



Federal Democratic Republic of Ethiopia
Ministry of Health

EFY 2005 (2012/13)

HSDP IV
**Annual Performance
Report**

Version I



HEALTH SECTOR DEVELOPMENT PROGRAMME IV

ANNUAL PERFORMANCE REPORT

EFY 2005 (2012/13)

VERSION 1

TABLE OF CONTENT



List of Tables	IV		
List of Figures	IV		
Acronyms	VI		
Executive Summary	XI		
CHAPTER 1: Introduction	3		
CHAPTER 2: Health Service Delivery and Quality of Care	7		
2.1. Health Extension Program	7		
2.1.1. Implementation of Health Development Army	7		
2.1.2. Hygiene and Environmental Sanitation	8		
2.2. Maternal and Newborn Health Services	9		
2.2.1. Regional Distribution of Antenatal Care Coverage	10		
2.2.2. Regional Distribution in the Percentage of Deliveries Assisted by Skilled Health Personnel	11		
2.2.3. Regional Distribution of Clean and Safe Delivery Service Coverage	13		
2.2.4. Regional Distribution of Postnatal Care Coverage	14		
2.2.5. Trend in the Contraceptive Acceptance Rate	14		
2.2.6. Regional Distribution of Contraceptive Acceptance Rate	15		
2.2.7. Prevention of Mother to Child Transmission of HIV	15		
2.2.8. Abortion Care	16		
2.3. Child Health Services	17		
2.3.1. Immunization	18		
2.3.1.1. Regional Distribution of Pentavalent 3 Immunization Coverage	19		
2.3.1.2. Regional Distribution of Pneumococcal Conjugate Vaccine 3 Immunization Coverage	20		
2.3.1.3. Regional Distribution of Measles Immunization Coverage	20		
2.3.1.4. Regional Distribution of Full Immunization Coverage	21		
2.3.2. Integrated Management of Neonatal and Childhood Illnesses	21		
2.3.3. Other Activities	22		
2.4. National Nutrition Program	22		
2.4.1. Vitamin A Supplementation and De-worming	23		
2.4.1.1. Transition from Enhanced Outreach Strategy to Community Health Days and Health Extension Program	23		
2.4.2. Community Based Management of Acute Malnutrition	24		
2.4.3. Community Based Nutrition as Part of Community Maternal, Neonatal and Child Health	24		
2.4.4. Salt Iodization	25		
2.4.5. Other Activities	26		
2.5. Prevention and Control of Communicable Diseases	27		
2.5.1. HIV/AIDS Prevention and Control	27		
2.5.1.1. Trend in the Number of Facilities Providing HCT, PMTCT and ART Services	27		
2.5.1.2. HCT Service	28		
2.5.1.3. Antiretroviral Treatment	28		
2.5.1.4. Other Activities	30		
2.5.2. Malaria Prevention and Control	30		
2.5.2.1. Long-Lasting Insecticide-Treated Net Distribution	30		
2.5.2.2. Trend in Malaria Cases	31		
2.5.3. Tuberculosis and Leprosy Prevention and Control	33		
2.5.3.1. TB Prevention and Control	33		
2.5.3.1.1. TB Case Notification	33		
2.5.3.1.2. TB Case Detection Rate	33		
2.5.3.1.3. TB Treatment Outcomes	34		
2.5.3.1.3.1. TB Treatment Success Rate	34		
2.5.3.1.3.2. TB Cure Rate	35		
2.5.3.2. Other Activities	35		
2.5.4. Prevention and Control of Neglected Tropical Diseases	37		
2.5.4.1. Dracunculiasis (Guinea Worm Infection)	37		
2.5.4.2. Onchocerciasis and Lymphatic Filariasis	38		
2.5.4.3. Leishmaniasis	38		
2.5.4.4. Trachoma	38		
2.5.4.5. Schistosomiasis and Soil Transmitted Helminthiasis	39		
2.6. Prevention and Control of Non-Communicable Diseases	39		
2.7. Public Health Emergency Preparedness and Response	40		
2.7.1. Epidemic Prevention and Control	41		
2.7.1.1. Measles	41		
2.7.1.2. Poliomyelitis	42		
2.7.1.3. Dysentery	43		
2.7.1.4. Meningococcal Meningitis	44		
2.7.1.5. Anthrax	45		
2.7.1.6. Rabies	46		
2.7.1.7. Influenza	47		

TABLE OF CONTENT



2.7.1.8. Relapsing Fever	48	4.2.2. In-service Training	74
2.7.1.9. Yellow Fever	49	4.2.3. Deployment	74
2.8. Quality of Health Services	49	4.3. Pharmaceutical Supply and Services	75
2.8.1. Quality Improvement	49	4.3.1. Procurement	75
2.8.2. Health Facility Reform	50	4.3.2. Storage and Distribution	76
2.8.3. Blood Safety	50	4.3.3. Infrastructure	76
2.8.4. Utilization of Health Services	51	4.3.4. Rational Drug Use	77
2.9. National Laboratory System	52	4.4. Health Information Technology	77
CHAPTER 3: Leadership and Governance	55	4.4.1. Electronic Health Management Information System	78
3.1. Evidence-Based Decision Making by Enhanced Harmonization and Alignment	55	4.4.2. Electronic Medical Record/Electronic Record Unit	78
3.1.1. Planning	55	4.4.3. Tele Education and Tele Medicine	78
3.1.2. Routine Data Collection and Aggregation	56	4.4.4. Mobile Health	78
3.1.3. Performance Monitoring and Coordination	58	4.4.5. Human Resource Information System	79
3.1.4. Evaluation	58	4.4.6. Geographic Information System for Health	79
3.2. Operational Research	59	4.5. Resource Mobilization and Utilization	79
3.3. Regulatory System	60	4.5.1. Health Care Financing	80
3.3.1. Inspection and Quality Assurance of "Products"	61	4.5.1.1. Revenue Retention For Quality Improvement	80
3.3.2. Inspection and Quality Control of "Premises"	61	4.5.1.2. Fee Waiver System for Enhanced Equity of Access to Health Services	80
3.3.3. Inspection of "Professional Practice"	61	4.5.1.3. Strengthen Health Facility Governance and Management	80
3.3.4. Inspection of "Food Products"	62	4.5.1.4. Private Wing and Outsourcing	80
3.4. Gender Mainstreaming	62	4.5.2. Health Insurance	81
CHAPTER 4: Health Infrastructure and Resources	65	4.5.2.1. Community-Based Health Insurance	81
4.1. Health Infrastructure Development, Rehabilitation and Maintenance	65	4.5.2.2. Social Health Insurance	82
4.1.1. Construction of Health Posts	65	4.5.3. Financial/Expenditure Management and Control	83
4.1.2. Expansion of Health Centers	66	4.5.3.1. Grant Management	83
4.1.3. Equipping of Health Posts and Health Centers	67	4.5.3.2. Integrated Financial Management Information System	83
4.1.4. Construction, Rehabilitation and Expansion of Hospitals	67	4.5.4. Public Budget Allocation	84
4.1.4.1. Federal Hospitals	67	4.5.4.1. Percentage Share of the Public Health Budget Allocation From the Total Budget	84
4.1.4.2. Regional Hospitals	68	4.5.5. Development Partners' Contribution to the Health Sector	84
4.1.5. Medical Equipment Management	69	4.5.5.1. Proportion of Each Donor's Contribution as Compared to the Total DP Disbursement	85
4.2. Human Capital and Leadership	69	4.5.5.2. MDG Performance Fund	87
4.2.1. Training	70	4.5.5.2.1. Implementation Progress of MDG Performance Fund	88
4.2.1.1. Medical Doctors	70	4.5.5.2.2. Implementation Status of the MDG Performance Fund	88
4.2.1.2. Integrated Emergency Surgery and Obstetrics Training	70	CHAPTER 5: Conclusion	91
4.2.1.3. Accelerated Midwifery Training	71		
4.2.1.4. Level "v" Anaesthesia Training	72		
4.2.1.5. Health Extension Workers	73		
4.2.1.6. Ambulance Service and Emergency Care/Paramedics Training	73		
4.2.1.7. Health Information Technicians	73		

LIST OF TABLES

Table 1: Maternal Health Indicators (EFY 2005 Baseline, Performance and Target and HSDP IV Target)	10
Table 2: Immunization Coverage Indicators (EFY 2005 Baseline, Performance and Target and HSDP IV Target)	19
Table 3: Distribution of Health Centers Providing IMNCI by Region (EFY 2005).....	22
Table 4: Distribution of Laboratory Confirmed plus Clinical Malaria Cases by Region (EFY 2005)	32
Table 5: Distribution of Suspected Measles Cases and Deaths by Region (EFY 2005).....	41
Table 6: Distribution of Suspected Dysentery Cases and Deaths by Region (EFY 2005)	44
Table 7: Distribution of Suspected Meningococcal Meningitis Cases and Deaths by Region (EFY 2005).....	45
Table 8: Distribution of Suspected Anthrax Cases and Deaths by Region (EFY 2005).....	46
Table 9: Distribution of Suspected Rabies Cases/Exposures and Deaths by Region (EFY 2005)	47
Table 10: Distribution of Suspected Relapsing Fever Cases and Deaths by Region (EFY 2005)	48
Table 11: Progress in the Scale-up of HMIS at Health Facilities by Region (EFY 2005)	56
Table 12: Cumulative Number of Staff Trained on CHIS by Region (EFY 2005)	57
Table 13: Progress in the Scale-up of CHIS by Region (EFY 2005)	57
Table 14: Cumulative Number of Available Health Posts by Region (EFY 2005).....	65
Table 15: Hospital Construction/Upgrading Status by Region (EFY 2005)	68
Table 16: Number of Medical Students by Year of Study and University (EFY 2005)	70
Table 17: Number of IESO Trainees and Number of Graduates (EFY 2005)	71
Table 18: Number of Trainees in Accelerated Midwifery Training Program (2nd and 3rd Round).....	71
Table 19: Number of Level V Anaesthesia Trainees (EFY 2005)	72
Table 20: Number of Anaesthesia Trainees in BSC Program by University and Year of Study (EFY 2005)	72
Table 21: Regional Distribution of HEWs Recruited for the Upgrading Program (EFY 2005).....	73
Table 22: Ambulance Service and Emergency Care/Paramedics Enrolment (EFY 2005).....	73
Table 23: Training Program of Health Information Technicians by Region (EFY 2005)	74
Table 24: Number of Health Personnel Deployed by Occupation (EFY 2005).....	75
Table 25: Commitment and Disbursement of Funds by Development Partners (EFY 2005)	85
Table 26: Areas of Support Funded by the MDG Performance Fund (EFY 2005).....	88

LIST OF FIGURES

Figure 1: Trend in Antenatal Care Coverage, Percentage of Deliveries Attended by Skilled Health Personnel and Postnatal Care Coverage (EFY 1998-2005)	10
Figure 2: Comparison of Baseline, Performance and Target of Antenatal Care Coverage by Region (EFY 2005).....	11
Figure 3: Comparison of Baseline, Performance and Target of Percentage of Deliveries Assisted by Skilled Health Personnel by Region (EFY 2005)	11
Figure 4: Comparison of Baseline, Performance and Target of Clean and Safe Delivery Service Coverage (EFY 2005)	13
Figure 5: Comparison of Baseline, Performance and Target of Postnatal Care Coverage by Region (EFY 2005)	14
Figure 6: Trend in Contraceptive Acceptance Rate (EFY 1998-2005).....	14
Figure 7: Comparison of Baseline, Performance and Target of Contraceptive Acceptance Rate by Region (EFY 2005)	15
Figure 8: Comparison of the Percentage of HIV-Positive Pregnant Women Who Received ARV Therapy or Prophylaxis to Prevent Maternal to Child Transmission (MTCT) by Region (EFY 2005)	16
Figure 9: Comparison of Trend in Under-5 Mortality Rate (per 1000 Live Births) in Ethiopia (in Green) and in Sub-Saharan Africa (in Red): Actual Trends During the Period 1990-2010 (in Bold Lines) and Trends Necessary for Achieving MDG 4 by 2015 (in Dotted Lines).....	17
Figure 10: Decline in Under 5 Mortality Rate in High-Mortality Countries from 1990 to 2012	18

Figure 11: Trends in DPT/Pentavalent 3 Immunization Coverage, Measles Immunization Coverage and Full Immunization Coverage (EFY 1998-2005)	19
Figure 12: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2005)	20
Figure 13: Comparison of Baseline, Performance and Target of PCV3 Immunization Coverage by Region (EFY 2005)	20
Figure 14: Comparison of Baseline, Performance and Target of Measles Immunization Coverage by Region (EFY 2005)	21
Figure 15: Comparison of Baseline, Performance and Target of Full Immunization Coverage by Region (EFY 2005)	21
Figure 16: Comparison of Baseline, Performance and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region (EFY 2005)	23
Figure 17: Comparison of Baseline, Performance and Target of Coverage of 2-5 Years Children De-wormed by Region (EFY 2005)	23
Figure 18: Number of Admissions and Number of CMAM Sites in Ethiopia (January 2003 to March 2013).....	24
Figure 19: Trend in Percentage of Underweight Children Under Two Years of Age in CBN Woredas (Aug 2008 - Feb 2013)	25
Figure 20: Trend in the Number of Facilities Providing HCT, PMTCT, and ART Services (EFY 1998-2005).....	27
Figure 21: Trend in the Number of Clients Using HCT (EFY 1998 - 2005)	28
Figure 22: Comparison of Baseline, Performance and Target of the Number of Clients Using HCT by Region (EFY 2005)	28
Figure 23: Trend in the Number of People Living with HIV/AIDS who Accessed Chronic HIV Care (EFY 1998 - 2005)	29
Figure 24: Distribution of PLWHA who Accessed HIV Chronic Care by Region (EFY 2005)	29
Figure 25: Comparison of Baseline, Performance and Target of the Number of PLWHA Currently on ART by Region (EFY 2005)	29
Figure 26: Trend in the Cumulative Number of Insecticide Treated Nets Distributed (EFY 1998 – 2005).....	31
Figure 27: Trend in Laboratory Confirmed Plus Clinical Malaria Cases by Month (EFY 2005)	31
Figure 28: Trend in Laboratory Confirmed Malaria Cases, Plasmodium falciparum Malaria Cases, and Plasmodium vivax Malaria Cases by Month (EFY 2005).....	32
Figure 29: Comparison of Baseline and Performance of TB Case Notification Rate by Region (EFY 2005).....	33
Figure 30: Comparison of Baseline, Performance and Target of TB Case Detection Rate by Region (EFY 2005)	34
Figure 31: Trend in TB Treatment Success Rate and TB Cure Rate (EFY 1998 - 2005).....	34
Figure 32: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2005).....	35
Figure 33: Comparison of Baseline, Performance and Target of the TB Cure Rate by Region (EFY 2005)	35
Figure 34: Trend in Guinea Worm Cases by Month (EFY 2001 to 2005).....	37
Figure 35: Trend in Suspected Measles Cases by Month (EFY 2004 and 2005)	42
Figure 36: Incidence of Measles IgM-positive Cases Per 100,000 Population by Age Group (EFY 2004 and 2005)	42
Figure 37: Comparison of Non-Polio Acute Flaccid Paralysis Rate Per 100,000 Children Under 15 Years by Region (EFY 2005).....	43
Figure 38: Comparison of AFP Stool Sample Adequacy Rate by Region (EFY 2005)	43
Figure 39: Trend in Suspected Dysentery Cases by Month (EFY 2004 and 2005).....	44
Figure 40: Trend in Suspected Meningococcal Meningitis Cases by Month (EFY 2004 and 2005).....	45
Figure 41: Trend in Suspected Anthrax Cases by Month (EFY 2004 and 2005)	46
Figure 42: Trend in Suspected Rabies Cases by Month (EFY 2004 and 2005)	47
Figure 43: Trend in Influenza Cases by Month (EFY 2005)	48
Figure 44: Trend in Suspected Relapsing Fever Cases by Month (EFY 2004 and 2005).....	48
Figure 45: Epidemic Curve of Yellow Fever Outbreak in South Omo Zone of SNNPR (EFY 2005).....	49
Figure 46: Trend in Blood Donation and Supply (EFY 1996 – 2005).....	50
Figure 47: Trend in OPD Attendance Per Capita (EFY 1998-2005).....	51
Figure 48: Comparison of Baseline and Performance of OPD Attendance Per Capita by Region (EFY 2005).....	51
Figure 49: Trend in the Cumulative Number of Available Health Posts (EFY 1998 - 2005)	65
Figure 50: Trend in the Cumulative Number of Available Health Centers (EFY 1999-2005).....	66
Figure 51: Comparison of Baseline, Performance and Target of the Cumulative Number of Available Health Centers by Region (EFY 2005)	66
Figure 52: Distribution of the Percentage of Total Budget Allocated to the Health Sector by Region (EFY 2004 and 2005).....	84
Figure 53: Distribution of Amount Committed and Disbursed by Development Partner (EFY 2005)	86
Figure 54: Percentage Distribution of Disbursement by Development Partner (Out of Total Disbursed) (EFY 2005)	86
Figure 55: MDG Performance Fund Disbursement (EFY 2001-2005)	87

ACRONYMS

AECID	Agencia Española de Cooperación Internacional para el Desarrollo (Spanish Aid Agency)
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
APR	Annual Performance Report
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	Australian Aid
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guérin
BEmONC	Basic Emergency Obstetric and Neonatal Care
BSC	Balanced Score Card
CAR	Contraceptive Acceptance Rate
CBHI	Community Based Health Insurance
CBN	Community Based Nutrition
CCO	Call Center Operator
CDC	Centre for Disease Control
CDR	Case Detection Rate
CDTI	Community Directed Treatment Intervention
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CFR	Case Fatality Rate
CHD	Community Health Day
CHIS	Community-based Health Information System
CIFF	Children's Investment Fund Foundation
CL	Cutaneous Leishmaniasis
CLTS	Community Led Total Sanitation
CMAM	Community-based Management of Acute Malnutrition
COC	Certification of Competence
CPD	Continuing Professional Development
CSA	Central Statistical Agency
DFID	Department for International Development
DNA	Deoxyribonucleic acid
DP	Development Partner
DPT-HebB-Hib	Diphtheria-Tetanus-Pertussis-Hepatitis B-Haemophilus Influenza type b
DTC	Drug and Therapeutics Committee
EDHS	Ethiopia Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHAQ	Ethiopian Hospitals Alliance for Quality
eHMIS	Electronic Health Management Information System

EHNRI	Ethiopian Health and Nutrition Research Institute
EHRIG	Ethiopian Hospital Reform Implementation Guideline
eIDSR	Electronic Integrated Disease Surveillance and Response
eMCS	Electronic Mobile Care Solution
EmONC	Emergency Obstetric and Neonatal Care
EMR	Electronic Medical Record
EOS	Enhanced Outreach Strategy
EPI	Expanded Program on Immunization
EQA	External Quality Assessment
ETB	Ethiopian Birr
FF	Family Folder
FMHACA	Food, Medicine and Healthcare Administration and Control Authority
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GC	Gregorian Calendar
GDP	Gross Domestic Product
GIS	Geographic Information System
GMP	Growth Monitoring and Promotion
GTMP	Global Trachoma Mapping Project
GTP	Growth and Transformation Plan
GW	Guinea Worm
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HCF	Health Care Financing
HCT	HIV Counselling and Testing
HDA	Health Development Army
HEP	Health Extension Program
HepB	Hepatitis B
HEW	Health Extension Worker
HF	Health Facility
HiB	Haemophilus Influenza type B
HIT	Health Information Technician
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health Officer
HP	Health Post
HPDP	Health Promotion and Disease Prevention
HPN	Health, Population and Nutrition
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSC	Health Science College
HSDP	Health Sector Development Program
HSS	Health Systems Strengthening
IC	Italian Cooperation

iCCM	Integrated Community Case Management
ICT	Information and Communication Technology
IEC	Information, Education, Communication
IESO	Integrated Emergency Surgery Officer
IFMIS	Integrated Financial Management Information System
IGAD	Intergovernmental Authority on Development
IHP	International Health Partnership
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IRS	Insecticide Residual Spraying
IT	Information Technology
ITN	Insecticide Treated Net
IUCD	Intra-Uterine Contraceptive Device
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financial Arrangement
JSC	Joint Steering Committee
LF	Lymphatic Filariasis
LIS	Laboratory Information System
LLIN	Long-Lasting Insecticide-treated Net
MAPPP-E	Medical Association of Physicians in Private Practice-Ethiopia
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health
MDA	Mass Drug Administration
MDG	Millennium Development Goal
MDG PF	MDG Performance Fund
MDR-TB	Multi-Drug Resistant TB
M&E	Monitoring and Evaluation
mHealth	Mobile Health
mhGAP	mental health Gap Action Programme
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MOFED	Ministry of Finance and Economic Development
MRI	Magnetic Resonance Imaging
MRU	Medical Record Unit
MT	Metric Tons
MTCT	Maternal to Child Transmission
MTR	Mid-term Review
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NICU	Neonatal Intensive Care Unit
NMEI	New Medical Education Initiative
NMR	Neonatal Mortality Rate
NNP	National Nutrition Program
NTCP	National Tuberculosis Control Program
NTD	Neglected Tropical Disease
OPD	Outpatient Department
OR	Operations Research

PCR	Polymerase Chain Reaction
PCV	Pneumococcal Conjugate Vaccine
PF	Plasmodium Falciparum
PFSA	Pharmaceutical Fund and Supply Agency
PHARMID	Pharmaceuticals and Medical Supplies Import and Distribution
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Maternal to Child Transmission of HIV
PNC	Postnatal Care
PPD	Policy and Planning Directorate
PV	Plasmodium Vivax
QA	Quality Assurance
QC	Quality Control
RDT	Rapid Diagnostic Test
REMO	Rapid Epidemiological Mapping for Onchocerciasis
RH	Reproductive Health
RHB	Regional Health Bureau
RUTF	Ready-to-Use Therapeutic Food
SHI	Social Health Insurance
SNNPR	Southern Nations, Nationalities and Peoples Region
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TLPC	Tuberculosis and Leprosy Prevention and Control
TOT	Training of Trainers
TSR	Treatment Success Rate
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
USMR	Under-5 Mortality Rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPS	Uninterruptible Power Supply
USD	United States Dollar
USI	Universal Salt Iodization
VAS	Vitamin A Supplementation
VL	Visceral Leishmaniasis
WDG	Women Development Group
WHO	World Health Organization
WMS	Welfare Monitoring Survey
WoFED	Woreda Finance and Economic Development
WorHO	Woreda Health Office



EXECUTIVE SUMMARY



15th ARM

The last lap towards MDGs: Promise renewed to end preventable maternal and child death in Ethiopia.

EXECUTIVE SUMMARY

This Annual Performance Report for the third year of the Fourth Health Sector Development Program (HSDP) (2010/11-2014/15) gives an overview of the performance of the health sector in addressing ten strategic objectives and how the various activities during the year have contributed to the improvement of the health status of the Ethiopian people. It examines the progress made, the efforts that are underway and the challenges faced by the sector in the promotion of health, and in the implementation, financing and governance of health services.

As in previous years, the development process of the Annual Performance Report for EFY 2005 was widely consultative, involving Regional Health Bureaus (RHB), the various Directorates of the Federal Ministry of Health (FMOH), and agencies accountable to the FMOH as well as Development Partners (DP).

The report highlights the major achievements and challenges of the health sector in EFY 2005, under the three Strategic Themes: (i) Health Service Delivery and Quality of Care; (ii) Leadership and Governance; and (iii) Health Infrastructure and Resources.

HEALTH SERVICE DELIVERY AND QUALITY OF CARE

This Strategic Theme comprises of the Health Extension Program (HEP), maternal and newborn health services, child health services, national nutrition program, prevention and control of communicable and non-communicable diseases, public health emergency preparedness and response, and quality of health services. The performance of the sector during EFY 2005 was as follows:

1. Health Development Army (HDA) implementation has been initiated since EFY 2003, and there has been progress on the organization and network formation in the past two years. In EFY 2005, capacity building was carried out at the community level based on the healthy behaviour bottleneck analysis. In Tigray Region, 27,320 Women Development Groups (WDG) were established, with more than 125,000 one-to-five network formations. Similarly in Southern Nations, Nationalities and Peoples Region (SNNPR), a total of 76,557 HDA groups with 485,771 one-to-five networks were formed in EFY 2005. Besides, Amhara Region also established networks at different levels and, so far, a total of 109,725 HDA groups and 539,693 one-to-five networks have been formed. In Oromia Region a total of 147,428 HDA groups and 732,259 one-to-five networks have been established in the same year.
2. One major component of the health extension packages is the hygiene and environmental sanitation program. With respect to implementation of this program, the plan in EFY 2005 was to increase the latrine coverage from 84% to 92%. However, the cumulative number of households with latrine was 15,645,216

(out of the total 18,274,255) at the end of EFY 2005, with a coverage of 86%, short of the 92% target set for the year. There is large variation across regions between 9% in Afar and 94% in SNNPR.

3. Concerning maternal health services, antenatal care (ANC) coverage (at least one visit) increased from 89.1% in EFY 2004 to 97.4% in EFY 2005, postnatal care (PNC) coverage increased from 44.5% to 50.5%, while the percentage of deliveries attended by skilled health personnel increased from 20.4% in EFY 2004 to 23.1% in EFY 2005. Conversely, clean and safe delivery coverage by health extension workers (HEW) declined from 13.2% in EFY 2004 to 11.6% in EFY 2005, much less than the planned coverage for the year. Contraceptive acceptance rate (CAR) slightly declined from 60.4% in EFY 2004 to 59.5 % in EFY 2005. The proportion of pregnant women counselled and tested for prevention of maternal to child transmission (PMTCT) of HIV increased from 36.7% to 54.9%. Only ANC coverage (97.4%) surpassed the target (90.6%).
4. The percentage of HIV-positive pregnant women who received efficacious ARV therapy or prophylaxis to prevent Maternal to Child Transmission (MTCT) of HIV has been estimated at 42.9% in EFY 2005, ranging between 3.4% in Somali and 126.1% in Harari. According to the 2013 UNAIDS Report, Ethiopia is one of the few “rapid decline” sub-Saharan African countries, with a reduction by 50% of new HIV infections among children between 2009 and 2012.
5. According to the “Levels and trends in child mortality – Report 2013” published by the UN Inter-Agency Group for Child Mortality Estimation, Ethiopia is one of the seven high-mortality countries (together with Bangladesh, Malawi, Nepal, Liberia, Tanzania and Timor) with the greatest declines (by two thirds or more) in lowering child mortality between 1990 and 2012.
6. In EFY 2005 pentavalent 3 immunization coverage was 87.6%, pneumococcal conjugate vaccine (PCV) 3 immunization coverage 80.4%, measles immunization coverage 83.2%, and the percentage of fully immunized children 77.7%. There was an increase in Pentavalent 3, PCV3, measles, and full immunization coverage in EFY 2005 when compared with the EFY 2004 coverage. However, at national level, none of the immunization coverage targets set for EFY 2005 has been met. The cumulative number of Health Centers (HC) providing Integrated Management of Neonatal and Childhood Illnesses (IMNCI) increased from 2,030 in EFY 2004 to 2,373 in EFY 2005.
7. The national VAS coverage among 6-59 months children in EFY 2005 was 93.1%, below the target set for the year (99.0%), with a range between 39.0% in Addis Ababa to more than 100% in Afar and Somali Regions.
8. In EFY 2005, the de-worming coverage of 2-5 years children (91.4%) was much higher than in EFY 2004 (19.8%), but below the annual target (95.0%). The coverage ranged between 20.1% in Addis Ababa to more than 100% in Tigray, Afar, Somali and Gambella Regions. The Community Based Nutrition Program is currently implemented in 365 woredas.
9. HIV/AIDS is one of the top priorities of HSDP IV. There was a steep increase in the number of facilities providing HIV Counselling and Testing (HCT), PMTCT and Antiretroviral Therapy (ART) services: the increase was from 2,881 in EFY 2004 to 3,040 in EFY 2005 for HCT, from 1,901 to 2,150 for PMTCT, and from 838 to 880 for ART in the same period. The number of HCT services increased from 11,294,426 in EFY 2004 to 11,965,533 in EFY 2005, above the target (10,902,756) set for the year at the national level.
10. A linear increase has been observed in the number of People Living With HIV/AIDS (PLWHA) ever enrolled, ever started and currently on ART over the past years; in particular, there was an increase between EFY 2004 and EFY 2005 from 666,147 to 744,339 for PLWHA ever enrolled in HIV/AIDS care (+78,192), from 379,190 to 439,301 for those ever started (+60,111), and from 274,708 to 308,860 for those currently on ART (+34,152).
11. In EFY 2005, a total of 12,562,286 Long-Lasting Insecticide-treated Nets (LLIN) were planned to be distributed to households in malaria endemic areas; however, only 1.2 million LLINs were distributed which increase the cumulative number of LLINs distributed so far to 46,976,866. With regards to vector control, the plan was to implement Indoor Residual Spray (IRS) in 6,000,000 households in the fiscal year.

However, in EFY 2005 a total of 5,032,693 households in malaria endemic areas were sprayed, which was higher than in EFY 2004 (4,383,819), but below the plan (6,000,000 households). In EFY 2005, the total number of laboratory confirmed plus clinical malaria cases were 3,862,735 (with an increase from 3,384,589 cases reported in EFY 2004). A total of 291 deaths were recorded in EFY 2005, with a Case Fatality Rate (CFR) of 0.01%.

12. In EFY 2005, the TB case detection rate was 58.9%, below the detection rate estimated in 2011 TB prevalence survey (72%) as well as below the target set for the year (82.7%). Variations were observed across regions, ranging from 33.7% in Somali Region to over 100% in Afar, Harari and Dire Dawa. TB treatment success rate showed an increase from 90.6% in EFY 2004 to 91.4% in EFY 2005 (below the target of 95% set for the year), and TB cure rate increased from 68.2% in EFY 2004 to 70.3% in EFY 2005 (below the target of 79% set for EFY 2005).
13. The multi-year National Master Plan for Control, Elimination or Eradication of Eight Neglected Tropical Diseases has been launched in June 2013. Mapping exercises as well as health education and advocacy activities have been carried out in EFY 2005.
14. Non-Communicable Diseases (NCD) are becoming an increasingly important public health problem as epidemiological transition is progressing in Ethiopia. Several activities were carried out in EFY 2005, with a major focus on mental health. A draft Implementation Program for the 5-year Strategic Framework for the Prevention and Control of Major Non-Communicable Diseases has been prepared.
15. For the epidemic prone diseases under surveillance, the number of cases reported in EFY 2005 was as follows: 11,721 suspected measles cases (CFR=0.4%); 263,457 suspected dysentery cases (CFR=0.01%); 2,289 suspected meningococcal meningitis cases (CFR= 2.5%); 1,233 suspected anthrax cases (CFR=1.2%); 2,065 suspected rabies cases and exposures (CFR=3.1%); and 8,571 suspected relapsing fever cases (CFR=1.2%). An outbreak of yellow fever, with a total of 139 suspected cases, was reported from South Omo Zone of SNNPR and was well controlled. In addition, among the 282 influenza samples from Addis Ababa, 93 (33.0%) were positive for Influenza B, and the remaining 189 (67.0%) for Influenza A. In EFY 2005, there was zero report of cases of Viral Haemorrhagic Fever. Furthermore, no polio cases were reported in EFY 2005, with non-polio Acute Flaccid Paralysis rate being estimated at 2.6 per 100,000 children under 15 years, above the WHO standard.
16. In relation to quality of health services, all hospitals are implementing the new Hospital Reform Implementation Guideline. To speed up the implementation of hospital reform measures and disseminate best practices, “change packages” have been prepared and distributed to hospitals. A Guideline on Establishment of Health Development Army for Hospitals has been prepared to assist in the setting up and monitoring of the implementation of hospital reforms. In EFY 2005, a total of 28,932,439 Outpatient Department (OPD) visits were provided, with an average of 0.34 OPD visit per person per year, and this performance was higher than the achievement in EFY 2004 (0.29 OPD visit per person per year).

LEADERSHIP AND GOVERNANCE

The Leadership and Governance chapter comprises of evidence-based planning, monitoring, evaluation, policy formulation and implementation. It also includes the development and implementation of a regulatory framework. Different activities had been performed in EFY 2005.

17. The status of implementation during the third year of HSDP IV was monitored by the FMOH and regions using various monitoring and reporting mechanisms.
18. One of the major planning activities performed during EFY 2005 was the finalization of the Woreda-based Core Plan for EFY 2005.
19. In EFY 2005 the newly re-designed Health Management Information System (HMIS) was implemented in 98% of the hospitals and in 87% of the health centers (HC). The implementation rate has, therefore,

improved in EFY 2005 compared to 93% for hospitals and 80% for HCs in EFY 2004.

20. Community Health Information System (CHIS) is being implemented, and 6,136,240 family folders for Health Posts (HP) have been distributed to all regions in EFY 2005. The implementation of CHIS reached 40% nation-wide, ranging from 0% in two regions (Afar and Gambella) to 100% in SNNPR and Dire Dawa. To scale-up CHIS in mobile pastoralist communities, an Operational Guideline has been developed.
21. In EFY 2005 a Mid-term Review (MTR) of HSDP IV was carried out in the period 21 April-18 May 2013 by an independent review team comprising of 14 core team members (6 international and 8 national consultants) and 28 external team members.
22. In EFY 2005, operational researches were performed by the Ethiopian Health and Nutrition Research Institute (EHNRI) in relation to HIV/AIDS, TB, malaria, other communicable diseases, nutrition and traditional medicine. This research included studies such as: a survey on the efficacy of Insecticide Treated Nets (ITN); the National Immunization Coverage Survey; a study on rotavirus; a national survey on influenza and other viruses affecting the respiratory system; the National Rabies Prevalence Survey; and a study to improve the acceptability of iron supplementation by pregnant women.
23. The regulatory system has been strengthened, and a number of activities related to Inspection and Quality Control of “Products”, “Premises”, “Professional Practice” and “Food Products” had been accomplished. In EFY 2005, 897 new and 275 existing health professionals were registered and licensed at federal level. The Guideline on Continuing Professional Development (CPD) has been completed, whereas the Guideline on Scope of Practice of Health Workers has been drafted. Import permits were given for pharmaceuticals, laboratory chemicals and reagents, medical equipment and instruments, and cosmetics, while export permits were given for drugs and cosmetics. Inspection and surveillance were carried out on a number of facilities, which included health facilities, water supply facilities, as well as food, pharmaceuticals, tobacco products and cosmetics import and distribution enterprises.
24. With respect to gender mainstreaming, the Gender Directorate of FMOH has drafted three major documents (i.e. the National Gender Mainstreaming Guideline, the National Gender Training Manual for the Health Sector and the Strategic Plan for the Gender Directorate). In collaboration with concerned stakeholders, it provided also training on gender-related concepts, harmful traditional practices, climate change and women’s health for a total of 1,379 (402 female and 977 male) participants, and rendered consistent follow-up and support to agencies, hospitals and RHBs with regards to the implementation of their yearly gender plans.

HEALTH INFRASTRUCTURE AND RESOURCES

25. In EFY 2005, a total of 380 new Health Posts (HP) were constructed, making a cumulative number of 16,048 HPs. During the year, a total of 209 HPs were equipped with medical kits.
26. In order to achieve universal health coverage, the target was to build a cumulative total of 3,525 HCs at the end of EFY 2005. The number of newly constructed and completed HCs in EFY 2005 was 246, increasing the cumulative total of available HCs from 2,999 in EFY 2004 to 3,245 in EFY 2005. A total of 522 newly constructed HCs were equipped with necessary materials.
27. In EFY 2005, a total of 4 new hospitals were completed in three regions, whereas on-going construction of 175 hospitals was reported by six regions. Six hospitals have been upgraded in four regions and the total number of hospitals available in EFY 2005 has reached 127 at the national level.
28. With regard to Human Resource Development, by increasing the intake capacity of 11 existing universities, and 13 new universities and hospital medical colleges under the New Medical Education Initiative (NMEI), a total of 11,291 medical students were being trained in 24 medical schools in EFY 2005.

29. With respect to the three year Integrated Emergency Surgery Officer (IESO) training program, by increasing the number of training facilities from 8 to 11 and by enrolling 240 health workers in existing and new training institutions, in EFY 2005 the plan to increase the number of graduates has been implemented, with a total of 400 IESO students being currently under training
30. During the first round of the three year program, a total of 1,558 midwifery students have graduated, while 1,632 have graduated during the second round. A total of 1,190 midwifery students are under training in 10 health science colleges (HSC) during the third round.
31. In EFY 2005, the FMOH has trained and deployed 96 Level V nurse anaesthetists and 50 degree graduates. A total of 115 nurse anaesthetists are currently under training in seven HSCs, while 471 trainees are attending BSC program in six Universities.
32. With respect to the upgrading program to Level IV for HEWs, 1,367 Level III HEWs were enrolled for the regular program in EFY 2004 and, out of these, 1,289 completed their training and then qualified for Level IV in EFY 2005; whereas a total of 2,240 second batch HEWs were enrolled in EFY 2005 for upgrading to Level IV.
33. A total of 160 paramedics graduated in Oromia and Amhara Regions and are ready for qualification examination, while 226 are enrolled in EFY 2005 at five training centers located in Amhara, Oromia and Harari Regions. At national level, a total of 1,259 health information technicians are attending the three year training program in EFY 2005. Other major activities in HRD performed in EFY 2005 include: the finalization of the National In-service Training Standardization and Institutionalization Guideline and Implementation Manual; the deployment of 2,056 health professionals (357 general practitioners, 50 anaesthetists, 93 IESOs, and other health professionals); the revision of Career Structure and Implementation Guideline, and the finalization and approval of the Continuing Professional Development Guideline.
34. Out of the planned procurement of pharmaceuticals and medical equipment worth ETB 6.00 billion, the Pharmaceutical Fund and Supply Agency (PFSA) has procured pharmaceuticals worth ETB 6.77 billion. Out of the planned distribution of drugs and medical equipment worth ETB 8.37 billion in EFY 2005, the Agency has distributed pharmaceuticals and medical equipment worth ETB 8.19 billion. Training on the integrated pharmaceutical and medical equipment logistics system has been provided to 3,587 professionals drawn from selected health facilities, as well as training on the operation of medical equipment and use of chemicals and reagents to 274 health professionals, and capacity building training on drug prescription and dosage to professionals drawn from 200 health facilities. Furthermore, 98% of the construction of ten large modern stores with prefabricated steel and around 95% of the construction of the seven medium size stores and offices have been completed. In addition, there are ongoing renovation of five existing stores and construction of 17 cold chain stores. The Agency has prepared a draft strategic plan, and has also prepared a draft guideline to strengthen transparency and accountability of drug supply administration and pharmacy services in health facilities.
35. One of the main challenges which hinder health care access and quality is the lack of resources. To address this challenge and hence to mobilize adequate resources for the health sector, different resource mobilization activities have been implemented, including: (i) revenue retention by health facilities for quality improvement; (ii) implementation of fee waiver system for enhanced equity; (iii) establishment of private wings and outsourcing for better efficiency; and (iv) pilot and implementation of community based and social insurance schemes for improved financial access to health services, avoiding payment at the point of care delivery. Revenue retention is additional to the block grant budget allocated from treasury, and it is used strictly for quality improvement activities. Currently 2,558 health facilities (101 hospitals and 2,457 HCs) are retaining and utilizing internally generated revenues to improve the quality of health services.
36. According to the latest information (as of August 2012), 2,510,067 fee waiver beneficiaries were screened for the service in the country (except in Somali and Afar Regions), and the government allocated a budget of ETB 25,527,418 for fee waiver beneficiaries. Among the 3,162 health facilities which are under the HCF

reform (115 hospitals and 3,047 HCs), 2,788 health facilities (107 hospitals and 2,681 HCs) have formed governing bodies, but, currently, 2,558 health facilities (101 hospitals and 2,457 HCs) have functional governing bodies. In EFY 2005, 45 public hospitals have opened private wing services nationwide (increasing from 31 public hospitals in EFY 2004). Private wing service is not yet started in SNNP, Harari, Afar, and Gambella Regions.

37. To tackle financial barriers to health care access, the government has initiated and is implementing two types of health insurance systems, namely, the Community Based Health Insurance (CBHI) for the rural population and urban informal sector, and the Social Health Insurance (SHI) for the formal sector employees. CBHI is being piloted in 13 woredas of four regions (Tigray, Amhara, Oromia and SNNP), and a total of 143,852 households have been registered at the end of EFY 2005. The CBHI scheme has generated ETB 21,065,787 in EFY 2005, showing an increment by 44.3% when compared with the amount of 14,600,714 ETB generated up to end of EFY 2004. The SHI Implementation Regulation was endorsed by the Council of Ministers. Deployment of employees for the Ethiopian Health Insurance Agency and its regional branch offices is underway.
38. The Global Fund budget on TB and malaria, the MDG Performance Fund (PF) budget, and the National Nutrition Program (NNP) budget were audited at FMOH, Agencies, some RHBs, including selected zones and woredas.
39. In EFY 2005, the percentage of total budget allocated to the health sector at regional level was 9.75%, which was higher than in EFY 2004 (9.13%). In EFY 2005, the per capita health allocation was ETB 100.16, increasing from ETB 74.27 in EFY 2004. The regional block grant budget allocated to the health sector ranged from 6.8% in Addis Ababa to 14.7% in Dire Dawa in EFY 2005. Although per capita allocation is increasing over time, the allocated budget for health in EFY 2005 was below the need of the sector for delivering quality care. This calls for further enhancing implementation of HCF reform and expansion of pre-payment schemes, such as community and social health insurance, as well as additional funds from different sources.
40. One of the main sources of funding for the health sector is the contribution from developing partners (DPs). In 2005 EFY, a total of USD 551 million was committed by DPs and a total of USD 531.13 million (96.4%) was disbursed. A total of USD 133.23 million was disbursed to MDG PF with a 26.5% increment from EFY 2004 (USD 105.35 million) and the MDG PF accounted for 25.1% proportion of total DPs' disbursement in EFY 2005. Among areas of support funded by the MDG PF, maternal health services received the higher proportion (47.8%) followed by medical equipment supply (21.3%) and prevention and control of communicable diseases (13.5%).

CHALLENGES

Some of the major challenges encountered during the implementation of the EFY 2005 Core Plan include the following:

- Slow implementation of HDA;
- Shortage of human resources in terms of number, capacity, and professional skills;
- Gaps in midwives, doctors and anaesthetists for provision of BEmONC and CEmONC services;
- Absence of 24 hours a day and 7 days a week service in many health facilities, especially in HCs;
- Low skilled care at birth as well as clean and safe delivery coverage;
- Inadequate supply of water and electricity at HPs and HCs;
- Shortage of transportation facilities;
- Inadequate quality of diagnostic laboratories;
- Limited community awareness on PMTCT services;

- Weak linkage between HPs and HCs;
- Low utilization of out-patient services;
- Limited capacity to provide on time supportive supervision and monitoring at each level;
- Limited capacity in data collection and analysis and in information use for decision making purposes;
- Failure to submit liquidation reports on time;
- Weak referral system;
- Lack of standard medical equipment management system; and
- Limited capacity to maintain cold chain system.

With respect to implementation of the initiatives detailed in HSDP IV, Ethiopia has made progress in most indicators and is on track to achieve many MDG targets. Despite these positive developments, the sector still faces formidable challenges. Decreasing the huge burden of maternal mortality remains the single most serious challenge to the sector. Even though appropriate strategies and initiatives are in place, there are serious shortages of the required trained human resources, and there are also cultural, social and economic barriers to be overcome. In particular, the percentage of deliveries assisted by skilled birth attendants is still very low (23.1% in EFY 2005). Major constraints to be addressed include gaps in midwives, doctors and anaesthetists for provision of EmONC services, absence of 24 hours a day and 7 days a week service in most health facilities, rapid turnover of highly trained professionals, and inadequate availability of drugs, supplies and medical equipment.

Such constraints should be tackled if the MDGs are to be achieved by the target date. Hence, vigorous and concerted efforts are still required on the part of the Government and all other stakeholders to scale up high impact interventions and enhance and sustain health system strengthening efforts.

CHAPTER 1



INTRODUCTION



Introduction

The Fourth Health Sector Development Program (HSDP) IV for the period 2010/11-2014/15 has passed its third year of implementation. This Annual Performance Report (APR) describes the implementation status of the Program in 2012/13 and is structured around the following ten strategic objectives of the health sector:

1. Improve access to health services;
2. Improve community ownership;
3. Improve quality of health services;
4. Improve public health emergency preparedness and response;
5. Improve pharmaceutical supply and services;
6. Improve evidence-based decision making, harmonization and alignment;
7. Improve regulatory system;
8. Improve health infrastructure;
9. Improve human capital and leadership; and
10. Maximize resource mobilization and utilization.

The report gives an overview of the performance of the sector in addressing these strategic objectives and how the various activities during the year have contributed to the improvement of the health status of the Ethiopian people. It examines the progress made, the efforts that are underway and the challenges faced by the sector in

the promotion of health, and in the organization, financing and governance of health services. In particular, the report provides information on:

- Health service coverage levels for priority programs;
- Performance against target set in the core plan, using national and regional level indicators;
- Trends of achievements and regional comparisons;
- Status of the health sector support systems; as well as
- Public sector and donor expenditure analysis for the Ethiopian Fiscal Year (EFY) 2005.

The theme of this Annual Review Meeting (ARM) is “the last lap towards Millennium Development Goals (MDG): promise renewed to end preventable maternal and child death in Ethiopia”, and, therefore, special attention has been given to the analysis of the level of achievement of health MDGs.

In the preparation of this report, a uniform structure of presentation has been followed by indicating in each section the background, targets, achievements, challenges and the way forward. The report contains 26 Tables and 55 Figures that depict regional comparisons and trends of indicators selected for monitoring the implementation of the third year of HSDP IV.

It is divided into five chapters:

Chapter 1: is an Introduction that covers the background of the Annual Performance Report and a brief description of the report's contents;

Chapter 2: covers an overview of the sector performance for EFY 2004 with respect to Health Service Delivery and Quality of Care;

Chapter 3: deals with implementation status concerning Leadership and Governance;

Chapter 4: details the performance in the area of Infrastructure and Resources; while

Chapter 5: sums up the Conclusions of the report.

Both quantitative and qualitative data have been used in the preparation of this report, whose primary source has been the Health Management Information System (HMIS) aggregated quarterly reports for EFY 2005, with the exception of data for certain programs not covered by the HMIS. Population figures were based on the estimates from the 2013 intercensus population survey provided by the Central Statistical Agency (CSA).

Even though the HMIS is the main source of data, this report also used other key sources of information such as earlier Annual Performance Reports, reports by the Federal Ministry of Health (FMOH) programs and other central level institutions, and surveys and studies undertaken by various stakeholder institutions.

As in previous years, the development process of the Annual Performance Report for EFY 2005 was widely consultative, involving stakeholders from Regional Health Bureaus (RHB), the various Directorates of FMOH, and agencies accountable to the FMOH as well as Development Partners (DPs). The overall coordination and technical support was provided by a Committee led by the Policy and Planning Directorate (PPD) with oversight being provided by the Joint Core Coordinating Committee (JCCC). Representatives of DPs and consultants employed for this purpose provided technical support in the compilation, formatting and collating process of the report in close collaboration with the Coordinating Committee at PPD. Draft submissions were made by RHBs, Directorates at FMOH, and agencies under the FMOH. Identified gaps were rectified by the relevant authority. The final draft was presented, for comments and approval, to RHBs, directorates, and finally to the Management Committee at the Head Office.

One of the objectives of the fifteenth ARM 2013 is to review the performance of the sector in EFY 2005 against targets and actions set in the plan. The major management tool that serves this purpose is the Annual Performance Report which is one of the core agenda items at the ARM. With this in view, and to accelerate the achievement of the universal health coverage, participants of the fifteenth ARM are expected to discuss the issues highlighted in the report and offer valuable comments and suggestions that will contribute to improvements in performance during the subsequent plan period.

CHAPTER 2



HEALTH SERVICE DELIVERY AND QUALITY OF CARE



15th ARM

The last lap towards MDGs: Promise renewed to end preventable maternal and child death in Ethiopia.

Health Service Delivery and Quality of Care

Under health service delivery and quality of care theme, the provision and management of curative, preventive, rehabilitative and emergency health services as well as the promotion of good health practices are discussed in the following paragraphs, including provision of maternal, neonatal, child, youth and adolescent health services and public health emergency services.

The flagship programme to ensure health service delivery and quality of care is the Health Extension Programme (HEP), which is the main vehicle for prevention, health promotion, behavioural change communication (BCC) and basic curative services through effective implementation of essential packages and mobilization of the Health Development Army (HDA).

The desired result is a community practicing and producing good health, being protected from emergency health hazards, and having access to quality health care.

2.1. HEALTH EXTENSION PROGRAM

HEP is an innovative community-based strategy to deliver preventive and promotive services and selected high impact curative interventions at community level. It brings community participation through creation of awareness, behavioural change, and community organization and mobilization. It also improves the utilization of health services by bridging the gap between the community and health facilities through the deployment of Health Extension Workers (HEW). The main objective is to improve access to essential health services provided at village and household levels, contributing to the improvement of the health status of the families, with their full participation, using local technologies and the skill and wisdom of the communities.

In this context, with the aim to promote community mobilization and adoption of healthy lifestyles, a major initiative undertaken by the Ethiopian Government is the implementation of the HDA. The organization and mobilization of the HDA started in Tigray and Southern Nations, Nationalities and Peoples (SNNP) Regions in 2010/11 and was expanded to all agrarian regions to capacitate families who are lagging behind in terms of adopting safe health practices. In particular, the strategy used in Tigray for HDA formation was the women-centered one-to-five network development, called Women Development Group (WDG) formation, while the other agrarian regions set up mixed (male and female) HDA groups.

2.1.1. IMPLEMENTATION OF HEALTH DEVELOPMENT ARMY

HDA refers to an organized movement of the community through participatory learning and action meetings. Organizing a functional HDA requires the establishment of health development teams (HDA groups) that

comprise of up to 30 households residing in the same neighbourhood. The health development team is further divided into smaller groups of six members, commonly referred as one-to-five networks. The leaders of the health development teams and the one-to-five networks are selected by the team members. The main criteria for selection of the leaders are being a model family and having the trust of the members in mobilizing the community. The formation of the health development teams and the one-to-five networks is facilitated by HEWs and the kebele administration.

In EFY 2005, capacity building was carried out based on the healthy behaviour bottleneck analysis. In particular, the training emphasises on improving utilization of high impact maternal and newborn health services, and it is facilitated by HEWs with support from the primary health care unit (PHCU) and the woreda health office (WorHO). The HDA is designed to accomplish the following critical tasks: (i) identify locally salient bottlenecks that hinder families from utilizing key services and implementing the HEP, and prioritize those that they want to address as a team; (ii) come up with feasible strategies to address these problems; (iii) implement the strategies; and (iv) evaluate their activities.

The progress made in different regions on the formation of HDA groups and networks in EFY 2005 is described as follows.

In Tigray Region, 27,320 WDGs have been established so far, with more than 125,000 one-to-five network formations. Similarly, in SNNPR a total of 76,557 HDA groups with 485,771 one-to-five networks have been formed. Besides, Amhara Region has also established 109,725 HDA groups and 539,693 one-to-five networks, while in Oromia Region a total of 147,428 HDA groups and 732,259 one-to-five networks have been established in the same year.

In urban areas, HDA formation started in EFY 2004. In Addis Ababa, model households were selected and, under each model household, other four were organized for experience sharing reaching a total of 128,815 one-to-five networks. In Harari, 966 HDA groups with 4,706 one-to-five networks were established, while 2,074 HDA groups with 10,230 one-to-five networks were established in Dire Dawa.

In order to promote equitable development of HDA, priority attention and integrated and regular support will be given for the management and professional staff in their efforts to undertake social mobilization activities in pastoralist regions.

As a result, HDA formation is showing promising progress in promoting health and preventing disease at the community level.

CHALLENGES

- Lack of commitment and low level of skills and experience on the part of management in implementing HDA;
- Failure of woreda and kebele level management staff to perform regular supportive supervision; and
- Unsatisfactory collaboration among sector offices having important roles in implementing HDA strategy.

WAY FORWARD

- Undertake capacity building measures for management staff;
- Perform regular supportive supervision at woreda and kebele levels; and
- Strengthen collaboration among sector offices.

2.1.2. HYGIENE AND ENVIRONMENTAL SANITATION

In EFY 2005 it was planned to increase the latrine coverage from 84% to 92%. However, the cumulative number of households with latrine was 15,645,216 (out of the total 18,274,255) at the end of EFY 2005, with a coverage of 86%, short of the 92% target set for the year. There is a large variation across regions, ranging between 9.3% in Afar and 94.2% in SNNPR.

Other hygiene and environmental sanitation activities carried out in EFY 2005 were:

- Community Led Total Sanitation (CLTS) training in line with HDA was given for 100 participants in Somali, Gambella and Afar resettlement areas;
- World Wash Day was celebrated by organizing a hygiene and sanitation national festival on latrine handling and use, personal hygiene, and safe water handling and use;
- A design manual was prepared on latrine functioning with and without water; and
- In order to protect safe water from contamination and therefore prevent diarrhoeal diseases, the following activities were undertaken: (i) a draft National Strategic Plan on Safe Water Surveillance was prepared; (ii) training was given for professionals from both health and water sectors by FMOH and other partners; and (iii) a manual on water quality control, testing kits and related chemicals were supplied to regions by FMOH.

CHALLENGES

- Absence of regular and integrated Monitoring and Evaluation (M&E) activities;
- Inadequate capacity to scale-up best practices; and
- Uncoordinated support from partners.

WAY FORWARD

- Ensure integrated M&E activities;
- Strengthen the capacity of regions to scale-up best practices; and
- Strengthen harmonization and alignment according to “One-Plan, One-Budget, and One-Report” principle.

2.2. MATERNAL AND NEWBORN HEALTH SERVICES

Government of Ethiopia is committed to achieve the MDG5 to improve maternal health, with a target of reducing Maternal Mortality Ratio (MMR) by three-quarters over the period 1990 to 2015. HSDP IV aims to reduce MMR from 676/100,000 live births to 267/100,000 live births. Another target of MDG 5 is to achieve, by 2015, universal access to reproductive health, including access to safe, affordable and effective methods of contraception. Contraceptive use contributes also to improvements in maternal, newborn and infant health by preventing unintended or closely spaced pregnancies as well as pregnancies in very young women, which can be risky. It has been documented that contraceptive use can have an impact in reducing maternal mortality by averting more than half of maternal deaths.

HSDP IV has devised a set of key inter-related performance indicators to monitor the progress made in improving maternal and newborn health. A measure of contraception - contraceptive acceptance rate (CAR) - is presented as a tracer of reproductive health. Antenatal care (ANC) coverage provides a measure of access to the health system and is critical to identify maternal risks and improve health outcomes for the mother and the newborn. Measures of coverage of skilled care at birth and birth attendance by HEWs, as well as postnatal care (PNC) services, are critical elements of the continuum of care. Human immunodeficiency virus (HIV)-related indicators are included to emphasize the need towards a more holistic approach to health care, and to promote further integration of the programs to prevent mother to child transmission (MTCT) of HIV and maternal health services. These indicators are summarized in Table 1 showing, for each indicator, EFY 2005 baseline, performance and target, as well as the overall HSDP IV targets set for EFY 2007.

ANC coverage (at least one visit) increased from 89.1% in EFY 2004 to 97.4% in EFY 2005, PNC coverage increased from 44.5% to 50.5%, while the percentage of deliveries attended by skilled health personnel increased from 20.4% in EFY 2004 to 23.1% in EFY 2005 (Figure 1). Conversely, clean and safe delivery coverage (by HEWs) declined from 13.2% in EFY 2004 to 11.6% in EFY 2005, much less than the planned coverage for the year. CAR slightly declined from 60.4% in EFY 2004 to 59.5% in EFY 2005.

Table 1:

Maternal Health Indicators

(EFY 2005 Baseline, Performance and Target and HSDP IV Target)

Indicators	EFY 2005 Baseline	EFY 2005 Performance	EFY 2005 Target	HSDP IV Target (EFY 2007)
Antenatal care coverage	89.1%	97.4%	90.6%	90.0%
Percentage of deliveries attended by skilled health personnel	20.4%	23.1%	49.2%	62.0%
Clean and safe delivery coverage (percentage of deliveries attended by HEWs)	13.2%	11.6%	35.2%	38.0%
Postnatal care coverage	44.5%	50.5%	70.1%	78.0%
Contraceptive acceptance rate	60.4%	59.5%	76.2%	82.0%
Percentage of pregnant women counselled and tested for PMTCT	36.7%	54.9%	76.0%	83.0%

The proportion of pregnant women counselled and tested for Prevention of Maternal to Child Transmission (PMTCT) of HIV increased from 36.7% to 54.9%, while the proportion of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy or prophylaxis was estimated at 42.9% in EFY 2005. Out of these key indicators, only ANC (97.4%) surpassed the target set for the year (90.6%).

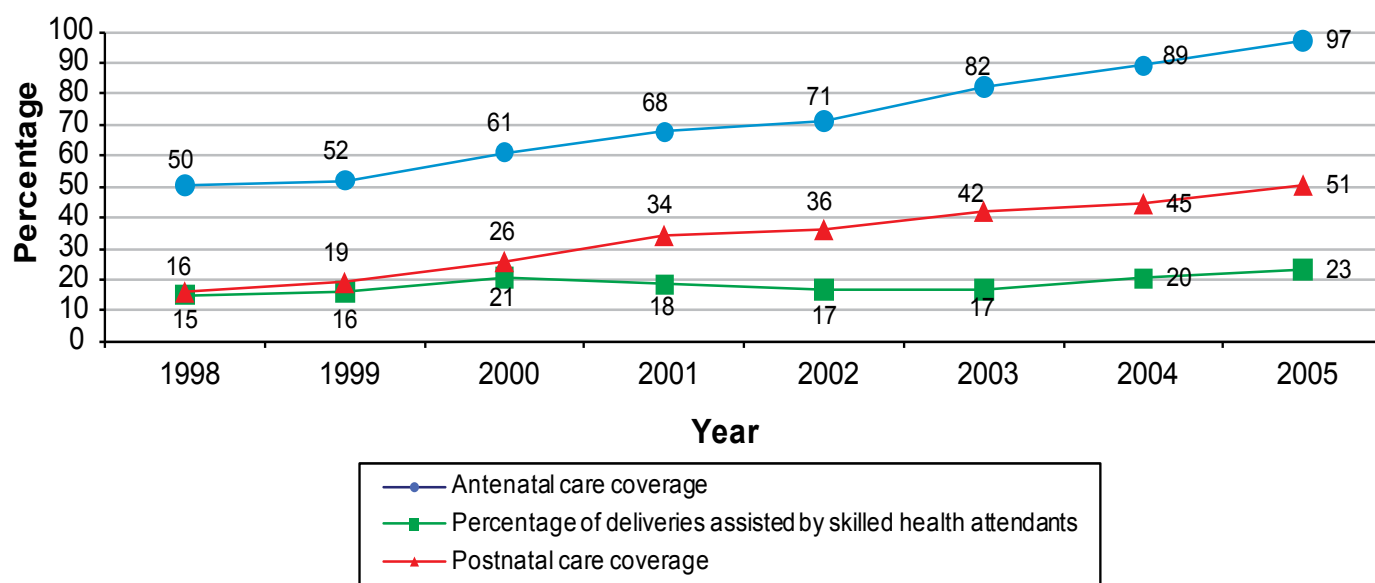


Figure 1: Trend in Antenatal Care Coverage, Percentage of Deliveries Attended by Skilled Health Personnel and Postnatal Care Coverage (EFY 1998-2005)

2.2.1. REGIONAL DISTRIBUTION OF ANTENATAL CARE COVERAGE

ANC coverage showed wide variation across regions, ranging from 41.6% in Somali to 100% in Tigray, Oromia, SNNP, Harari, and Dire Dawa, that have achieved their EFY 2005 target; when compared to their baseline, four other regions improved their performance (Afar, Amhara, Benishangul Gumuz, and Gambella) (Figure 2). This high level of ANC coverage may be related not only to high performance, but also to over reporting of first antenatal visits (i.e. by double counting subsequent ANC visits performed in different facilities, counting a subsequent ANC visit as first ANC visit in the same facility etc.).

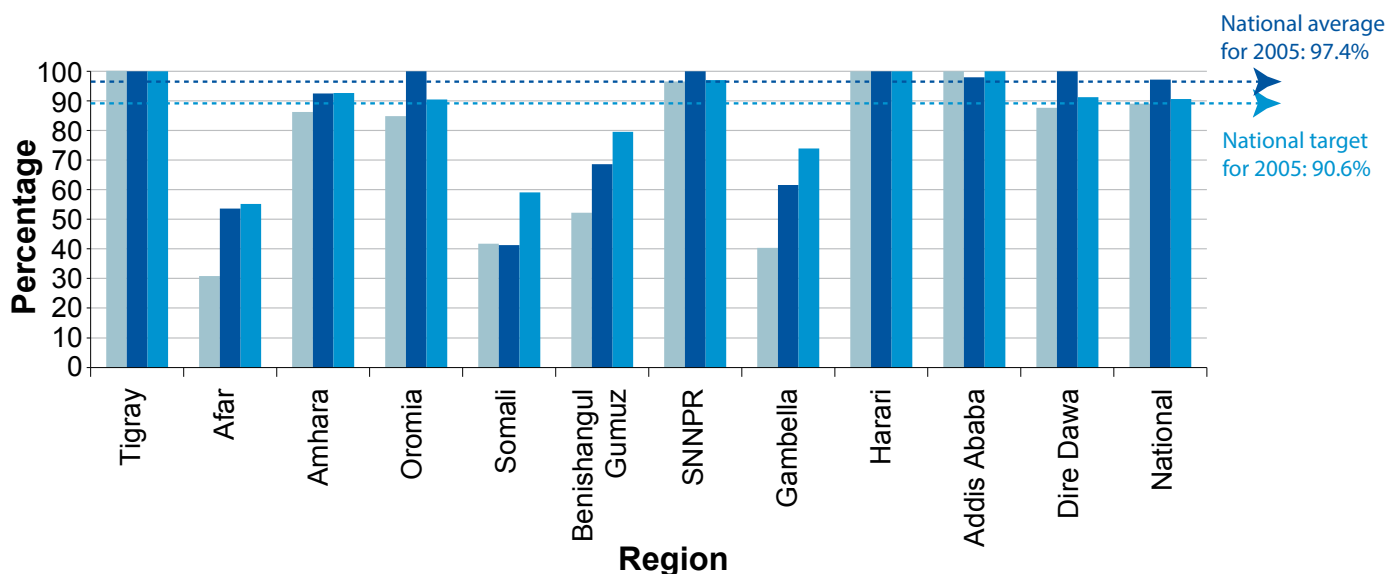


Figure 2: Comparison of Baseline, Performance and Target of Antenatal Care Coverage by Region (EFY 2005)

2.2.2. REGIONAL DISTRIBUTION IN THE PERCENTAGE OF DELIVERIES ASSISTED BY SKILLED HEALTH PERSONNEL

Skilled attendance at birth is the most important intervention in reducing maternal mortality and one of the MDG indicators to track national effort towards safe motherhood. The percentage of deliveries assisted by skilled health personnel increased from 20.4% in EFY 2004 to 23.1% in EFY 2005, but remained below the target of 49.2% set for the year. There was wide variation across regions, ranging from 14.4% in Benishangul Gumuz to 72.9% in Addis Ababa. Compared to the baseline, an increase was observed in ten regions (Tigray, Afar, Amhara, Somali, Benishangul Gumuz, SNNP, Gambella, Harari, Addis Ababa, and Dire Dawa), while a decrease from 24.2% to 21.4% was observed in Oromia Region (Figure 3). It is only two regions (Harari with 72.0% and Dire Dawa with 51.0%) that exceeded their regional targets (66.7% and 46.1%, respectively).

The better performance found in some regions during the year is accounted by the extensive effort made by HDA to convince pregnant mothers to give birth in health facilities. Best practices found in a region have been expanded to other regions in EFY 2005. Despite such positive developments, however, the percentage of skilled attendance at birth is still very low, and further efforts are needed for promoting skilled birth care.

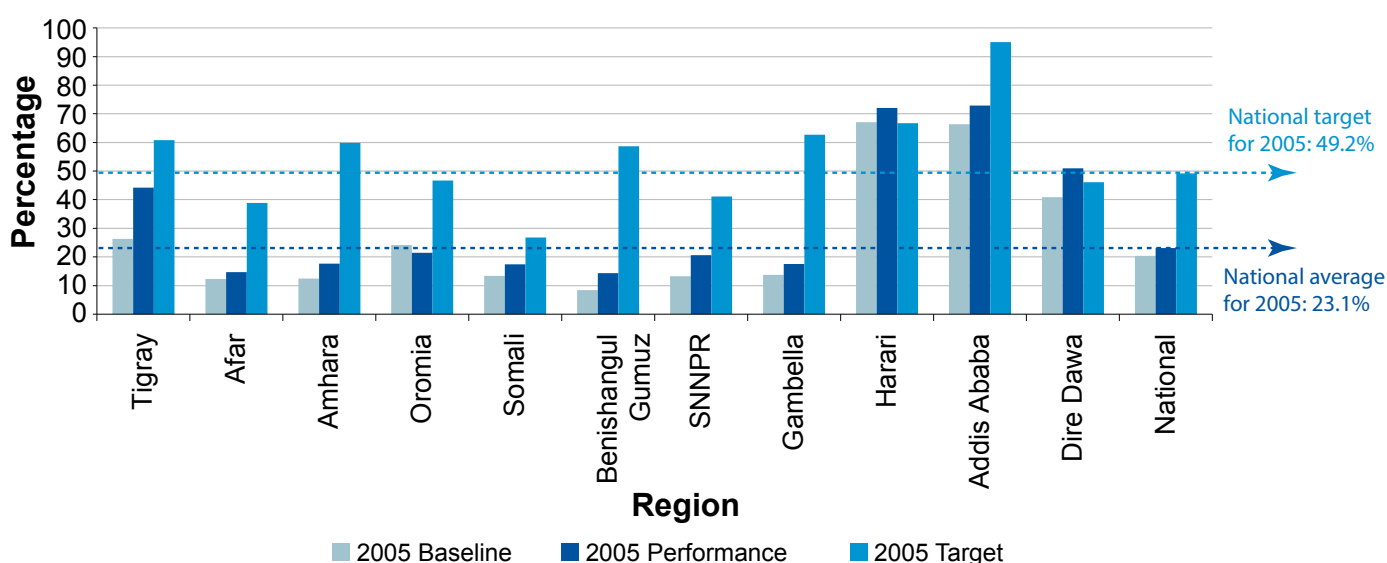


Figure 3: Comparison of Baseline, Performance and Target of Percentage of Deliveries Assisted by Skilled Health Personnel by Region (EFY 2005)

The FMOH uses multiple high impact interventions at both facility and community levels to address the 3 delays in: (i) seeking appropriate medical care for an obstetric emergency; (ii) reaching an appropriate emergency obstetric and neonatal care (EmONC) facility; and (iii) receiving adequate care when the facility is reached. Since the advent of HSDP, to solve the three delays accounting for high maternal and newborn mortality in the country, strategies have been designed and relevant activities are being performed to remove the bottlenecks hampering access to safe motherhood services, such as harmful traditional beliefs and practices, poor infrastructure, shortage of transportation facilities, and inadequate care at health facilities.

In order to address the first delay, the work of organizing and mobilizing the HDA at all levels is being performed intensively in order to promote behavioural change as well as to ensure the implementation of all health extension packages in the communities so that they can produce and sustain their own health, including maternal health.

To solve the shortage of transportation facilities, 372 ambulances were procured and distributed to regions in EFY 2004, while 440 ambulances have been procured and distributed in EFY 2005. Thus, out of the planned 840 ambulances, a total of 812 ambulances are in place and are providing the needed service at woreda level. A National Guideline on Utilization of Ambulances has been prepared and is being implemented to ensure the proper use of ambulances for the intended purposes only.

Furthermore, in order to address the issue of financial barriers, in addition to the provision of free maternity services at HC level, the FMOH has initiated free maternity services at hospital level. To solve the bottleneck related to inadequate capacity for timely intervention, several activities are in progress, including training of human resources, provision of adequate drugs, medical supplies and equipment, as well as equitable deployment of adequate number of health professionals in health facilities.

Concerning the expansion of basic emergency obstetric and neonatal care (BEmONC) services, training manual and monitoring forms have been prepared, and around 3,000 health workers have been trained, with an increase in number of Health Centers (HC) providing BEmONC services from 752 in EFY 2004 to 1,813 in EFY 2005. A total of 15 hospitals have been accredited to serve as permanent training centers. Comprehensive emergency obstetric and neonatal care (CEmONC) services are being provided in 105 hospitals (an increase from 69 in EFY 2004). To expand the service in additional health facilities, activities are underway to provide training to 1,000 health professionals, and to make the necessary inputs available beforehand.

Treatment with magnesium sulphate (MgSo4) and pre-referral clinical care has been started at HCs. A directive has been prepared to start “Maternal Death Surveillance and Response” in all hospitals, and its implementation will fill the existing data gap pertaining to maternal deaths in hospitals.

In addition, the following best practices have been registered in Tigray, Amhara, Oromia and SNNP Regions.

Tigray Region:

- Preparation of porridge in health facilities: there is a deep rooted cultural belief in Tigray that would require a mother to eat porridge after giving birth. If the mother does not have access to porridge, it is believed that evil things could happen to either the mother or the newborn. Hence, women prefer to give birth at home. To address this issue, HDA has started to prepare porridge in health facility if a woman from the team is in labour.
- Traditional ambulance: in Tigray the terrain poses a significant challenge. The HDA came up with a locally made stretcher and had also organized the youth to carry a labouring mother to the nearby health facility or major road where the regular ambulance could be accessed.
- Monthly conferences with all pregnant women in the village: the HDA has played a critical role in commencing a monthly conference with all pregnant women, facilitated by HEWs and midwives from the PHCU. The conferences are used to improve peer-to-peer support.
- Dialogue with traditional birth attendants (TBA): since the majority of TBAs are women, they were easily convinced to take the labouring mothers to health facilities instead of home delivery.

Amhara Region:

- Conference with TBAs: the dialogue with TBAs has been instrumental to raise their awareness on the harmful effects of home deliveries and promote the referral of pregnant mothers for delivery at health facilities; furthermore, during the conference, the participants have been encouraged to take part in voluntary testing for HIV.

Oromia Region:

- Preparation of “coffee ceremony”: in some localities of Oromia Region, there is a belief that mothers should immediately drink coffee after delivery. In order to persuade pregnant mothers to deliver in health facilities rather than at home, “coffee ceremony” at health facilities has been initiated by health workers and local leaders. This practice has not only strengthened the social relation between mothers and health workers, but also contributed to significant increases in institutional deliveries.

SNNPR:

- Traditional practice of applying butter on the heads of mothers after delivery: in some localities of SNNPR, according to local beliefs, mothers should apply butter on their heads immediately after delivery. To convince pregnant women to deliver in health facilities, the practice of mothers applying butter after institutional delivery has been initiated by health workers and local leaders. This practice has played a significant role in increasing the number of mothers delivering at health facilities.
- Promotion of “home delivery-free kebeles”: taking the example of expanding “open defecation-free kebeles”, intensive efforts are being made to create “home delivery-free kebeles”. Hence, encouraging results have been registered by some localities in SNNPR such as Gurage and Silte Zones. Promotion of “home delivery-free kebeles” have been also expanded in kebeles located in other regions, such as Tigray and Amhara.

2.2.3. REGIONAL DISTRIBUTION OF CLEAN AND SAFE DELIVERY SERVICE COVERAGE

A decline was observed in the clean and safe delivery service coverage, from 13.2 % in EFY 2004 to 11.6% in EFY 2005, below the target set for the year (35.2%). Wide variations were observed across regions, ranging from 0.4% in Gambella to 26.4% in SNNPR. The same decreasing pattern had been observed in EFY 2003 and 2004. An increase in performance was observed in four regions (Afar, Somali, Benishangul Gumuz, and Harari), while a decrease was observed in six regions (Tigray, Amhara, Oromia, SNNP, Gambella, and Dire Dawa). These services were not supposed to be performed in Addis Ababa.

None of the regions achieved its regional target (Figure 4). The decline in the clean and safe delivery service coverage observed in some regions (such as Tigray and SNNP) may be explained at least partly by the expansion of HCs and the subsequent provision of skilled care at birth in the catchment areas.

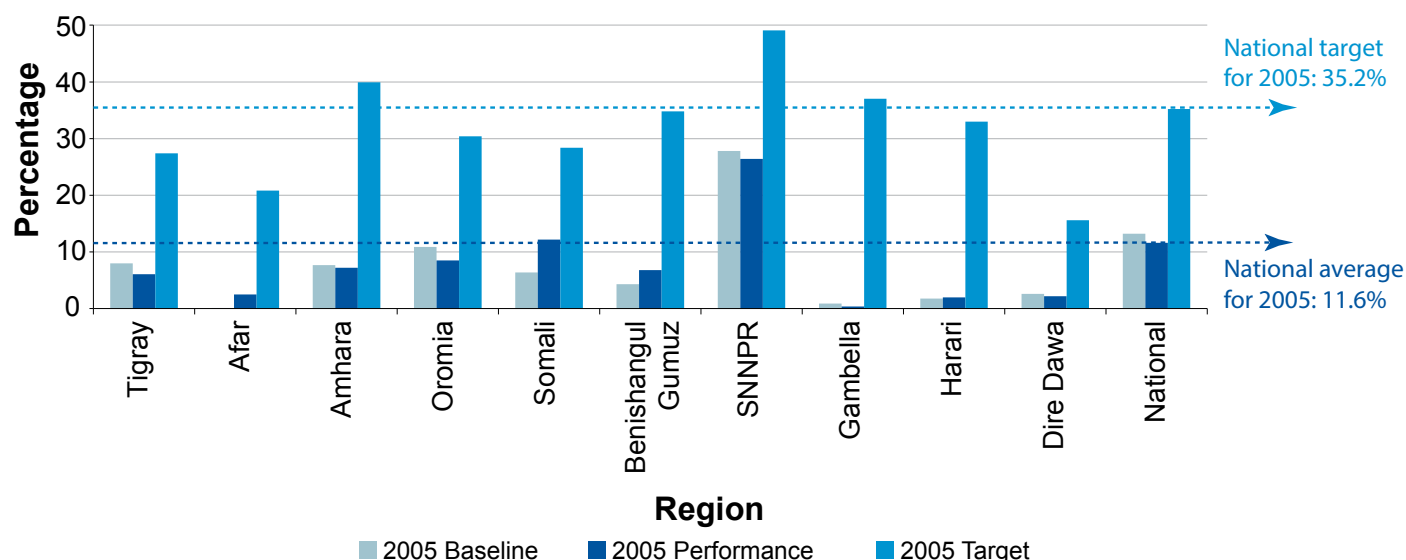


Figure 4: Comparison of Baseline, Performance and Target of Clean and Safe Delivery Service Coverage (EFY 2005)

2.2.4. REGIONAL DISTRIBUTION OF POSTNATAL CARE COVERAGE

PNC coverage increased from 44.5% in EFY 2004 to 50.5%, but the increase was much below the target set for the year (70.1%). With respect to the regional distribution of PNC services, the highest coverage in EFY 2005 was observed in SNNPR (65.4%), followed by Tigray (65.2%) and Harari (52.9%) (Figure 5). In addition to these three regions, an increase was also observed in other seven regions (Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Gambella, and Addis Ababa), while a decrease was observed in only one region (Dire Dawa).

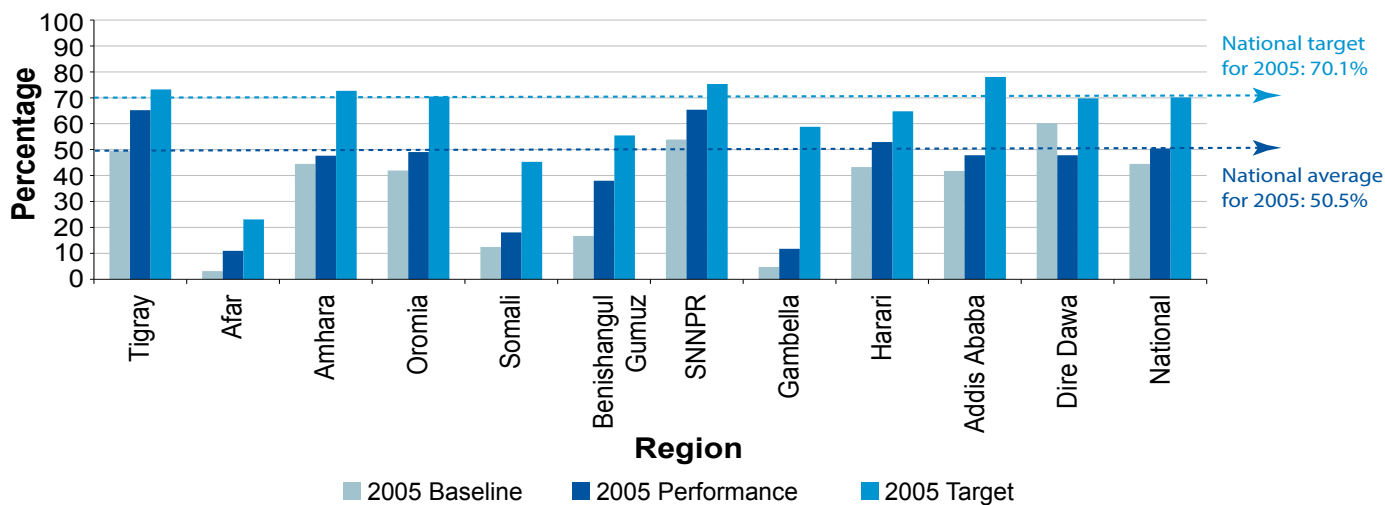


Figure 5: Comparison of Baseline, Performance and Target of Postnatal Care Coverage by Region (EFY 2005)

2.2.5. TREND IN THE CONTRACEPTIVE ACCEPTANCE RATE

CAR is presented as a tracer of reproductive health service performance, and is one of the service indicators used to measure progress towards the achievement of MDG5. 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. It is worth noting that the increase in use of long-acting contraceptives, together with the difficulty in tracking long-acting contraceptive users for annual CAR estimation purposes, may affect the calculation of the indicator by underestimating the numerator (number of new and repeat acceptors).

CAR slightly decreased from 60.4% in EFY 2004 to 59.5% in EFY 2005, below the target of 76.2% set for the year (Figure 6).

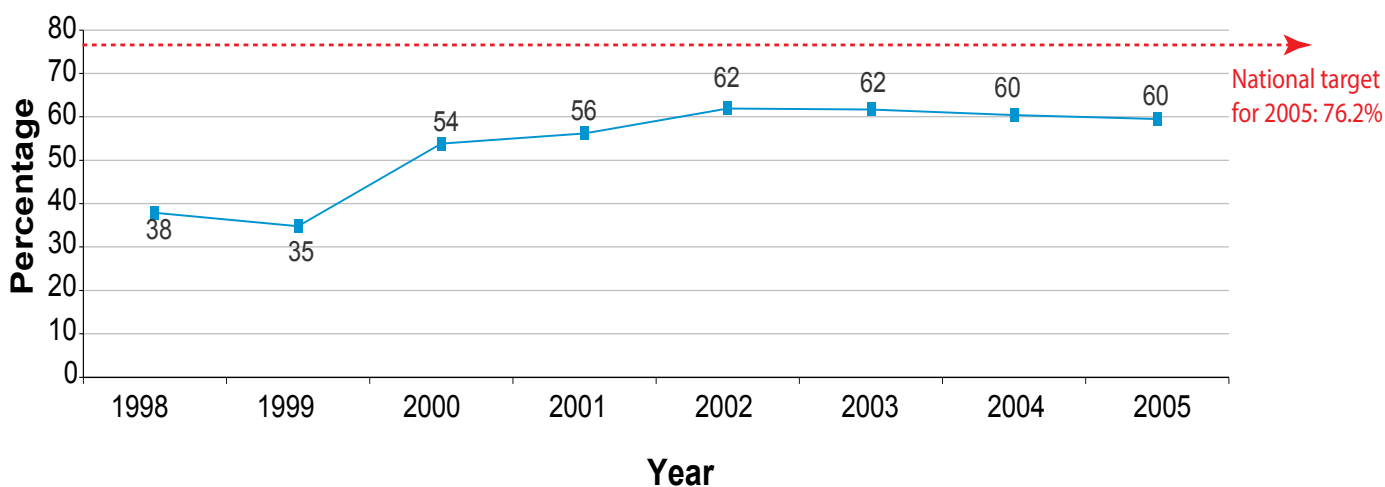


Figure 6: Trend in Contraceptive Acceptance Rate (EFY 1998-2005)

In EFY 2005, to increase the low utilization of contraceptives in pastoralist areas related to local culture and beliefs, awareness raising meetings were held with 143 managers, 130 religious and clan leaders, and members of women's organizations.

Extensive efforts have been underway during the last three years to expand access to long-acting contraceptives. In EFY 2005, although training on Implanon insertion was planned for 14,000 HEWs, it was given for only 4,765 HEWs; prior to this training, a Training of Trainers (TOT) was given for 463 health professionals.

In accordance with the plan to expand Intra-Uterine Contraceptive Device (IUCD) services from the existing 116 woredas to 416 woredas, community conversation has been conducted in agrarian and urban areas, and, by training 86 health professionals, it was possible to start IUCD insertion services in 78 additional woredas. An exploratory survey is being conducted to identify bottlenecks in the implementation of IUCD insertion services. With respect to the plan to initiate permanent family planning services in seven hospitals located in densely populated zones, the service has been started in six hospitals in three regions (two in Oromia, two in Amhara, and two in SNNP).

Contraceptives and medical supplies and equipment worth Ethiopian Birr (ETB) 681 million have been procured and distributed to health facilities, and procurement is underway to meet the future requirements.

Problems of youth reproductive health services have been assessed, and, on this basis, a document that enables the provision of comprehensive support has been prepared.

A national Family Planning Symposium was held in Bahir Dar (26-28 November 2012) to establish a platform for knowledge sharing and documentation of best practices in family planning and facilitate translating evidence into action. Furthermore, preparation has been made for the Third International Conference on Family Planning, which will be held in November 2013, with the National Steering Committee being officially launched in February 2013.

2.2.6. REGIONAL DISTRIBUTION OF CONTRACEPTIVE ACCEPTANCE RATE

Wide variations were observed across regions in EFY 2005, with the lowest rate (8.3%) being reported from Somali Region, and the highest (86.3%) reported from Amhara. An increase was observed in six regions (Afar, Amhara, Somali, Benishangul Gumuz, Gambella, and Dire Dawa); however, none of the regions performed above their annual targets (Figure 7).

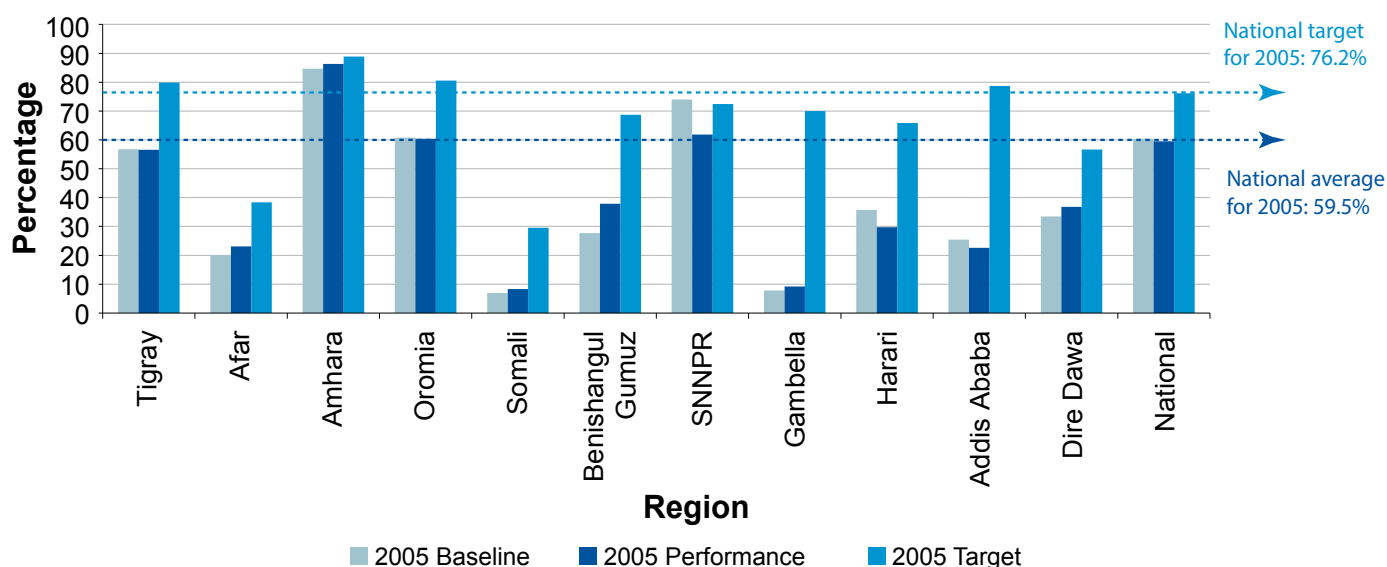


Figure 7: Comparison of Baseline, Performance and Target of Contraceptive Acceptance Rate by Region (EFY 2005)

The low rates observed in pastoralist areas are related to negative influences primarily caused by cultural and religious beliefs and practices and low level of community awareness about family planning (FP) services.

2.2.7. PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

The percentage of HIV-positive pregnant women who received efficacious ARV therapy or prophylaxis to prevent Maternal to Child Transmission (MTCT) of HIV has been estimated at 42.9% in EFY 2005, ranging

between 3.4% in Somali and 126.1% in Harari (Figure 8). Furthermore, as mentioned above, Ethiopia is one of the “rapid decline” countries, with a reduction by 50% or more of new HIV infections among children between 2009 and 2012.

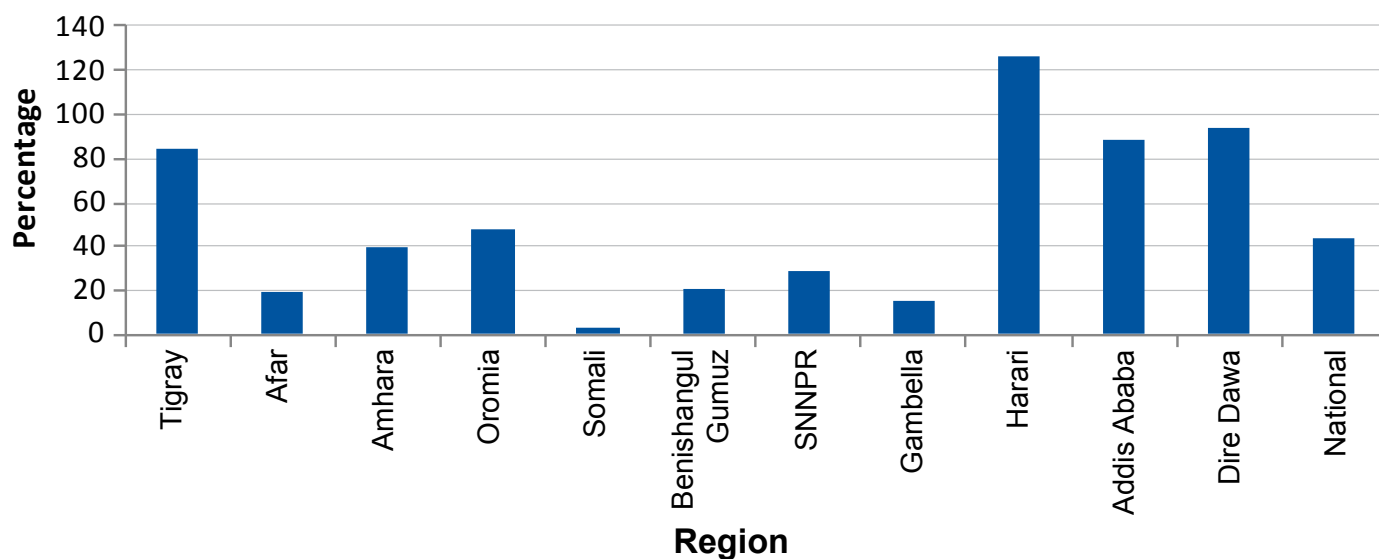


Figure 8: Comparison of the Percentage of HIV-Positive Pregnant Women Who Received ARV Therapy or Prophylaxis to Prevent Maternal to Child Transmission (MTCT) by Region (EFY 2005)

Of note is the fact that, in EFY 2005, the strategy shifted to “Option B+”: it is a “test and treat” strategy in which HIV-positive pregnant women start ART regardless of their CD4 count and are maintained on treatment for life. Option B+ represents a cost-effective strategy not only for preventing new HIV infections among infants, but also for improving the survival of HIV-infected mothers and reducing orphanhood, with a vision of an HIV free new generation.

Therefore, there is a shift in the PMTCT paradigm, which is no longer viewed as a time-limited intervention around pregnancy and breastfeeding, but it is rather reconceived as ART-for-life regimen. This shift has wide implications in terms of integrating maternal, newborn and child health (MNCH) programmes and ART programmes to support alternative service delivery models, build integrated skills for health professionals, and address infrastructural constraints. To ensure successful implementation of Option B+, the FMOH is using a phased approach, prioritizing sites providing PMTCT services.

2.2.8. ABORTION CARE

Abortion care was given for 138,303 clients in EFY 2005 (less than the planned 177,292, with a target achievement of 78.0%). Only three regions (Harari, Addis Ababa and Dire Dawa) surpassed their planned target for provision of safe abortion service. In addition, 53 health professionals drawn from regions were given training on clean and safe abortion services.

CHALLENGES

- Gaps in midwives, doctors and anaesthetists for provision of EmONC services;
- Absence of 24 hours a day and 7 days a week service in most health facilities, especially in HCs;
- Lack of a separate newborn corner and absence of a neonatal unit in some health facilities;
- Low clean and safe delivery coverage;
- Low coverage of skilled delivery and newborn care;
- Inadequate supply of water and electricity at HP and HC levels;
- Inadequate skill on the part of HEWs and health professionals;
- Harmful traditional beliefs and practices affecting maternal health;
- Lack of regular supply of inputs to health facilities; and
- Weak data collection, handling and analysis for decision making purposes.

WAY FORWARD

- Scale-up the training of midwives and improve the availability of human resources (HR) capable to provide BEmONC services in all HCs;
- Provide round the clock delivery services in HCs nation-wide;
- Establish a newborn unit in all hospitals and a newborn health corner in all delivery rooms and maternity wards of all health facilities;
- Strengthen clean and safe delivery services as well as skilled care at birth;
- Provide CEmONC in all hospitals and selected HCs by putting up functional maternities, nurseries, maternity theatres and laboratory services;
- Ensure availability of water and electricity at HP and HC levels;
- Undertake skill upgrading training;
- Strengthen HDA;
- Ensure the supply of inputs at regional and facility levels; and
- Promote the use of information for decision making at point of data collection.

2.3. CHILD HEALTH SERVICES

In order to achieve MDG 4 to reduce child mortality, with a target of reducing under 5 mortality rate (U5MR) by two thirds over the period 1990-2015, several activities were articulated in HSDP IV, including strengthening routine immunization, expanding community and facility-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI), establishing newborn corners and Neonatal Intensive Care Units (NICU), capacity building on program management for child health services, strengthening HEP, and implementing locally relevant and effective child health interventions in pastoralist areas.

The objective is to consolidate and even accelerate the downward trend in U5MR observed between 1990 and 2010, with an annual rate of reduction of 5.0%. Figure 9 shows the consistent decline in U5MR (from 217 to 88 per 1,000 live births between 1990 and 2010) observed in Ethiopia. The thick green line shows the actual child mortality rates in Ethiopia, that is not only on track to achieve MDG4 (shown by the green dotted line), but also much steeper than the sub-Saharan Africa (SSA) average (shown by the thick red line).

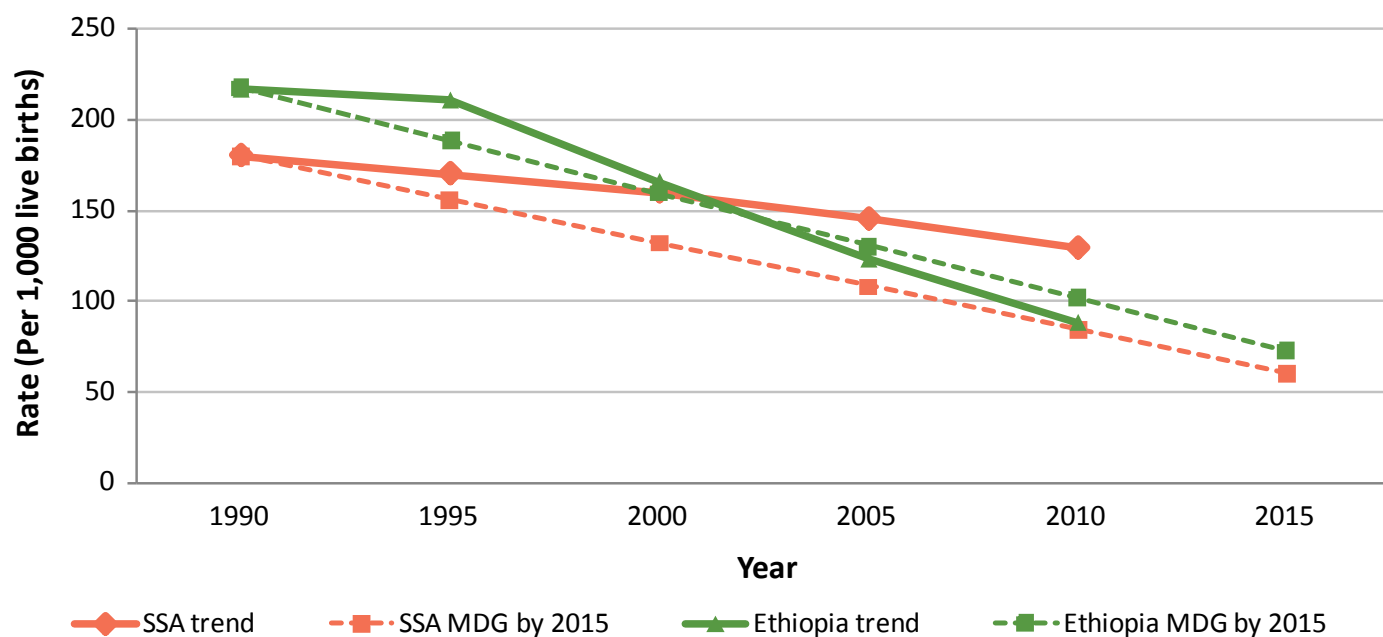


Figure 9: Comparison of Trend in Under-5 Mortality Rate (per 1000 Live Births) in Ethiopia (in Green) and in Sub-Saharan Africa (in Red): Actual Trends During the Period 1990-2010 (in Bold Lines) and Trends Necessary for Achieving MDG 4 by 2015 (in Dotted Lines).

According to the “Levels and trends in child mortality – Report 2013” published by the UN Inter-Agency Group for Child Mortality Estimation, Ethiopia is one of the seven high-mortality countries (together with Bangladesh, Malawi, Nepal, Liberia, Tanzania and Timor) with the greatest declines (by two thirds or more) in lowering child mortality between 1990 and 2012, therefore achieving MDG4 before the 2015 deadline (Figure 10). Ethiopia has implemented pro-poor policies and has performed better than other SSA countries, being an example that it is possible to sharply reduce preventable child deaths, even in resource-constrained countries, when concerted action, sound strategies, appropriate technologies, strong partnership, and political commitment are consistently applied in support of MNCH. These “within and across” analyses make it possible to explain differences in outcomes as well as to provide hints on how to speed the pace of change observed in the past into dramatically faster progress in order to achieve MDG4 by 2015.

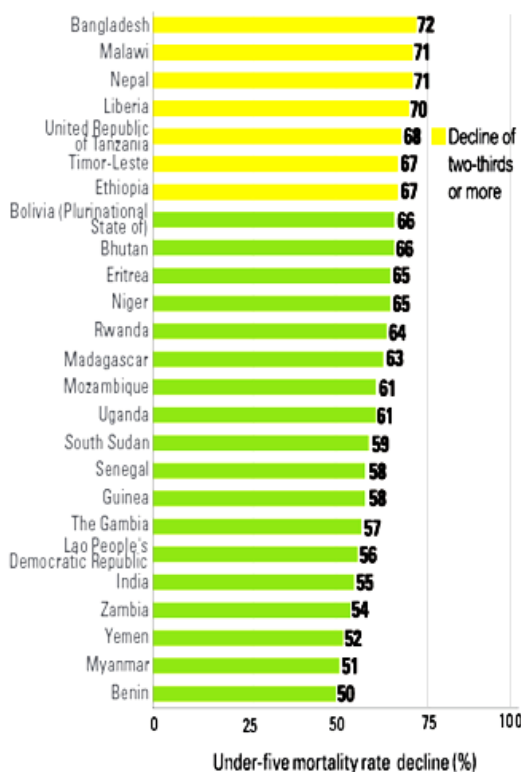


Figure 10: Decline in Under 5 Mortality Rate in High-Mortality Countries from 1990 to 2012

2.3.1. IMMUNIZATION

The expanded program on immunization (EPI), one of the oldest and most cost effective programs, has continued to make a steady progress.

In EFY 2004, the new pneumococcal conjugate vaccine (PCV) has been introduced into the routine infant immunization schedule nationwide and its coverage in EFY 2005 has been included in this report. It protects against the most severe forms of pneumococcal disease in childhood, such as meningitis, pneumonia, and bacteraemia. Since diarrhoea is a major cause of death in infancy and childhood, preparatory activities have been also carried out during the year for the initiation of rotavirus vaccination.

In EFY 2005 pentavalent 3 immunization coverage was 87.6%, PCV3 immunization coverage 80.4%, measles immunization coverage 83.2%, and the percentage of fully immunized children 77.7% (Table 2).

As shown in Figure 11, there was an increase in Pentavalent 3, measles and full immunization coverage rates, without meeting, however, any of the immunization coverage targets set for EFY 2005.

Other activities performed in EFY 2005 include the following:

- With respect to vaccine supply, an adequate amount of Bacillus Calmette-Guérin (BCG), pentavalent, PCV, and tetanus toxoid vaccines have been distributed to regions. A guideline that helps to accelerate the procurement process and ensure continuous supply of vaccines has been prepared.

Table 2:

Immunization Coverage Indicators

(EFY 2005 Baseline, Performance and Target and HSDP IV Target)

Indicators	EFY 2005 Baseline	EFY 2005 Performance	EFY 2005 Target	HSDP IV Target (EFY 2007)
Pentavalent 3 Vaccine Coverage	84.9%	87.6%	94.0%	96.0%
Pneumococcal Conjugated 3 Vaccine Coverage	44.4%	80.4%	83.0%	96.0%
Measles Vaccine Coverage	79.5%	83.2%	91.0%	90.0%
Full Immunization Coverage	71.4%	77.7%	87.0%	90.0%

- Polio immunization campaign has been carried out in woredas along the border of neighbouring countries. In order to avert the spread of polio cases detected recently in Kenya and Somalia, preparations are being made to conduct vaccination campaigns in nine zones of Somali Region, six zones of Oromia Region, and two zones of SNNPR.

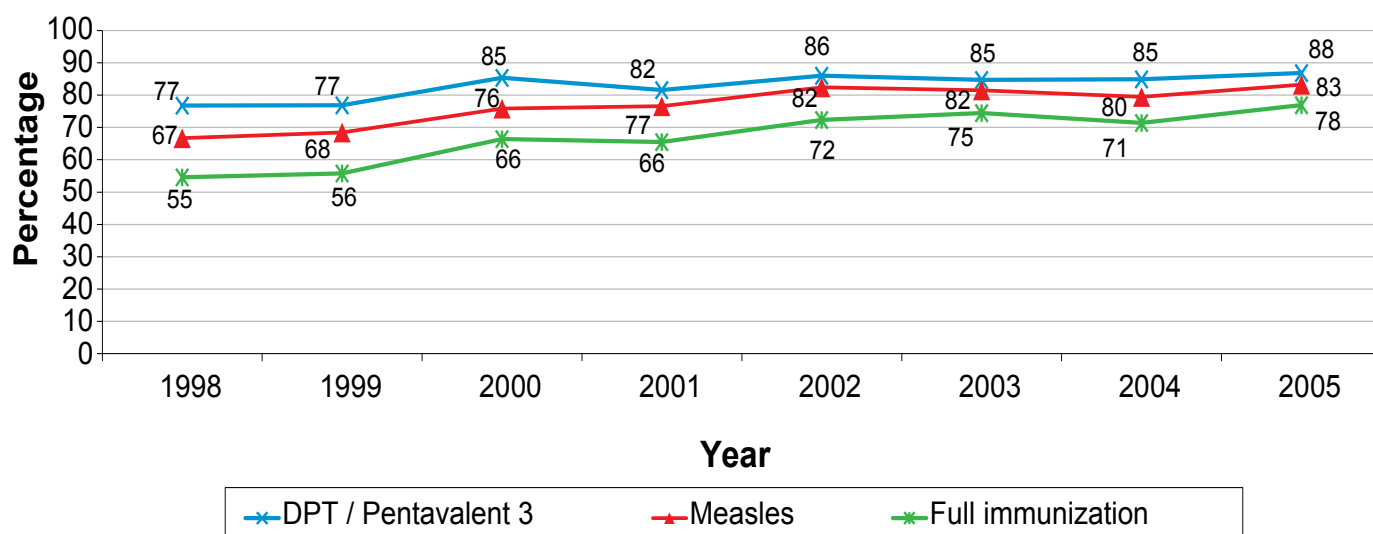


Figure 11: Trends in DPT/Pentavalent 3 Immunization Coverage, Measles Immunization Coverage and Full Immunization Coverage (EFY 1998-2005)

2.3.1.1. REGIONAL DISTRIBUTION OF PENTAVALENT 3 IMMUNIZATION COVERAGE

Pentavalent 3 coverage was 87.6% at the national level in EFY 2005, above the performance in EFY 2004 (84.9%), but short of the target (94.0%) set for the year. The highest coverage (100%) was found in SNNPR and the lowest in Gambella (43.5%) (Figure 12). An increase in performance was observed in all regions; however, except SNNP and Somali, all other regions performed below the target set for the year.

Of note is the fact that it is difficult, for the high performing regions, to further increase their immunization coverage and meet the target set for the year; therefore, the interpretation of target achievement should be made taking into account the regional performance context.

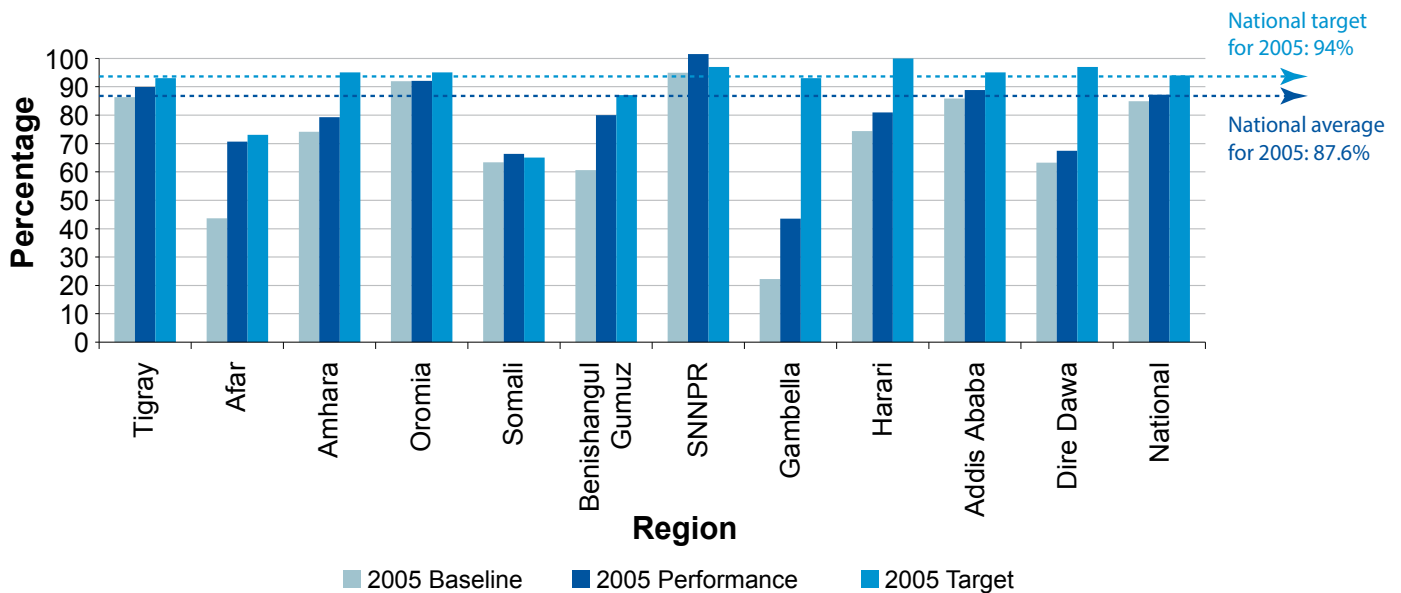


Figure 12: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2005)

2.3.1.2. REGIONAL DISTRIBUTION OF PNEUMOCOCCAL CONJUGATE VACCINE 3 IMMUNIZATION COVERAGE

PCV3 coverage was 80.4% at the national level in EFY 2005, above the performance in EFY 2004 (44.4%), but below the target (83.0%) set for the year. The highest coverage (99.2%) was found in SNNPR and the lowest one in Somali (8.8%) (Figure 13). All regions increased their performance in EFY 2005 (except Somali), with four regions (Afar, Amhara, Oromia, and SNNP) achieving their regional target.

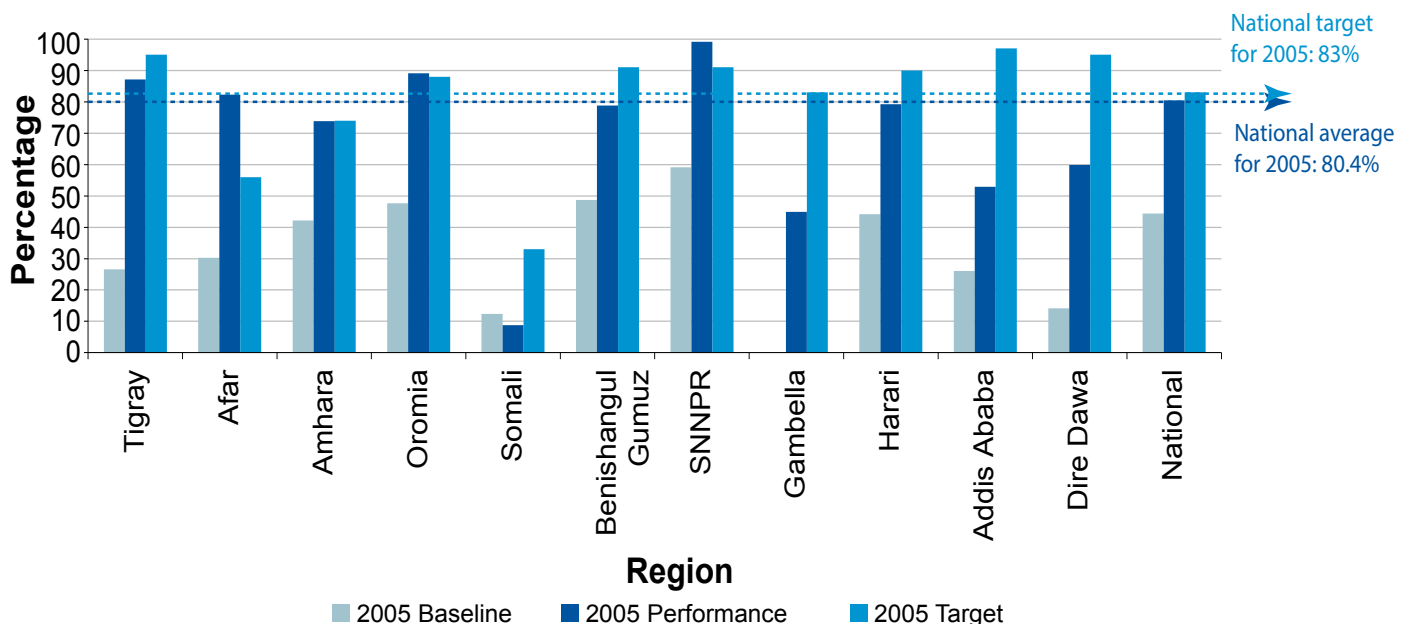


Figure 13: Comparison of Baseline, Performance and Target of PCV3 Immunization Coverage by Region (EFY 2005)

2.3.1.3. REGIONAL DISTRIBUTION OF MEASLES IMMUNIZATION COVERAGE

In EFY 2005, there was an increase in the measles immunization coverage (83.2%) from EFY 2004 performance (79.5%), short of the target set for the year (91.0%). Regional distribution showed that SNNP was the best performing region (99.3%) and Gambella performed the least (32.1%) (Figure 14). SNNP and Afar were the only regions performing above the targets set for the year, while the other nine regions showed a better performance in EFY 2005 than in EFY 2004, but below their regional target.

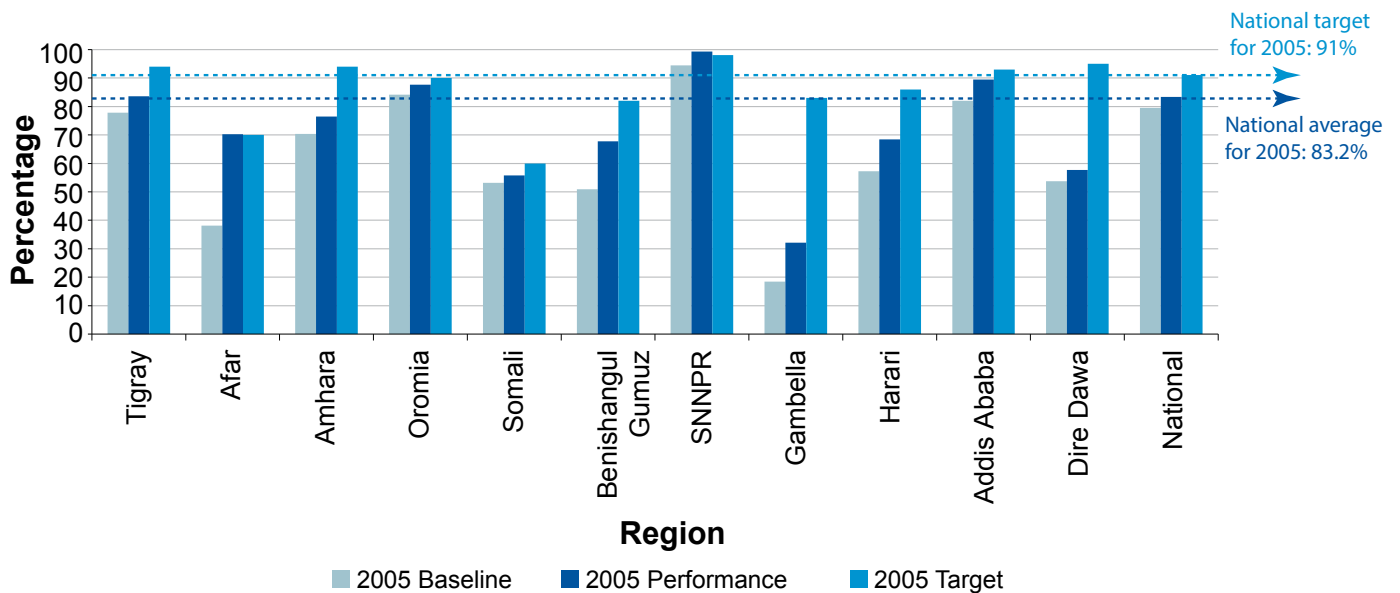


Figure 14: Comparison of Baseline, Performance and Target of Measles Immunization Coverage by Region (EFY 2005)

2.3.1.4. REGIONAL DISTRIBUTION OF FULL IMMUNIZATION COVERAGE

In EFY 2005, the full immunization coverage reached 77.7%, which was above the EFY 2004 performance (71.4%), and below the target (87.0%) set for the year. The highest coverage was observed in SNNPR (93.7%) and the lowest one in Gambella Region (26.4%) (Figure 15). Afar and SNNPR performed above their own target set for EFY 2005, whereas the performance of the remaining regions was below their regional target. However, all regions showed a better performance in EFY 2005 than in EFY 2004.

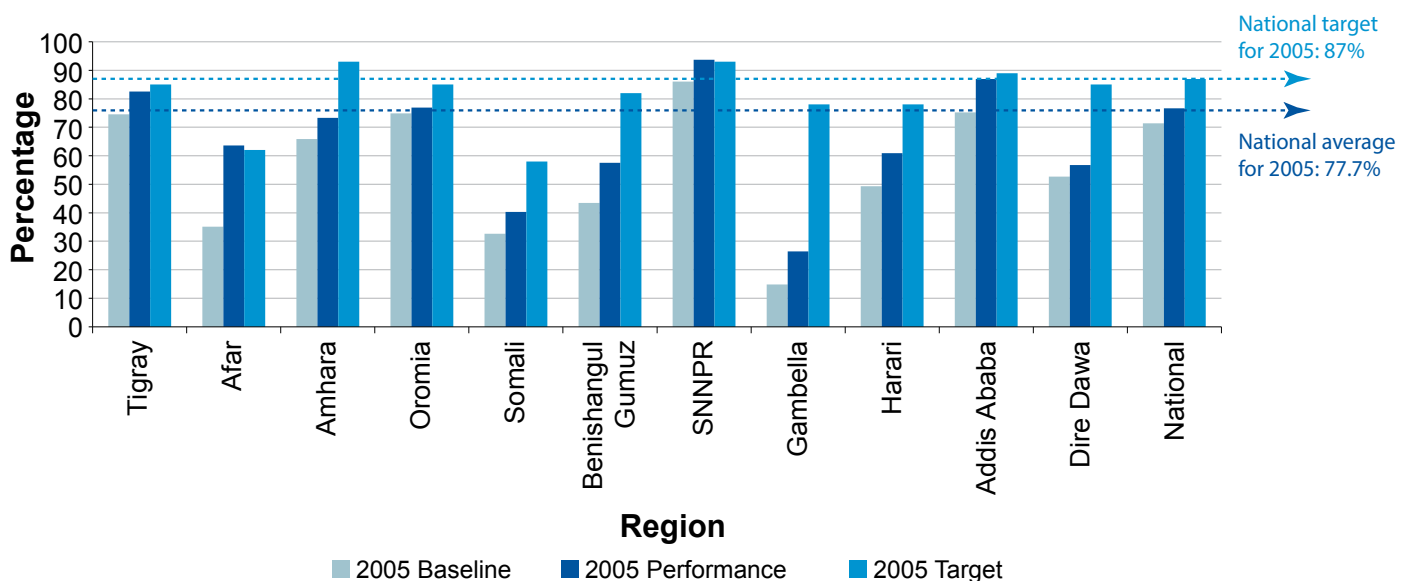


Figure 15: Comparison of Baseline, Performance and Target of Full Immunization Coverage by Region (EFY 2005)

2.3.2. INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES

The 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. It is therefore an integrated approach to child and neonatal health that aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age.

The cumulative number of HCs providing IMNCI increased from 2,030 in EFY 2004 to 2,373 in EFY 2005 (Table 3).

Table 3:

Distribution of Health Centers Providing IMNCI by Region

(EFY 2005)

Regions	Cumulative Number of HCs Providing IMNCI Service in EFY 2004	Cumulative Number of HCs Providing IMNCI Service in EFY 2005	Cumulative Number of HCs Available in EFY 2005
Tigray	181	183	214
Afar	19	19	62
Amhara	658	707	805
Oromia	545	668	1215
Somali	13	37	140
Benishangul Gumuz	15	32	32
SNNPR	522	638	663
Gambella	12	12	28
Harari	11	8	8
Addis Ababa	39	53	62
Dire Dawa	15	16	16
National	2,030	2,373	3,245

2.3.3. OTHER ACTIVITIES

According to the 2011 Ethiopia Demographic and Health Survey (EDHS), the reduction of neonatal mortality rate (NMR) has been slow during the last decade. In order to improve service delivery, the plan included establishment of NICUs (level III) in 16 university hospitals. To this end, 98 nurses drawn from 10 hospitals have been trained on neonatal intensive care services. In addition, the plan to expand neonatal care units in 40 regional hospitals is being implemented by strengthening the service in 27 hospitals that have already started the service. Furthermore, 1,546 professionals drawn from 850 health facilities without newborn corners have been trained and such corners have been established in 900 health facilities.

CHALLENGES

- Shortage of spare parts and accessories for refrigerators at HP level, and lack of proper concern for the cold chain system;
- Lack of daily vaccination services at HPs;
- Weak linkage between HPs and HCs;
- Health professionals giving more attention to mothers during delivery and less attention to neonates;
- High turnover of experienced health workers; and
- Inadequate knowledge and skills on neonatal care given to health professionals during their regular training prior to employment.

WAY FORWARD

- Strengthen cold chain management system through regular supply of spare parts and accessories for refrigerators at HP level;
- Provide daily vaccination services at HPs;
- Strengthen antenatal care and immunization services and decrease the number of drop outs by organizing HDA and initiating social mobilization;
- Strengthen the linkage between HPs and HCs;
- Devise and/or revise appropriate strategies for retention of experienced staff; and
- Promote both pre-service and in-service training and transfer of skills on neonatal care to health professionals.

2.4. NATIONAL NUTRITION PROGRAM

Implementing Vitamin A supplementation (VAS) and de-worming as well as scaling up community-based nutrition (CBN) and Universal Salt Iodization (USI) were the main activities planned in EFY 2005. Accordingly, the following activities were carried out during the year.

2.4.1. VITAMIN A SUPPLEMENTATION AND DE-WORMING

The national VAS coverage among children aged 6-59 months in EFY 2005 was 93.1%, below the target set for the year (99.0%), with a range between 39.0% in Addis Ababa to more than 100% in Afar and Somali Regions (Figure 16).

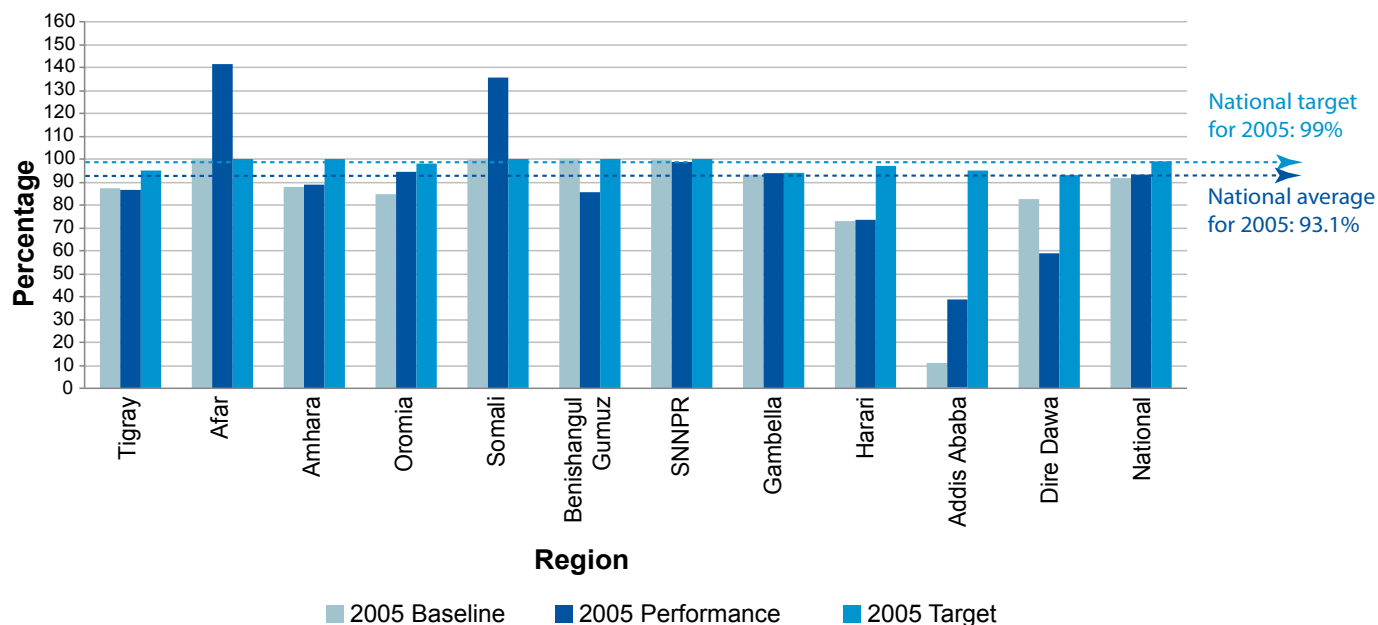


Figure 16: Comparison of Baseline, Performance and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region (EFY 2005)

In EFY 2005, the de-worming coverage of 2-5 years children (91.4%) was much higher than in EFY 2004 (19.8%), but below the annual target (95.0%).

The coverage ranged between 20.1% in Addis Ababa to more than 100% in Tigray, Afar, Somali and Gambella Regions (Figure 17).

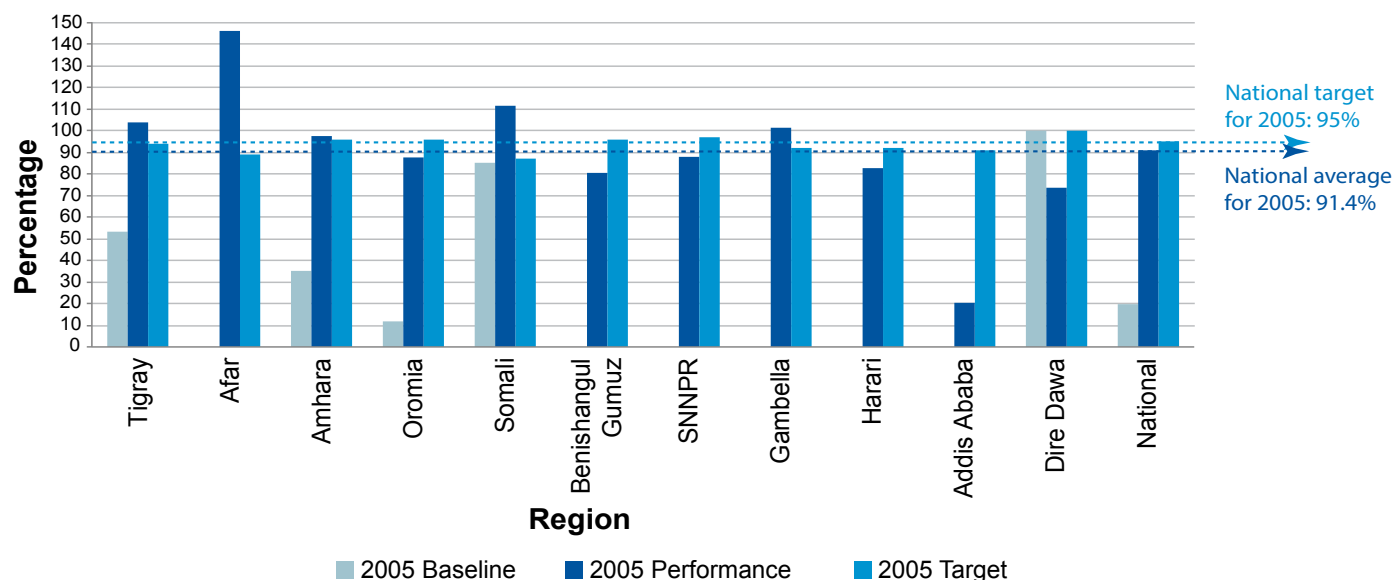


Figure 17: Comparison of Baseline, Performance and Target of Coverage of 2-5 Years Children De-wormed by Region (EFY 2005)

2.4.1.1. TRANSITION FROM ENHANCED OUTREACH STRATEGY TO COMMUNITY HEALTH DAYS AND HEALTH EXTENSION PROGRAM

In HSDP IV and in 2008 National Nutrition Program (NNP), it was planned to shift the delivery mechanism from Enhanced Outreach Strategy (EOS) to routine services as a way to ensure sustainability of the programs. Accordingly, the FMOH and its partners have developed the transition plan for VAS, de-worming and

nutritional screening delivery mechanism from vertical EOS to routine HEP. To facilitate this transition, a national orientation workshop was conducted and later cascaded to regional, zonal and woreda levels in order to provide guidance to the health staff involved in the shift from campaign mode to routine service delivery mode.

Currently EOS has already shifted to Community Health Days (CHD) in all 673 woredas of Amhara, Oromia, Tigray and SNNP Regions. In addition, CHDs have been shifted to routine HEP in 31 woredas of Amhara, Oromia and SNNP Regions. All the 27 woredas in the three urban regions (Harari, Addis Ababa and Dire Dawa) have also been shifted from EOS to routine HEP and are currently implementing the activity. The HEP modality is a routine (daily) service delivery of VAS which is a mix of facility-based and house-to-house delivery mechanism. In addition to VAS, de-worming and nutritional screening for children and pregnant and lactating women are also provided on a daily basis. In EFY 2006, all woredas in Tigray Region, 27 woredas in Amhara Region, 23 woredas in Oromia Region, and 20 woredas in SNNPR will implement routine delivery of VAS, de-worming and nutritional screening.

2.4.2. COMMUNITY BASED MANAGEMENT OF ACUTE MALNUTRITION

A total of 290,352 severely malnourished children were treated in EFY 2005, with a cure rate of 86.0%, a defaulter rate of 3.7%, and a mortality rate of 0.4%: these outcomes were similar to those recorded in EFY 2004 (85.2%, 4.1%, and 0.4%, respectively).

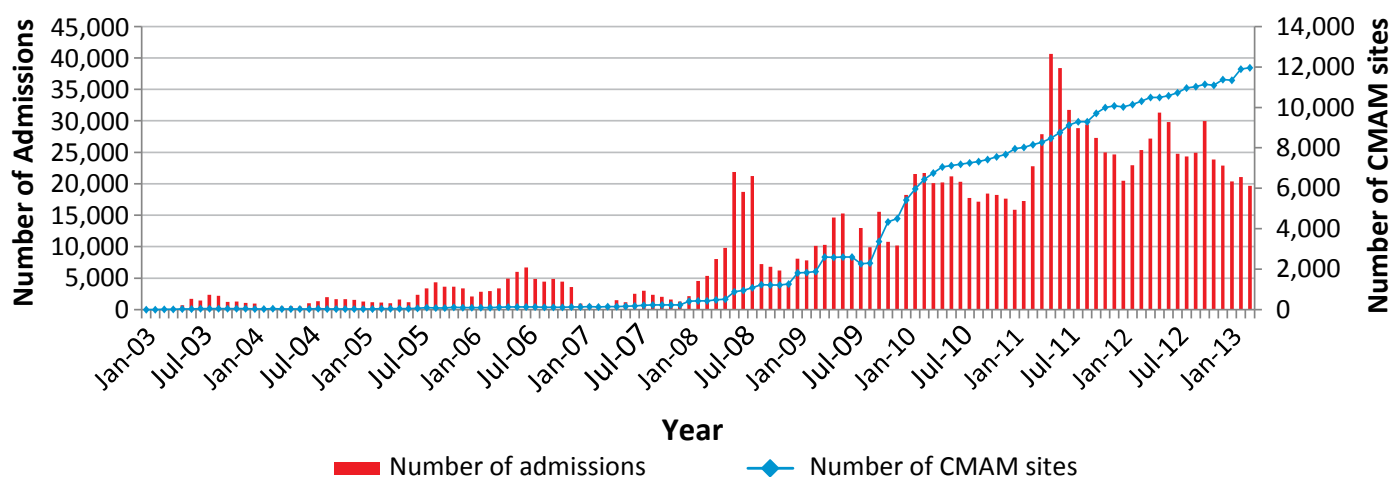


Figure 18: Number of Admissions and Number of CMAM Sites in Ethiopia (January 2003 to March 2013)

The monthly trend of admissions indicates that seasonal variation of malnutrition was less marked in EFY 2005 with respect to previous years (Figure 18). It is also worth noting the steady increase in community-based management of acute malnutrition (CMAM) sites over the past five years. Almost three fourth (64%) of the severely malnourished children were found in Oromia and SNNP Regions, and concerted efforts are needed to strengthen prevention of malnutrition and early response in case of emergency in these regions.

Moreover, 142,368 cartons (1,965 tons) of ready-to-use therapeutic foods (RUTF), 2,772 cartons of F100, 3,046 cartons of F75 and 210,031 bottles of Amoxicillin were distributed for the treatment of severe acute malnutrition together with registration books and patient follow up forms.

2.4.3. COMMUNITY BASED NUTRITION AS PART OF COMMUNITY MATERNAL, NEONATAL AND CHILD HEALTH

Malnutrition contributes to over half of child deaths in Ethiopia. Much progress has been made in addressing acute malnutrition through EOS for child survival, yet chronic malnutrition had been neglected, despite the fact that it constitutes 80% of all forms of malnutrition and may be causing irreversible consequences on children's physical and mental health.

In order to prevent malnutrition among children, family and community should be the first line of protection, therefore NNP gives a critical importance to the CBN. Currently, CBN activities are implemented in 365 woredas, and mothers/caregivers with children under two years of age are monthly weighed and counselled by HEWs to improve their nutritional status.

As a result, at the end of EFY 2005, 98 woredas started the implementation of CBN and about 900,000 children under the age of 2 years were weighed. The coverage of children under two years for Growth Monitoring and Promotion (GMP) sessions has increased from 38% in July 2012 to 46% in June 2013. The reporting rate from kebeles has also increased from 38 % in July 2012 to 79% (300 woredas) in June 2013.

The program has shown a consistent downward trend in underweight prevalence over time, with 1.8% reduction in EFY 2005 in CBN implementing woredas (Figure 19).

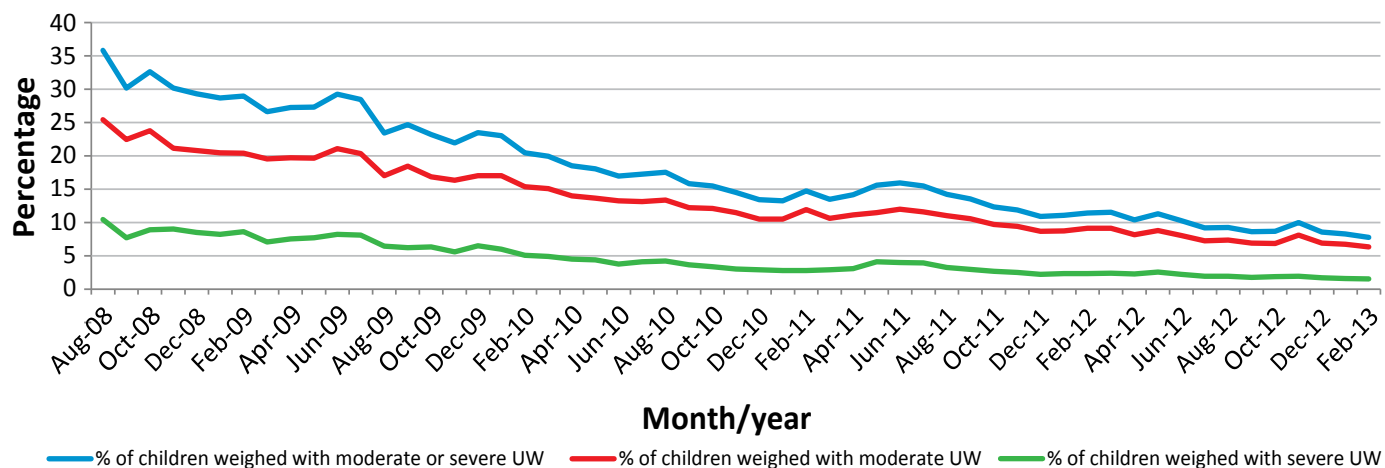


Figure 19: Trend in Percentage of Underweight Children Under Two Years of Age in CBN Woredas (Aug 2008 - Feb 2013)

2.4.4. SALT IODIZATION

The salt iodization momentum observed in EFY 2004 has continued in EFY 2005. According to reports from salt producers in Afdera, Dobi and Gudusbo, 3,449,607 quintals of iodized salt were produced, out of which 3,418,174 quintals were distributed to the market (99.1%), meeting 94.9% of the estimated annual demand of 3,600,000 quintals. There is general concern about iodization quality related to lack of focus by salt producers, wide use of low iodization technology (knapsacks) and delay in establishing proper Quality Assurance (QA)/Quality Control (QC) mechanism. Addressing QA/QC concerns as well as strengthening enforcement of the salt regulation will be main focus areas during EFY 2006.

The program used to be totally dependent on external donations; however, the newly initiated cost recovery scheme to make potassium iodate supply sustainable has made marked progress: as a result, over ETB 20 million were recovered and deposited in the central FMOH account so far. The process for procurement of 14 Metric Tons (MT) of new potassium iodate through Pharmaceutical Fund and Supply Agency (PFSA) using funds from cost-recovery mechanism is in progress. Delivery of the new potassium iodate is expected in the next 4-6 months, while the remaining stock of 12 MT will continue to be used for the same period. Overall facilitation of the procurement process and other alternatives need to be considered in order to avoid any supply breakdown. In EFY 2005 a total of 21 MT of potassium iodate was distributed to salt producers in the three areas with prepayment.

A joint assessment coordinated by the Ministry of Trade, Ministry of Industry, FMOH, FMHACA and two Salt Producers Associations, is currently underway to estimate the market demand and supply for iodized salt and address the imbalance between the increasing interest of salt producers to produce and sell more salt on one hand and the scarce supply of potassium iodate on the other hand.

2.4.5. OTHER ACTIVITIES

In EFY 2005, the revised NNP has been launched jointly by the FMOH, the Federal Ministry of Education (FMOE) and the Federal Ministry of Agriculture, based on the implementation framework for supporting the scaling up and monitoring of key nutrition interventions in the country:

- To address the nutrition problem in the country by taking into account the multispectral and multidimensional nature of nutrition and focusing on the Lifecycle Approach;
- To strengthen initiatives that were not adequately addressed in the 2008 NNP and to include initiatives that have emerged later, such as the Accelerated Stunting Reduction Initiative, the National Food Fortification Programme, and the multispectral linkages among key NNP implementing sectors;
- To align the end of the first phase of the NNP with the Growth and Transformation Plan (GTP) and MDGs—that is, to extend the first phase by 2 years to 2015;
- To implement a revised accountability and results matrix in order to show how each of the results can be realized and how each NNP implementing sector should contribute for better nutritional outcomes over the course of the lifecycle.

The National Micronutrient Intervention Guideline revision was done to incorporate some of the gaps identified in the previous guideline like: (i) food fortification; (ii) zinc; (iii) iron/folate; (iv) USI; and (v) public health approaches for the control of micronutrient deficiency.

FMOH has also planned to develop an Integrated Blended Nutrition Training Module for health workers at different levels. Accordingly, a steering committee was established, thematic areas were identified, and, based on their expertise, group members were assigned to each thematic area. The purpose of this module is to harmonize nutrition training materials used by different organizations/partners, and to improve the competency of the health workers. A national working group has been formed by FMOH to lead the process of development of the training material.

FMOH continued facilitating and coordinating the Food Fortification Steering Committee meetings. It finalized also the National Food Fortification Training Material and facilitated a consultative workshop and training on multi-stakeholder implementation of food fortification programme in Ethiopia with a total of 32 participants from donors, partners, different government sectors, academia and the media.

The revision of the “National Micronutrient Intervention Guideline” has been initiated by establishing a working group that has identified the following thematic areas: (i) iron folate; (ii) zinc; (iii) iodine; (iv) Vitamin A; (v) food fortification; (vi) food diversification; (vii) public health approach of prevention and control of micronutrient deficiencies; (viii) program communication, and (ix) M&E. Focal persons for each thematic area have also been nominated to identify gaps in the existing guideline and finalize the collection of information which could be an input for the revised guideline.

FMOH has also established a team who had taken the food fortification training from different sectors, agencies and authorities with the aim to work out the national food fortification programme plan of action in line with the NNP.

CHALLENGES:

- Shortage of supplies (like Albendazole, iron folate, potassium iodate);
- Lack of regional commitment to shift VAS, deworming and nutritional screening from CHD to routine service delivery according to the EOS transition plan;
- Inadequate adherence to regulation for salt iodization (such as low level of commitment of salt producers to improve quality, delay in establishing functional QA/QC systems, and weak enforcement of salt regulation and standards);
- Inadequate community mobilization through HDA;
- Weak supportive supervision and inadequate periodicity of review meetings; and
- Shortage of trained human resource in nutrition.

WAY FORWARD:

- Ensure supplies (like Albendazole, iron folate, potassium iodate);
- Ensure smooth transition to routine HEP service delivery of VAS, de-worming and nutritional supplementation;
- Ensure quality in salt iodization and strengthen the enforcement of salt regulation;
- Mobilize community through HDA;
- Strengthen supportive supervision and review meetings;
- Strengthen multispectral coordination for nutrition; and
- Ensure retention of staff.

2.5. PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

The following section explains what has been targeted and what has been achieved on HIV/AIDS, Tuberculosis (TB) and malaria prevention and control in EFY 2005.

2.5.1. HIV/AIDS PREVENTION AND CONTROL

HIV/AIDS is one of the top priorities of HSDP IV. According to the “HIV related estimates and projections for Ethiopia-2012” published by FMOH and Ethiopian Health and Nutrition Research Institute (EHNRI), the adult HIV prevalence is estimated at 1.3% (0.9% in males and 1.7% in females) and the adult HIV incidence at 0.03% in 2013.

Encouraging results have been achieved in HIV/AIDS control over the past years, with combination of sustained prevention efforts and increased ART coverage. Ethiopia has also made substantial gains in access to HIV prevention and treatment services among pregnant women living with HIV. As a result, the number of new infections among children has dropped. According to the “2013 progress report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive” published by the Joint United Nations Programme on HIV/AIDS (UNAIDS), Ethiopia is one of the seven countries – together with Botswana, Ghana, Malawi, Namibia, South Africa, and Zambia – showing a rapid decline by 50% or more of new HIV infections among children between 2009 and 2012.

Progress in the prevention and control of HIV/AIDS achieved in EFY 2005, as well as challenges still to be addressed, are presented on the basis of key service indicators.

2.5.1.1. TREND IN THE NUMBER OF FACILITIES PROVIDING HCT, PMTCT AND ART SERVICES

There was a steep increase in the number of facilities providing HIV Counselling and Testing (HCT), PMTCT, and ART services in the EFY 1998-2005 period (Figure 20): in particular, the increase was from 2,881 in EFY 2004 to 3,040 in EFY 2005 for HCT, from 1,901 to 2,150 for PMTCT, and from 838 to 880 for ART in the same period.

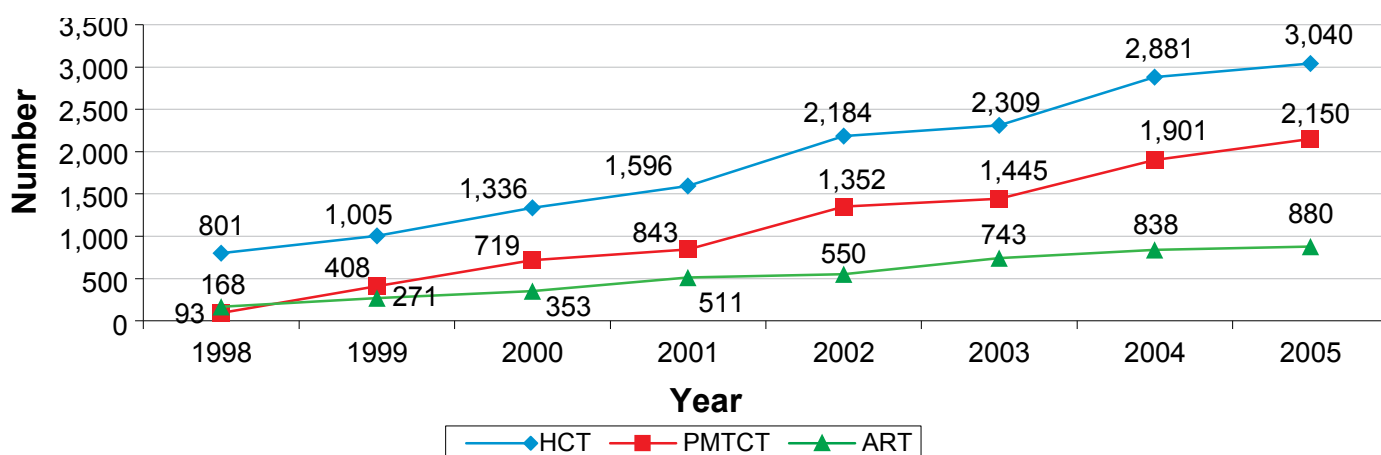


Figure 20: Trend in the Number of Facilities Providing HCT, PMTCT, and ART Services (EFY 1998-2005)

2.5.1.2. HCT SERVICE

The number of HCT services increased from 11,294,426 in EFY 2004 to 11,965,533 in EFY 2005 (Figure 21), above the target (10,902,756) set for the year at the national level.

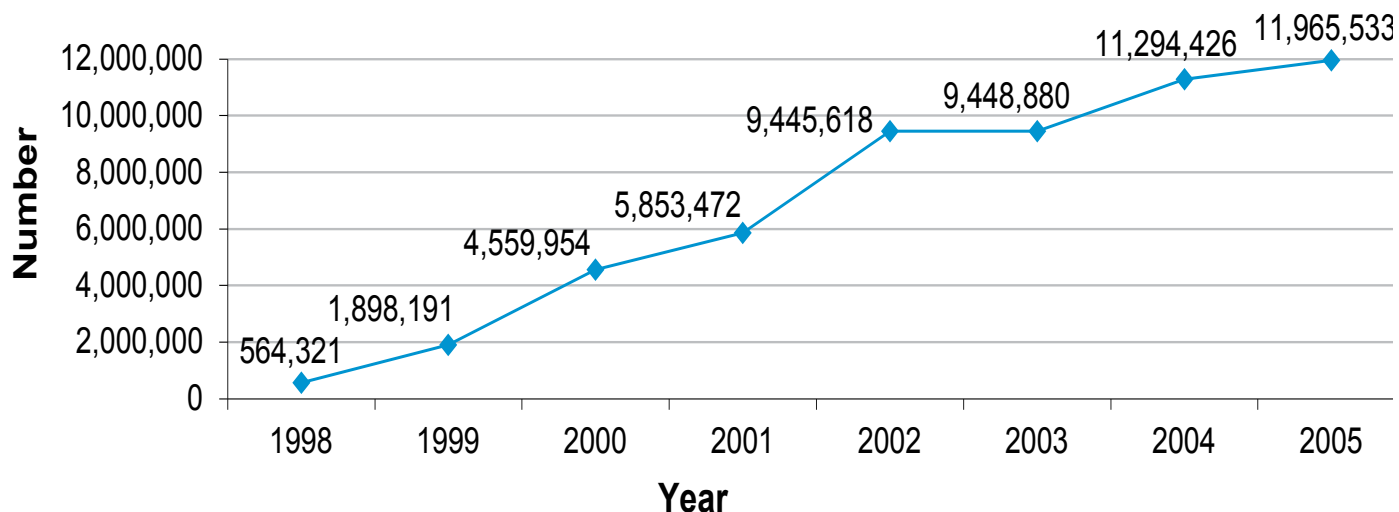


Figure 21: Trend in the Number of Clients Using HCT (EFY 1998 - 2005)

There were variations across regions, with four regions (Amhara, SNNP, Gambella, and Addis Ababa) increasing the number of clients using HCT in EFY 2005 with respect to the previous year (Figure 22). Four regions achieved their regional target (Amhara, SNNP, Harari, and Addis Ababa), while seven regions (Tigray, Afar, Oromia, Somali, Benishangul Gumuz, Gambella and Dire Dawa) performed below target.

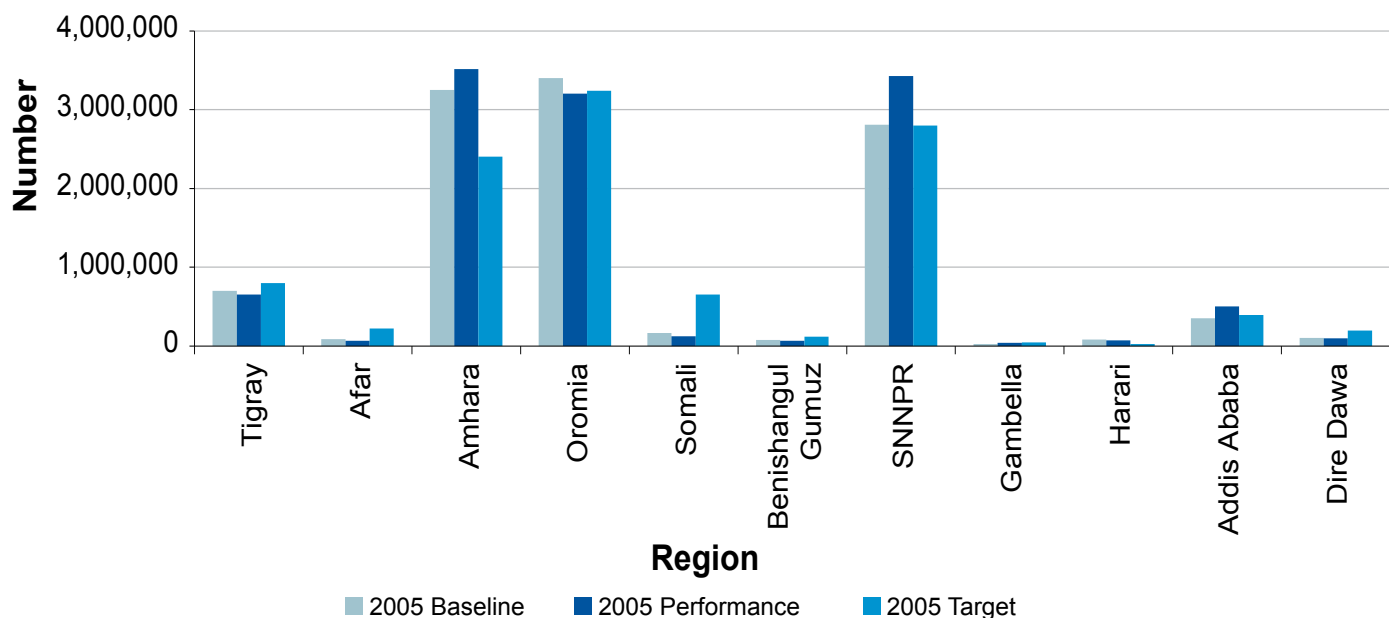


Figure 22: Comparison of Baseline, Performance and Target of the Number of Clients Using HCT by Region (EFY 2005)

2.5.1.3. ANTIRETROVIRAL TREATMENT

A linear increase has been observed in the number of PLWHA ever enrolled, ever started and currently on ART over the past seven years (Figure 23); in particular, there was an increase between EFY 2004 and EFY 2005 from 666,147 to 744,339 for PLWHA ever enrolled in HIV/AIDS care (+78,192), from 379,190 to 439,301 for those ever started (+60,111), and from 274,708 to 308,860 for those currently on ART (+34,152).

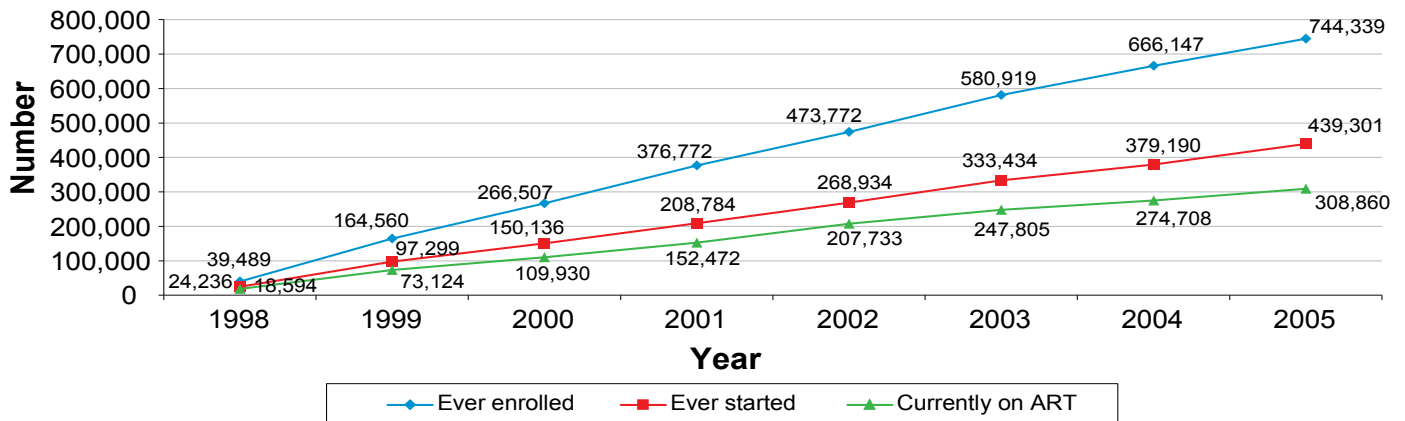


Figure 23: Trend in the Number of People Living with HIV/AIDS who Accessed Chronic HIV Care (EFY 1998 - 2005)

Figure 24 depicts the current pattern of access to chronic HIV care, showing the regional distribution of the cumulative number of PLWHA ever enrolled, ever started and currently on ART in EFY 2005. The highest number of PLWHA ever enrolled, ever started and currently on ART was found in Amhara, Oromia, and Addis Ababa Regions, followed by Tigray and SNNP Regions.

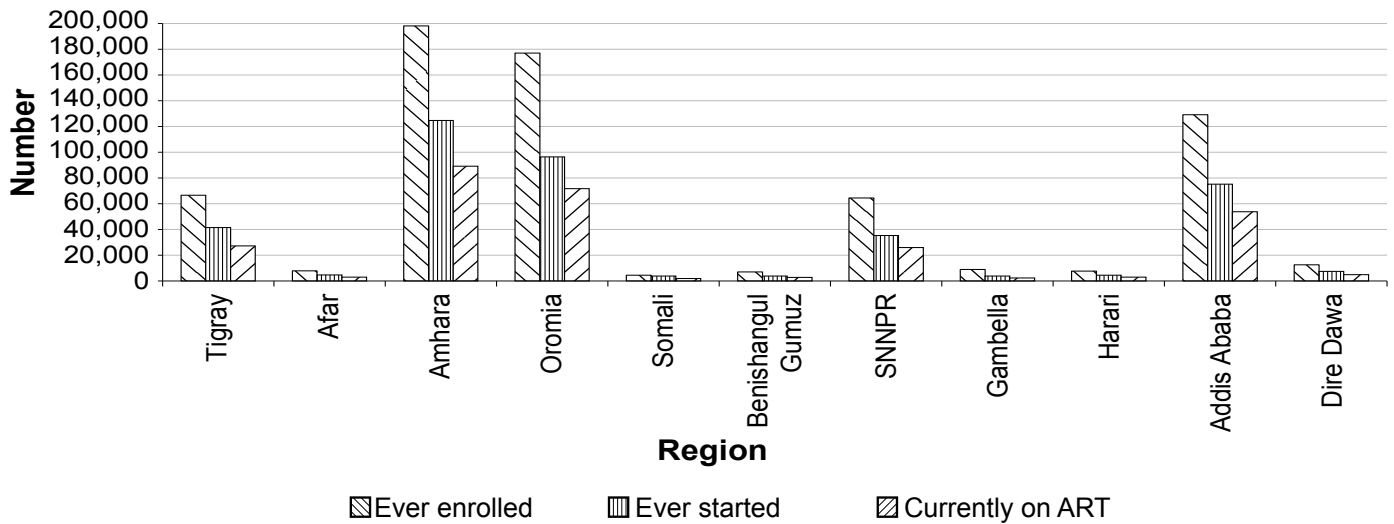


Figure 24: Distribution of PLWHA who Accessed HIV Chronic Care by Region (EFY 2005)

Concerning PLWHA currently on ART, out of the target of 409,426 set for the year, 308,860 PLWHA were currently on ART at the end of EFY 2005, with an average target achievement of 75.4%. Wide variations were observed across regions (Figure 25).

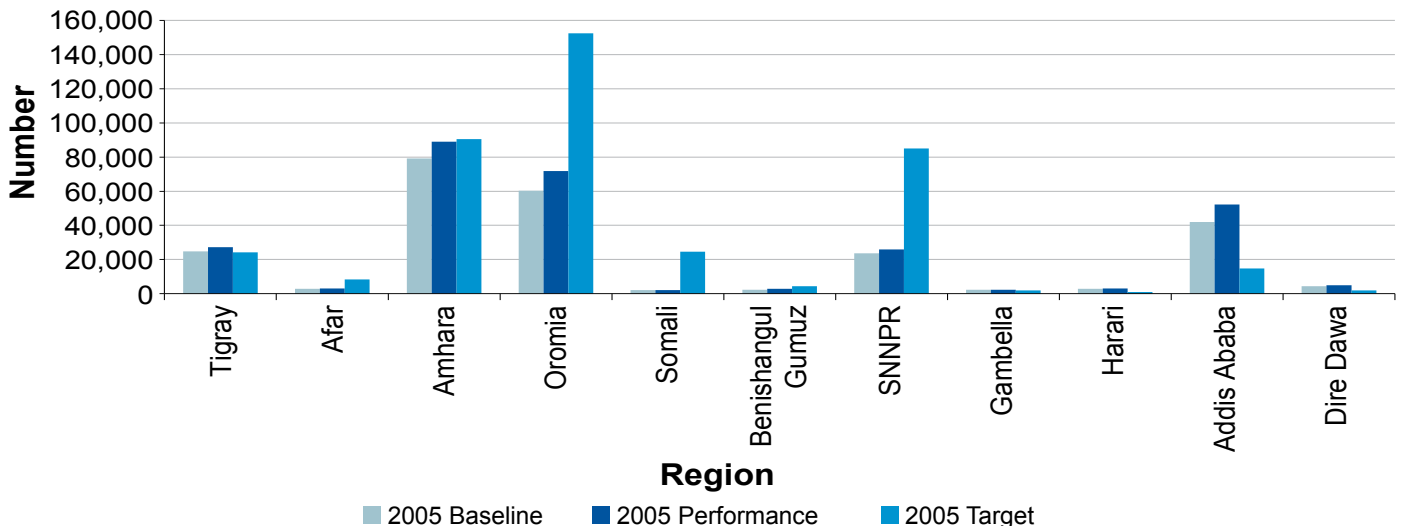


Figure 25: Comparison of Baseline, Performance and Target of the Number of PLWHA Currently on ART by Region (EFY 2005)

2.5.1.4. OTHER ACTIVITIES

In EFY 2005, a total of 139 million condoms were distributed to regions. Besides, a manual on the replacement of stavudine by zidovudine and tenofovir so as to reduce possible side-effects was prepared and distributed to regions.

With regard to PLWHA care and support, 67,852 PLWHAs received food support and 118,897 received psychosocial support. Furthermore, food support was provided to 141,025 orphaned and vulnerable children.

HIV/AIDS mainstreaming is also another area that was accomplished during EFY 2005. A total of 17 sector federal offices worked out on the mainstreaming of HIV/AIDS and put HIV/AIDS-related activities in their annual plan. Out of them, 12 designed HIV/AIDS policy according to their working environment and 15 assigned a coordinator. Twelve sector federal offices also formed a task force coordinating HIV/AIDS activities and 13 offices formed an AIDS fund.

CHALLENGES

- Absence of regular supportive supervision;
- Shortage of condoms and rapid diagnostic kits;
- Inadequate continuum of care before, during, and after delivery;
- Poor community awareness on PMTCT services;
- Difficulty in delivering services in pastoralist areas; and
- Limited capacity in data collection and use as well as in information dissemination.

WAY FORWARD

- Enhance supportive supervision;
- Ensure regular provision of condoms and other supplies;
- Ensure appropriate scale-up of Option B+ strategy;
- Promote behavioural change and community awareness through HDA;
- Implement service delivery adapted to mobile communities in pastoralist areas; and
- Strengthen the capacity in information use and dissemination.

2.5.2. MALARIA PREVENTION AND CONTROL

The two main goals of malaria prevention and control in the GTP are:

- Increase the percentage of under-five children who slept under a net from 41.2% in EFY 2002 to 86% in EFY 2007; and
- Increase the percentage of households with at least one mosquito net in malaria-endemic areas from 65.6% in EFY 2002 to 100% in EFY 2007.

The major activities planned for malaria prevention and control focused on expanding vector control and strengthening malaria case detection and treatment.

2.5.2.1. LONG-LASTING INSECTICIDE-TREATED NET DISTRIBUTION

In EFY 2005, a total of 12,562,286 Long-Lasting Insecticide-treated Nets (LLIN) were planned to be distributed to households in malaria endemic areas; however, only 1.2 million LLINs were distributed which increase the cumulative number to 46,976,866 (Figure 26).

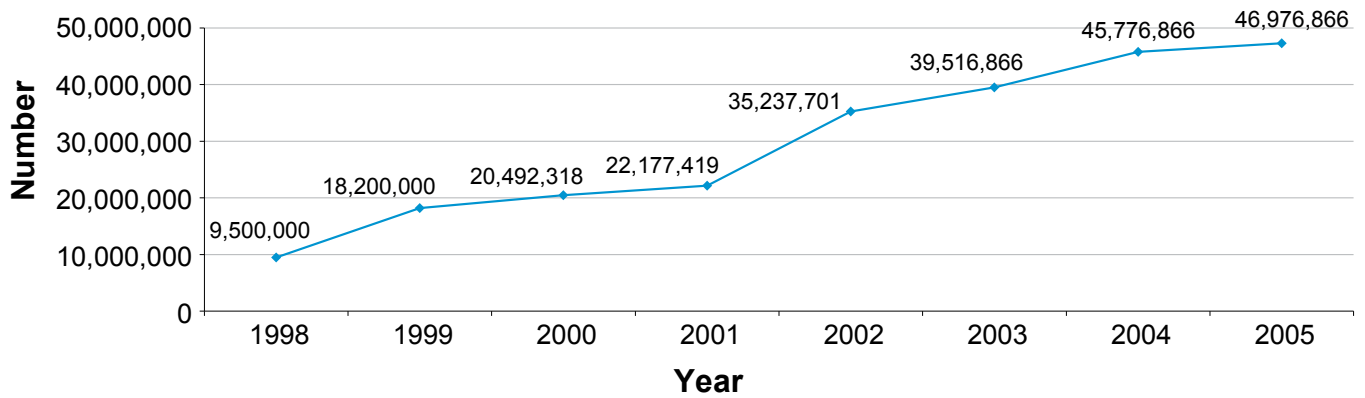


Figure 26: Trend in the Cumulative Number of Insecticide Treated Nets Distributed (EFY 1998 – 2005)

With regards to vector control, the plan was to implement Indoor Residual Spray (IRS) in 6,000,000 households in the fiscal year. However, in EFY 2005 a total of 5,032,693 households in malaria endemic areas were sprayed, which was higher than in EFY 2004 (4,383,819 households), but below the plan (6,000,000 households).

In order to strengthen the diagnosis and treatment of malaria in health facilities, rapid diagnostic tests (RDT) that can serve 18.3 million patients and anti-malarial drugs that can treat 12.8 million people have been distributed to malaria prone regions. In order to strengthen the malaria prevention and control activities, training was given for health professionals drawn from all regions, which was followed by supportive supervision visits. Different Information, Education, Communication (IEC)/BCC and promotional messages were disseminated through medias regarding vector control activities, Insecticide Treated Net (ITN) utilization, and malaria diagnosis and treatment.

2.5.2.2. TREND IN MALARIA CASES

In EFY 2005, the total number of laboratory confirmed plus clinical malaria cases was 3,862,735 (with an increase from 3,384,589 cases reported in EFY 2004). In particular, the monthly pattern showed an increase in the first half of EFY 2005 (reaching 597,617 cases in November), followed by a decrease in March (215,276) and an increase in the last three months of the year (Figure 27). A total of 291 deaths were recorded in EFY 2005, with a Case Fatality Rate (CFR) of 0.01%.

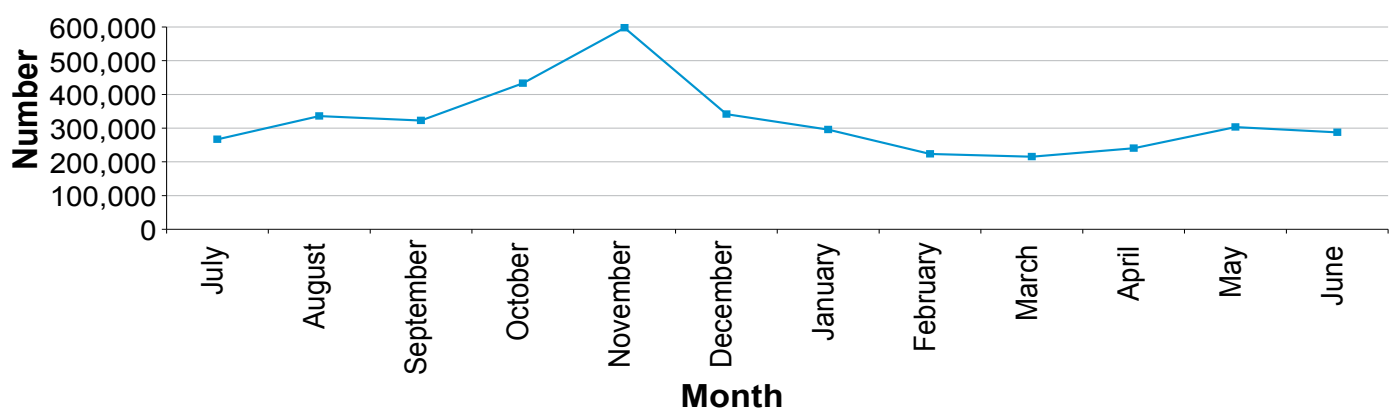


Figure 27: Trend in Laboratory Confirmed Plus Clinical Malaria Cases by Month (EFY 2005)

Out of the total 3,862,735 malaria cases reported in EFY 2005, 2,851,897 (73.8%) were confirmed by either microscopy or RDT tests, out of which 1,806,318 (63.3%) were Plasmodium falciparum (PF) and 1,045,579 (36.7%) were Plasmodium vivax (PV). The percentage of laboratory confirmed cases in EFY 2005 (73.8%) was higher than the percentage (53.0%) estimated in EFY 2004. The monthly patterns of the total laboratory confirmed malaria cases, PF malaria cases and PV malaria cases (Figure 28) were similar to the overall pattern of malaria cases (laboratory confirmed plus clinical) reported in EFY 2005.

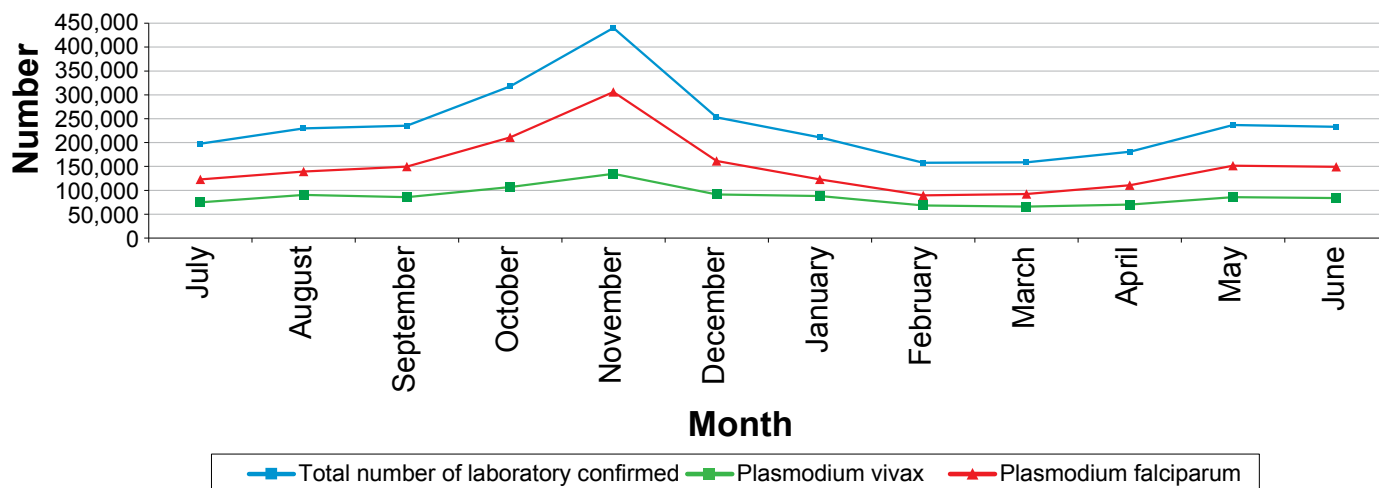


Figure 28: Trend in Laboratory Confirmed Malaria Cases, Plasmodium falciparum Malaria Cases, and Plasmodium vivax Malaria Cases by Month (EFY 2005)

In EFY 2005, the highest number of laboratory confirmed plus clinical malaria cases was reported from SNNPR (1,273,317), accounting for about one third (33.0%) of the total cases at the national level, followed by Amhara Region (1,185,111 cases, 30.7% of the total), and Oromia Region (708,530 cases, 18.3% of the total) (Table 4). Of note is the fact that the regional distribution of reported cases has changed in EFY 2005 with respect to EFY 2004, with an increase being observed in Amhara Region (from 655,966 to 1,185,111) and in Oromia Region (from 652,229 to 708,530), while a decrease was observed in SNNPR (from 1,587,771 to 1,273,317).

Table 4:

Distribution of Laboratory Confirmed plus Clinical Malaria Cases by Region (EFY 2005)

Region	Population at risk	Cases		
		Number	Incidence per 100,000 at risk population	Percent
Tigray	3,602,481	312,804	8,683	8.1%
Afar	1,607,906	63,734	3,964	1.6%
Amhara	15,236,981	1,185,111	7,778	30.7%
Oromia	21,923,328	708,530	3,232	18.3%
Somali	4,660,432	33,461	781	0.9%
Benishangul Gumuz	768,985	219,209	28,506	5.7%
SNNPR	11,607,175	1,273,317	10,970	33.0%
Gambella	390,593	54,353	13,916	1.4%
Harari	177,513	6,832	3,849	0.2%
Addis Ababa	310,190	4,043	1,303	0.1%
Dire Dawa	198,787	1,341	675	0.0%
National	58,369,959	3,862,735	6,618	100.0%

CHALLENGES

- Budget constraints at woreda level to conduct IRS activities;
- Delay in LLIN procurement to replace the old ones; and
- Inadequate utilization of LLINs.

WAY FORWARD

- Ensure budget for IRS activities;
- Ensure replacement of “old” LLINs; and
- Promote LLIN utilization

2.5.3. TUBERCULOSIS AND LEPROSY PREVENTION AND CONTROL

The main 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.

In EFY 2005, it was planned to start TB case management at HP level, to increase the number of facilities that treat Multi-Drug Resistant TB (MDR-TB), and to strengthen leprosy case detection and treatment.

It is worth reminding that, as described in the EFY 2004 Report, a TB prevalence survey was carried out in 2011: in this survey, the prevalence of all forms of TB in Ethiopia was estimated at 240 per 100,000, meaning that Ethiopia has around 192,000 cases. In the same year of the survey (2010/11), the TB case notification rate to the National Tuberculosis Control Program (NTCP) was 172 per 100,000, and the Case Detection Rate (CDR) was 73% (consistent with the CDR of 72% published in the 2011 WHO Global TB Control Report). This estimate was slightly above the international standard of 70%. However, despite this result, constant efforts and resources should be ensured to address the remaining challenges and sustain achievements.

2.5.3.1. TB PREVENTION AND CONTROL

2.5.3.1.1. TB CASE NOTIFICATION

In EFY 2005, a total of 130,614 TB cases (all forms) were reported with a TB case notification rate of 152 per 100,000 population; this performance was below that observed in EFY 2004, when 145,367 cases (all forms) were reported with a TB case notification rate of 172 per 100,000 population. Out of the 130,614 cases reported in EFY 2005, 33.4% were smear positive pulmonary TB, 34.5% were smear negative pulmonary TB, and 32.1% were extra pulmonary TB.

There was regional variation in TB case notification, ranging from 87 per 100,000 population in Somali to 635 per 100,000 population in Harari (Figure 29). Cases may be missed by routine notification system because TB patients do not seek care, seek care but remain undiagnosed, or are diagnosed by public or private providers that do not report cases.

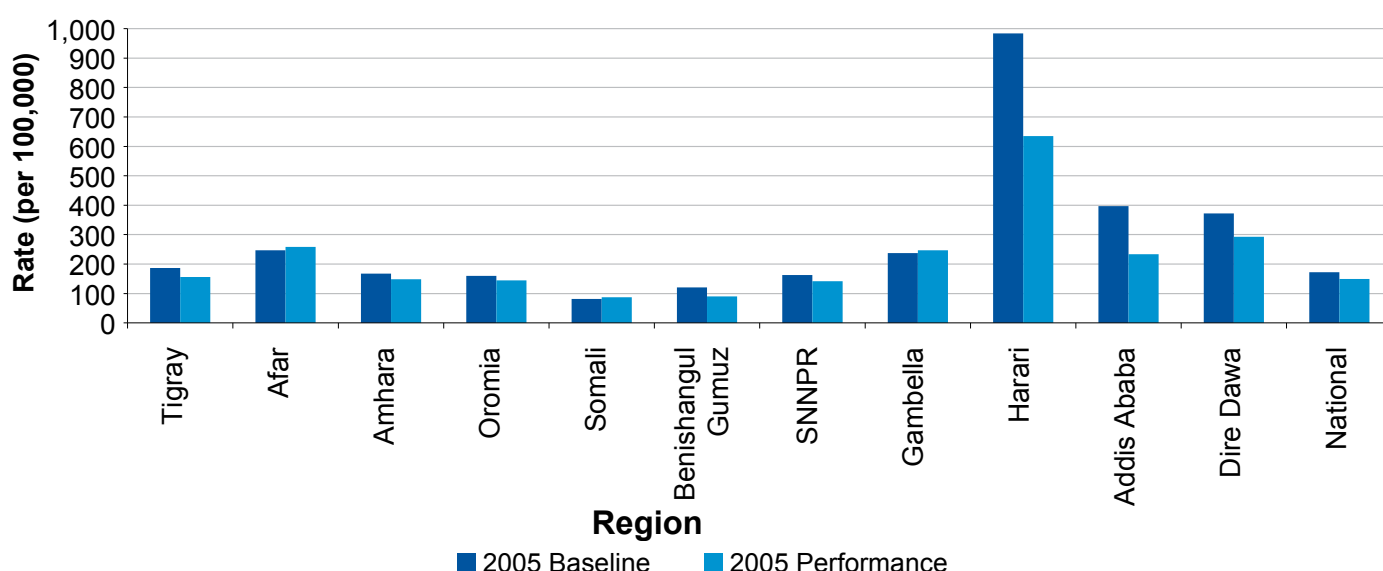


Figure 29: Comparison of Baseline and Performance of TB Case Notification Rate by Region (EFY 2005)

2.5.3.1.2. TB CASE DETECTION RATE

In EFY 2005, the TB case detection rate was 58.9%, below the detection rate estimated in 2011 TB prevalence survey (72%) as well as the target set for the year (82.7%). Variations were observed across regions, ranging from 33.7% in Somali Region to over 100% in Afar, Harari and Dire Dawa (Figure 30).

The lower detection rate in EFY 2005 is related to a decrease in numerator (due to the lower number of case detected).

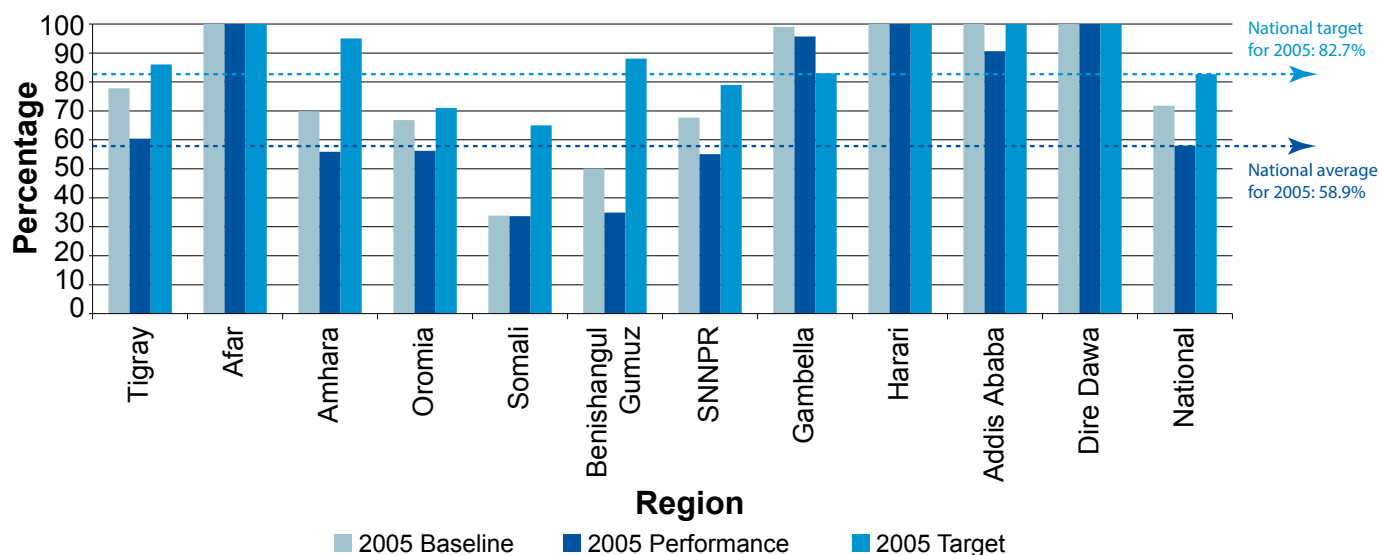


Figure 30: Comparison of Baseline, Performance and Target of TB Case Detection Rate by Region (EFY 2005)

2.5.3.1.3. TB TREATMENT OUTCOMES

Concerning treatment outcomes two indicators are presented: TB Treatment Success and Cure Rates.

TB treatment success rate (TSR) showed a slight increase from 90.6% in EFY 2004 to 91.4% in EFY 2005 (below the target of 95% set for the year), while TB cure rate increased from 68.2% to 70.3% in the same period (below the target of 79% set for EFY 2005) (Figure 31).

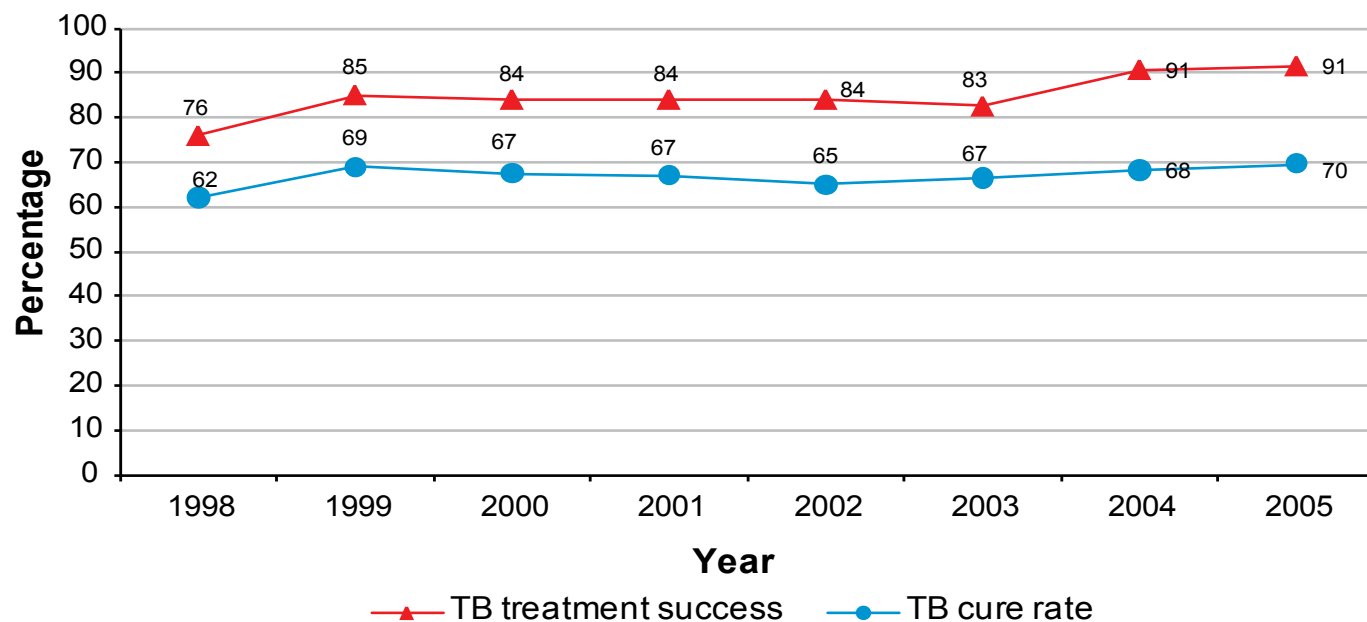


Figure 31 : Trend in TB Treatment Success Rate and TB Cure Rate (EFY 1998 - 2005)

2.5.3.1.3.1. TB TREATMENT SUCCESS RATE

TB TSR slightly increased from 90.6% in EFY 2004 to 91.4% in EFY 2005, which was below the target set for the year (95%). Large variations were seen across regions, with the highest performance being observed in Gambella and Dire Dawa Regions. The lowest performance was observed in Harari Region, where TB patients from other regions get diagnosis (being included in the cohort and counted in the denominator for the estimation of TSR), while returning back to their regions for treatment (not being counted in the numerator of TSR in the region).

Five regions (Amhara, Oromia, Gambella, Harari, and Dire Dawa) improved their performance in EFY 2005, while a decrease in performance was observed in six regions (Tigray, Afar, Somali, Benishangul Gumuz, SNNP and Addis Ababa) (Figure 32).

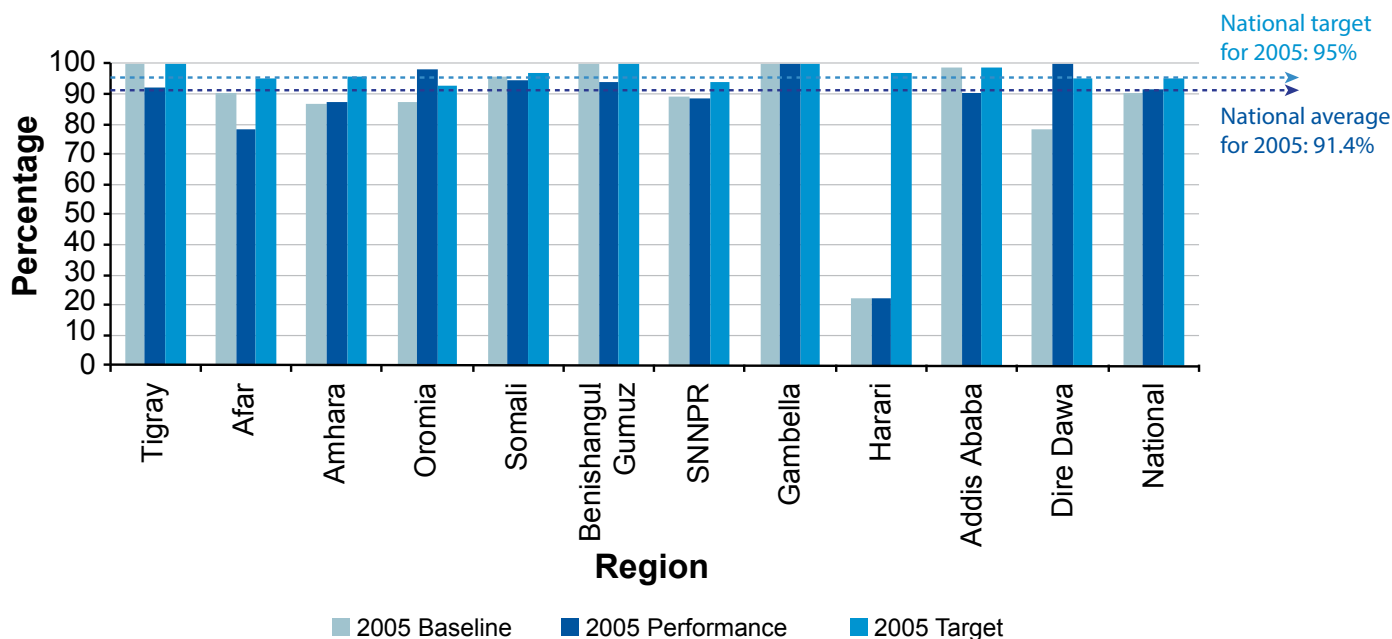


Figure 32: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2005)

2.5.3.1.3.2. TB CURE RATE

TB cure rate increased to 70.3% in EFY 2005 from 68.2% in EFY 2004, but it was below the target set for the year (79%) (Figure 33). The best performance was found in SNNPR (80.6%), while five regions (Tigray, Afar, Benishangul Gumuz, Gambella and Addis Ababa) decreased their performance in EFY 2005.

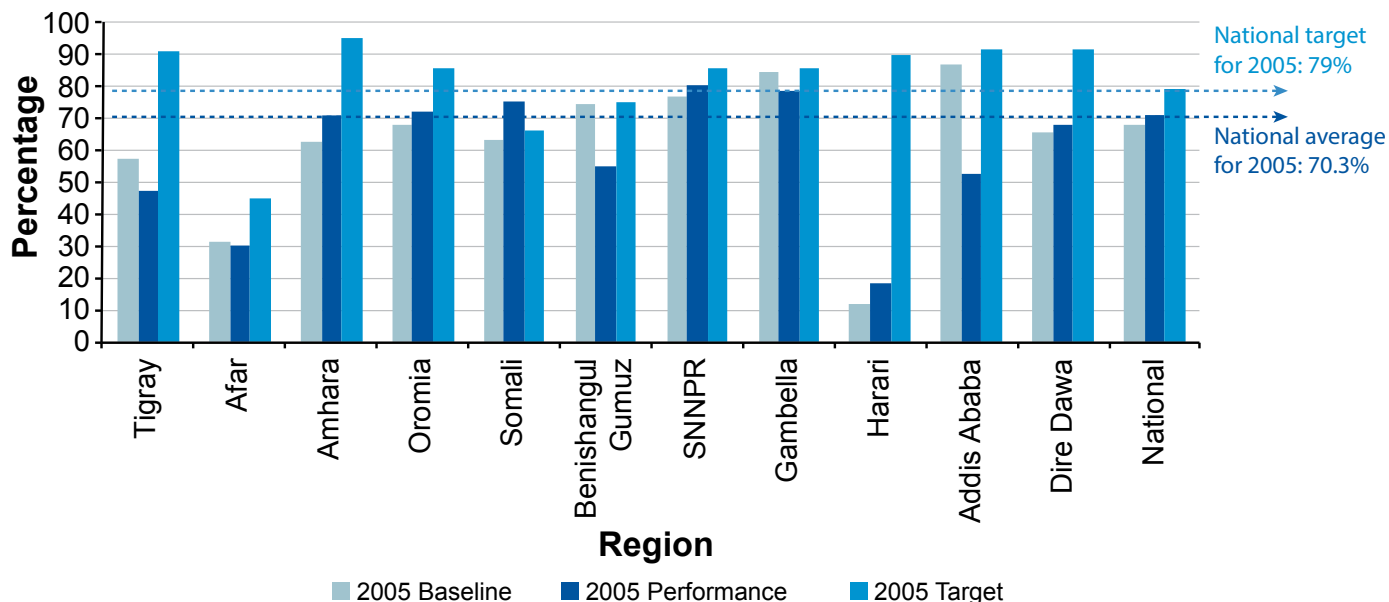


Figure 33: Comparison of Baseline, Performance and Target of the TB Cure Rate by Region (EFY 2005)

2.5.3.2. OTHER ACTIVITIES

To increase the awareness of the community on TB, different messages were broadcasted in different languages through various medias. A total of 10,000 copies of reference material for school children on TB prevention and control were prepared and distributed to schools.

The 8th National Tuberculosis Research Advisory Committee Annual Conference was held in Addis Ababa (21 -23 March 2013). This conference was organized jointly by the FMOH, EHNRI and Addis Ababa City

Administration Health Bureau on the theme “Evidence for Action: Strengthening operational research and innovative approaches for TB control in Ethiopia”, highlighting the need for evidence to guide actions and decisions, as well as to design strategies and interventions in addressing the burden of TB in Ethiopia. More than 2,000 participants attended the conference and 70 scientific papers were presented.

To start using anti-TB patient kits in selected zones, an implementation manual was developed, and 760 health professionals were trained, including pharmacy technicians drawn from regional, zonal and woreda levels.

To strengthen TB prevention and control activities in prisons, assessment was done in selected federal and regional prisons in collaboration with the Federal Prisons Administration Authority. Based on the assessment findings, an implementation plan was developed and finalized in a workshop involving all RHBs, all regional prison administrations, and partners.

In EFY 2005, TOT was provided for 50 health professionals coming from 17 hospitals in order to initiate MDR-TB treatment for 900 patients in these hospitals. Furthermore, six health facilities (Nekemt, Dilchora, Borumeda, Mekele, Shashemene, and Geda HCs) started MDR-TB treatment, and eight health facilities (Minilik, Hosana, Yirgalem, Chiro, Shene Gibe, Debre Markos, Debre Birhan, and Finote Selam Hospitals) completed their preparatory work and will start MDR-TB treatment in the coming fiscal year. The total number of MDR-TB treating health facilities has increased from 3 in EFY 2004 to 18 in EFY 2005.

In addition, a total of 600 new MDR-TB patients have started the treatment (below the planned 900) in EFY 2005, reaching the cumulative number of 940 MDR-TB patients under treatment.

MDR-TB diagnostic laboratories increased from 2 to 7 with the newly functional TB culture services at Adama, Bahir Dar, Mekele, Hawasa and Jimma Regional Laboratories, and 2,764 MDR-TB suspected samples were examined.

To increase the capacity of health professionals working in leprosy prevalent areas, 70 health professionals were provided with a 3 weeks in-service leprosy and dermatology training.

Algorithms and job aids on TB case finding among HIV positives, screening and implementation of Isoniazid Preventive Therapy, infection control measures, suspect identification and diagnostic algorithm of MDR-TB were developed, printed and distributed to health facilities.

A total of 162,970 anti TB drugs and 53,000 TB diagnostic reagents were distributed to respective regions.

CHALLENGES

- Irregular supply of reagents;
- Inadequate implementation of External Quality Assessment (EQA);
- Underutilization of TB culture diagnostic services due to insufficient sample transportation mechanism;
- Incomplete and delayed reporting from some Health Facilities (HF) and Woreda Health Office (WorHO);
- Low ownership of MDR-TB at all levels stalling the expansion of MDR-TB treatment sites; and
- Inadequate implementation of daily observed treatment at facility level.

WAY FORWARD

- Strengthen the supply of reagents;
- Improve the quality of laboratories through strengthening External Quality Assessment (EQA) coverage and provision of quality microscopes;
- Strengthen sputum sample transportation to effectively utilize TB culture diagnostic facilities;
- Promote community participation on suspect TB identification through HDA and community TB care expansion;
- Strengthen planning, M&E, reporting and implementation capacity; and
- Implement daily observed treatment at facility level.

2.5.4. PREVENTION AND CONTROL OF NEGLECTED TROPICAL DISEASES

The multi-year National Master Plan for the Control/Elimination/Eradication of Neglected Tropical Diseases (NTD) was launched in EFY 2005, including dracunculiasis, onchocerciasis, lymphatic filariasis, leishmaniasis, schistosomiasis, soil transmitted helminths, trachoma, and podoconiosis. Most of these diseases are either preventable through mass drug administration (MDA) and proper hygiene and sanitation, or treatable through systematic case finding and management.

NTDs share some common features: they affect neglected population (those least able to demand and access services) and they are often related to poverty and disadvantage. Furthermore, different NTDs show similar or even overlapping epidemiological distribution and affect the same population groups; therefore, documenting their co-endemicity helps to implement integrated MDA strategies. It is for this reason that HSDP IV includes initiatives for completing maps of NTDs, and putting in place an integrated approach as well as co-implementation of intervention packages.

In this perspective, a National Symposium on NTDs was held in Addis Ababa in the period 12-14 June 2013, under the theme: “End the neglect, integrate, scale up and sustain”, with the participation of over 400 representatives of relevant line ministries and government agencies, RHBs, research institutions, non-governmental organizations, and development partners. During the symposium, a platform was established for knowledge sharing and documentation of best practices in NTDs, and the National NTD Master Plan was launched.

2.5.4.1. DRACUNCULIASIS (GUINEA WORM INFECTION)

Since its commencement in 1994, the Guinea Worm (GW) eradication program has been making good progress with rapid decline of GW cases in Ethiopia. Currently, only Gambella Region is still endemic, with six cases being reported from two districts (Abobo and Gog) in EFY 2005. Despite the decrease in number of cases observed over the past years (Figure 34), GW eradication remains a challenge.

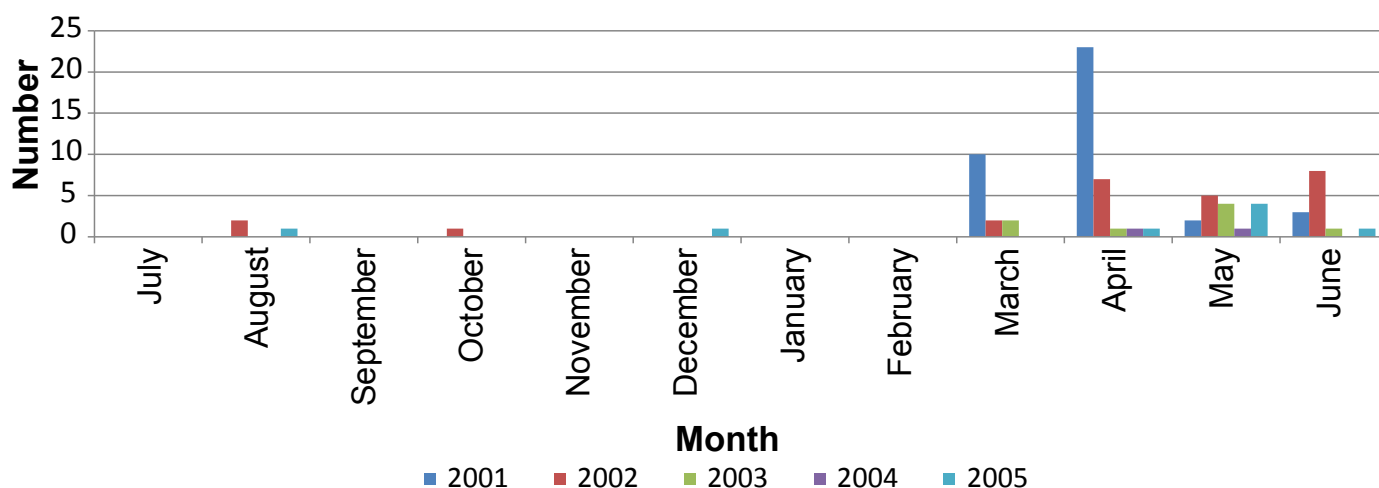


Figure 34: Trend in Guinea Worm Cases by Month (EFY 2001 to 2005)

Mapping exercises as well as health education and advocacy activities have been carried out in EFY 2005. In particular, mapping of risk villages, ponds, and crossing points has been conducted in three districts in Gambella Region, and it is still ongoing in the others, as well as in South Omo and Bench Maji Zones of SNNPR. Village volunteers selection and training have been also conducted. To enhance community awareness, a film show program was performed using mobile van in Gambella Region and in Bench Maji and South Omo Zones (SNNPR). Nationwide awareness campaign has also been performed on Ethiopian broadcasting radio stations and Ethiopian TV. High level advocacy mission on GW eradication was conducted in Gambella Region, led by the Minister of Health H.E. Dr. Kesetebirhan Admassu, with the participation of FMOH, EHNRI and RHB officers as well as DP representatives.

2.5.4.2. ONCHOCERCIASIS AND LYMPHATIC FILARIASIS

Onchocerciasis is endemic in five regions (Oromia, Amhara, SNNP, Gambella, and Benishangul Gumuz). In 2012, the third round of the Rapid Epidemiological Mapping for Onchocerciasis (REMO) was carried out in 33 suspected districts that are adjacent to the 34 endemic districts already identified in the second REMO round conducted in 2011: these new districts have been included in the 2013/2014 plan for Community Directed Treatment Intervention (CDTI). The number of people requiring Ivermectin treatment was 6,446,552 in 2012, increasing to 11,353,243 in 2013/14 on the basis of the 2011 and 2012 REMO results. The number of trained community drug distributors and health workers reached 93,860 and 5,894, respectively. The preparation of the Action Plan for Onchocerciasis Elimination is under way and will be finalized next year.

Concerning lymphatic filariasis (LF), in the national LF survey carried out in the period 2008-2010, 34 districts were found endemic in five regions: Benishangul-Gumuz, Gambella, SNNP (Keffa, Sheka, and Benchmaji Zones), Oromia (West Wollega Zone), and Amhara (North Gondar Zone). Out of these districts, 20 were found co-endemic for LF and onchocerciasis and included in the plan for MDA under the co-implementation strategy. MDA will be implemented in the other LF endemic districts during the next year.

Furthermore, co-mapping of LF with podoconiosis has been carried out in 692 districts of the country.

2.5.4.3. LEISHMANIASIS

The control of leishmaniasis is one of the targets of HSDP IV. Both visceral and cutaneous leishmaniasis are endemic in Ethiopia: visceral leishmaniasis (VL), the fatal form of the disease, is mainly affecting the low lands of Amhara and Tigray Regions (with 3 million people being at risk), whereas cutaneous leishmaniasis (CL) is widely distributed in the highland part of the country (where 17 million people are at risk).

Of note is the fact that Ethiopia is one of the major VL endemic countries with an estimated annual number of incident cases of 3,700-7,400. The national VL control programme was established in 2006 following the Libo Kemkem outbreak in Amhara Region, making Ethiopia the only African country with established national control programme. It focuses on early diagnosis and prompt treatment, integrated and decentralized service provision, integrated vector management, as well as on improved disease surveillance and public awareness. The VL/HIV co-infection is one of the highest in the world, with reported 15-20% co-infection rate.

Capacity building of health care workers, procurement and distribution of drugs and diagnostics, as well as revision, printing and distribution of the second national guideline are among the activities conducted in EFY 2005. Mapping the geographical distribution and investigations on entomological risk factors are also under way.

Moreover, Ethiopia is one of the four countries in the world selected for free donation of Liposomal Amphotericin B. The VL services have been decentralized to the endemic regions. Currently 18 health facilities provide treatment for VL.

2.5.4.4. TRACHOMA

Trachoma mapping in Ethiopia is being carried out under the Global Trachoma Mapping Project (GTMP). Mapping was completed in Oromia, Tigray, SNNP, and Somali Regions, while it is still under way in Afar. Mapping of other two regions (Gambella and Benishangul-Gumuz) is planned for the next year. As a result of this mapping exercise, it will be possible to identify the suspected endemic districts nationwide and plan control activities accordingly.

Nationally, there are 226 districts (27,000,000 people) which are receiving zithromax annually, with Amhara Region being the biggest receiver. In EFY 2005, 8,706,461 people have received the drug and the remaining will receive it in the next year. Among the regions having already completed the mapping exercise, Oromia has already prepared its Trachoma Action Plan, while the planning exercise is still under way in SNNP and Tigray Regions and will be completed in the next year.

2.5.4.5. SCHISTOSOMIASIS AND SOIL TRANSMITTED HELMINTHIASES

In order to estimate the national prevalence of schistosomiasis and soil transmitted helminthiases, a school-based national integrated survey has been planned in all districts of Ethiopia in September and October 2013.

In EFY 2005, 3.5 million tablets of Praziquantel and 6.8 million tablets of Mebendazole have been distributed for regions, and scale up of MDA activities has been planned after completion of the mapping exercise.

CHALLENGES

- Incomplete mapping for some NTDs;
- Limited coordination and co-implementation of activities;
- Limitation in the surveillance system; and
- Limited community mobilization.

WAY FORWARD

- Complete the mapping of NTDs;
- Strengthen coordination and co-implementation of activities;
- Strengthen surveillance nationwide; and
- Promote community mobilization.

2.6. PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

Non-Communicable Diseases (NCD) are becoming an increasingly important public health problem as epidemiological transition is progressing in Ethiopia. Several activities were carried out in EFY 2005, with a major focus on mental health.

According to the HSDP IV initiative to integrate and expand mental health service into the routine health service delivery system, TOT was given for 11 professionals drawn from different regions; and this training has been cascaded and given for 66 health professionals. To raise the awareness of society about mental health, television messages have been screened in collaboration with partner organizations. Furthermore, FMOH is currently completing the construction of a state-of-the-art hospital specializing in mental health care and will be establishing a National Institute of Mental Health to oversee the co-ordination of mental health activities across the country. A number of higher learning institutions have established academic graduate degree programs to train mental health professionals. FMOH is also collaborating with the WHO as one of the six pilot sites for the implementation of mental health Gap Action Programme (mhGAP) focused on scaling up mental health services.

Furthermore the major activities performed in EFY 2005 were as follows:

- NCD unit has been established at FMOH;
- In collaboration with a partner, screening for cervical cancer has been started in 25 hospitals in five regions (Tigray, Amhara, Oromia, SNNP, and Addis Ababa);
- Eighty one health professionals (medical doctors and nurses) have been trained to provide screening service for cervical cancer;
- The national quantification document for chemotherapy drugs has been formulated;
- The national comprehensive design for radiotherapy and nuclear medicine site expansion has been prepared;
- Population-based cancer registry has been established under Black Lion Specialized Teaching Hospital in collaboration with a partner;
- Piloting of mhGAP was done in 20 PHC facilities in four regions of the country (Tigray, Amahara, Oromia and SNNP).

- Strategic eye plan has been finalized; and
- A draft Implementation Program for the 5-Year Strategic Framework for the Prevention and Control of Major NCDs has been prepared.

CHALLENGES

- Absence of NCD unit before the restructuring of the Health Promotion and Disease Prevention (HPDP) General Directorate;
- Limited mental health service coverage;
- Lack of technical and financial support;
- Low level of awareness on NCDs and their risk factors both in the general population and among health professionals; and
- Limited number of national and international partners working on NCDs.

WAY FORWARD

- Launch and disseminate strategic framework, and review and adapt the national and sub national NCDs detailed action plan;
- Scale up mhGAP into the PHC system in all regions;
- Ensure technical and financial support to NCDs plan;
- Conduct intensive awareness raising campaign on NCDs and their risk factors nationwide;
- Conduct a national survey on NCDs and their risk factors based on the WHO step wise approach; and
- Carry out high level advocacy to increase the number of national and international partners working on NCDs.

2.7. PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE

Public Health Emergency Management (PHEM) is the process of anticipating, preventing, preparing for, detecting and communicating, responding to, controlling and recovering from consequences of public health threats in order to minimize health and economic impact.

Therefore, the strategic objective aims to improve how the health system copes with existing and emerging disease epidemics, acute malnutrition, and natural disasters of national and international concern. The desired responses include improved health risk identification, early warning, response and recovery from the disasters. The expected outcomes of this strategic objective are early detection and verification, rapid response and containment of public health emergencies and recovery and rehabilitation of the communities affected.

The specific strategies that are under way during HSDP IV include: (i) community involvement; (ii) resource mobilization; (iii) integrated communication and information systems across multiple sectors; (iv) advanced operational readiness assessment; (v) multi-sectoral coordination for emergency preparedness and response; (vi) comprehensive training and evaluation; and (vii) proper application of Information and Communication Technology (ICT).

These strategies will contribute towards an effective early warning, preparedness, response, recovery and rehabilitation system.

In EFY 2005, the PHEM Center accomplished several activities, including: (i) identification of major public health risks and assessment of vulnerability; (ii) verification and timely response to outbreak rumours; (iii) strengthening of public health surveillance and database management system; (iv) resource mobilization, coordination and collaboration with partners; and (v) preparation, revision, and distribution of guidelines.

In EFY 2005, 29 disease outbreaks and other events were reported, and all were verified and investigated within 3 hours by the center and regions. Weekly Epidemiological Bulletin was prepared for 48 weeks and distributed to partners and other stakeholders for information and action.

In terms of human resources capacity building, training was provided to 245 experts on the new e-HMIS/PHEM and influenza surveillance. In order to implement its activities, the center has also mobilized a total of ETB 341,426,449 for public health emergency management.

Regional distribution and monthly patterns of the main epidemic prone diseases are presented in this section. For comparison purposes, monthly patterns are presented for EFY 2004 and 2005. Data are collected and reported through the PHEM surveillance system.

Regarding the epidemiologic surveillance system in Ethiopia, it is important to note that, following the institutionalization of PHEM in 2009, the system of data collection was expanded to include also the HPs: in fact, before 2009, data collection used to start from the HC level, while afterwards it started from the HP level. In EFY 2005 a total of 18,543 governmental health facilities including 15,327 HPs, 3,096 HCs, and 120 hospitals have been identified as reporting units. This number of government health facilities (18,543) expected to report is the denominator for the calculation of the reporting completeness.

The percentage of reporting completeness has been increasing steadily over the past four years, reaching the 80% WHO minimum standard of weekly reporting rate in 2012. Currently, the completeness has reached above 80% standard for most of the regions, even though few are still below 50%.

In interpreting the trend of cases of epidemic-prone diseases under surveillance, we have to take into consideration the improvement in the surveillance system: for example, an upward trend may be related to an actual increase in cases (i.e. due to low coverage in preventive and control services or other factors outside the control of the health sector, such as rainfall levels) and/or to an increase in reported cases due to the increment in reporting completeness.

2.7.1. EPIDEMIC PREVENTION AND CONTROL

2.7.1.1. MEASLES

In EFY 2005, a total of 11,721 laboratory confirmed and epidemiologically linked measles cases were reported from all regions (Table 5), with a decrease with respect to those reported in EFY 2003 and 2004 (38,288 and 12,422 respectively). Out of these cases, 4,359 (37.2%) were reported from Oromia Region, followed by SNNPR with 3,612 cases (30.8%). The incidence rate is highest in Benishangul Gumuz Region (810 per 100,000 U5 children). Out of the total number of 47 deaths, 15 were reported from SNNPR (31.9%), followed by Oromia with 8 deaths (17.0%). The average national CFR was 0.4%.

Table 5:

Distribution of Suspected Measles Cases and Deaths by Region

(EFY 2005)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 U5 Children)	Number	Percent	CFR (%)
Tigray	188	1.6	25	2	4.3	1.1
Afar	109	0.9	45	6	12.8	5.5
Amhara	1,576	13.4	55	6	12.8	0.4
Oromia	4,359	37.2	90	8	17.0	0.2
Somali	497	4.2	64	5	10.6	1.0
Benishangul Gumuz	973	8.3	810	0	0.0	0.0
SNNPR	3,612	30.8	135	15	31.9	0.4
Gambella	25	0.2	43	2	4.3	8.0
Harari	38	0.3	118	0	0.0	0.0
Addis Ababa	314	2.7	67	0	0.0	0.0
Dire Dawa	30	0.3	50	3	6.4	10.0
National	11,721	100.0	91	47	100.0	0.4

The monthly pattern of laboratory confirmed and epidemiologically linked measles cases is presented in Figure 35, showing a peak in November and February.

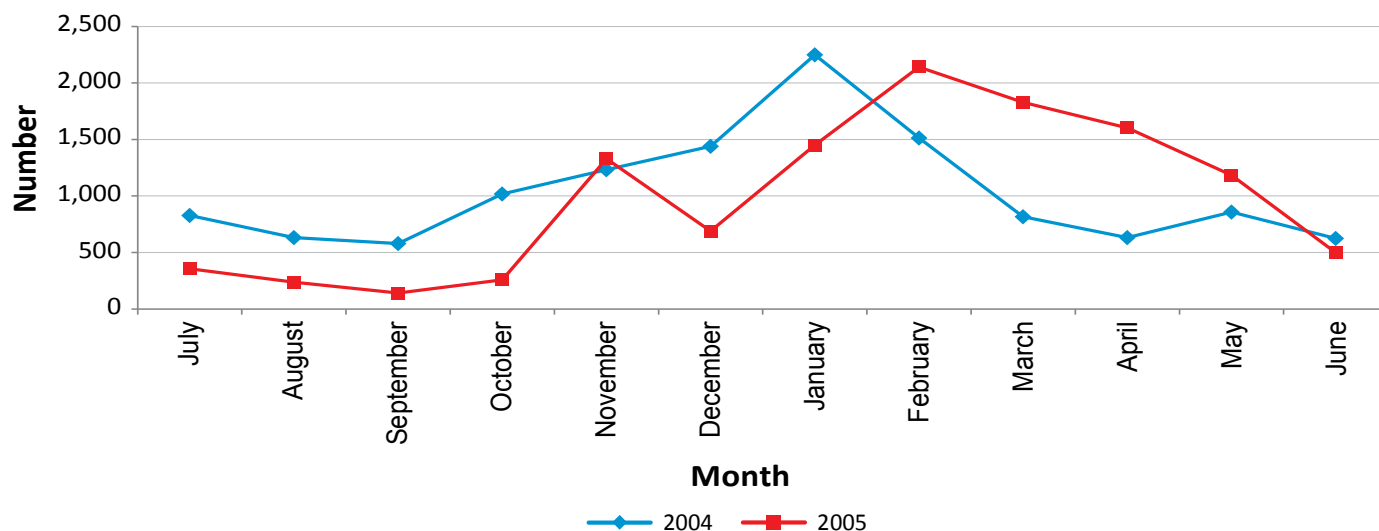


Figure 35: Trend in Suspected Measles Cases by Month (EFY 2004 and 2005)

In EFY 2005, a total of 5,553 serum samples for measles IgM testing were received at the national laboratory. The number of measles IgM-positive cases was 1,578. The IgM-positive cases seen in EFY 2004 and 2003 were 959 and 1,746 respectively.

The incidence of Igm-positive measles cases in EFY 2005 was highest in infants under 1 year (5.6 per 100,000 population) as shown in Figure 36, followed by the 1-4 years age group.

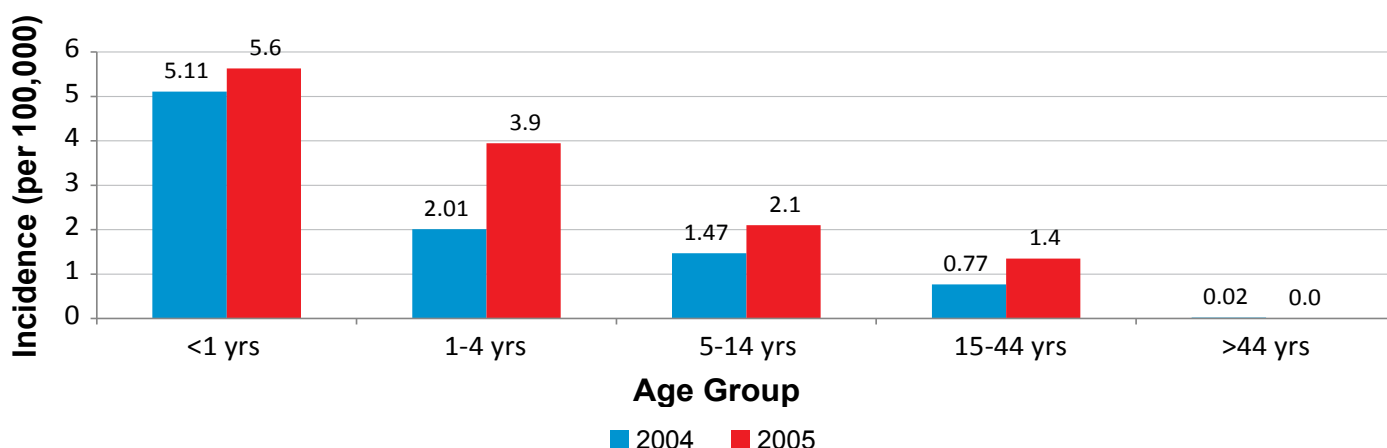


Figure 36: Incidence of Measles IgM-positive Cases Per 100,000 Population by Age Group (EFY 2004 and 2005)

Out of the 1,578 measles IgM-positive cases in EFY 2005, 549 (34.8%) were in the age group 5-14 years, 499 (31.6%) in the 15-44 age group, 413 (26.2%) in 1-4 age group, 116 (7.4%) were among under 1 year olds, and 1 (0.1%) in the age group over 44 years.

Regarding the vaccination status of the measles Igm-positive cases in EFY 2005, 888 (56.3%) had unknown vaccination history, 499 (31.6%) were not vaccinated, while 191 (12.1%) were vaccinated (one or more doses).

2.7.1.2. POLIOMYELITIS

In EFY 2005, a total of 1,061 stool samples of suspected Acute Flaccid Paralysis (AFP) cases were received at national laboratory for diagnosis. No wild polio virus was identified. In order for a country to be declared polio free, it must have no polio cases and have non-polio AFP rate of at least 2 per 100,000 children under 15 years, demonstrating that the surveillance system is sensitive enough to detect polio cases. In EFY 2005, most regions reported more than the minimum WHO requirement (Figure 37), while some regions still need to strengthen their surveillance. At national level, non-polio AFP rate in EFY 2005 was 2.6 per 100,000 children under 15

years in EFY 2005, which was above the WHO standard and similar to the performance in EFY 2004 (2.8). In EFY 2005, SNNPR showed the lowest non-polio AFP rate.

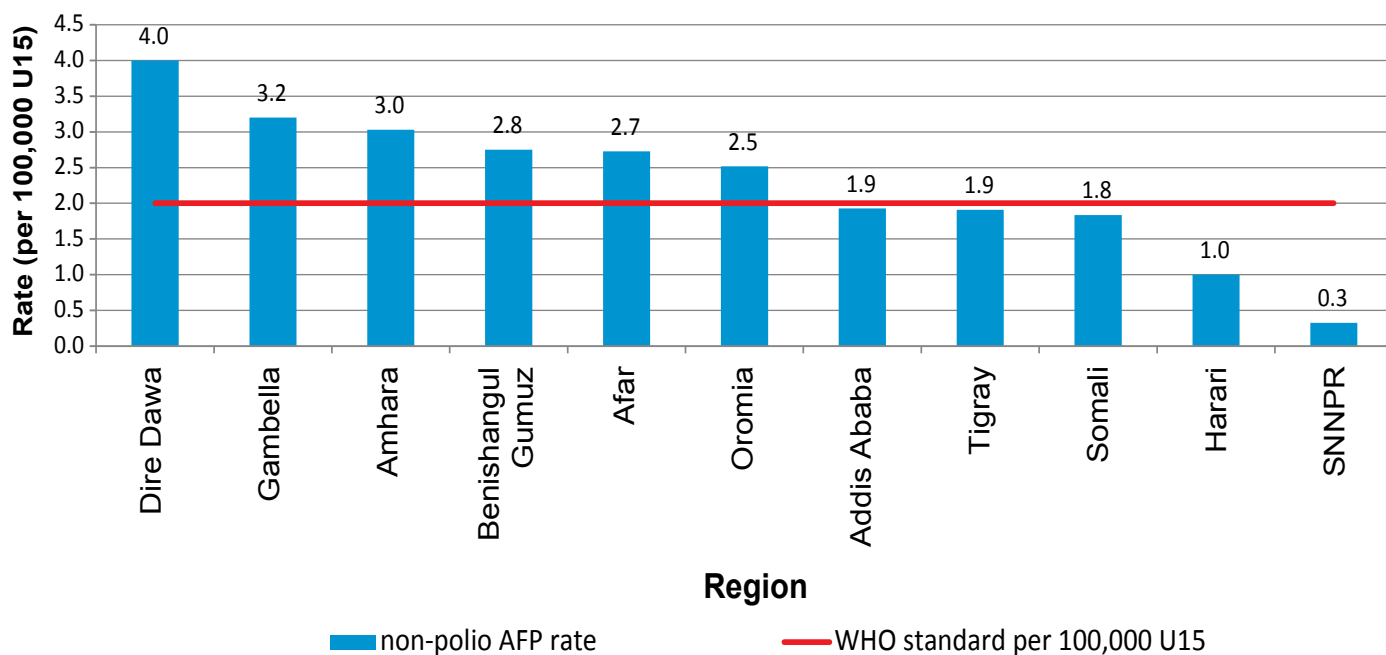


Figure 37: Comparison of Non-Polio Acute Flaccid Paralysis Rate Per 100,000 Children Under 15 Years by Region (EFY 2005)

AFP stool sample adequacy rate is another indicator used to measure the effectiveness of the surveillance system. All regions, except Amhara, achieved above the WHO minimum standard of 80% (Figure 38).

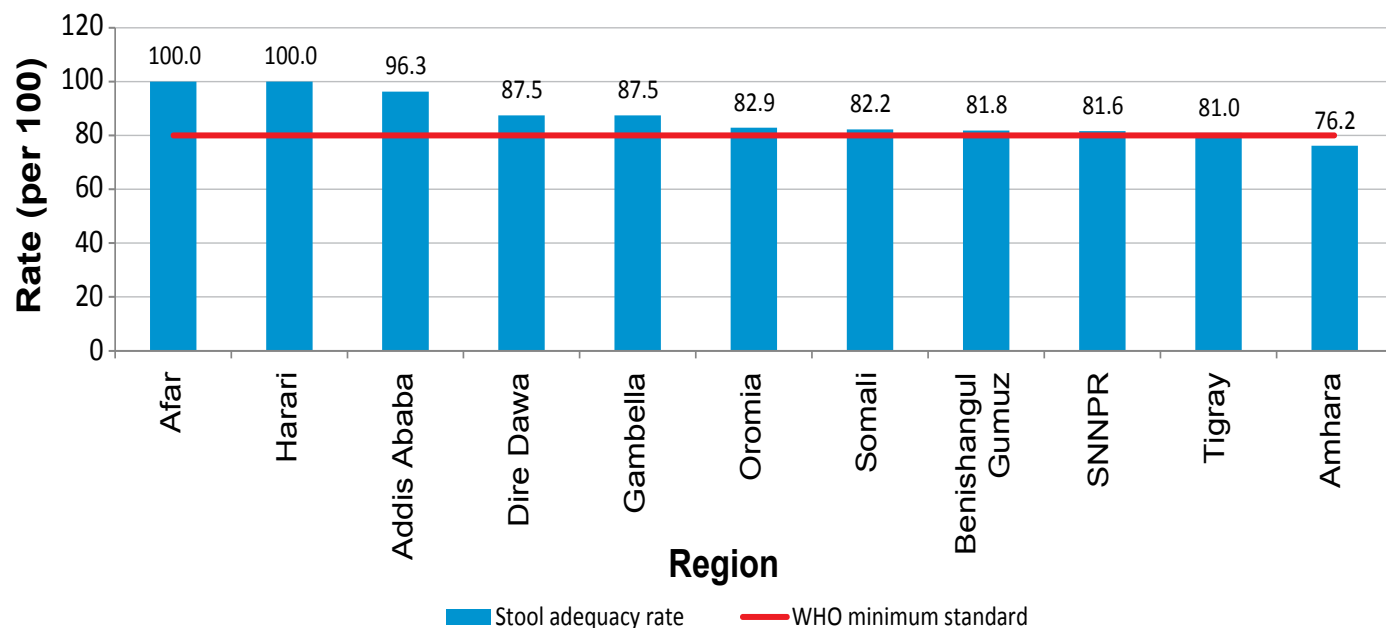


Figure 38: Comparison of AFP Stool Sample Adequacy Rate by Region (EFY 2005)

2.7.1.3. DYSENTERY

In EFY 2005, a total of 263,457 cases of dysentery were reported from all regions, and this figure is higher than the number reported in EFY 2004 (208,380¹) and in EFY 2003 (140,867). The highest number of cases was reported from Oromia (75,382, corresponding to 28.6%), followed by Amhara (64,656, corresponding to 24.5%) (Table 6). The incidence rate was highest in Benishangul Gumuz Region (1,572 per 100,000 population). A total of 17 deaths were reported from four regions, with Amhara reporting 12 deaths and accounting for 70.6% of the total deaths. The national CFR was 0.01%.

¹The number of cases reported in the Annual Performance Report EFY 2004 (443,579) has been corrected to 208,380 and the regional distribution for EFY 2004 has been also corrected in Table 6.

Table 6:

Distribution of Suspected Dysentery Cases and Deaths by Region

(EFY 2005)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000)	Number	Percent	CFR (%)
Tigray	32,906	12.5	658	0	0.0	0.00
Afar	5,957	2.3	370	1	5.9	0.02
Amhara	64,656	24.5	339	12	70.6	0.02
Oromia	75,382	28.6	234	2	11.8	0.00
Somali	7,514	2.9	145	2	11.8	0.03
Benishangul Gumuz	12,591	4.8	1,572	0	0.0	0.00
SNNPR	43,200	16.4	242	0	0.0	0.00
Gambella	1,354	0.5	347	0	0.0	0.00
Harari	529	0.2	247	0	0.0	0.00
Addis Ababa	16,644	6.3	537	0	0.0	0.00
Dire Dawa	2,724	1.0	685	0	0.0	0.00
National	263,457	100.0	307	17	100.0	0.01

The monthly pattern of dysentery cases shows fluctuations throughout the year (Figure 39), with slight increase during the raining season probably due to contamination of drinking water.

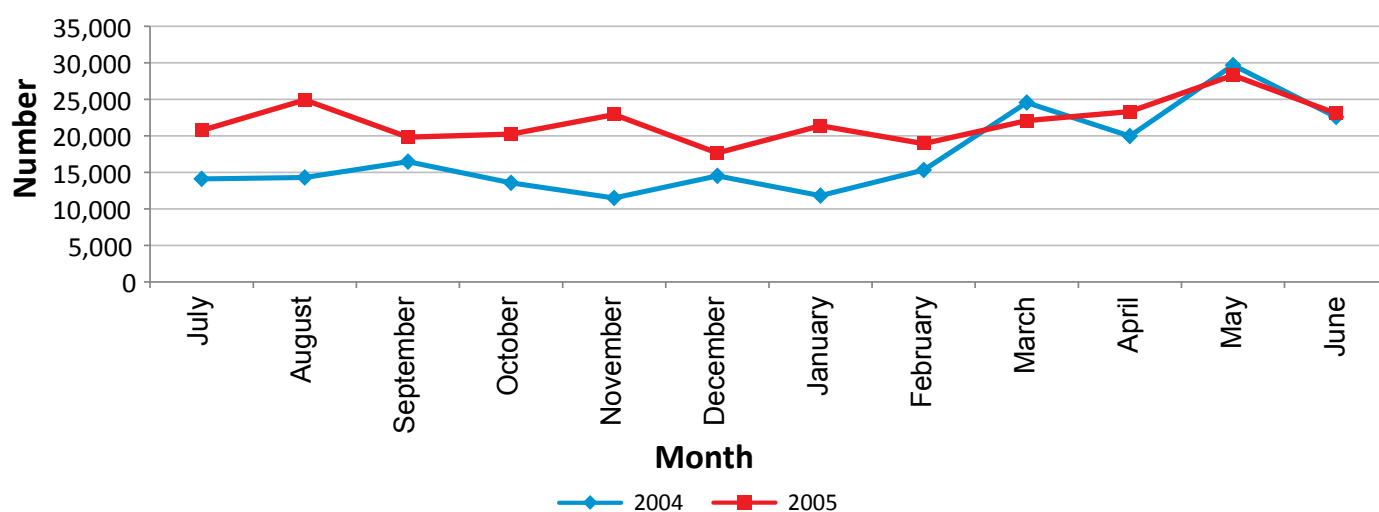


Figure 39: Trend in Suspected Dysentery Cases by Month (EFY 2004 and 2005)

2.7.1.4. MENINGOCOCCAL MENINGITIS

In EFY 2005, a total of 2,289 meningococcal meningitis cases were reported from all regions, with the highest number of cases being reported from SNNPR (1,307 corresponding to 57.1%), followed by Oromia (527 corresponding to 23.0%) (Table 7). A total of 57 deaths were also reported, out of which SNNP accounted for 35 (61.4%).

The overall cases fatality rate was 2.5% at the national level. In EFY 2005 an outbreak of meningococcal meningitis was occurred in Shebedino Woreda of Sidama Zone, Hawassa town, Ofa, Sodo Zuria and Humbo Woredas of Walayta Zone, Arba Minch Zuria Woreda of Gamo Gofa Zone, and Semen Bench and Debub Bench Woredas of Bench Maji Zone in SNNPR. During the same time, Shashemene Zuria, Shalla, Dodola Zuria and Wondo Woredas and Shashemene town of West Arsi Zone, Hababo Guduru Woreda of Horo Guduru Zone in Oromia Region were affected by the epidemics.

Table 7:

Distribution of Suspected Meningococcal Meningitis Cases and Deaths by Region

(EFY 2005)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000)	Number	Percent	CFR (%)
Tigray	38	1.7	0.8	1	1.8	2.6
Afar	10	0.4	0.6	2	3.5	20.0
Amhara	170	7.4	0.9	7	12.3	4.1
Oromia	527	23.0	1.6	7	12.3	1.3
Somali	119	5.2	2.3	1	1.8	0.8
Benishangul Gumuz	9	0.4	1.1	1	1.8	11.1
SNNPR	1,307	57.1	7.3	35	61.4	2.7
Gambella	43	1.9	11.0	3	5.3	7.0
Harari	0	0.0	0.0	0	0.0	0.0
Addis Ababa	30	1.3	1.0	0	0.0	0.0
Dire Dawa	36	1.6	9.1	0	0.0	0.0
National	2,289	100.0	2.7	57	100.0	2.5

The monthly distribution of the number of cases is presented in Figure 40. Less than 100 cases per month, which were widespread geographically, were observed till end of November, and, afterwards, a high increase in cases, which were localised geographically, were observed, corresponding to the outbreak that was occurred in the woredas listed above. These woredas were affected at different times till May.

A reactive vaccination campaign was carried out in zones that were affected as well as in the most at risk zones. A total of 2,897,798 people were vaccinated. Furthermore, rapid diagnostic kits and medical supplies were sent to all regions for performing specimen collection and rapid diagnosis at the field level.

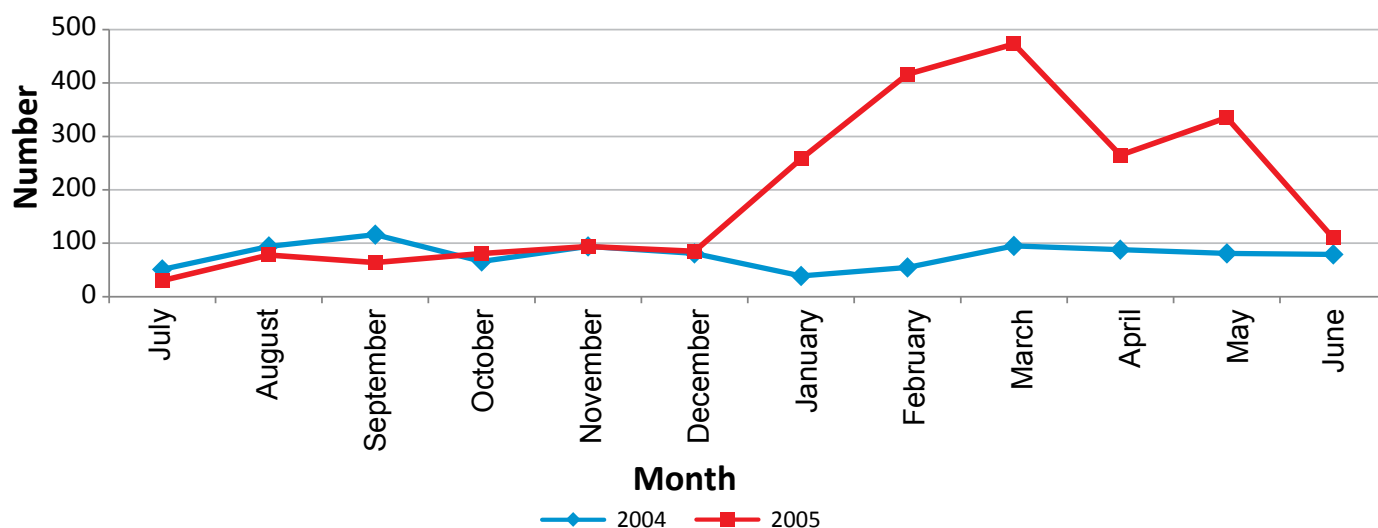


Figure 40: Trend in Suspected Meningococcal Meningitis Cases by Month (EFY 2004 and 2005)

2.7.1.5. ANTHRAX

A total of 1,233 suspected anthrax cases were reported from four regions (Amhara, Tigray, SNNP and Oromia) (Table 8). The highest number of cases was reported from Amhara (929 cases corresponding to 75.3%), followed by Tigray (124 corresponding to 10.1%). The incidence rate was also highest in Amhara Region (4.9 per 100,000 population). Out of the total number of 15 deaths (with a CFR of 1.2% at the national level), 8 (53.3%) were reported from Amhara Region.

Table 8:

Distribution of Suspected Anthrax Cases and Deaths by Region

(EFY 2005)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000)	Number	Percent	CFR (%)
Tigray	124	10.1	2.5	0	0.00	0.0
Afar	0	0.0	0.0	0.0	0.0	0.
Amhara	929	75.3	4.9	8	53.3	0.9
Oromia	89	7.2	0.3	4	26.7	4.5
Somali	0	0.0	0.0	0	0.0	0.0
Benishangul Gumuz	0	0.0	0.0	0	0.0	0.0
SNNPR	91	7.4	0.5	3	20.0	3.3
Gambella	0	0.0	0.0	0	0.0	0.0
Harari	0	0.0	0.0	0	0.0	0.0
Addis Ababa	0	0.0	0.0	0	0.0	0.0
Dire Dawa	0	0.0	0.0	0	0.0	0.0
National	1,233	100.0	1.4	15	100.0	1.2

The monthly pattern of suspected anthrax cases reported in EFY 2005 was quite stable, differently from EFY 2004 when fluctuations were observed in October, February and May (Figure 41). There was not large-scale outbreak report and all cases were managed at the woreda level as per the guideline.

Animal carcass disposal was managed with the support of veterinary services. Of note is the fact that all cases were reported on a clinical basis without laboratory confirmation because the central and regional laboratories have not yet attained the level of bio-safety necessary to perform laboratory test on suspected anthrax specimens. It is therefore necessary to upgrade the laboratory capacity as well as to strengthen the coordination with veterinary services.

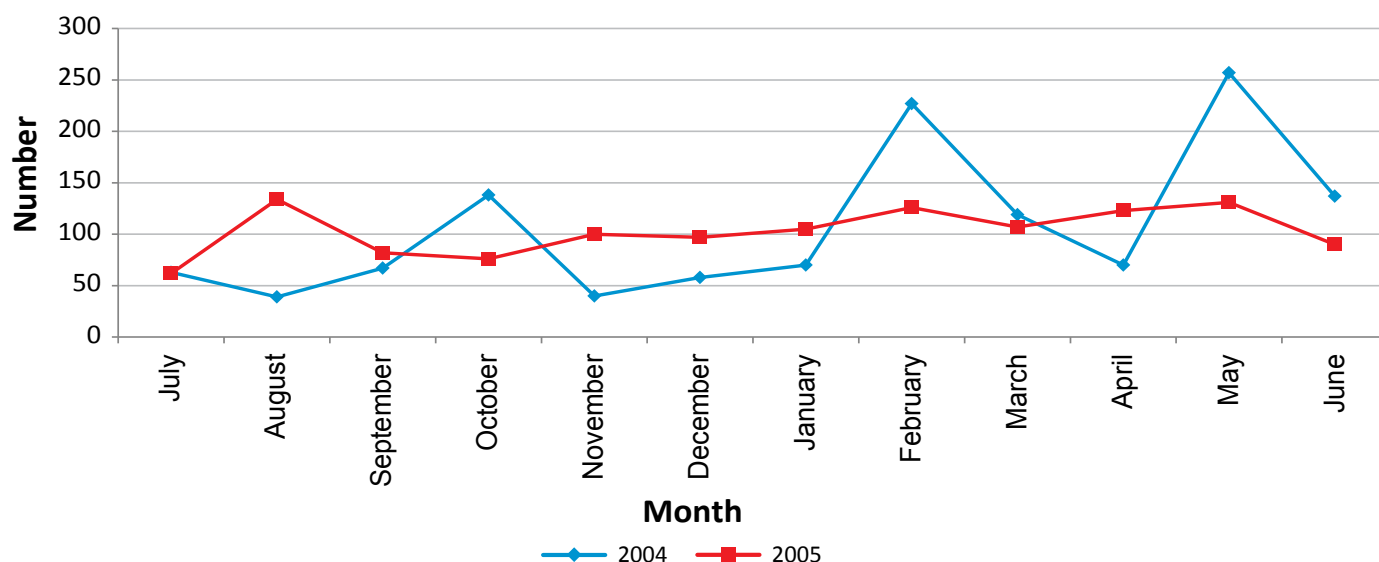


Figure 41: Trend in Suspected Anthrax Cases by Month (EFY 2004 and 2005)

2.7.1.6. RABIES

In EFY 2005, a total of 2,065 rabies cases and exposures were reported from seven regions (Table 9). The highest number of cases was reported from Tigray (1,158 corresponding to 56.1% of the total), followed by Amhara (332) and SNNPR (270). Out of the total 64 deaths (with a CFR of 3.1% at the national level), 32 were reported from Oromia Region (50.0%).

Table 9:

Distribution of Suspected Rabies Cases / Exposures and Deaths by Region

(EFY 2005)

Region	Cases / Exposures			Deaths		
	Number	Percent	Incidence Rate (per 100,000)	Number	Percent	CFR (%)
Tigray	1,158	56.1	23.1	2	3.1	0.2
Afar	0	0.0	0.0	0	0.0	0.0
Amhara	332	16.1	1.7	16	25.0	4.8
Oromia	265	12.8	0.8	32	50.0	12.1
Somali	0	0.0	0.0	0	0.0	0.0
Benishangul Gumuz	25	1.2	3.1	0	0.0	0.0
SNNPR	270	13.1	1.5	14	21.9	5.2
Gambella	11	0.5	2.8	0	0.0	0.0
Harari	0	0.0	0.0	0	0.0	0.0
Addis Ababa	0	0.0	0.0	0	0.0	0.0
Dire Dawa	4	0.2	1.0	0	0.0	0.0
National	2,065	100.0	2.4	64	100.0	3.1

The monthly distribution in EFY 2005 shows that the lowest number was reported in January with an increase towards the end of the fiscal year (Figure 42).

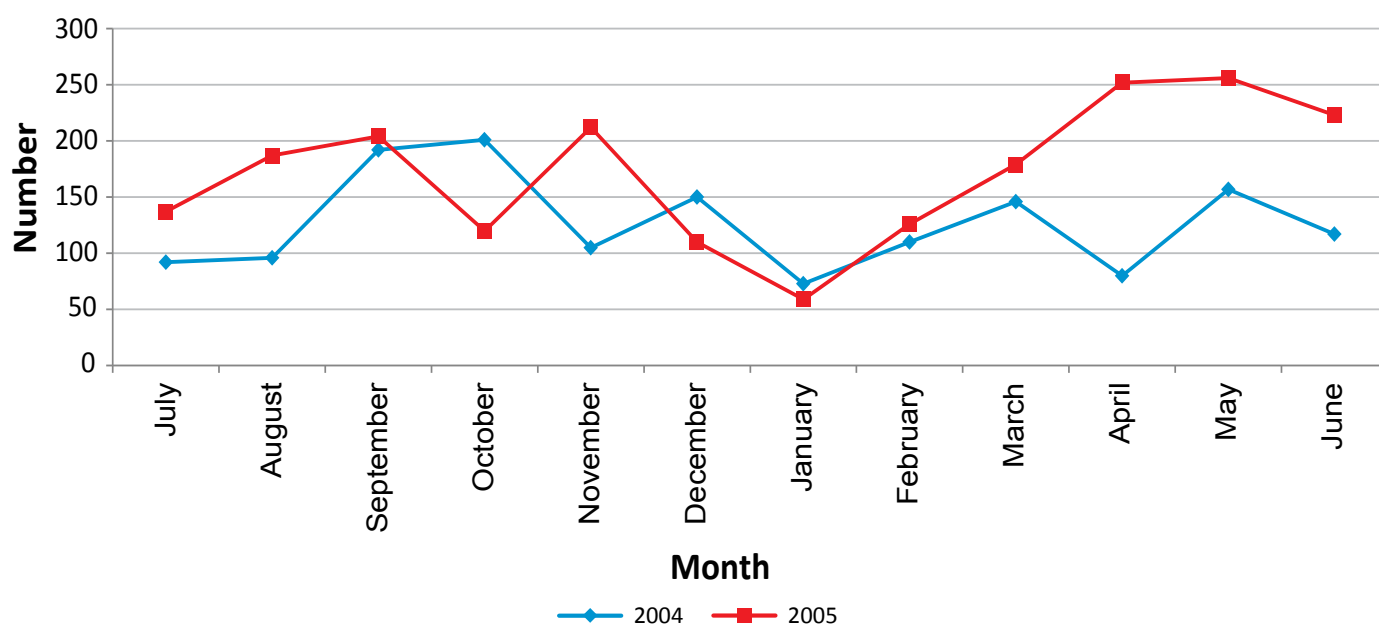


Figure 42: Trend in Suspected Rabies Cases by Month (EFY 2004 and 2005)

2.7.1.7. INFLUENZA

Sentinel surveillance for influenza started in September 2008 by establishing two sentinel sites in Addis Ababa. In EFY 2005, out of 1,080 throat swab collected from suspected cases, 282 (26.1%) were positive for influenza; out of these 282 positive cases, 93 (33.0%) were positive for Influenza B, and the remaining 189 (67.0%) for Influenza A. Among Influenza A cases, 143 (75.7%) were pandemic Influenza A/H1N1, and 46 (24.3%) were seasonal influenza A/H3N2. All were sporadic cases from Addis Ababa (Figure 43).

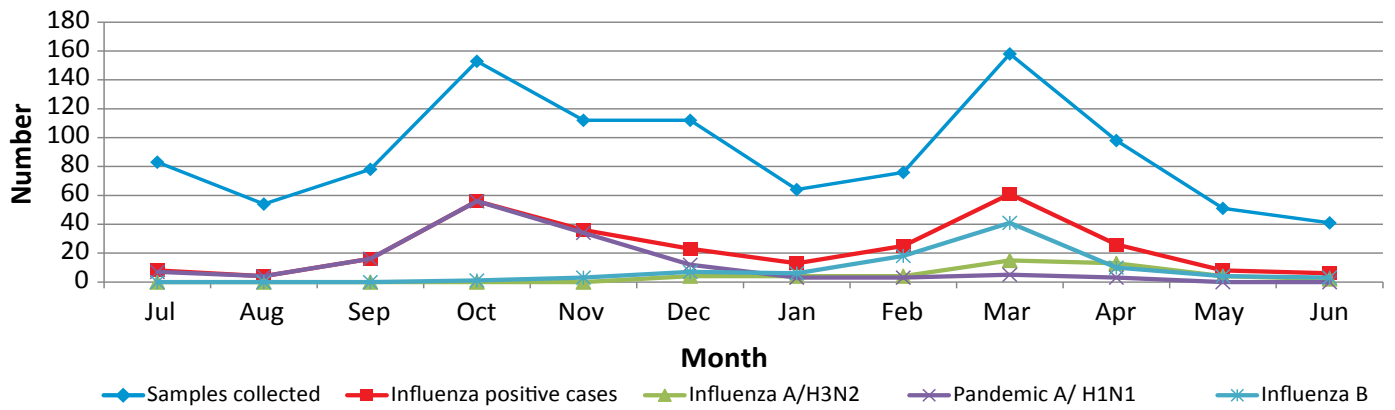


Figure 43: Trend in Influenza Cases by Month (EFY 2005)

2.7.1.8. RELAPSING FEVER

In EFY 2005, a total of 8,571 relapsing fever cases were reported from all regions (Table 10). The highest number of cases was reported from SNNPR, with 3,862 cases (45.1%), followed by Oromia with 3,162 cases (36.9%). Out of the total 100 deaths, 79 were reported from Tigray and 14 from Amhara. CFR was 1.2% at the national level in EFY 2005.

Table 10:

Distribution of Suspected Relapsing Fever Cases and Deaths by Region (EFY 2005)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000)	Number	Percent	CFR (%)
Tigray	118	1.4	2.4	79	79.0	66.9
Afar	65	0.8	4.0	0	0.0	0.00
Amhara	831	9.7	4.4	14	14.0	1.7
Oromia	3,162	36.9	9.8	1	1.0	0.03
Somali	9	0.1	0.2	0	0.0	0.00
Benishangul Gumuz	149	1.7	18.6	0	0.0	0.00
SNNPR	3,862	45.1	21.6	4	4.0	0.1
Gambella	20	0.2	5.1	0	0.0	0.00
Harari	23	0.3	10.8	0	0.0	0.00
Addis Ababa	313	3.7	10.1	2	2.0	0.6
Dire Dawa	19	0.2	4.8	0	0.0	0.00
National	8,571	100.0	10.0	100	100.0	1.2

The monthly pattern of cases shows that the highest number occurred in July and August and then gradually decreased in the following months (Figure 44).

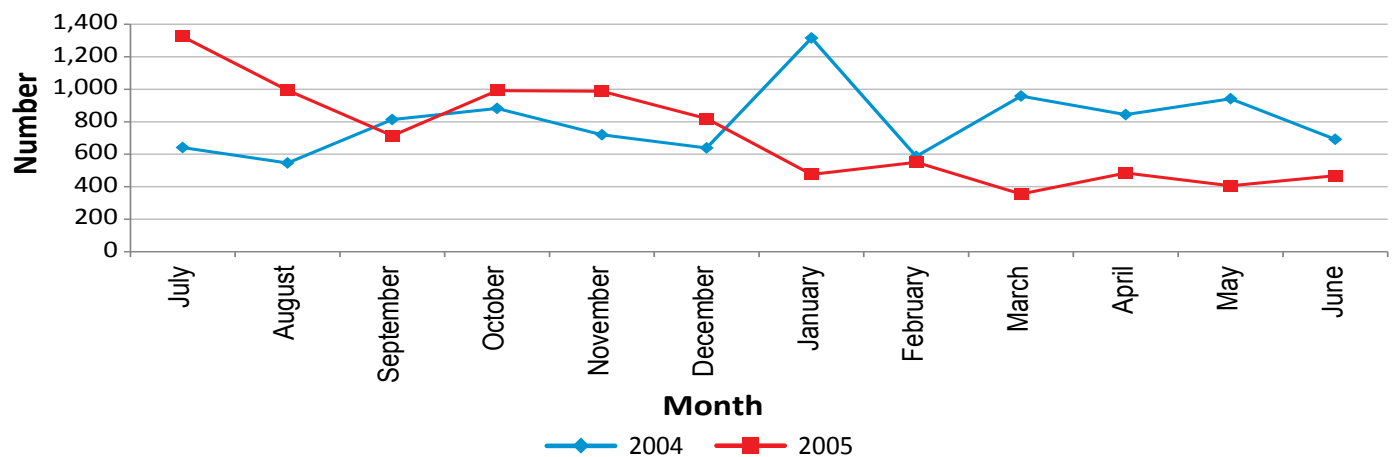


Figure 44: Trend in Suspected Relapsing Fever Cases by Month (EFY 2004 and 2005)

2.7.1.9. YELLOW FEVER

In EFY 2005 a total of 139 suspected yellow fever cases were reported from South Omo Zone of SNNPR. The outbreak was well controlled. The monthly epidemic curve is shown in Figure 45.

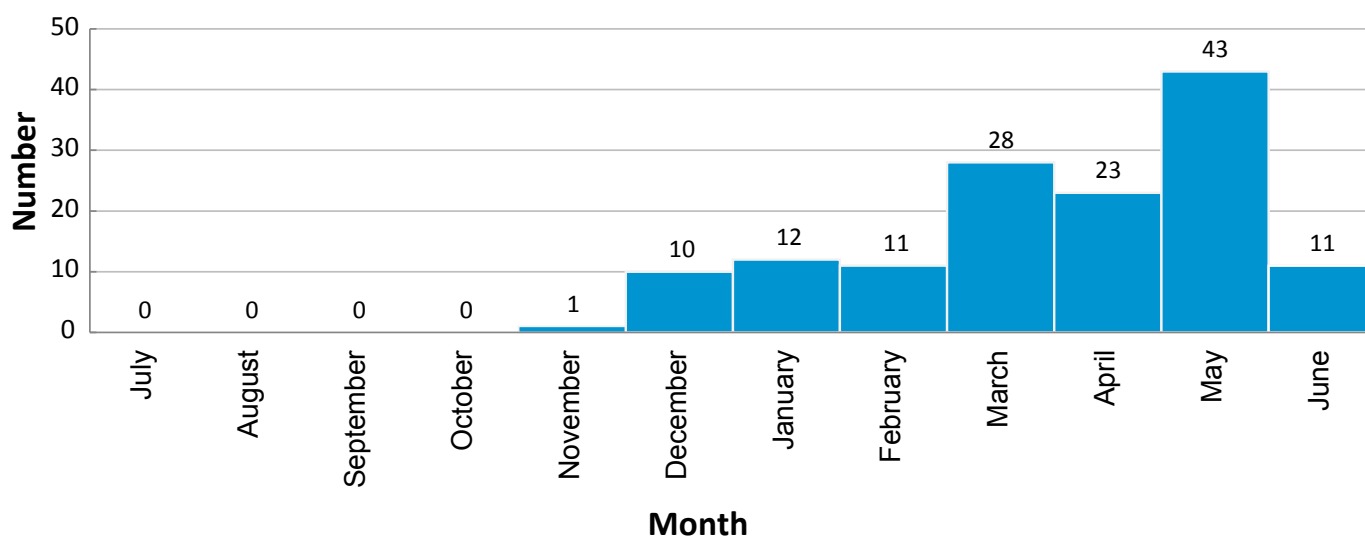


Figure 45: Epidemic Curve of Yellow Fever Outbreak in South Omo Zone of SNNPR (EFY 2005)

CHALLENGES

- Variation in reporting completeness affecting trend analysis of epidemic-prone diseases;
- Data quality still not as expected;
- Inadequate data analysis and use, especially at lower levels; and
- Limited laboratory capacity to provide confirmation of diagnosis.

WAY FORWARD

- Ensure consistently high reporting completeness through implementation of electronic reporting system;
- Continue training of health workers and PHEM officers to strengthen data quality and use for action; and
- Expand diagnostic capacity of measles to regional level, provide national and regional levels with equipment and supplies, and link each level of PHEM with hospital and HC laboratories.

2.8. QUALITY OF HEALTH SERVICES

HSDP IV focuses on a comprehensive and continuous quality monitoring mechanism that will enable all levels of the health system to look at all aspects of performance and quality of services. Improving the quality of services will be realized through scrupulous implementation of tools, manuals and standards. In EFY 2005, the performance of the sector with respect to improving quality of services was as follows.

2.8.1. QUALITY IMPROVEMENT

Health sector reforms have been implemented by the FMOH for some years as a component of the HSDP. The Ethiopian Hospital Reform Implementation Guideline (EHRIG) is an outcome of this reform process. The implementation of this reform process since EFY 2002 has resulted in improved service delivery at public hospitals. However, while many hospitals have achieved improvements in quality, inadequate performance still persists in others.

Hence, with a view towards increasing customer satisfaction, and to speed up the implementation of hospital reform measures and disseminate best practices, “change packages” have been prepared and distributed to

hospitals based on concrete study findings of Ethiopian Hospitals Alliance for Quality (EHAQ).

A Guideline on Establishment of Health Development Army for Hospitals has been prepared to assist in the setting up and monitoring of the implementation of hospital reforms based on the concept of the HDA.

The administrative professionals of new hospitals that started operation during the year were given training on implementation of hospital reforms, and, to enable them draw lessons from existing hospitals, they were made members of the EHAQ, which in addition gave them training on strategies to increase customer satisfaction.

Supportive supervision of hospitals was conducted in all regions four times during the year, and problems like inadequate maintenance of medical equipment, insufficient drug supply, shortage of medical specialists and the like were reviewed.

2.8.2. HEALTH FACILITY REFORM

To support and monitor the implementation of nursing reforms that are being carried out country wide, evaluation checklist has been piloted in 10 hospitals. Preparations are being made to analyze and document the best practices of these hospitals.

In order to strengthen activities related to infection prevention and patient safety, the second edition of a reference book on Infection Prevention and Patient Safety is under circulation. In addition, evaluation and monitoring checklist for ensuring infection prevention and patient safety has been prepared, and, to build the capacity of regions and health institutions, training was given for 60 health professionals.

2.8.3. BLOOD SAFETY

In accordance with the federal and regional level strategic initiative to improve quality of health services, a management structure that ensures the availability of adequate and safe blood in health care facilities had been created during the past years. Furthermore, efforts were made to provide equitable services, and thereby reduce the suffering and death caused by shortage of safe blood. The strategy aims to substitute replacement donors by voluntary non-remunerated blood donors and enable each blood bank to supply safe blood to hospitals within 100 kilometres radius, avoiding the delay caused by the current practice of getting blood from Addis Ababa and few regional centers.

The construction of 17 blood banks has been completed and they are currently functional, while two blood banks are still under construction in EFY 2005. Equipment and other inputs procured for new blood banks in EFY 2004 have been distributed to regional blood banks in EFY 2005. In EFY 2005, the National Blood Bank has collected 60,090 units of blood. The number of non-remunerated voluntary blood donors is increasing from year to year and, compared to the past year, their number has increased by 10%. To ensure the availability of adequate and safe blood, the strategy is to increase the number of voluntary non-remunerated blood donors by mobilizing the society using multiple media outlets. The trend in collection of blood during the last ten years is shown in the Figure 46.

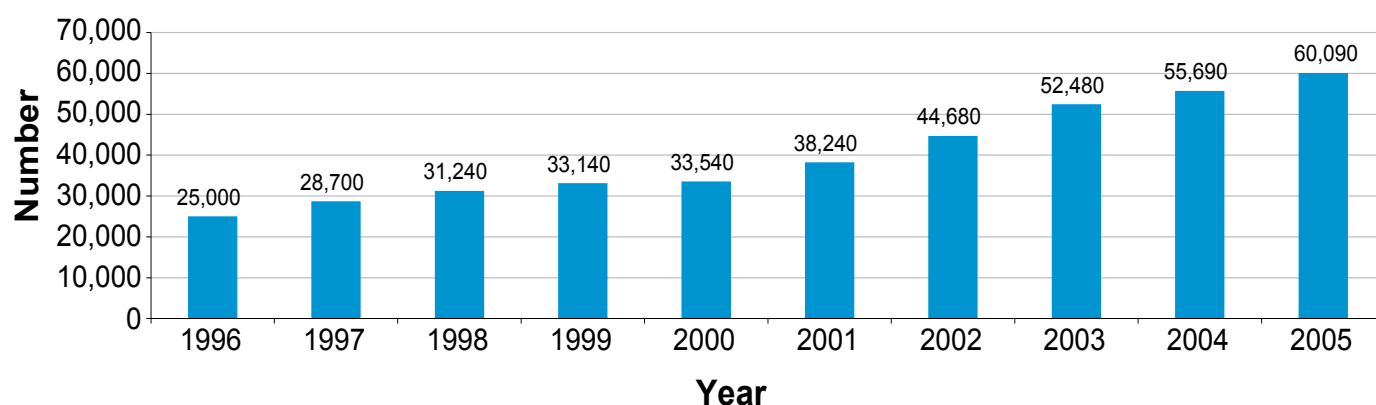


Figure 46 Trend in Blood Donation and Supply (EFY 1996 – 2005)

2.8.4. UTILIZATION OF HEALTH SERVICES

Health service utilization is measured by outpatient department (OPD) attendance per capita, which is an indicator of accessibility of the services, reflecting the interaction between demand and supply of outpatient care.

In EFY 2005, a total of 28,932,439 OPD visits were provided with an average of 0.34 OPD visit per person per year; this performance was higher than the achievement in EFY 2004 (0.29 OPD visit per person per year) (Figure 47).

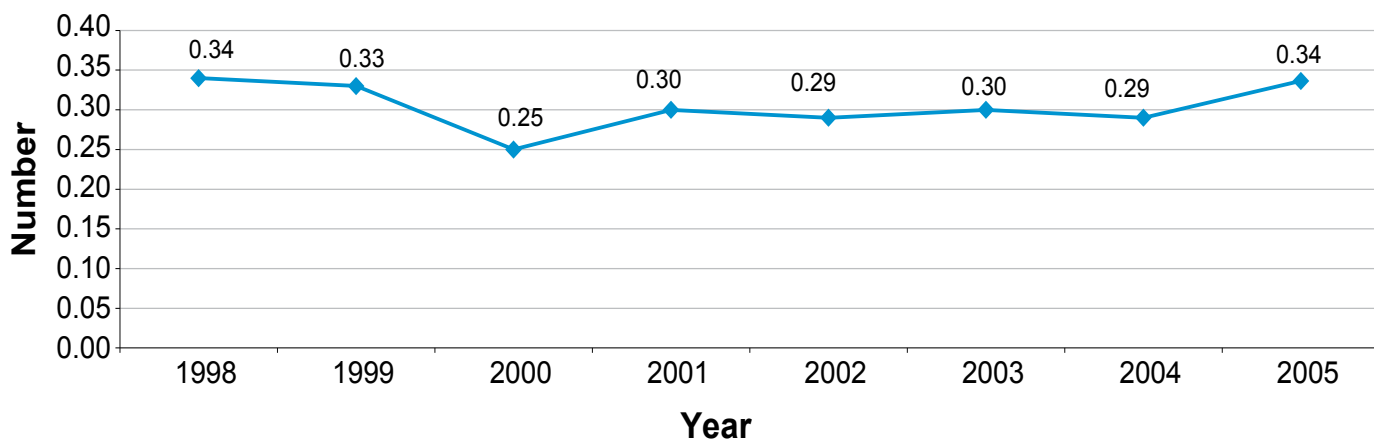


Figure 47: Trend in OPD Attendance Per Capita (EFY 1998-2005)

Wide variations were observed across regions, ranging between 0.78 visits per person per year in Addis Ababa and 0.12 in Somali Region (Figure 48).

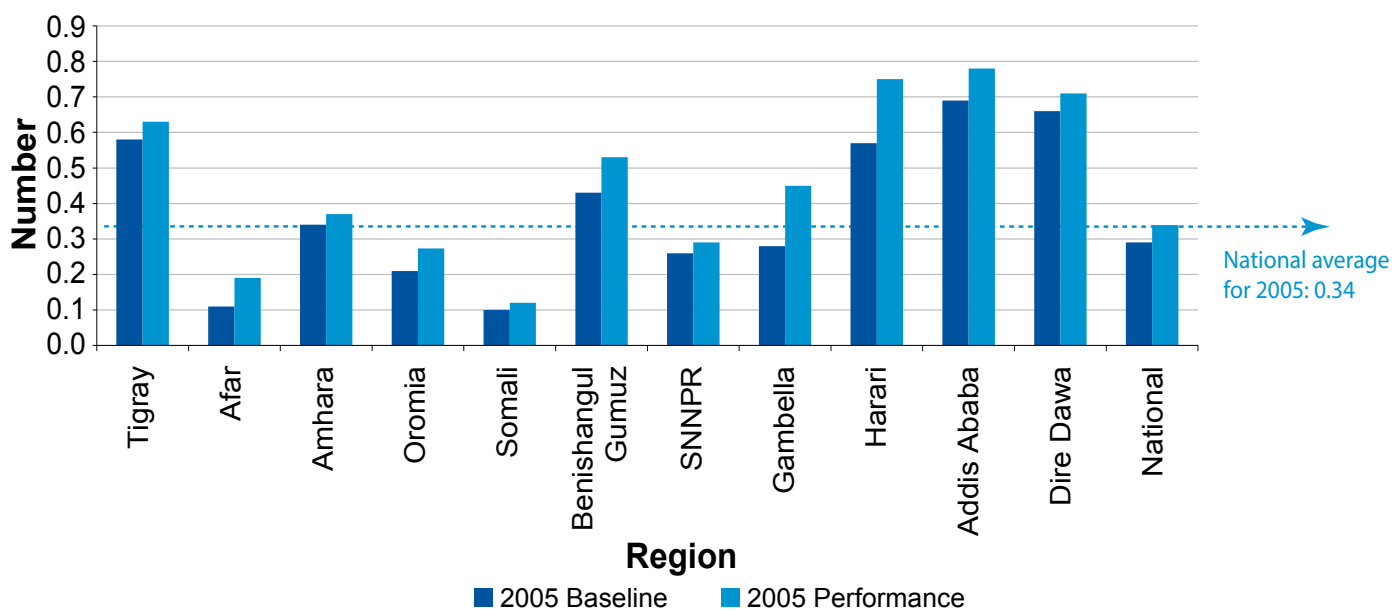


Figure 48: Comparison of Baseline and Performance of OPD Attendance Per Capita by Region (EFY 2005)

The number of cases seeking treatment for chronic diseases at higher level medical care centers within the country is very high, and, since there is a mismatch between demand and supply of services, clients are forced to wait for long time to get the required service at home or go abroad in search of care.

In order to minimize “medical tourism” and provide such services within the country, parallel to improving quality of services, the government is making efforts to avail alternative measures by mobilizing the “Diaspora” and all other stakeholders. The support made towards the initiation of kidney transplant and treatment of cancer within the country is a good example of the efforts made in this direction.

CHALLENGES

- Failure to plan and provide skill-based training at each level;
- Weakness in scaling-up of best practices;
- Lack of functional performance monitoring team; and
- Low OPD attendance per capita.

WAY FORWARD

- Introduce skill based and hands-on training to health professionals;
- Implement Balanced Score Card (BSC) for ensuring accountability;
- Strengthen the monitoring and evaluation system and make the performance monitoring team functional; and
- Promote the use of health services through improved access and provision of quality care.

2.9. NATIONAL LABORATORY SYSTEM

One of the strategic objectives of the Five Year Strategic Plan of EHNRI was to establish in all regions a reliable laboratory system of good quality. To meet this objective, the key activities performed in EFY 2005 are as follows.

To achieve the strategic objective of improving quality of medical care, various activities have been carried out to enable 56 laboratories get WHO/AFRO quality assurance accreditation (Star 1, 2 and 3). To this end, pre-training assessment of 15 laboratories has been performed.

Viral load count machines have been given for two clinical laboratories and TB culture media equipment for four regional laboratories (Mekelle, Harari, Hawassa and Jimma), respectively. In addition, TB equipment (Molecular Test, Line Probe Assay) has been provided to Jimma University Hospital. Furthermore, equipment provided during the year included: equipment for chemical analysis (5010 Photometer) for three health facility chemistry laboratories, CD4 count equipment (FACS Count) for two health facilities, haematology laboratory equipment (Cell Dyn 1800) for five health facilities as well as sample transport boxes for all regions. Similarly, equipment that facilitate laboratory activities such as Uninterruptible Power Supply (UPS), Micro Pipettes, Thermometers and the like have been provided to 25 health facilities.

The following services are being provided at the various laboratories: deoxyribonucleic acid-polymerase chain reaction (DNA-PCR) tests on infants are performed in one center, viral load count in four regional laboratories (Dessie, Jimma, Mekelle and Harari, including Tikur Anbessa Hospital) and measles test in one regional laboratory. TB culture and TB molecular test have been started at Mekelle Regional Laboratory, whereas Hawassa, Harari, and Jimma Laboratories are carrying out the validation process that will enable them to start the service.

Training on various laboratory services has been given for 535 laboratory technicians, 325 medical graduates from eight universities and 21 public relations staff.

One hundred twenty laboratories have participated in quality control activities through provision of quality control samples imported from abroad or prepared within the country.

Laboratory information system (LIS) initiated in nine health facilities is being supported and monitored and 105 professionals were given training on LIS. One hundred fifty five laboratories have been made beneficiaries of sending sample tests and results through the post office. In addition, to provide examination results promptly through SMS, training has been given for the staff in 26 laboratories.

Request for maintenance of 597 ART laboratory equipment was made by regions, and, out of these, the repair of 548 equipment has been made by engineers from EHNRI and by representatives of private companies. Similarly,

requests for maintenance of 146 various types of laboratory equipment were made within the Institute, and, out of them, 142 have been repaired.

At regional level, preventive maintenance has been carried out on 348 ART laboratory equipment. Preventive maintenance work and the replacement of filter on bio-safety cabinets have been carried out in regions in collaboration with professional staff from South Africa.

CHALLENGES

- Shortage of skilled and capable human resources;
- Inadequate transport facilities and spare parts for equipment; and
- Shortage of laboratory inputs.

WAY FORWARD

- Implement relevant recruitment and retention mechanisms;
- Provide adequate transport facilities and spare parts for equipment; and
- Ensure adequate supply of laboratory inputs

CHAPTER 3



LEADERSHIP AND GOVERNANCE



15th ARM

The last lap towards MDGs: Promise renewed to end preventable maternal and child death in Ethiopia.

Leadership and Governance

3.1. EVIDENCE-BASED DECISION MAKING BY ENHANCED HARMONIZATION AND ALIGNMENT

This strategic objective will support improved evidence-based decision making through enhanced partnership, harmonization and alignment, and integration of projects and programs at the point of health service delivery. It includes identification of health system bottlenecks, research, HMIS, performance monitoring, quality improvement, surveillance, use of information for policy formulation, planning, and resource allocation.

The outcome is the development of evidence-based planning, the appropriate use of information for decision-making, the realization of “One-plan, One-budget and One-report”, and the effective integration and alignment of health programs and projects to address the critical health problems of the community. In EFY 2005, the performance of the sector towards attainment of this strategic objective was as follows.

3.1.1. PLANNING

As in previous years, HSDP IV was used as the basis for developing the annual plan at all levels. During the development of the EFY 2006 Annual Woreda-based Health Sector Plan, a technical working group (TWG) guided by a term of reference was organized to facilitate the overall planning process. A plan of action was communicated to all RHBs after approval by Council of Directorates of FMOH. Command post was established at FMOH level to lead the planning process and, in RHBs and ZHDs, command posts were also established to guide the planning process in their respective levels.

The preparatory phase was started by updating planning guidelines, developing different formats, collecting new evidence from CSA and other sources, customizing Marginal Budgeting for Bottlenecks (MBB) tools for each region by incorporating new evidences, and making financial arrangement for the planning process. Actual planning process commenced through provision of Master TOT and facilitator’s training at regional level for 60 and 209 participants, respectively. All of the participants who attended facilitator’s training were from RHBs and ZHDs.

This year’s planning process was well prepared, showing an improvement with respect to the previous year’s planning process. The existence of the HDA was considered at the time of planning. HDA ignition document and indicative plan that include initiatives to be incorporated in the annual planning were prepared at national level and utilized by the time of actual planning at all levels. In EFY 2005, there was also good participation,

engagement and ownership of regions, zones, woredas and HCs. Each planning facilitator was assigned for a maximum of five woredas to provide technical input and conduct hands-on training and planning. Actual woreda level planning sessions were conducted in all regions in two rounds, with 7,519 participants from woreda administration, WorHOs, HCs, and Woreda Finance and Economic Development (WoFED) offices, and Non-Governmental Organizations (NGO). In this phase, after providing training, each woreda developed annual plans after analyzing their actual situation based on the HDA implementation, and using evidence-based planning approach and Balanced Scorecard as framework. In EFY 2005 efforts were made to integrate the woreda-based plan process and the drug quantification exercise in collaboration with PFSA, therefore ensuring consistency between number of planned services and quantity of procured drugs necessary to provide these services. The public hospitals also prepared their annual plan.

Finally, FMOH and RHBs prepared EFY 2006 (2012/13) HSDP IV Woreda-based Annual Core Plan for the sector by aggregating woreda plans from 835 woredas, and reconciling them with regional and national health sector development plans in order to avoid discrepancies in the performance measures. Additionally, plan alignment was also conducted with RHB's and federal level agencies.

3.1.2. ROUTINE DATA COLLECTION AND AGGREGATION

The goal of HMIS is availing reliable, timely and complete information to make evidence-based decision making possible at each level. Through the efforts made so far, the timeliness, completeness and reliability of data have improved and it has been possible to use the data for woreda-based plan preparation and performance monitoring purposes.

The newly re-designed HMIS has been implemented since EFY 2000. In EFY 2005 it was implemented in 122 hospitals (98% of the total) and in 2,697 HCs (87%). The implementation rate has, therefore, improved in EFY 2005 compared to 93% for hospitals and 80% for HCs in EFY 2004. The progress in the scale-up of the HMIS in health facilities is presented in the following Table 11.

Table 11:

Progress in the Scale-up of HMIS at Health Facilities by Region
(EFY 2005)

Region	Hospitals			Health Centers			Total Health Facilities		
	Functional	Implementing HMIS	%	Functional	Implementing HMIS	%	Functional	Implementing HMIS	%
Tigray	15	15	100%	214	214	100%	229	229	100%
Afar	5	5	100%	62	28	45%	67	33	59%
Amhara	19	19	100%	801	678	85%	820	697	85%
Oromia	41	41	100%	1,123	966	86%	1,164	1,007	87%
Somali	9	6	67%	112	59	53%	121	65	54%
Benishangul Gumuz	2	2	100%	32	31	97%	34	33	97%
SNNPR	19	19	100%	642	611	95%	661	630	95%
Gambella	1	1	100%	28	24	86%	29	25	86%
Harari	2	2	100%	8	8	100%	10	10	100%
Addis Ababa	11	11	100%	62	62	100%	73	73	100%
Dire Dawa	1	1	100%	16	16	100%	17	17	100%
National	125	122	98%	3,100	2,697	87%	3,225	2,819	87%

With respect to printing forms and supplying other materials for HMIS in EFY 2005, 8,379,400 integrated folders for HCs and hospitals, and 6,136,240 family folders for HPs have been distributed to all regions. So far, a cumulative total of 37,674,817 integrated folders and 12,556,704 family folders have been distributed to regions; furthermore, filing racks and tickler boxes have been dispatched to regions to equip 5,198 HPs.

TOT was given for 3,718 health professionals and, subsequently, training was given for a total of 19,228 HEWs (Table 12).

Table 12:

Cumulative Number of Staff Trained on CHIS by Region

(EFY 2005)

Region	Number of Health Professionals Who Received ToT Training	Number of Health Extension Workers Trained
Tigray	412	1,600
Afar	69	107
Amhara	1,937	6,234
Oromia	1,212	3,018
Somali	36	166
Benishangul Gumuz	13	133
SNNPR	0	7,834
Gambella	17	65
Harari	12	40
Dire Dawa	10	31
National	3,718	19,228

To gather complete data reflecting country-wide situations, training was given for 698 professionals drawn from Federal Police, Ministry of Defence, Iron Works Engineering and Prison Administration, and implementation has started in central level hospitals owned by the Police and Ministry of Defence.

To base the decision-making process on evidence derived from HMIS, fill the gap in data quality and utilization, and create capacity at each level, training was given for 1,720 professionals drawn from all regions.

Community Health Information System (CHIS) has been designed to make the information system and decision making effective and successful at the grassroots level, and to ensure birth and death registration. It is being implemented since EFY 2003. Registration of family health information on family folders is being carried out, and, as shown in Table 13, the implementation of CHIS reached 40% nation-wide, ranging from 0% in two regions to 100% in SNNPR and Dire Dawa and 98% in Tigray Region.

Table 13:

Progress in the Scale-up of CHIS by Region

(EFY 2005)

Regions	Available HPs	HPs Implementing CHIS	%
Tigray	650	638	98%
Afar	314	0	0%
Amhara	3,302	204	6%
Oromia	6,368	1,692	27%
Somali	1,062	15	1%
Benishangul Gumuz	361	28	8%
SNNPR	3,829	3,817	100%
Gambella	105	0	0%
Harari	26	12	46%
Dire Dawa	31	31	100%
National	16,048	6,437	40%

To scale-up CHIS in mobile pastoralist communities, an Operational Guideline has been developed. To assess data quality and performance of HMIS, routine data quality assessment was also conducted in EFY 2005, showing improvements in timeliness, completeness and practice of checking data quality at facility level using Lot Quality Assurance Sampling (LQAS) method. In EFY 2005 Guideline on Information Use was revised taking into account recent changes in health system organization, particularly in the PHCU. The guideline attempts to link HMIS indicators to priority programs and create a mechanism for improving data quality at regional and district levels. The guideline further strengthens the woreda-based annual health sector planning process as a continuum in “See-Do-Plan” cycle of performance management.

3.1.3. PERFORMANCE MONITORING AND COORDINATION

M&E of implementation of the HSDP IV (2010/11 to 2014/15) is based on periodic reporting and reviews of information generated by the HMIS and other data sources. M&E aims at informing policy makers about progress towards achieving targets as set in the annual health sector plans and HSDP, and at supporting managers to make evidence-based decisions.

In accordance with the guideline of BSC, the status of implementation of the third year of HSDP IV was monitored weekly, monthly, quarterly, and biannually by the FMOH and RHBs. Monitoring the implementation of EFY 2005 plan was done through meetings every two months of the Joint Steering Committee (JSC) of the FMOH and RHBs. Quarterly meetings of the Joint Consultative Forum (JCF) and bi-weekly meetings of the Joint Core Coordinating Committee (JCCC) were also held. In EFY 2005, most of the RHBs undertook their annual performance review meetings with woredas, zones and other stakeholders. During these meetings, strengths and challenges of the respective regions were reviewed. In EFY 2005, the national ARM was conducted in Bahir Dar (10-12 October 2012) in the presence of stakeholders representing federal, regional, woreda, and community level organizations as well as development partners.

As in previous years, issues of coordination, harmonization, financing and monitoring were addressed in EFY 2005 by the Joint FMOH-Health, Population and Nutrition (HPN) Donors Group Consultative Forum. Bi-annual and annual performance reports have been submitted to the Prime Minister's Office, and annual and three-year GTP reports have been submitted to the Ministry of Finance and Economic Development (MOFED).

The booklet "Health and Health-related Indicators" for EFY 2004, has been printed and is ready for distribution to stakeholders.

In order to enhance the use of information, a "Special Annual Review Meeting Bulletin" was published for the first time in October 2012. The bulletin was disseminated at the 14th ARM to inform participants on major progress updates, best practices, new initiatives, and summary of articles on key operational researches, surveys and programme evaluations carried out in EFY 2004.

The Health Bulletin "Policy and Practice" was published by FMOH in May 2013, documenting new strategies, innovative experiences, effective interventions as well as emerging and persistent challenges still to be addressed, thereby bridging the gap between policy and practice.

3.1.4. EVALUATION

In the schedule of the HSDP Harmonization Manual, a Mid-Term Review (MTR) has to take place halfway in the third year of the HSDP, and, accordingly, a MTR of HSDP IV was carried out in the period 21 April-18 May 2013 by an independent review team comprising of 14 core team members (6 international and 8 national consultants) and 28 external team members. The aim was to measure and document the extent to which the targets set for the HSDP IV period are achieved or on track, assess constraints and/or challenges encountered and solutions provided, draw best lessons learned and experiences gained, and forward recommendations to improve future governance, management and implementation of activities to attain HSDP IV goals. The Final MTR Report is one of the agenda items for presentation at this ARM.

To set up a system of evaluation of economic aspects of public health services, a TOT was provided for 30 participants drawn from four universities, four RHBs, agencies, and FMOH. Based on the training, FMOH and DPs made preparation for carrying out evaluation focusing on efficient budget allocation for selected programs.

CHALLENGES

- Delay in finalizing the comprehensive plan;
- Limited capacity in analysis and information use for decision making purposes;

- Multiple reporting systems;
- Limited involvement of private and NGO facilities in HMIS implementation;
- Physical and logistic constraints in health facilities hindering HMIS implementation (dimension of card rooms, space for filing records, etc.);
- Delay in distribution of shelves and difficulties due to limited printing capacity; and
- Lack of data warehouse that incorporates all data sources (population-based and facility-based).

WAY FORWARD

- Give proper attention to the preparation of comprehensive plan on time;
- Provide training on information use to health facility staff;
- Ensure adherence to the “One-Report” principle;
- Strengthen the involvement of the private sector and NGOs in HMIS implementation and reporting;
- Strengthen logistics and infrastructure support to improve HMIS scale up;
- Speed-up the distribution of shelves and strengthen printing capacity; and
- Establish a data warehouse.

3.2. OPERATIONAL RESEARCH

Operational research is performed in the health sector in order to identify and study priority problems of public health importance and produce evidence that would help decision-makers to improve the services and develop realistic health sector policies and strategies. One strategic objective in the Five Year Strategic Plan of EHNRI concerns strengthening of operational research, surveillance studies and reviews on health problems.

In EFY 2005, the following operational research studies focusing on malaria, immunization, communicable diseases, traditional medicine, nutrition, and policy, have been conducted by the EHNRI.

A survey on the efficacy of ITNs is underway, samples collected from 16 study sites in Oromia, Amhara, SNNP and Tigray Regions have been tested, and the results of the survey communicated to the FMOH. The study findings have implications on selection of ITNs and the need for periodic testing of their effectiveness and acceptability. Furthermore, the study on the efficacy of Coartem for the treatment of Falciparum Malaria, started in EFY 2004, has been completed and the report presented to the concerned bodies. The study results showed that the drug has an efficacy rate of more than 95% and remains the drug of choice.

The National Immunization Coverage Survey (2012) has been completed and the results have been disseminated at a workshop in the presence of top management of FMOH, RHBS, professional staff working on immunization program, and partner organizations.

A study on rotavirus was undertaken at Tikur Anbessa, Yekatit 12 and Betezatha Hospitals, and, out of 282 samples, 27.7% were positive for rotavirus. This virus is the cause of diarrhoea which in turn is a major cause of death in infancy and childhood. Hence, as part of the overall efforts made to decrease infant and child morbidity and mortality, it is necessary to address this public health problem and the preparation for the initiation of rotavirus vaccine administration is underway.

Laboratory tests have been made on 2,434 samples taken from children in all regions, confirming that in the past twelve months there was no case of wild polio virus in the country. Out of 4,792 samples collected for measles examination, measles virus was found in 25.4% of the samples; whereas, out of 3,467 samples collected for examination of rubella, the virus was found in 27.7% of the samples.

National survey on influenza and other viruses affecting the respiratory system is being conducted as planned. Laboratory tests have been made on 1,080 samples collected from surveillance stations, out of which 282 (26.1%) resulted positive for influenza virus.

The National Rabies Prevalence Survey, started in EFY 2004, has been concluded in EFY 2005, and the prevalence of rabies in the country was estimated at 12 per 100,000 and the mortality rate at 1.6%.

In order to create close collaboration, and eventually integrated delivery of traditional and modern health services, a community-based study was undertaken in 123 woredas in EFY 2004, and the technical report has been presented to the relevant authorities in EFY 2005. The study shows that traditional health services are utilized by 10% of the population, underscoring also the need for ensuring the efficacy, safety and quality of traditional drugs and practices prior to development of integrated delivery of traditional and modern health services.

A study to improve the acceptability of iron supplementation by pregnant women had been conducted in the four agrarian regions in EFY 2004, and, on this basis, teaching materials were prepared in three languages, and training given for more than 300 HEWs in the study woredas in EFY 2005.

Activities related to evidence-based decision-making are the preparation of draft policy documents for discussion by policy makers. In this connection, policy briefs on the implementation of technology transfer and research have been prepared, including the improvement of insecticide resistance management in malaria vector control, institutional delivery and human resource for malaria elimination.

Forty eight draft research proposals were reviewed for their relevance, ethical standards and use of scientific methodology; out of these proposals, 38 have been approved and 10 are being evaluated.

CHALLENGES

- High attrition of professionals and inability to hire professionals; and
- Difficulty to get inputs on time due to the slow procurement process.

WAY FORWARD

- Speed up the approval and implementation of the incentive package aimed at retention of high level professionals; and
- Speed-up the procurement process.

3.3. REGULATORY SYSTEM

This strategic objective concerns mainly ensuring safety and quality in the delivery of health services, products and practices. It also includes: (i) preventing professional malpractice; (ii) strengthening quarantine services; (iii) enhancing environmental health activities; (iv) enforcing regulations and prevention of drug abuse; (v) increasing the capacity of local drug manufacturing enterprises; (vi) controlling institutional solid and liquid waste disposal; and (vii) building HDA for quality control of inputs to health and health related services.

In EFY 2005, the following key activities were planned at federal and regional levels: (i) conduct registration and provide license to 2,000 new graduates, and renew licenses of 720 health professionals; (ii) conduct inspection in 225 health facilities and in 230 health related facilities; (iii) strengthen inspection of illegal trade of food items and drugs; (iv) strengthen health and health related quality of service; (v) strengthen quality control system; (vi) implement the new monitoring and evaluation strategies on quality of food and drugs; (vii) strengthen technical capacity of local factories; (viii) conduct post market assessment on food items and drugs; (ix) conduct supportive supervision to drug factories and to 300 food factories; and (x) capacitate health facilities to improve quality of health service delivery.

In EFY 2005, the following activities were carried out by the Food, Medicine, Health Administration and Control Authority (FMHACA).

3.3.1. INSPECTION AND QUALITY ASSURANCE OF “PRODUCTS”

In accordance with the annual plan to register and carry out quality control on pharmaceuticals and medical equipment, registration certificate authorizing their entry into markets was given for 603 pharmaceuticals (out of which 18 were vaccines) and medical equipment.

Quality control tests have been made and import permit given for 2,738 pharmaceuticals, 248 raw materials for drug production, 597 laboratory chemicals and reagents, 1,339 medical equipment and instruments, 22 narcotic and psychotropic drugs, 222 prescription drugs to be imported into the country, 935 samples of cosmetics, and 218 samples of raw materials for the production of cosmetics.

After the necessary quality control tests were made on samples of drugs and cosmetics, export permit was given for 194 drugs and 75 cosmetics. Feedback was given on 370 physico-chemical, 245 microbiology and 391 toxicology tests made on samples of materials and on 117 condom samples.

Community participation is a key factor for the establishment of an effective regulatory system and provision of quality services. In order to raise the awareness of the public towards strengthening of the regulatory system, joint consultation was made to promote the collaboration of individuals, society and stakeholders. Two joint inspection teams and a forum have been formed to prevent the illegal circulation of food items and drugs.

3.3.2. INSPECTION AND QUALITY CONTROL OF “PREMISES”

Inspection and surveillance was carried out on a number of facilities, which included 13 health facilities, 58 health related facilities, 21 referral health facilities, 4 water supply facilities serving more than one region, 422 food import and distribution enterprises, 208 pharmaceutical import and distribution enterprises, 73 tobacco products importers and distributors, and 63 cosmetics importers and distributors.

As a result of inspection activities, 46 expired drugs and raw materials and 40 spoiled food items have been disposed, and 30 food items and drugs that were denied entry permit were seized and eliminated.

Furthermore, 715 exporters, importers and distributors of food items, 69 of pharmaceuticals, 88 of cosmetics and sanitary products, 21 of tobacco, two specialized health facilities, and two inter-regional health facilities which fulfilled the requirements, were given certificate of competence and resumed their work; while licenses were renewed for 152 food, 343 drug, 34 cosmetics and sanitary goods, 52 tobacco exporters, importers and distributors, one hospital, two specialized health facilities, and ten inter-regional health facilities.

With respect to inspection of local factories, 128 new and 106 old food producing factories were inspected. Inspection on good manufacturing practice was also made on 20 pharmaceutical factories and 234 food factories in-country, as well as on 49 factories exporting pharmaceutical products to Ethiopia.

As part of the quarantine services, 44,000 international passengers were given vaccination certificates for yellow fever, and 26,241 for meningitis.

Appropriate examinations have been made and entry permit given for 635 human remains and exit permit given for 38.

Other activities performed in EFY 2005 include the airing of 36 radio programs, 17 radio spots, seven television spots, and five panel discussions on radio and television.

3.3.3. INSPECTION OF “PROFESSIONAL PRACTICE”

In EFY 2005, 897 new and 275 existing health professionals were registered and licensed at federal level.

To enable health professionals provide services of good quality, Guideline on Continuing Professional Development (CPD) has been completed, whereas a Guideline on Scope of Practice of Health Workers has been drafted.

Inspection on ethical practice of health workers was made and petitions were filed on 28 health workers, out of whom, 17 were fined for breaches of ethical practice.

3.3.4. INSPECTION OF “FOOD PRODUCTS”

Trade permits were given for 79 samples of milk to be imported into the country, nine samples of iodized salt, 89,766.56 tons of different types of food, 280 food supplements, 254 unprocessed food items, and 134 additional types of food.

After conducting quality control tests to ensure the safety of food items, export permit was given for 3,991 types of food, and for 42,952.04 tons of food; furthermore, 422 food import and distribution enterprises and salt distribution enterprises were inspected, and the license of 20 was revoked, while two were given warning.

CHALLENGES

- Lack of a short and long-term capacity building program;
- Slow implementation of the BSC system;
- Inability to provide on time supportive supervision and monitoring at each level;
- Inadequate implementation capacity; and
- Shortage of human resources in terms of professional mix and skill.

WAY FORWARD

- Minimize the four bottlenecks related to attitude, skills, supply and utilization of inputs, and planning monitoring and support;
- Enhance the implementation of the Balanced Scorecard for measuring performance and accountability;
- Conduct supportive supervision;
- Strengthen HDA; and
- Strengthen human resources.

3.4. GENDER MAINSTREAMING

Gender mainstreaming is a strategy for incorporating the concerns and experiences of both women and men as integral dimension in the design, implementation, monitoring and evaluation of the health sector programs. These dimensions need to be addressed mainly through: (i) promotion of gender equality and women empowerment; (ii) increasing use of health services by women; and (iii) enhancing equal opportunities in access and control of health services including economic opportunities and social development. The following planned gender mainstreaming and women empowerment activities were carried out in EFY 2005:

- In order to mainstream and institutionalize gender in the health sector, the Gender Directorate of FMOH has drafted three major documents: (i) the National Gender Mainstreaming Guideline; (ii) the National Gender Training Manual for the Health Sector; and (iii) the Strategic Plan for the Gender Directorate;
- In collaboration with concerned stakeholders, various gender-related trainings were organized during the reporting period, and a total of 1,379 (402 female and 997 male) participants received training on gender-related concepts, harmful traditional practices, climate change and women's health;
- In order to assist women to be role models and play enhanced roles in the HDA, 79 women took training on leadership, assertiveness, and decision-making;
- Consistent follow-up and support was rendered to agencies, hospitals and RHBs with regards to the implementation of their yearly gender plans. In addition, in collaboration with concerned stakeholders, the directorate has carried out various activities such as establishment of a gender TWG, mainstreaming of gender in the national nutrition strategy, and preparation of IEC/BCC materials focused on gender.

CHALLENGES

- Lack of budget for implementation of planned activities; and
- Low level of awareness on gender issues.

WAY FORWARD

- Finalize, launch and make use of the major documents developed in EFY 2005 and allocate budget for implementation; and
- Scale-up awareness raising education on gender at all levels through mass media and gender focal persons in institutions and agencies.

CHAPTER 4



HEALTH INFRASTRUCTURE AND RESOURCES



Health Infrastructure and Resources

4.1. HEALTH INFRASTRUCTURE DEVELOPMENT, REHABILITATION AND MAINTENANCE

This section describes the progress made in EFY 2005 in constructing and equipping HPs and HCs as well as in constructing, rehabilitating and expanding hospitals and strengthening medical equipment management.

4.1.1. CONSTRUCTION OF HEALTH POSTS

In EFY 2005, a total of 380 new HPs were constructed, making a cumulative number of 16,048 HPs (Figure 49).

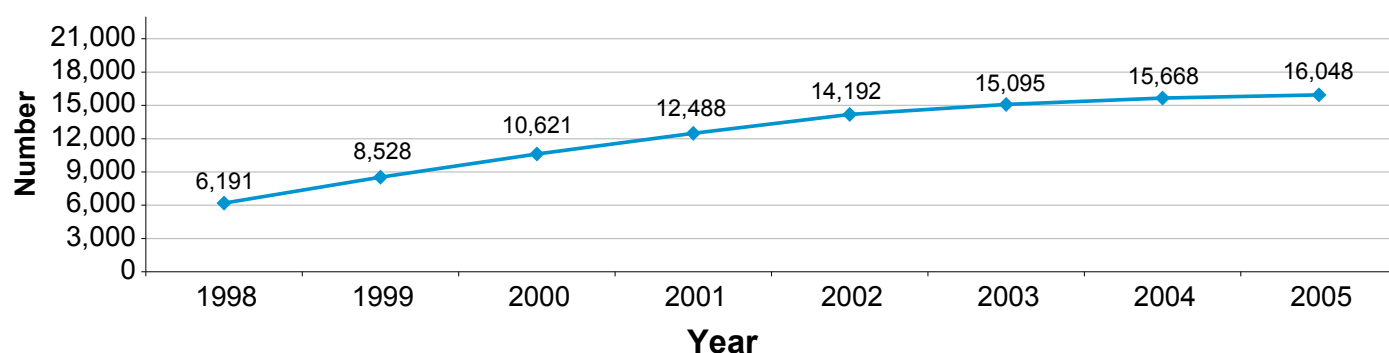


Figure 49: Trend in the Cumulative Number of Available Health Posts (EFY 1998 - 2005)

The highest number of HPs is found in Oromia Region (6,368), accounting for 39.7% of the total, followed by SNNPR (3,829) and Amhara (3,302) Regions (Table 14).

Table 14:

Cumulative Number of Available Health Posts by Region
(EFY 2005)

Region	Cumulative Number of Available HPs in EFY 2005
Tigray	650
Afar	314
Amhara	3,302
Oromia	6,368
Somali	1,062
Benishangul Gumuz	361
SNNPR	3,829
Gambella	105
Harari	26
Dire Dawa	31
National	16,048

4.1.2. EXPANSION OF HEALTH CENTERS

Expansion of HCs plays a pivotal role for the achievement of universal health coverage. Expanding, equipping, furnishing, maintaining, and managing health facilities are priority areas of HSDP IV. Therefore, this section explains the progress towards expansion of HCs in EFY 2005.

In order to achieve universal health coverage, the target was to build a cumulative total of 3,525 HCs in EFY 2005. The number of newly constructed and completed HCs was 246, increasing the cumulative total of available HCs from 2,999 in EFY 2004 to 3,245 in EFY 2005.

Nationally, there was a steep increase in number of available HCs over the past seven years, from 668 in EFY 1999 to 3,245 in EFY 2005 (Figure 50).

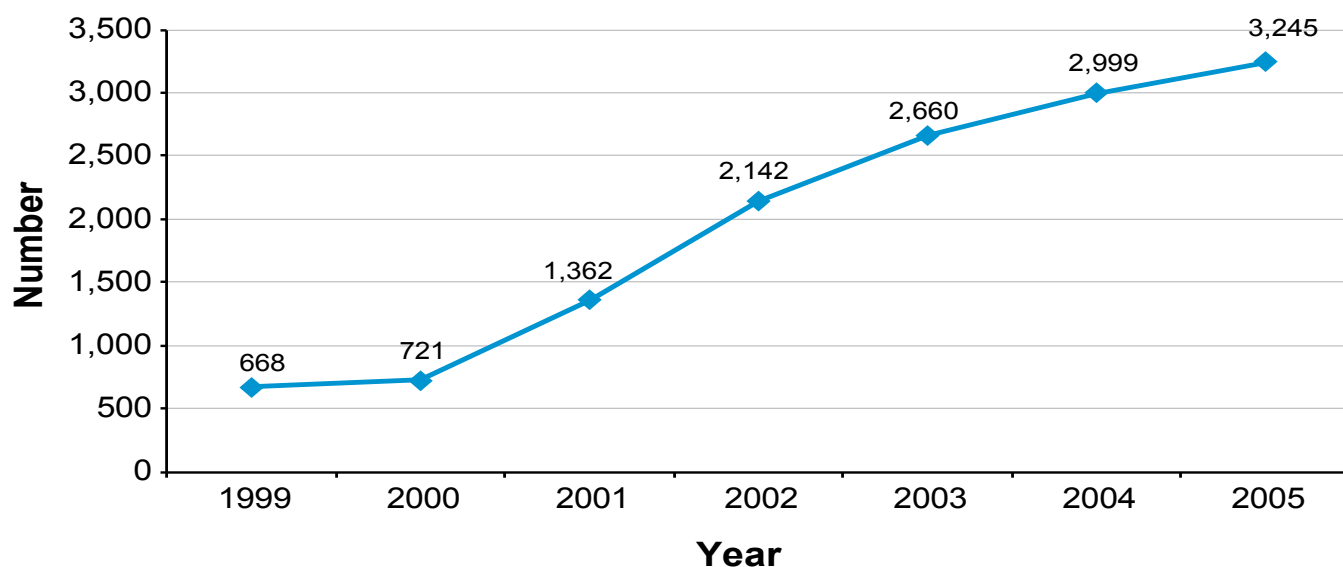


Figure 50: Trend in the Cumulative Number of Available Health Centers (EFY 1999-2005)

In EFY 2005, two regions reached the target of HCs available set for the year: Harari (8) and Dire Dawa (16). The remaining nine regions performed below the target set for the year: Tigray (214), Afar (62), Amhara (805), Oromia (1,215), Somali (140), Benishangul Gumuz (32), SNNPR (663), Gambella (28), and Addis Ababa (62). In general, the highest number of HCs available was found in Oromia (1,215), followed by Amhara (805) and SNNPR (663) (Figure 51).

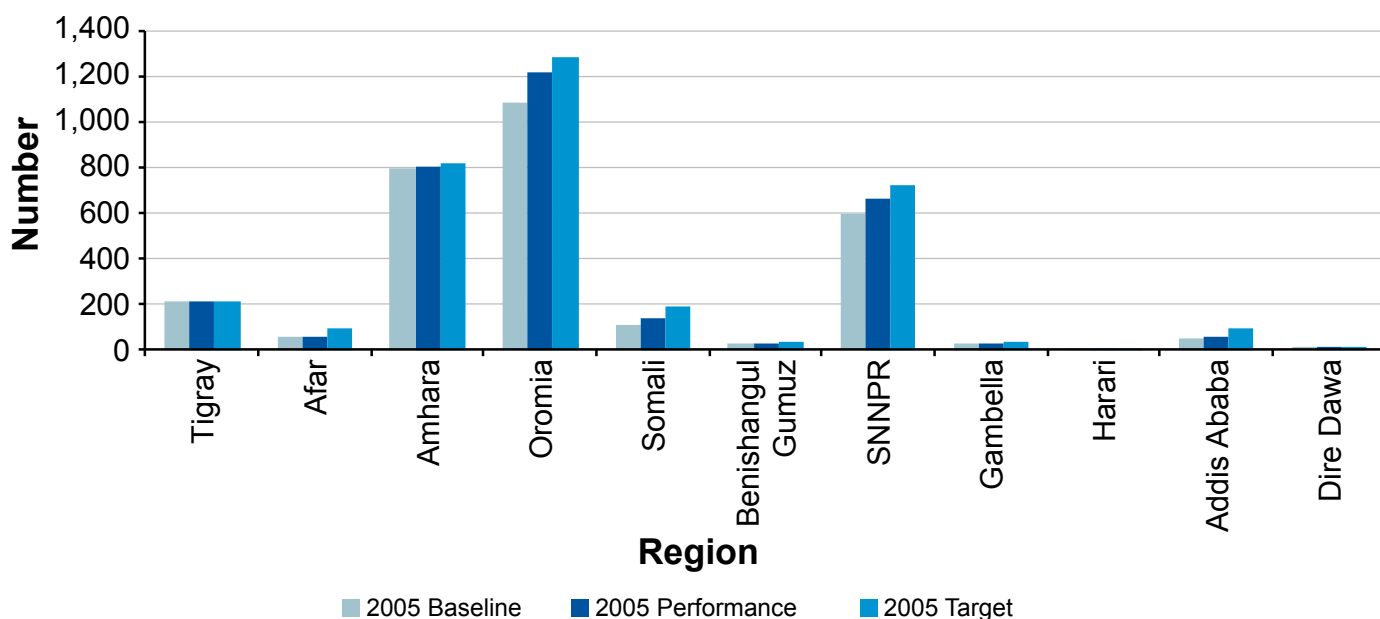


Figure 51: Comparison of Baseline, Performance and Target of the Cumulative Number of Available Health Centers by Region (EFY 2005)

4.1.3. EQUIPPING OF HEALTH POSTS AND HEALTH CENTERS

Newly constructed HCs in some woredas have not yet started to provide full services due to inadequate staffing, shortage of drugs and medical supplies, and unavailability of electricity, water and other utilities. However, in EFY 2005, a total of 209 HPs and 522 HCs were equipped with necessary materials.

On the other hand, in order to tackle the electricity problem, solar power system was installed for some HCs as a substitute to hydroelectric power. There is a plan to expand the solar system for other remote woredas without electricity. Equipping health facilities with basic utilities and deploying human resources are major priorities of the health sector in the coming years.

The other bottleneck in the provision of HEP was shortage of housing for HEWs operating in remote areas of the country. Construction of 167 houses was being done, constituting 84.3 % of the target (198) set for EFY 2005. Out of the 167 houses, 81 were fully completed, and the others reached 50-90% completion. Construction of the remaining 31 houses has yet to begin.

4.1.4. CONSTRUCTION, REHABILITATION AND EXPANSION OF HOSPITALS

4.1.4.1. FEDERAL HOSPITALS

Amanuel General Hospital and Mental Health Research Institute: The project has been carried out in two major phases:

Phase I: construction of the new general hospital which includes 161 inpatient beds. The construction has reached 87.3% of physical progress and it will be completed in March 2014.

Phase II: construction of the Research Center and administration buildings with offices and housing for staff, including: (i) offices for 50 administration staff; (ii) different training rooms for 50 to 100 students; and (iii) 20 family guest rooms. Currently, a consultant has been selected through open tender and the design will be completed in November 2013. The construction will start before May 2014.

St. Paul's Millennium Medical College: the first phase of the design has been completed and started to provide dormitory services for 600 students. The second phase of the project is under design process and will be completed in November 2013.

St. Paul's Maternal and Child Health (MCH) Building: it comprises of eight floors, 308 inpatient beds, and two lecture rooms, and has a capacity of eight delivery rooms at one time. The project is underway and 23% of the work has been completed.

St. Paul's Guest House Building: it comprises of guest rooms, lecture rooms, conference rooms, meeting hall and multi-purpose room. The project is being constructed and 95% of the work has been completed.

St. Paul's Magnetic Resonance Imaging (MRI) Building: in the premises of St. Paul's Millennium Medical College, the construction of the MRI building has been completed.

St. Peter G+1 Multipurpose Hall Construction: 100% of the construction has been completed and started to provide service.

St. Peter TB Specialized Hospital Expansion Building: the preparation phase, including the design development and bid preparation process, has been completed.

Alert Hospital Emergency Unit: the construction process has reached 70%.

EHNRI Cold Room, Animal House and Drainage System: renovation design and construction have been completed.

4.1.4.2. REGIONAL HOSPITALS

In EFY 2005, a total of 4 new hospitals were completed in Oromia, Somali and SNNP Regions, whereas ongoing construction of 175 hospitals was reported by six regions. Six hospitals in four regions have been upgraded and the total number of hospitals available in EFY 2005 has reached 127 (Table 15).

Table 15:

Hospital Construction/Upgrading Status by Region (EFY 2005)

Region	Newly completed	Ongoing construction	Upgrade	Total Available Hospitals
Tigray	0	0	0	15
Afar	0	1	0	5
Amhara	0	55	0	19
Oromia	2	56	0	41
Somali	1	0	1	9
Benishangul Gumuz	0	4	0	2
SNNPR	1	58	1	21
Gambella	0	0	3	1
Harari	0	0	0	2
Addis Ababa	0	0	0	11
Dire Dawa	0	1	1	1
National	4	175	6	127

Concerning hospital design, a project is underway to produce the standard design of general hospital at national level, with 100 beds as per the new redesign of the health care delivery tier system, and serving a catchment area of 1,000,000 population; 80% of preliminary design development process has been completed.

CHALLENGES

- Limited capacity of some contractors to finalize their construction, especially related to financial constraints;
- Difficulty in conducting timely repair of HCs being constructed in remote places, which is mainly related to road inaccessibility;
- Delays in terminating contractual agreements with contractors who do not accomplish their task as per the agreement;
- Limited overall supervision and support at regional and zonal levels, especially for HCs constructed by FMOH;
- Design problem which resulted in difficulty during finishing stages, especially for the interior design sections;
- Low community participation for transporting construction materials to the construction sites;
- Internal management problems (logistics, per-diem, personnel etc.);
- Serious shortage and unexpectedly high price of construction materials; and
- Limited capacity of the contractors and RHB contract administration.

WAY FORWARD

- Prepare mechanisms with contractors to solve their financial constraints and improve their capacity;
- Put in place new working modalities to transfer budget to woredas in order to complete the constructions;
- Provide support and supervision to regions and zones;
- Implement a new and cost-efficient redesign of constructions;
- Promote community mobilization to support the construction of health facilities;
- Strengthen the collaboration with all stakeholders and mobilize qualified contractors; and
- Strengthen the capacity of RHB on contractual management.

4.1.5. MEDICAL EQUIPMENT MANAGEMENT

The aim of medical equipment management is to standardize and facilitate health institutions to have a better medical equipment acquisition, utilization and disposal system.

Medical Equipment Management System: to improve the medical equipment management system, training and supervision have been conducted in 15 leading hospitals as per EHRIG.

Medical Equipment Standard: to provide a comprehensive resource for acquisition of medical equipment and improve effectiveness and efficiency in equipment management, general and primary hospital standard medical equipment lists and specifications have been prepared to address issues related to maintenance of medical equipment and acquisition of spare parts.

CHALLENGES

- Low managerial awareness on medical equipment management system;
- Shortage of biomedical engineers and technicians in various levels;
- Lack of integrated structure on biomedical equipment management at all levels; and
- Lack of a National Guideline on Medical Equipment Management.

WAY FORWARD

- Establish a medical equipment management unit at health facilities level according to EHRIG guideline;
- Support the medical equipment technician training at Technical and Vocational Education and Training (TVET) centers and biomedical engineering training;
- Allocate appropriate budget for maintenance of medical equipment, acquisition of spare parts, and employment of biomedical technicians and engineers; and
- Prepare a National Guideline on Medical Equipment Management based on the existing national health policy.

4.2. HUMAN CAPITAL AND LEADERSHIP

This strategic objective entails: (i) leadership development; (ii) human resource planning, development and management; (iii) community capacity development; and (iv) technical assistance management. HSDP IV uses a mix of strategies to achieve the expected outcome of the strategic objective, i.e. adequate availability of skilled and motivated health staff committed to work and stay in a well managed sector.

The strategic initiatives to strengthen human resource development and management in EFY 2005 included: (i) increase the capacity of medical students intake to 4,000 and improve quality of education; (ii) increase the Integrated Emergency Surgery Officers (IESO) intake capacity from 160 to 240 by increasing the number of IESO teaching institutions from 8 to 12; (iii) increase intake of HEWs from 1,100 to 2,000 to upgrade them from Level III to IV; (iv) increase intake of the third round accelerated midwifery trainees to 1,190; and (v) by providing financial and educational support, increase the intake capacity of health science colleges (HSC) for health professions that are in short supply.

In this context, the sector has already ensured adequate availability of low and mid-level manpower to staff PHC facilities. For instance, the WHO standard of one nurse per 5,000 population has been surpassed already since the current ratio for nurses is 1:2,311. Five thousand health officers have been trained and deployed, and first degree graduates in laboratory technology, pharmacy, environmental health and nursing have been trained in sufficient numbers more or less in line with the absorption capacity of public sector health facilities. However, there is still acute shortage of physicians, midwives and anaesthetic nurses. In particular, physicians used to migrate abroad for better pay. In order to fill the gap in service provision caused by the brain drain, the FMOH has increased the intake and number of medical schools, and curtailed the brain drain by holding successive consultations with new graduates.

The following section describes the performance of the sector in implementing the federal and regional level strategic initiatives to improve human capital and leadership in EFY 2005.

4.2.1. TRAINING

4.2.1.1. MEDICAL DOCTORS

According to the WHO standard for developing countries, the physician to population ratio is one physician per 10,000 population. Compared to EFY 2004 (36,158), this ratio has improved to some extent in Ethiopia, and stood at one physician per 26,943 population in EFY 2005. To fill the shortage of medical doctors, a new modular curriculum was developed, and medical doctors are being trained in 10 new universities and in three hospital medical colleges. Overall, by increasing the intake capacity of 11 existing universities, and in 13 new universities and hospital medical colleges under the New Medical Education Initiative (NMEI), a total of 11,291 medical students were being trained in 24 medical schools during EFY 2005 (Table 16).

To strengthen teaching capacity, lecture notes, modules, books, ICT and laboratory aids have been distributed to the medical schools. Furthermore, first copy of bio-medical, skill laboratory and e-learning standard has been completed.

Table 16:

Number of Medical Students by Year of Study and University

(EFY 2005)

University	1 st Year	2 nd Year	3 rd Year	4 th Year	5 th Year	6 th Year	Total
Adama	0	0	94	134	101	0	329
Addis Ababa	245	320	235	290	294	177	1,561
Arba Minch	125	107	62	62	51	0	407
Bahir Dar	235	169	106	108	72	66	756
Defence	0	30	0	0	28	0	58
Gondar	245	100	200	212	173	194	1,124
Haromaya	225	225	188	108	66	67	879
Hawassa	252	258	125	258	110	80	1,083
Jimma	395	310	222	213	199	148	1,487
Mekele	252	323	175	184	199	119	1,252
St. Paul	170	125	127	42	33	38	535
Total*	2,144	1,967	1,534	1,611	1,326	889	9,471
NMEI	987	833	0	0	0	0	1,820
Grand Total	3,131	2,800	1,534	1,611	1,326	889	11,291

*The difference between the number of medical students published in the EFY 2004 Annual Performance Report is due to the inclusion of Arba Minch, Bahir Dar, Defence, Haromaya Universities, and St. Paul Medical School in the present report for EFY 2005.

4.2.1.2. INTEGRATED EMERGENCY SURGERY AND OBSTETRICS TRAINING

One of the major initiatives designed by the FMOH in EFY 2001 was to improve the provision of emergency obstetric care and surgical services at primary hospital level where a gynaecologist or surgeon are not available. The IESO training was thus started as a three years master's program for health officers in five universities aimed at reducing maternal mortality related to pregnancy and child birth. So far, 40 health officers have completed the training and have been deployed in different health facilities. In EFY 2005, the number of training facilities increased from eight to 11, and 240 health professionals were enrolled in existing and new training institutions, with a total of 400 professionals being under training (Table 17).

To build the capacity of new universities through provision of educational materials, teaching aids and medical equipment, 834 books entitled "Surgical Care at the District Hospital" have been distributed to 11 universities providing the training.

Table 17:

Number of IESO Trainees and Number of Graduates

(EFY 2005)

University/College	Number of Students on Training	Number of Graduates
Jimma	49	20
Mekele	51	24
Hawassa	52	17
Haromaya	62	14
Gondar	61	18
Adama*	40	0
SPHMMC*	13	0
Wollo*	28	0
Dilla	15	0
Arba Minch	14	0
Wolaita Sodo	15	0
Total	400	93

*Training initiated in EFY 2004

4.2.1.3. ACCELERATED MIDWIFERY TRAINING

In order to give prompt response to problems arising during pregnancy and child birth, and to reduce maternal and neonatal mortality, the other strategy designed and implemented by the FMOH was the accelerated midwifery training program and the plan to staff each HC with two midwives.

During the first round of this three year program, a total of 1,558 midwifery students have graduated, while 1,632 have graduated during the second round. A total of 1,190 midwifery students are under training in 10 HSCs during the third round (Table 18). It has to be noted that, though the number which was expected to be enrolled in the second round in EFY 2004 was stated as 1,746 in last year's report, those who were actually enrolled and attended classes were 1,672.

In order to strengthen the professional competence of midwives who graduated during the first round, a mentorship program was designed and activities are underway, in collaboration with the Ethiopian Midwives Association, to mobilize experienced midwives to HCs where the graduates have been assigned.

Table 18:

Number of Trainees in Accelerated Midwifery Training Program

(2nd and 3rd Round)

Region / College	Intake (2 nd round)	Number of Graduated (2 nd round)	Intake (3 rd round)
Amhara Region			
Debre Tabor	147	147	90
Dessie	184	167	81
Teda	150	141	86
Bahir Dar	195	193	97
Debre Birhan	146	145	79
Oromia Region			
Metu	100	98	137
Nekemte	150	148	159
Shashemene	140	136	171
Negele	90	90	167
Fechi	140	140	-
Somali Region			
Jijiga	91	91	123
Benishangul Gumuz Region			
Pawi	41	41	0
Addis Ababa			
Menelik	98	95	0
Total	1,672	1,632	1,190

4.2.1.4. LEVEL “V” ANAESTHESIA TRAINING

Anaesthetists play a critical role in the provision of emergency surgery at primary hospitals and HCs, and are essential members of the team comprising of IESOs and nurse midwives. In order to increase access to the services of nurse anaesthetists, in EFY 2005 the FMOH has taken up the initiative and trained and deployed 96 Level V nurse anaesthetists and 50 degree graduates. A total of 115 nurse anaesthetists are under training in seven HSCs in EFY 2005 (Table 19), while 471 trainees are attending Bachelor of Science Program in six Universities (Table 20).

In order to strengthen the learning and teaching process, various books, assorted materials, modules, and 624 different books on anaesthesia have been dispatched to 12 HSCs. In addition, 60 adult airway trainers and 60 lumbar puncture modules have been procured and distributed to 13 HSCs and six universities. The EFY 2005 budget for the training facilities has been transferred through the RHBs to HSCs in Tigray, Harari, Amhara, SNNP and Oromia Regions.

Table 19:

Number of Level V Anaesthesia Trainees

(EFY 2005)

Region	Health Science College	Number of Graduates (EFY 2004 Intake)	Number of Students Under Training (EFY 2005 Intake)
Harari	Harari	28	20
Amhara	Dessie	22	0
	Bahir Dar	16	0
	Teda	9	0
Tigray	Dr. Tewolde	21	0
SNNPR	Hawassa	0	15
	Hosana	0	8
	Arba Minch	0	12
Oromia	Shashemene	0	20
	Adama Hospital Medical College	0	20
	Nekemte	0	20
Total		96	115

Table 20:

Number of Anaesthesia Trainees in BSC Program by University and Year of Study

(EFY 2005)

University	1 st Year	2 nd Year	3 rd Year	4 th Year	Total
Addis Ababa	25	60	41	31	157
Jimma	---	35	33	30	98
Dilla	---	17	15	15	47
Gondar	30	27	26	30	113
Wolaita Sodo	16	16	---	---	32
Mekele	24	---	---	---	24
Total	95	155	115	106	471

4.2.1.5. HEALTH EXTENSION WORKERS

Based on philosophy of HEP to provide community level services that are efficient and meet the needs of individuals and families at household level, career development of HEWs has been started in order to update and improve the skills and knowledge of the Level III HEWs to achieve certification at Level IV. The Level IV Health Extension Service Training eventually used standard curriculum and learning modules that were prepared based on unit of competence and occupational standards developed by FMOH and FMOE. In EFY 2004, 1,367 Level III HEWs were enrolled for the regular program and, out of these, 1,289 completed their training and then qualified for Level IV in the EFY 2005. As indicated in Table 21, a total of 2,240 second batch HEWs were enrolled for upgrading to Level IV in EFY 2005.

Table 21:

Regional Distribution of HEWs Recruited for the Upgrading Program

(EFY 2005)

Region	No of Training Centers	Number of HEWs Graduated in EFY 2005	Number of HEWs Enrolled in EFY 2005
Oromia	4*	795	1,060
Amhara	5	246	500
SNNPR	5**	208	290
Tigray	2	40	200
Somali	2	---	106
Dire Dawa	0***	---	44
Harari	1	---	40
Total	19	1,289	2,240

* There were five training centers in Oromia Region in EFY 2004, but one center was closed and in EFY 2005 there were only four centers.

** There were four training centers in SNNPR in EFY 2004, but the number has increased by one center in EFY 2005.

*** There was one training center in Dire Dawa in EFY 2004, but there was no such center in EFY 2005.

4.2.1.6. AMBULANCE SERVICE AND EMERGENCY CARE/PARAMEDICS TRAINING

This training program is a new category in Human Resources for Health (HRH) pre-service training in Ethiopia. The objective of this training program is to improve pre-hospital emergency care in managing all emergencies, including maternal emergencies. All graduates are expected to serve at any level of pre-hospital emergency care using ambulances. The training standard and model curriculum have been developed and revised in order to fit Level III training. A total of 160 paramedics graduated in Oromia and Amhara Regions and are ready for qualification examination. Table 22 indicates the number of graduates and level of enrolment in EFY 2005.

Table 22:

Ambulance Service and Emergency Care/Paramedics Enrolment

(EFY 2005)

Region	Number of Training Centers	Number of Graduates in EFY 2005	Number of Enrolled in EFY 2005	Remark
Oromia	2	114	139	
Amhara	2	46	53	
Harari	1		34	For Gambella, Benishangul Gumuz, Somali, Afar, Dire Dawa and Harari Regions
Total	5	160	226	

4.2.1.7. HEALTH INFORMATION TECHNICIANS

The purpose of the Health Information Technician (HIT) program is to train and deploy HITs in the category of mid-level professionals, who will be responsible for the collection, analysis, maintenance, and retrieval and reporting of health data, in accordance with data quality and regulatory standards of Ethiopia.

With this understanding, almost all regions except Addis Ababa, assigned the first graduates of HIT in their respective health care facilities. Addis Ababa has proposed to start accelerated HIT training program with 80 Level III graduates who have information technology (IT) background and passed Level III Certification of Competence (COC). Table 23 shows the distribution of HIT trainees by batch (year) in EFY 2005.

Table 23:

Training Program of Health Information Technicians by Region

(EFY 2005)

Regions	1 st Year	2 nd Year	3 rd Year	Total
Tigray	0	32	164	196
Afar	41	0	23	64
Amhara	146	131	124	401
Oromia*	0	0	0	0
Somali	46	0	33	79
Benishangul Gumuz	4	0	16	20
SNNPR	110	198	139	447
Gambella	10	0	14	24
Harari	8	0	4	12
Dire Dawa	6	0	10	16
National	371	361	527	1,259

Note: Oromia Region has started a new accelerated program of training IT level III to HIT level IV, so the column “Year 1” in the table above does not include the 409 trainees attending the new program in Oromia.

4.2.2. IN-SERVICE TRAINING

In order to ensure quality of service, in-service training provided to the health workforce should be standardized and institutionalized. The National In-service Training Standardization and Institutionalization Guideline and Implementation Manual was finalized, the launching workshop was conducted, the regional in-service training focal person was assigned, and the regional in-service training action plan was developed. Thirty five local training institutions were selected for the provision of standardized in-service training.

National Leadership Management and Governance Training Module has been developed for senior health managers, woreda health managers and health facility managers.

The Continuing Professional Development (CPD) Guideline was finalized and approved. In addition, the first draft of the Health Professional Scope of Work was developed in collaboration with FMHACA. National in service data base has been incorporated in the Human Resources Information System (HRIS). FMOH staff capacity building was done based on predetermined need for 85 professionals.

4.2.3. DEPLOYMENT

The FMOH has been engaged in establishing a human resources database by gathering timely data, and, based on the database, the plan included the carrying out of equitable deployment of health manpower, especially those that are in short supply. Accordingly, 357 general practitioners, 50 anaesthetists, 93 IESOs, and other health professionals have been deployed during the year (Table 24).

In addition, the Implementation Guideline for Career Structure, and the Guideline for Competence Requirements, On-duty Pay Rates and Other Fringe Benefits for health workers have been completed, and the documents have been presented to the Office of the Prime Minister.

Table 24:

Number of Health Personnel Deployed by Occupation

(EFY 2005)

Occupation	Number of Health Professionals Deployed
General Practitioners	357
Health Officers	764
Optometrists	53
Anesthetists	50
Medical Equipment Technicians	34
IESOs	93
BSC Nurses	546
Midwives	159
Total	2,056

CHALLENGES

- Inadequate resource allocation by regions;
- Inadequate absorption by regions;
- Limited capacity to train qualified HRH as per expected competence level;
- Non-standardized and well equipped skill laboratory, including infrastructure;
- Shortage of qualified teaching staff;
- Lack of regular monitoring of training activities by regions; and
- Lack of experience in organizing an up-to-date data collection, storage and retrieval system.

WAY FORWARD

- Increase resource allocation and utilization by regions;
- Identify and fill gaps in the availability of various inputs, such as teaching aids and books, required for the ongoing health worker's training programs;
- Improve quality of training;
- Establish standardized and equipped skill laboratories and infrastructure;
- Provide an adequate number of qualified teaching staff;
- Provide regular monitoring of training activities by regions; and
- Establish and strengthen a regular, adequate, good quality and up-to-date data exchange system.

4.3. PHARMACEUTICAL SUPPLY AND SERVICES

Increasing the availability of quality pharmaceuticals at an affordable price and in a sustainable manner, achieving improved rational drug use and reduced pharmaceutical wastage, and expanding modern drug storage and distribution facilities were the major tasks planned for implementation in EFY 2005.

The performance of the planned activities in EFY 2005 was as follows.

4.3.1. PROCUREMENT

Out of the planned procurement of pharmaceuticals and medical equipment worth ETB 6.00 billion, PFSA has procured pharmaceuticals worth ETB 6.77 billion.

The agency has continued to provide support to local manufacturers of pharmaceuticals and medical equipment by: (i) providing 30% local preference margin for purchase of products which local manufacturers have won through transparent national bid process; (ii) rewarding 25% of protection rights and 30% of advance payments when the procurement is through international bid; and (iii) signing tripartite agreement with the development bank to allow local manufacturers to get loan for 70% of the cost. Accordingly, out of the purchase order given by the agency to local manufacturers, they have been able to produce and supply pharmaceuticals and medical equipment worth ETB 790.8 million.

4.3.2. STORAGE AND DISTRIBUTION

In terms of distribution, out of the planned distribution of drugs and medical equipment worth ETB 8.37 billion in EFY 2005, PFSA has distributed pharmaceuticals and medical equipment worth ETB 8.19 billion. Furthermore, the agency has endorsed a contractual agreement to deliver 165 types of essential drugs and medical equipment to WorHOs for distribution to 1,858 HCs located in Amhara and Oromia Regions. Overall, the performance rate of the agency in the supply of different types of drugs and medical supplies has increased from 85% to 94%, and, out of the available budget, 99% has been utilized in EFY 2005.

Furthermore, by providing training on storage and distribution of drugs and medical supplies for health workers and heads of WorHOs, the agency has enabled them to prepare procurement list of drugs and medical equipment for the use of 1,850 health facilities.

To ensure continuity of supply of drugs and medical equipment, the needs of facilities have been identified and drugs for special programs (malaria, TB, HIV, family planning etc.) have been distributed in an integrated manner to 2,100 health facilities and WorHOs. For purposes of IMNCI program, drugs and medical supply kits worth ETB 11.15 million have been distributed to 1,996 HPs and to WorHOs.

The agency has packed and distributed medical equipment kits directly to 149 newly constructed HCs and 1,845 HPs, and has also distributed PCV and polio vaccines and malaria Rapid Diagnostic Test (RDT) kits worth ETB 1.5 billion.

In order to reduce wastage as well as shortage of drugs and medical equipment by establishing modern and effective storage and distribution facilities, the following activities have been carried out by the agency:

- Training on the integrated pharmaceutical and medical equipment logistics system has been provided to 3,587 professionals drawn from selected health facilities, and supportive supervision has been made to 2,091 health facilities to monitor supply and storage administration and rational drug use.
- To establish a computer-based logistics system in selected health facilities, bulk procurement of computers, UPS and Code Division Multiple Access (CDMA) devices worth ETB 6.6 million has been accomplished; in addition, to organize stores in selected health facilities, 350 shelves, ladders, ventilators, pallets and other necessary inputs have been procured and put to use.
- Over-stocked drugs and drugs with short expiry dates have been circulated among branches of the agency and utilized, and a manual on compensation for errors committed during inventory has been prepared and distributed to facilities.

4.3.3. INFRASTRUCTURE

Strengthening and expanding modern storage and distribution networks throughout the country has been one of the major tasks given emphasis in the EFY 2005 Annual Plan of PFSA. The annual plan envisaged the completion of the construction of 17 modern stores and offices, the construction of 11 cold storage facilities, and the improvement in service provision by completing the renovation of six existing stores and offices, starting the construction of a new office building for a large store, renovating an existing office, and carrying out the procurement of heavy and medium trucks.

Accordingly, 98% of the construction of ten large modern stores with prefabricated steel and around 95% of the construction of the seven medium size stores and offices have been completed. In addition, there is ongoing renovation of five existing stores as well as the construction of 17 cold chain stores.

During EFY 2005, the agency has procured and deployed 50 medium size trucks, and also carried out the procurement of 14 pick-up vehicles through the Government Procurement Service. At the same time, the bid process has started for the procurement of 17 trucks with refrigeration facilities, 22 medium transport trucks, 17 generators, 34 refrigerators and cold chain equipment. The procurement of racks, ladders, trolleys and fork-lifts worth ETB 83 million has been carried out for the use of the modern stores whose building is being completed.

4.3.4. RATIONAL DRUG USE

Training on drug prescription and dosage was given to professionals drawn from 200 health facilities that established Drug and Therapeutics Committees (DTC) and prepared list of essential drugs. Training on the operation of medical equipment and use of chemicals and reagents was also given to 274 health professionals.

In accordance with the plan to start clinical pharmacy services in selected health facilities, training of one month duration was given for 108 professionals drawn from 33 hospitals. Furthermore, training on drug information service was given for professionals drawn from 37 health facilities. In order to enable community pharmacies to provide services of good quality and high ethical standard, a draft document has been prepared in consultation with the Ethiopian Pharmacist's Association and other concerned stakeholders.

After extensive review of the implementation process and constraints, the agency has prepared a draft strategic plan. At national level, regular awareness raising education broadcasts on rational drug use and harmful effects of drugs have been transmitted to the public through 24 radio programs and 144 radio spots. Similarly, 20 articles on different topics concerning rational drug use have been printed in "Addis Zemen" newspaper.

A draft guideline has been prepared to strengthen transparency and accountability of drug supply administration and pharmacy services in health facilities. In line with the plan to establish a computer-based drug distribution system, training was provided to 41 professional staff drawn from 23 health facilities.

CHALLENGES

- Delay in payment by customers for services provided by the agency;
- Delay in completion of construction of storage facilities for pharmaceuticals and medical equipment due to inadequate capacity of building contractors;
- Inability to undertake timely auditing of the past accounts taken over by PFSA from the former Pharmaceuticals and Medical Supplies Import and Distribution (PHARMID) Agency;
- Delay of drugs at port of entry; and
- Low level of commitment for service on the part of some managers and workers.

WAY FORWARD

- Devise mechanisms for timely payment of unsettled accounts;
- Strengthen harmonization and collaboration with relevant government institutions and development partners to solve the delay at ports of entry, for timely audit of accounts and construction of storage facilities; and
- Strengthen the commitment of managers and workers through continuous in-service training, supportive supervision and other similar administrative measures.

4.4. HEALTH INFORMATION TECHNOLOGY

The health information technology is an innovative solution to improve the quality and access of health services and to promote the practice of evidence-based decision making by introducing health-related technologies and practices. The overall goal of the Electronic health (eHealth)/HIT initiative in Ethiopia is to bring about fully developed eHealth solutions that can support the achievement of the HSDP IV strategic objective: "improve accessibility and quality of health services".

In EFY 2005, the following main HIT activities were carried out.

4.4.1. ELECTRONIC HEALTH MANAGEMENT INFORMATION SYSTEM

The electronic Health Management Information System (eHMIS) is a comprehensive system which includes also PHEM, Electronic Mobile Care Solution (eMCS), Electronic Integrated Disease Surveillance and Response (eIDSR), Geographic Information System (GIS), and is part and parcel of the smartcare- Electronic Medical Record (EMR); eHMIS addresses the growing need for a timely, complete and accurate reporting across the health system. In EFY 2005, a total of 2,781 computers and accessories were distributed to Tigray (434), Afar (88), Amhara (907), Oromia (1,173), Somali (105), Benishangul-Gumuz (60), Harari (3), and Addis Ababa (11). The computers were distributed to HCs, hospitals, WorHOs, ZHDs and RHBs. A total of 3,806 professionals were trained on eHMIS/ePHEM system. The system has been implemented at 1,260 health facilities in 10 regions and 173 health facilities in SNNPR.

4.4.2. ELECTRONIC MEDICAL RECORD/ELECTRONIC RECORD UNIT

Medical Record Unit (MRU)-EMR is the component of Electronic Health Record System/Smartcare used to computerize patients' registration and retrieval at MRU/card rooms. During EFY 2005, the MRU-EMR application has been deployed, along with computer and networking equipment, in 15 hospitals in Amhara Region, where all MRU users were also trained. So far MRU-EMR has been implemented in 45 hospitals, including federal hospitals (4), hospitals in Addis Ababa (5), Dire-Dawa (1), Harari (2), Tigray (13), Oromia (2), and Amhara (18) as well as in 59 HCs in Dire-Dawa (14), Harari (4), Oromia (15), and Addis Ababa (26).

4.4.3. TELE EDUCATION AND TELE MEDICINE

The FMOH has been implementing tele education and telemedicine systems in collaboration with different stakeholders.

The eGranary system facilitates personal access to relevant health journals and documents, while helping the health sector as teaching aid and also as a mechanism for retention of health professionals. In EFY 2005, the FMOH, in collaboration with partners, has implemented the eGranary system at four medical colleges (Yirgalem, Dire Dawa, Debremarkos, and Wollega). IT and health professionals were trained on the use of the system.

The FMOH, in collaboration with the FMOE, has started to implement tele education at 13 newly opened medical universities; the FMOH has also procured and distributed the required ICT devices, and installation has been done already in three university hospitals (St. Paul's, Adama and Yirgalem) in collaboration with partners.

The Therasim Software helps the students to simulate medical cases and has been implemented in nine newly opened universities, where the software has been installed in the hospital server; demonstration on how to use it has been done for 30 health professionals and 27 IT professionals.

4.4.4. MOBILE HEALTH

The FMOH identified mobile health (mHealth) as a tool to strengthen the implementation of the HEP in Ethiopia and help accelerate the achievement of the health-related MDGs. The FMOH with partners has identified five priority areas (referrals, data exchange, supply chain management, training and education, and consultation) for mHealth integration within the health system. Indicators (regarding family planning, ANC, delivery, immunization, malnutrition, malaria, TB, front-line stock out, and vital statistics), derived from routine data sources (including family folder, HEW tally sheets and HMIS report), were selected to be tracked through mHealth. In 2012, the mHealth roadmap to help guide the design and implementation processes was finalized. Finally, in 2013 an initial pilot has been implemented in four woredas located in four regions based on the roadmap.

The pilot project has been implemented in two phases:

Phase 1a-Voice: it was implemented since September 2012, using a call center (voice) to accommodate about 200 HEWs from four woredas who were involved in the initial implementation. At the call center, there is one

Call Center Operator (CCO) per region/language for data recording into a web-based electronic data entry system.

Phase 1b–Data forum: in December 2012 all of the four pilot woredas have moved to phase 1b collection of data using mobile phone. To prepare the phase 1b, the HEWs and other relevant professionals were trained on the use of the CommCare application for direct collection of data. The call center is still operational, functioning as a support line for the HEWs to address technical issues.

Mobile health is being piloted in 102 HPs located in four woredas: (i) 25 HPs in Kelete Awelalo Woreda (Tigray Region); (ii) 25 HPs in Enjibara Woreda (Amhara Region); (iii) 25 HPs in Adea Woreda (Oromia Region); and (iv) 27 HPs in Shebedino Woreda (SNNPR).

4.4.5. HUMAN RESOURCE INFORMATION SYSTEM

In EFY 2005, in collaboration with partners, the Human Resource Information System (HRIS) upgraded version 1.3.0 has been implemented at FMOH, Oromia RHB, Addis Ababa RHB, and FMHACA. HRIS-License Module is sharing health professionals' license information across the regions. The system has been deployed at the FMHACA and Oromia, Addis Ababa and Tigray Regional Regulatory Departments, and is currently available online for public access. Users of the system have been trained on the upgraded version.

4.4.6. GEOGRAPHIC INFORMATION SYSTEM FOR HEALTH

The Geographic Information System (GIS) is a system that enables the collection, storage, management, analysis, retrieval, modelling and visualization of spatially referenced information to improve monitoring of the spread of the disease, modelling its future diffusion, and planning timely allocation of resources. In EFY 2005 GIS data were collected from Tigray, SNNPR and Addis Ababa, and 14 professionals from EHNRI were trained on the full GIS package; furthermore, 29 other professionals from different institutions were also trained.

CHALLENGES

- Insufficient budget allocation for running and ensuring sustainability of the eHealth initiatives; and
- Inadequate harmonization among several eHealth initiatives.

WAY FORWARD

- Secure enough budget for the eHealth system and running costs; and
- Finalize the eHealth policy as a national guideline for standardization, interoperability and harmonization of different eHealth projects.

4.5. RESOURCE MOBILIZATION AND UTILIZATION

Health services in Ethiopia are financed from the federal and regional governments, grants and loans from bilateral and multilateral donors, NGOs, and private contributions. Although health financing has improved significantly over years, it remains a major challenge for the health system. Since HSDP III, a Health Care Financing (HCF) strategy was adopted, mainly focusing on increasing resource flow, improving the efficiency of allocation and utilization of resources, ensuring sustainable HCF system as well equitable access. Accordingly, a comprehensive HCF reform is being implemented, mainly dealing with mobilization of additional resources from DPs, retention and utilization of user fee revenues at health facility level, implementation of fee waiver and exemption services, establishment of health facility governing boards, introduction of private wings in the public hospitals, and development of risk sharing and pre-payment schemes.

The following section explains major HCF-related activities carried out in EFY 2005.

4.5.1. HEALTH CARE FINANCING

One of the main challenges which hinder health care access and quality is the lack of resources. To address this challenge and hence to mobilize adequate resources for the health sector, different activities have been implemented, including: (i) revenue retention by health facilities for quality improvement; (ii) implementation of fee waiver system for enhanced equity; (iii) establishment of private wings and outsourcing for better efficiency; and (iv) pilot and implementation of community based and social insurance schemes for improved financial access to health services, avoiding payment at the point of care delivery.

This section outlines the performance of the major HCF reform projects during EFY 2005.

4.5.1.1. REVENUE RETENTION FOR QUALITY IMPROVEMENT

Revenue retention is additional to the block grant budget allocated from treasury, and it is used strictly for quality improvement activities.

Currently 2,558 health facilities (101 hospitals and 2,457 HCs) are retaining and utilizing internally generated revenues to improve the quality of health services. Based on reports from health facilities, they have utilized the retained revenues to: (i) purchase drugs; (ii) improve laboratory services (i.e. purchase of microscopes, haematology complete blood count machines, centrifuges, haematology diagnostic products, chemicals and reagents, etc.); (iii) improve medical equipment (i.e. purchase of Doppler ultrasound machines, operating and patient monitoring tables, modern dental equipment, etc.); (iv) improve the infrastructure of health facilities (i.e. safe water supply, water tank installation, generator, laundry, etc.); (v) renovate and expand the constructions (i.e. patient waiting areas, card rooms, triage rooms, pit latrines, etc.); (vi) improve HMIS (i.e. purchase of computers, installation of local network, printing of consultation cards, request formats, prescriptions, and patient referral slips etc.); and (vii) improve staff motivation (i.e. construction of staff residence, provision of transportation and cafeteria services, etc.)

4.5.1.2. FEE WAIVER SYSTEM FOR ENHANCED EQUITY OF ACCESS TO HEALTH SERVICES

Fee waiver scheme is being implemented as a mechanism for financial risk protection to promote equity of access to health services. Citizens who can present evidence documenting their inability to pay for their medical expenses are entitled to the fee waiver scheme, and any authority providing waiver certificate shall cover costs incurred for the service provided. According to the latest information (as of August 2012), 2,510,067 fee waiver beneficiaries were screened for the service in the country (except in Somali and Afar Regions), and the government allocated a budget of ETB 25,527,418 for fee waiver beneficiaries.

4.5.1.3. STRENGTHEN HEALTH FACILITY GOVERNANCE AND MANAGEMENT

As per the legal framework of health service delivery administration, governance and management, health facilities shall be administered by a joint governing body established from the community, staff of the health institutions, and representatives from other government offices.

Therefore, among the 3,162 health facilities which are under the reform (115 hospitals and 3,047 HCs), 2,788 health facilities (107 hospitals and 2,681 HCs) have formed governing bodies, but currently 2,558 health facilities (101 hospitals and 2,457 HCs) have functional governing bodies.

4.5.1.4. PRIVATE WING AND OUTSOURCING

Private wing has been designed to increase health workers' motivation and reduce attrition of highly qualified medical doctors. Besides, it provides alternative choices of health care for clients, mobilizes additional resources to improve quality of services in the non-private wing sections of the other wards, and reduces inefficiencies.

In EFY 2005, 45 public hospitals have opened private wing services nationwide (increasing from 31 public hospitals in EFY 2004): four federal, referral, and teaching hospitals, nine in Tigray Region, four in Amhara Region, 21 in Oromia Region, one in Somali Region, one in Benishangul Gumuz Region, four in Addis Ababa and one in Dire Dawa City Administrations. Private wing service is not yet started in SNNP, Harari, Afar, and Gambella Regions.

Concerning outsourcing of non-clinical services, 58 hospitals in six regions (with the exception of Harari, Dira Dawa, Afar, Somali and Gambella) have already started the process of transferring non-clinical services to an outside supplier by contracting out to the third party having the expertise to provide services outsourced. Currently, construction, printing, maintenance, catering, gardening, security and others services are outsourced. The objectives are to reduce costs, improve quality and efficiency, and use expertise which is not available in-house, allowing also health facilities to focus on the provision of their core clinical services.

4.5.2. HEALTH INSURANCE

Over the past two decades, Ethiopia has made significant progress in key health outcomes. Despite these positive results, the vision of achieving universal health coverage cannot be fully realized without addressing one of the major barriers to access health care: the financial barrier. To address the financial barrier and ensure a more equitable financing mechanism, the Government of Ethiopia (GOE) has fully articulated health insurance into its health policy and health sector strategies. Considering the large informal sector and the relatively low proportion of formal sector, Ethiopia adopted two health insurance models: community based health insurance (CBHI) for the informal sector, and social health insurance (SHI) for the formal sector (including pensioners).

4.5.2.1. COMMUNITY-BASED HEALTH INSURANCE

In EFY 2005, the major planned activities were: (i) strengthening the pilot CBHI scheme in 13 implementing woredas; and (ii) expanding the pilot CBHI to 161 woredas to learn more and inform the final design and scale up of CBHI scheme at the national level.

In the 13 CBHI pilot woredas, the number of total households is estimated at 300,605. In EFY 2004, the CBHI scheme registered a total of 125,142 households, increasing to 143,852 households in EFY 2005. With regard to beneficiaries, 564,331 were registered in EFY 2004, increasing to 608,675 beneficiaries in EFY 2005. As a result, the enrolment rate has increased from 41.6% in EFY 2004 to 47.9% in EFY 2005.

Out of 608,675 beneficiaries (members and dependents) registered in the schemes, 563,127 beneficiaries have been served so far in health facilities in all pilot woredas; out of these, 282,099 beneficiaries were served in EFY 2005. Accordingly, this year alone, 13 CBHI schemes reimbursed ETB 8 million to health facilities.

So far, the Federal Government subsidized a cumulative total of ETB 6.7 million for CBHI to support members, with an increase from ETB 2.92 million in EFY 2004 to ETB 3.84 million in EFY 2005. Regions also contributed with a total of ETB 3 million for indigents in EFY 2005.

A total of ETB 6,465,072.22 was collected from registration fee and premiums, with large variations across regions depending on the number of households involved in the scheme. Amhara Region generated the largest amount (ETB 2,114,112.24), whereas SNNPR generated the least amount (ETB 1,197,669.98) in EFY 2005. In general, the CBHI scheme has generated ETB 21,065,786.62 in EFY 2005, increasing by 44.3% as compared to ETB 14,600,714.40 generated in EFY 2004.

Regarding the expansion of the CBHI pilot woredas, Amhara, Oromia, SNNP and Tigray Regional Cabinets discussed on the proposal made by FMOH, and decided to expand the CBHI pilot program in different regional zones. A total of 161 woredas were selected from different zones of the four regions for the implementation of CBHI pilot expansion: 39 in Amhara, 60 in Oromia, 47 in SNNP and 15 in Tigray. Subsequently, discussion on the CBHI pilot expansion, specifically on the implementation strategies, directives and other key issues, was held in all piloting regions. Participants were drawn from the CBHI pilot zones, newly selected zones and special woredas for pilot expansion.

Amhara and Tigray Regional Governments agreed to cover 70% of the targeted subsidy and decided that respective woreda administrations should cover the balance (30%). Oromia and SNNP Regional Governments are also expected to do so. The commencement of the newly selected CBHI schemes will be realised in EFY 2006.

4.5.2.2. SOCIAL HEALTH INSURANCE

The key planned initiatives in EFY 2005 were to: (i) follow up the approval of SHI regulation; (ii) finalize the SHI implementation directives and operational manual; (iii) develop fee schedules/capitation for OPD services; (iv) develop SHI medicine list; (v) provide support and follow-up on the approval of job grading, job descriptions and salary scale of the Agency; (vi) conduct targeted awareness creation campaign on SHI to various stakeholders and provide TOT for the implementing government agencies and health providers; and (vii) enter into contract with selected health facilities, and commence the SHI scheme at the end of July EFY 2005. Major achievements are briefly described below.

The Council of Ministers reviewed and endorsed the SHI Implementation Regulation, and this is one of the key developments achieved. Following the endorsement of the regulation, consultation/awareness creation campaigns were conducted on the SHI concept and legal framework in Amhara, Tigray, Oromia, SNNP and Harari Regions in the presence of regional presidents and their cabinets. Furthermore, consultations were held at the federal level with 20 federal government institutions in the presence of ministers and top management members, along with the Ethiopian Confederation of Trade Unions and Ethiopia Employers' Federation, leaders and branch managers.

Consequently, TOT on SHI legal framework was provided to professionals and public relations/communications heads of those institutions. The TOT was aimed to provide detailed explanation on the legal framework and implementation procedures, namely on data requirement, data exchange, data update and communication between Ethiopian Health Insurance Agency (EHIA), employers and members. A total of 109 persons drawn from 69 institutions attended this event.

Different guidelines and manuals have been finalized in EFY 2005 and are expected to be approved by the Board and FMOH: Draft SHI Implementation Directive and Operational Manual, and Draft Fee Schedules/Capitation for OPD Services. A zero draft SHI Medicine List was also developed and a consultation will be held in the coming first quarter, after which the list will be submitted to FMOH for approval. Job grading, job descriptions and salary scale study of the Agency were approved by the Ministry of Civil Service and Prime Minister's Office.

Besides, consultation on studies conducted in areas of SHI, such as financial sustainability, provider payment mechanism, and institutional arrangement, was held in the presence of international health specialists and key partners in this area. Comments were received and a roadmap was also developed accordingly.

Concerning the recruitment of EHIA staff, 19 professionals have been recruited and deployed. Staff recruitment for the 24 branch offices will be initiated in the coming quarter. The commencement of the SHI was extended by 6 months as it was necessary to implement further preparatory activities, that are currently underway.

CHALLENGES

- Delay in finalization of preparatory works for the implementation of SHI;
- Lack of adequate human resources and staff turnover in CBHI scheme;
- Limited political leadership at some zonal levels and ownership in some woreda administrations; and
- Low quality of health care services (i.e., caused by unavailability of drugs, medical supplies, and adequate staff) and low commitment of health providers which in turn affect client satisfaction.

WAY FORWARD

- Accelerate the finalization of the preparation phase and start implementation of SHI as planned;
- Deploy CBHI staff as per the design and directive;
- Establish frequent communications with Regional Governments;
- Include the CBHI and SHI performance indicators in the HDA checklist at all levels so that the implementation of the health insurance will be streamlined with the health indicators; and
- Identify the root cause of medicine stock-out and find out alternative solutions to avail adequate drugs and medical supplies.

4.5.3. FINANCIAL/EXPENDITURE MANAGEMENT AND CONTROL

4.5.3.1. GRANT MANAGEMENT

The Global Fund budget on TB and malaria disbursed during the EFY 2005 was audited at the FMOH level, Oromia RHB and some selected zones and woredas, SNNP RHB and some selected zones and woredas, Afar RHB, and Malaria Consortium. The report was communicated to FMOH and participating regions.

With regards to MDG Performance Fund (PF) budget, the amount disbursed in the fiscal year was audited at the FMOH level, Amhara RHB and selected zones, woredas and health colleges, Somali RHB and health college, and Afar RHB. The audit report was submitted to FMOH and participating regions.

With regards to the NNP budget, the amount disbursed in EFY 2005 was audited at the FMOH, EHNRI, Tigray RHB and selected woredas, Amhara RHB and selected woredas, Gondar University, and SNNP RHB and selected woredas. The report was compiled and submitted to the FMOH Minister's Office and participating regions. Similarly, the performance audit on hospitals, which was being carried out by the Office of Auditor General, was completed and the fact sheets sent to the FMOH Minister's Office. In addition, a performance audit on GIZ-constructed HCs and on the EFY 2005 budget is being undergone by the Office of Auditor General.

4.5.3.2. INTEGRATED FINANCIAL MANAGEMENT INFORMATION SYSTEM

The Integrated Financial Management Information System (IFMIS) is one of the major financial reform programs in the public sector, which is expected to come up with an enhanced information system for all public bodies in a uniform platform. The health sector represented by FMOH has been participating in the national project since EFY 2003. A team comprising of nine FMOH staff joined the national project and was trained on ORACLE EBS, the Enterprise Resource Planning application to be installed for IFMIS with the following nine modules: General Ledger, Accounts Payable, Accounts Receivable, Fixed Asset, Cash Management, Inventories, Purchasing, Payroll and Public Sector Budgeting. Currently, 6 key users from FMOH are participating on the implementation of the application.

Since EFY 2003 seven major IFMIS project milestones have been performed, out of which the major one is system design. The design process has been conducted using three conference room piloting sessions. During the design, the requirements of the health sector were carefully addressed. As a result, an acceptable and flexible solution was provided for Channel 2 fund management, integrating all Channel 2 grant fund users, and enabling them to work on a unified and integrated modality.

In EFY 2005, the national project successfully completed the pilot test phase of the overall implementation of IFMIS. The next step will be the production phase which will be conducted with the help of information system database, network and application experts. As a result, the health sector will benefit from the calibrated Chart of Accounts and Program Budgeting structures which are part of the project.

During the fiscal year, the new solution was launched at FMOH level for treasury account. Besides, IT infrastructure and user connectivity activities were performed at FMOH, Oromia RHB and EHNRI for 50 professionals who will be users for testing sessions. In line with this, IT infrastructure team was established, and training on the solution was provided for these staff members. Furthermore, orientation sessions were conducted with different stakeholders in the health sector.

CHALLENGES

- Inadequate execution of change management;
- Absence of effective communication mechanisms to collect statement of expenditures from regions and health facilities; and
- Staff turnover.

WAY FORWARD

- Conduct change management workshops at different levels;
- Prepare beginning balance for all Channel 2 funds and launch the system at FMOH and 5 selected regions and institutions; and
- Ensure motivation and stability of staff.

4.5.4. PUBLIC BUDGET ALLOCATION

This section explains the allocation to the health sector out of the total public budget in EFY 2005. The source of data is MOFED. Besides, it shows only the allocation to the health sector at regional level.

4.5.4.1. PERCENTAGE SHARE OF THE PUBLIC HEALTH BUDGET ALLOCATION FROM THE TOTAL BUDGET

In EFY 2005, the percentage of total budget allocated to the health sector at regional level was 9.75%, which was higher than in EFY 2004 (9.13%) (Figure 52). In EFY 2005, the per capita health allocation was ETB 100.16, increasing from ETB 74.27 in EFY 2004. The regional block grant budget allocated to the health sector ranged from 6.8% in Addis Ababa to 14.7% in Dire Dawa in EFY 2005. An increase in the percentage share of health budget from EFY 2004 to EFY 2005 was observed in eight regions (Tigray, Afar, Amhara, Oromia, Benishangul Gumuz, Gambella, Harari and Addis Ababa), whereas three other regions (Somali, SNNPR, and Dire Dawa) showed a decrease.

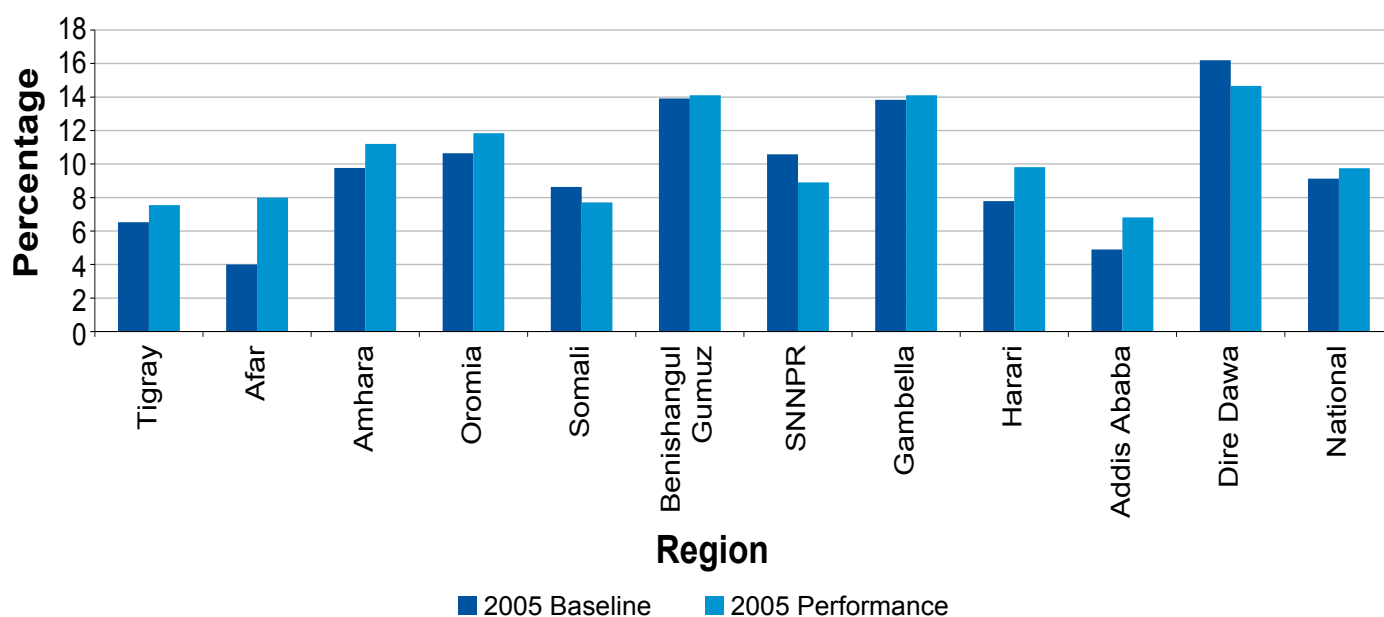


Figure 52: Distribution of the Percentage of Total Budget Allocated to the Health Sector by Region (EFY 2004 and 2005)

Although per capita allocation is increasing over time, the allocated budget for health in EFY 2005 was below the need of the sector for delivering quality care. This calls for enhancing implementation of HCF reform and expansion of pre-payment schemes, such as community and social health insurance, as well as additional funds from different sources.

4.5.5. DEVELOPMENT PARTNERS' CONTRIBUTION TO THE HEALTH SECTOR

One of the main sources of funding for the health sector is the contribution from DPs. The following section explains how much was contributed and disbursed by development partners to the health sector.

4.5.5.1. PROPORTION OF EACH DONOR'S CONTRIBUTION AS COMPARED TO THE TOTAL DP DISBURSEMENT

In EFY 2005, a total of USD 551.00 million was committed by DPs and a total of USD 531.13 million (96.4%) was disbursed using Channel 2 modality (Table 25), which was higher than EFY 2004 disbursement (USD 411.00 million).

Table 25:

Commitment and Disbursement of Funds by Development Partner

(EFY 2005)

S.N.	Source of Fund	Commitment (in USD) in EFY 2005	Disbursement (in USD) in EFY 2005	Percentage Disbursement
1	MDG Performance Fund			
	DFID	106,000,000.00	106,964,000.00	100.9%
	WHO			
	UNICEF	1,000,000.00	1,000,000.00	100.0%
	UNFPA	1,000,000.00	0.00	0.0%
	Irish Aid	2,467,532.00	2,447,777.00	99.2%
	Spanish Cooperation	4,545,455.00	4,547,543.00	100.0%
	AusAID	12,500,000.00	12,561,360.00	100.5%
	Italian Cooperation			
	Netherlands Embassy	5,714,285.00	5,714,275.00	100.0%
	TOTAL	133,227,272.00	133,234,955.00	100.0%
2	Technical Assistance Pooled Fund			
	DFID	294,370.00	294,370.00	100.0%
	UNICEF			
	Italian Cooperation			
	AusAID	516,530.00	516,530.00	100.0%
	USAID	1,000,000.00	0.00	0.0%
	TOTAL	1,810,900.00	810,900.00	44.8%
3	Global Initiative			
	GAVI HSFP	6,255,481.00	3,120,250.33	49.9%
	GAVI CSO (B)	1,289,578.01	1,289,578.01	100.0%
	GAVI ISS	80,222,000.00	79,753,500.00	99.4%
	TOTAL	87,767,059.01	84,163,328.34	95.9%
4	Global Fund			
	Malaria	75,481,650.00	120,336,282.00	159.4%
	HIV	111,759,350.00	39,238,000.00	35.1%
	TB	18,821,000.00	5,668,847.25	30.1%
	TOTAL	206,062,000.00	165,243,129.25	80.2%
5	UN Partners			
	UNICEF	71,249,658.00	107,683,723.38	151.1%
	UNFPA	18,958,057.00	501,137.92	2.6%
	WHO	6,182,000.00	5,706,233.30	92.3%
	World Bank	6,132,000.00	25,518,793.08	416.2%*
	TOTAL	102,521,715.00	139,409,887.68	136.0%
6	US Partners			
	CDC	13,560,744.00	3,760,201.62	27.7%
	TOTAL	13,560,744.00	3,760,201.62	27.7%
7	Other Partners			
	Italian Cooperation	2,272,727.00	2,272,727.00	100.0%
	IGAD		67,459.46	
	CIFF	3,467,056.00	1,871,198.00	54.0%
	Imperial College of Sciences	300,000.00	300,000.00	100.0%
	TOTAL	6,039,783.00	4,511,384.46	74.7%
	GRAND TOTAL	550,989,473.01	531,133,786.35	96.4%

* The percentage is higher because World Bank has already disbursed in EFY 2005 the amount committed for EFY 2006

Global Fund, with a total of USD 206.06 million committed and USD 165.24 million disbursed for malaria, HIV and TB programs, is providing the largest contribution to the health sector in EFY 2005 (Figure 53).

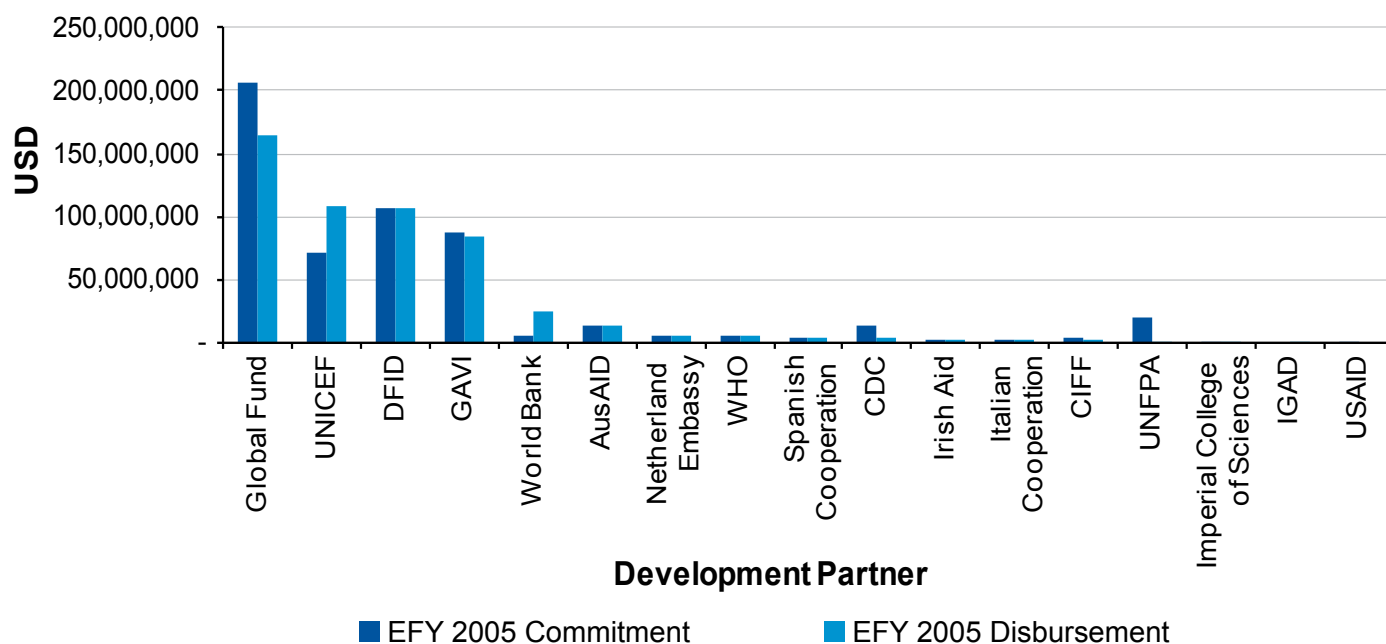


Figure 53: Distribution of Amount Committed and Disbursed by Development Partner (EFY 2005)

As share of DPs disbursement, Global Fund accounted for 31.1% of the total, followed by UNICEF (20.5%), DFID (20.2%), GAVI (15.8%) World Bank (4.8%), Australian AID (2.5%), Netherland Embassy (1.1%) and WHO (1.1%) (Figure 54).

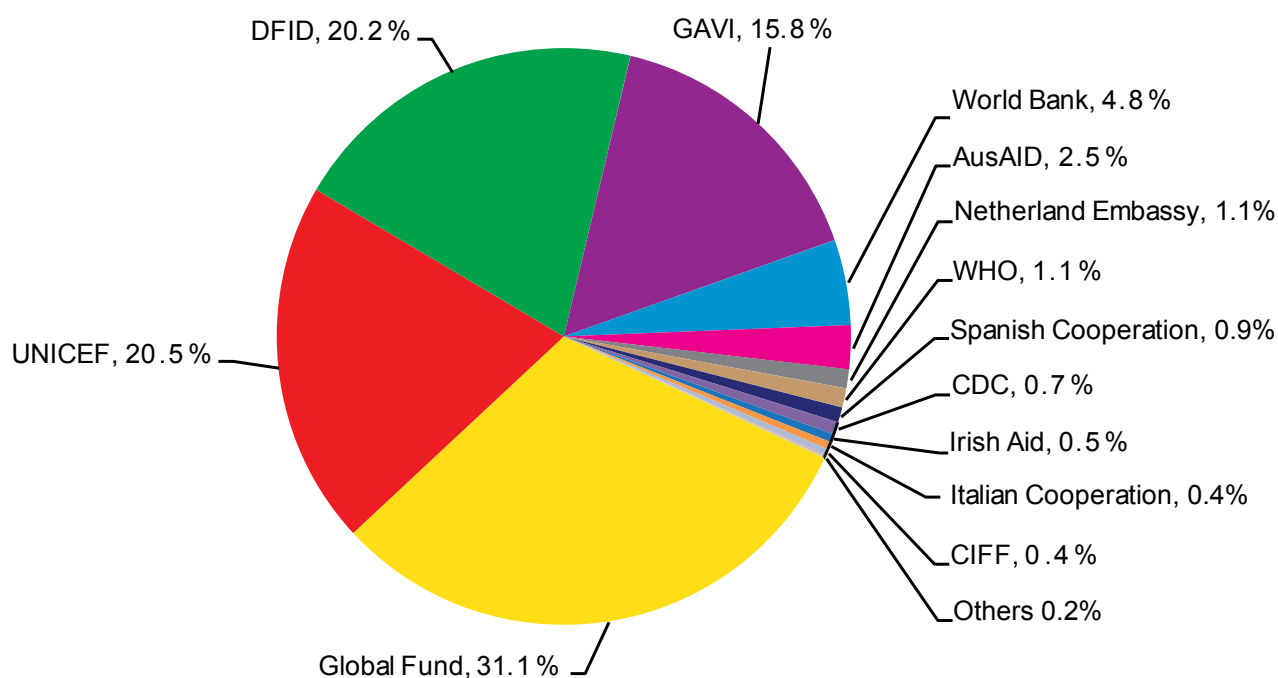


Figure 54: Percentage Distribution of Disbursement by Development Partner (Out of Total Disbursed) (EFY 2005)

Channel 3 contributors are not accounted for in the above mentioned disbursement and are not included in Figure 54; however US partners dedicated a considerable amount of resources through Channel 3 modality.

The following activities were also carried out in EFY 2005.

A technical committee was established, with relevant governmental and non-governmental organizations, and consensus held to encourage the involvement of different Ethiopian diaspora consortia and professional associations, and hence to increase their participation in the Ethiopian health sector. Accordingly, a

memorandum of understanding was signed with Volunteer Service Overseas to encourage the involvement of international and Ethiopian diaspora volunteers for HRD in the country.

An audit report was submitted to the Federal Ministry of Finance and Economic Commission, which highlighted the performance of FMOH and its implementing partners in EFY 2004. Major challenges identified during the auditing process were communicated to the relevant FMOH bodies. In addition, the FMOH Finance Department was audited on the 1st, 2nd, and 3rd quarters of EFY 2005. The audit report was then submitted to FMOH, and Federal Ministry of Finance and Economic Commission in due time.

4.5.5.2. MDG PERFORMANCE FUND

The MDG PF is a funding mechanism managed by the FMOH using the Government of Ethiopia’s (GOE) procedures. In the framework of the Ethiopia International Health Partnership (IHP) compact, it provides flexible resources, consistent with the “One-Plan, One-Budget, and One-Report” principle, to secure additional finance to HSDP. It is one of the GoE’s preferred modalities for scaling up DPs assistance to support HSDP implementation.

MDG PF was established in 2007 with the Global Alliance for Vaccines and Immunization (GAVI) Health Systems Strengthening (HSS) contribution. After the signing of the Ethiopia country compact in August 2008, a JFA was prepared and signed by MoFED, FMOH and seven DPs. Later, Italian Cooperation in EFY 2003, Australian Aid (AusAID) in mid EFY 2004 and the Netherlands Embassy at the end of EFY 2004 have joined MDG PF. In EFY 2005, only six partners contributed to the MDGPF.

A total of USD 133.23 million was disbursed to MDG PF, with a 26.5% increment from EFY 2004 (USD 105.35 million); the MDG PF accounted for 25.1% of total DPs’ disbursement in EFY 2005.

In EFY 2005, the UK Department for International Development (DFID) was the major contributor to MDG PF, accounting for 80.3% of the total amount disbursed by DPs, followed by Australian Aid (AusAID), Netherland Embassy, AECID (Spanish Aid), Irish AID and UNICEF. No disbursement was made by WHO, UNFPA and Italian Cooperation in EFY 2005 (Figure 55).

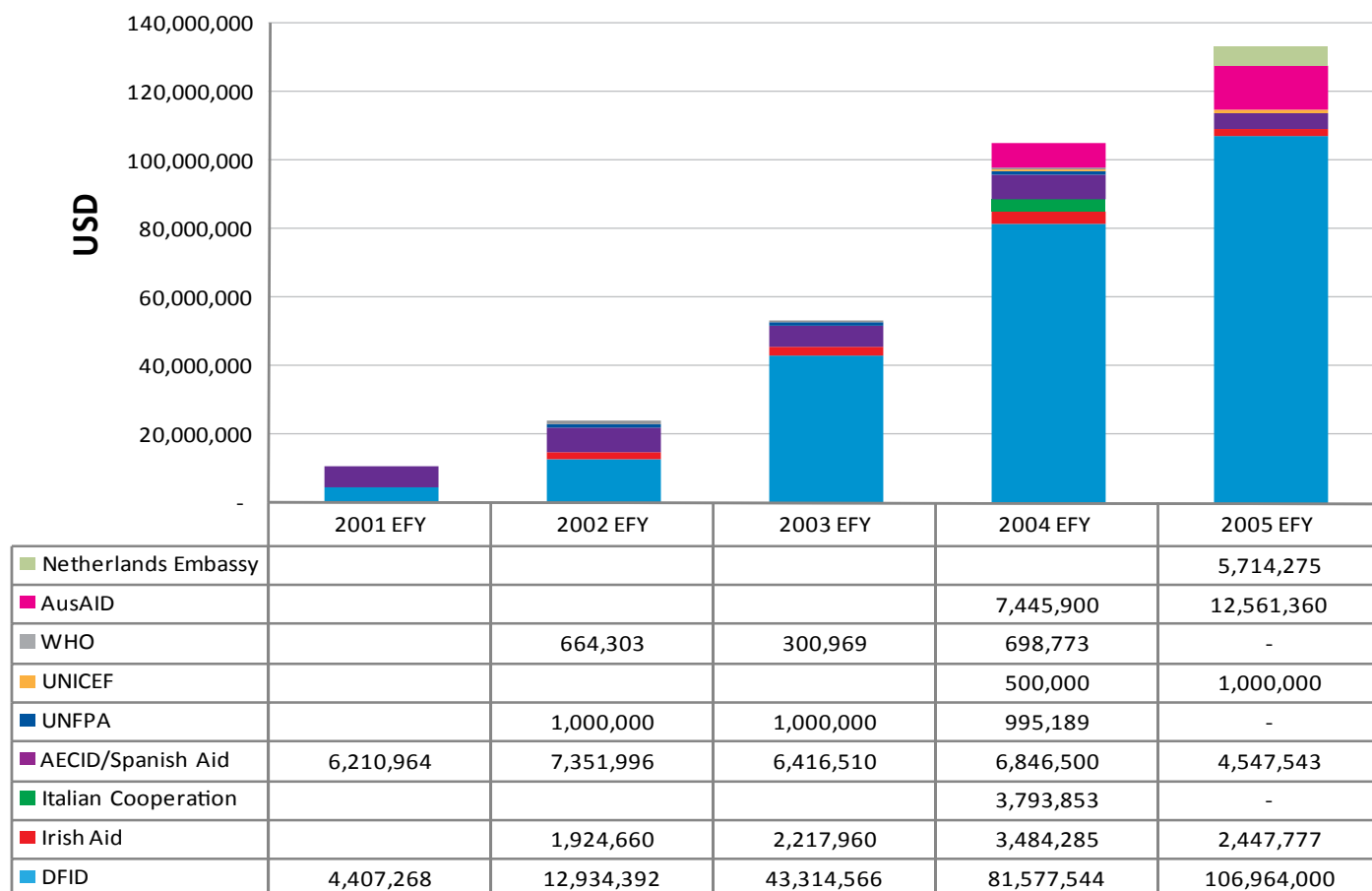


Figure 55: MDG Performance Fund Disbursement (EFY 2001-2005)

4.5.5.2.1. IMPLEMENTATION PROGRESS OF MDG PERFORMANCE FUND

As indicated in the Joint Financing Arrangement (JFA), the MDG PF is established to finance the gaps identified in the comprehensive plan; therefore, urgent gaps to be financed by the MDG PF are identified after the preparation of the comprehensive plan. The specific activities are identified in line with the eligible expenditures stated on the JFA. The major areas funded through the MDG PF in EFY 2005 are indicated in Table 26.

Table 26:

Areas of Support Funded by the MDG Performance Fund
(EFY 2005)

Areas of Support	Amount in USD	Percentage
Health Extension Program	4,907,400	3.3%
Maternal health	71,431,158	47.8%
Child health	14,357,011	9.6%
Medical equipment	31,800,000	21.3%
Communicable diseases	20,178,081	13.5%
Health care financing	1,000,000	0.7%
HMIS	2,300,000	1.5%
Human Resources	3,273,850	2.2%
Governance	283,325	0.2%
Total	149,530,825	100%

Maternal health services received the higher proportion (47.8%) of funds, followed by medical equipment supply (21.3%), and prevention and control of communicable diseases (13.5%).

4.5.5.2.2. IMPLEMENTATION STATUS OF THE MDG PERFORMANCE FUND

MDG PF is used to fill the financial gap in most underfunded priorities of the sector. In particular, the MDG PF focused mainly on the following areas in EFY 2005: (i) HEP, (ii) maternal and newborn health, (iii) child health, (iv) communicable diseases and (v) HSS that include infrastructure, strengthening human resources, equipping hospitals and HCs, supporting governance, HCF and HMIS. Accordingly, a separate plan was developed for the MDG PF at the beginning of EFY 2005 based on the comprehensive plan. More than 90% of the MDG PF was used for procurement in bulk, adding value for money. The implementation of the MDG PF was reported to JCCC quarterly, and, after comments were received from JCCC members and contributing partners, final reports were compiled and sent to all contributors.

Health Extension Program

While equipping and furnishing HPs was done during HSDP III, continuous supply of consumables was needed for appropriate provision of services. Supply of consumables, support to pre-service HEP training, and support for implementation of HEP, especially in emerging regions, have been funded from MGD PF.

Maternal and Newborn Health

In order to address the three delays in access to obstetrical care, transportation was strengthened through the procurement of ambulances, while provision of obstetrical care was supported through procurement of EmONC drugs and supplies, EmONC equipment, and contraceptives. In order to strengthen the newborn health service, equipment for newborn corners enough for 2,000 health facilities were already procured in the previous two years; moreover, equipment for 100 neonatal units and 16 NICUs are being procured in EFY 2005.

Child Health

In order to strengthen the child health program, the MDG PF has supported various activities such as procurement of vaccines, cold room equipment and spare parts as well as trainings. The construction of cold rooms at PFSA warehouses is also being supported.

Communicable diseases

Although activities for controlling communicable diseases have been funded through other major partners, like GFATM, there existed critical gaps in procurement of insecticide chemicals and drugs such as Coartem and Chloroquine. In EFY 2005, the major allocation from MDG PF was for procurement of a new larvicidal chemical, Bendiocarb; furthermore, the procurement of spray pumps for Temephos chemical is also started in EFY 2005.

Health System Strengthening

Under HSS, different areas were supported depending on the financial gap identified and the resources available that were documented through resource mapping from different stakeholders. Concerning Human Resource Development (HRD), support to midwifery training, anaesthesia training, and paramedic training was provided through the MDG PF.

The support to infrastructure was provided mainly to finalize the already started construction of HCs through various partners, like GFATM and GAVI. Required medical equipment for emergency services, like operation theatre and intensive care unit, are being procured in order to improve the quality of services.

HCF was supported through availing funds for the general subsidy for CBHI and for various trainings at all levels. HMIS scale up was one of the underfunded priority areas for FMOH, and was supported by MDG PF mainly to cover the expenses of trainings and printing of HMIS formats.

CHAPTER 5



CONCLUSION



15th ARM

The last lap towards MDGs: Promise renewed to end preventable maternal and child death in Ethiopia.

CONCLUSION

This report examines the progress made in the health sector, identifies the constraints in achieving universal health coverage, and provides the way forward to attain the strategic objectives set in HSDP IV. In EFY 2005, particular emphasis has been put on implementing cost-effective and high-impact interventions to meet MDGs, as shown by the ARM theme: “the last lap towards MDGs: promise renewed to end preventable maternal and child death in Ethiopia”.

Central to Ethiopia’s health performance is the country’s strategy to deliver more and better health care to women and children-especially in the most rural and remote communities. To this end, the HSDP has been successful in putting in place the HEP which has contributed in a major way to improved availability and accessibility of PHC services, and paved the way for the achievement of the MDGs.

HEWs are the first point of contact of the community with the health system, delivering integrated preventive, promotive and basic curative health services, with a special focus on maternal and child health. Results are already apparent: for example, HEWs contributed to promoting behavioural change and providing family planning and other MNCH services. Furthermore, the implementation of the HDA is underway with the aim to drive behavioural change and expand safe health practices at community level. The vision is to consider the community as a potential producer of health, instead of as a mere consumer of medicines and curative services. Good practices adapted to local environment and culture have been documented and promoted, and results are already apparent, showing an increase in skilled care at birth and, in general, in use of MNCH services in regions where HDA is fully implemented and functional.

In particular, several interventions were put in place to increase PHC coverage and ensure continuity of care throughout the lifecycle (adolescence, pregnancy, childbirth, postnatal period, and childhood) and also between places of care giving (households and communities, outpatient and outreach services, and clinical-care settings), having wide implications for the achievement of MDGs in Ethiopia. These interventions included training of key health professionals and their deployment mainly in under served areas, expansion of health facilities especially in rural areas, provision of key inputs such drugs and equipment, better financing of the sector, and improved evidence-based planning and use of information for decision making.

Concerning MDG4, a rapid decline in U5MR has been achieved, with an annual rate of reduction of 5.0% over the past 20 years. In this regard, it is worth noting that Ethiopia has been identified as one of the seven high-mortality countries with the greatest declines (by two thirds or more) in lowering child mortality. Ethiopia has implemented pro-poor policies and has performed better than other SSA countries, providing an

example that it is possible to sharply reduce preventable child deaths, when concerted action, sound strategies, adequate partnership and political will are consistently applied in support of MNCH. However, challenges still remain; for example, according to EDHS results, NMR, that accounts for 42% of U5MR, has been stagnant over the past ten years. With the aim of saving newborn lives and achieving MDG4 by 2015, interventions have been carried out across the different levels of the health referral system. These interventions include the development of community-based newborn care, implementation of integrated community case management of common childhood illnesses, and establishment of newborn corners in health centers, neonatal units in regional hospitals, and neonatal intensive care units in tertiary hospitals.

In conjunction with the above activities, interventions are underway to remove the bottlenecks hampering access to safe motherhood services, such as harmful traditional beliefs and practices, poor infrastructure, shortage of transportation facilities, and inadequate care at health facilities, so that to address the 3 delays in seeking appropriate medical care for an obstetric emergency, reaching an appropriate EmONC facility, and receiving adequate care when the facility is reached. In particular, a steep increase has been observed in number of HCs providing BEmONC (from 752 in EFY 2004 to 1,813 in EFY 2005) and hospitals providing CEmONC (from 69 in EFY 2004 to 105 in EFY 2005), together with an increase in coverage for antenatal and postnatal care and for skilled care at birth. However, although increasing, the percentage of deliveries assisted by skilled birth attendants (which is considered as the single most important intervention for reducing maternal mortality) was still very low (23%) in EFY 2005.

Concerning MDG6, a general increase in coverage of key MDG-related interventions for disease control has been observed over time. Encouraging results have been achieved in HIV/AIDS control, with combination of relatively low HIV prevalence (1.3%), sustained prevention efforts and increased ART coverage. Of note is the fact that good progress has been made also in programs that were considered as critical areas of underachievement in the past years, such as those for the reduction of mother to child transmission of HIV. In fact, improved access to HIV prevention and treatment services in the last years has led to steady increase in percentage of HIV-positive pregnant women who receive efficacious ARV therapy or prophylaxis, reaching 42.9% in EFY 2005. As a result, Ethiopia is one of the few “rapid decline” SSA countries, with a reduction by 50% of new HIV infections among children between 2009 and 2012. However, despite the estimated decrease in newly HIV infected children from 19,000 in 2009 to 9,500 in 2012 (according to the 2013 UNAIDS Report), this number is still too high and further efforts are needed to reduce mother to child transmission of HIV. It is for this reason that FMOH is shifting its strategy from a time-limited intervention around pregnancy and breastfeeding (PMTCT) to the lifelong therapy for pregnant women living with HIV (“Option B+”). Option B+ is a “test and treat” strategy aimed not only at preventing new HIV infections among infants, but also for improving the survival of HIV-infected mothers and reducing orphanhood, with a vision of an HIV free new generation. This shift has wide implications in terms of integrating MNCH programmes and ART programmes to support alternative service delivery models, build integrated skills for health professionals, and address infrastructural constraints.

Concerning TB control, which was considered in the past as another area of concern because of the low capacity of detecting TB cases, the 2011 TB prevalence survey showed a TB prevalence (all forms) of 240 per 100,000 population, that was lower than the previous model-based estimate (572 per 100,000 population), with a subsequent increase in case detection rate, reaching the international standard of 70%. However, in EFY 2005, from data derived from HMIS, TB case detection rate was estimated at 59% and TB cure rate at 70%, below the international standard of 70% and 85%, respectively, while TB treatment success rate was 91% (above the international standard of 85%). To address these challenges, efforts should be made to strengthen the capacity of detecting and reporting TB cases as well as to ensure adequate availability of trained staff and laboratory equipment to perform sputum-smear examination during treatment. Concerning MDR-TB, there was an increase in number of facilities providing services in EFY 2005, with 600 new MDR-TB patients having started the treatment in the year.

Concerning malaria control, while the three-pronged approach consisting of early diagnosis and effective treatment, selective vector control and epidemic prevention and control have been successfully implemented,

with subsequent increase in IRS coverage and use of malaria case-management services (as documented in the 2011 Malaria Indicator Survey and in the present report), challenges are still to be addressed in ensuring availability and use of LLINs. In this regard, procurement and distribution of LLINs should be speeded-up as well as HDA should be mobilized to promote appropriate use of LLINs.

Progress has been made also in developing partnership and increasing resource mobilization and utilization towards the achievement of MDGs. A critical step towards “One Budget” has been the establishment of the MDG Performance Fund to facilitate resource pooling in order to finance the priorities under the HSDP, with an increasing number of DPs joining MDG Performance Fund over time: as a result, the total amount disbursed to MDG Performance Fund by DPs increased from USD 105 million in EFY 2004 to USD 133 million in EFY 2005. A particular focus at the moment is to build on recent increases in health care access to improve quality of care in general, and maternal and newborn care in particular.

However, the performance is still inadequate in key areas, such as skilled care at birth, relying on functional health systems and 24-hour availability of clinical services. These mixed results highlight that, although interventions needed to control disease and to avert much of the burden of maternal and child disease are known, they require a functioning health system to have an effect at the population level. To this end, interventions are underway to address key issues, such as gaps in midwives, doctors and anaesthetists for provision of EmONC services, absence of 24 hours a day and 7 days a week service in health facilities, rapid turnover of highly trained professionals, and inadequate transport facilities and spare parts for equipment.

In conclusion, strengthening health systems and ensuring universal access to quality services are the crucial challenges to assist progress toward MDGs; furthermore, MDGs cannot be met with the limited resources available and Ethiopia will require further support from partners with improved aid effectiveness: this framework is inherent in MDG8 “Develop a global partnership for development”.

This report tries to address the critical question of how to speed the pace of change observed in the past into dramatically faster progress during HSDP IV period, whose end in 2014/15 corresponds to the deadline of the quantitative, time-bound framework of accountability of MDGs. The past experience of achievements and challenges provides important hints to guide policies, strategies and programmes to be implemented in the next years with the support of all partners in order to achieve MDGs by 2015.

The participants at ARM 2013 are invited to examine this report in depth and come up with recommendations that will enhance implementation of the strategic initiatives detailed in HSDP IV.

