4: Summary of All AHOTP Students and Graduates by University, Type and Years of Training (EFY 2002)

University	AHOTP Post Basics [Batch III, Year III]			AHOTP Generics [Batch III, Year III]			Sub-Total Students	Graduated to date			Grand Total
	Male	Female	Total	Male	Female	Total		Post basic	Generic	Total	
Hawassa	239	57	296	67	29	96	392	571	350	921	1313
Haromaya	182	70	252	80	46	126	378	387	648	1035	1413
Jimma	111	70	181	96	34	130	311	399	327	726	1037
Gonder	189	48	237	84	27	111	348	515	360	875	1223
Mekelle	110	16	126	4	-	4	130	261	53	314	444
Total	831	261	1092	331	136	467	1559	2133	1738	3871	5430

As shown in the table 4, the total number of both post basic and generic students who graduated up to August 2010 was 3871 (71.3% of the total). In EFY 2002, 1559 students (28.7% of the total) were under training and, with their graduation, the target for AHOTP will be fully met.

Integrated Emergency Surgical Officer

The other major initiative was to address the HRH requirement for Emergency Surgery, Comprehensive Emergency Obstetric Care (CEOC) and Basic Emergency Obstetric Care (BEOC) at Primary Health Care Units (PHCU). To this effect, the training of Integrated Emergency Surgery Officer (IESO), which was designed in EFY 2001, has been commenced as a three year Master Programme. In EFY 2002 a total of 148 health officers have been enrolled at Mekelle, Jimma, Hawassa, Gonder and Haromaya Universities.

Medical Doctors

Improving the availability and equitable geographic distribution of medical doctors has also been the other major focus area in the EFY 2002 through introducing new initiatives as well as building upon and scaling up previous successful initiatives. One of such initiatives is the opening of a medical school under the health sector, at Millennium Medical College (MMC) The enrolment at MMC has increased over the years and currently a total of 202 medical students are under training.

As per the plan of EFY 2002, assessment has been completed to implement the New Medical Education Initiative (NMEI) in selected hospitals under the health sector, through the use of an innovative curriculum. The existing evidence suggests that the use of such innovative approach enhances the clinical skill and social accountability of medical doctors. In addition, it is also expected to contribute towards improved retention and distribution of medical doctors, due to its unique admission criteria.

Furthermore, to improve the availability and distribution of medical doctors in EFY 2002, a total of 698 General Practitioners have been deployed to Regions, Federal hospitals and Universities as per the identified needs. Pre-deployment training for 15 days has also been provided to these graduates to enhance their understanding of the health sector and overall country situation. The pre-deployment training is considered as one of the successful strategies that have resulted in the retention of over 95% of the new graduates.

Health Information Technicians

In order to sustain the M&E/HMIS reform, creating the appropriate cadre of workers was of paramount importance. To this end, the FMOH in collaboration with the Federal Ministry of Education (FMOE) and the Technical Vocational Educational Training (TVET) Agency has initiated the training of Health Information Technicians (HIT). To date, 1,110 students from all Regions have been enrolled in 15 TVETs. A development partner has provided reference books, training for instructors, financial and other support to the TVETs. All 15 colleges were provided with 102 textbooks each in two rounds. Training to build capacity was conducted for 94 instructors from the 15 TVETs on selected topics relevant to health information management and information technology. Financial support was provided for Harari, Mekele and Axum health science colleges. Harari Health Science College has enrolled students from all the emerging regions. Mekele and Axum HSC have the largest number of students, 120 students per school. Consistent follow up and supervision was conducted throughout the year; while Quality Assurance/ Enhancement tools and guides have been developed. The orientation on the quality and competence of the HIT students will the focus in the coming year. In the next fiscal year, all TVETs will continue to enroll new students. Preparatory work including the curriculum for an accelerated program has been completed and will start enrolling students at the St Paul MMC. Furthermore, a supplementary HIM curriculum for already employed health information technicians for a work based capacity building program has been completed and is expected to be implemented within the coming year.

Other HRH Categories

Aligning the supply of HRH with the health sector need requires collaboration with other relevant sectors and institutions mainly; FMOE and training institutions. Discussion has

been held with the education sector and training institutes to align HRH training categories with the health sector need. Furthermore, to enhance health sector capacity in the area of hospital management and health sector monitoring and evaluation in EFY 2002, the FMOH in collaboration with Jimma University and development partners has enrolled 30 trainees for hospital administration and 38 trainees in M&E Masters Program. Similarly, to address problems related with medical equipment maintenance, 64 trainees have been enrolled for level-IV training.

3.3 Human Resource Information System

Organizing reliable, relevant and updated HRH information is critical for HRH planning and improved HRH management. In 2002, the plan was to develop and implement a Human Resources Information System (HRIS). In line with the national health sector human resource development strategy, FMOH in collaboration with a development partner has developed a HRIS that includes accurate and effective personnel management, health workforce stock, profile, distribution and human resource for health licensing functionalities. HRIS has been implemented in FMOH, EHNRI, DACA, Addis Ababa RHB, Oromia RHB, 4 federal hospitals, one zone in Oromia and 16 Woreda Health Offices in East Shewa zone of Oromia. Training has also been provided for relevant staff at the deployed sites. Additionally Health Professional and Facility Licensing Information System have been deployed at FMHACA. The development of the planning component of the application is on progress.

Challenges

Notwithstanding with these achievements, there are also some major challenges encountered in the implementation process. Some of these challenges were:

- Shortage of physicians, midwives and anesthesia professionals;
- Attrition of trained workers and management staff;
- Lack of standardized in-service training;
- Limited capacity of HRM at all levels;
- Insufficient reading and writing skills of some HEWs recruited in pastoralists and semi pastoral areas; and
- Some HEWS not recruited according to the selection criteria (for example, selection was from other Kebeles, and in some regions, most of the HEWs are males).

Way Forward

To alleviate the above mentioned challenges, major initiatives to be undertaken during HSDP IV include the following:

- Enhance training of medical education in selected hospitals using innovative curriculum and scale up training of midwives, anesthesia professionals and Integrated Emergency Surgical Officers (IESO) in a team based approach;
- Implement retention mechanisms for the health workforce;
- Introduce Continuing Professional Development (CPD) program for technical and administrative staff linked to health sector needs and career development;
- Provide training on HRM tools to human resource officers at various levels; and
- Train and deploy female HEWs in pastoral and semi pastoral areas.

CHAPTER IV

Essential Medical Products and Technologies

Essential Medical Products and Technologies

4.1 Health and Health Related Services and Product Regulation

The main objective of this program is to undertake Inspection and quality control of drugs, facilities, professional personnel and food products (one stop service, 4 Ps= Product, Premises, Professional Practice and Food Products) in an integrated manner and to make the approval procedure of drugs for the market efficient.

The annual plan of this sub-program was to provide strengthened and sustainable regulatory activities through a decentralized regulatory system; to prepare standards for health institutions, drugs and medical equipment, to make laboratory examinations the basis for the regulatory process and to this effect to prepare and introduce implementation guidelines.

Inspection and quality control of "Products": The Proclamation on Food, Drugs and Health Care Facilities and Inspection has been approved. Model proclamation, that enables regions to prepare their own legal framework on inspection of food, drugs and health care facilities has been prepared and distributed to regions.

To get international recognition by improving drug quality control tests, two guidelines have been implemented while eight have been revised. Building of mini laboratories is nearing completion in five branch offices and equipment essential for these laboratories has been procured.

Based on the needs of the sector, preparation of draft document comprising of 17 new inspection standards has been completed. These cover specialized, general, primary and specific specialized hospitals, health center and health post levels.

Post market quality control tests have been made on a sample of 30 different drugs and 10 food items. To ensure quality of drugs in the country, market survey has been made on a sample of veterinary drugs and quality control tests have been conducted on anti-malaria drugs. To verify quality of drugs and food items, different quality control tests have been performed including 174 physio-chemical, 114 micro-biological, 167 toxicology and 69 condoms.

Inspection and quality control of "Premises" : in order to safeguard the well being of clients by ensuring the safety, efficacy, quality and proper and equitable distribution of drugs and pharmaceutical supplies; 129 drugs, medical equipment and supplies import and distribution firms and nine referral and teaching hospitals have been inspected.

Checks on good manufacturing practice were made on 12 food and 11 pharmaceutical factories and 46 foreign manufacturing plants.

Inspection of "Professional Practice": Registration certificate was given for products of drug factories in the country that meet the WHO criteria. Accordingly, out of 439 new drugs seeking registration, 219 drugs that met the criteria have received the certificate.

To ensure application of standards by health facilities, different types of permits have been given for facilities, professional staff, drug procurement purposes, change of site etc. License has been given for 5871 new health workers, 122 expatriates and for 887 interns. The responsibility of giving professional license and license of drug retail shops has been transferred to RHBs. In order to organize and use data base on

health inputs and service sector inspection information system, studies have been made on health workers and facilities registration and licensing software as well as on the software used for drug registration.

On the basis of the reporting and control system of narcotic and psychotropic drugs adopted by Ethiopia, permit allowing procurement has been given to 17 psychotropic; seven narcotic and eleven precursor drugs; and data have been filled in the proper national report form and reported to the concerned international agencies (INCO and UNODC). Medical units for drug addicts have been established in five regional hospitals. Training on harmful drugs and on rational drug use has been provided to 33 professional personnel drawn from regional inspection bodies.

Inspection and quality control of "Food Products": Import and export permits have been given for 148,328 metric tons and 11,519 metric tons of food stuff meeting the required criteria respectively. Import permits for drugs, medical equipment and supplies have been given to 3,074 clients at all customs posts including airport customs.

Challenges

- Inadequate budget;
- Shortage of staff with capacity to prepare and revise the large number of new standards required from time to time;
- Lack of urgently required spare parts for medical products quality control laboratory equipment within the country;
- Delay in the installation and maintenance of laboratory equipment that could not be undertaken in-country due to limited capacity; and
- Delay in the construction of laboratory buildings.

Way Forward

- Mobilize additional financial resources and technical assistance;
- Integrate the activities of existing human resources with technical support of partner organizations to prepare standards and to develop maintenance capacity by training personnel; and
- Arrange maintenance schedules and spare parts stock for laboratory equipments.

4.2 Pharmaceuticals Supply

This program aims at ensuring regular and adequate supply of effective, safe and affordable essential drugs, medical supplies and equipments in the public and private sectors and ensures their rational use. Since its establishment by Proclamation in September 2007, the Pharmaceuticals Fund and Supply Agency (PFSA), has performed a number of basic activities concerning forecasting, procurement, distribution, fleet management, warehouse infrastructure, and capacity building. The following activities have been carried out in EFY 2002: -

Revolving Drug Fund (RDF): Throughout the last two years the Agency has increased its working capital from about 8 million Birr in February 2009, to about USD 37 million dedicated for essential health commodities. To avail essential health commodities at an affordable price, the agency has procured essential health commodities worth around 1.2 billion birr during the last one year. In addition to the regular supplies, anti-cancer, anti-psychotic and cardiac drugs were also procured for the first time.

Forecasting: PFSA has a prepared a procurement list to support its activities. An integrated workshop has been organized to prepare five years forecast on pharmaceuticals required for HIV/AIDS, Malaria and TB programs.

Procurement, Storage and Distribution: The procurement value has increased over the last couple of years from 600 million birr to 3.04 billion ETB. These procurement packages include drugs and supplies for Reproductive Health, HIV/AIDS, TB and Malaria programs. Out of this, 73 million USD worth of test kits, OI, IP, STI, and ARV drugs and related supplies have been procured for HIV/AIDS prevention and control program and have arrived in the country. PFSA as per the BPR distributes drugs and supplies to facility level and it has started by delivering the procured HIV/AIDS drugs and supplies to all health facilities that are providing ARV treatment.

As part of the HSDP III plan to expand the primary health service delivery, the Agency has procured, through international competitive bidding, standard equipment for 2299 Health Centers and 7,000 Health Posts at a cost of nearly 72.3 million USD. Procurement of additional equipment for 295 Health Centers has already started during the reporting period. Out of these procured equipment, repackaging and distribution to 1,700 HCs and 1,600 HPs were completed.

Hospital equipments such as MRI, CT Scan, Mammography, Anesthesia machine, X-ray machines, CD4 count machine, Hematology and Chemistry analyzer and others were also procured.

The distribution of 11.2 million bed nets to 410 Woreda Health Offices has been completed within one and half months. Based on the BPR design, direct delivery of consignment from port of Djibouti to Mekele, Bahir Dar, Dessie and Gondar has been realized and all local manufacturers are delivering essential health commodities directly to PFSA branches.

Based on the stretched objectives of BPR new design the plan was to reduce the procurement lead-time to 120 days from the previous average of 396 days. The procurement lead-time for most of the packages have ranged from 90 to 180 days. Furthermore, equipments procured based on the new design has shown significant cost reduction ranging from 15% to 58 % in different procurement packages as compared to the previous procurement modalities.

Regarding the improvement of storage conditions, national competitive bidding has been finalized for the construction of 18 modern and standard warehouses. This will include expanding the existing five warehouses, construction of six new major warehouses and seven new secondary hubs. All regional governments have allocated land (from 5,000 to 10,000 square meters) and site plans have been received from all regions. Local Competitive Bidding process has been finalized and awards are given to five local contractors.

Integrated Pharmaceuticals Fund and Supply Management Information System (IPFSMIS): The design for the logistics system known as the IPFSMIS was started during the reporting period and will be finalized and implemented to enhance the information flow within PFSA structure and with health facilities. The network structure will link central PFSA with its major and secondary hubs to provide timely information for decision making at all levels. The new system is expected to either replace or integrate different automation systems based on justified relevance and appropriate means to avoid duplication of resources and efforts.

The system will be interfaced with other systems of the sector. To facilitate the implementation of the information system, computers, printers, servers and warehouse equipment have been procured at a cost of ETB 10 million and have been distributed to PFSA branches.

Capacity building support on inventory management and promoting rational use of pharmaceuticals: To execute its responsibility, the agency has signed joint plan with Development Partners and has secured funds to provide different capacity building training programs. Accordingly, in the last year, 2,944 professionals have been trained on 15 different topics including DTC, IPLS, warehouse management, and drug supply management at a cost of 8.77 million birr. In order to establish and strengthen Drug and Therapeutics Committees at public health facilities, trainings have been given for 181 professionals. The Agency has also signed joint plan with USAID/DELIVER for robust inventory control system in the public health facilities. To this effect, 1370 health professionals have been trained on IPLS.

Challenges

- Huge financial gap, to scale up practically tested systems, ensure the availability of essential health commodities, develop warehouse infrastructure and implement IPFSMIS;
- Transportation is an obstacle to execute the planned service at facility levels; and
- Delay in the construction of Pharmaceutical Hubs.

Way Forward

In order to address these challenges, the following key activities have to be given due consideration in HSDP IV.

- Mobilize additional funding to fill the huge gap in RDF capital, and strengthen revolving drug fund management system;
- Expedite the construction of hubs;
- Accelerate the implementation of the IPFSMIS;
- Strengthen rational drug use;
- Strengthen quantification/forecasting and procurement system;
- Strengthen pharmaceutical storage and inventory control system; and
- Strengthen pharmaceutical hubs and transport system.

CHAPTER V

SERVICE DELIVERY AND QUALITY OF CARE

Service Delivery and Quality of Care

The Goal of this program is to enable health facilities at all level to provide efficient and cost-effective, equitable and quality health care services to the population. The performance of this program in EFY 2002 is described below.

5.1 Health Extension Programme

The Health Extension Programme (HEP) is an innovative community-based health care delivery system that has been implemented as a component of HSDP II since EFY 1994. It is a family and community-based intervention, which target households to improve the health status of the families and their members. The HEP is considered as a key program for achieving the health–related Millennium Development Goals (MDGs).

The HEP in agrarian area is composed of 16 packages of interventions categorized into four areas: Hygiene and Environmental Sanitation (7 packages), Family Health (5 packages), Disease Prevention and Control (3 packages), and Health Education and Communication (one package).

The HEP has been expanded to urban areas, with the aim of improving access and equity in the delivery of essential health services and with 15 packages of interventions categorized into four areas: Hygiene and Environmental Sanitation (4 packages), Family Health (5 packages), Disease Prevention and Control (5 packages), and Accident prevention, first aid and referral (one package).

Households have been graduated as Model Families, a strategy through which female and male household heads are selected from each household and given basic training for 96 hours on the 16 HEP packages. HEWs identify and train model families. The Model Family Package is based on the diffusion theory, the process by which an innovation is communicated through certain channels over time among members of a social system, and proceeds by steps in the community because not all people in a social system adopt an innovation at the same time.

In EFY 2001, the cumulative number of graduated households was 4,061,532, while the target for EFY 2002, was to train and graduate additional 7,422,664 households; however, the number of households graduated in the EFY 2002 was 5,918,174 (80.0% of the annual target). As a result, the cumulative number of graduated households was 9,979,706 (87.1% of the cumulative annual target), with a better performance with respect to that observed in EFY 2001 (57%). Of note is the fact that this cumulative number (9,979,706) was 62.0% of the total eligible households (16,094,504).

One of the major components on HEP packages, Hygiene and Environmental Sanitation, has been implemented in EFY 2002. In line with this, it was planned to increase the number of households with latrines from 9,878,199 (59.4% of latrine coverage) in EFY 2001 to 14,347,072 (84.8% of latrine coverage) in EFY 2002. Out of the annual target of 4,468,873 new latrines in EFY 2002, a total of 2,596,031 households built latrines and the annual performance rate was 58.1%. The addition of the new latrines (2,596,031) constructed in EFY 2002 plus the baseline of 9,878,199 resulted in a cumulative total of 12,474,230 households with latrine, with a coverage of 73.7%, short of the 85% target set for the year in the Core Plan.

Based on the BPR design and the new structure change in the FMoH it was decided

that agrarian signifies the four regions namely Tigray, Amhara, Oromia and SNNP Regions. Whereas urban refers to Harari, Addis Ababa and Dire Dawa City Administration. Similarly, it was decided that pastoralist and semi pastoralist refers to Afar, Somali, Benishangul Gimuz and Gambella Regions. Within this context, the following sections summarizes the progress that has been made in agrarian, urban and pastoralist areas in EFY 2002 in line with Health Extension Programme.

Agrarian Health Extension Programme (Tigray, Amhara, Oromia and SNNPR)

Based on these packages, a total of 5,887,331 households have graduated as Model Families in EFY 2002. The regional distribution of the EFY 2002 baseline, performance and target of the cumulative number of graduated households shows that no region performed above the target set for EFY 2002. Oromia (97.2%) had the best performance followed by Amhara (91.8%), SNNPR (84.7%) and Tigray (78.7%) (Figure 4).

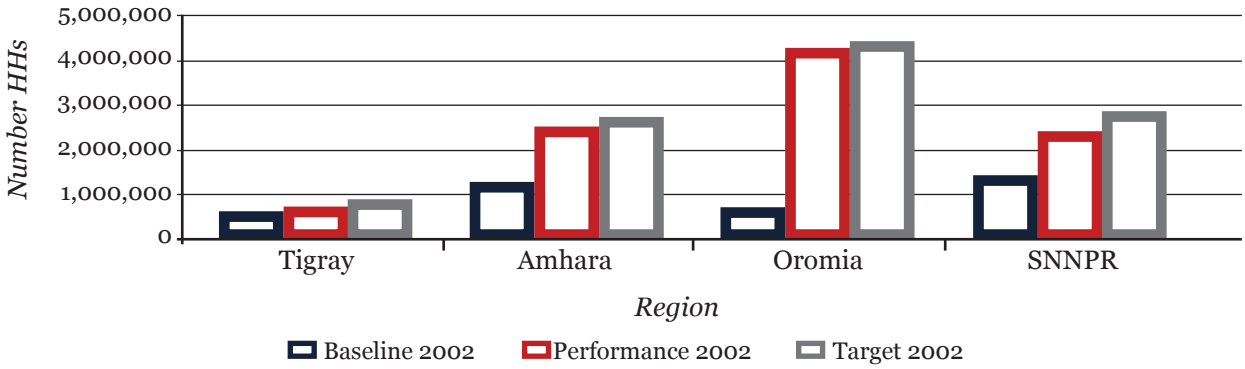

Figure 4: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households in Tigray, Amhara, Oromia and SNNP Regions (EFY 2002)

Table 5: Comparison of Baseline, Performance and Target for the Cumulative Number of Model Households Graduated with Percentage of Target Achievement in Tigray, Amhara, Oromia and SNNP Regions (EFY 2002)

Region	Cumulative number of Graduated Households at the end of EFY 2001	Number of Graduated Households in EFY 2002	Cumulative number of Graduated Households at the end of EFY 2002	EFY 2002 target for the number of Graduated Households	Annual Performance (%)	EFY 2002 target for the cumulative number of Graduated Households	Cumulative performance (%)	EFY 2001 eligible number of Households	Percentage of Graduated Households (out of the total eligible) at the end of EFY 2002 (%)
	(A)	*(B)*	*(C)= (A+B)*	*(D)*	*(E)= (B*100)/(D)*	*(F)*	*(G) =(C*100)/(F)*	*(H)*	*(I) =(C*100)/ (H)*
Tigray	629,369	73,783	703,152	264286	27.9%	893,655	78.7%	1,072,902	65.5%
Amhara	1,262,943	1,245,529	2,508,472	1469565	84.8%	2,732,508	91.8%	3,951,152	63.5%
Oromia	703,756	3,596,531	4,300,287	3,751,357	95.9%	4,423,315	97.2%	5,964,002	72.1%
SNNPR	1,445,524	971,488	2,417,012	1407608	69.0%	2,853,132	84.7%	3,246,118	74.5%

Comparison across regions on latrine coverage shows that SNNPR and Amhara had better performance with coverage of 97.0% and 84.9%, respectively. SNNPR was the only region performing above its regional target (Figure 5).

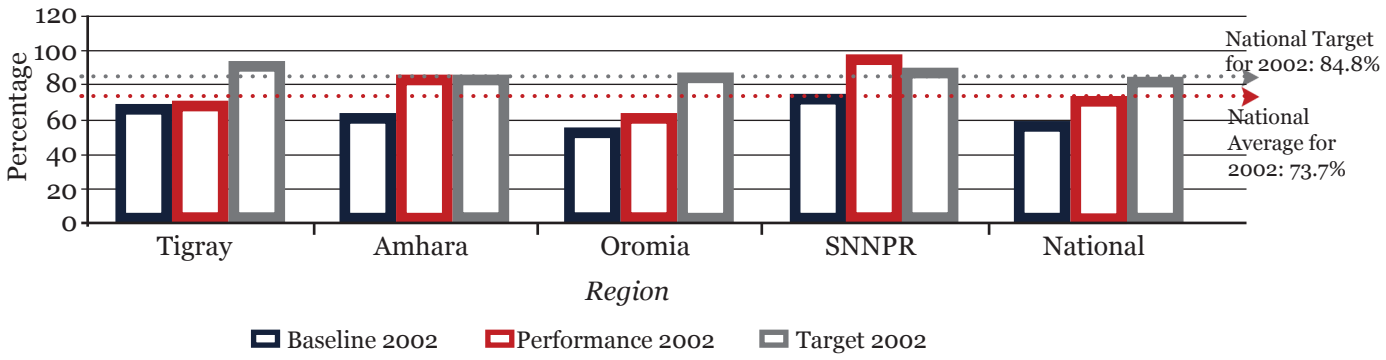

Figure 5: Comparison of Baseline, Performance and Target of Latrine Coverage in Tigray, Amhara, Oromia and SNNP Regions (EFY 2002)

In EFY 2002, the preparation of the draft manual for the design and construction of low cost latrines, the implementation guideline, the training manual for community-led total sanitation (CLTS), and the manual on the construction, utilization and maintenance of latrines (meeting minimum standards) was completed. Similarly, draft guideline to improve utilization of latrines was prepared for HEWs to improve implementation of hygiene and sanitation activities in schools and at the community level; and TOT on community-led total sanitation was given to 37 experts drawn from 34 Woredas. Besides, TOT on community-led sanitation was given to 90 health extension supervisors and experience-sharing visits were made to Kebeles free of open-field defecation located in Haromaya and Serbo Woredas; a total of 66 Health Extension Coordinators also participated in an experience sharing visit to Shebedino Woreda in SNNPR. The Hygiene and Sanitation Task Force was established in Amhara Region in collaboration with partners

In addition, the site for the construction of the residential building for the workers at Dewele Quarantine Center was handed over to the contractor. To control the spread of Acute Watery Diarrhea (AWD) in places of worship, public toilets for 100 persons became operational at Tsadkane Mariam Church, while public toilets with a capacity to accommodate 12 and 25 persons at a time were built at Gishen and Debre Kusquam Mariam Church, respectively. Furthermore, printing and distribution of 500,000 copies of a leaflet on AWD were carried out during EFY 2002.

Regarding health education and communication, as part of the school health education program initiated in 9,000 Kebeles and 20,000 copies of the study report on environmental sanitation in schools are being printed, while the draft design and construction manual on Sanitation Facilities of Primary Schools is being finalized based on feedbacks received from stakeholders. Youth health messages for media use have been prepared and sent to the regions.

Urban Health Extension Programme (Harari, Addis Ababa and Dire Dawa)

A total of 3,711 households have graduated as Model Families in Harari and Dire Dawa in EFY 2002. The cumulative number of graduated households reached in these regions to 2,159 and 2,400 Households, respectively. No households have graduated form Addis Ababa Region (Table 6).

Table 6: Comparison of Baseline, Performance and Target for the Cumulative Number of Model Households Graduated with Percentage of Target Achievement in Harari, Addis Ababa and Dire Dawa (EFY 2002)

Region	Cumulative number of Graduated Households at the end of EFY 2001	Number of Graduated Households in EFY 2002	Cumulative number of Graduated Households at the end of EFY 2002	EFY 2002 target for the number of Graduated Households	Annual Performance (%)	EFY 2002 target for the cumulative number of Graduated Households	Cumulative performance (%)	EFY 2001 eligible number of Households	Percentage of Graduated Households (out of the total eligible) at the end of EFY 2002 (%)
	(A)	*(B)*	*(C)= (A+B)*	*(D)*	*(E)= (B*100)/(D)*	*(F)*	*(G) =(C*100)/(F)*	*(H)*	*(I) =(C*100)/(H)*
Harari	428	1,731	2,159	12505	13.8%	12933	16.7%	19,670	11.0%
D. Dawa	420	1,980	2,400	3800	52.1%	4009	59.9%	27,748	8.6%
Addis Ababa	0	0	0	178,279	0.0%	178,279	0.0%	710,830	0.0%

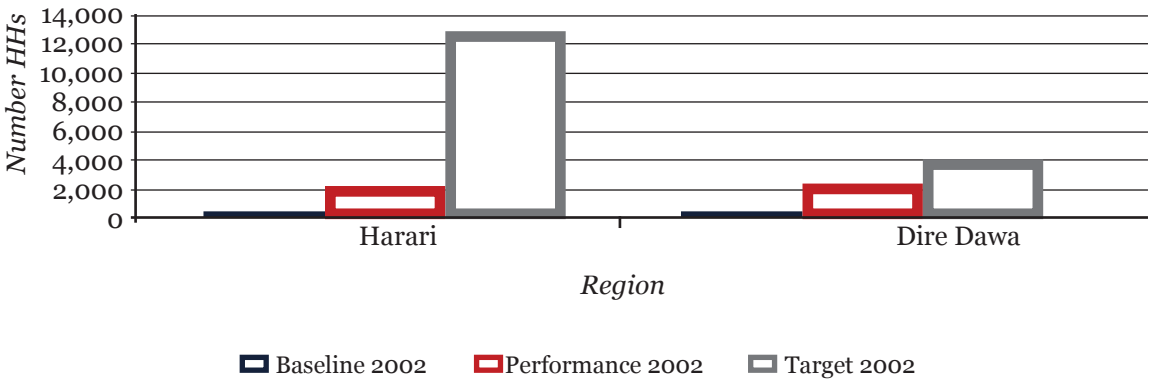

Figure 6: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households in Harari and Dire Dawa (EFY 2002)

Addis Ababa had better performance with larine coverage of 93.0%. Harari and Dire Dawa performed below the national average.

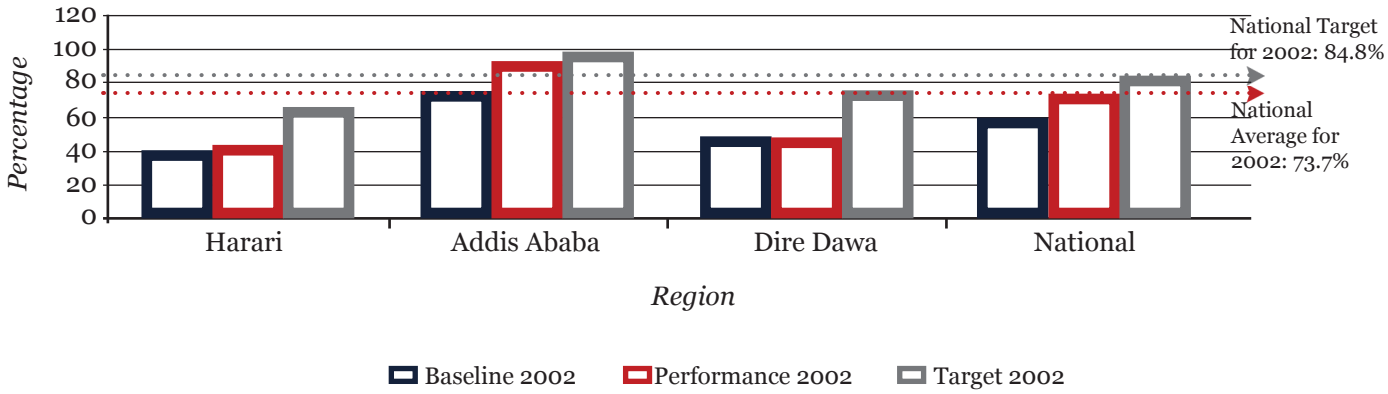

Figure 7: Comparison of Baseline, Performance and Target of Latrine Coverage in Harari, Addis Ababa and Dire Dawa (EFY 2002)

Regarding health education and communication, as part of the school health education program initiated in 2,100 Kebeles, 20,000 copies of the Management Guideline on Sanitation and Hygiene Facilities are being printed. In regions, implementing the urban HEP, top management participated in awareness creation and other advocacy activities. Messages on the urban HEP were disseminated through the mass media. A study paper was presented to a panel discussion of 60 participants organized at the Walta Information Center.

Pastoralists Health Extension Programme (Afar, Somali, Benishangul Gumuz and Gambella)

In EFY 2002, Benishangul Gumuz (15.3%) performed well among areas of pastoralist semi pastoralist, low achievement was registered in Afar (0.6%), Somali (10.6) and Benishangul Gumuz (15.3%) on Model household graduation and no households graduated in Gambella Region.

Table 7: Comparison of Baseline, Performance and Target for the Cumulative Number of Model Households Graduated with Percentage of Target Achievement in Afar, Somali, Benishangul Gumuz and Gambella (EFY 2002)

Region	Cumulative number of Graduated Households at the end of EFY 2001	Number of Graduated Households in EFY 2002	Cumulative number of Graduated Households at the end of EFY 2002	EFY 2002 target for the number of Graduated Households	Annual Performance (%)	EFY 2002 target for the cumulative number of Graduated Households	Cumulative performance (%)	EFY 2001 eligible number of Households	Percentage of Graduated Households (out of the total eligible) at the end of EFY 2002 (%)
	(A)	*(B)*	*(C)= (A+B)*	*(D)*	*(E)= (B*100)/(D)*	*(F)*	*(G) =(C*100)/(F)*	*(H)*	*(I) =(C*100)/(H)*
Afar	0	130	130	21716	0.6%	21716	0.6%	145,368	0.1%
Somali	8490	22,000	30,490	207287	10.6%	215,777	14.1%	724,315	4.2%
B. Gumuz	10602	5,002	15,604	91294	5.5%	101896	15.3%	160,538	9.7%
Gambella	0	0	0	14967	0.0%	14967	0.0%	71,861	0.0%

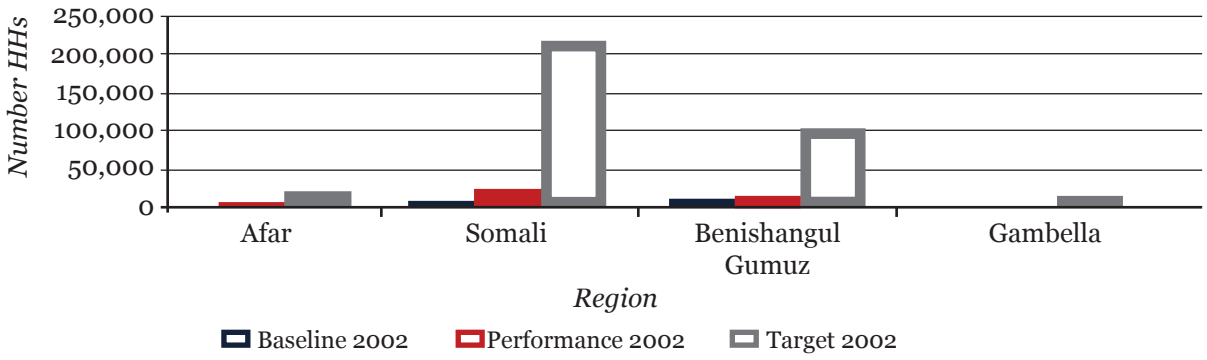

Figure 8: Comparison of Baseline, Performance and Target of the Cumulative Number of Graduated Households in Afar, Somali, Benishangul Gumuz and Gambella (EFY 2002)

With regard to hygiene and environmental sanitation, the lowest performers were seen in Afar, Gambella and Benishangul Gumuz regions with performance rates of 6.9%, 22.4% and 35.6%, respectively. Somali (41%) performed well when it is compared with the other three regions (Figure 9).

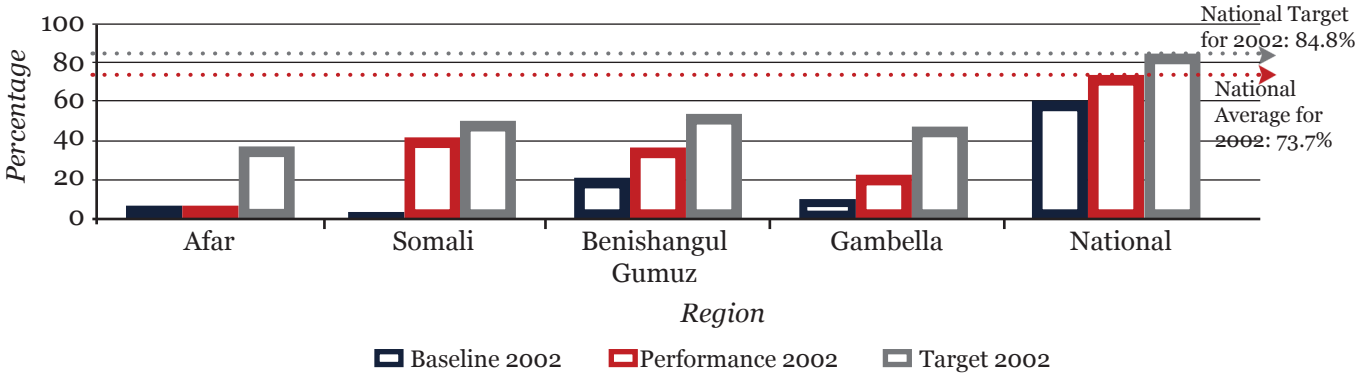

Figure 9: Comparison of Baseline, Performance and Target of Latrine Coverage in Afar, Somali, Benishangul Gumuz and Gambella (EFY 2002)

Challenges

The challenges encountered in the implementation of HEP can be summarized as follows. Woreda Health Offices, Regional Health Bureaus and FMOH continuously address the challenges and constraints encountered during implementation of the HEP. However, the following challenges still need attention and continuous follow-up:

- Low performance and quality in training and deployment of model families due to low capacity and poor follow up;
- Shortage of time and training materials hampering the provision of TOT for urban HEP Supervisors;
- Limited knowledge of trainers about the reality of working with pastoralist communities;
- Limited capacity on implementation modalities of HEP in pastoralist areas at Woreda level;
- Not all the graduated HEWs are working in their respective HPs; and
- Majority of HEWs in pastoralists area are male, limiting the contact with mother and females.

Way Forward

- Ensure full implementation of the pastoral HEP;
- Strengthen the support and follow up of the graduation of model households by HEP supervisors and Woreda Health Offices;
- Carry out continuous advocacy and experience sharing with regions having best practice in the implementation of HEP;
- Conduct assessment of Pastoralist HEP;
- Conduct advocacy workshops at the regional level involving officials from zonal and Woreda levels to increase awareness about HEP and obtain their commitment; and
- Training and deployment of female HEWs in pastoralist area and strengthen the capacity through training, technical support and close supervision.

5.2 Maternal Health Services

The Government of Ethiopia is strongly committed to achieve MDG5 to improve maternal health, with a target of reducing maternal mortality ratio (MMR) by three-quarters over the period 1990–2015. HEP, accelerated expansion of HCs, provision of Basic Emergency Obstetric Care (BEOC) and Comprehensive Emergency Obstetric Care (CEOC) in health facilities and provision of safe blood and adequate pharmaceuticals are still the major strategies that have been designed to meet this target. These strategies have been implemented and there has been a decline in MMR from 871 deaths per 100,000 live births in 2000 EDHS to 673 deaths per 100,000 live births in 2005 EDHS. Trends in maternal mortality from 1990 to 2008 have been assessed and estimates have been developed by WHO, UNICEF, UNFPA, and World Bank. According to these estimates, MMR in Ethiopia was 470 deaths per 100,000 live births in 2008. However, maternal mortality is still high and it is expected that the implementation of the HEP packages and the provision of BEOC and CEOC services at HC and hospital levels, will contribute to further reduction of maternal mortality in the years ahead, and with the current rate reduction, MDG5 is likely to be met by 2015.

Five major HMIS indicators have been selected to measure the progress towards the achievement of MDG5. Table 8 shows 2002 baseline, performance and target for these indicators, including the overall HSDP targets set for EFY 2002. As shown in Table 8, the coverage of maternal health services is still low and the national targets set for EFY 2002 were not achieved.

Table 8 Maternal Health Indicators (2002 Baseline, Performance and Target and HSDP III Target for EFY 2002)

Indicator	EFY 2002 Baseline	EFY 2002 Performance	EFY 2002 Target	HSDP III Target
Antenatal Care Coverage	67.7%	71.4%	80%	80%
Percentage of deliveries attended by skilled health personnel	18.4%	16.8%	37%	32%
Clean and safe delivery service coverage (Percentage of Deliveries attended by Health Extension Workers)	12.3%	17.0%	29%	50%
Postnatal Care Coverage	34.3%	36.2%	55%	31%
Contraceptive Acceptance Rate	56.2%	61.9%	69%	

Four maternal indicators showed improvement compared to the figures in EFY 2001. Antenatal care coverage increased from 67.7% in EFY 2001 to 71.4% in EFY 2002 and clean and safe delivery service coverage (by HEWs) from 12.3% in EFY 2001 to 17.0% in EFY 2002. Contraceptive acceptance rate rose from 56.2% in EFY 2001 to 61.9% in EFY 2002, while postnatal care coverage increased from 34.3% to 36.2% in the same period.

However, the percentage of deliveries attended by skilled health personnel declined from 18.4% in EFY 2001 to 16.8% in EFY 2002 (Figure 10). This percentage is very low, largely below the Sub Saharan African average of 47% in 2009 (according to Assessing Progress in Africa toward the Millennium Development Goals, MDG Report 2010). Of note is the fact that increase in the percentage of birth attended by skilled health personnel is a key intervention for reducing maternal deaths and it is considered as a proxy indicator for measuring improvements in the maternal mortality.

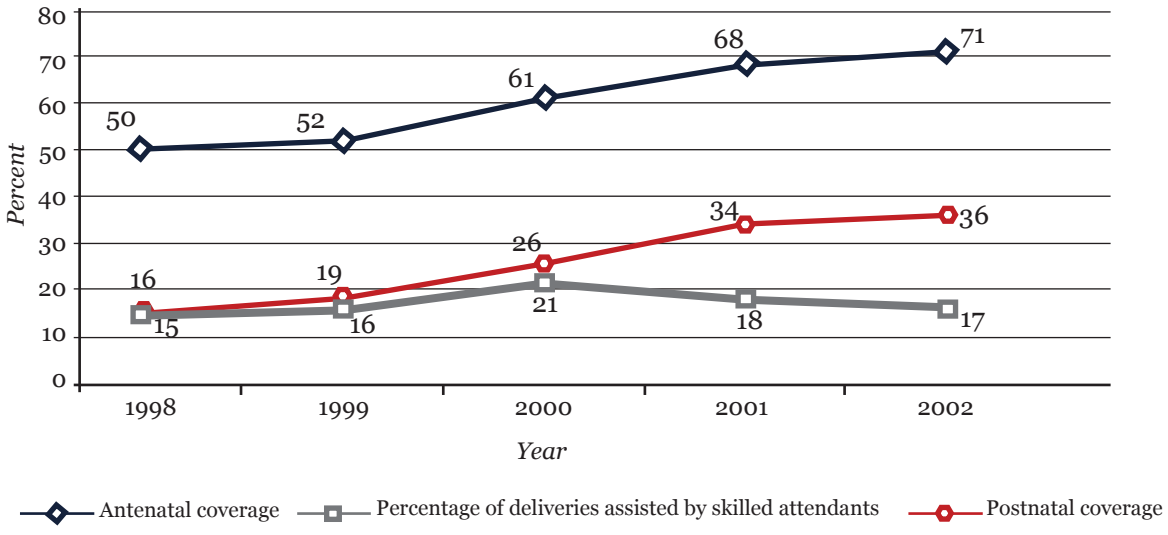

Figure 10: Trend in Antenatal Coverage, Percentage of Deliveries Assisted by Skilled Health Personnel and Postnatal Coverage (EFY 1998-2002)

Regional Distribution of Antenatal Care Coverage

Performances of antenatal care coverage shows wide variation across regions ranging from 25.3 % in Afar Region and 31.3% in Gambella Region to 100 % in Addis Ababa. An

increasing trend has been observed in five regions (Oromia, Somali, Benishangul Gumuz, Harari, and Dire Dawa), with Addis Ababa maintaining 100% coverage, while there have been decreases in the other five regions. Three Regions (Somali, Harari and Addis Ababa) achieved their target (Figure 11). These regional performances resulted in a national increase in the antenatal coverage from 67.7% in EFY 2001 to 71.4% in EFY 2002, which is still below the target set for EFY 2002 (80.0%).

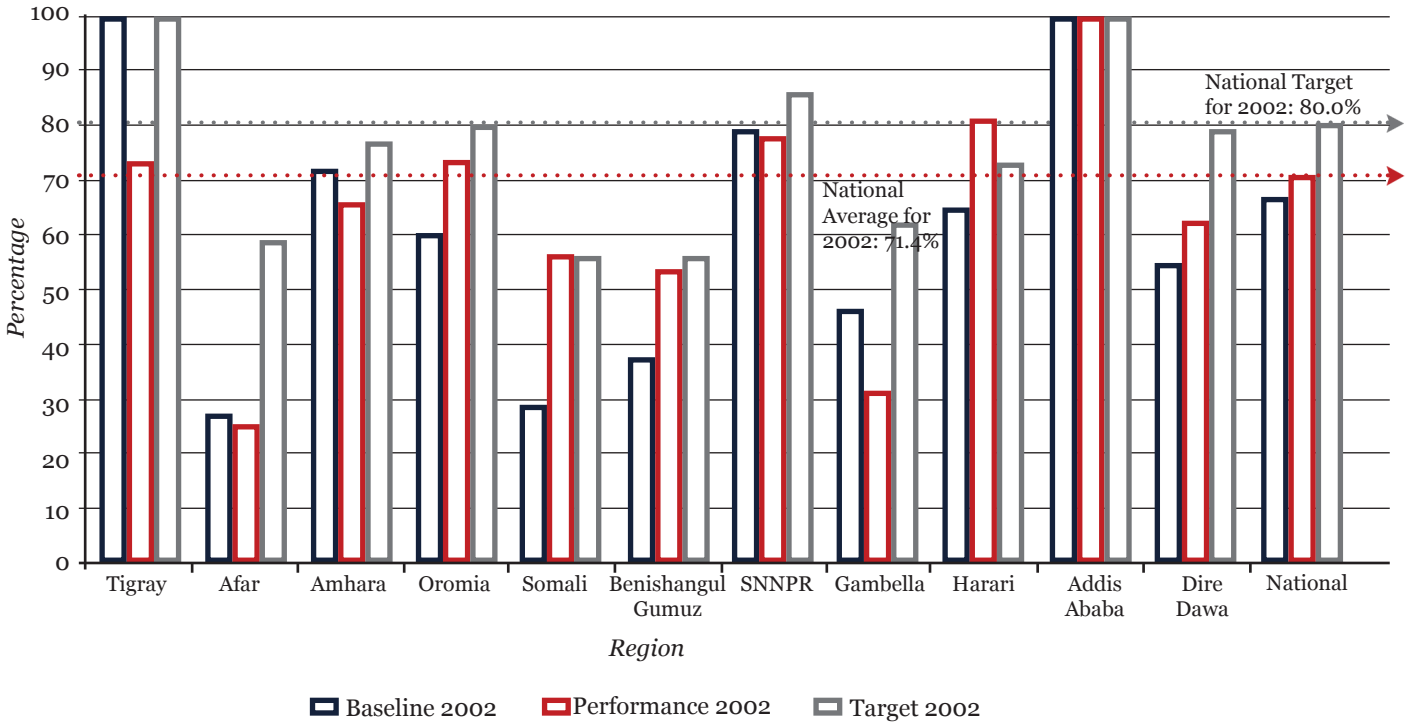

Figure 11: Comparison of Baseline, Performance and Target of Antenatal Care Coverage by Region (EFY 2002)

Regional Distribution in the Percentage of Deliveries Assisted by Skilled Health Personnel

Modest decline was observed in the percentage of deliveries assisted by skilled health personnel from 18.4% in EFY 2001 to 16.8% in EFY 2002, which is much below the target of 37.0% set for EFY 2002, with wide variations across regions ranging from 5.7% in Benishangul Gumuz to 60.9% in Addis Ababa. An increase was observed in six regions (Tigray, Afar, Oromia, Somali, Benishangul Gumuz, and Harari), while a decrease was observed in the other five regions (Figure 12). Harari was the only region exceeding its regional target: this increase is likely to be related to the availability of skilled personnel and obstetrical services in public and non-governmental facilities with subsequent improved access to these services.

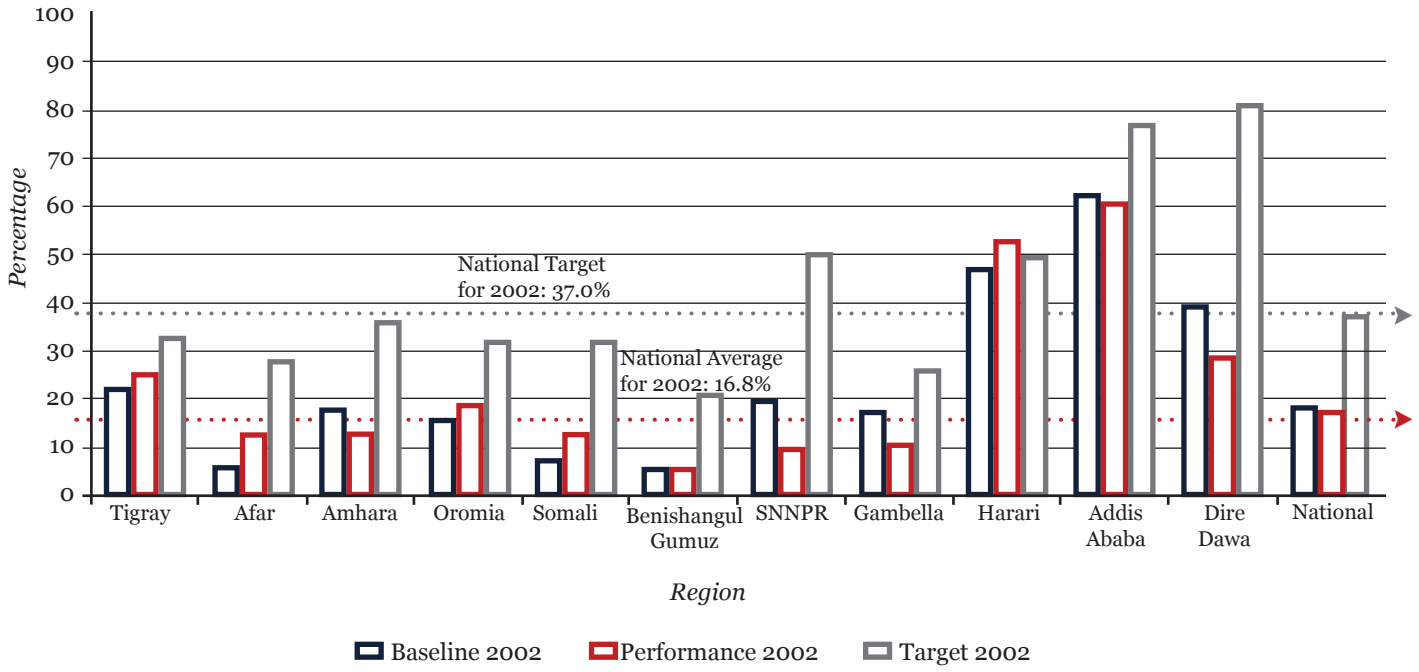

Figure 12: Comparison of Baseline, Performance and Target of the Percentage of Deliveries Assisted by skilled Health Personnel by Region (EFY 2002)

Regional Distribution of Clean and Safe Delivery Service Coverage (Percentage of Deliveries Attended by Health Extension Workers)

An increase was observed in the clean and safe delivery service coverage, reaching 17.0% in EFY 2002, a level that is still below the target set for the year (29.0%). Wide variations were observed across regions ranging from 0.4% in Gambella Region, 13.6% in Oromia and 39.5% in SNNPR. An increase in performance was observed in eight regions (Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, SNNPR, and Harari); however, only one region (SNNPR) achieved its regional target (Figure 13). There was a decrease in the remaining two regions (0.4% in Gambella, and 1.1% in Dire Dawa).

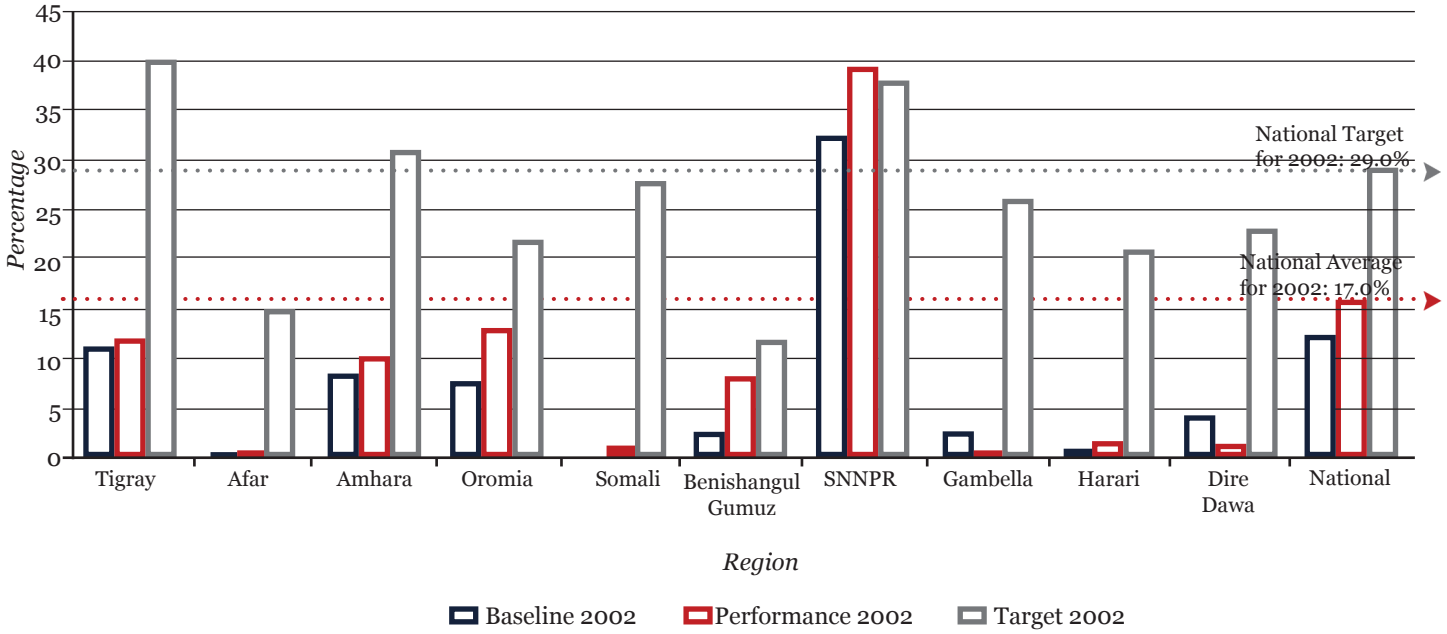

Figure 13: Comparison of Baseline, Performance and Target of the Clean and Safe Delivery Service Coverage (EFY 2002)

The following activities were performed in EFY 2002:

- Training on safe and clean delivery was given to 1,213 HEWs;
- 7,000 copies of trainers' manual on safe and clean delivery, 15,000 copies of reference materials for HEWs, and 15,000 copies of implementation guidelines were distributed to regions;
- TOT on safe and clean delivery was provided to 12 professionals in the four emerging regions; and
- Expendable supplies for 1.2 million mothers were procured and distributed to regions.

Challenges

- Low community awareness; and
- Inadequate training of HEWs on clean and safe delivery.

Additional challenges reported from pastoralist areas include the fact that most HEWs are males, therefore limiting their contact with mothers and making difficult their relationship with TBAs.

Regional Distribution of Postnatal Care Coverage

Concerning the regional distribution of the postnatal care services, the highest coverage in EFY 2002 was observed in Tigray (61.0%) and Dire Dawa (42.5%) followed by SNNPR (41.7%), Addis Ababa (39.7%), Amhara (37.9%), and Harari (34.8%) (Figure 14). A decrease was observed in four regions (Amhara, Gambella, Harari and Addis Ababa) compared to the performance in EFY 2001. There was an increase in postnatal coverage from 34.3% in EFY 2001 to 36.2 % in EFY 2002, and this figure is substantially below the target (55%) set for EFY 2002.

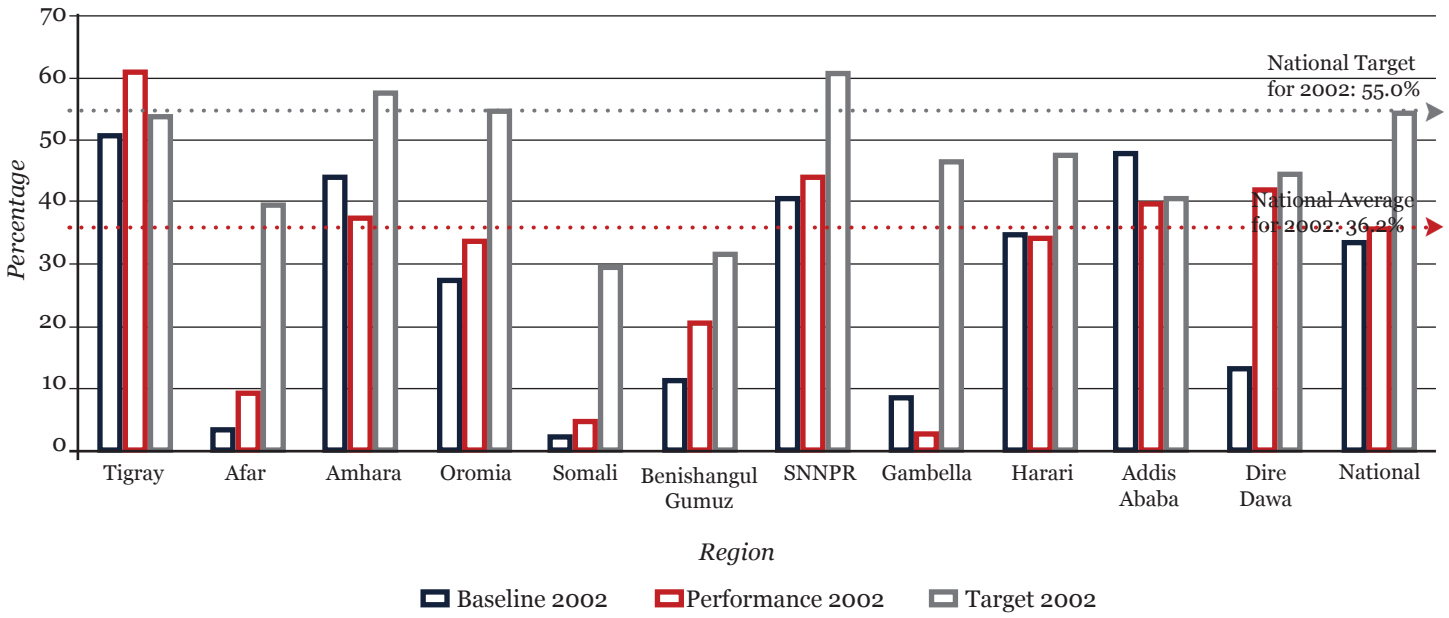

Figure 14: Comparison of Baseline, Performance and Target of Postnatal Care Coverage by Region (EFY 2002)

The following activities were performed in EFY 2002:

- Draft manual on postnatal care for integrated refresher training of HEWs has been prepared; and
- Three million misoprostol tablets have been procured and distributed to Regions.

Trends in the Contraceptive Acceptance Rate

Contraceptive Acceptance Rate (CAR) is the proportion of women of reproductive age (15-49 years) who are not pregnant and are accepting a modern contraceptive method (new and repeat acceptors). Each acceptor is counted only once, the first time s/he receives contraceptive services in the calendar year. CAR has increased from 56.2% in EFY 2001 to 61.9% in EFY 2002, although this figure represents short of the target (69.0%) set for the year (Figure 15).

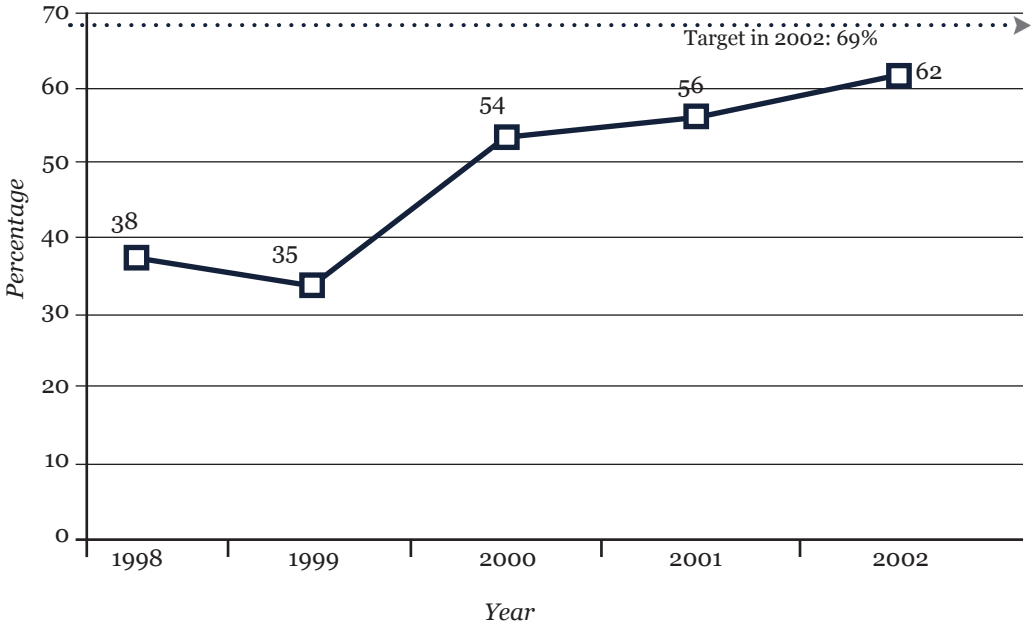

Figure 15: Trend in the Contraceptive Acceptance Rate (EFY 1998-2002)

During the 2002 EFY, the FMOH has launched Implanon scale up initiative. The biggest achievement of the initiative is the decision that the Ministry has taken to give the implanon insertion service by Health Extension Workers (HEWs). This has brought a tremendous effect in increasing access of the service to the community.

To make the initiative very effective, the MOH has developed a very detailed plan with the participation of all stakeholders including partners working in the RH area. For the '1st wave of learning phase', 32 woredas were carefully selected from Amhara, Tigray, SNNP and Oromia regions. Then, the initiative is expanded to additional 100 drought-prone woredas.

Trainers' and participants' manuals were developed, printed and distributed to the training sites. Then, a series of TOTs for HEWs supervisors and roll out trainings for HEWs were conducted. Excluding the trainings and other activities conducted by other partners with respect to Implanon insertion services, during the 2002 EFY, a total of about 552 HEW supervisors were trained on TOT of Implanon insertion and removal and 6,854 HEWs were trained on implanon insertion by FMOH. The HEWs are implementing the service in high scale.

One Federal and four regional sensitization workshops were conducted. Social Mobilization manual was developed and series of advocacies were conducted using brochures, leaflets, and exhibitions. Messages about Implanon was also transmitted through the Ministry of Health's magazines which is published by the PR. Radio messages were also aired through 2 national and 4 regional radio stations concerning long-term family planning methods, particularly Implanon.

Family Planning Decision Making Tool was developed, reviewed, translated into three local languages and on printing process in addition to other job aids to standardize and make the task of HEWs very easy.

The Family Planning Implementation Guideline has been revised and is ready for printing. Training on family planning and reproductive health has been given to 48 journalists.

Regional Distribution of Contraceptive Acceptance Rate

There have been variations among regions. As in the past year, the lowest rate (8.6%) was reported from Somali Region, and the highest rate (88.9%) from Dire Dawa. An increase was observed in seven regions (Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz and Dire Dawa), while there was a decrease in three regions (Gambella, Harari and Addis Ababa), with SNNPR showing a stable pattern. Both Tigray and Dire Dawa were the only regions that performed above their annual targets (Figure 16). In general, low rates were observed in pastoralist areas due to negative influence mainly from cultural and religious beliefs and low level of community awareness about family planning services.

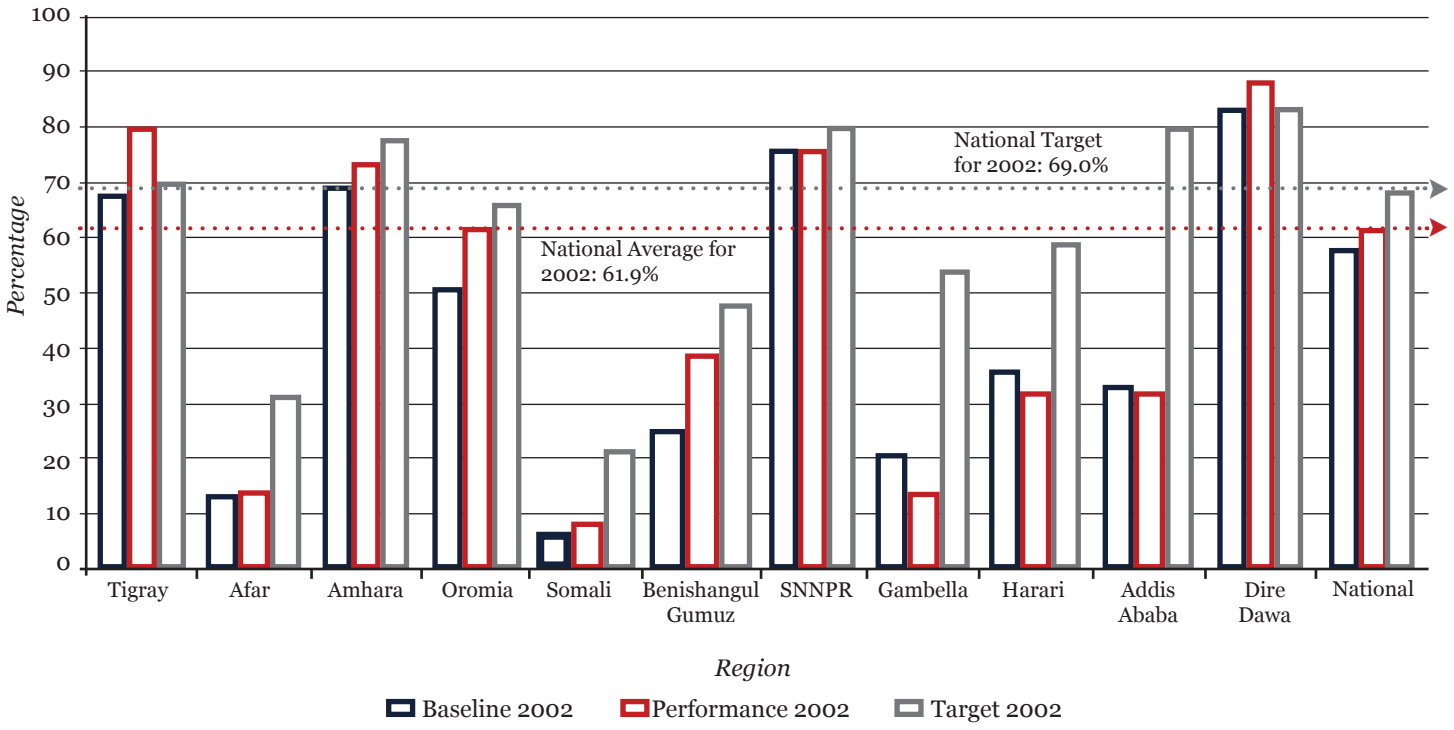

Figure 16: Comparison of Baseline, Performance and Target of Contraceptive Acceptance Rate by Region (EFY 2002)

The Government of Ethiopia has dedicated every January as the Safe Motherhood Month (SMM). The main purpose is to draw attention and effort from all walks of society to move towards 'No Woman Should Die from Giving Life'. It is a commitment made by the government of Ethiopia to reach MDG 5. Accordingly, the first Safe Motherhood Month was launched in January, 2010 by the president of the Federal Democratic Republic of Ethiopia in the presence of prominent religious leaders, ambassadors, and dignitaries. Ethiopia also officially launched CARMMA in the same month in extension to the Maputo plan of action. The month was also marked by different activities including public parade, infotainments involving popular celebrities and athletes, various media engagements, workshops ,and panel discussions among different professional societies. The SMM did not only focus on social mobilization and awareness creation, but also had concrete deliverables, both short term and long term.

Challenges

- Absence of 24 hours a day and 7 days a week services in most health facilities (HF), especially in HCs;
- Inadequate numbers and high turnover of midwives;
- Funding gap for health systems;
- Shortage of drugs, supplies and equipment forcing mothers to buy gloves, drugs and IV fluids;
- Poor delivery room environment;
- Lack of a separate newborn corner and absence of a neonatal unit (where sick newborns can be admitted) in health facilities; and
- Weak referral system.

Way forward

- Provide round the clock delivery services in health centers nation-wide;
- Provide C-EmOC in all hospitals and selected HCs by putting up functional maternities, nurseries, maternity theatres and laboratory services;
- Scale-up the training of midwives and apply retention mechanisms;
- Scale up the competency training for HEWs to provide clean and safe delivery including essential newborn care closer to the community;
- Deploy female HEWs in pastoralist communities;
- Ensure availability of family planning commodities in HFs;
- Establish a newborn unit in all hospitals and a newborn health corner in all delivery rooms and maternity wards of all HFs; and
- Implement a functional Referral Strategy.

5.3 Child Health Services

Improving child health was one of the priority interventions of HSDP III, which set a target for the reduction of under-five mortality rate from 123 to 85 per 1000 live births and the infant mortality rate from 77 to 45 per 1000 live births. The progress made in Ethiopia in this regard is encouraging. A special emphasis was put on the Expanded Programme on Immunization (EPI) and the Integrated Management of Neonatal and Childhood Illnesses (IMNCI).

Immunization

A comprehensive EPI Multi-Year Plan 2006-2010 was prepared based on HSDP III with the goal of reducing the morbidity and mortality from vaccine preventable diseases by providing good quality immunization services. In particular, the plan aims to reduce vaccine preventable diseases through integrated interventions that would strengthen the overall health system, encompassing all components of immunization services: service delivery, vaccine supply, quality and logistics, disease surveillance and accelerated disease control, advocacy, social mobilization and communication and programme management. Of note is the fact that Pentavalent vaccine (Hepatitis B-HepB- and Haemophilus influenzae type b-Hib- vaccines in addition to Diphteria, Pertussis and Tetanus–DPT- vaccines) replaced DPT vaccine in March 2007 and it has been in use since then; therefore the two targets for DPT3 and Hib/HepB vaccines coverage are now merged in the target for Pentavalent 3 vaccine coverage.

Table 9 shows EFY 2002 baseline, performance and target for pentavalent 3 immunization coverage, measles immunization coverage and full immunization coverage as well as the overall HSDP target set for EFY 2002. In EFY 2002 pentavalent immunization coverage was 86.0%, measles immunization coverage was 82.4%, while the percentage of fully immunized children was 72.3%, therefore surpassing the targets set in HSDP III. However, the more ambitious annual targets set for EFY 2002 in the Woreda Plan were not met.

Enhanced Routine Immunization Activities (ERIA) were implemented in the second half of EFY 2002 with a special focus on areas lagging behind in the EPI coverage. These activities included: (i) Regional/ zonal level orientation; (ii) House-to-house registration of target group; (iii) Implementation of immunization; and (iv) Supervision.

Table 9: Immunization coverage indicators (2002 Baseline, Performance and Target and HSDP III Target for EFY 2002)

Indicator	EFY 2002 baseline	EFY 2002 performance	EFY 2002 Target	HSDP III target (for EFY 2002)
Pentavalent 3 Vaccine Coverage	81.6%	86.0%	88.6%	85%
Measles Vaccine Coverage	76.6%	82.4%	84.2%	75%
Full Immunization Coverage	65.5%	72.3%	81.4%	54%

Trend in Immunization Coverage

There were upward trends in immunization coverage between EFY 1998 and 2002. DPT/ Pentavalent 3 vaccine coverage increased from 77% in EFY 1998 to 86.0% in EFY 2002, measles vaccine coverage from 67% to 82.2%, and full immunization coverage from 55% to 72.3% in the same period (Figure 17).

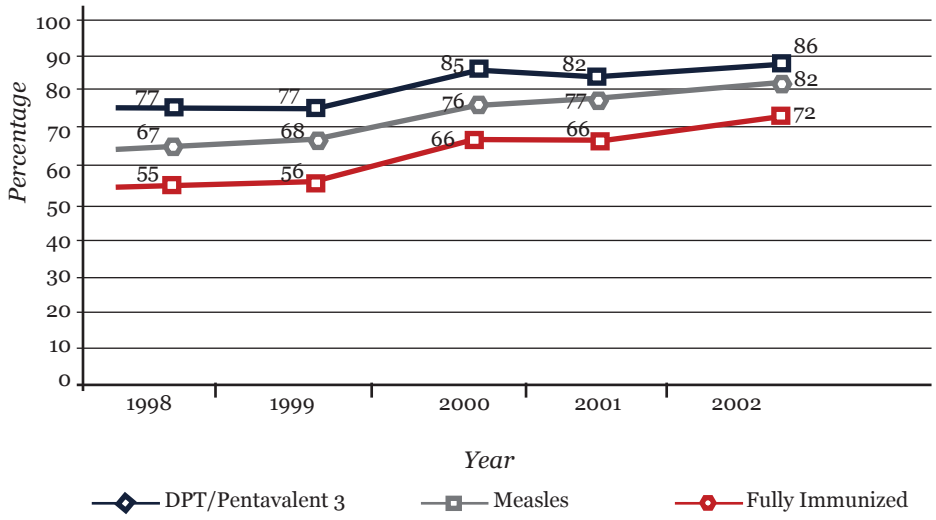

Figure 17: Trend in DPT/Pentavalent 3 Immunization Coverage, Measles Immunization Coverage and Percentage of Fully Immunized Children (EFY 1998-2002)

Regional Distribution of Pentavalent 3 Vaccine Coverage

Pentavalent 3 coverage was 86.0% at the national level in EFY 2002, short of the target (88.6%) set for EFY 2002 and above the performance in EFY 2001 (81.6%). The highest coverage (93.2%) was found in Oromia Region, with the lowest one being observed in Somali (51.5%) (Figure 18). Two regions (Oromia and Benishangul-Gumuz) performed above their annual targets, while, in addition to the two above mentioned regions, an increase in performance was observed in five other regions (Afar, Somali, SNNPR, Gambella and Dire Dawa), contributing to the increased coverage at the national level. A declining performance was observed in EFY 2002 in five regions (Tigray, Amhara, Harari, and Addis Ababa).

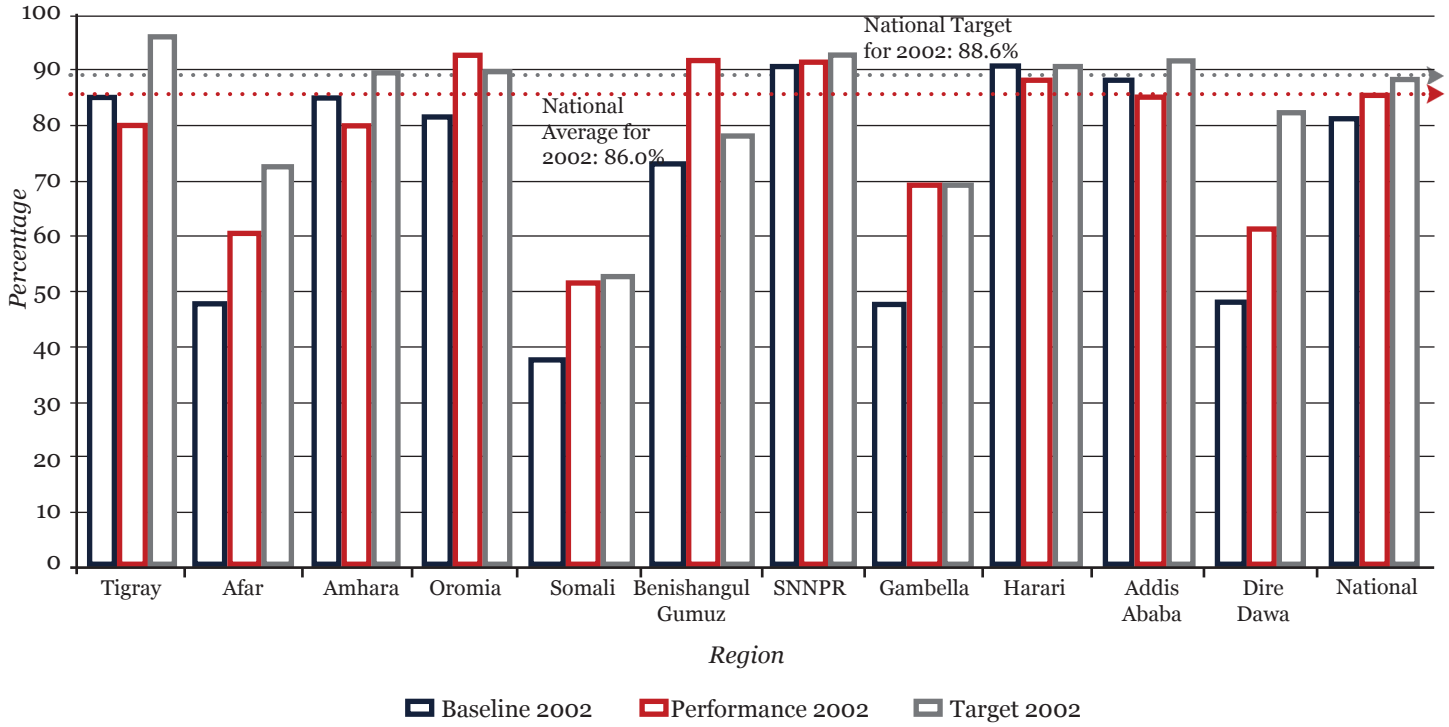

Figure 18: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2002)

Regional Distribution of Measles Vaccine Coverage

Similar patterns were observed in measles vaccine coverage, that was 82.4% at the national level in EFY 2002, short of the target (84.2%) set for the year, but above the performance in EFY 2001 (76.6%). Although measles coverage was high in SNNPR (91.9%) and Oromia (85.9%), there was still a large number of measles cases and deaths being reported from these regions (15,927 cases and 14 deaths from SNNPR and 1,678 cases and 10 deaths from Oromia), raising questions that would require further investigations and explanations. Measles vaccine coverage was also high in Addis Ababa (84.0%), while five additional regions (Afar, Somali, Benishangul-Gumuz, Gambella and Dire Dawa) showed improved performance with respect to EFY 2001; however, Amhara Region showed a stable performance (79.0%) (Figure 19).

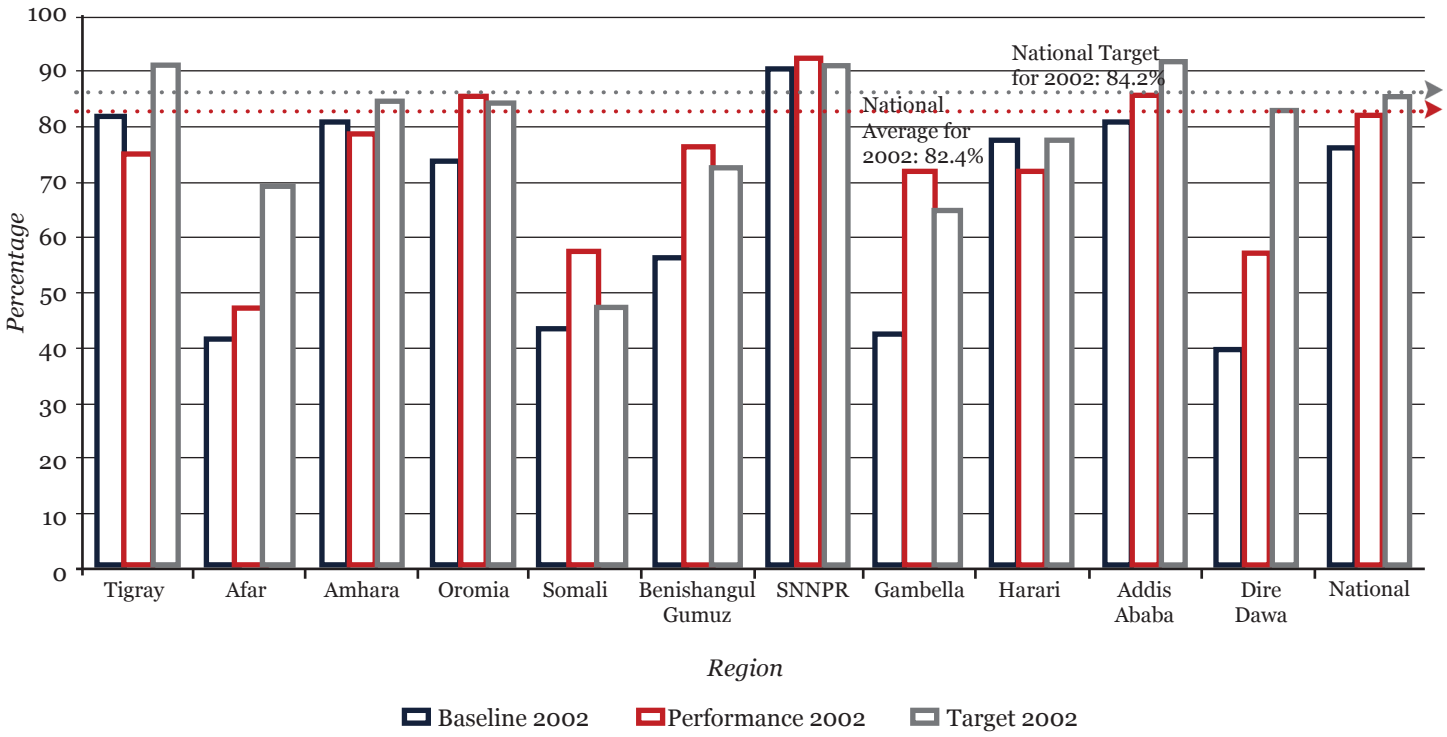

Figure 19: Comparison of Baseline, Performance and Target of Measles Immunization Coverage by Region (EFY 2002)

Regional Distribution of Full Immunization Coverage

There was an increase in full immunization coverage from 65.5% in EFY 2001 to 72.3% in EFY 2002, still short of the target (81.4%) set for EFY 2002. The highest coverage was in SNNPR (82.1%), while the lowest one was in Somali (38.0%) (Figure 20). Eight regions (Afar, Oromia, Somali, Benishangul-Gumuz, SNNPR, Gambella, Addis Ababa and Dire Dawa) increased their performance, with Dire Dawa showing the highest increase (+17.4%). Three regions decreased their performance, with the highest decrease being found in Harari (-7.6%).

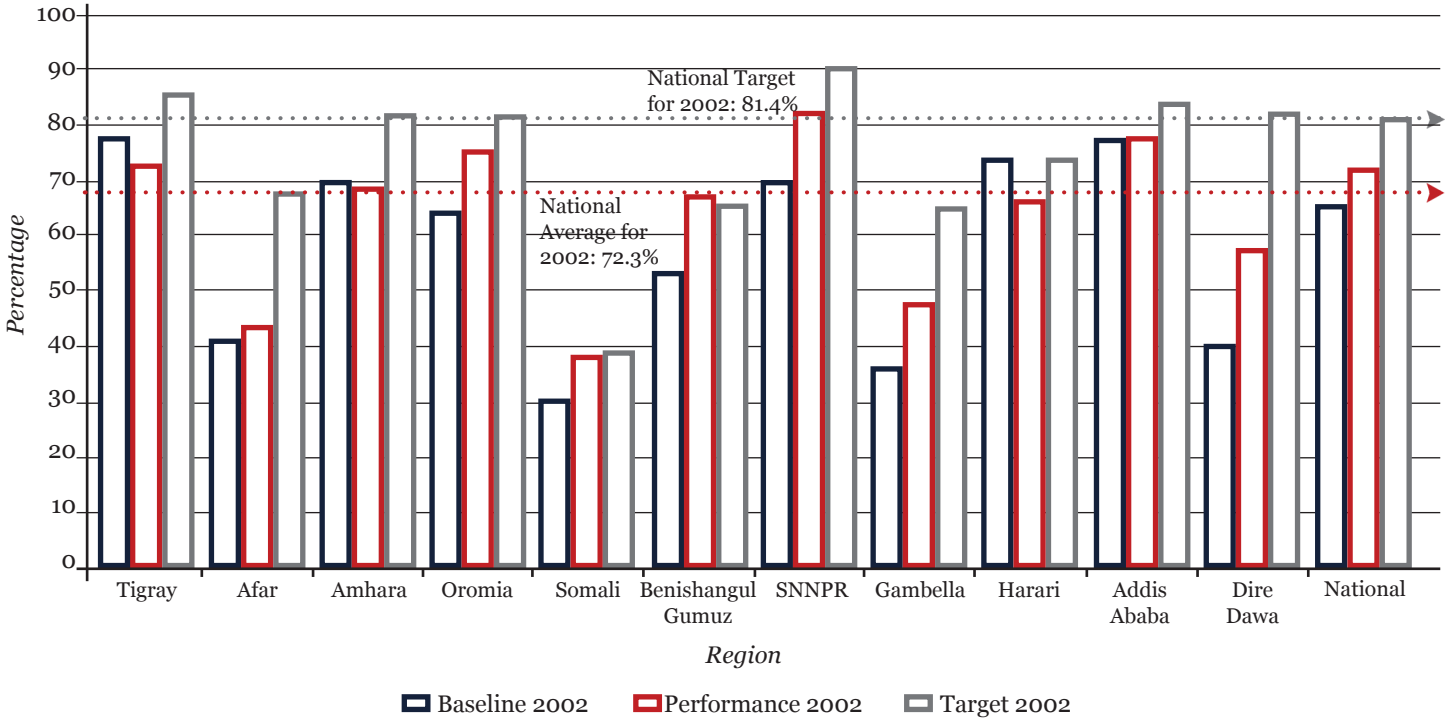

Figure 20: Comparison of Baseline, Performance and Target of Full Immunization Coverage by Region (EFY 2002)

The Integrated Management of Neonatal and Childhood Illnesses

The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) is the strategy to improve the quality of management of childhood illnesses, linking preventive and curative services so that programs, such as immunization, nutrition, and control of malaria and other infectious diseases, are implemented in an integrated manner. The main activities under IMNCI are prevention and control of Acute Respiratory Infections (ARI), diarrhea, malaria, malnutrition, measles and HIV/AIDS. At the end of EFY 2002, 1,267 HCs and 81 hospitals (EFY 2001 data) were providing IMNCI, while 578 Woredas were providing Community IMNCI interventions (Table 10).

Table 10: Distribution of Health Centers Providing IMNCI by Region (EFY 2002)

Regions	Cumulative number of HCs providing IMNCI in EFY 2001	Cumulative Number of HCs providing IMNCI service at end of 2002 EFY	Cumulative number of HCs Available in EFY 2002
Tigray	99	119	170
Afar	13	11	28
Amhara	225	398	520
Oromia	252	367	825
Somali	13	13	35
Ben-Gum	14	15	29
SNNPR	269	289	463
Gambella	8	8	23
Harari	4	6	8
Dire Dawa	7	15	15
Addis Ababa	26	26	26
Federal	930	1,267	2,142

5.4 National Nutrition Programme

Ethiopia remains in a precarious situation as it relates to nutrition status with malnutrition remaining the underlying cause of over half of the child deaths. Malnutrition is widespread across the country. Infant and young child feeding (IYCF) practice in terms of early initiation of breastfeeding, exclusive breastfeeding up to 6 months, and appropriate timing and practice of complementary feeding are poor contributing heavily to malnutrition. Vitamin A deficiency also affects over 5 million children under five, significantly contributing to visual impairment and increased susceptibility, delayed recovery and increased mortality from infections. Iodine deficiency disorder (IDD) is causing physical and mental growth retardation.

One of the biggest achievements of HSDP III is the development and implementation of the National Nutrition Strategy and subsequently the launching of National Nutrition Programme (NNP).

According to the Core Plan the following are two targets to be achieved in EFY 2002:

- Increase the coverage of children 6-59 months who received two doses of Vitamin A supplementation (VAS) from 95% to 97.7%; and
- Ensure the deworming coverage (twice) for children 2-5 years of age at 97.2%.

Vitamin A supplementation (VAS)

Out of the eligible population of 10.9 million children aged 6-59 months, the performance of the sector during EFY 2002 on Vitamin A supplementation shows that 10.7 million were given the 1st dose of vitamin A supplementation and 9.9 million received the 2nd dose. The national Vitamin A coverage in EFY 2002 has mixed results increasing from 95% average supplementation (two doses) to 98% in the 1st round and decreasing to 83% in the 2nd round.

Comparison of the performance of each region in EFY 2002 with their own target shows that three regions (Oromia, Benishangul Gumuz and SNNPR) performed above the regional target for the 2 doses of vitamin A; while Afar, Amhara, Gambella and Harari exceeded their own targets only for one dose of vitamin A. Tigray, Somali and Dire Dawa were below their regional target (Figure 21). However, five regions (Afar, Somali, Gambella, Harari and Dire Dawa) missed one round of VAS. Addis Ababa is not implementing VAS through Expanded Outreach Service (EOS), but through routine services, VAS was given to 27,644 children.

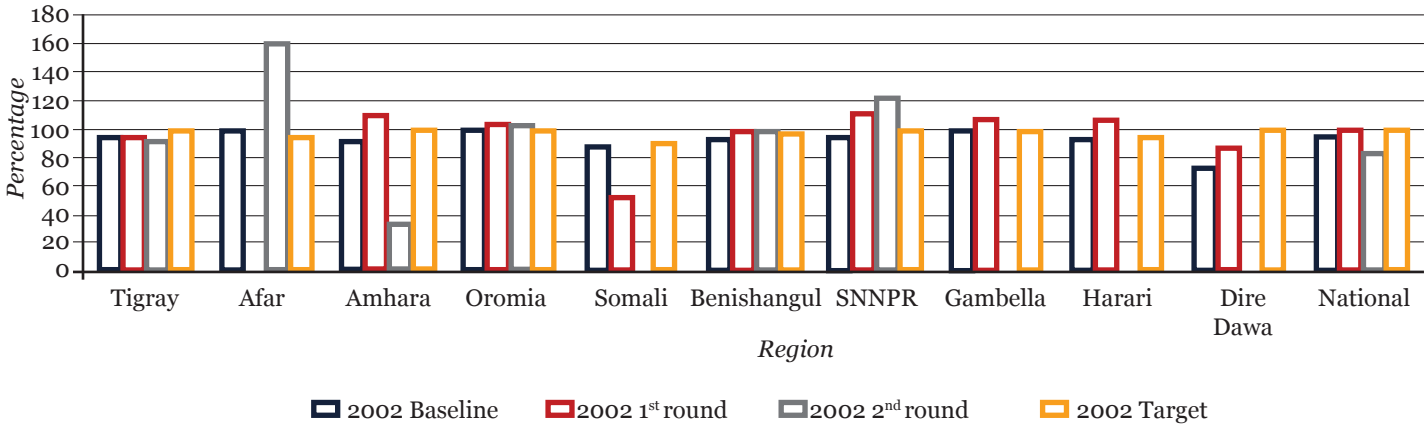

Figure 21: Comparison of Baseline, Two Rounds of Performance and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region (EFY 2002)

EOS activities are integrated into the HEP in 170 Woredas through the Child Health Days (CHDs) . In addition, training has been given to all urban HEWs.

Deworming

Out of the eligible population of 7.6 million 2-5 years old children, the deworming coverage declined from 98% on average (2 doses) in EFY 2001 to 93% in the 1st round and 83% in the 2nd round in EFY 2002, below the target of 97.2% set for the year (Figure 22).

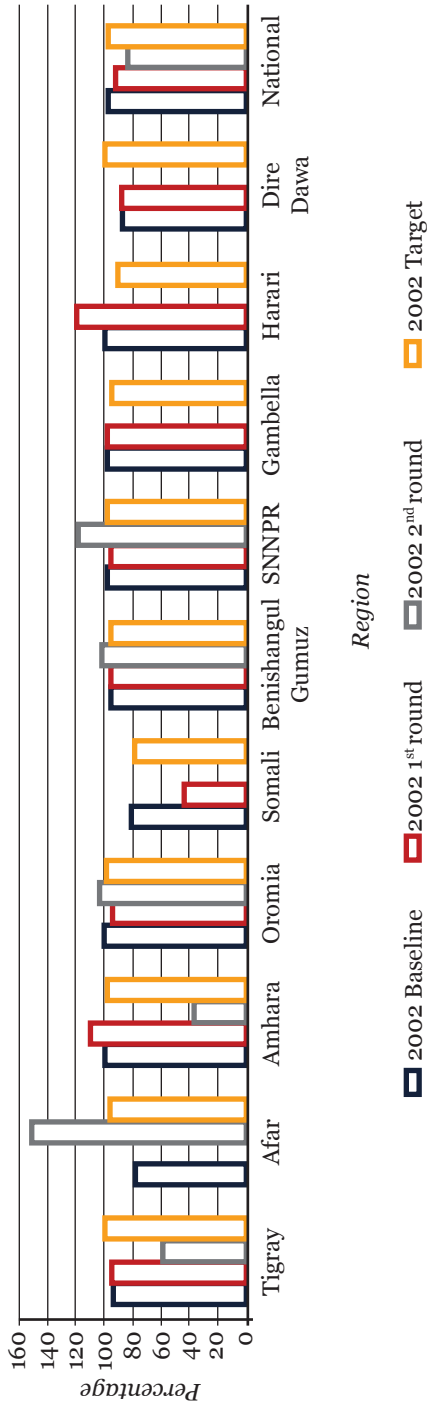

Figure 22: Comparison of Baseline, Two Rounds of Performance and Target of Coverage of 2-5yrs of Children Dewormed by Region (EFY 2002)

If we compare the achievement with the targets, only one region (Benishangul Gumuz) achieved its own regional target during the two rounds (even exceeding it in the second round). Six regions (Afar, Amhara, Oromia, SNNP, Gambella and Harari) exceeded the target at only one round. However, Afar, Somali, Gambella, Harari, and Dire Dawa Regions missed one round. As mentioned earlier for VAS, Addis Ababa did not implement deworming through EOS, but through routine services; as a result, 4,875 children were dewormed in EFY 2002.

Iodization of Salt

The planned target was to increase the proportion of households using iodized salt from 4.2% to 50%. To achieve this target, key activities performed in EFY 2002 include the following:-

To increase capacity in salt iodization at Afdera (Afar Region), one big iodization machine with about 30 tons per hour (tph) owned by Afar Salt Producers Share Company and other 10 small mobile iodization machines with 5 tph capacity have started operation in EFY 2002. A total of 8900 metric tons of salt has been iodized at Afdera between Miazia and Ginbot of EFY 2002 and is being marketed.

Iodine capsules amounting to 7.1 million have been procured for supplementation of 2.7 million children 6-23 months old and 1.9 million pregnant and lactating mothers for the bridging period until salt iodization will markedly progress. In five regions (Tigray, Amhara, Oromia, Benishangul Gumuz and SNNPR), the supplementation of iodine capsules have been carried out with a coverage of 92% and 85% for children 6-23 months old and pregnant and lactating mothers, respectively.

Challenges faced during the implementation of the salt iodization program include: (i) Lack of motivation and sense of ownership of the program on the part of salt producers and their association; (ii) Frequent breakdown of salt iodization machines not withstanding the harsh weather; (iii) Poor handling of spare parts and lack of maintenance of facilities; and (iv) Delay in approval and enforcement of salt legislation.

The target for EFY 2002 was to increase the number of pregnant mothers taking Iron Folate from 0% to 80%. To achieve this target, 50,000 packs of Iron/Folate is procured and distributed to the regions and 40 million Iron Folate tablets are being procured through the PFSA and 30,000 copies of fact sheets on Iron Folate supplementation are being printed.

Severe Acute Malnutrition (SAM)

In EFY 2002, the number of health posts providing out-patient therapeutic programme (OTP) for the severely malnourished children increased from 2,600 to 7,108 (50%) in 670 Woredas, while 17% of health centres and hospitals are providing in-patient care for the complicated cases.

Over 3,170 health workers and 8,978 HEWs were trained in the management of SAM in EFY 2002. Training video has been produced in three local languages demonstrating key skills of assessing and treating cases with severe acute malnutrition.

This resulted in the admission and treatment of 188,421 severely malnourished children in EFY 2002 compared with 130,408 in EFY 2001. The performance was very good with 84.5% recovery rate, while the defaulter rate was 5.3% and mortality rate was 0.7%.

Community-Based Nutrition

The objective of the program is to strengthen the knowledge of mothers /caregivers and communities on infant and child caring practices(IYCF) through one to one counseling and community dialogue. To support the process, 200 Master trainers, 4,500 HEWs and 46,000 VCHWs are being trained. In addition, 1.7 million printed Family Heath Cards, 5,000 copies of the Guideline on Community-Based Nutrition, Salter scales, Uniscales, and 300,000 community growth-monitoring charts have been prepared and distributed to 77 Woredas in Oromia, Amhara, SNNP and Tigray Regions .

In previous community based nutrition implementing 93 Woredas, 350,000 children under the age of two were weighed and mothers/caregivers were counseled on key nutrition messages to enhance child growth. From the growth monitoring data collected from these Woredas, the reduction of underweight is observed.

Other Key Nutrition-Related Activities

The following additional activities have been performed to strengthen the health sector based nutrition services: (i) Global Breast-feeding week has been observed nationally for the 2nd time early in EFY 2002, with the aim of "Promoting the Use of Breast-Feeding", (ii) A more focused strategy is under development for an accelerated stunting reduction strategy to achieve the MDG1 (Target 1c); and (iii) High impact key nutrition activities and corresponding indicators have been adequately incorporated into HSDP IV.

5.5 Prevention and Control Of Communicable Diseases

Disease control has been one of the priorities of HSDP III, with the objective to decrease the disease burden related to HIV/AIDS, tuberculosis, malaria and other major diseases. HSDP III is focusing on high-impact and cost-effective health interventions to reach this objective; however, although interventions needed to control disease and to avert much of the morbidity and mortality burden are known, they require a functioning health system to have an effect at the population scale. This is crucial to achieve MDG6 at the end of HSDP IV, with two targets to be achieved by 2015: (i) to have halted, and begun to reverse, the spread of HIV/AIDS, and (ii) to have halted, and begun to reverse, the incidence of malaria and other major diseases.

HIV AIDS Prevention and Control

HIV/AIDS is one of the top priorities of HSDP III. The main HSDP III targets were: (i) to achieve the provision of Voluntary Counselling and Testing (VCT) services in 100% hospitals and HCs and the provision of Prevention of Mother to Child Transmission (PMTCT) services in 100% of hospitals and 70% of HCs; (ii) to increase the number of People Living With HIV/AIDS (PLWHA) on Anti Retroviral Therapy (ART) from 13,000 to 263,000; (iii) to increase the proportion of children from HIV+ mothers getting PMTCT from 0.1% to 25%; and (iv) to reduce the adult incidence of HIV from 0.68% to 0.65% and maintain the prevalence of HIV at 3.5% .

Ethiopia has developed and implemented the Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support 2007–2010. Since then it has updated its planning framework with ambitious targets to achieve universal access and it has also launched a Millennium AIDS Campaign that has catalyzed more rapid scale up of key prevention and treatment programs. The achievements being made to date in HIV testing, PMTCT and ART programs are summarized in the following sections.

Current Status of the HIV/AIDS Epidemic in Ethiopia

According to the Single Point HIV Prevalence Estimate, the adult HIV prevalence was estimated at 2.3% in EFY 2002 (1.8% among males and 2.8% among females). Urban and rural HIV prevalence rates were estimated at 7.7% and 0.9% respectively, with large variations across regions. In fact, urban HIV prevalence ranged from 2.3% in Somali

Region to 10.9% in Afar Region, while rural HIV prevalence ranged from 0.4% in Somali Region to 1.4% in Amhara Region. The adult HIV incidence was estimated at 0.28% in the same year. The total number of HIV-positive people was estimated at 1,116,216, and, out of these, 336,160 were eligible for ART. The total number of HIV positive pregnant women and annual HIV positive births were 84,189 and 14,140 respectively. A total of 44,751 AIDS related deaths were estimated in the same year, with 855,720 AIDS orphans being estimated in the country.

Trend in the Number of Facilities Providing HCT, PMTCT and ART Services

There was a marked increase in the number of sites providing HCT, PMTCT and ART services during the HSDP III period: from 801 sites for HCT in EFY 1998 to 2,184 in EFY 2002, from 93 to 1,352 for PMTCT, and from 168 to 550 for ART (Figure 23). Of note is the fact that an even steeper increase was found in the last year for HCT from 1,596 sites in EFY 2001 to 2,184 in EFY 2002 (+36.8%), and for PMTCT from 843 to 1,352 (+60.4%), while there was a slight increase for ART sites from 511 to 550 (+7.6%).

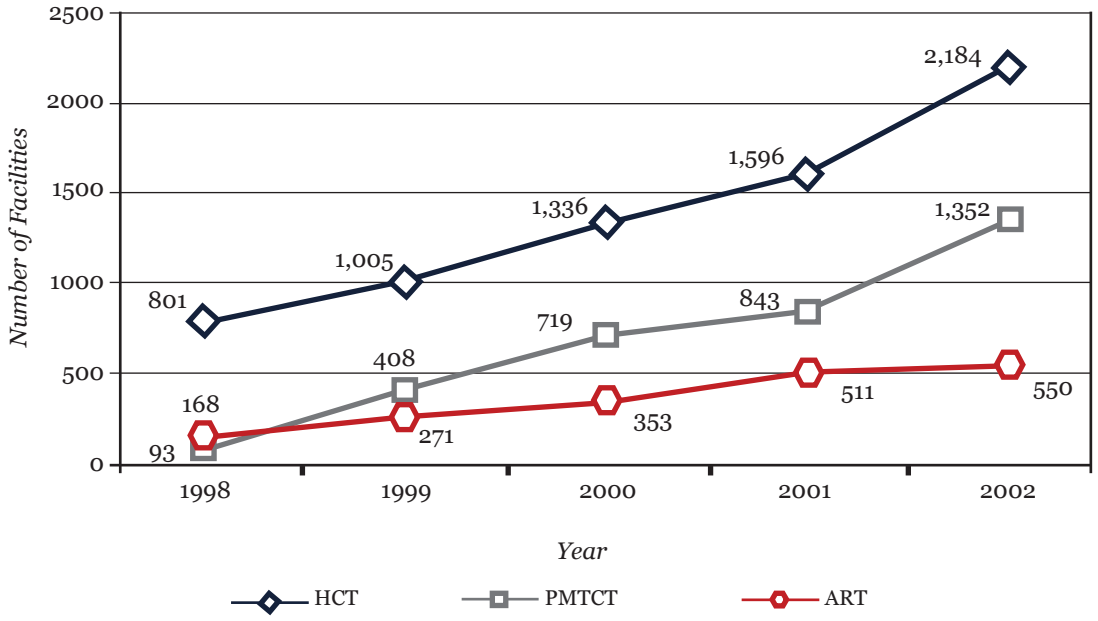

Figure 23: Trend in the Number of Facilities Providing HCT, PMTCT and ART services (EFY 1998-2002)

The number of clients using HCT services also increased substantially during the HSDP III period from 564,321 in EFY 1998 to 9,445,618 in EFY 2002. Despite the steep increase observed in the last year from 5,853,472 in EFY 2001 to 9,445,618 in EFY 2002 (+61.4%), the performance was short of the target (75.0%) set for the year (12,591,468) (Figure 24).

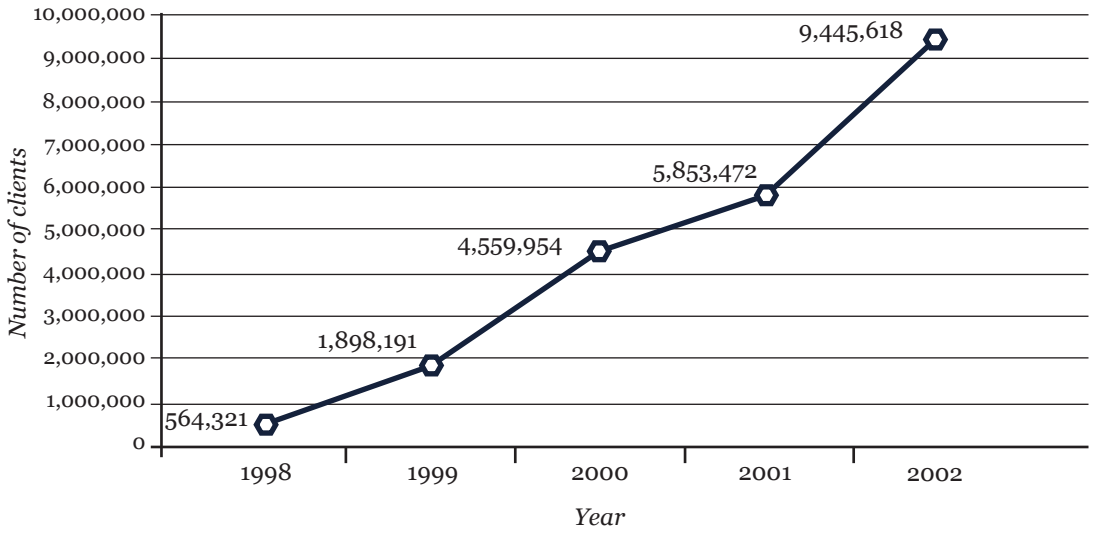

Figure 24: Trend in the Number of Clients Using HCT (EFY 1998-2002)

Wide variations were observed across regions in the number of clients using HCT. Four regions (Tigray, Gambella, Harari and Dire Dawa) surpassed their regional targets set for EFY 2002, with all other regions (except Afar) improving their performance with respect to EFY 2001. The highest increase was found in Amhara Region (+1,495,860). The performance in two regions (Afar and Addis Ababa) was lower than half of their targets, while, among the other regions which have not reached their targets, the performance ranged between 58% of the target in SNNPR and 91% in Benishangul-Gumuz (Figure 25).

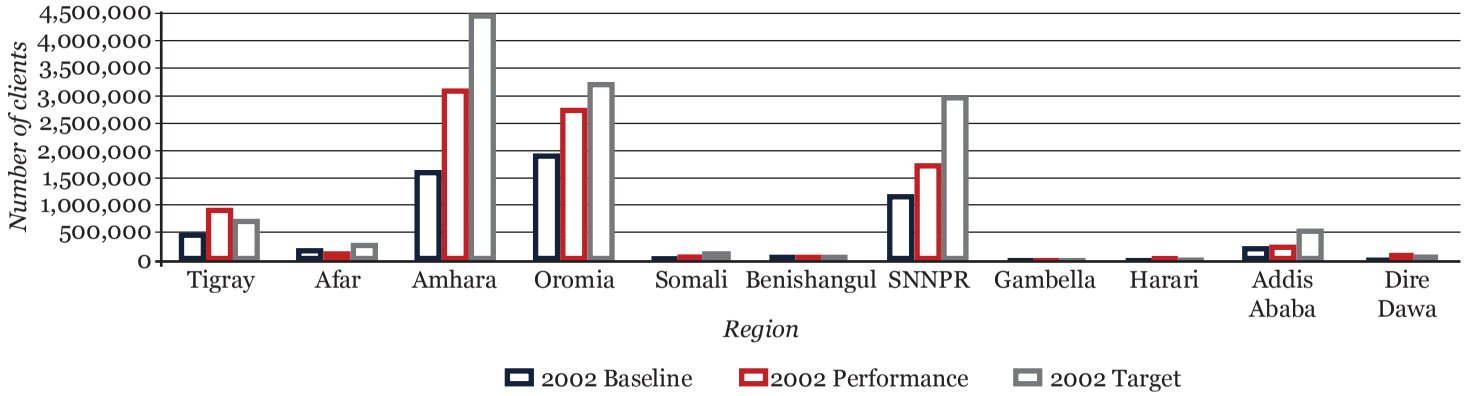

Figure 25: Comparison of Baseline, Performance and Target of the Number of Clients Using HCT by Region (EFY 2002)

Prevention of Mother to Child Transmission (PMTCT) of HIV

A total of 6,990 HIV-positive mothers received PMTCT prophylaxis in EFY 2002, a performance which is slightly above the achievement of EFY 2001 (6,466), but far below the target set for EFY 2002 (37,408). Therefore, only 18.7% of the target was achieved in EFY 2002 (Figure 26). No region achieved the target set in EFY 2002, with five regions (Somali, Benishangul-Gumuz, Harari, Addis Ababa, and Dire Dawa) even worsening their performance compared to EFY 2001. Six regions (Tigray, Afar, Amhara, Oromia, SNNPR, and Gambella) improved their performance compared to EFY 2001. The highest number of HIV-positive mothers provided with PMTCT prophylaxis was in Amhara Region (1,959), followed by Oromia (1,719) and Addis Ababa (1,206), showing a similar pattern to EFY 2001.

According to current estimates, there are 84,189 HIV-positive pregnant mothers and 14,140 HIV-infected births within a year. In EFY 2002, 6,990 mothers received antiretroviral treatment, amounting to only 8.3% of those eligible (84,189). Out of 14,140 HIV-infected births, 5,051 newborns (35.7%) received PMTCT prophylaxis. Despite the relatively high ANC coverage (71.4%), PMTCT coverage at national level is very low (8.3%). In view of the integration of PMTCT and ANC services, this discrepancy should be investigated and related issues should be addressed as a matter of urgency.

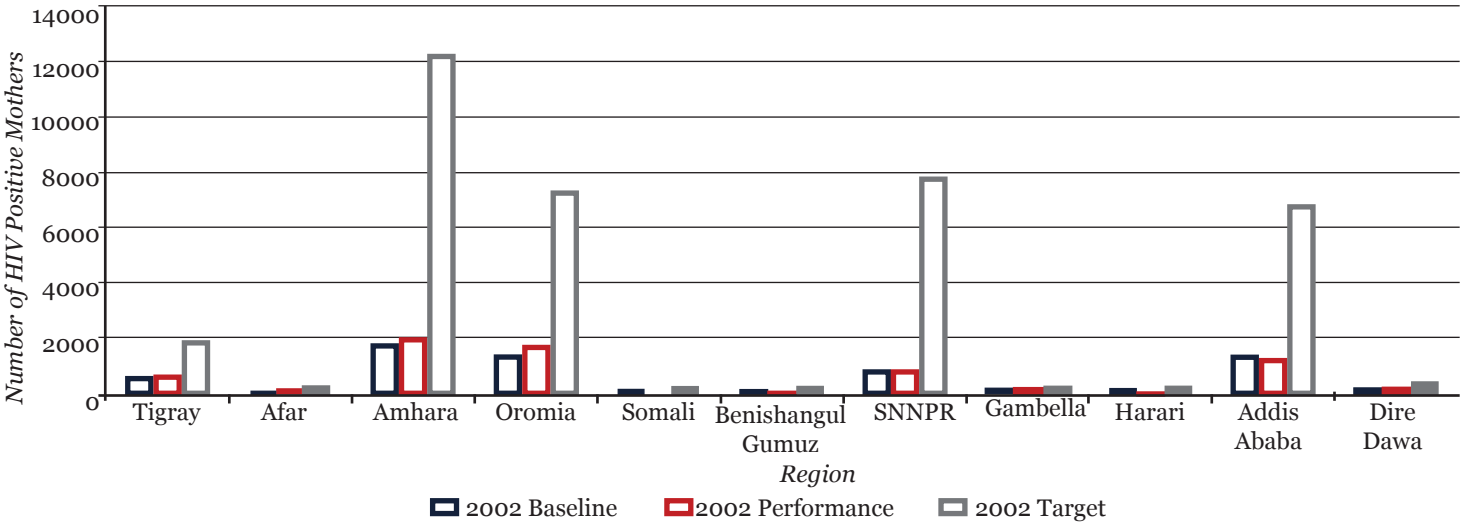

Figure 26: Comparison of Baseline, Performance and Target of the Number of HIV-Positive Mothers Provided with PMTCT Prophylaxis by Region (EFY 2002)

Antiretroviral Treatment

A steep increase was observed in the number of PLWHA ever enrolled in the ART program (from 39,489 in EFY 1998 to 473,772 in EFY 2002), ever started ART (from 24,236 to 268,934 in the same period) and currently on ART (from 18,594 to 207,733 in the same period) (Figure 27). The upward trend was consistent over time and it was confirmed in the last year: from 376,772 in EFY 2001 to 473,772 in EFY 2002 (+25.7%) for PLWHA ever enrolled in the ART program, from 208,784 to 268,934 (+28.8%) for those ever-started ART and from 152,472 to 207,733 (+ 36.2%) for those currently on ART.

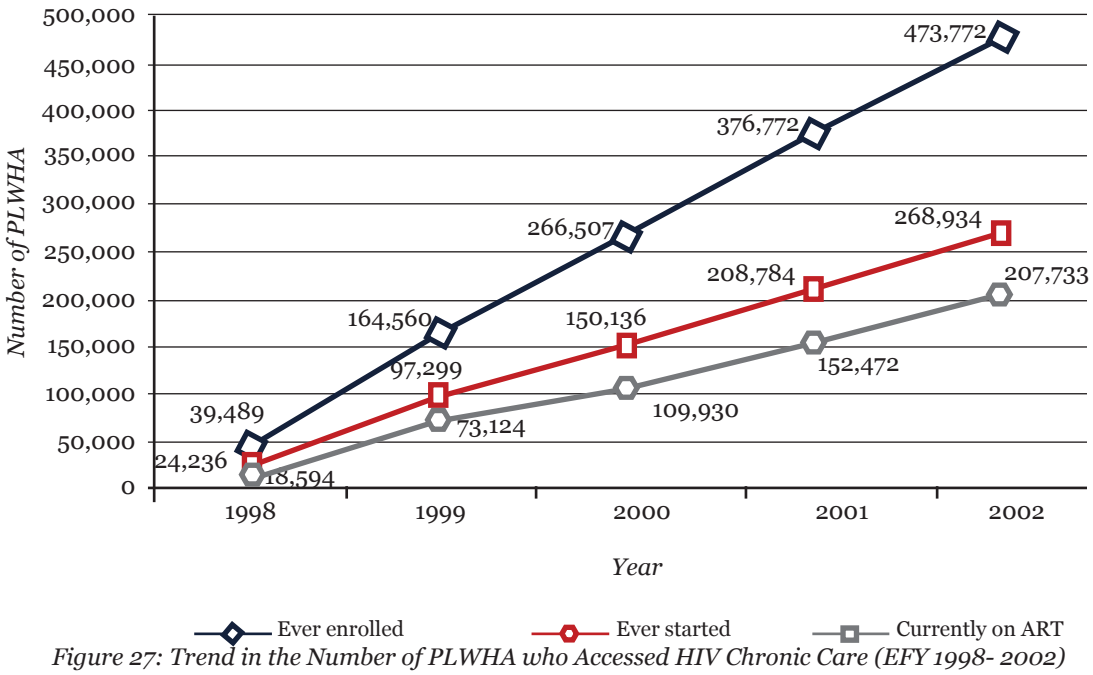

Figure 27: Trend in the Number of PLWHA who Accessed HIV Chronic Care (EFY 1998- 2002)

Wide variations in the number of PLWHA who accessed HIV chronic care were observed across regions. The highest cumulative number of PLWHA who ever started ART was found in Amhara (72,316) and in Addis Ababa (66,144), with the highest increase being reported from Addis Ababa (+18,391), Amhara (+16,669), and Oromia (+13,098) (Figure 28).

The highest number of PLWHA currently on ART was found to be in Amhara (64,648) and in Addis Ababa (47,887). ART is given free of charge in all regions. ART coverage (percentage of PLWHA currently on ART out of the total eligible) was 61.8% in EFY 2002 with an increase compared to the performance in EFY 2001 (52.6%).

It is also above the average ART coverage in Sub-Saharan Africa (44% in 2008 GC, the latest year for which data are available and published in the MDG Report 2010), where a twenty-fold increase in treatment coverage was observed in just five years (from 2% in 2003 GC). Therefore, the increase in ART coverage in Ethiopia has been steeper than in Sub Saharan Africa over the past five years.

As in previous years, the performance in the provision of PMTCT services in EFY 2001 has shown very slow progress and the coverage has been extremely low.

Challenges

- Inadequate use of PMTCT service even where it is available;
- Poor integration of PMTCT with ANC services;
- Low percentage of deliveries attended by skilled health personnel;
- Limited number of skilled and motivated human resources;
- Gaps in mobilization and use of financial resources;
- Shortage of test kits for HIV;
- Delay in provision of medical supplies;
- Weak M&E system;
- Poor community awareness about the importance of using maternal and PMTCT services;
- Transportation problems; and
- Difficulty in delivering services in pastoralist communities.

Other challenges faced by the HIV/AIDS prevention and control program include: (i) Poor reporting; (ii) Inadequate settlement (liquidation) of advances made to regions and different sectors; and (iii) Weak documentation of data at all levels.

Way Forward

- Increase the number of health facilities (both public and private) providing PMTCT services;
- Enhance capacity building;
- Strengthen the supply chain management system;
- Strengthen the integrated multi-sectoral response at all levels;
- Enhance the integration of HCT and PMTCT with ANC services as per the BPR design;
- Enhance sustained follow-up in HIV chronic care;
- Strengthen M&E system; and
- Improve accountability and implement the Integrated Financial Management System.

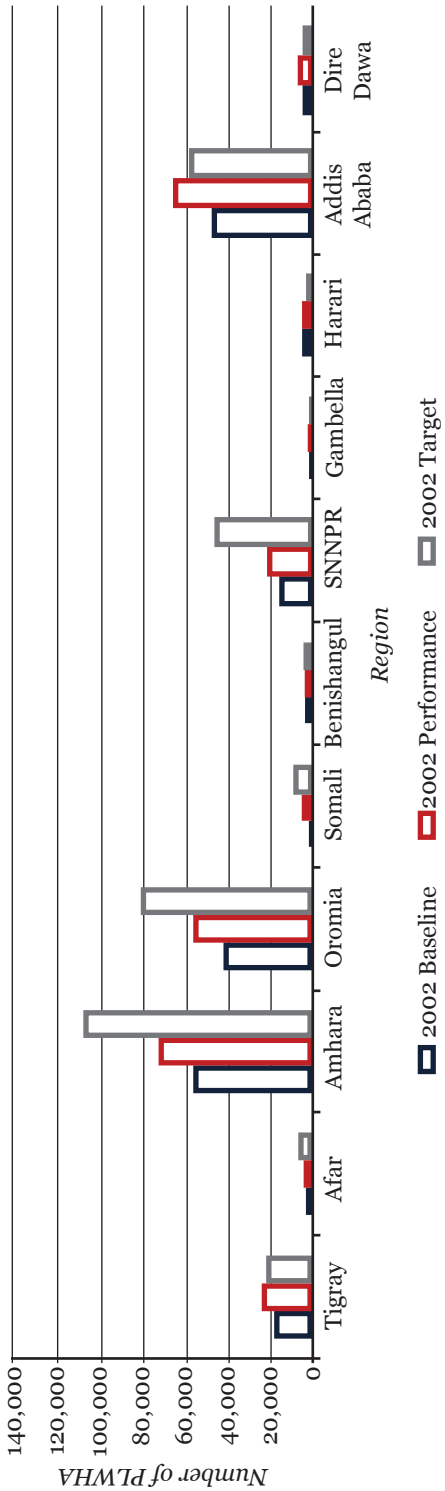

Figure 28: Comparison of Baseline, Performance and Target of the Number of PLWHA who Ever Started ART by Region (EFY 2002)

Malaria Prevention and Control

The Malaria Prevention and Control Programme in Ethiopia is guided by the National Five-year Strategic Plan for Malaria Prevention and Control (2006-2010). A three pronged approach has been implemented consisting of (i) early diagnosis and effective treatment, (ii) selective vector control and (iii) epidemic prevention and control.

According to the core plan, 18.5 million ITNS were planned to be distributed to maintain universal coverage ITN; however, 13,060,282 million were procured and distributed to regions. The remaining LLINs are under procurement through PFSA and financial support has been secured from development partners to fill the gap. The cumulative number of ITNs distributed to regions increased from 22,177,419 in EFY 2001 to 35,237,701 in EFY 2002 (Figure 29).

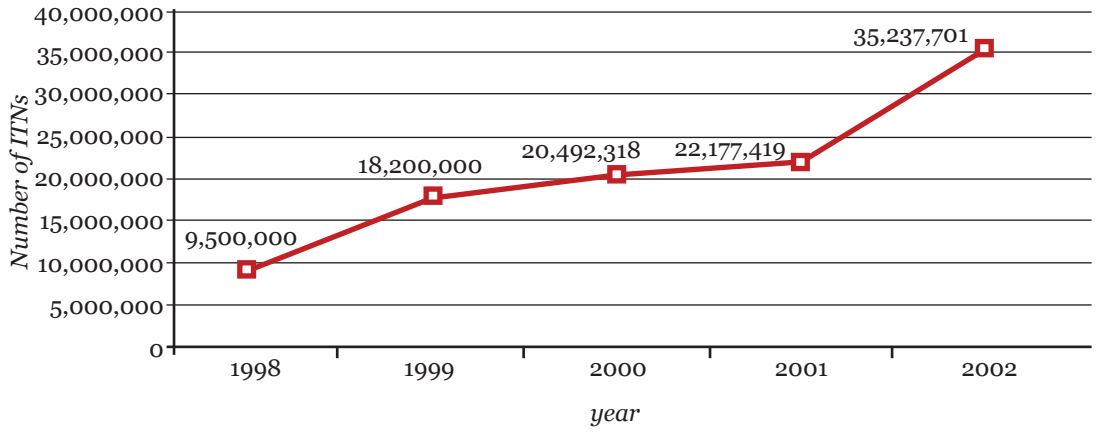

Figure 29: Trend in the Cumulative Number of Insecticide-Treated Nets (ITNs) Distributed (EFY 1998-2002)

To raise the effective utilization of 35.2 million ITNs that have been distributed up to the end of EFY 2002, educational message have been prepared and transmitted through television and radio. Out of the target to train 160 persons engaged in malaria control activities, training on malaria has been provided to 172 professionals.

In EFY 2002, a decision was made to shift from DDT to Delthametrine, because of mosquito resistance to DDT. Delthametrine 1,000MT was procured that can spray 10,000,000 unit structure. From total sprayable housing units at risk of malaria 5,174,406 (86%) households have been sprayed with an achievement rate of 86%. Furthermore, agreement has been reached to produce Delthametrine at Adami Tulu Insecticide Production Factory to produce 600 tons of 2.5% WP Delthametrine and additional 400 tons Delthametrine with the same formulation with 50% of the production cast to be covered by RHBs, and additional 60 tons of 25% WDG Delthametrine had been procured and distributed to regions. Besides, out of the planned 9,297 insecticide spray equipment, 7,100 (76.4%) have been procured and is being distributed to regions.

As mentioned earlier, one of the approaches to malaria control is early diagnosis and effective treatment. HEWs have a major role in the implementation of this approach. Accordingly, 12 million doses Coartem have been procured to Regions. A total of 11 million RDTs were planned for procurement and distribution to HPs, out of which 3.2 million were distributed and 8 million are under procurement.

In addition, during a campaign in SNNPR, an additional one million doses of Coartem, 666,000 doses of chloroquine and 430,000 Rapid Diagnostic Tests (RDT) have been provided to the region. During this campaign, 1.8 million LLINs had been distributed in 52 Woredas.

Trend of Malaria Cases and Deaths

This year, seven regions reported 854,080 malaria cases, with most cases being reported from four regions (Tigray, Amhara, SNNPR and Oromia). Of note is the fact that reporting was incomplete, with only some regions keeping reporting consistently throughout the year.

At national level a steep increase in malaria cases was observed from Miazia up to Sene, with 49% of them being reported from Amhara Region and 23% from SNNPR following the minor rainy season (Figure 30).

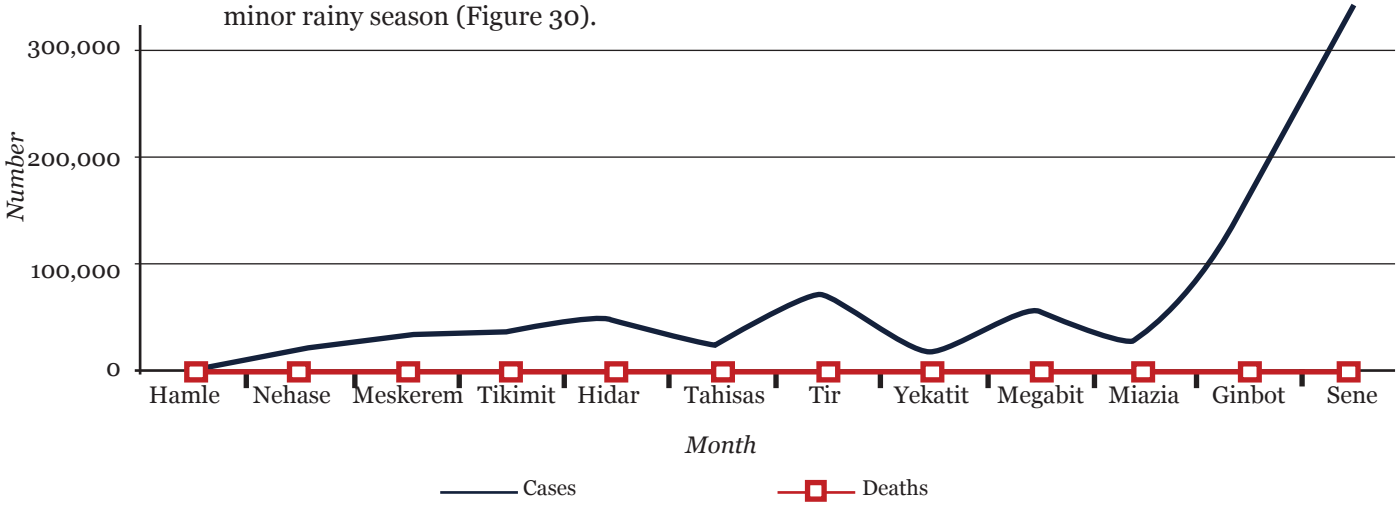

Figure 30: Trend of Malaria Cases and Deaths by Month (EFY 2002)

Chamllenges

- Resistance of mosquitoes to insecticide;
- Shortage of spray equipment (spray pump); and
- Shortage of RDTs.

Way forward

- With the support of DPs, bulk procurement of RDTs and spray pumps is underway.
- There is a plan to study resistance of mosquito to different insecticides following the major rainy season. This will be used to implement evidence based IRS strategy.

Tuberculosis and Leprosy Prevention and Control

Ethiopia ranks 7th among the top twenty-two TB High Burden Countries in the world, and one of the top three in Africa, with regard to the estimated number of incident cases of tuberculosis. The incidence rate of all forms of TB is estimated at 378 per 100,000 population in EFY 2002, while the incidence rate of smear-positive TB is 163 per 100,000. The prevalence of all forms of TB is estimated at 579 per 100,000, with the mortality rate due to TB being at 92 per 100,000.

The general objective of the Tuberculosis and Leprosy Prevention and Control (TLPC) is to reduce the incidence and prevalence of TB and Leprosy as well as the occurrence of disability and psychological suffering related to both diseases and the mortality resulting from TB to such an extent that both diseases are no longer public health problems.

The main HSDP III targets were: (i) to reduce the mortality attributed to TB from 7% to 4% of all treated cases; (ii) to increase the health facility coverage of the Directly Observed Treatment – Short course (DOTS)/Multi-Drug Therapy (MDT) from 53.6% to 72%; (iii) to increase the case detection rate of new smear positive pulmonary TB patients from 34% to 50%; (iv) to increase the number of TB patients notified and treated from 118,000 to 178,000; (v) to increase the treatment success rate from 76% to 85%; (vi) to reduce the prevalence of leprosy to less than 1 per 10,000; (vii) to reduce the prevalence of leprosy grade II disability from 12% to less than 10%.

TB prevention and control

The target set for TB control in the Woreda Plan for EFY 2002 was to increase TB case detection rate from 34% to 66%, TB treatment success rate from 84% to 90%, and TB cure rate from 67% to 85% in the same period.

A Millennium TB Campaign was launched and simple clinical definition of a suspect case to be referred was set up and disseminated through massive sensitization efforts to get all HEWs onboard for identification and referral of suspect cases. The normative standardized tools for the TB control programme were updated and in place. The free dispensation of TB drugs was ensured countrywide according to the national standardized regimens. In-service trainings for clinicians, laboratory technicians and public health managers were carried out to keep up with staff attrition. In accordance with the international recommendations, new components were added into the DOTS activities, such as involvement of the private-for-profit sector, TB-HIV collaborative actions, and tackling the threat of the MDR by starting a pilot MDR care programme at St. Peter Hospital. The TB prevalence survey has been planned and its preparation is already under way.

Trend in TB case detection rate, TB treatment success rate and TB cure rate

TB indicators were quite stable in EFY 2002 with respect to EFY 2001, with TB case detection rate being at 35.8%, TB treatment success rate at 84.0% and a TB cure rate at 65.2%. Overall, slight upward fluctuations were observed during HSDP III, with an increase of the TB case detection rate from 30% in EFY 1998 to 35.8% in EFY 2002 (HSDP III target=50%), TB treatment success rate from 76% to 84.0% (HSDP III target=85%), and TB cure rate from 62% to 65.2% in the same period (Figure 31). Therefore, TB case detection rate is still far below HSDP III target, while the HSDP III target for TB treatment success rate has been almost achieved.

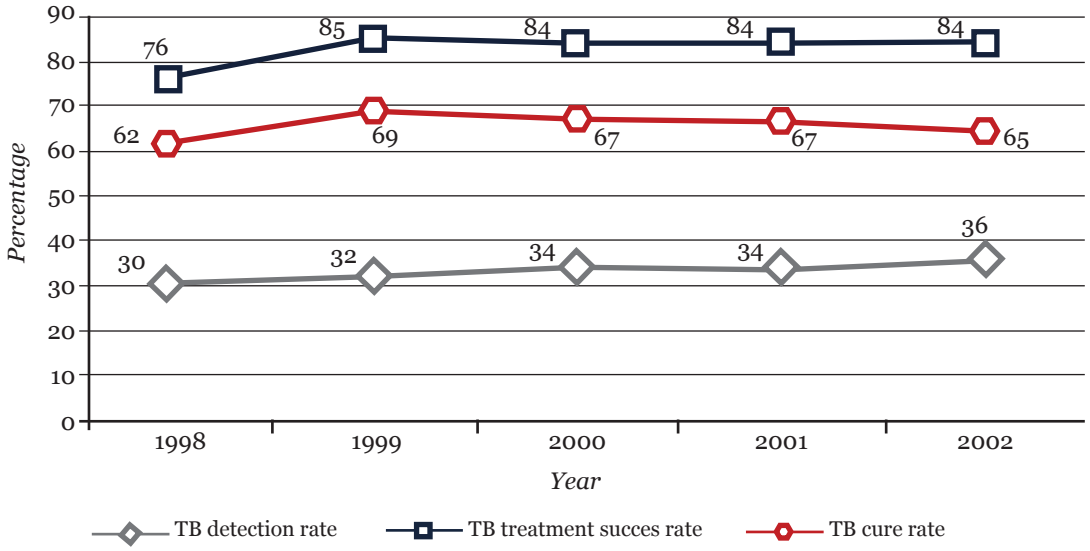

Figure 31: Trend in TB Case Detection Rate, TB Treatment Success Rate and TB Cure Rate (EFY 1998-2002)

TB Case Detection Rate

In EFY 2002, 46,419 new sputum smear positive TB cases were detected. The national target for TB case detection rate was set at 66% in the EFY 2002 Woreda Plan. However, since the current rate stands at 35.8%, the performance is still far below the planned target.
Large variations were observed across regions, ranging between 17.6% in Somali Region and over 100% in Harari (meaning that, in Harari, the number of TB cases detected was higher than the estimated one). An increase was observed in 8 regions (Tigray, Amhara, Oromia, Benishangul-Gumuz, SNNPR, Gambella, Harari, and Dire Dawa), with Harari even surpassing its regional target. A decrease was observed in the other 3 regions, with Afar Region showing the steepest decline (Figure 32).

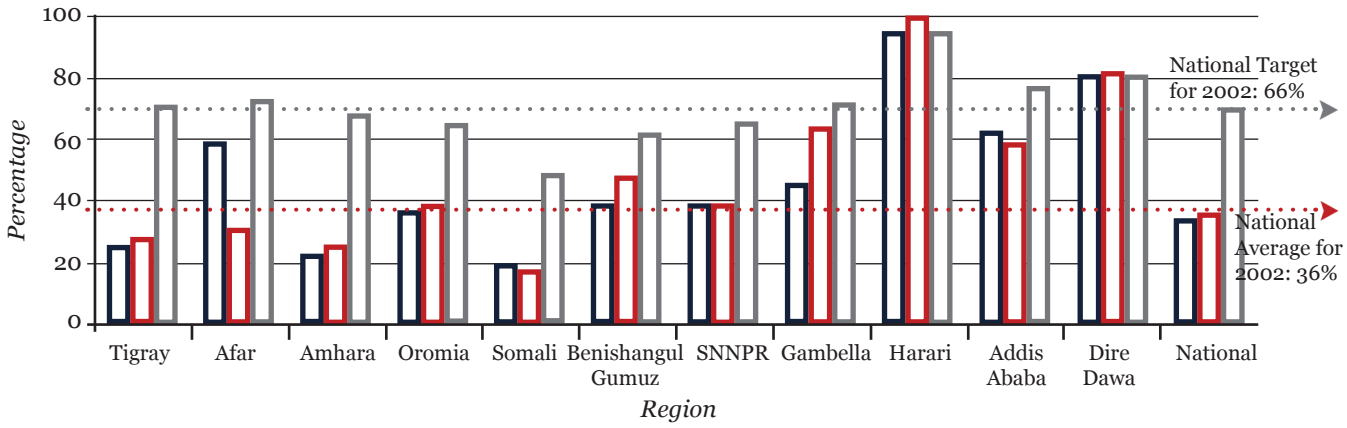

Figure 32: Comparison of Baseline, Performance and Target of the TB Case Detection Rate By Region (EFY 2002)

The low TB case detection rate is related to inadequate diagnostic capacity and human resources for sputum smear microscopic examination, and insufficient health education to raise the awareness of the community.

Furthermore, there is the possibility that TB incidence applied to estimate the denominator of TB case detection rate may be overestimated in the Ethiopian context, leading to the underestimation of the indicator; this issue will be addressed by the TB prevalence survey already under way.

TB Treatment Success Rate

In EFY 2002, the TB treatment success rate was stable at 84.0% which is near the international standard (85%). Large variations were observed across regions, ranging from 75.7% in Somali to 93.9% in Gambella. Tigray and Gambella performed above their regional targets, with an increase being also observed in five other regions (Afar, Amhara, Oromia, Harari, and Addis Ababa). The highest increase was observed in Harari (+16%). Conversely, a decrease in performance was observed in four regions, with Somali Region showing the steepest decline (-9%) (Figure 33)

The main reason for this performance is attributed to the strong focus on improving treatment at TB clinics through training and supervision, with subsequent strengthening of clinical services.

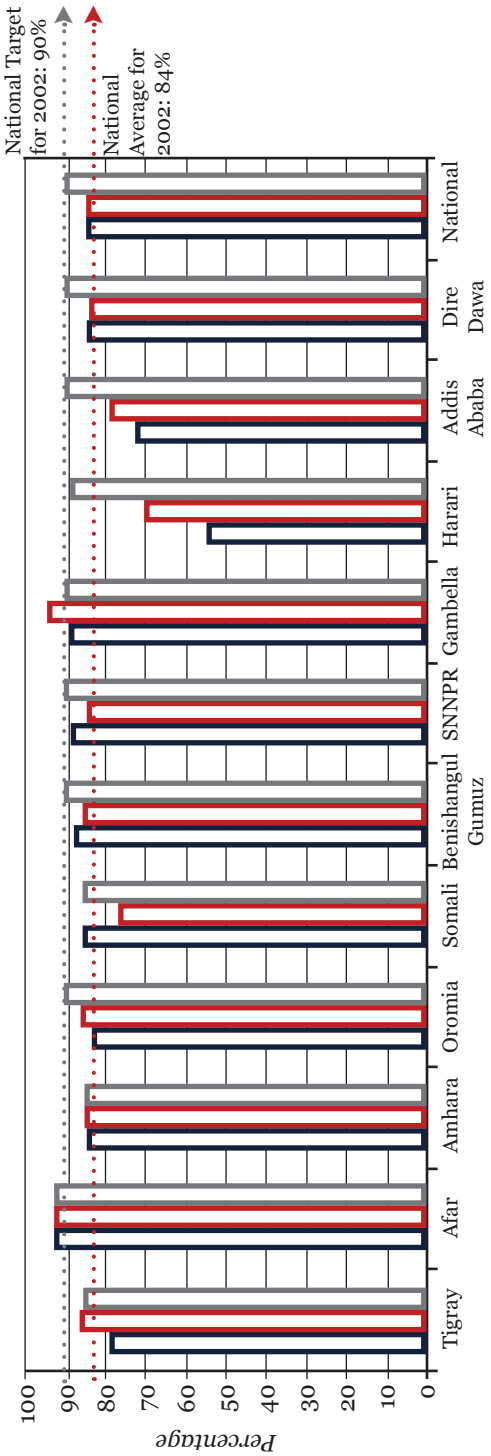

Figure 33: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2002)

TB Cure Rate

In EFY 2002, TB cure rate slightly decreased from 67.0% to 65.2%, short of the target of 85% set for the year. The best performance was achieved in Tigray Region (78.5%), while the lowest cure rate was found in Afar (29.8%). An increase was observed in EFY 2002 in only four regions (Tigray, Oromia, Harari, and Addis Ababa), with a decrease being observed in the other seven regions (Figure 34). Of note is the fact that no region achieved its regional target. The lack of improvement indicates the presence of problems related to the lack of capacity at the grass roots level.

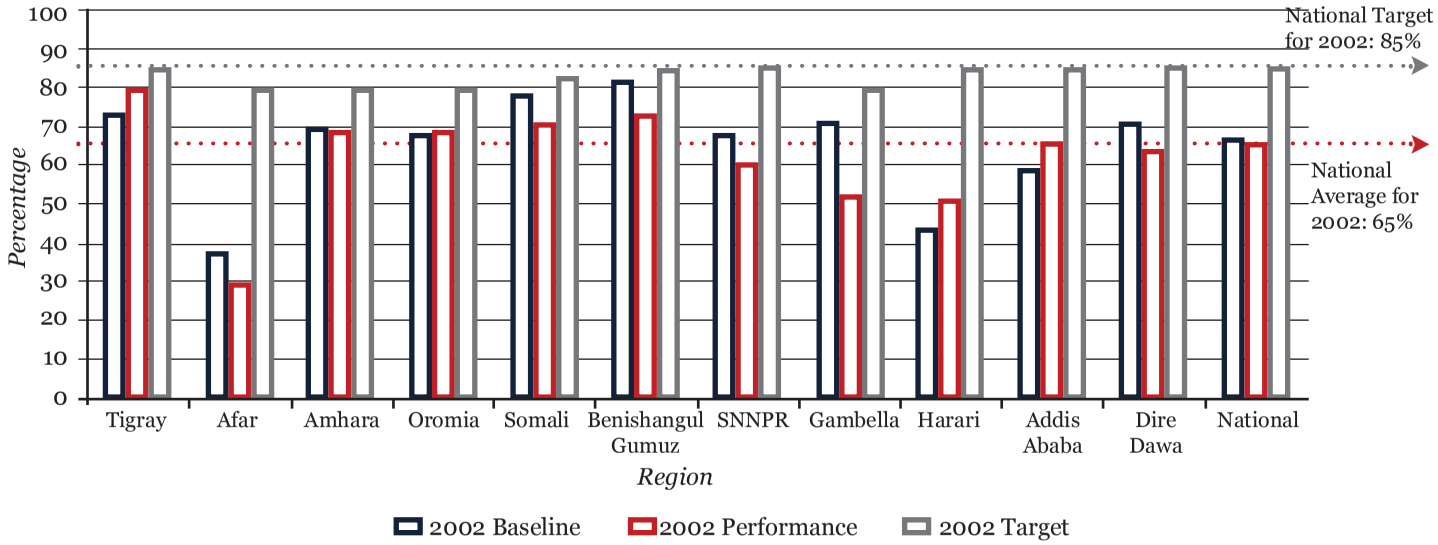

Figure 34: Comparison of Baseline, Performance and Target of the TB Cure Rate by Region (EFY 2002)

The challenges are as follows:

- Low community awareness about TB as reflected in low demand for service;
- Inadequate involvement of HEWs to refer suspect TB cases;
- Weak coordinating mechanisms for Stop TB partnership;
- Inadequate implementation of TB/HIV collaborative activities at HF level;
- Weak diagnostic laboratory services;
- Weak implementation capacity at all levels;
- High staff turnover at all levels; and
- Incomplete and delayed reporting from some HFs/Woreda Health Offices.

Additional challenges reported from pastoralist areas include: (i) Lack of strategies addressing problems specific to pastoralist communities; (ii) Transportation problems in distribution of TB drugs and reagents to HFs; and (iii) Poor forecasting and inadequate provision of TB/HIV commodities to HFs.

The recommendations are as follows:

- Enhance use of HEP for prevention and control of TB;
- Enhance integration and coordination of TB/HIV collaborative activities;
- Enhance laboratory capacity at all levels as per BPR;
- Strengthen programme planning, M&E and implementation capacity;
- Implement strategy for staff retention,
- Address issues specific to pastoralist areas, including problems of transportation and supply of commodities;
- Undertake extensive review of problems accounting for the low TB detection rate and for the inadequate TB cure rate and take appropriate measures based on the results of the review.

Leprosy Prevention and Control

Like TB, leprosy control is based on enhancing the detection rate and completion of regularly provided treatment. The prevalence rate of leprosy was 0.7 per 10,000 in EFY 2002, therefore meeting the HSDP III target (<1 per 10,000). The highest prevalence (4.1 per 10,000) was found in Gambella Region, while the lowest one (0.1 per 10,000) was found in Somali Region (Figure 35).

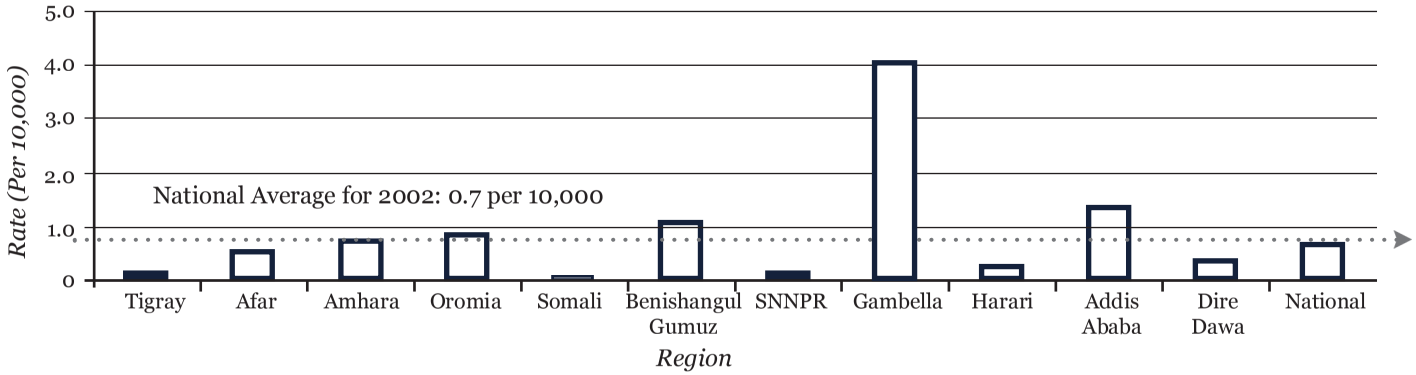

Figure 35: Distribution of the Leprosy Prevalence Rate (per 10,000) by Region (EFY 2002)

The number of new leprosy cases detected was 4,430 in EFY 2002. The proportion of grade 2 disabilities among new leprosy cases was 9% in EFY 2002, therefore meeting the HSDP III target (<10%).

The treatment completion rate of multibacillary leprosy was 85% in EFY 2002, above the target set in the Woreda Plan for the year (81.6%), ranging from 100% in Dire Dawa and 20% in Afar (Figure 36). Eight regions performed above their regional targets (Tigray, Somali, Benishangul-Gumuz, SNNPR, Gambella, Harari, Addis Ababa, and Dire Dawa). There were upward fluctuations from 82% in EFY 1997 to 85% in EFY 2002 during HSDP III. In general, there was an improvement in performance for leprosy control, but incomplete and inconsistent reporting was still a major challenge.

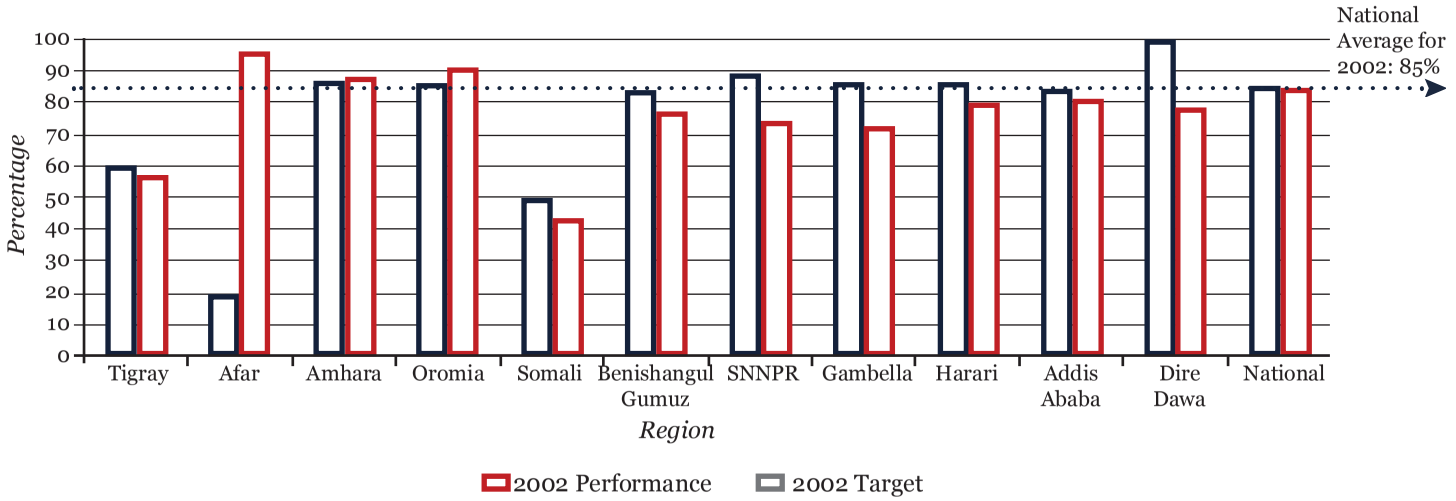

Figure 36: Comparison of Performance and Target of the Leprosy Treatment Completion Rate by Region (EFY 2002)

Trachoma Prevention and Control

Blindness is one of the major public health problems in Ethiopia with a national prevalence of 1.6%. Cataract and trachoma account for more than 60% of all blindness cases. On the other hand, about 90% of blindness cases in Ethiopia are preventable and/or treatable. The broad strategic approaches of the National Five-year Strategic Plan for Eye Care in Ethiopia (2006 – 2010), are disease control, human resource development and strengthening of infrastructure/equipment. This plan has been implemented as part of HSDP III for the last five years.

The major activities carried out in EFY 2002 are described below.

The number of Woredas implementing the WHO recommended SAFE (Surgery, Antibiotics, Facial cleanliness, and Environmental Improvement) strategy for trachoma control, increased from 124 to 180 (out of 281 targeted Woredas) and Zithromax® tablets adequate for 15 million people have been imported. Out of this amount, 1.2 million Zithromax® tablets have been distributed for rural areas.

Proposal to mobilize resources for procurement and distribution of 500 Trachomatous Trichiasis (TT) Kits and basic eye care equipment has been prepared for 10 selected hospitals that intend to carry out cataract surgery.

The annual meeting of the National Committee for the Prevention of Blindness (NCPB) has been convened, with the aim of expanding eye care services by strengthening the integrated work with Development Partners.

To strengthen eye care services in health facilities, basic eye care equipment and supplies provided by a development partner have been distributed to regions. Education on eye care and on increased vulnerability of women to blindness has been provided during World Sight Day. In addition, 2,000 leaflets and 500 posters have been prepared and distributed to regions.

The main challenge encountered during implementation is that the committed budget (USD 736,664) is not yet available for procurement of eye care equipment.

To address this challenge FMOH is making proper follow-up on implementation of the proposal prepared for the purpose of mobilizing financial resources from Development Partners.

Public Health Emergency Management

Public Health Emergency Management (PHEM) is one of the sub programs required to improve the effectiveness of the health sector response and comply with Ethiopia's obligation under the new International Health Regulation. It focuses on preparedness, alert, rapid detection and prompt response; capacity enhancement, information and communications systems, structures and jobs needed to handle health hazards of national importance.

The plan for EFY 2002 included performance of the following key activities: (i) Drawing best practice from a study of the current work process; (ii) Design the Public Health Emergency Management System; (iii) Prepare a public health network alert software; and (iv) Make early detection and map community health hazards.

The achievements in EFY 2002 include the following:- Distribution map of certain epidemic prone diseases (AWD, Malaria, Measles) has been prepared on the basis of the six months data collected earlier by various bodies; and preparedness activities undertaken using these data. Contingency plans have been prepared and made available to partner organizations on the basis of surveillance of seasonal health emergencies undertaken in collaboration with the Ministry of Agriculture and Rural Development.

Concerning early warning and risk mapping, PHEM participated in the national multisectoral assessment of the potential risk factors, identified the potential health related emergencies (Meningitis, Malaria, Measles, Severe Acute Malnutrition, AWD and Floods) and shared the findings to partners. The overall estimated funding requirement was 31,567,606 USD. Gap analysis and identification of drugs and medical equipment needed for epidemic response have been performed. Drugs worth ETB 70,263,536 have been procured with donor support and have been distributed to regions. The first draft of the PHEM guideline has been completed. Data collection formats and case definitions of diseases under surveillance have been prepared and sent to regions.

At the national level, 20 diseases have been identified for daily and weekly surveillance work and surveillance and monitoring of these diseases and other health hazards have been conducted from Woreda to regional levels. Compilation, analysis and interpretation of the collected data has been made and the results reported to concerned stakeholders and used for prevention and control purposes. In addition, feedback on the data analysis has been provided to regions.

PHEM/EHNRI identified gap in reporting from regions and conducted training for 903 PHEM experts at Regional, Zonal and Woreda levels on sensitization of PHEM activities, emergency management, surveillance and reporting. The training covered all Woredas and Zones in five regions (Tigray, Amhara, Oromia, SNNPR, and Gambella). Extensive orientation on PHEM and surveillance was given to 813 Federal and Regional partners.

Support on surveillance and outbreak management was provided by deploying federal teams to SNNPR, Afar, Oromia, and Tigray regions. PHEM supported regions with finance, drugs and medical supplies and also facilitated the support given through the Multi Sectoral Technical Working Group.

In order to build capacity on the early warning on epidemic diseases; list of inputs required for PHEM coordination office has been prepared with support from professionals seconded by a development partner. In collaboration with the Ethiopian Telecommunication Corporation, the unit has also reached agreement to use IT to network with different sections and the FMOH head office. Furthermore, manuals and standard operational procedures (SOPs) software are being prepared. Though the plan was to fully verify epidemic alert within 24 hours, epidemic alerts related to various diseases have been registered and verification work has been done within 48 hours.

In accordance with the plan to take proper and prompt action in response to PHE alerts, efforts have been made to control epidemics of AWD and meningitis. In addition, current

data on public health emergencies have been disseminated to the public through radio, television and other print media.

Preparations are being made to establish an Emergency Operation Center at EHNRI. The first draft of a PHEM Guideline has been prepared including Guidelines on Acute Watery Diarrhea, H1N1 Influenza infection prevention and H1N1 case management. Standard case definitions and community case definitions have been prepared and discussed with 45 professionals drawn from RHBs and partner organizations.

Furthermore, health workers have provided technical assistance and made follow-up through field visits to Amhara, Afar, Oromia, Addis Ababa and SNNPR, where AWD and meningitis epidemics have been prevalent.

Epidemic Prevention and Control

Acute Watery Diarrhea

During EFY 2002, PHEM mainly supported the management of AWD outbreaks. A total of 19,331 cases and 167 deaths (0.9% CFR) were reported in EFY 2002. The monthly pattern showed a peak in Nehase mainly due to high caseload in Addis Ababa (Figure 37).

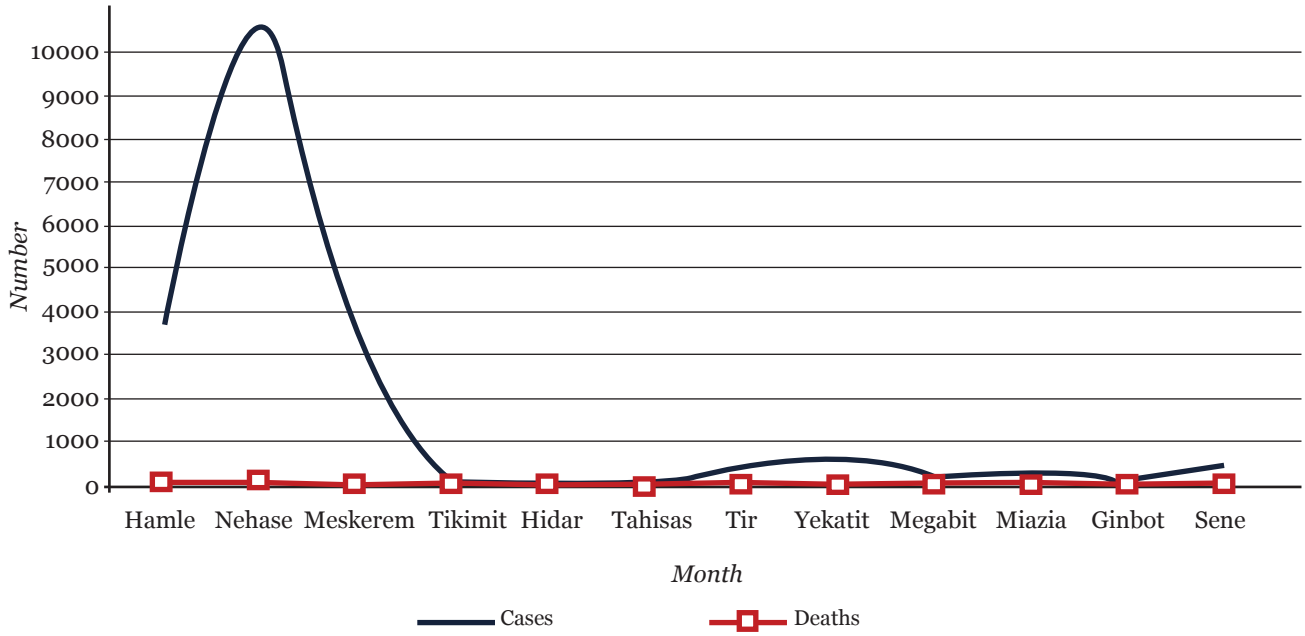

Figure 37: Trend of Acute Watery Diarrhea Cases and Deaths by Month (EFY 2002)

Seven regions were affected, with Addis Ababa reporting and managing about half of the national caseload, while Harari was the least affected region. The national average Case Fatality Rate (CFR) of 0.9% was relatively low, indicating an adequate AWD case management according to WHO international standard (CFR < 1%), but there were wide regional variations ranging from 0% in Harari to 2.4% in Afar. Benishangul Gumuz, Dire Dawa, Tigray and Gambella regions were not affected in EFY 2002.

The strategies implemented during the course of the epidemic include: (i) Raising the awareness of the communities; (ii) Educating the public on personal hygiene and environmental sanitation; (iii) Providing medical care; and (iv) Involving HEWs and the Woreda Administration in strengthening the coordination of the epidemic response.

The challenges encountered:

- Irregular and delayed notification of reports;
- Delayed and inadequately coordinated response at the lower levels;
- Poor hygiene and sanitation; and
- Lack of stock of drugs and medical supplies at lower level/Woreda for initial response.

Measures taken included:

- Provision of technical assistance in mobilizing the federal technical team to regions and Woredas;
- Provision of drugs and medical supplies to the regions; and
- Organization of the AWD TWG and promotion of the multisectoral response

The way forward is as follows:

- Support regions to ensure the weekly reporting and the immediate reporting of outbreaks;
- Equip regions, zones and Woredas with communication facilities;
- Support regions in early warning and response mechanism and avail minimum regional stock for initial response; and
- Strengthen the multisectoral response at all levels.

Measles

In EFY 2002, 17,929 suspected cases and 27 deaths were reported from all regions except Gambella and Dire Dawa. The monthly patterns showed a low peak in Yekatit and a high peak in Sene in EFY 2002 (Figure 38).

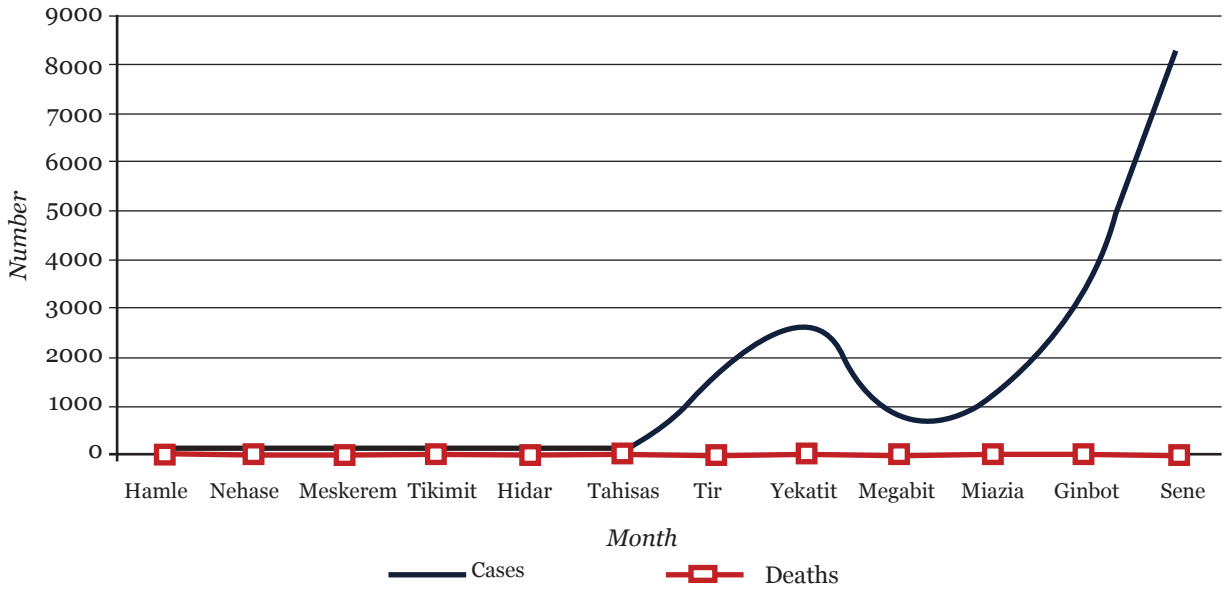

Figure 38: Trend of Suspected Reported Measles Cases and Deaths by Month (EFY 2002)

The following challenges were observed: (i) Delay in immediate reporting (within 2 hours) of reportable diseases leading to delayed responses; and (ii) Inaccessibility of some woredas posing a threat for smooth communication.

Poliomyelitis

No polio cases were reported in EFY 2002. In order for a country to be declared polio free it must have no polio cases and have Acute Flaccid Paralysis (AFP) non-Polio rate of at least 1 per 100,000 children under 15 years. AFP non-Polio rate is important to demonstrate that the surveillance system is sensitive enough to detect Polio cases. At national level, the number of suspected AFP cases reported from all regions was 1,106. Somali and Dire Dawa are under reporting regions, while other regions reported more than 100% of the expected non-Polio AFP cases.

Dysentery

Seven regions reported 53,740 cases and 13 deaths from bloody diarrhea. Tigray region reported the highest number of cases (51%), while Harari reported the least number of cases.

Fluctuations were observed in EFY 2002, with an increase in number of cases in Meskerem, Tir and Megabit, and a high peak starting from Miazia up to Sene (Figure 39).

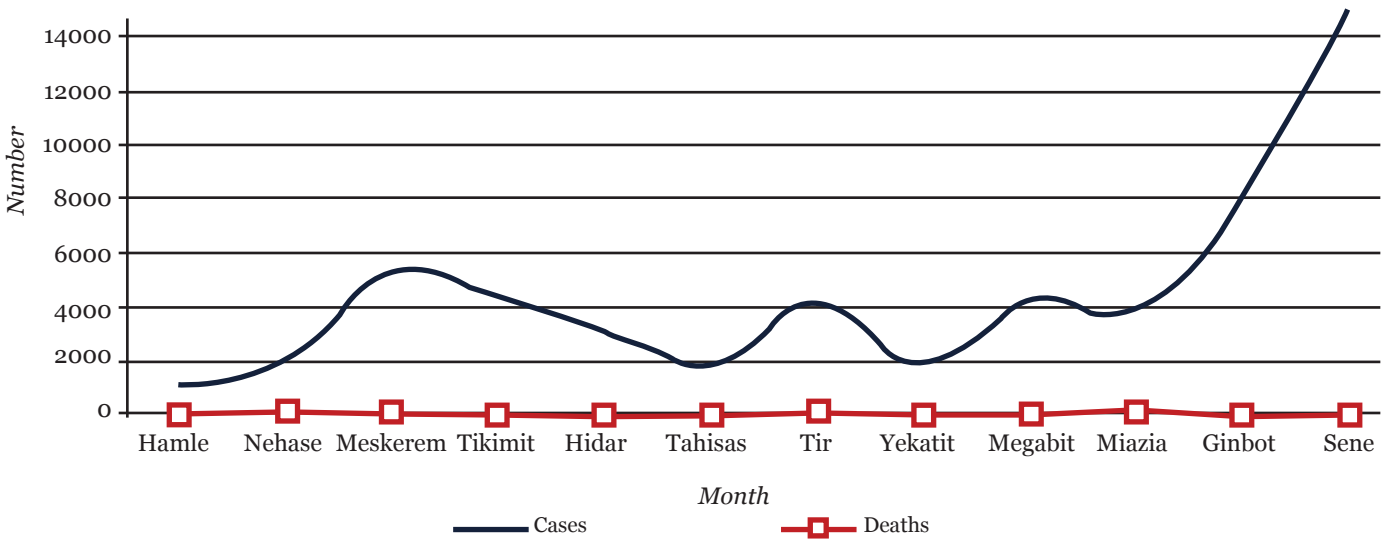

Figure 39: Trend of Dysentery Cases and Deaths by Month (EFY 2002)

Meningitis

A total of 918 cases and 19 deaths were reported from five regions, with a Case Fatality Rate of 2.1% at the national level. There was a first low peak in meningitis cases in Hamle followed by a decrease in Nehase, with a second high peak in Tahisas followed by a sharp decrease in Tir and a final increase starting from Miazia up to Sene (Figure 40).

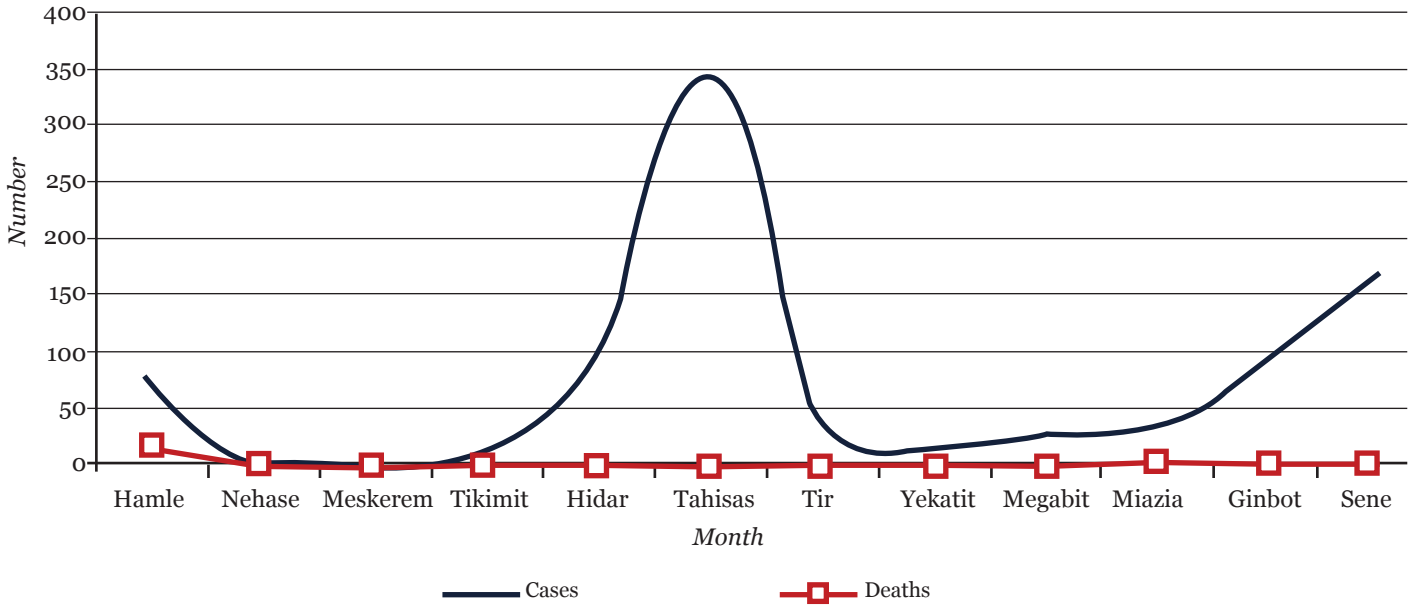

Figure 40: Trend of Meningitis Cases and Deaths by Month (EFY 2002)

Seven regions were affected, with the highest number of cases being reported from Oromia (532), followed by Amhara (199).

Relapsing Fever

Five regions reported 1,595 cases and 5 deaths, with 44 % of the cases being reported from Oromia, while 4 out of 5 deaths were reported from Addis Ababa.

Typhoid Fever

Seven regions reported 68,723 cases of Typhoid Fever and 10 deaths. Over half of the cases (54%) and 9 out of 10 deaths (90%) were reported from Oromia and SNNP Regions.

Anthrax

Three regions reported 1,066 anthrax cases and 6 deaths, with 88% of the cases being reported from Tigray, and 8.4% from Amhara Region. These two regions reported three deaths each in EFY 2002.

Rabies

Rabies is one of the zoonotic diseases under monitoring. Five regions reported 649 cases and 2 deaths, with 80% of the total cases being reported from Tigray.

Pandemic Influenza

Two influenza sentinel surveillance sites have been strengthened (Yekatit Hospital and Shiromeda HC) and the expansion to other sites (Akaki and Kolfe HC) has been finalized. Laboratory investigation is conducted at EHNRI.
In EFY 2002, a total of 27 cases of H1N1 with zero death were reported from three regions: Addis Ababa (18), Amhara (8) and SNNPR (1).

Some of the challenges encountered during plan implementation have hampered timely reporting and speedy epidemic response. These include:

- Lack of focal point to monitor epidemics in some regions due to the delay in BPR implementations, and in regions where BPR implementation has been made on time, the failure to establish and to strengthen PHEM structure up to Woreda level;
- Shortage of trained human resources at all levels and lack of willingness on the part of health workers to be assigned in PHEM positions resulting in staff turnover,
- Difficulty to involve concerned institutions and strengthen the multi-sectoral response to epidemics due to inability to appreciate the urgency of the problem; and
- Insufficient early preparedness at all levels.

These constraints are being addressed through implementation of the Public Health Emergency Management as per the BPR design.

5.6 Prevention and Control of Non-Communicable Diseases

In the context of the epidemiological transition in Ethiopia, a double burden of disease is already emerging with the mix of persistent, emerging and re-emerging infectious diseases and increasing non-communicable diseases (NCDs) and injuries. This will lead to fundamental changes in the volume and composition of demand for health care, with more complex case mix and more costly service utilization patterns.

As a result, NCDs and injuries are already among the major contributors to high level of morbidity and mortality. The FMOH has taken important steps to combat NCDs. The following are some of the major steps taken to strengthen prevention and control of NCDs:

- A national strategy on prevention of NCDs has been designed. The strategy has outlined five major NCDs and the strategic approaches for their prevention and control;
- Target and strategic initiatives for prevention of NCDs have been included into HSDP IV;
- NCDs and injuries constitute one of the 15 packages for Urban Health Extension Program;
- NCDs screening tools have been integrated into the Urban HEW Family Folder and Health Card; and
- A National Mental Health Strategy is under development.

Challenges in this area are the lack of data on NCDs and the complexity and costs of interventions to reduce their burden. Inadequate data availability has to be addressed through development of surveys and research in this area, in particular assessment of risk factors associated with NCDs.

5.7 National Laboratory System

In accordance with the provisions of the National Laboratory Master Plan (2005–2010), the focus of the EFY 2002 plan has been on capacity building of regional and hospital laboratories in terms of laboratory equipment and instruments.

The key activities planned for implementation during the year include: (i) Installing laboratory equipment for testing of viral load in eight regional and in five other hospital laboratories; (ii) Prepare and distribute to all regional laboratories, manuals on laboratory mentoring, referral services, training and quality control on malaria and TB examinations, and on DNA-PCR and viral load examinations; (iii) Establish a data base on training, quality control and maintenance of equipment in eight regional laboratories; (iv) Provide maintenance service for all laboratories, and strengthen maintenance workshops in seven regional centers; (v) Install equipment for clinical chemistry and haematology in 205 health centers, and install equipment for CD4, haematology and clinical chemistry in 27 hospital laboratories; and (vi) Establish a laboratory information system (LIS) to facilitate exchange of information between eight regional laboratories and ten hospitals.

The status of these planned activities in EFY 2002 is described below.
Five hundred fifty laboratories have participated in the national and international quality control program that were conducted in EFY 2002. Guidelines on Quality indicators are being prepared and to implement quality control activities in EHNRI laboratories, 421 standard operational procedures have been completed.

To ensure External Quality Assurance (EQA) for laboratories, samples of CD4, chemistry, and haematology have been imported and distributed to 104 laboratories in three rounds, while samples of DNA PCR have been secured and distributed to seven laboratories in three rounds.

Special type of viral load testing equipment has been installed in five regional laboratories. In collaboration with partner organizations, renovation and provision of support and monitoring has been done for two regional laboratories (Adama and Bahir Dar). Technical assistance and material support is being provided to Regional Laboratories in Afar and Somali Regions. Five vehicles and 12 motorcycles for supporting the TB quality control work have been made available to regional laboratories and for St.Peter's Hospital in Addis Ababa.

A total of 369 professional personnel have been given training on CD4, chemistry and haematology, malaria microscopy, AFB microscopy, laboratory management, laboratory biosafety and biosecurity, viral load, mentoring, and laboratory assessment etc. A total of 227 laboratory technicians have been trained on different methods of laboratory examinations and on maintenance of laboratory equipment. Moreover, 734 health extension workers were also given training on implementation of rapid HIV testing.

Draft manuals have been prepared on (i) Mentoring, Coaching and Supervisory skills; (iii) Referral Linkage; (iii) Quality System; (iv) Viral load, DNA PCR, and TB liquid culture; and (v) Malaria Quality Control Manual, TB Quality Control Manual, RDT Job Aid, AFB Microscopy Job Aid, Health and Safety Manual, Manual on Rapid HIV Testing and Training Curriculum for HEWs have been prepared and distributed to concerned institutions. Sixteen standard operational procedures have been completed and were distributed to regions.

In addition, based on the data about malfunctioning laboratory equipment which were received from all regions, maintenance work on 264 equipment has been carried out. Concerning laboratory examinations that could not be done at hospital level, referral service has been given for 9919 cases.

EHNRI has prepared a research protocol to study the liver disease of unknown origin that has occurred in six Woredas of Tigray Region using a multidisciplinary intervention and investigation approach, and a household cross sectional survey is being carried out. In addition, EHNRI has coordinated the efforts of 15 governmental and international institutes involved in the study.

EHNRI has prepared four standard operational procedures for the breeding of laboratory animals, and it has bred 6005 laboratory animals for use in the production of anti-rabies vaccine and for use by the different sections of the Institute for research purposes. Some of these animals have been distributed to different educational institutions. The soft copies of results and basic data set of research undertaken during the past 25 years have been prepared.

Challenges

The main challenges or constraints faced during implementation include:

- Shortage of skilled and capable human resources;
- Inadequate transport facilities and spare parts for equipment;
- Lack of synchronization between the schedule of EHNRI and international partners in sending samples and undertaking training programs;
- Heavy workload and difficulty to procure laboratory chemicals and reagents on time.

Way Forward

To address these problems, measures to be taken in EFY 2003 include:

- Make close follow up of procurement activities and undertake speedy and timely procurement of laboratory chemicals and reagents;
- Arrange through SCMS the procurement of spare parts for ART equipment adequate for one year; and
- Build the capacity of maintenance teams by providing training and other support services as agreed with manufacturing companies.

5.8 Health Infrastructure, Expansion, Equipping and Rehabilitation

Construction and Equipping of Health Posts (HPs)

There was a steep upward trend in the cumulative number of Health Posts (HPs) constructed during the HSDP III period from 6,191 in EFY 1998 to 14,192 in EFY 2002 (Figure 41). Despite this increase, the performance in EFY 2002 was below the target that has been set for the year (15,842 HPs).

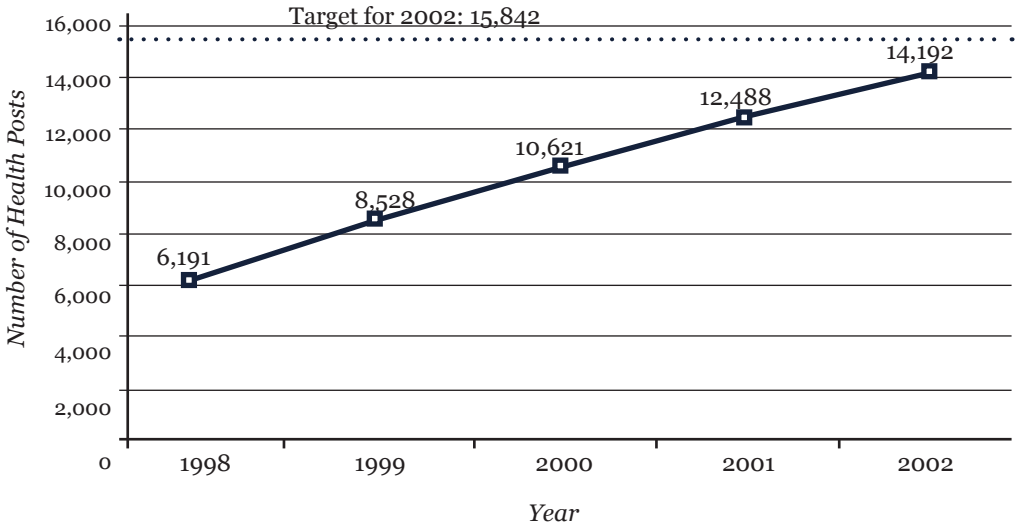

Figure 41: Trend in the Cumulative Number of Health Posts Constructed (EFY 1998-2002)

In EFY 2002, out of the 3,352 new HPs planned for construction, 1,704 were completed during the year, with a performance rate of 50.8%, ranging between 94.1% in Oromia Region and 5.1% in Tigray (Table 11).

Table 11: Construction of Health Posts (EFY 2002)

Region	EFY 2002 target for the cumulative number of available HPs	Cumulative number of HPs available in EFY 2001	EFY 2002			Cumulative number of HPs available in EFY 2002	EFY 2002 Performance for the cumulative number of available HPs
			Plan	Completed	Annual Performance (%)		
Tigray	810	538	272	14	5.1%	552	68.1%
Afar	324	238	86	13	15.1%	251	77.5%
Amhara	3,169	2,856	313	85	27.2%	2,941	92.8%
Oromia	6,008	4,685	1323	1,245	94.1%	5,930	98.7%
Somali	959	547	412	154	37.4%	701	73.1%
Benishangul Gumuz	437	235	202	56	27.7%	291	66.6%
SNNPR	3,852	3,238	614	102	16.6%	3,340	86.7%
Gambella	229	99	130	33	25.4%	132	57.6%
Harari	19	19	0	1	-	20	105.3%
Dire Dawa	35	33	0	1	-	34	97.1%
Total	15,842	12,488	3,352	1,704	50.8%	14,192	89.6%

Concerning the cumulative number of HPs constructed, out of the 15,842 HPs planned, 14,192 HPs were constructed at the end of EFY 2002, with a performance rate of 89.6%. Variations were observed across regions, ranging between 57.6% in Gambella and 105.3% in Harari. Oromia (98.7%), Dire Dawa (97.1%), Amhara (92.8%), and SNNPR (86.7%) almost reached their regional targets. Gambella, Benishangul Gumuz, Somali and Afar have to accelerate the construction of HPs to reach their regional targets.

Oromia registered the highest increase in the number of new HPs constructed in EFY 2002 (1,245), followed by Somali (154) and SNNPR (102) (Figure 42).

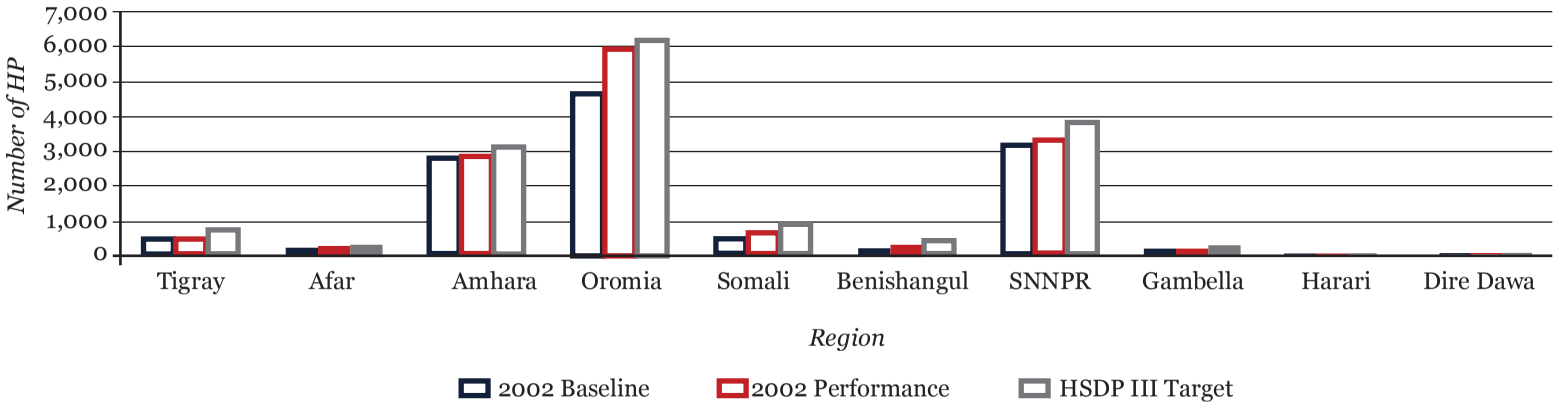

Figure 42: Comparison of Baseline, Performance and Target of the Cumulative Number of Health Posts Constructed by Region (EFY 2002)

Equipping of Health Posts: The implementation of sustained promotive and preventive health actions by HEWs can materialize only if inputs like medical kits, bicycles and other equipment are provided on time and utilized effectively. A total of 1,730 HPs with medical kits were equipped in EFY 2002.

The cumulative total of HPs equipped during HSDP III rose from 10,797 in EFY 2001 to 12,527 in EFY 2002, amounting to 79.1% of the cumulative target of equipping 15,842 HPs. This amount does not include medical kits distributed to HPs in urban centers.

Concerning the supply of equipment for urban Health Extension Professionals, a total of 4,452 medical kits were distributed, based on regional programs, to Addis Ababa (1,468), Tigray (352), Amhara (350), SNNP (726), and Oromia Region (1,556). In addition, uniforms and badges were distributed for 1,468 urban Health Extension Professionals in Addis Ababa.

Concerning the installation of Solar Power to Health Posts, in accordance with the agreement made by the FMOH with the Rural Energy Development Center, the plan was to install solar power in 200 HPs which are lacking hydroelectric supply. Project sites have been selected for this purpose and solar panels have been installed in 196 HPs. The installation work in the remaining 4 HPs is in progress and expected to be completed at the beginning of EFY 2003.

Expansion and Equipping of Health Centers

The expansion of the Health Centers (HCs) is one of the critical inputs necessary for the achievement of the planned universal primary health care coverage. HCs provide curative health care services and also support the HEP by acting as referral and technical assistance centers for HEWs, thus playing a crucial role in the delivery of primary health care to the population.

Construction of Health Centers: To achieve the planned universal primary health care coverage, the target of HSDP III was to construct 3,200 HCs in rural areas by EFY 2002.

To achieve this target, FMOH and RHBs concluded an agreement at the Annual Review Meeting in 2007, whereby for every HC to be constructed by the FMOH, the RHB would have matched this by one HC to be constructed by the region (the so called "matching HC"). In addition, the FMOH would have supplied the medical equipment for all HCs newly constructed by both FMOH and RHBs.

The HSDP III target does not include the HCs planned to be constructed in Addis Ababa (99) and one additional HC planned to be constructed in Amhara Region, reaching the total target of 3,300 HCs to be completed in EFY 2002 (Table 12).

Table 12: Status of Health Center Construction (EFY 2002)

	HSDP III Target	EFY 2002 Baseline for HCs available	HCs available at the end of EFY 2002	EFY 2001 Baseline for HCs available plus under construction	HCs available plus under construction at the end of EFY 2002	EFY 2002 Target to HCs available plus under construction	Gap between EFY 2002 performance and target	Gap between EFY 2002 performance and HSDP III
	(A)	(B)	(C)	(D)	(E)	(F)	(E-F)	(E-A)
	3,200	**1,362**	**2,142**	**1,620**	**2,822**	**3,300**	**478**	**378**
Baseline in EFY 1999					644	644		
FMOH					1,249	1,456	**207**	
RHB					929	1,200	**271**	

In summary, the status of the HCs available is as follows:

- The cumulative number of HCs available at the beginning of EFY 2002 was 1,362 (including Addis Ababa);
- The cumulative number of HCs available at the end of EFY 2002 was 2,142;
- The number of new HCs completed during EFY 2002 was 780;
- The number of HCs under construction at the end of EFY 2002 was 680.

As part of the EFY 2002 Core Plan, FMOH increased its contribution towards HC construction in the emerging regions from 50% to 75%, leaving a 25% share for the emerging regions: as a result, 65 additional HCs will be constructed by the FMOH.

The national EFY 2002 baseline was 1,362 HCs and, in addition to these baseline figures, the construction of 780 HCs was completed, while 680 HCs were still under construction at the end of EFY 2002, thereby reaching the cumulative total of 2,822 HCs available plus under construction in EFY 2002 (including Addis Ababa), which is 85.5 % of the target.

The regions with the highest number of HCs constructed and under construction in EFY 2002 were as follows: Oromia with 1,057 HCs (91.9% of its regional target), Amhara with 673 HCs (82.1%), and SNNPR with 592 HCs (92.2%) (Figure 43). No Region has reached the target set for EFY 2002.

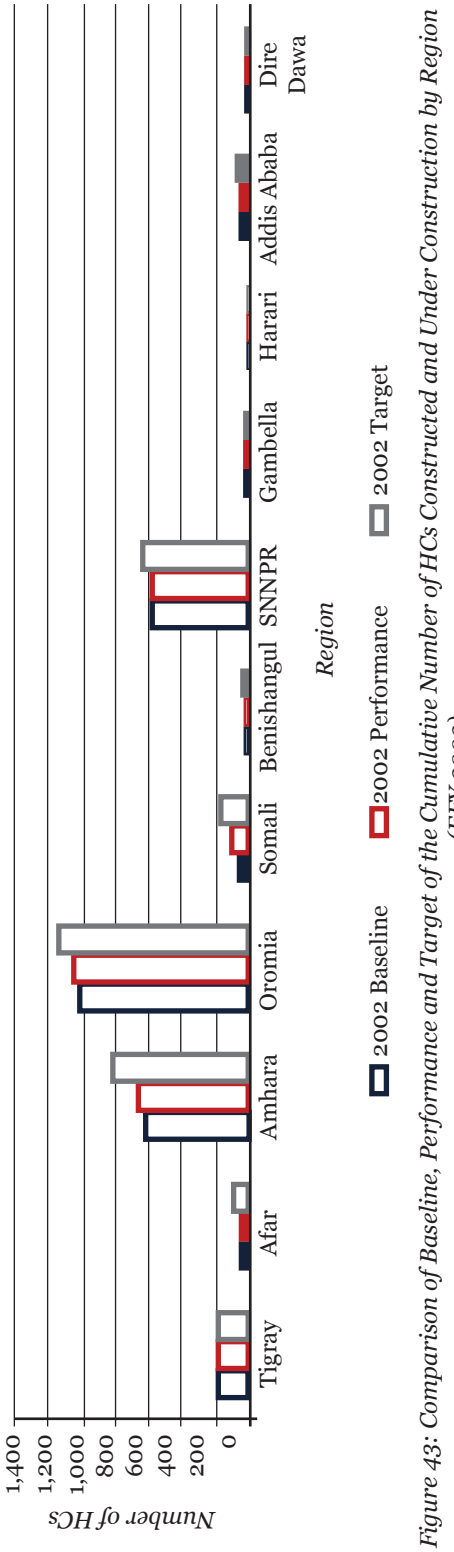

Figure 43: Comparison of Baseline, Performance and Target of the Cumulative Number of HCs Constructed and Under Construction by Region (EFY 2002)

With respect to the number of HCs available at the end of EFY 2002, the highest number was to be found in Oromia (825), Amhara (520) and SNNPR (463) (Figure 44).

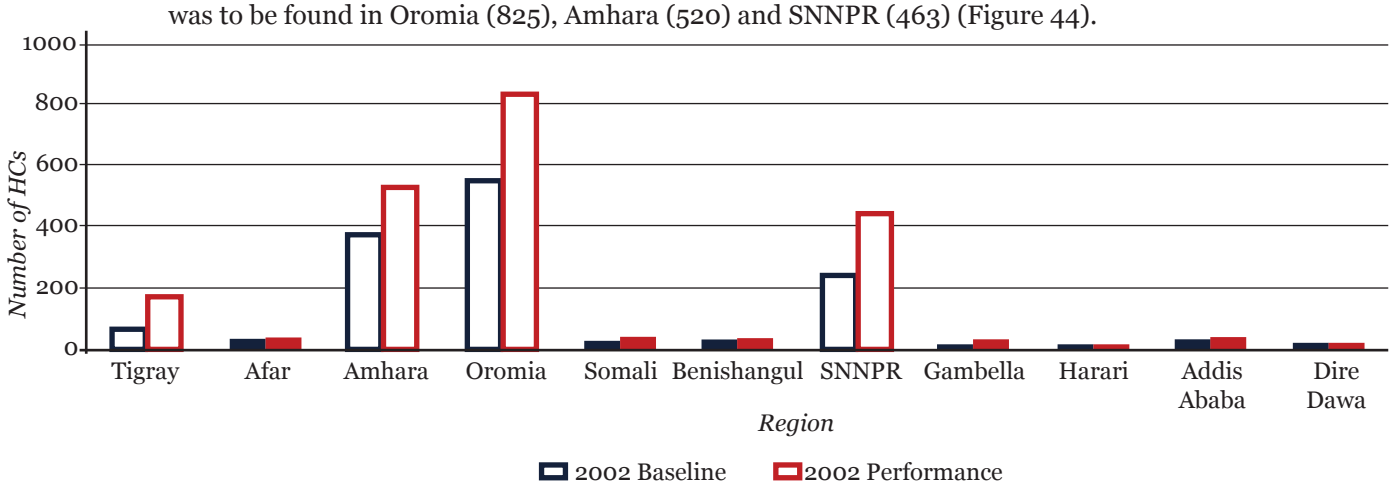

Figure 44: Comparison of Baseline and Performance of the Cumulative Number of HCs Available by Region (EFY 2002)

Nationally, the number of available Health Centers went up from 721 in EFY 2000 to 1,362 in EFY 2001 and to 2,142 in EFY 2002 (Figure 45).

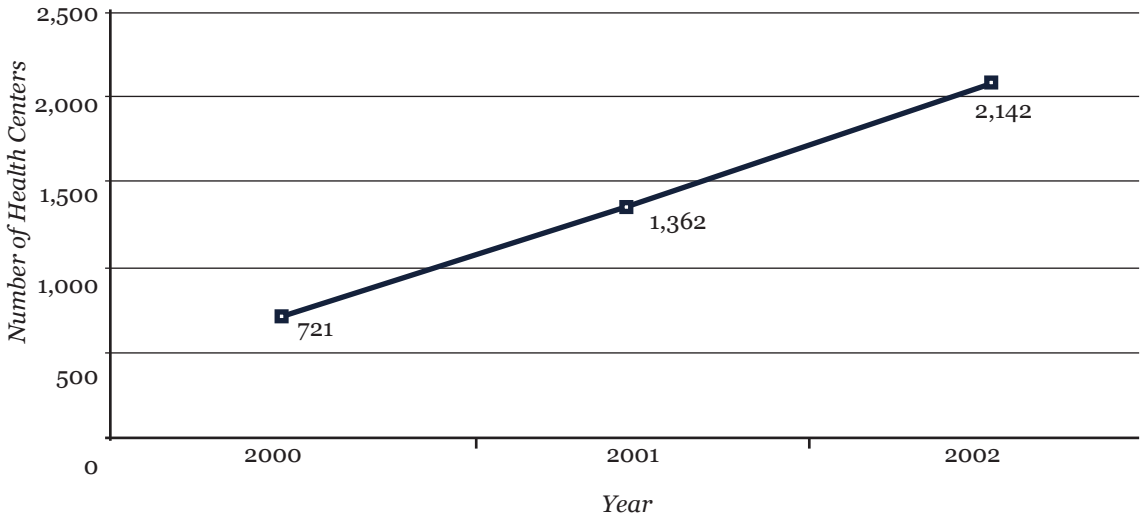

Figure 45: Trend in the Number of Available Health Centers by year (EFY 2002)

Construction of Health Centers by FMOH

The target for the FMOH has been revised to 1,456 HCs as a result of the increased commitment towards the emerging regions. Out of this target, 848 HCs are already completed and 401 HCs are under construction.

Some funds reallocation has occurred resulting in additional HCs to be placed under the management responsibility of the FMOH. Of the total FMOH target, 92 HCs are placed under the management of a partner. A total of 207 HCs have not yet been placed under contract. All HCs by the FMOH (1,456) are targeted for completion by the end of EFY 2003.

Accordingly, Table 13 shows the detailed construction status for the HCs by FMOH at the end of EFY 2002.

Table 13: Status of Health Centers Construction Supported by FMOH Across Regions (EFY 2002)

Region	Total Number of Sites Planned in EFY 2002	Number of Sites Available Plus Under Construction in EFY 2002		Number of Sites Completed at the end of EFY 2002	
		Number	Percentage	Number	Percentage
Tigray	86	83	96.5%	65	75.6%
Afar	62	43	69.4%	14	22.6%
Amhara	342	283	82.7%	208	60.8%
Oromia	517	454	87.8%	328	63.4%
Somali	132	79	59.8%	13	9.8%
Benishangul Gumuz	19	15	78.9%	14	73.7%
SNNPR	264	264	100.0%	180	68.2%
Gambella	20	15	75.0%	13	65.0%
Harari	5	5	100.0%	5	100.0%
Dire Dawa	9	8	88.9%	8	88.9%
Total Matching	1,456	1,249	85.8%	848	58.2%

Construction of Matching Health Centers by the Regions

The plan for EFY 2002 was to have all matching HCs (1,200 including Addis Ababa) under construction. However, not all regions managed to pledge /commit the funds for their outstanding HCs (Amhara, SNNPR, Somali and Afar) resulting in 159 HCs not placed under contract. Note that only one region (Tigray) exceeded its regional target and two regions (Gambella and Dire Dawa) achieved their regional target (Table 14). The remaining HCs to be built by the regions are expected to be placed under contract in EFY 2003.

Table 14: Status of Health Center Construction Supported by RHBs Across Regions (EFY 2002)

Region	Total Number of Sites Planned in EFY 2002	Number of Sites Available Plus Under Construction in EFY 2002		Number of Sites Completed at the end of EFY 2002	
		Number	Percentage	Number	Percentage
Tigray	72	73	101.4%	65	90.3%
Afar	20	0	0.0%	0	0.0%
Amhara	288	199	69.1%	121	42.0%
Oromia	441	411	93.2%	305	69.2%
Somali	44	17	38.6%	7	15.9%
Benishangul Gumuz	6	2	33.3%	0	0.0%
SNNPR	221	167	75.6%	122	55.2%
Gambella	7	7	100.0%	2	28.6%
Addis Ababa	99	52	52.5%	2	2.0%
Harar	1	0	0.0%	1	100.0%
Dire Dawa	1	1	100.0%	1	100.0%
Total Matching	1,200	929	77.4%	626	52.2%

Equipment for Health Centers:
In accordance with the agreement made by the FMOH with GTZ–AMESE, the plan was to install solar power for 90 health centers lacking hydroelectric supply. Project sites have been selected for this purpose, and solar panels have been installed for 40 health centers. The installation work in the remaining 50 HCs is in progress and expected to be completed in the middle of EFY 2003.

Construction, Rehabilitation and Expansion of Hospitals

Federal Hospitals

Emmanuel General Hospital and Mental Health Institution: To mitigate some problems encountered in the existing buildings of female and male wards, detailed engineering investigation has been conducted and problems have been identified. Currently the construction is underway and about 50% of the maintenance, work has been completed. The design of the new General Hospital and Mental Health Institution was finalized with the approval of the Ministry of Works and Urban Development. The new Mental Institution will provide outpatient and inpatient services, pediatric services, psychological therapy, forensic care, and other services like electroencephalography and radiology. The building is expected to have 214 inpatient beds for mental and other inpatients. Outpatient Department (OPD) and administration services are also included in the main block.

St. Peter's TB-Specialized Hospital: Final acceptance was made for the HIV wing of the hospital, which is already providing services. Renovation construction of the female ward for MDR TB treatment has been completed and provisional acceptance has been made, with services being already provided for 50 MDR TB inpatients. The facility is the first of its kind comprising of an OPD, patient recreation block and two inpatient blocks. Additional expansion work has started to scale up the services.

St. Paul's General Specialized Hospital: A new medical and surgical emergency block was completed and the provisional acceptance was made. In addition, the Emergency Unit was inaugurated. To change the current condition of the ex-St. Paul's Nursing School, a full-scale maintenance work was done in the current year and 70% of the maintenance work was completed including maintenance of the hospital ward. The design work of St. Paul's Maternity and Pediatrics Hospital and St. Paul's Millennium Medical College are completed including the approval of the design by the Ministry of Works and Urban Development. The selection of contractors was also completed. Site handover was formally made for the medical college and the demolishing work was finalized for the old buildings. The college building was designed to provide full academic and residential services for 600 regular students. In addition, the administration and all other supporting blocks were included in the design. In a similar way, the design work of St. Paul's Guest House was completed and approval was obtained from in-house engineering professionals.

All Africa Leprosy, TB and Rehabilitation Training Center (ALERT): The construction of the library and office buildings was completed Due to remarks given by the supervisor and the hospital officials, provisional acceptance was not obtained. Nearly 100% of the new waiting room of the Dermatology OPD and full maintenance work for the training center department had been completed.

Regional Hospitals

In EFY 2002, regions have reported the construction of eight new hospitals, the ongoing construction of 27 hospitals, and the expansion or upgrading of nine hospitals (Table 15).

Table 15: Status of Hospital Construction/Upgrading by Region (EFY 2002)

Region	New	Ongoing	Rehabilitation	Expansion/ Upgrading	Total Available Hospitals
Tigray	2	1	-	2	14
Afar	1	4	-	-	4
Amhara	1	-	-	-	17
Oromia	2	14	5	7	42
Somali	-	1	-	-	7
Benishangul Gumuz	-	1	-	-	2
SNNPR	-	2	-	-	16
Gambella	-	-	-	-	1
Harari	1	2	-	-	2
Addis Ababa	-	-	-	-	10
Dire Dawa	1	2	-	-	1
Total	**8**	**27**	**5**	**9**	**116**

The challenges faced in the construction, rehabilitation and expansion of hospitals were: (i) Shortage of qualified contractors willing to take contracts in remote sites; and (ii) Serious shortage and unexpectedly high prices of construction materials.

To address these challenges, actions have been taken by the FMOH and the concerned hospital management. These measures include strengthening the collaboration with the Ministry of Works and Urban Development and regional and zonal authorities to further alleviate the problems in the timely availability of construction materials and also in mobilization of qualified contractors.

Construction of Blood Banks

Although it was planned to meet 80% of the needs of blood and blood products of the hospitals in EFY 2002, the construction of the 16 blood banks is not completed for several reasons, including shortage of construction materials, continuous price escalation, and delay in settling payment obligations for the completed construction. Accordingly, out of the construction of 16 blood banks, 100% of the work has been completed in Debre Markos and Metu, 95% in Debre Birhan, Goba, and Debre Tabor, 90% in Hawassa, Jimma, Harari, Chiro, Adama, Hossana, and Gambella, and 85% in Assosa, Axum, Woliso and Mekelle.

Biomedical Engineering

Maintenance of BioMedical Equipment has started in five selected hospitals. Twelve regulations and guidelines on management of medical equipment have been prepared for use at the national level. In addition, proposal at national level on inventory of medical equipment, training of biomedical technicians and management of medical equipment has been prepared. In hospitals run by the Addis Ababa RHB, 74 different types of medical equipment have been repaired by volunteer maintenance technicians from Egypt. Forty students have been trained on maintenance of surgical instruments and anesthesia equipment.

Tele-Medicine and Tele-Education

The aim of the Tele-Mdicine and Tel-Education program is to use ICT as support for health care delivery and training of health and medical professionals.

In EFY 2001, setting up Tele-Medicine and Tele-Education had been carried out in one university and six hospitals (the Jimma University Network). In EFY 2002, the plan was to expand Tele-Medicine and Tel-Education at four Universities (Makelle, Gondar, Hawassa and Haromaya) and 18 regional hospitals. In addition, the plan included implementation of key activities such as undertaking assessment study prior to implementation, select site coordinator and conduct awareness raising activities, procure and handover Tele-Medicine equipment to the site coordinator, put tele medicine software to use, and train 300 professionals on subjects related to Tele-Medicine and Tele-Education.

With respect to the performance status of the planned activities in EFY 2002, Tele-Medicine has been implemented in five hospitals in Addis Ababa and connections have been established for hospitals in Dire Dawa and Harar. Draft document on National strategy on Electronic Health has been prepared. Assessment study on broad band has been carried out and the necessary inputs have been imported to establish knowledge centers at Durame, Bishoftu and Wukro Hospitals. Accordingly, knowledge centers have been established already at Bishoftu and Durame Hospitals.

Electronic Health Record

SmartCare is a comprehensive national Electronic Health Record (EHR) and reporting and analysis system, designed to enable better patient care, enhance efficiency and to make the reporting and analysis system more accurate, timely and effective starting from community health workers to health facilities, to the level of Woredas, Zones, Region and Federal Ministry of Health to envisage informed decision support. This system will enable and empower the health care system to acquire accurate and timely patient and health information and also to enhance health information exchange.

In EFY2002, EHR in all points of service within the health facilities has been successfully implemented one hospital at Federal level (St. Paul Hospital), five hospitals in Addis Ababa Region, two hospitals in Oromia Region and one hospital each in Dire-Dawa and Tigray Regions.

With regard to EMR at health center level, a total of 18 health centers are now implementing

in Dire-Dawa (14 HCs) and Harari (4 HCs) Regions. Phase one implementation of EHR that only includes medical record unit SmartCare module and reporting and analysis module (eHMIS) has been successfully implemented in one hospital at Federal level (Black Lion Hospital), 26 health centers in Addis Ababa Region and 26 health centers in Oromia Region, East Shewa Zone.

In line with the implementation of Community Health Information System, SmartCare module that automates the data capture and enabling reporting, analysis and availing mapping and GIS functionalities for the community health extension workers for surveillance.

Challenges

The following main challenges have been encountered during implementation phase in the construction, expansion, equipping and rehabilitation of health facilities:

- Lack of timely information on location and distance of rural HPs without medical equipment and supplies;
- Delay in the procurement, repackaging and distribution of HP kits;
- Escalation of price of construction materials;
- Shortage of cement;
- Heavy and unexpected rainfall accounting for delays in construction activities;
- Lack of experience on the part of new contractors and difficulty to get access to remote sites; and
- Cancellation of contract for some sites handled by new contractors.

To address these challenges, the following actions have been taken by the FMOH and RHBs: (i) Cement has been imported from abroad and cost adjustments have been made to the contractual agreement; (ii) For smooth implementation of the construction work, meeting has been arranged between the contractors and building supervisors; and (iii) Performance evaluation of the contractors has been made and report has been sent monthly to Ministry of Works and Urban Development.

Way forward

- Undertake supportive supervision on a regular basis to tackle delays in construction of HPs and facilitate the flow of information on the status of construction activities;
- Map location and distance of HPs using Geographic Information System (GIS) and prep are a functional distribution framework for medical equipment and supplies to HPs;
- Accelerate the construction of HPs and improve the supply chain system;
- Ensure the proper equipping and functioning of the new HPs;and
- Strengthen close collaboration with Ministry of Works and Urban Development and regional and zonal authorities to further alleviate the problems related with construction materials and in mobilizing willing and qualified contractors.

5.9 Utilization of Health Services

OPD attendance per capita is one of the indicators used in this report to measure the utilization of health services. It is the average number of outpatient visits (first and repeat) per person per year, reflecting the interaction between demand and supply of outpatient care.

Figure 46 shows the trend in OPD attendance per capita for EFY 1998 to 2002.

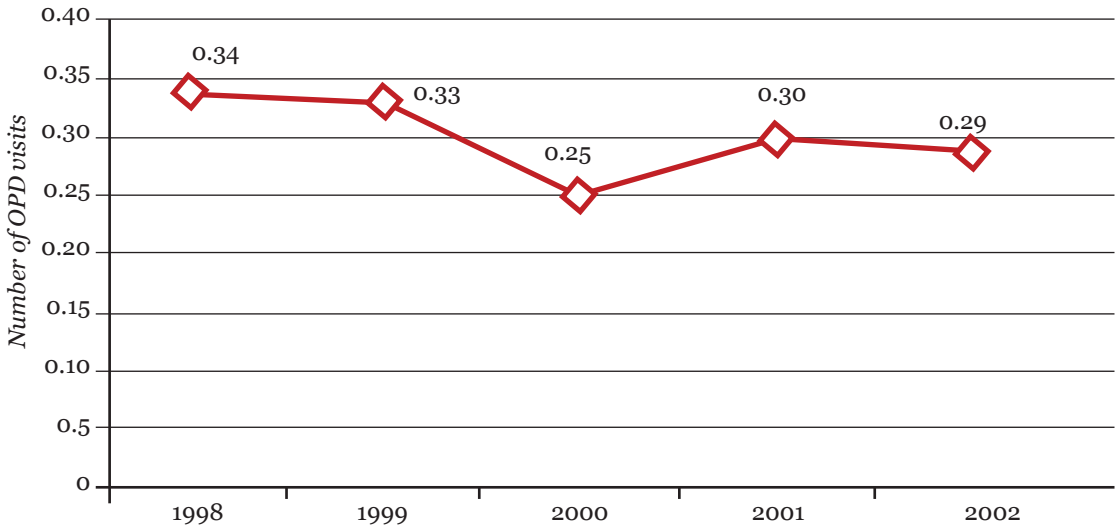

Figure 46: Trend in OPD Attendance Per Capita (EFY 1998-2002)

With regard to trend over time, there were downward fluctuations in OPD attendance per capita from 0.34 in EFY 1998 to 0.29 in EFY 2002. The highest rate was reported in EFY 1998 and the lowest in EFY 2000. The attendance rate for EFY 2002 is much lower than the target set for the end of HSDP III (0.66). Figure 47 demonstrates baseline and performance of OPD attendance per capita by region in EFY 2002.

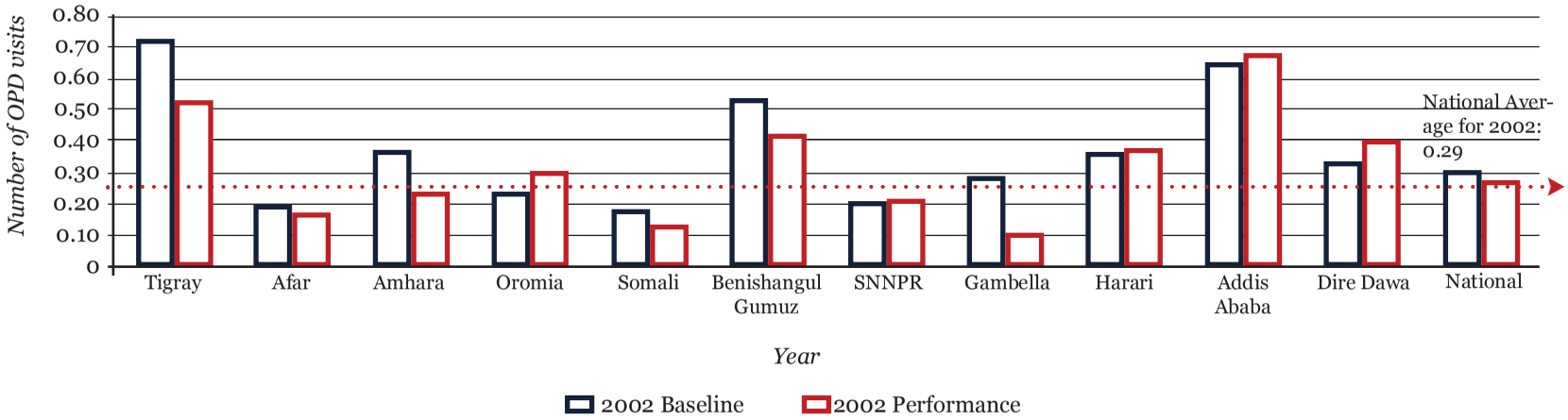

Figure 47: Comparison of Baseline and Performance of OPD Attendance per Capita by Region (EFY 2002)

Wide variations were observed across regions in EFY 2002, ranging between 0.11 OPD visit per capita in Gambella Region and 0.68 in Addis Ababa, with six regions showing a performance rate above the national average: Addis Ababa (0.68 OPD visit per capita), Dire Dawa (0.40), Harari (0.38) , Benishangul Gumuz (0.42), Tigray (0.53) and Oromia (0.31). Five regions had OPD attendance per capita below the national average in EFY 2002: Afar (0.17), Amhara (0.24), Somali (0.13), Gambella (0.11) and SNNPR (0.21). Except Oromia, SNNPR, Harari and Dire Dawa, the rest of the regions had OPD attendance in EFY 2002 much lower than in EFY 2001 (Figure 47). This could be due to under reporting or decrease in OPD service utilization.

CHAPTER VI

HEALTH FINANCING

Health Financing

6.1 Health Care Financing

This program aims at developing a sustainable health care financing system, mobilizing increased resources to the health sector, and promoting the efficient allocation of resources so as to improve the quality of health care. The reform components include facility revenue retention and utilization, facility governance, systematization of fee waiver and exemption, user fee revision, out-sourcing of non-clinical services and establishment of private wing with the objective of strengthening the supply side & deliver quality health services. In addition to the above reform components, the FMoH has recently initiated the introduction of community based and social health insurance to address the demand side and thereby remove financial barriers to access health services. In both reform components significant achievements have been made during the fiscal year.

Revenue Retention and Utilization: A Guideline on Revenue Retention and Utilization for quality improvement was finalized during the year, which will complement the existing HCF implementation manual. Furthermore the manual was adapted in Amhara, Benishangul-Gumuz, Oromia, SNNP, and Addis Ababa Regions through consultative meetings. Training was provided to facility managers in their respective regions to implement the guideline. Training/ refresher trainings on HCF reform implementation was given to a total of 1,284 people drawn from RHB, ZHDs, Woreda Health Offices and health facilities in Amhara, Oromia, SNNP and Dire Dawa Regions. Several consultative workshops were undertaken to revise and update the financial management manual so as to facilitate the implementation of the revenue retention. The manual was translated into three local languages (Amharic, Afan Oromo and Tigrigna). Based on the translated manual and in collaboration with the Regional Bureau of Finance, a total of 1,127 finance personnel drawn from hospitals and health centers were trained for seven days in Oromia, SNNP, Benishangul Gumuz, Amhara, Gambella and Tigray Regions. Following the training, follow-up visits were made to assist the trainees in the application of the skills gained during the training. For example, in Oromia 209 health facilities in 18 zones were visited to assist in the application of modified cash-based accounting.

Fee waiver and User fee revision: Implementation of the fee waiver system is the most difficult task among the reform components. It is implemented well in Amhara Region compared to other regions. The challenge is mainly related to the selection of indigents who will benefit from the fee waiver system. To address the problem, sensitization and consultation workshop was conducted for a total of 1,500 participants drawn from health centers, woreda health offices, woreda administrations in Oromia Region to create the necessary awareness and implement accordingly. Furthermore, training was provided to a total of 84 mass media people drawn from TV, Radio, Press, Regional and Zonal Information Bureaus in Amhara, SNNPR and Oromia regions. This has helped to bridge the gap and disseminate the procedures & benefits of implementing the fee waiver system. In addition, a study on fee waiver implementation is commissioned to identify the major problems and come up with recommendations. Similarly, based on the regions demand to revise user fees, a study which will guide such revision has been commissioned during the fiscal year. Both studies are expected to be completed and utilized in the EFY 2003.

Facility governance: The role of facility governing bodies both at hospital & health center level is critical in promoting and overseeing the successful implementation of the HCF reforms. This was confirmed by the findings of the quarterly supportive supervision as the difference in implementation of HCF reform status from region to region was mainly due to the strength and corresponding performance of the facility management boards and governing bodies. Therefore, a two day experience sharing and networking workshop was conducted in order to highlight and share experiences of the successful practices of governing bodies and other HCF reforms across regions. This national level event was held in Addis Ababa and included 123 people drawn from health, finance and administration sectors from all regions. This successful event served to enlighten the general public and relevant stakeholders about the HCF reforms, and progress and achievements made to date. In addition, the standard two-day training for facility governing bodies and management boards were provided to a total of 1,127 board members in Tigray, Amhara, Benishangul-Gumuz and Gambella Regions and Dire Dawa City Administration.

Out-sourcing and private Wing: The manuals developed for outsourcing of non-clinical services and establishment of private wings at hospital level were enriched through consultation with the involvement of relevant stakeholders including Regional Health Bureaus.

Generally, HCF reforms are being implemented well in all regions except Somali and Afar which will start implementation in the coming year. The current status of HCF implementation in the seven regions and two city administrations is shown in the following table 16.

Table 16: Status of Health Care Financing Reform Implementation in Ethiopia (EFY 2002)

S/N	Region/City Administration	Number of Woredas covered	Cumulative Number of Facilities Implementing the Reform	
			Hospitals	Health Centers
1	Tigray	46	12	118
2	Amhara	146	17	274
3	Benishangul Gumuz	20	2	18
4	Oromia	303	32	546
5	SNNP	156	14	257
6	Addis Ababa	10	5	26
7	Harari	9 Kebeles	2	8
8	Dire Dawa	47 Kebeles	1	13
9	Gambella	13	1	8
		Total	**86**	**1268**

Overall, all facilities started revenue retention and utilization in Tigray, Addis Ababa and two hospitals in Harari; while 10 new hospitals in Oromia and one hospital each in Gambella and Dire Dawa have started revenue retention. Seventy health centers in Amhara, eight special woredas and 22 town administrations in SNNP and all facilities in Benishangul-Gumuz have started HCF reform in EFY 2002. With respect to private wings, it is being implemented in Felege-Hiwot & Dessie hospitals in Amhara region, Adama and Bishoftu hospitals in Oromia, St. Mary and Abi Adi hospitals in Tigray, and at Ras Desta and Yekatit 12 hospitals in Addis Ababa.

Health Insurance

In an effort to address the financial barriers to access health services, the government has initiated two types of health insurances: community based health insurance (CBHI) for the rural and urban informal sector and social health insurance (SHI) for the formal sector. Significant progress has been made in the implementation of both types of health insurance during the year.

Social Health Insurance: A proclamation which states the major aspects of the health insurance enriched by the feedbacks from stakeholders was submitted for the Council of Ministers in the preceding year. During the current year, the proclamation was approved by the Council of Ministers and subsequently by the Parliament. This is a major milestone to proceed with the next steps in the implementation of SHI. A draft regulation which contains the details including the premium and benefit packages has also been prepared during the fiscal year. However, as per the direction of the Council of Ministers, before its submission and approval a series of consultative meetings will be undertaken to get feedback from each potential member organization and employees. Apart from these legal frameworks, other operational documents such as operational manual, provider payment mechanism, organizational structure with the required manpower requirements of the Health Insurance Agency are under preparation. After completing all preparatory works in the coming year, SHI is expected to commence operation in early 2004 EFY.

Community Based Health Insurance: As per the health insurance strategy, CBHI will be piloted first in selected areas for two years and based on the lessons learnt it will be scaled-up throughout the country. Accordingly, a significant achievement has been made in completing preparatory activities to commence the pilot operation. Feasibility studies focusing on the 13 pilot woredas in the four pilot regions (Tigray, Amhara, Oromia and SNNP) were completed. Based on the findings of the feasibility studies, the FMOH has decided on different parameters including membership, institutional arrangement, subsidy to cover a certain portion of the premium for all members as general subsidy and also the targeted subsidy for indigents to cover the full premium. Based on the overall directions from the FMOH, regional steering committee of each pilot region has undertaken policy workshop to decide on specific parameters of the CBHI schemes. In this regard, with the exception of Amhara Region, all regions have finalized the decisions on the basic parameters and subsequent activities are being implemented. For example, trainings for Woreda cabinet members and Woreda Health Insurance Steering Committees have been provided in Tigray and SNNPR. Following this, trainings will be provided to Kebele Cabinet and Kebele Initiative Committees in all of the 285 kebeles. These Committees at woreda and kebele level are responsible to undertake sensitization & create awareness of the population which would facilitate enrollment in CBHI schemes. Other preparatory activities, such as preparation of directive to provide legal backing for CBHI schemes and Financial and administrative management manual for the schemes, have also been produced during the year.

Evidence Generation: In an effort to track the progress and inform the preparation of HSDP IV, the fourth round of National Health Account (NHA) was finalized during the year. Unlike the previous rounds, the fourth round was based on household surveys (10,000 households) to estimate household expenditure on health. In addition to the household survey, PLWHA survey (3,000 households) was also undertaken to estimate the health expenditure among people living with HIV and AIDS. The fourth NHA, in addition to the general NHA has produced six-sub accounts: HIV/AIDS, reproductive health, child health, malaria, TB, and health information system. The finding of the study was disseminated to a total of 161 government and development partners in a day long national workshop.

The study revealed that there has been a tremendous increment in overall health expenditure (NHE) both in nominal and real terms since the third round in 2004/05. The nominal total health sector spending increased from Birr 4.5 billion (US$522 million) in 2004/05 to more than Birr 11.12 billion (US$1.2 billion) in 2007/08. Per capita national health expenditure (NHE) also grew substantially from US$7.1 per capita per annum in 2004/05 to US$16.1 in 2007/08, but this is still far below the US$34 dollars per capita spending recommended by the Commission for Macroeconomics and Health (WHO, 2001). In 2007/08, the overall financing of the health sector mainly originated from the rest of the world, households and government; they contributed to 40%, 37% and 21% of NHE respectively. All other sources, including private employers and other private funds, accounted for the remaining 2% of NHE.

Challenges

The following were the key challenges encountered during the implementation of the HCF reform in EFY 2002:

- High turnover of health facility key finance staff;
- Uneven implementation of the fee-waiver system across regions; and
- Difficulty in identification of indigents.

Way Forward

To address these challenges, the sector has to implement activities such as:

- Speed up the full scale implementation of SHI and CBHI;
- Increase public awareness and knowledge about the benefits of health insurance through the mass media; and
- Enhance advocacy to increase resource mobilization from internal sources, international donors and health development partners.

6.2 Financial/Expenditure Management and Control

The goal of this program is to establish an efficient, transparent and cost-effective financial management and control system which will serve to effectively allocate and utilize financial resources

Financial/Expenditure management

The Federal Ministry of Health has taken three initiatives for short and long term solutions to strengthen the financial management and administration system after careful review of the existing systems, audit reports and a commitment to promote a transparent and accountable system. The three initiatives are briefly described as below.

1. **Finance Technical Assistants (FTAs)**
   Four Finance Technical Assistants were recruited to assess the existing grant accounting and control systems at federal, regional and implementing bodies and come up with alternative solution to promote strong financial practices and accountability at all levels. The assessment at federal level already commenced and is on progress. Based on the progress reports, quick fixes are being introduced since Hamle EFY 2002. Activity based reporting that gives budget Vs actual figures, segmental chart of account that address reporting needs for each round, and maintaining subsidiary ledgers for debtors and creditors are some of the quick fixes that are being introduced in the new fiscal period.

2 **Accountancy firm**

FMoH has contracted an accountancy firm to assist and facilitate the settlement of long outstanding grant advances at federal, regional and other implementing institutions, train implementing staff and capacitate for the duty, establish and maintain fixed asset register, assist regional and woreda health bureau staff in Statement of Expenditure (SOE) preparation and closing books of accounts at year end. The accountancy firm has been employed months back and has already started undertaking this task. It is believed that this will enhance grant advance settlement, report production, year end closing and audit, which in return will further improve the confidence of DPs in the Financial Management system.

3 **Integrated Financial Management Information System (IFMIS)**

Integrated Financial Management Information System (IFMIS) will provide FMoH the ability to link accounting and financial management activities of the Ministry, with the planning and programming activities, to enable the management at all levels of the health system in decision making. The IFMIS is a web based information system designed and will be implemented end to end, i.e from the Federal Ministry of Health to Regions, Zones, and Woredas levels. Some of the key areas where significant improvement is expected are:

- Implementing uniform financial recording and reporting system at all levels of the health sector;
- Updated financial data at all levels;
- A financial monitoring and evaluation system that can easily generate reports as per stakeholders requirement;
- Integration between fiscal and financial information at all levels;
- Improved fixed asset management system; and
- Efficient planning, monitoring, evaluation, and decision making.

As a result of implementing HS-IFMIS, FMoH will undertake major transformation in ensuring efficiency and effectiveness of the financial management system and thereby enhancing FMOH's accountability to its stakeholders and partners. During the reporting period the design of the system and awarding contract to the implementing institution is finalized.

Programme Based Audit

An audit and Inspection Office has been designed to enhance efficient utilization of government resources towards the realization of the objectives of the institution.

In EFY 2002 an inventory to settle EFY 2001 accounts was undertaken and reported to MoFED, an investigative audit was conducted and the internal audit system of projects and programs was evaluated so as to strengthen the system and to follow the proper disbursement and utilization of funds. Based on the inventory report, follow-up has been made to ensure whether appropriate actions have been taken to correct irregularities.

Moreover, the six month account of the regular budget of the FMOH has been audited including the storage and registration of non-expendable items of the Ministry, and construction materials managed by the Project Management Unit of the FMOH.

Regular follow-up was done for timely audit of project funds and regular budget administered by the FMOH, as a result most fund accounts have been audited on time.

Challenge

- Lack of qualified staff to undertake performance audit which was planned to be done in mid-December.

Way forward

- Recruitment of the right technical people to conduct performance audit so that the performance audit will be conducted according to the required frequency.

6.3 Public Budget Allocation and Expenditure

This section reviews the section and expenditure of public budget in EFY 2002. The source of data for this section is the Ministry of Finance and Economic Development.

Percentage share of the Health Budget Allocation from Total Budget

As shown in Figure 48, the percentage of the Regional block grant budget allocated to the health sector ranged from 4.4 % in Addis Ababa to 12.9 % in SNNPR, Oromia and Dire Dawa. The national average for the year was 10.4 %. The percentage share of health budget from total budget increased in five regions (Afar, Amhara, Gambella, Dire Dawa and Addis Ababa). A decrease in the share of the health budget is observed in Tigray, Oromia, Somali, Benishangul Gumuz, SNNPR and Harari. The percentage of the total budget allocated to the health sector has increased from 10.1% in EFY 2001 to 10.4 % in EFY 2002. The allocation on health per capita is ETB 39.82 in EFY 2002 as opposed to ETB 38.03 in EFY 2001.

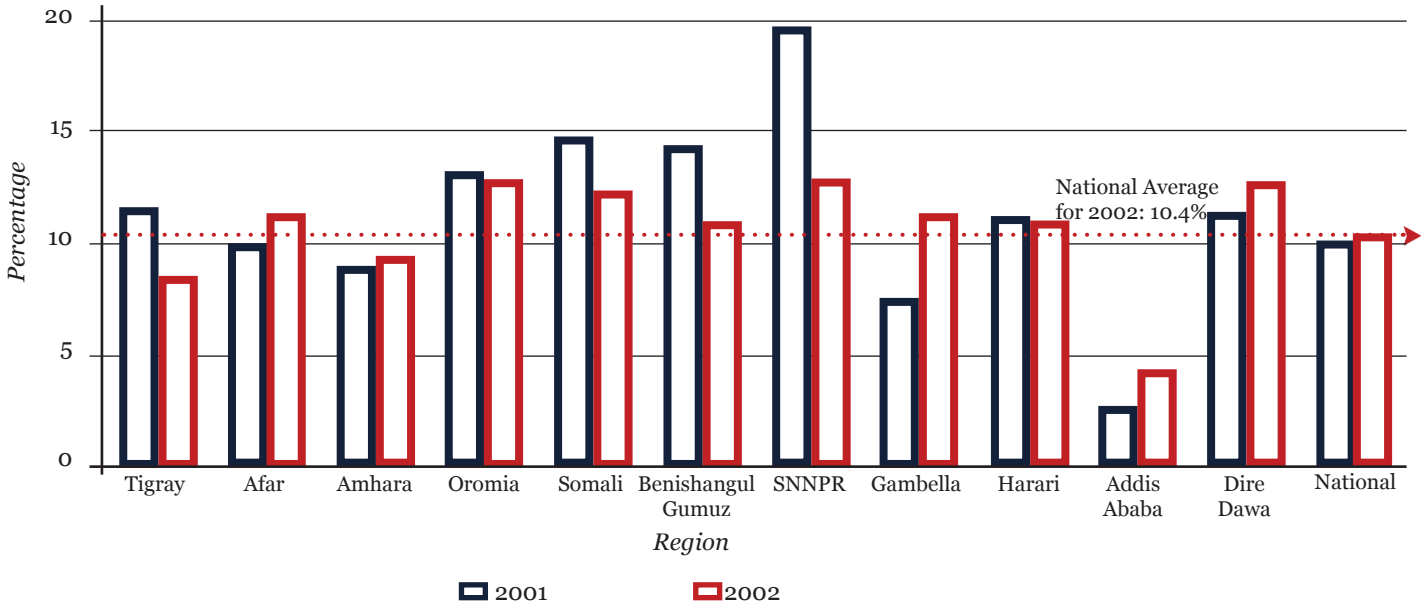

Figure 48: Distribution of the Percentage of Total Budget Allocated to the Health Sector by Region (EFY 2001 and 2002)

The total and per capita allocation of ETB 39.8 on health is below the need of the sector for delivery of accessible and quality health care services in the country. This calls for enhanced implementation of the ongoing Health Care Financing reform such as facility level revenue retention and use as well as facilitating the expansion of social and community-based health insurance.

Per Capita Public Expenditure on Health

Per capita public expenditure on health indicates the amount of public expenditure on health divided by the population.

As depicted in the Figure 49, the per capita public expenditure on health rose from ETB 16.00 in EFY 1998 to ETB 34.55 in EFY 2002, doubling the amount compared to the beginning of HSDP III.

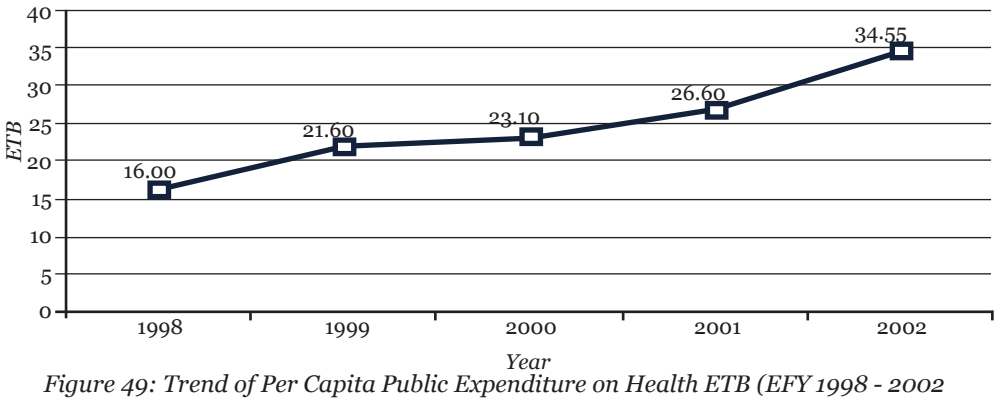

Figure 49: Trend of Per Capita Public Expenditure on Health ETB (EFY 1998 - 2002

A wide variation seen across regions from ETB 27.32 in Amhara to ETB 134.38 in Harrari. Amhara (27.32), SNNPR (29.37), Afar (32.20), Oromia (34.44) had per capita public expenditure for health lower than the national average (34.55) (figure 50).

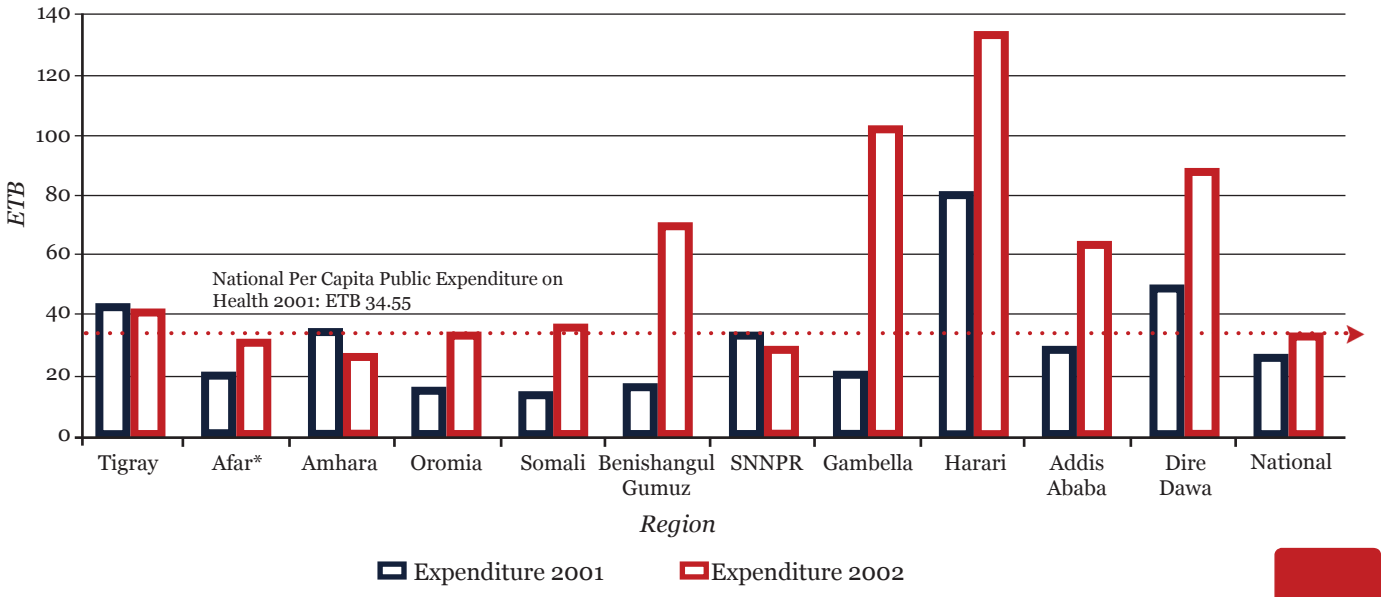

Figure 50: Compariosn of Per Capita Expenditure on Health (ETB) in EFY 2001 and 2002

* Note that Afar report only includes nine month data.

At the national level, the per capita allocation was ETB 39.82 and the per capita expenditure was ETB 34.55. Regions with higher allocation per capita had a sightly lower expenditure rate as seen in Dire Dawa and Gambella when it is compared with other regions, However, those regions which had low allocation had better budget utilization like in Tigray, Amhara and Oromia.

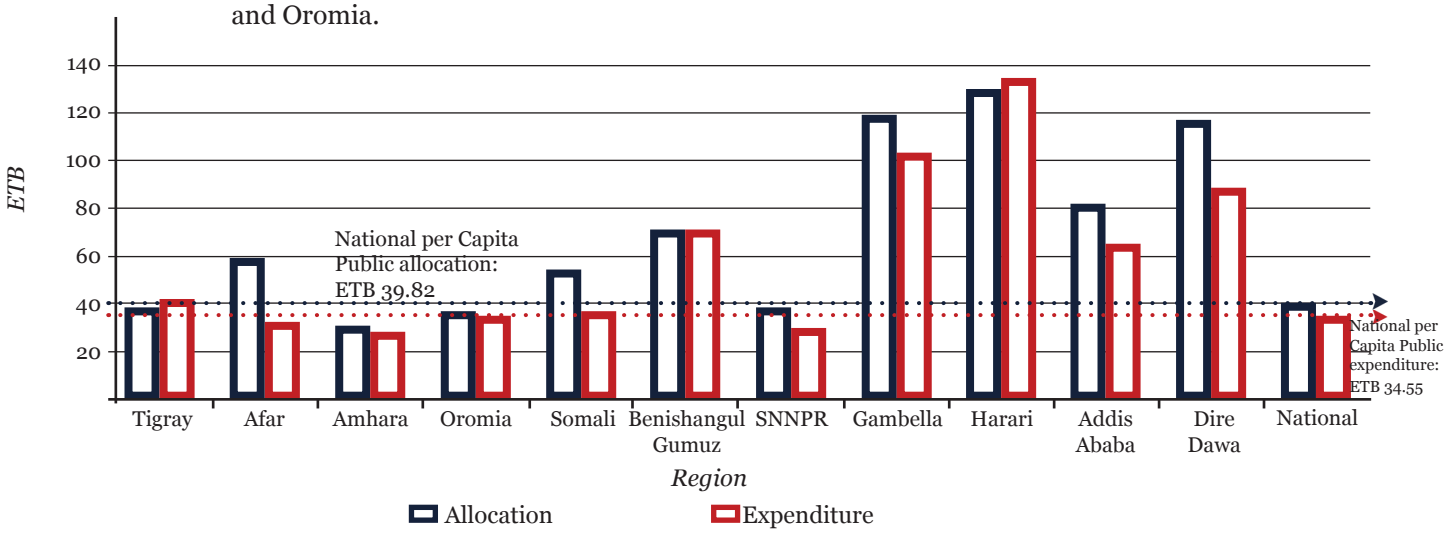

Figure 51: Comparison of Per Capita Public Allocation and Per Capita Pubic Expenditure on Health (ETB) (EFY 2002)

6.4 Development Partners' Contribution to the Health Sector

One of the sources of finance for the health sector is assistance from development partners (DPs). In EFY 2002 there has been a significant financial contribution from DPs for the achievement of the HSDP III targets. The harmonization and alignment process, reinforced by the International Health Partnership (IHP) Compact and the Joint Financing Arrangement (JFA), has supported the overall program implementation, making financial support more effective and flexible. The key principle underpinning the process of harmonization and alignment is the establishment of "One-Plan, One-Budget and One-Report" to provide predictable funding in support of results-oriented national plans and strategies. A critical step towards "One Budget" is the establishment of the MDG Pooled Fund to facilitate resource pooling in order to finance the priorities under the HSDP.

Comparison of committed and disbursed funds by Development Partners

In EFY 2002 a total of 413,194,009 USD was committed by DPs, out of which 368,476,556 USD (89%) was disbursed (Table 17) with a disbursement rate much higher than in EFY 2001 (55.4%). The gross amount of fund disbursed in EFY 2002 also increased by 62% from the previous year.

Regarding the MDG PF, USD 34.5 million (100%) of the committed amount was disbursed in EFY 2002, while it was 93% in EFY 2001. DPs contributing to the Technical Assistance Pooled Fund also disbursed 100% of their commitment for EFY 2002.

When the regular budget from the multilateral partners was analyzed, UNICEF reported that the disbursement was more than what was committed in the Country Program Action Plan (CPAP) due to additional funding mobilized during the fiscal year, whereas UNFPA disbursed only 33% of the total amount, scoring the minimum disbursement rate in the year.

Table 17: Commitment and Disbursement of Funds by Development Partners (EFY 2002)

S. No.	Source of Fund	Commitment (in USD) in 2002 EFY	Disbursement (in USD) in 2002 EFY	% Disbursement
Pooled Fund Arrangements				
1	**MDG Pooled Fund**			
	DFID	17,292,678.00	17,292,678.00	100
	WHO	634,336.00	634,336.00	100
	UNFPA	1,000,000.00	1,000,000.00	100
	Irish Aid	1,924,660.00	1,924,660.00	100
	Spanish Cooperation	13,690,062.00	13,690,062.00	100
	TOTAL	**34,541,736.00**	**34,541,736.00**	**100**
2	**Technical Assistance Pooled Fund**			
	DFID	250,417.00	250,417.00	100
	Irish Aid	450,000.00	450,000.00	100
	Italian Cooperation	750,000.00	750,000.00	100
	Royal Netherlands Embassy	300,000.00	300,000.00	100
	Total	**1,750,417.00**	**1,750,418.00**	**100**
3	PBS			
	World Bank	10,000,000.00	10,000,000.00	100
	Italian Cooperation	10,200,000.00	10,200,000.00	100
	Royal Netherlands Embassy	10,900,000.00	10,900,000.00	100
	CIDA Canada	56,600,000.00	18,000,000.00	32
	Total	**87,700,000.00**	**49,100,000.00**	**56**
Global Initiatives				
4	GAVI			
	CSO	1,900,000.00	1,900,000.00	100
	ISS	18,445,777.00	18,445,777.00	100
	Total	**20,345,777.00**	**20,345,777.00**	**100**
5	Global Fund			
	Malaria	80,494,576.00	80,494,576.00	100
	HIV	19,223,081.00	13,362,426.00	70
	TB	-	-	-
	Total	**99,717,657.00**	**93,857,002.00**	**94**
UN Partners				
6	UN Organizations			
	UNICEF	68,158,000.00	75,074,771.00	110
	UNFPA	2,236,681.00	730,980.00	33
	WHO	19,237,171.00	19,237,171.00	100
	Total	**89,631,852.00**	**95,042,922.00**	106
US Partners				
7	Clinton Health Access Initiative			
	Clinton Health Access Initiative	**9,148,501.00**	**8,767,954.00**	**96**
8	USAID			
	USAID	**39,845,064.00**	**34,557,742.00**	**87**
9	CDC			
	CDC/PEPFAR	**18,992,000.00**	**18,992,000.00**	**100**
Other Bilateral Partners				
10	Bilateral Partners			
	Spanish Cooperation	7,113,000.00	7,113,000.00	100
	Irish Aid	2,050,000.00	2,050,000.00	100
	Italian Cooperation	2,358,005.00	2,358,005.00	100
	Total	**11,521,005.00**	**11,521,005.00**	**100**
	GRAND TOTAL	**413,194,009.00**	**368,476,556.00**	**89**

Proportion of each donor's contribution as compared to the total DP disbursement

Concerning the share of DPs' contribution out of the total amount disbursed in EFY 2002, the largest stake (26%) was covered by the Global Fund, followed by UNICEF (20%) and Protection of Basic Services (PBS) (13%) (Figure 52).

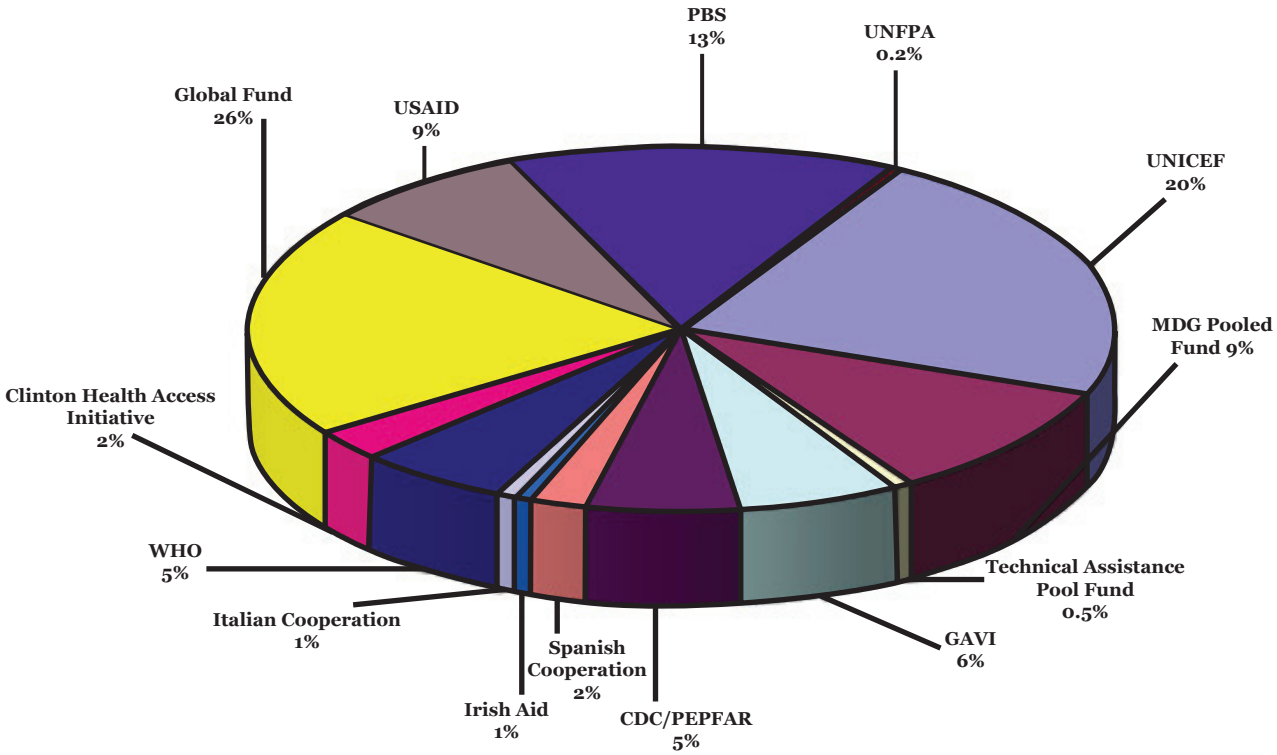

Figure 52: Percent Distribution of Disbursement by Development Partners (Out of the Total Disbursed) (EFY 2002)

PEPFAR, through USAID and CDC, contributed to 14% of the total disbursement in the year. However, it should be noted that most of the funds from PEPFAR was disbursed through Channel 3 (i.e., international and national NGOs), and this amount is not captured in this report. This Channel is the least preferred by the government as it is difficult to bring these resources to one plan and has the biggest transaction cost.

The most preferred channel of disbursement (the MDG Pooled Fund) accounted only for 9% of the total disbursed amount for the year. DFID and Spanish Cooperation accounted for 50% and 40% respectively, of the total contribution to the MDG Pooled Fund (Figure 53). As per the national IHP compact, it is expected that an increasing share of funding to the health sector should be channelled through the MDG Pooled Fund.

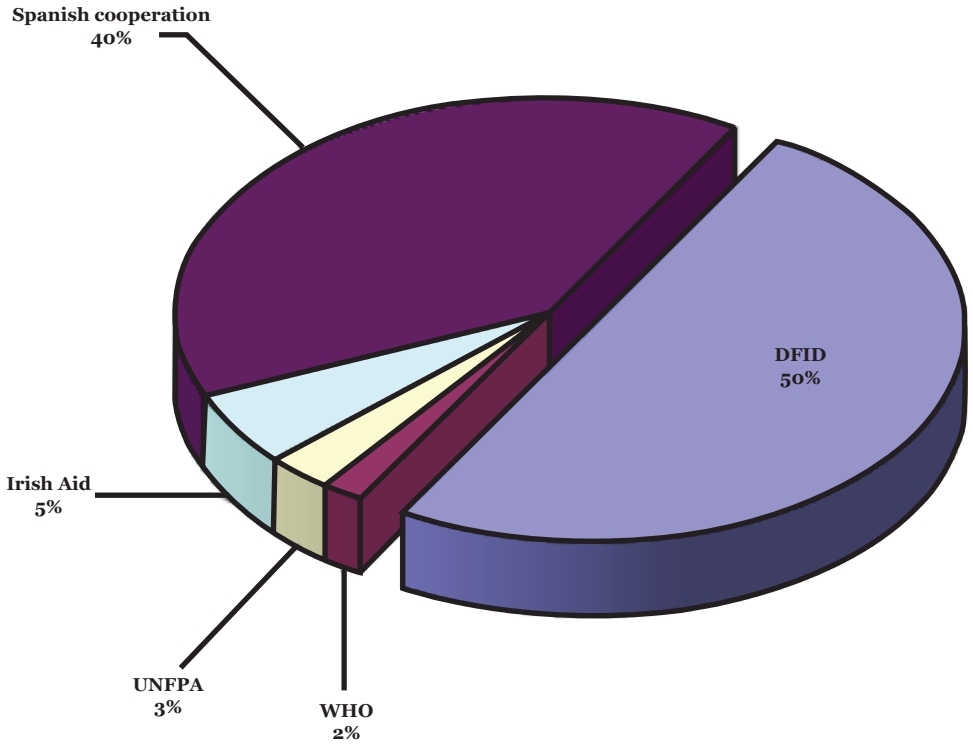

Figure 53: Percent Distribution of Disbursement for the MDG Pooled Fund (Out of the Total Disbursed) by Development Partners (EFY 2002)

Comparison of disbursement by Development Partners in EFY 2001 and in EFY 2002
Technical Assistance Pooled Fund, also referred to as Health Pooled Fund (HPF), was established mainly to support FMOH on TA recruitment, seminars, research and conferences and is administered by UNICEF. In EFY 2002 the disbursement of funds to the HPF (1,750,417 USD) was far less than in 2001 EFY (3,136,630 USD). The only DP increasing its contribution in EFY 2002 was the Italian Cooperation.

Concerning the MDG Pooled Fund, a significant increase in disbursement was witnessed in EFY 2002. Two of the seven partners disbursed funds for the first time since the establishment of the pool during the fiscal year (Figure 54). In addition, the Italian Coorporation is about to join the MDG Pool Fund.

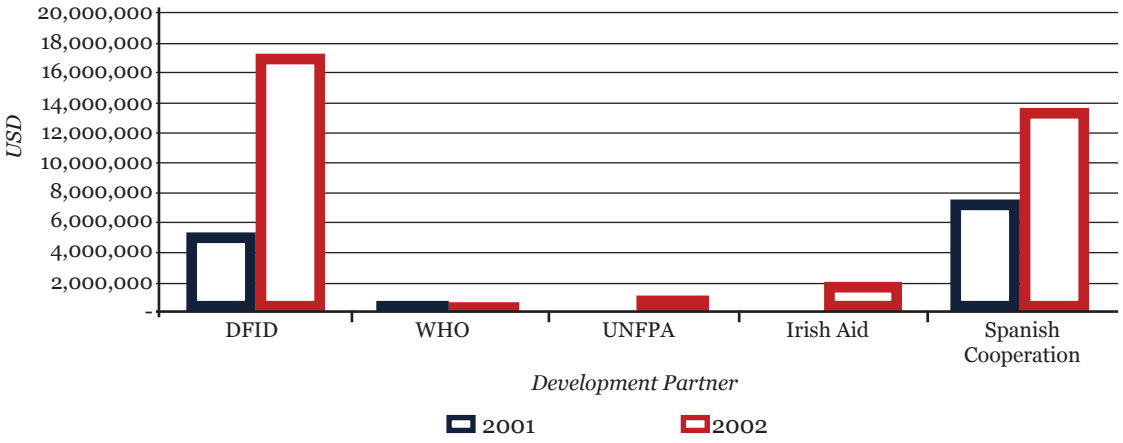

Figure 54: Comparison of Fund Disbursement for the MDG Pooled Fund by Development Partners (EFY 2001 and EFY 2002)

Implementation Status of the MDG Pooled Fund

MDG Pooled Fund is used to fill the financial gap in four eligible funding areas as per the JFA signed between GOE and seven development partners (i) Health Extension Program; (ii) Health Service Delivery; (iii) Procurement of Health Commodities; and (iv) Health System Strengthening. Accordingly a separate plan was developed for the MDG fund at the beginning of the FY. The plan was based on the annual woreda based plan and DPs its implementation was reported to JCCC quarterly.

Health Extension Programme

Health Extension Program is one of the four eligible funding areas, and, for its implementation, it should be supported by an effective community-level information system for planning and monitoring purposes as well as for supporting decision making at the HP level. For this purpose, a Family Folder was developed to record and trace every family's health information, including birth, immunization, service and disease data, as well as cause of death.

Since it is planned to have one Family Folder for each of the 16 million families in Ethiopia, and because of the high printing cost, budget was allocated from the MDG Pooled Fund to cover the financial gap of 6.5 million USD. Currently the printing is underway, and Family Folders are being delivered to regions.

Health Service Delivery

In the Health Service Delivery area, budget was allocated to fill the gap for the implementation of planned, but underfunded, Maternal and Child Health activities and

services. In particular, a total budget of 457,000 USD was allocated to improve the cold chain capacity for child immunization services (i.e., construction of cold rooms). Currently, the design of cold rooms has been started. A total of 1,926,235 USD was also allocated for training, advocacy and printing activities under maternal health programs (1,578,235 USD) and child health programs (348,000 USD). Trainings on Implanon insertion have been conducted in various regions and are still being conducted. Advocacy works especially on the new Pneumococcal and Rota vaccines have been started.

Procurement of Health Commodities

The MDG Pooled Fund contributed to fill the financial gap for procurement of important health commodities. The planned commodities to be procured in EFY 2002 were vaccines, Implanon, ITNs, commodities for maternal health, and spare parts and equipment for cold chain.

Procurement of Vaccines

It was planned to procure BCG, OPV and TT10 vaccines using the MDG Pooled Fund. The first round of procurement of these vaccines costing 2,137,243 USD was delivered, and a total of 7.3 million BCG, 6.6 million TT10 and 10 million OPV doses were used. The second round of procurement costing 2,393,208 USD is planned for EFY 2003.

Procurement of Implanon

It was planned to deliver Implanon for 3 million women in EFY 2002. Accordingly, Implanon costing 3.1 million USD was planned to be procured using the MDG Pooled Fund. Currently the procurement process has reached its final stage as the Implanon is under shipment.

Essential Drugs

A total of 6,845,097 USD was allocated from the MDG Pooled Fund to the procurement of essential drugs. Currently, the Letter of Credit has been opened and delivery is expected in 90 to 120 days.

Insecticide Treated Nets (ITNs)

After the distribution of 20 million bed nets in the previous years, it was necessary to replace them. In addition to the procurement made through the Global Fund and PBS, a total of 6,845,097 USD from the MDG Pooled Fund contributed to fill the gap. ITNs are under delivery.

Commodities for Maternal Health

A total of 2,472,500 USD was allocated from the MDG Pooled Fund for the procurement of essential commodities for maternal health services. Procurement is in its final stage and some of these items are delivered to PFSA.

Spare parts and Equipments for Cold Chain

In order to improve the cold chain capacity for the existing vaccines and for the new ones to be introduced during HSDP IV, a total of 1,354,154 USD was allocated from the MDG Pooled Fund to procure spare parts for cold rooms. Currently the procurement process is underway.

Health System Strengthening

The planned activities in the HSS were the Health Center (HC) construction, and Community Based Health Insurance (CBHI). A total of 15 million USD was allocated to fill the funding gap for HC construction. Almost 85% of the allocated amount was transferred to the regional Project Management Units (PMUs) to facilitate the construction process.

The Community Based Health Insurance (CBHI) was given a total of 630,650 USD to be used for the piloting of the CBHI. The piloting has been started in 13 woredas of four regions. But the allocated amount was not utilized as the process didn't proceed as planned.

Fund Utilization Status

The total utilization rate of the MDG Pooled Fund was 99% in EFY 2002, which was much higher than in EFY 2002 (24%). The majority of the expenditures are mainly at receivable level as most of the procurement processes are not finalized.

Challenges

- Slow progress in increasing the contribution MDG PF by DPs; and
- The principle of additional funds as per IHP compact is not being practiced.

Way forward

- FMoH need to advocate about MDG PF using all available forum and media; and
- DPs already using the MDG PF need to advocate those DPs that have not yet joined the fund.

CHAPTER VII

CONCLUSION

Conclusion

An overview of the planned activities, major achievements and key challenges encountered in the implementation of HSDP III in EFY 2002 have been presented in this report including the way forward for EFY 2003.

The general goals of HSDP III were to reduce child mortality, to improve maternal health, and to combat HIV/AIDS, malaria, TB and other diseases. In terms of progress in the implementation of priority health programs including prevention and control of infectious communicable diseases, there have been commendable achievements during the year.

One of the indicators used to monitor progress towards the achievement of MDG 4 is immunization coverage. In EFY 2002 Pentavalent coverage stands at 86.0% and measles immunization coverage at 82.4%, while the percentage of fully immunized children has reached 72.3%; surpassing the targets set in HSDP III. It should be noted that some of the unusual findings like high measles vaccination coverage with occurrence of measles epidemic within a region should be the basis for future operational research.

The HSDP III target for Postnatal care coverage has been achieved. The contraceptive acceptance rate has reached 61.9 % in EFY 2002 approaching the target of 69% by end of HSDP III. There has been an increase in the percentage of clean and safe delivery service coverage from 12.3% to 17.0%.

Steady progress has been made in addressing national health issues. However, despite the progress observed in EFY 2002, the performance measured by some indicators is still below the target, and several challenges remain to be addressed. As has been indicated in Chapter 5 of this report, the maternal mortality ratio continues to be of growing concern.

HIV/AIDS has been recognized as one of the top priorities for the last three phases of HSDP. As a result, there have been sustained prevention efforts and stable HIV prevalence, which make the achievement of MDG6 a possible outcome. In EFY 2002, there have been marked increases in the number of health facilities and sites providing HCT, PMTCT, and ART services. However, as in the previous years, progress in the provision of PMTCT services has been very slow and the coverage has been extremely low (8.3% in EFY 2002).

In Malaria Prevention and Control, a major achievement so far has been the distribution of a cumulative number of 35.2 million ITNs in EFY 2002. The major proportion of these ITNs are long lasting insecticide treated nets (LLITN) and have been distributed to communities including those living in hard to reach areas through health facilities, enhanced outreach strategy, and through special community campaigns. The main strategy has been the use of HEP for prevention and control of malaria.

Tuberculosis has remained one of the major global public health problems. In EFY 2002, the treatment success rate stood at 84%, almost reaching the target. But, the case detection rate remains 35.8%, much less than the HSDP III target. Despite the efforts made during HSDP III and the fact that community-based Directly Observed Treatment-Short Course (DOT) is among the most cost-effective interventions

in the health sector, TB detection rate in Ethiopia is still inadequate to meet the target for TB control.

EFY 2002 is the last year of HSDP III. All of the strategic issues included in HSDP III have been addressed through the Civil Service Reform Program and the BPR, which has been used as a tool for a comprehensive analysis, redesign and revamping of the health sector in Ethiopia. Several of these activities have laid the groundwork for a more responsive and quality-oriented health care system. One notable achievement has been the steady growth in the number of health workers trained and deployed during HSDP III. Overall, the available professionals at the end of HSDP III compared to the HSDP III targets shows that the target has been met for community level and most of the mid-level health professionals (MLHP). Even though the number has significantly increased compared to previous levels, there is still a major gap with regard to medical doctors, midwives and anesthetists.

At the end of HSDP III, we see that there have been challenges to implementation such as: weak implementation capacity, shortage of RDTs, inadequate use of PMTCT service even where it is available; poor integration of PMTCT with ANC services; low percentage of deliveries attended by skilled health personnel; limited number of skilled human resources and gaps in mobilization and use of financial resources.

In order to address these challenges, the way forward has been indicated in this performance report. Some of the major measures recommended for implementation in EFY 2003 and beyond include the following:

- Reduction of maternal mortality should continue to be given priority attention using cost effective interventions; especially access and utilization of Basic Emergency Obstetric Care (BEOC) and Comprehensive Emergency Obstetric Care (CEOC). Skilled attendance at delivery should be increased through accelerated training of midwives and emergency surgeons; equipping health centers with BEOC; equipping all hospitals including primary hospitals to provide CEOC; improving availability of safe blood and pharmaceutical supplies and improving the referral system.

- To improve the performance in TB prevention and control, it is necessary to scale-up the community-based Directly Observed Treatment-Short Course (DOTs) program, strengthen the capacity at grass roots level and improve the reporting system. TB case detection should be strengthened through effective use of HEP as a vehicle to detect new cases; contact tracing and treatment follow up; strengthened laboratory network; improving information systems, including notification and referral routines and correct estimation and regular updating of the TB burden. Consistent low TB case detection rate may be due to the use of the denominator estimated by the WHO. This has called for undertaking the ongoing assessment study to determine the right denominator for the estimation of the TB case detection rate.

- To address the challenges encountered in the provision of PMTCT, the program should be enhanced through application of measures such as integration with MNCH; linking with HEP; community mobilization; improving ANC and institutional delivery coverage; carrying out routine HIV testing during ANC; improving service accessibility; promoting public-private partnership; ensuring male involvement and involving PLHIV in program implementation activities.

- Harmonization and Alignment should be enhanced further through adherence to the provisions of the IHP Compact and addressing the prevailing gap in financing the priorities of HSDP.

- Further strengthening of health systems is called for to achieve the MDGs; in particular, improvements in human capital and leadership.

- Scaling up and consolidation of the HMIS is still critical to support planning, M&E, and the decision-making process at all levels.

The participants at ARM 2010 are invited to examine this report in depth; and to come up with additional recommendations and measures that will help to consolidate gains made so far, foster exchange of information and best practices among regions, improve on weaknesses and accelerate implementation to achieve the targets set for EFY 2003 in HSDP IV.

Tulane University

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