Federal Democratic Republic of Ethiopia

Ministry of Health

HEALTH SECTOR TRANSFORMATION PLAN-I

ANNUAL PERFORMANCE REPORT

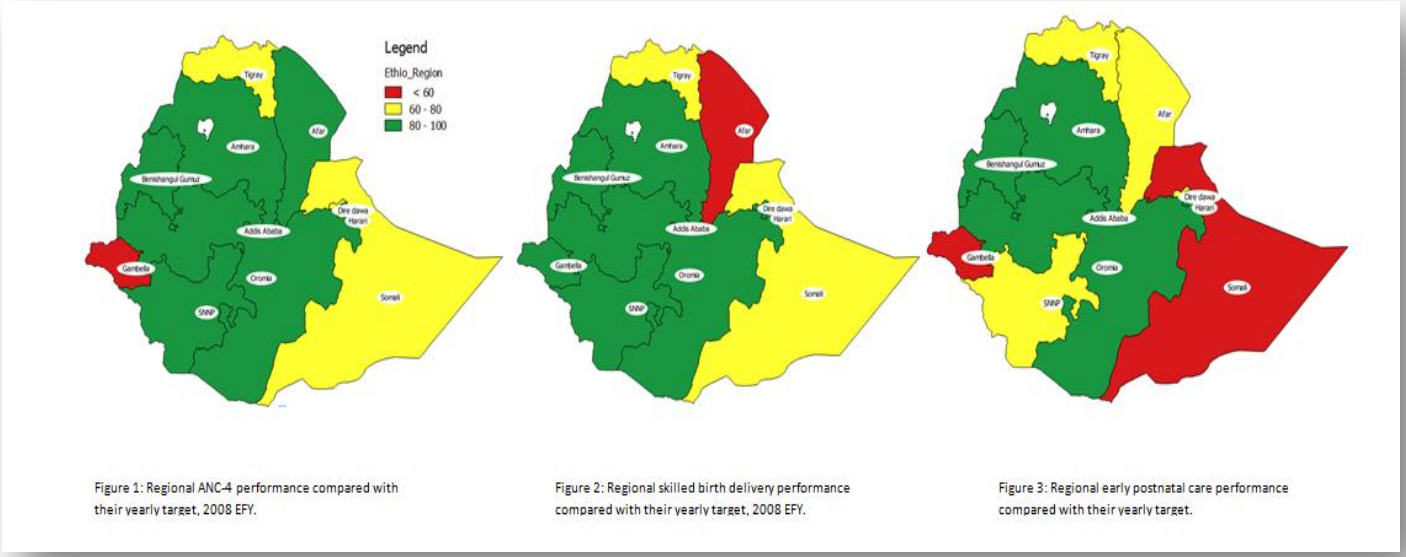

Figure 1: Regional ANC-4 performance compared with their yearly target, 2008 EFY.

Figure 2: Regional skilled birth delivery performance compared with their yearly target, 2008 EFY.

Figure 3: Regional early postnatal care performance compared with their yearly target.

EFY 2008 (2015/2016)

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CHAPTER ONE

INTRODUCTION

In the last two decades, the Government of Ethiopia (GOE) has strengthened the health system by applying pro-poor policies and strategies which resulted in significant gains in improving the health status of citizens. To this end, Ethiopia performed remarkably well in meeting most of the MDG targets. As a continuumeffort, the successful implementation of these pro-poor policies and strategies havecontinuedto bring further gains in the era of the Health Sector Transformation Plan (HSTP).

The EFY 2008 marks the beginning of the first year of HSTP Icovering the period of 2015/2016-2019/2020 (EFY 2008 to 2012).

The present ARM is the eighteenth in the series of annual reviews that took place since the implementation of the HSDP I.

This annual performance report describes theimplementation status of the HSTP I in 2015/2016by highlightingthe three key features of quality andequity, universal health coverage (UHC), and transformation underfourpillars of excellence of HSTP: (i) Health Service Delivery;(ii) Quality Improvement and Assurance; (iii) Leadership and Governance; and (iv) Health System Capacity.The reportalso addresses the fifteen Strategic Objectives of the health sector under the four Strategic Themes/pillars of HSTP:

1. Improve health status;
2. Enhance community ownership;
3. Improve efficiency and effectiveness;
4. Improve equitable access to quality health services;
5. Improve health emergency risk management;
6. Enhance good governance;
7. Improve regulatory system;
8. Improve supply chain and logisticsmanagement;
9. Improve community participation and engagement;
10. Improve resource mobilization;
11. Improve research and evidence for decision-making;
12. Enhance use of technology and innovation;
13. Improve development and management of HRH;
14. Improve health infrastructure; and
15. Enhance policy and procedures.

The report gives an overview of the performance of the sector on addressing the strategic objectives and, in particular, onflagship initiatives. It also highlightshowactivities conducted during the year have brought desired outcomes on the health status of the Ethiopian people. In addition, 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 selected program indicators;
- Performance against targets set in the HSTP woreda-based health sector annual core plan,
- Trends of achievements and regional comparisons in line with equity;
- Qualitative description on the selective health program outputs/outcomes; as well as
- Status of the health sector support systems.

, A consistent structure has been applied to this report, with divided chapters indicatingthe background / description, baseline, targets, achievements, challenges, and the way forward.

Both quantitative and qualitative data are used in the preparation of this report. The source is the Health Management Information System (HMIS)/PHEM aggregated monthly and quarterly and annual reports for the EFY 2008, with some exceptions of data for certain program areas that are not covered by the HMIS (i.e. administrative reports and surveys undertaken by different institutions). Population figures are used based on the projection estimates for the fiscal year provided by the Central Statistical Agency (CSA) and conversion factors from the same source. This was a precondition for the appropriate analysis of population-based indicators, such as comparison across regions and over time. Further, for simple measures of inequality, ratio is applied for comparisons of equity stratifications such as geography (pastoralist/non-pastoralist), place of residence (urban/rural), sex (male/female), and age (adult/child) to show relative inequality reflecting proportional differences in health among subgroups. TheAccountabilityScorecard concept is also applied for the comparison across regions and is presented in different coloring (Green: High performer, Yellow: Intermediate performer and Red: Low performer). This concept is mainly used in map presentations.

The report contains sevenchapters, (Chapter One: Introduction, Chapter Two: Health Service Delivery, Chapter Three: Quality Improvement and Assurance, Chapter Four: Leadership and Governance, Chapter Five: Health System Capacity, Chapter Six:The Health Sector Transformation Agendas,and Chapter Seven: Conclusion)with35 tables,48 figures, and 4 maps that depict regional comparisons and trends of indicators selected for monitoring the implementation of EFY 2008 health sector performance.

CHAPTER TWO

HEALTH SERVICE DELIVERY

This pillar refers to the promotion of good health practice at individual, family, and community levels and the provision of preventive, curative, rehabilitative, and emergency health services by addressing existing gender, geographic, economic, and sociodemographic inequities. This section provides information on the status of provision of the health extension program; reproductive, maternal, neonatal, child, adolescents, and youth health services; national nutrition program; prevention and control of both communicable and non-communicable diseases; andpublic health emergency preparedness and response.

2.1.Health Extension Program

The Health Extension Program (HEP) is a pioneering community-centered strategy. Its primary purpose is to deliver preventive, promotive health services and selected high-impact curative interventions at a community and household level. The program bridges community engagement through awareness creating, behavioral change, community organization, and mobilization. The health service utilization was improved at a community level in the last decades since the introduction of the program and the deployment of Health Extension workers (HEW). The package being implemented at schools,youth centers, community and household levels contributes to the improvement of the health status of the families, with their full participation, using locallyavailable technologies and skills, and wisdom of the communities. In this context, with the objective of promoting community ownership of the health programs and adoption of healthy lifestyles, a major initiative undertaken by the Ethiopian Government is the implementation of the Health Development Army (HAD).

Implementation of Health Development Army

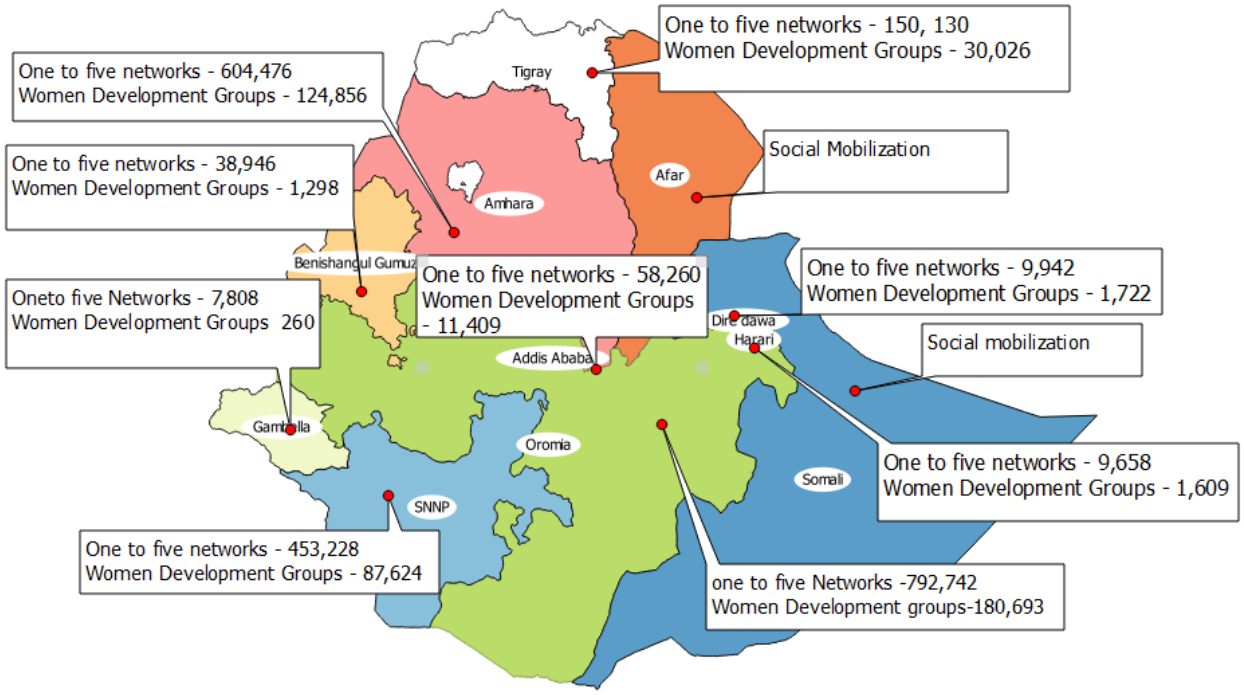
The objective of the HDA is to enable the community to get control over its own health and the factors affecting it by letting the community have ownership and a lead role in health programs..This requires an organizedsocial movement fueled by technical and knowledge-based inputs provided by the health sector.

In EFY 2008,the HDA movement scored encoraging results which contirbuted to the overall health improvements of women and children.

- The community demonstrated its commitment by constructing and equiping Maternity Waiting Homes(MWH) in Amhara,Oromia,SNNPR, and Tigray Regions. In some places, the community also collected foods for pregnant mothers waiting in MWHs. This included a total of 900 quintals of cereals in Oromia, a total of 22,604 quiantals of cereals in Amhara, and additional land was availedin 19 kebeles to supplment food for MWHs.

- In addition to the ambulances procured and distributed by the Ministry of Health (MOH), the community is contributing to local ambulance funds. In Oromia, a total of 115 million Birr was mobilized, from this, 45 ambulances worth about 45 million Birr were procured and distirbuted. In Amhara region, 74 million Birr was mobilized and the procurement of 132 ambulance is underway.
- Model Household graduation is another result of organized community movement. Model Households are those households that managed to successfully implement all 16 packages of HEP. In EFY 2008, a total of 666,217 additional Model Households were graduated, for a cummulative number of graduated Model Households of 6,045,595 at a national level. The community is also working closely with HEWs to identify those families who regress.

The progress made by regions interms oforganizing women in Development Groups and one-to-five networks during the fiscal year is depicted as follows.



Map 1: Number of Women in Development groups and one -to -five networks by Region,EFY 2008

In summary, a total of439,497Development Groups with2,125,190 Oneto five networks were formed at a national levelin EFY 2008.

Other activities

- Second generation HEW implementation guideline development and advocacy workshop in Southern Nations, Nationalities, and Peoples' Region(SNNPR) and Tigray carried out.
- Family health team was piloted in three woredas at Addis Ababa as part of Urban primary health care reform,

- Urban HEP implementation manual was revised and Urban HEW generic training initiated in Addis Ababa.
- Pilot training was started to upgrade HDA to level 1 in Oromia and Tigray. As a result, 1,255 were trained of which 99% completed training, 85% were assessed, and 89% became competent.

Challenges

- Disparity among regions on the implementation of HDA;
- Lack of commitment and low level of skills and experience on the part of management in implementing HDA;
- Inadequate performance of graduated Model Households in some packages;
- Inadequate number of woreda and kebele level management staff to perform regular supporting supervision; and
- Unsatisfactory collaboration among sector offices having important roles in implementing HDA strategy.

Way forward

- Undertake capacity building measures on HDA implementation for management staff;
- Improve the process and quality of training and graduation of Model Households;
- Strengthen the process of model kebels graduation;
- Implement level I&II HEPcompentency testing and certification;
- Strengthen Urban Health Extention Program;
- Strengthen regular supporting supervision at woreda and kebele levels; and
- Strengthen collaboration among sector offices.
- Strengthen social mobilization,1to 5 network and WDG in Afar and Somali

2.1.1. Hygiene and Environmental Health

Various hygiene and environmental health activities were carried out in EFY 2008. With regard to Open Defecation Free (ODF) kebeles, a cumulative number of kebeles delared as ODF increased to 6,830from that of 5,177 in EFY 2007.

Other activities carried out in EFY 2008 include:

- Integrated Urban Sanitation and Hygiene Strategic Plan developed for Small, Medium and Mega Cities
- National hygiene and sanitation strategy developed,
- Manestrual Hygiene Management Guideline developed
- Hygiene and Environmental Health Communication Guidelene developed

- The final standard design of urban/town sanitation facilities was completed and circulated to regions for implementation;
- CLTSH Implementation Outcome Evaluation Conducted in 8 Regions,
- Sanitation marketing curriculum and sanitary construction standard was desinged in collaboration with technical and vocational training agency;
- To strengthen the primary health care unit revitalization of the existing system based on the assesment, findings and advocacy was done at Addis Ababa and selected woredas for implementation; and
- To strengthen urban HEP, training mannuals were prepared and supportive follow up guidelines were desinged to improve the linkage with PHCU.

Challenges

- Inadequate number of environmental health professionals at regions, zones, and woredas, as well as health centres;
- Absence of regular and integrated monitoring and evaluation (M&E) activities;
- Inadequate implementation ofhygiene and environmental health package in HEP;
- Limited attention on urban sanitation;
- Inadequate capacity to scale-up best practices;
- Uncoordinated support from partners; and
- Loose multisectoral actions.

Way forward

- Recruit and train environmental health professionals at all levels;
- Ensure integrated M&E activities;
- Improve the implementation of the hygiene and environmental health package in HEP;
- Give due attention to urban sanitation;
- Strengthen the capacity of regions to scale-up best practices; and
- Strengthen harmonization and alignment.

2.1.2. Health Education and Communication

In EFY 2008,a number of activities were carried out under four strategic initiatives, namely: strengthening social behavior change communication, strengtheningadvocacy and social moblization activities;strengthening intersectoral collaboration; and enhancingthe use of new technologies for health education programming.

1. Strengthening Social Behavior Change Communication

Under this strategic intiative, the following activites were carried out:

- Based on situaltional andneeds assessment of people with visual impairment, four health learning materials on the topic of hypertension, Diabetes Mellitus, cervicalcancer, and breast cancer wereproduced and translated to Braille to easily reach the target audaince. After translation,the materials were distrbuted to each library of the association.
- The previous Family Health Guidewas modifiedand printed in color with the addition of new key messages on NCD and NTD, and Diabetes Mellitus.

2. Strengthen Advocacy and Social Moblization Activities

Under this strategic intiative, the following activites were carried out:

- In collaborationwith Partners International, the Social and Behavior Change Communication (SBCC) Summit was organized with the theme of "Elevating the Science and Art of SBCC". It brought together over 800 participants from more than 50 countries from the global community of SBCCorganizations, professionals, and researchers to advance the practice of SBCC in health.The summitoffered a valuable opportunity for the practitioners and students to interact with one another and share valuable resources and successful models which could be of use in the coming days in previously unexplored areas with new and defined target groups.

3. Strengthen Intersectoral Collaboration

- The national health promotion and communication strategy was produced and endorsed.
- First draft of health literacy and health system literacy implementation manual was produced.
- Other planning activities performed during the year included provision of technical and financial support to Radio Fana Broadcasting Corporation to transmit messages on health related issues to strengthen community awareness. In total, 54 health messages on four different regional languages were transmitted, namely in Amharic, Afan Oromo, Af Somali, and Af Afar.

4. Enhance Use of Technologies for Health Education Programming

Concerning the technologies for health education programming, the 952 Wegen AIDS talkline was identified and adapted for the ministry after the termination of the donor project. The aim of the transition was to provide the 952 hotline services to the general public and expand the services provided to include other national priority health areas in line with the Minister's goals. in addition to HIV/AIDS, sexually transmitted disease, and Tuberculosis, the talkline provides counseling, information, and referral service to the general public on Acute Watery Diarrhea (AWD) in collaboration with public Health Emergency Command post.

Challenges

- Inadequate number of health education experts at each level;
- Absence of staff and structure at regional, zonal, and woreda level for the management of health education and communication interventions;
- Inadequate strategic guidance and follow-up of health education and communication interventions;
- Limited attention for health education and communication;
- Inadequate capacity to asess, identify, and scale-up best practices on the area; and
- Inadequate monitoring and evaluation mechanisms in place to follow-up and assess the effectiveness of health communications and their impacts.

Way forward

- Recruit and train health eduction and communication professionals at each level;
- Advocate for the enrollment of staff on health education and communication at each level;
- Ensure the utilization of national heath promotion and communication strategy;
- Ensure the utilization of health learning material development guidelines;
- Give attention to health education and communication;
- Enhance the capacity at all levels to asess, identify, and scale-up best practices on the area; and
- Ensure integrated M&E activities related to health education and communication.

2.2.Reproductive, Maternal, Neonatal, Child, Adolescents, and Youth Health Services

The Government of Ethiopia is committed to improve and maintain the health status of women, neonates, children, adolescent,and young people in Ethiopia. To materialize this, the national Health Policy as a governing guide has recently been revised. As a vehicle for the implementation of the revised health policy, a comprehensiveHealth Sector Transformation Program (HSTP) has been formulated taking into account the Growth and Transformation Plan (GTP-2). This strategic framework is based on the concepts and principles of equity and universal access to primary healthcare.

The proposed goal three of the global sustainable development goals (SDGs) by the United Nationsaims to “ensure healthy lives and promote well-being for all at all ages” and to address domestic and global inequalities by 2030. As sub-activities further state, the goal by 2030 isto reduce the global maternal mortality ratio to less than 70 per 100,000 live births; and also by 2030, to ensure universal access to sexual and reproductive health services, including information and education and the integration of reproductive health into national strategies and programs.

The current National Reproductive Health Strategy follows a logical approach which stepped up the implementation of the three-component strategic plans: maternal and newborn health, family planning and fertility, and adolescent and youth reproductive health, contingent upon the implementation of the HSTP.

Ethiopia is among the countries with a good progress in reducing maternal mortality. According to Ethiopian Demographic and Health Surveys (EDHS), Maternal Mortality Ratio (MMR) has dropped from 871 in 2000 to 676 in 2011 per 100,000 live births. According to estimates by the UN Inter-Agency Group (UN-IAG), substantial declines in maternal deaths have been achieved over the last two decades. According to this estimate, the MMR had declined from 1,400 to 353 maternal deaths per 100,000 live births between 1990 and 2015. The absolute number of women who died during pregnancy or childbirth had also decreased nearly by 75%, from 31,000 in 1990 to around 11,000 in 2015. Therefore, Ethiopia is acknowledged as one of the countries in progress toward MDG5 MMR target of 267 maternal deaths per 100,000 live births.

Among other remarkable changes, the total fertility rate has declined from 5.5 children in 2000 to 4.1 children per woman in 2014; and the contraceptive prevalence rate has increased from 8% in 2000 to 42% in 2014. In 2015, the ANC4+ visits coverage and skilled person attended delivery increased to 67% and 60%, respectively. Adolescent pregnancy rate has decreased from 17% in 2010 to 12% in 2014.

The implementation strategy encompasses (i) improving maternal and newborn health (MNH), (ii) improving family planning, (iii) improving adolescent and youth reproductive health, (iv) prevention and management of reproductive organ health problems, and(v) addressing the social determinants of reproductive health throughimproving equitable access to the full spectrum of essential and quality health services to mothers, neonates, children, adolescents and youth.

Performance measures for this section include: contraceptive acceptance as a tracer of reproductive health; women having at least four visits of Antenatal care; deliveries attended by skilled health personnel; women attending postnatal care; HIV-positive pregnant mothers who received ART to prevent MTCT of HIV;and children received pentavalent 3, measles, and full vaccine.

2.2.1. Reproductive and Maternal Health Services

There was an increment on CAR from 69.9% in EFY 2007 to 71.0% in EFY 2008. Likewise, ANC coverage (at least one and at least four visits) increased from 96.9% and 67.9% in EFY 2007 to 98.4% and 76.0% in EFY 2008, respectively. Similarly, the percentage of deliveries attended by skilled health personnel increased from 60.7% to 72.7% in the same period. However, PNC coverage slightly decreased from 90.0% in EFY 2007to 89.3% in EFY 2008. On the other hand, the proportion of pregnant women counseled and tested for the prevention of mother to child

transmission (PMTCT) of HIV increased from 92.6% to 95.0%; however, the percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV decreased from 64.9% in EFY 2007 to 62.1% in EFY 2008.

Although these reproductive and maternal health indicators showed significant progress in most aspects, none of them surpassed the target set for the year and HSTP (Table 1).

Table 1: Maternal Health Indicators (EFY 2008 Baseline, Performance and Target and HSTP Target)

Indicators	EFY 2008 Baseline	EFY 2008 Performance	EFY 2008 Target	HSTP Target
Antenatal 1+ care coverage	96.9	98.4		
Antenatal 4+ care coverage	67.9	76.0	83	95
Percentage of deliveries attended by skilled health personnel	60.7	72.7	77	90
Postnatal care coverage	90	89.3	94	95
Contraceptive Acceptance Rate	69.9	71.0	80	
Percentage of pregnant women counseled and tested for PMTCT	92.6	95.0	98	
Pregnant women tested positive for HIV who received ART to prevent Maternal to Child Transmission (MTCT)	64.9	62.1	93	95

2.2.1.1.Contraceptive Acceptance Rate

Regional Distribution of Contraceptive Acceptance Rate

Disparities were observed across regions in EFY 2008 on CAR. Like the previous years, the lowest rate (9.0%) was reported from Somali Region, and the highest rate (92.7%) was reported from Amhara Region. Except Tigray, Amhara, and SNNP Region, the remainingeight regions increased their performance from EFY 2007. Except Afar Region, the other regions performed below their targets set for the year (Figure 1). In EFY 2008, the private for profit and non profit health facilities contributed 10.5% to the overall performance of CAR.

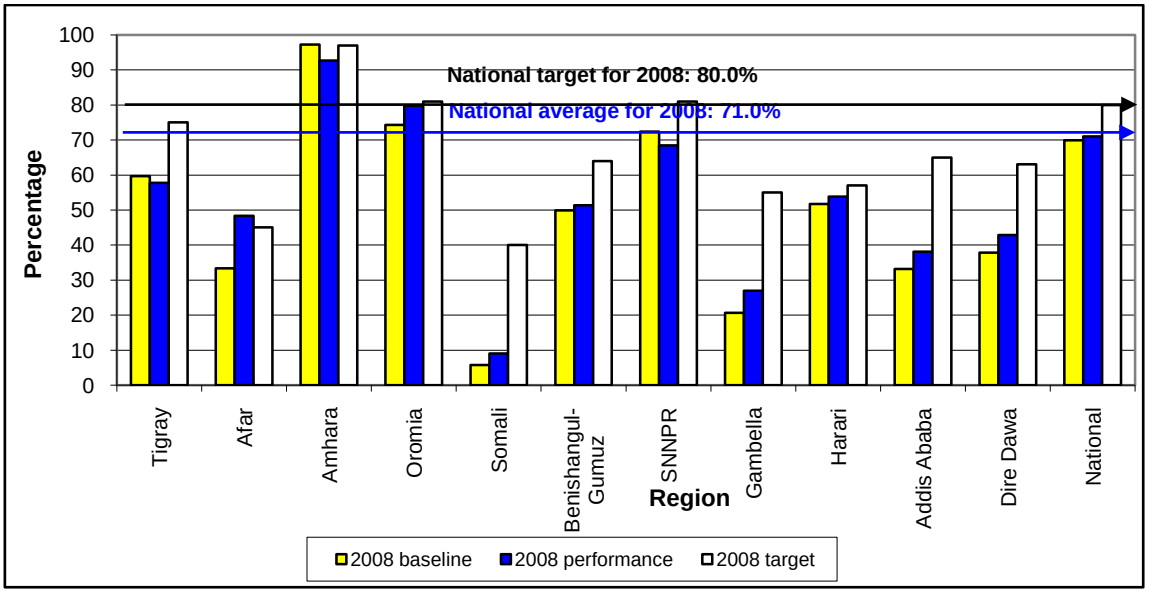
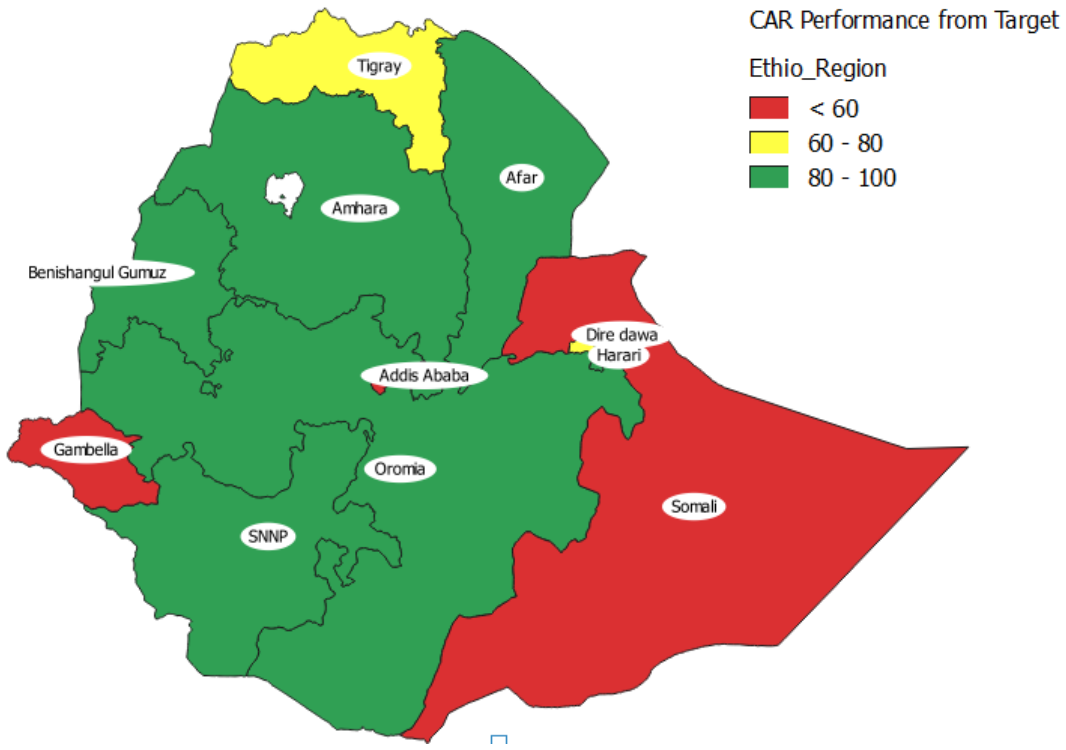


Figure 1: Comparison of Baseline, Performance, and Target of Contraceptive Acceptance Rate by Region (EFY 2008)



Map 2: Contraceptive Acceptance Rate Performance Out of Annual Target Set for the year by Region,EFY 2008

In EFY 2008, the utilization of family planning services in terms of choice of method showed that of the available methods of family planning, users mainly preferred injectable (52%), followed by long term contraceptive (28%) (implant(25 %) and IUCD (3%)) and oral contraceptives (15 %)(Figure 2).

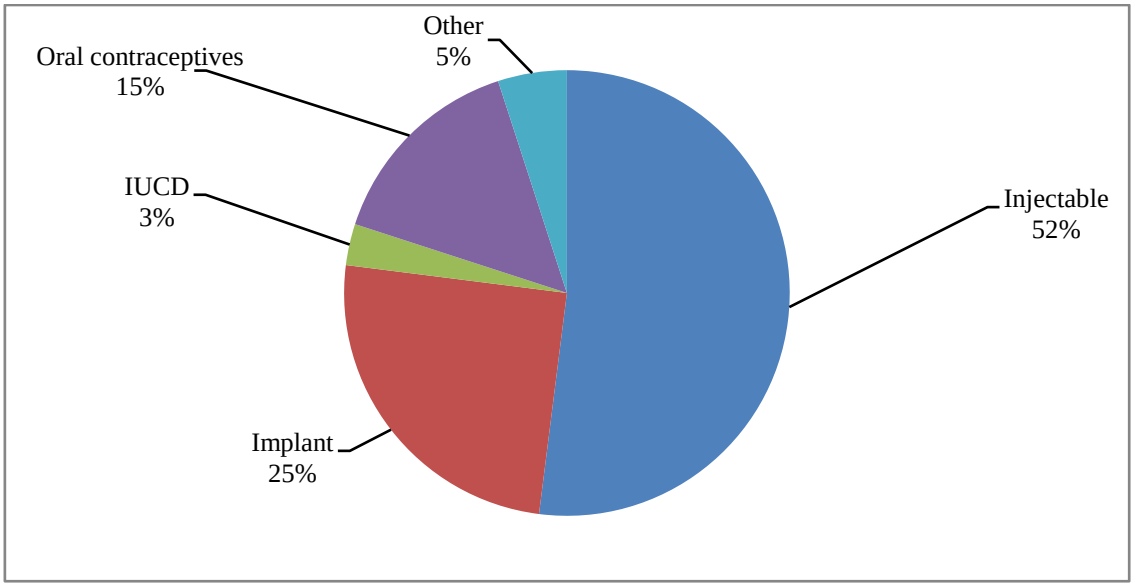


Figure 2: Utilization of Family Planning Services in Terms of Choice of Method, EFY 2008

With regard to the expansion of IUCD service, a total of 1,282 health facilities were supplied with IUCD kits in all regions and level IV HEWs from 66 health posts were trained on the IUCD service provision.Furthermore, a total of 100 health institutions with a high load of delivery services were provided with supplies of family planning methods for post-delivery family planning.A total of 127 health facilities have been identified and supplied with appropriate materials to start the service on permanent method of family planning.

2.2.1.2.Antenatal Care Coverage

Regional Distribution of Antenatal 1+ Care Coverage

In EFY 2008, ANC (at least one) coverage showed variation across regions, ranging from 68.4% in Gambella to 100% in Tigray, Afar, Amhara, Oromia, Benishangul Gumuz, SNNP, Harari, Addis Ababa, and Dire Dawa. When the performance is compared to the baseline, all regions either improved or remain the same from the previous year performance (Figure3). In the same period, the private for profit and non profit health facilities contributed 4.8% of the overall performance toantenatal 1+ care.

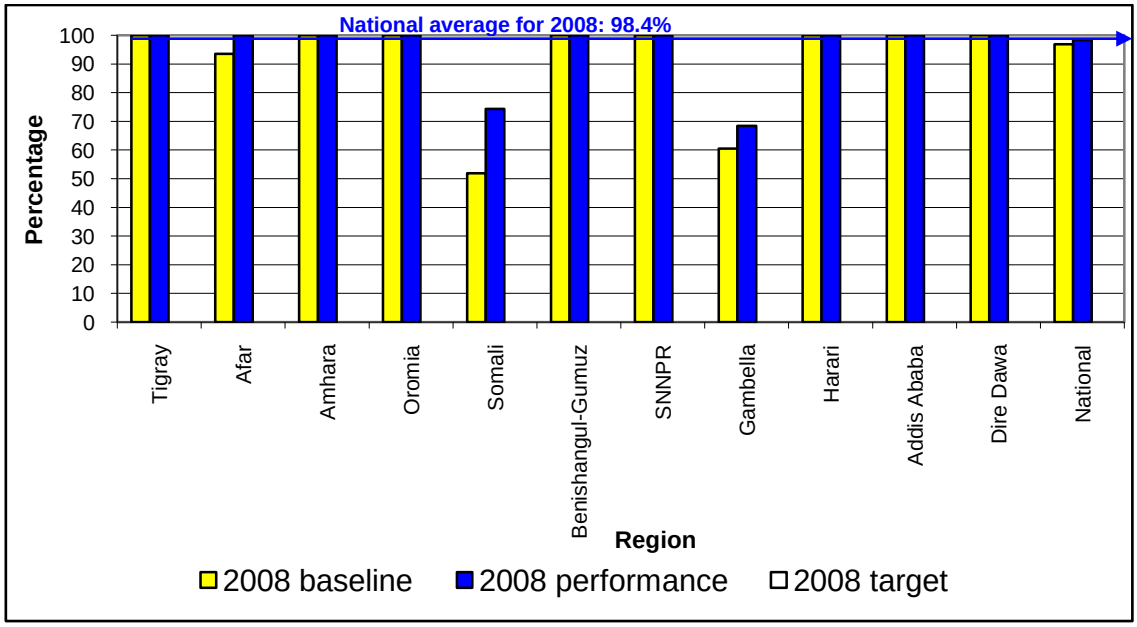


Figure 3: Comparison of Baseline and Performance of Antenatal Care Coverage 1+ by Region (EFY 2008)

Regional Distribution of Antenatal 4+ Care Coverage

Similarly, ANC (at least four visits) coverage also varied across regions from 14.4% in Gambella Region to 100% in Addis Ababa in EFY 2008. Except SNNP and Harari Regions, the remaining nine regions improved their performance from the previous year. On the contrary, exceptAddis Ababa City administration, the remaining 10 regions did not achieve their annual target (Figure 4). Furthermore, the private for profit and non profit health facilities contributed 4.3% to the overall performance of antenatal 4+ care.

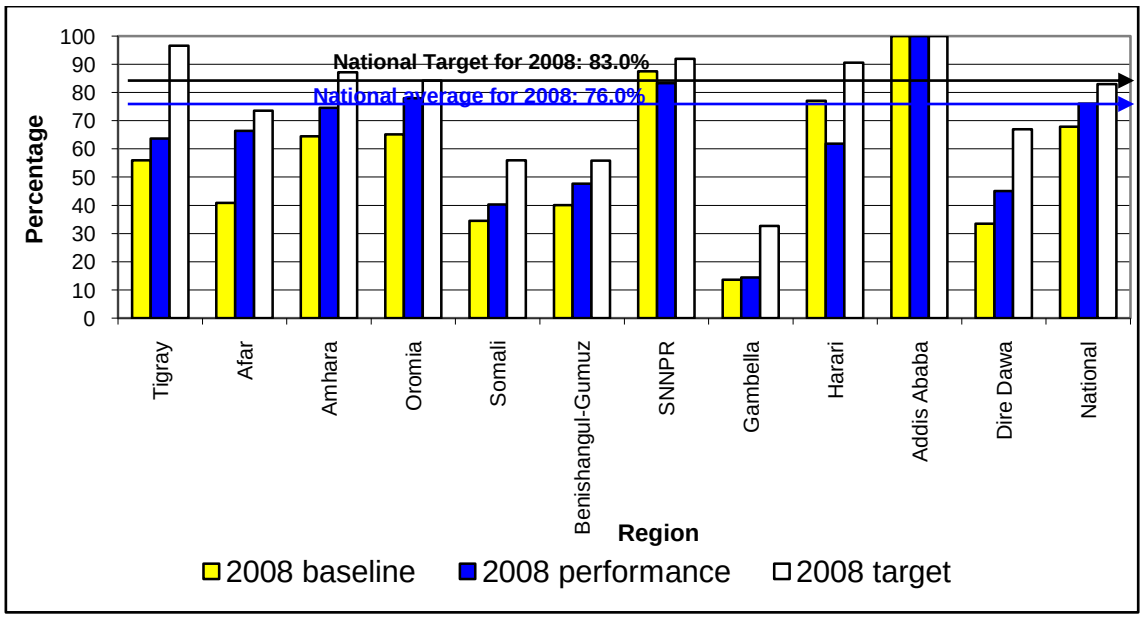


Figure 4: Comparison of Baseline, Performance and Target of Antenatal Care Coverage 4+ by Region (EFY 2008)

2.2.1.3.The Percentage of Deliveries Assisted by Skilled Health Personnel

The percentage of deliveries assisted by skilled health personnel at national level showed anincrease from 60.7% in EFY 2007 to 72.7% in EFY 2008; however, it remained below the target of 77% set for the year.

There was wide disparity across regions, ranging from 25.0% in Somali to 100% in Harari and Addis Ababa.However, all regions improved their performance from the previous year. With the exception of Oromia, Gambella, Harari, and Addis Ababa, the remaining seven regions did not achieve their annualregional target (Figure 5). Only 3% contribution was from private for profit and non profit health facilities for the percentage of deliveries assisted by skilled health personnel in the fiscal year.

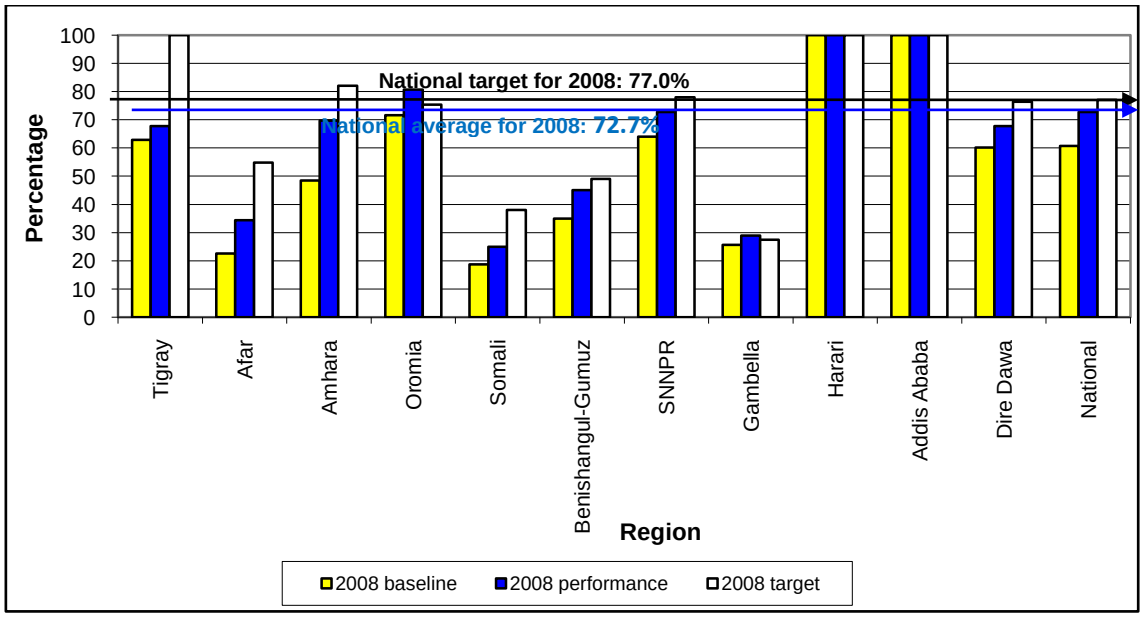


Figure 5: Comparison of Baseline, Performance and Target of Percentage of Deliveries Assisted by Skilled Health Personnel by Region (EFY 2008)

The dramatic change on the percentage of deliveries assisted by skilled health personnel mainly attained by (i) building community Health Development Army to carry out a coordinated mannerduring the summer“Kiremet” time by facilitating institutional delivery and (ii) creating a comfortable environment in health facilities for pregnant mothers and their babies by building appropriate accommodations in health facilities.

In order to strengthen the basic emergency management of obstetric and neonatal care services, basic obstetric and gynecologic medical equipment were provided to 500 health centers and 55 hospitals. Furthermore, additional operation room supplies were also distributed to 55 hospitals in the fiscal year. On the other hand, a total of 548 health professionals were trained on basic emergency management of obstetric and neonatal care.

2.2.1.4.Postnatal Care Coverage

PNC coverage at national level slightly decreases from 90.0% in EFY 2007 to 89.3% in EFY 2008 and below the target set for the year (94.0%). There was a wide variation across regions from 33.2% in Gambella to 100% in Oromia, Harari, and Addis Ababa.Except three regions (Tigray, SNNP, and Dire Dawa), the remaining eight regions either increased or remain the same from the previous year. On the other hand, four regions (Oromia, Benishangul Gumuz, Harari, and Addis Ababa) achieved the target set for the year(Figure 6).

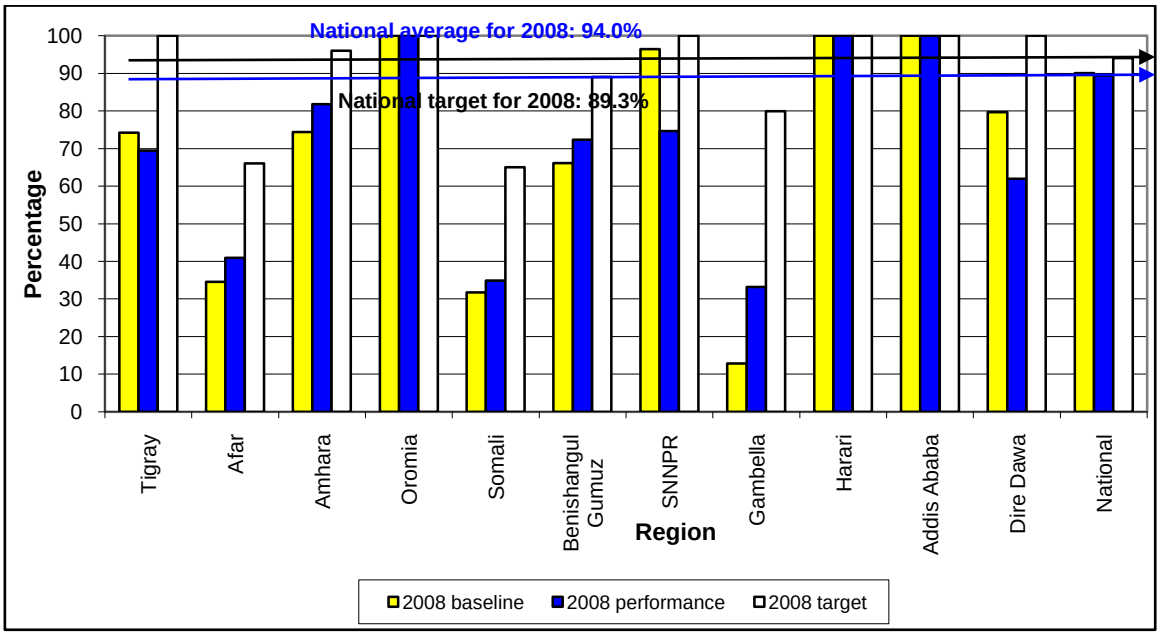


Figure 6: Comparison of Baseline, Performance and Target of Postnatal Care Coverage by Region (EFY 2008)

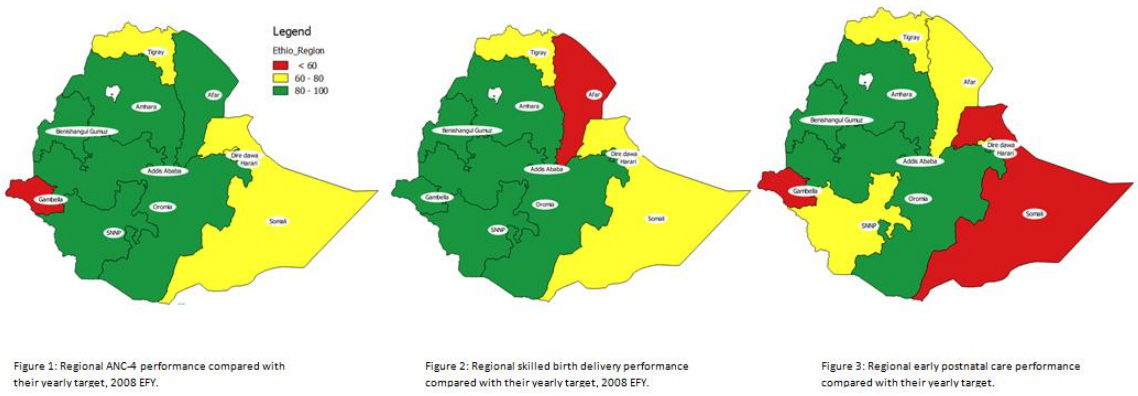


Figure 1: Regional ANC-4 performance compared with their yearly target, 2008 EFY.

Figure 2: Regional skilled birth delivery performance compared with their yearly target, 2008 EFY.

Figure 3: Regional early postnatal care performance compared with their yearly target.

Map 3 : Antenatal Care 4+ Coverage,Percentage of Delivery Assissted by Skilled Health Personnel and Post Natal Care Coverage, Performance out of Annual Target Set for the year by Region,EFY 2008

2.2.1.5.Prevention of Mother to Child Transmission of HIV

Prevention of Mother to Child Transmission of HIV Testing Rate

The proportion of pregnant women counseled and tested for the prevention of mother to child transmission (PMTCT) of HIV out of the eligible increased from 92.6% in EFY 2007 to 95.0% in

EFY 2008. In the same period, the private for profit and non profit health facilities contributed 5% to the overall performance of pregnant women counseled and tested for the PMTCT.

There was regional variation ranging from 42.5% in Somali and 100% in Oromia, Harari, Addis Ababa, and Dire Dawa. Except four regions (Tigray, Amhara, Benishangul Gumuz, and SNNP), the remaining seven regions either increased or remained the same their performance from the previous year. On the other hand, except Afar, Oromia, Harari, Addis Ababa, and Dire Dawa, the other six regions did not achieve their annual target set for the year (Figure 7).

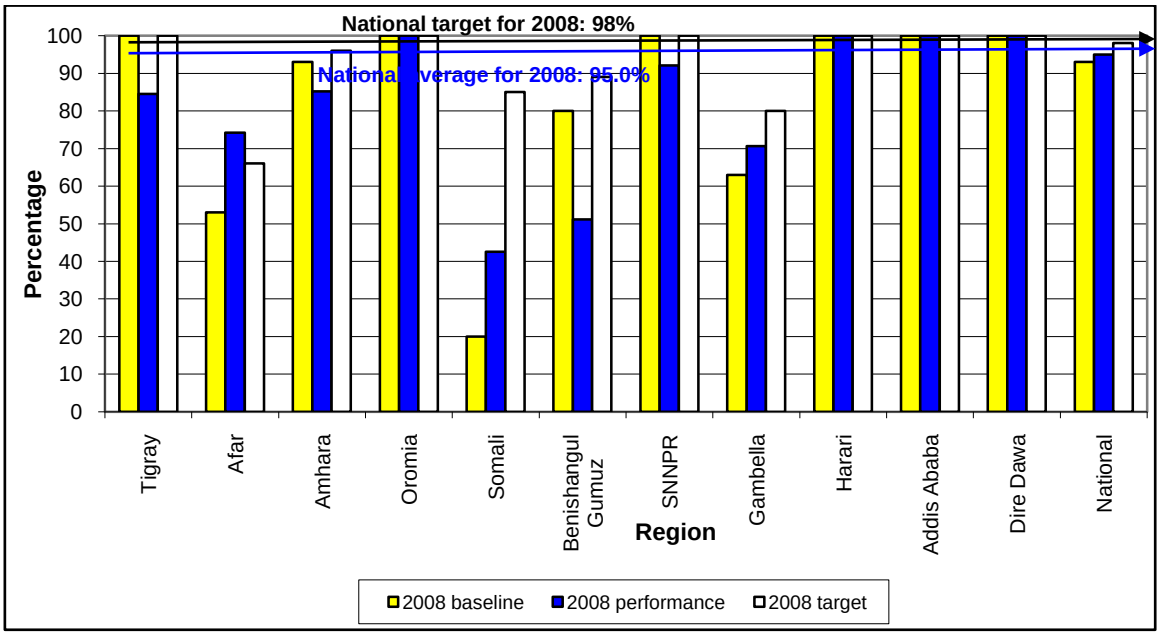


Figure 7: Comparison of Baseline, Performance, and Target of the Proportion of Pregnant Women Counseled and Tested for the Prevention of Mother to Child Transmission (PMTCT) of HIV by Region (EFY 2008)

Out of 3,532,551 pregnant women who received at least one ANC visit, 2,944,320 (83.3%) pregnant women were tested for HIV and it was lower than in EFY 2007 (95.6%).

HIV Positive Pregnant and Lactating Mothers Received ARV (ART as per Option B+) to prevent MTCT of HIV

The percentage of HIV-positive pregnant women who received efficacious Antiretroviral (ARV) therapy to prevent Maternal to Child Transmission (MTCT) of HIV was estimated at 62.1% in EFY 2008 (16,557out of the estimated 26,643 HIV-positive pregnant women eligible)(Figure 8)which was lower than in EFY 2007 (64.9%).On top this, a total of 473 mothers were on either maternal AZT prophylaxis or triple ART prophylaxis.

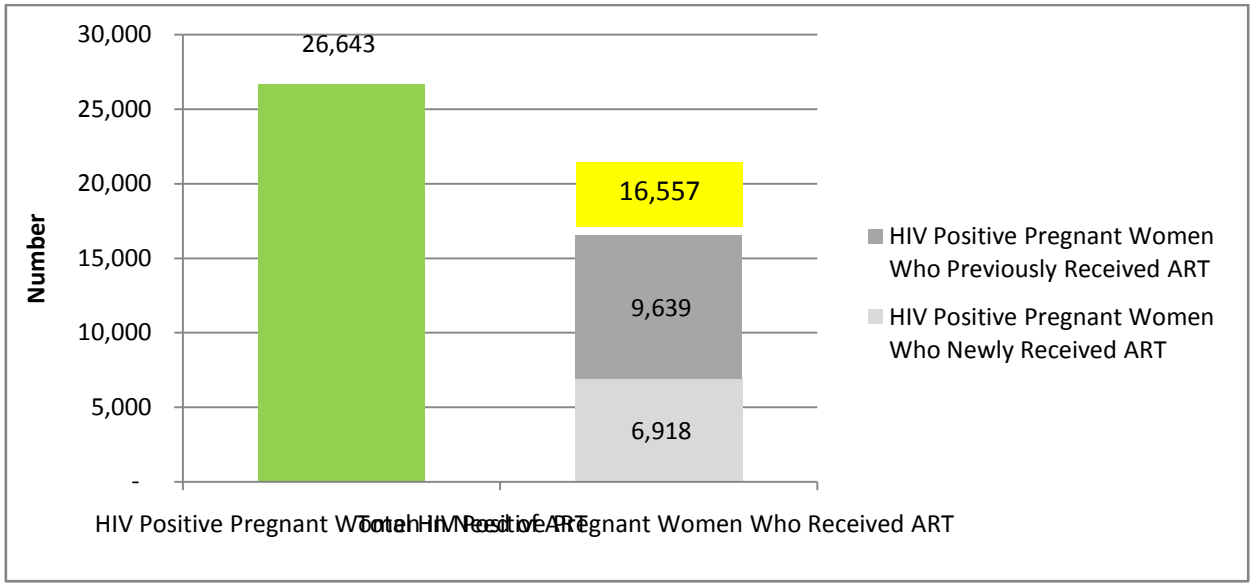


Figure 8: Status of Pregnant Women Tested Positive for HIV Who Received ART to Prevent Maternal to Child Transmission (MTCT) (EFY 2008)

Forecasting was done on HIV test kits by considering all pregnant mothers and their mates, Dry Blood Sample (DBS) test kits for HIV exposed infants, and ART drugs for pregnant and lactating mothers tested positive for HIV in the fiscal year. Medical and drug supplies were available accordingly.

A total of 2,815 health facilities have been providing early infant diagnosis to prevent maternal to child HIV transmission.

2.2.1.6.Other activities

Maternal Death Surveillance and Response

As depicted inTable2, maternal deathsthat were reported in EFY 2008 through PHEM system/MDSRis 535, which is only 5% and far below from the expected death report from regions based on the UN estimate (11,025 materan death per year).From the total reported maternal death, Amhara accountedfor the highest with 239 followed by Tigraywith 89 and Oromiawith 76. Except Dire Dawa city administration,the remaining ten regions reported maternal deaths below the estimates for the year.

Table 2: Maternal Deaths through PHEM/MDSR System by Region, EFY 2008

Region	Expected MD/year as per UN estimate	Number of Maternal Deaths	Percentage
Tigray	618	89	14%
Afar	212	0	0%
Amhara	2,493	239	10%
Oromia	4,150	76	2%
Somali	672	0	0%
Benishangul Gumuz	124	0	0%
SNNPR	2,247	69	3%

Gambella	51	0	0%
Harari	29	9	31%
Addis Ababa	402	20	5%
Dire Dawa	27	33	122%
National	**11,025**	**535**	**5%**

Still Birth Rate

There were a total of 24,856 stillbirths at national level with 11 stillbirths per 1,000 deliveriesin EFY 2008. The highest stillbirth rate was reported in Harari (55 stillbirths per 1,000 deliveries) and the lowest in SNNP (8 stillbirths per 1,000 deliveries) (Figure 9).

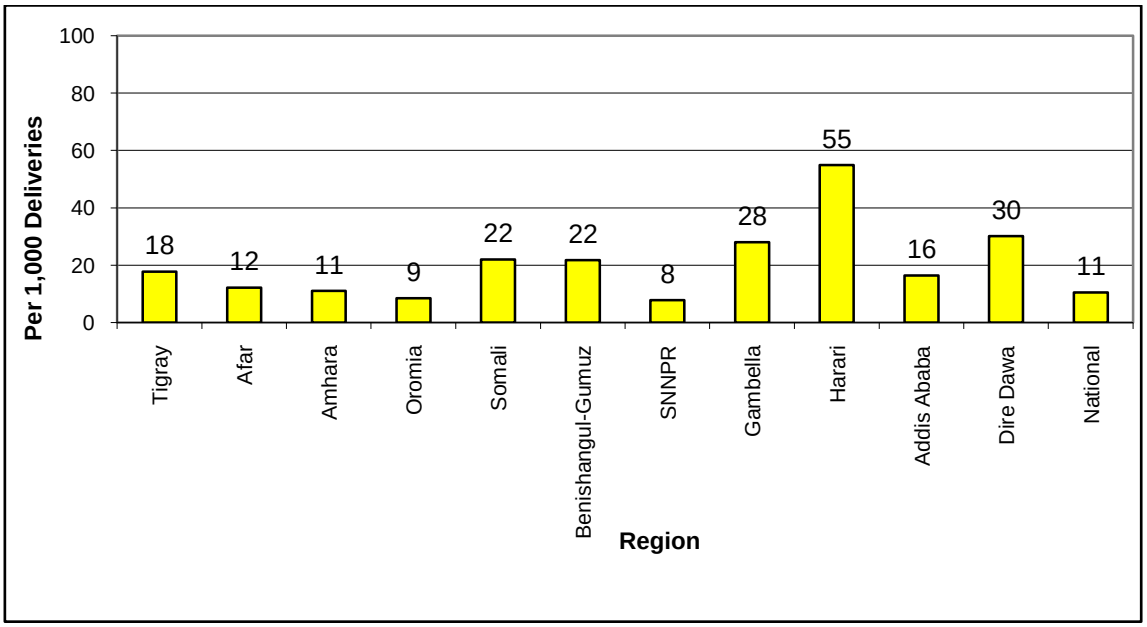


Figure 9: Stillbirth Rateby Region, EFY 2008

Safe Abortion Service

A total of 227,028women received comprehensive abortion care service in EFY 2008 which was above the number of women received in EFY 2007 (221,533).There were a considerable number of women under the age of 18 years who received the comprehensive abortion care service. Thus, this needs strengthening of the implementation of adolescent and youthreproductive health services and the application of guidelines for safe abortion service in the country.

Caesarean Section Rate

In EFY 2008, the percentage of births by caesarean section was 3.8% at national level. There was huge variation across regions. The highest performance was in Addis Ababa at 25.7% and the lowest was seen in both Afar (1.3%). In line with this, private for profit and non profit health institution contribution to CS rate was 19.9% to the overall performance.

According to international standards, the caesarean rate should be between 5% and 15%(Figure 10).

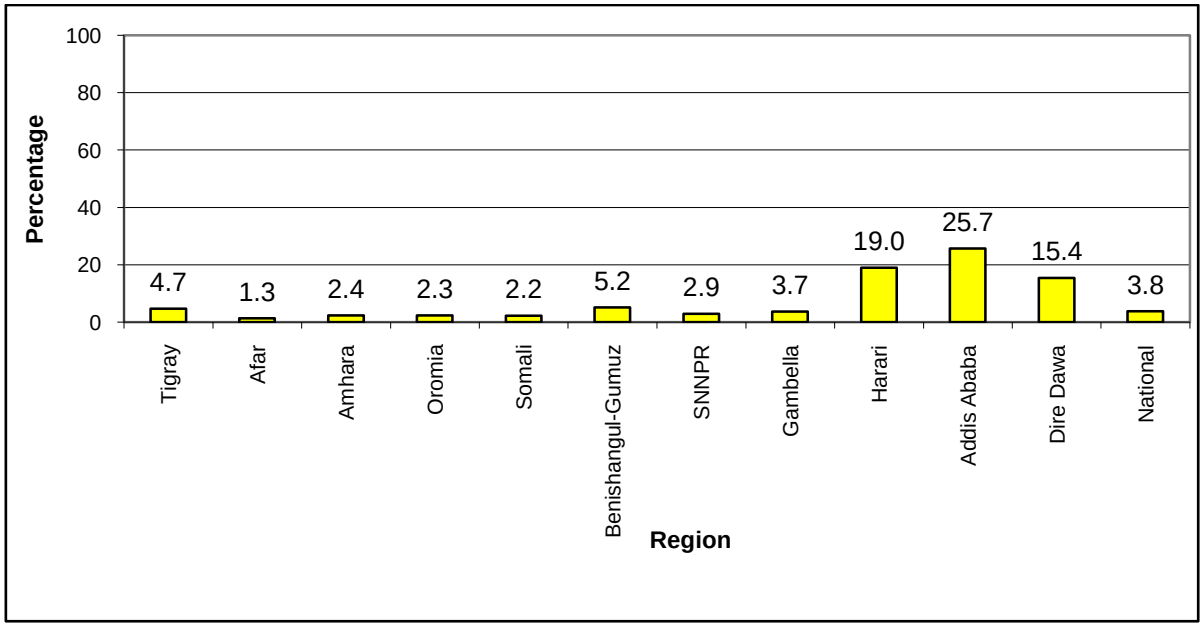


Figure 10: Caesarean Section Rate by Region, EFY 2008

Fistula Service Provision

In EFY 2008, a training manual on fistula screening and pre-diagnosis to identify cases of fistula and uterine vaginal prolapse (UVP) has been developed. Furthermore, an action plan on eradication fistula from Ethiopia has been prepared and communicated to respective stakeholders.

In the fiscal year, out of suspected 2,527fistulacases, a total of 2,162 received a pre-diagnostic test and 1,225 cases of fistula were identified and treated accordingly.

Challenges

- Inadequate utilization of health institutions for delivery attended by skilled personnel and significant number of home delivery;
- Non-dignified maternity care;
- Weak data collection and analysis of MDSR and other maternal health services;
- Presence of regional disparity on the performance of maternal health care;
- Poor quality of post-natal care service; and
- Weak intersectoral collaboration on the implementation of adolescent and youth health services.

Way forward

- Improve the quality of service across the RMNCH-N;
- Work together to narrow the gaps for developing regional states;
- Quality information and data for evidence generation and decision making;

- Respectful (compassionate) maternity and other RMNCH-N activities for better health outcomes;
- Expand and strengthen maternity waiting home as per the national manual;
- Implement safe child birth checklist in all facilities;
- Implement for postnatal stay >=24 hours;
- Strengthen MDSR; and
- Refocus on adolescent and youth health.

2.2.2. Neonatal, Child, Adolescent, and Youth Health Services

Child mortality has also declined significantly, decreasing the under-five mortality rate from about 205 deaths per 1,000 live births in 1990 to 59 deaths per 1,000 live births in 2015. Despite remarkable success in improving child health and declaring achievement of MDG4 three years before the deadline, the neonatal mortality rate (NMR) is still in the high range. The most recent estimate by the UNInter-Agency Group revealed that the NMR in the country in 2015 was 28 per 1,000 live births. Over two-thirds of childhood deaths in Ethiopia are caused by few easily preventable conditions; mainly infections, neonatal conditions, and malnutrition.

The National Newborn and Child Survival Strategy (2015-2020) plans to reduce under five mortality to at least 29 /1,000, infant mortality rate to 20/1000, and NMR to 11/1,000, by 2020. The guiding principles for strategy implementation are: equity and accessibility; community engagement, empowerment, and ownership; efficient use of resources; innovation and use of evidence-based interventions; provision of quality MNCH services; and strong monitoring and dissemination of best practices.

Several activities were articulated in HSTP, including strengthening routine immunization, expanding community and facility-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI), establishing new-born corners and Neonatal Intensive Care Units (NICU), capacity building on program management for child health services,and implementing locally relevant and effective child health interventions.

Accordingly, the following section describes what was done in EFY 2008.

2.2.2.1.Immunization

In EFY 2008, pentavalent 3 immunization coverage was 97.6%, Pneumococcal Conjugate Vaccine (PCV) 3 immunization coverage was 97.2%, measles immunization coverage was 94.3%, and the percentage of fully immunized children was 90.9% (Table 3).

Table 3: Immunization Coverage Indicators (EFY 2008 Baseline, Performance and Target and HSTP Target)

Indicators	EFY 2008 Baseline	EFY 2008 Performance	EFY 2008 Target	HSTP Target
Pentavalent 3 Vaccine Coverage	94.4	97.6	98	98

Pneumococcal conjugated 3Vaccine Coverage	93.9	97.2	98	
Measles Vaccine Coverage	90.3	94.3	97	95
Full Immunization Coverage	86.4	90.9	94	95

There was an increase in all immunization coverage rates; however, none of thecoverage met the targets set for the year.

Regional Distribution of Pentavalent 3 Immunization Coverage

In EFY 2008, pentavalent 3 coverage was 97.6% at the national level which was above the performance in EFY 2007 (94.4%), but short of the target (98.0%) set for the year. The highest coverage (100.0%) was in Afar, Oromia, Harari and Addis Ababa, while the lowest coverage was observed in Somali (75.8%) (Figure 11). Except Tigray and SNNPR, the remaining nine regions increased or were equal to their performance from EFY 2007. On the other hand, except for Afar, Oromia, Benishangul Gumuz, Gambella, Harari, and Addis Ababaregions, the remaining five regions performed below the target set for the year.

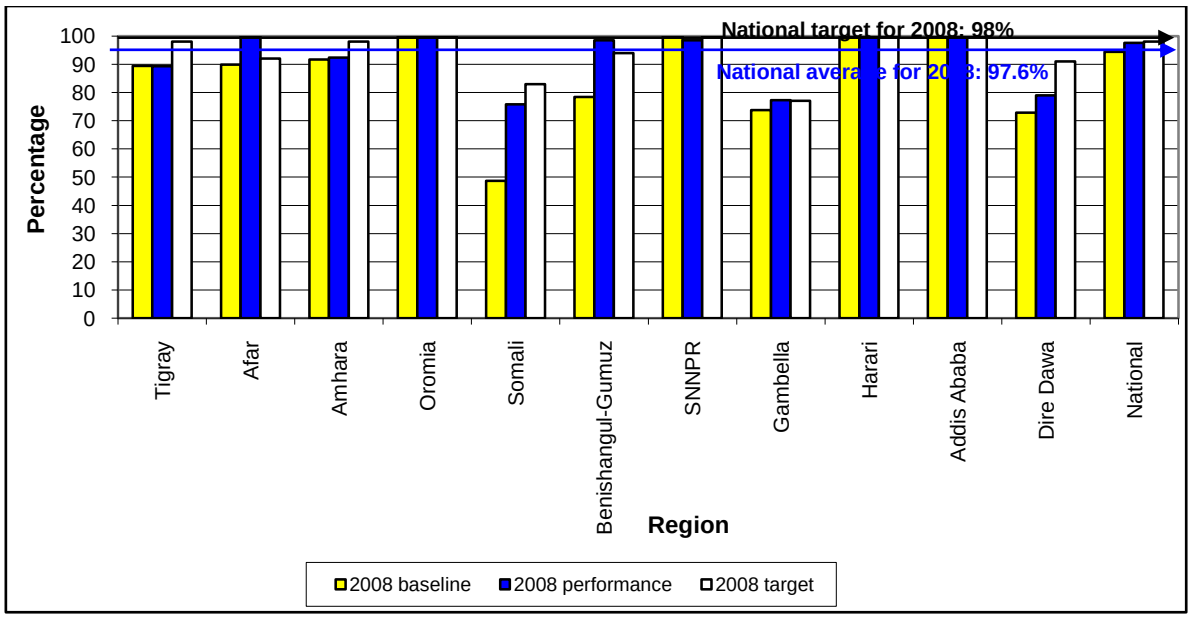


Figure 11: Comparison of Baseline, Performance and Target of Pentavalent 3 Immunization Coverage by Region (EFY 2008)

Regional Distribution of Pneumococcal Conjugate Vaccine 3 Immunization Coverage

Similarly, in the fiscal year, PCV3 coverage was 97.2% at the national level, above the performance in the previous year (93.9%), but below the target (98.0%) set for the year. The highest coverage (100.0%) was found in Oromia, Harari, and Addis Ababa. In contrary, the lowest one was in Gambella Region (74.9%) (Figure 12). Except for SNNPR, the remaining ten regions either increased or remained the same on their performance from the previous year. Besides, six regions (Afar, Oromia, Benishangul Gumuz, Gambella, Harari, and Addis Ababa) achieved their annual regional target set for EFY 2008.

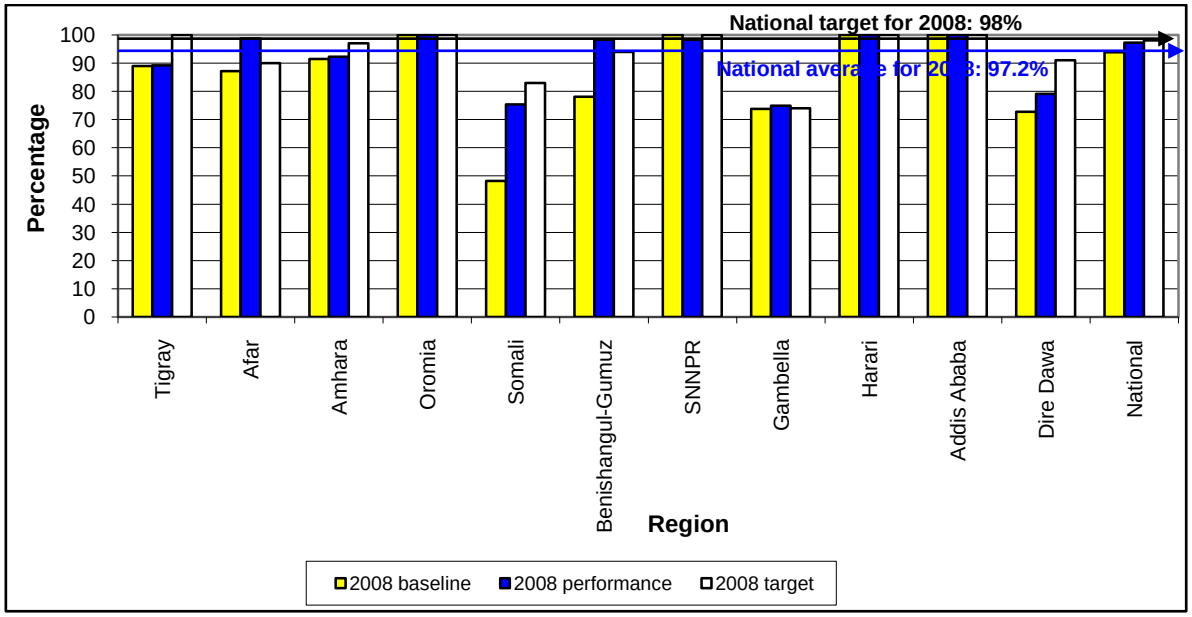


Figure 12: Comparison of Baseline, Performance and Target of PCV3 Immunization Coverage by Region (EFY 2008)

Regional Distribution of Measles Immunization Coverage

As it was documented in other immunization coverage rates, there was an increase in measles immunization coverage from 90.3% in EFY 2007to 94.3% in EFY 2008, but below the target set for the year (97.0%). Regional distribution showed that only Addis Ababa was the best performing region (100.0%) and Gambella performed the least (61.0%) (Figure 13).Afar, Somali, Benishangul Gumuz,and Addis Ababa were the only fourregions whichachieved their regional targets set for the year. On the other hand, with the exception of SNNPR, Gambella, and Harari regions, the remaining eight regions either increased or remained the same on their performance from EFY 2007.

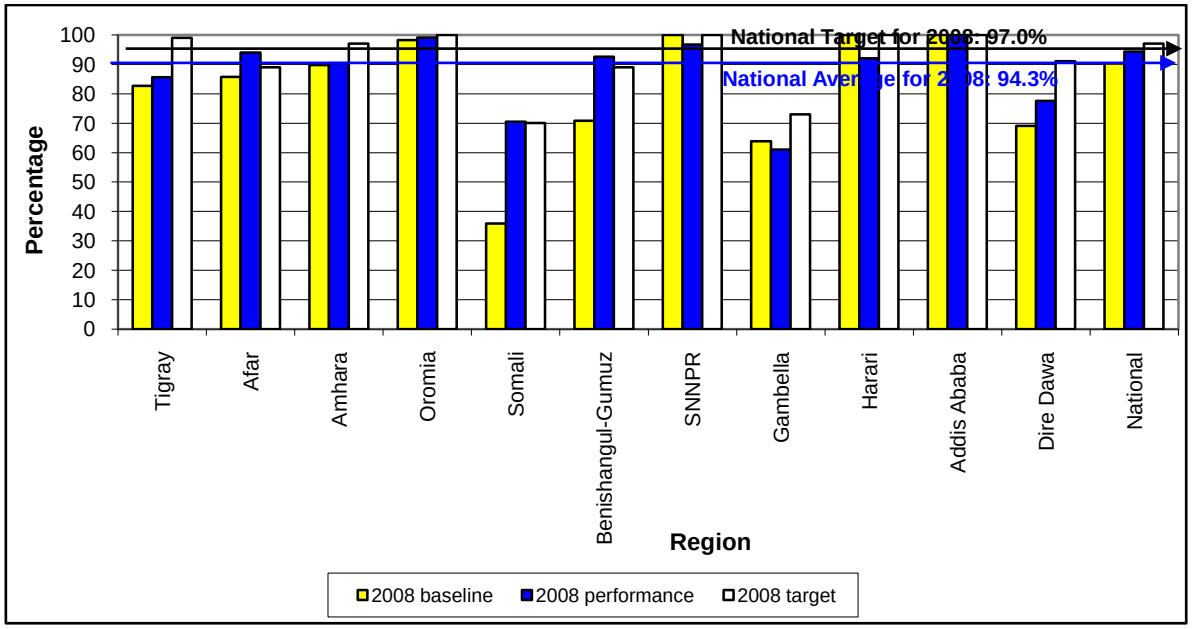


Figure 13: Comparison of Baseline, Performance, and Target of Measles Immunization Coverage by Region (EFY 2008)

Regional Distribution of Full Immunization Coverage

In EFY 2008, full immunization coverage was 90.9%, above the EFY 2007 performance (86.4%) but below the target (94.0%) set for the year. The highest coverage was observed inAddis Ababa (100.0%) and the lowest was in Gambella region (55.2%) (Figure 14).The only three regions (Oromia, Benishangul Gumuz, and Addis Ababa) achieved their regional target set for the year. Except SNNPR and Harari regions, the remaining nineeither maintained or increased their performance from EFY 2007.

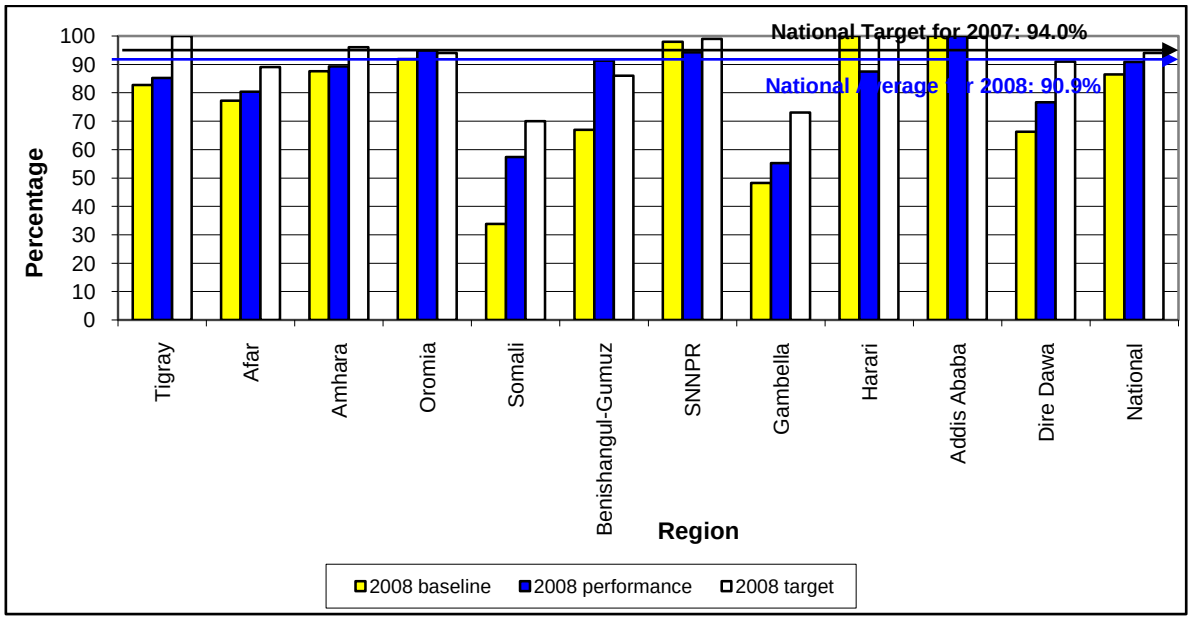
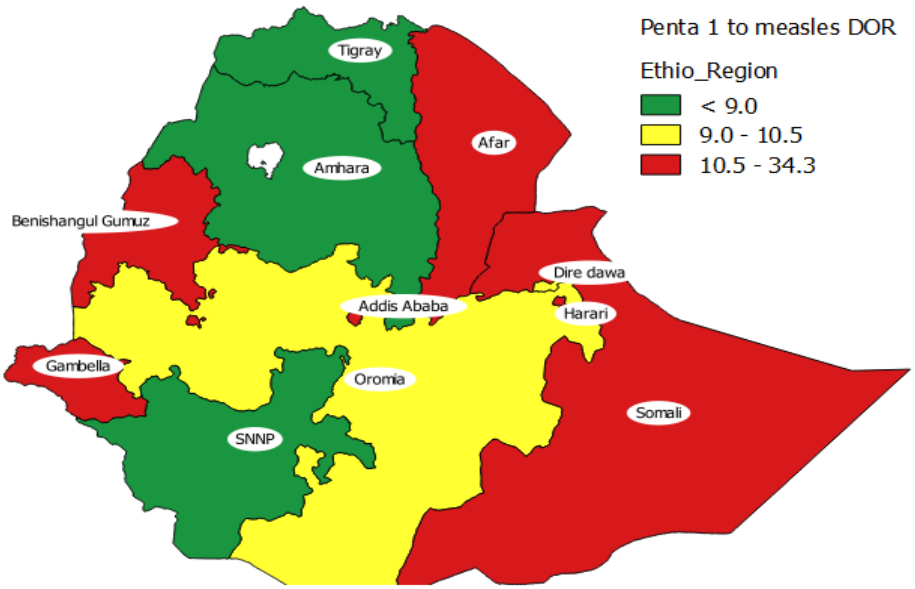


Figure 14: Comparison of Baseline, Performance, and Target of Full Immunization Coverage by Region (EFY 2008)

Dropout Rate Penta1 to Measles

In EFY 2008, at national level the pentavalent 1 to Measles immunization dropout rate was 9.0%, but below the target set for the year (7%). Four regions (Tigray, Amhara, SNNPR, and Dire Dawa) performed well according to the international standard (10%). However, Gambella (34.3%), Harari (24.9%), Somali (24.1%), Benishangul Gumuz (17.4%),and Afar (14.6%) had higher dropout rates. On the other hand,Addis Ababa (10.9%) and Oromia (10.1%) had mild dropout rates.(Map 4)



Map 4:Pentavalent 1 to Measles Immunization Drop Out Rate by Region (EFY 2008)

Woredas with Pentavalent 3 Immunization Coverage above 80%

In EFY 2008,pentavalent 3 coverage was 97.6% at the national level and the highest coverage (100.0%) was in Afar, Oromia, Harari and Addis Ababa. In line with this, three out of four woredas had pentavalent 3 immunization coverage above 80% at national level.

There were disparities across regions with the highest achievement in Addis Ababa (90% of woredas/subcities with pentavalent 3 immunization coverage >=80%) and the lowest achievement in Somali (23% woredas with pentavalent 3 immunization coverage >=80%). With the exception of Benishangul Gumuz, woredas (60% in Gambella, 53% in Afar, and 23% in Somali) in Regions Requiring Special Support (RRSS) had low achievement of pentavalent 3 coverage above 80%.(Figure 15).

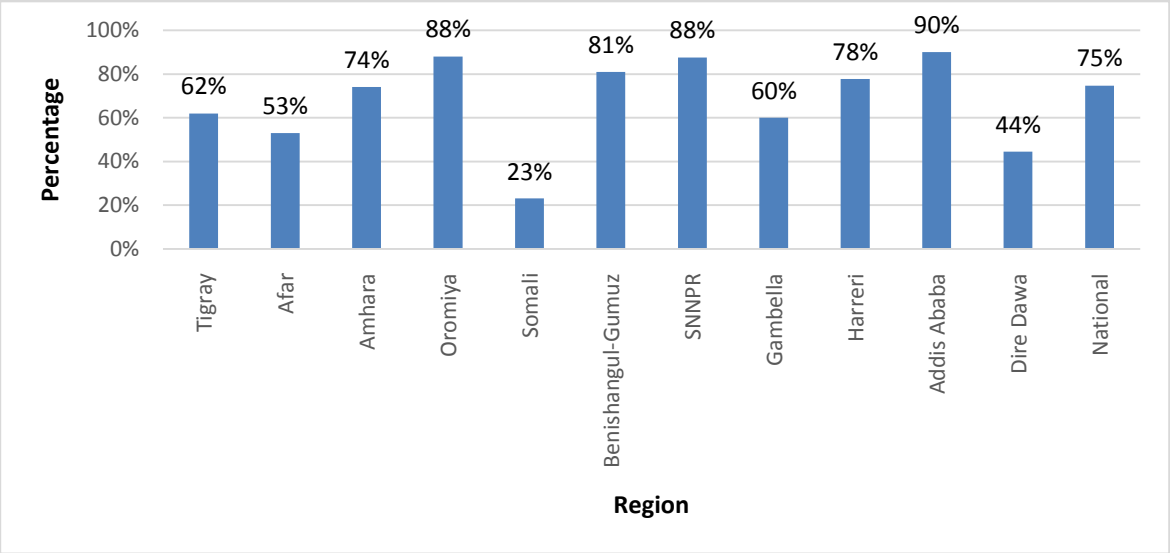


Figure 15: Woredas with Pentavalent 3 Immunization Coverage above 80% by region, EFY 2008

2.2.2.2.The Management of Newborn, Neonatal and Childhood Illnesses

Health Facilities Providing Integrated Management of Neonatal and Childhood Illness

The cumulative number of health faciliess providing IMNCI increased from 3,033 in EFY 2007 to 3,302 in EFY 2008 (Table 4).

Table 4: Distribution of Health Facilities Providing IMNCI by Region (EFY 2008)

Regions	Cumulative Number of HFs Providing IMNCI in EFY 2007	Cumulative Number of HFs Providing IMNCI Service at End of EFY 2008
Tigray	221	239
Afar	73	84
Amhara	725	821
Oromia	1033	1047
Somali	146	208
Benishangul Gumuz	32	39
SNNPR	684	715
Gambella	28	29
Harari	10	10
Addis Ababa	65	94
Dire Dawa	16	16
National	**3,033**	**3,302**

In EFY 2008, a total of 486 pediatric beds and 1,017 neonatal beds distributed at 141 and 231 hospitals, respectively. Further, a total of 196 hospitals and 218 health centers received radiant warmer sets for infantmedical care. To help with neonatal resuscitation efforts, ambu bag and mask and suction bulbswere distributed to 922 health centers and 185 hospitals.

Furthermore, medical supplies and logistics were provided for themanagement of childhood illnesses at facility and community level. These included: ORS and Zinc dispersible tablet for diarrhea, Amoxicillin dispersible tablet for pneumonia, supplies for possible serious bacterial infection for newborns, and other program related drugs. Similarly, medical supplies for management of childhood illness (incubators, ambubag, mask, and suction bulbs) are under way for distribution to 84 hospitals and 1,947 health centers.

Community Based Newborn Care Management (CBNC)

As part of the implementation of Community-Based Neonatal Care (CBNC), training was provided to health professionals and health extension workers in 556 woredas of Amhara, Oromia, SNNPR and Tigray regions. In EFY, a total of 12,982 HEWs were provided with CBNC training.

A total of 1,550 facilitators from national, regional, and zonal levels have been equipped with the training and facilitation skills for CBNC. A total of 5,303 health extension supervisors received supervisory skill on CBNC, a total of 26,570 HEWs received competency based training, and a total of 11,582 health posts received post training follow-up in the fiscal year. Furthermore, out of 100 CIFF woredas, HEWs in 90 woredas provided with CBNC training, and a cumulative total of 13,789 health posts from the four agrarian regions, have initiated community-based newborn care management.

Integrated Community Case Management (ICCM)

At the end of EFY 2008, pre-deployment iCCM/CBNC training was given to 1,281 students in Health Science Colleges.Acumulative number of 15,551 (94%)health posts have been providing ICCM package of interventions to the community in rural woredas throughout the country. Moreover, a total of 4,727 supervisors were trained on supervisory skill and about 97% of trained HEWs were supervised and given clinical mentoring. Furthermore, 2,801 health workers were trained on IMNCI to strengthen the referral linkage.In regard to the supplies, nearly 90% HPs have all the essential ICCM drugs and supplies. In EFY 2008, over six million children received iCCM service. ICCM is being implemented at national scale with full coverage of all regions, except Afar region (240 health posts) and Somali region (398 health posts) which were being partially covered.

Neonatal Intensive Care Unit (NICU)

In EFY 2008, a total of 94 hospitals openedNICU and started giving neonatal intensive carefor acumulative number of 184 (Figure 16) with 90 receiving service strengthening. Similarly, a total of 369 nurses, 24 health science college teachers, 192 physicians, and health officers were provided with NICU training. Furthermore, NICU gap-filling training was given to66 nurses in the same

period. In addition, 137 hospitals have received NICU equipment (CPAP, neonatal bed, phototherapy, and incubator) and 80 hospitals are in the process of procurement of equipment to establish Level III NICU. A total of 47 biomedical engineers and 50 NICU health professionals were trained to facilitate the setting up and maintenance of essential equipment.

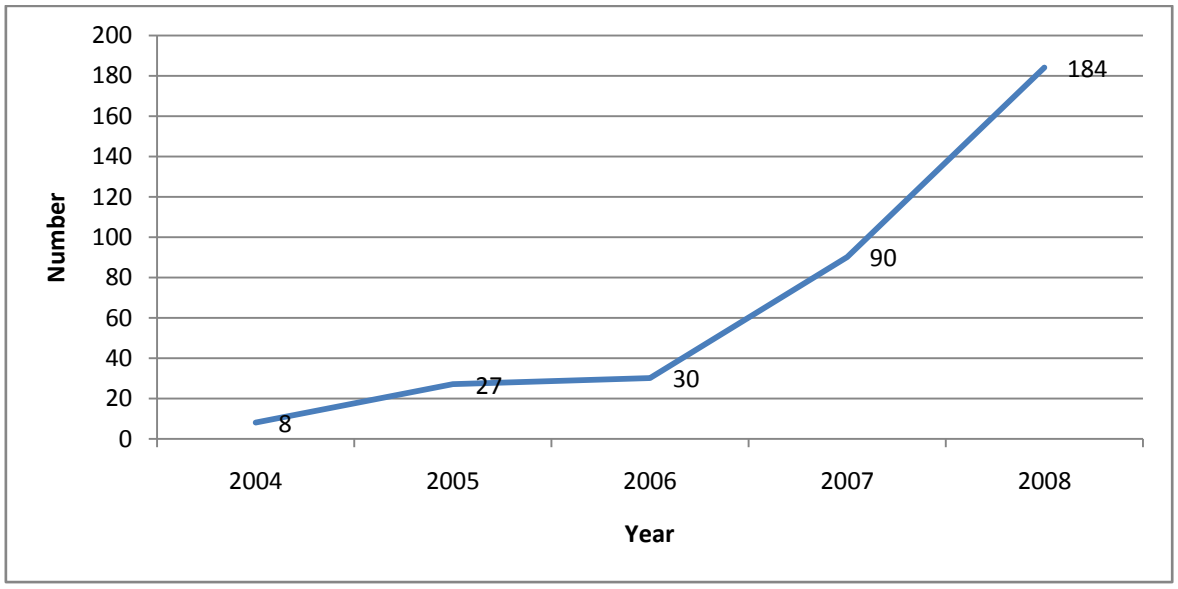


Figure 16: Trend of Hospitals Providing NICU service

Neonatal Care Corner

Neonatal Care Corner is a package of interventions to address gaps in preventing newborn morbidity and mortality by ensuring standard newborn care (essential newborn care and basic neonatal life support) immediately after birth in every health facility. The interventions included in NBC package are (i) Essential newborn care for every baby; (ii) Newborn resuscitation; (iii) Care for premature babies; (iv) Management of neonatal sepsis; (v) Breastfeeding (counseling and coaching of mothers); (vi) Kangaroo Mother Care (KMC); (vii) Postnatal care; and (viii) Referral and linkage. By the end of EFY 2008, a total of 2,782 of health centers started the NBC package in the country which was 44% increment from EFY 2007.

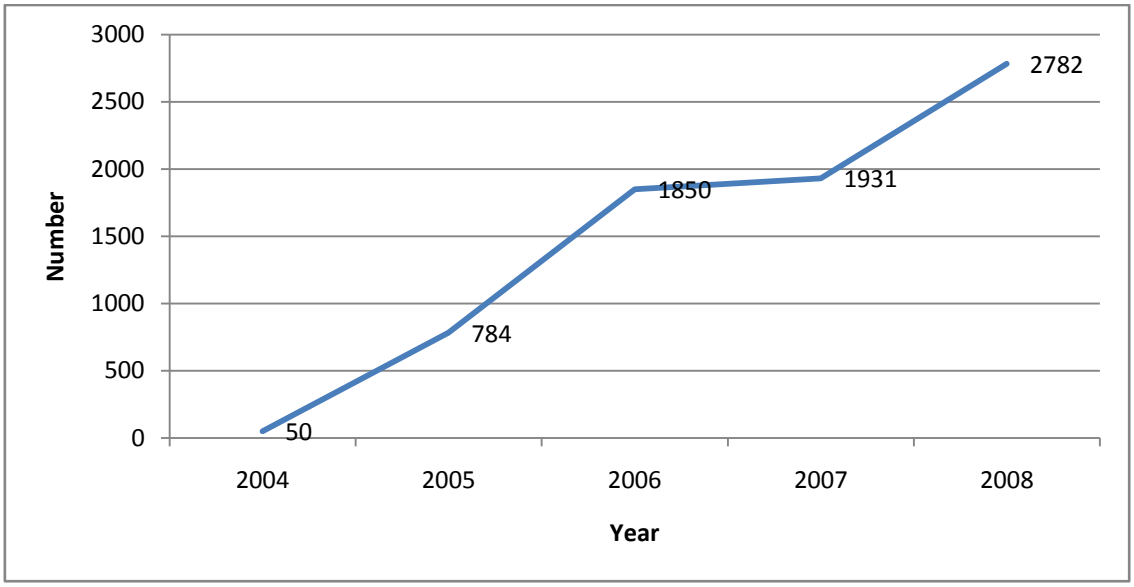


Figure 17: Trend in the Number of Health Centers with Newborn Corner

2.2.2.3.Other Activities

- To strengthen the cold chain system, in EFY 2008 a total of 1,000SDD refrigerators working in temperate climate were procured and 951(95%) were installed. An additional 1,000 SDD refrigerators for hot climate were procured and 747(75%) were installed.A total of 17 cold rooms were procured and installedand an additional 4 cold rooms were rehabilitated in Adama.
- A systemtransition wasinitiated from 5 tier (Center…Region…Zone….Woreda…Facility) to 3 tier (Center…Zone…Woreda/Facility) in four hubs (Mekelle, Bahir Dar, Dessie, and Gondar) to strengthen the smooth distribution of vaccines and associated logistics to the regions.
- Completed MeningococcalA preventive campaign (Phase 3) with coverage of 92.9% nationally (coverage survey) for 1 to 29 years.
- Inactivated Polio Virus Vaccine (IVP) has been introduced in the routine immunization program in order to enhance the effort oferadicating polio from the country.
- Validated to have successfully switched the tOPV to bOPV in the routine immunization.
- First year of HPV demonstration project was conducted in two districts with promising result (HPV1=92.6%; HPV2=86.3% DoR 6.3%).
- National Immunization Technical Advisory Group (NITAG) was established to help major immunization-related decision making in the country including schedule changes and new vaccine introductions.
- Wide range measles SIA in selected drought affected and measles hot spot in 545 woredas was conducted (94% coverage survey) with polio NID.

- The 5th round African Vaccination Week (AVW) and other social mobilization activities were conducted to build demand and community ownership in EPI.

Adolescents and Youth-Friendly Health Services

The National Adolescent and Youth Health (AYH) strategy was developed to initiate the strategic framework for tackling the full range of adolescent and youth health. The current strategy aims to improve the overall health status of adolescents and youth in Ethiopia and contribute toward realization of their full potential in national development.Through the implementation of this strategy, the country is expected to empower and engage adolescents and youth, their families, and the community at large for better health, development, and wellbeing of Ethiopian adolescents and youth.The Ministry of Health (MOH) will put forth every endeavor to strengthen partnership and coordination among stakeholders at all levels and develop a mechanism for joint ownership of the adolescent and youth health program in the country. Following the design of the strategy:

- A pilot project was launched to start the "safe space program" in Amhara and Oromia region to empower young girls aged from 11 to 14 years.
- The youth associations are invited to be a member of the AYH TWG to reflect the needs of the young people..

Challenges

- Measles outbreaks with age shifting to higher age recurring in low RI performance areas;
- Late and incomplete reporting of EPI activities;
- Data quality and reliability issues are not well guiding program decisions in all aspects;
- Lack of accountability in program management;
- High staff turnover at all levels and lack of tracking mechanism;
- In complete ICCM roll out;
- Turnover of trainedhealth workers;
- Low service utilization;
- Data use for decision making; and
- Model for pastoralist area expansion.

Way forward

- Emphasis on disease specific outcome/impact monitoring;
- Strengthen data quality and management at all levels;
- Sustain NITAG ;

- Continue intensified polio eradication efforts, strengthen IPV implementation, ensure virus containment and Polio legacy planning;
- Ensure measles mortality and morbidity reduction through conducting a wider age group measles SIA for remaining woredas in November 2016;
- Eliminate measles and advocate for the elimination of rubella and congenital rubella syndrome;
- Complete ICCM roll out in all regions;
- Scale up community based newborn care (CBNC)in regions;
- Providing pre-service training for newly recruited HEWs;
- Implementing IPLS to improve the supply management;
- Increase community awareness and create demand to improve service utilization;
- Utilizing HMIS based indicators for decision making ;
- Expand NBC and NICU service; and
- Improve quality of service.

2.3.National Nutrition Program

The main activities planned in EFY 2008 included implementing 1,000 days nutrition promotion, acute malnutrition management, nutrition screening, Vitamin A supplementation (VAS), and deworming as well as scaling up community-based nutrition (CBN) and food fortification including salt iodization. Accordingly, the following activities were carried out in the fiscal year.

2.3.1. Vitamin A Supplementation and Deworming

In HSDP IV, the FMOH clearly indicated the need to integrate EOS/EEOS program into the routine HEP as a way of making VAS sustainable. Accordingly, the FMOH has developed the EOS and CHD tomake routine the HEP transition plan for Vitamin A supplementation, deworming, and nutritional screening delivery mechanism from vertical EOS to routine HEP.

Currently, services have been provided through EOS in four developing regions(Afar, Benishangul Gumuz, Gambella, and Somali), CHD in two agrarian regions(SNNPR and Oromia), and routine delivery in 406 woredas of Amhara, Tigray, Oromia(142 woredas), SNNPR(68 woredas), Addis Ababa,Dire Dawa, and Harari. The different level of services delivery across the country linked with different data sources.

The national VAS coverage among children aged 6-59 months decreased from 89.5% in EFY 2007 to 77.0% in EFY 2008, but below the target set for the year (100%). There was a wide difference observed across regions ranging between 65% in SNNPR to 98.0% in Afar and SomaliRegions (Figure 18).

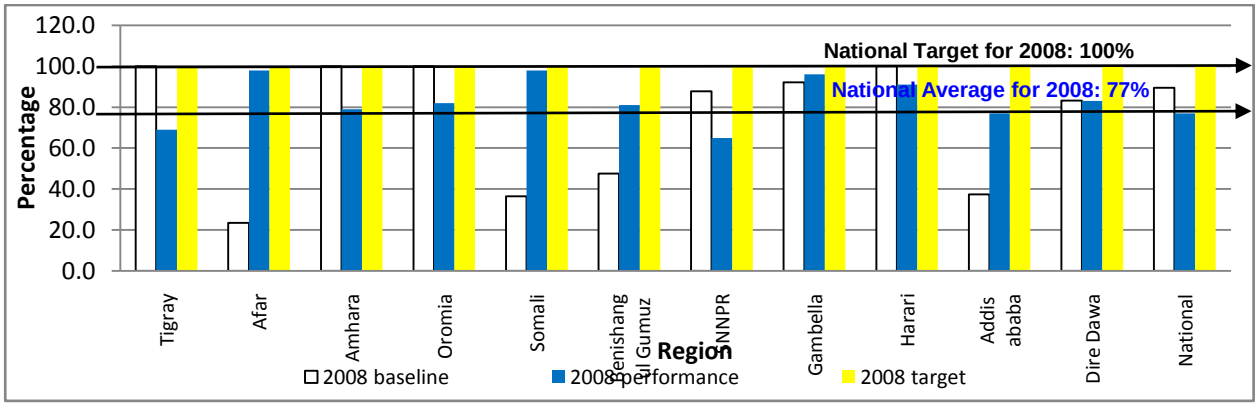


Figure 18: Comparison of Baseline, Performance and Target of Coverage of 6-59 Months Children Supplemented with Vitamin A by Region (EFY 2008)

In EFY 2008, the coverage of children ages 2-5 years de-wormed reached 76.0%. There was also wide variation across regions from 58% in SNNPR to98.0% in Afar and Somali Regions in the same period (Figure 19).

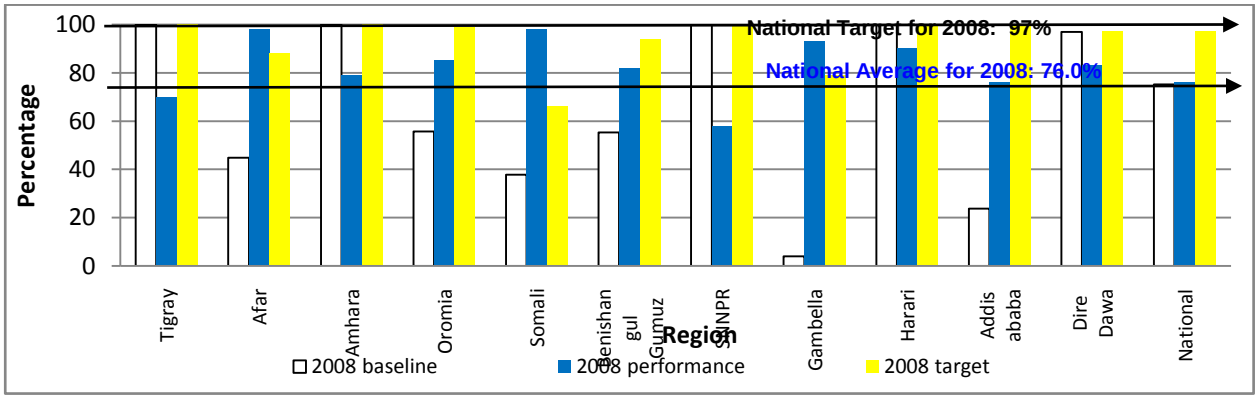


Figure 19: Comparison of Baseline, Performance and Target of Coverage of 2-5 Years Children De-wormed by Region (EFY 2008)

2.3.2. Community-Based Management of Acute Malnutrition

In EFY 2008, FMOH in collaboration with nutrition development partners implementedthe followingkey activities:

- Command post established at national and subnational levels;
- Sensitization document developed and workshop conducted to all regions;
- Monthly nutrition screening conducted to all hotspot woredas;
- Intensive supportive supervision conducted to Afar, Somali, SNNPR, Oromia, Amhara, and Tigray regions(two to three months);
- 70 epidemiologists trained on the management of acute malnutrition and deployed to Afar and Somali regions for more than six months;

- More than 300 HWs trained on the management of acute malnutrition and deployed to Afar for three months; and
- More than 15,000 sites providing OTP services, 4000 provided SC services.

Out of 378,778 severely malnourished children who were treated in EFY 2008, 90.0% of them recovered, 1.7% defaulted, and 0.2% died.

Compared to the previous years, the number of acute malnutrition cases in EFY 2008 steadily increased from 276,252 in 2007 to 378,778. The number of community-based management sites of acute malnutrition (CMAM) increased to more than 20,000 health facilities.

For the management of acute malnutrition, 5,841 cartons of F75; 6,267 cartons of F100; and 345,726 cartons of RUTFand other important nutrition commodities were distributed for use in the treatment of severe acute malnutrition together with registration books and patient follow-up forms.

2.3.3. Comprehensive and Integrated Nutrition Services (CINS)

A comprehensive and integrated nutrition services package (CINS) is an approach that links all nutrition programs (CBN, CMAM, EOS/CHD, and MAIYCN) service delivery at facility levels. At this juncture, CINS is a CBN plus program in whichit uses the opportunity of the monthly Growth Monitoring (GMP) of a child for nutrition screening, Management of MAM/SAM, Vitamin A supplementation,deworming, and counseling on the maternal, adolescent, infant, and young child nutrition services. Therefore, a child assessed for GMP will also be assessed for severe acute malnutrition and receive other nutrition services.

The National Nutrition Program (NNP) places a critical importance on the CINS to prevent children from different forms of malnutrition through providing comprehensive and integrated nutrition services at facility and community levels.

In EFY 2008, CINS activities implementation were started in 406 woredas through integration of the EOS/CHD to routine HEP transition. In those woredas, mothers/caregivers with children under two years of age were weighedmonthlyand counseled based on the children nutritional status.

2.3.4. Salt Iodization

In EFY 2008, a total of 54,684 quintals of iodized salt was produced in Afdera, Dobi, Gudusbo and other sitesand distributed throughout the country. Due to limited concern on the use of iodization technology (knapsacks) by local salt producers and delay in establishing proper Quality Assurance/Quality Control (QA/QC) mechanisms, there was an iodization quality gap that needed enforcement of the salt regulation. This quality-related concerns can be corrected through strengthening the enforcement of salt regulation and it remained as the main focus areas of EFY 2009.

The cost recovery scheme to make potassium iodate supply self-reliant and sustainable has made marked progress in EFY 2008. So far, the program was totally independent from external donations and a total of 372 quintal of potassium iodate was distributed to salt producers in more than four areas with prepayment in the same period. The national food fortification steeringcommittee meets twice a year and five years food fortification strategic plan has been developed. The central salt iodization facility assessment was done jointly with MOI, FMHACA, and local salt producers.

2.3.5. Other Activities

The following activities were also carried out to strengthen the NNP in EFY 2008.

- The first draft food and nutrition policy developed;
- The NNP II (2016 to 2020) has been developed and implementationhas started;
- The following NNP implementation guidelines have been finalized:
    - Micronutrient prevention and control guideline;
    - Acute malnutrition management guideline;
    - Maternal, adolescent, infant, and young children nutrition guideline; and
    - Multisectoral Nutrition implementation guideline.
- BINLM preparation finalized, national ToT provided for 26 participants, regional cascade training conducted for more than five regions;
- High-level,multisectoral nutrition coordination and linkage experience sharing visit was conducted in Uganda and Brazil;
- GOE launched an initiative known as “The Seqota Declaration,”a declaration to end child undernutrition in Ethiopia by 2030 through improvements in nutrition to propel sustainable development; and, in turn, sustainable development can bring malnutrition reduction. Major components of the Declaration include:
    - Zero stunted children less than 2 years;
    - Hundred percent access to adequate food all year round;
    - Hundred percentincrease in smallholder productivity and income;
    - Zero loss of food;
    - Sustainable food systems;
    - Education;
    - Water, sanitation, and hygiene; and
    - Social protection.
- Program delivery unit established at central level; and
- The recruitment of 11 additional staff has been progressing.

Challenges

- Limited awareness on nutrition among decision makers, managers, health workers, NNP implementing sectors, and the community at large;
- Lack of nutrition specific interventions integration;
- Unintegratednutrition supplies procurement, storage, and distribution mechanisms;
- Weak and non-existence of multisectoral nutrition coordination and linkage at regional, zonal, and woreda levels;
- High burden of acute malnutrition cases which lead the attention to EMERGENCY response that has an impact on developmental nutrition;
- Budget allocation for nutrition from NNP implementing sectors(except FMOH, other sectors do not have budget line for nutrition in the government treasury);
- Shortageor lack of nutrition human resource at all levels(no carrier structure for nutrition either in the health sectors or other NNP implementing sectors);
- Unclearrole and accountability of sectorsfor nutrition;
- No clear data collection, analysis, interpretation, utilization, and feedback mechanism for NNP implementing sectors on nutrition; and
- Nutrition specific indicators collected through HMIS is not adequate quality for use.

Way forward

- Improve the first 1,000 days nutrition;
- Improveadolescent nutrition;
- Improve nutrition among communicable and non-communicable/life-style related disease;
- Improve nutrition through sustainable undernutrition reduction in Ethiopia programs;
- Start implementation of baby-friendly hospital initiatives in 50 hospitals;
- Strengthening the transition of VAS, deworming, and nutrition screening through EOS to CHD and CHD to HEP;
- Improve the management of SAM and MAM;
- Strengthen multisectoral nutrition coordination and linkage;
- Start the implementation of Seqota declaration;
- Strengthenawareness creation activities on nutrition policies, strategies , programs, and implementation guidelines;
- Strengthen nutrition supplies management system;
- Strengthen nutrition information platform for evidence-based decision making;
- Strengthen the implementation of nutrition-sensitive intervention across sectors;
- Support the nutrition workforce development, recruitment, and structure;

- Strengthen nutrition development coordination; and
- Build the capacity of nutrition case team members.

2.4.Prevention and Control of Communicable Diseases

2.4.1. HIV/AIDS Prevention and Control

HIV/AIDS was one of the top priorities of HSTP. According to the "HIV related estimates and projections for Ethiopia-2012,"the adult HIV prevalence is estimated at 1.1% (0.7% in males and 1.4% in females) and the adult HIV incidence is 0.03% in 2016.

2.4.1.1.HCT Service

The number of HCT services provided in EFY 2008 was 8,485,379 and it was below the national target (13.024 million) set for the year at the national level.Shortage of rapid diagnostic kits is the major reason for the low performance in the budget year and to fill the performance gap, catch-up plan testing and counseling campaigns were prepared to test additional 2.7 million target clients.

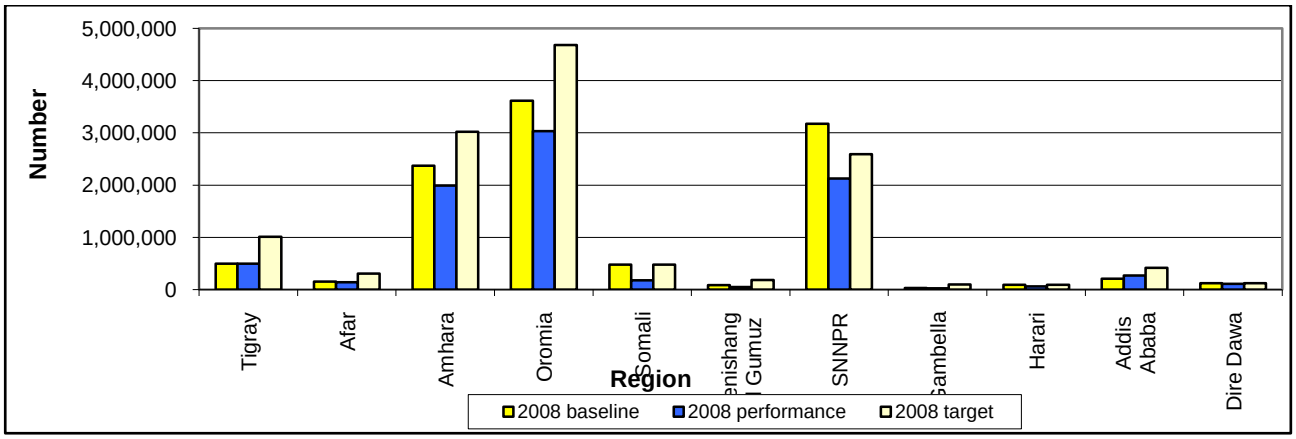


Figure 20: Comparison of Baseline, Performance, and Target of the Number of Clients Using HCT by Region (EFY 2008)

With the exception of Addis Ababa, city administration performance for all regions was below the last year baseline and none of the regions met EFY 2008 target. The major reason for the low performance in the budget year is acute shortage of the diagnostic kit.

2.4.1.2.Antiretroviral Treatment

In total from 515,963patients from the annual plan,393,609 (76%) clients are on ART of which 21,028 are children. When looking at regional performance, PLHIV currently on ART showed increment in all regions except Benishangul-Gumuz, while Harari and Somali met the target for the budget year.

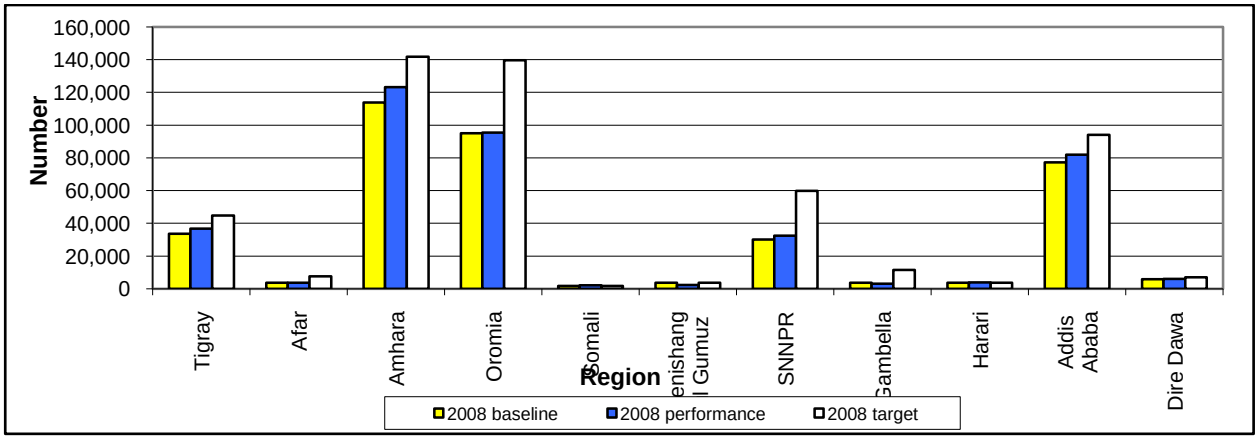


Figure 21: Comparison of Baseline, Performance and Target of the Number of PLHIV Currently on ART by Region (EFY 2008)

2.4.1.3.90-90-90 Status

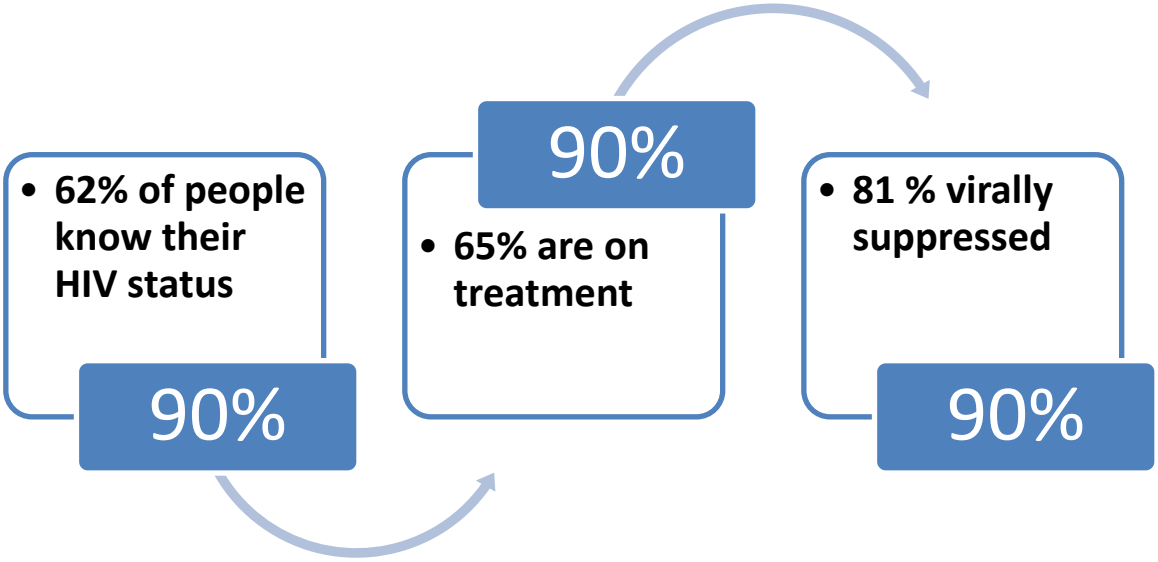


Figure 22: 90-90-90 Status

To meet the 90-90-90 target set for the year 2020, the FMOH adopted the target testing approach that aims to raise the proportion of people who know their HIV status to 90% in 2020 through an appropriate approach in responding the community demand for testing and by focusing on the most at-risk populations for better yield. In line with escalating the first 90, efforts are underway to put 90% of people diagnosed with HIV on ART at existing ART sites with further expansion. In the same token, to meet the third 90, the FMOH is working to strengthen the regional laboratory with further expansion to perform viral count for patients who are on ART.

2.4.1.4.Other Activities

- Revitalization of multisectoral HIV/AIDS response and national AIDS council was done in response to the set target for 2020 and 2030.
- 148 woredas with high burden of HIV were identified and woreda-level micro plan was finalized to counsel and test 4 million people in three rounds.
- Revision was done on the STI syndromic approach and 262,211 cases total were treated.

Challenges

- Inadequate implementation of supportive supervision at all levels;
- Shortage of condoms and rapid diagnostic kits;
- Inadequate continuum of care before, during, and after delivery;
- Delay in maintenance ofCD4 count machines;
- Staggered implementation of routine viral load monitoring;
- Lack of revised operational procedure guidelines on different HIV-related laboratory diagnoses;
- Prolonged procurement process for HIV test kits;
- Duplication of efforts in interventions on MARPs by different partners;
- Poor coordination and information gap among agencies and RHBs;
- Weak participation of partners on integration of multisectoral responses to HIV/AIDS;
- Difficulty in delivering services in pastoralist areas; and
- Limited capacity in data collection and use as well as in information dissemination.
- Low data quality in viral count report for patients on ART

Way forward

- Enhance supportive supervision;
- Ensure regular provision of condoms and other supplies;
- Ensure appropriate scale-up of Option B+ strategy;
- Ensure on-time maintenance of CD4 count machines;
- Strengthen implenetation of routine viral load monitoring;
- Prepare the revised operational procedure guideline on HIV-related laboratory diagnoses;
- Harmonize interventions on MARPs among partners;
- Set clear roles and responsibilities for agencies and RHBs;
- Reach consensus with partners on integration of multi-sectoral responses to HIV/AIDS and strengthen the follow-up;
- Implement service delivery adapted to mobile communities in pastoralist areas;

- Strengthen capacity in information use and dissemination;
- Innovation around reaching MARPs with different HIV/AIDS services.

2.4.2. Tuberculosis and Leprosy Prevention and Control

TB is among major public health problems throughout the world and its burden will remains enormous in Ethiopia. Ethiopia is among the 30 high burden countries for TB, TB/HIV, and MDR-TB with annual estimated TB incidence of 207/100,000 populations and death rate of 33 per 100,000 population for 2014(WHO 2015 report). Cognizant of this, the Government of Ethiopia has given due attention to the control of TB and included the prevention and control of TB and Leprosy among the priority health programs in the country's HSTP.

2.4.2.1.TB Prevention and Control

2.4.2.1.1. TB Case Notification

In EFY 2008, a total of 125,801 TB cases (all forms) were reported with a TB case notification rate of 136 per 100,000 population; this performance was lower than that observed in EFY 2007 (151 per 100,000 population). Out of 125,801 cases reported in EFY 2008, 34.6% were bacteriological confirmed pulmonary TB cases, 29.8% were clinically diagnosed new TB cases, 31.7% were extra pulmonary TB, and 3.9% were previously treated TB cases.

There was regional disparity in TB case notification; very high (>200/100,000)TB case notification rates per 100,000 populations were reported in Addis Ababa, Gambela,, and Harari; whereas, Dire Dawa region reported less than 100 TB cases per 100,000 populations, far lower than the national level. Among the major agrarian regions, highest TB CNR was observed in Tigray region(Figure 23).

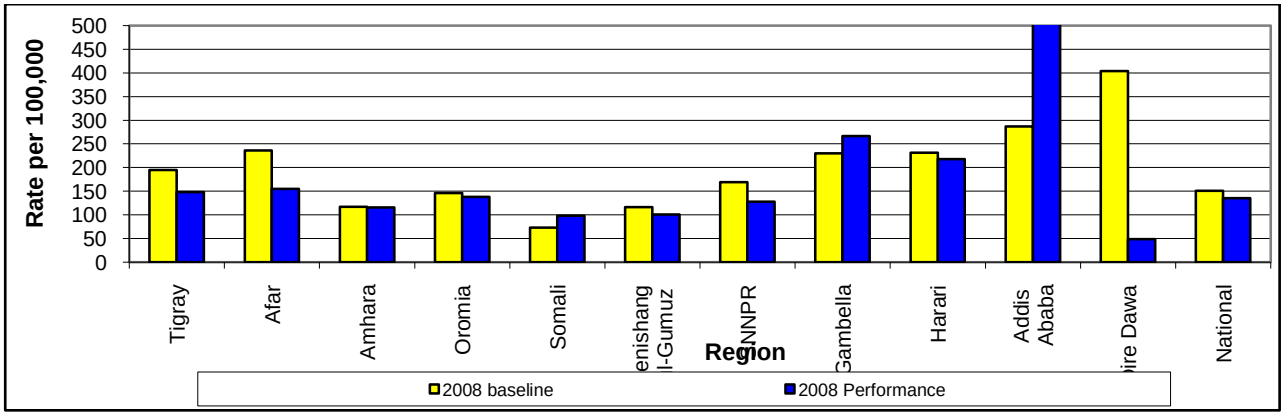


Figure 23: Comparison of Baseline and Performance of TB Case Notification Rate by Region (EFY 2008)

2.4.2.1.2. TB Case Detection Rate

In EFY 2008, the TB case detection rate was 61%, which was less than last year (67.3%) and also below the target set for the year (79.0%). Differences were observed across regions, ranging from 44% in Somali region to over 100% in Gambella, Addis Ababa, and Dire Dawa. Except at three

regions (Gambela, Addis Ababa, and Dire Dawa) the rest did not achieve their target set for the year(Figure 24).

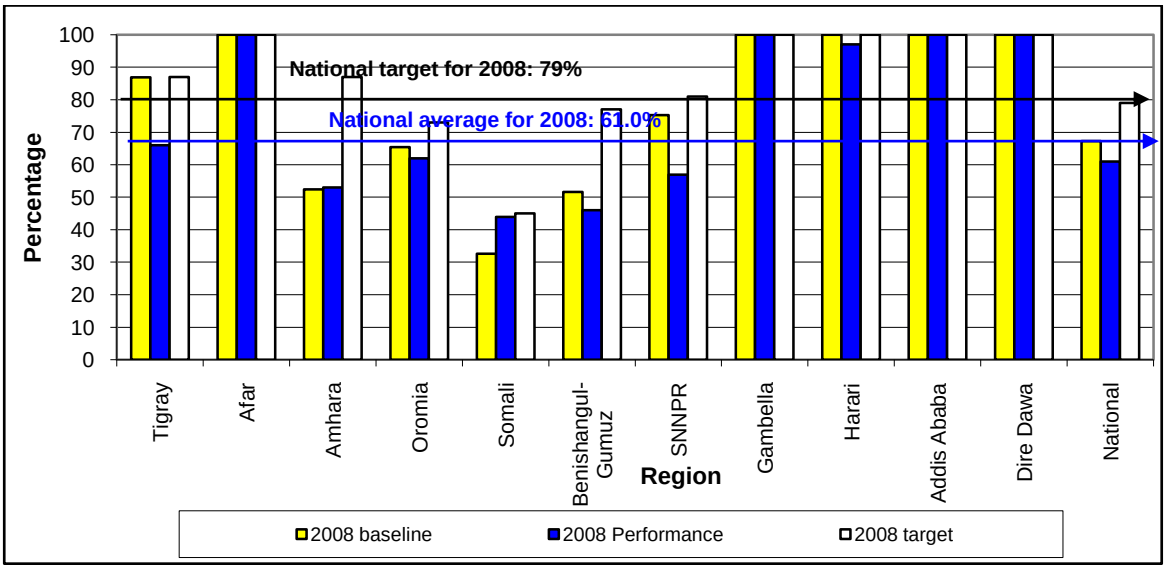


Figure 24: Comparison of Baseline, Performance, and Target of TB Case Detection Rate by Region (EFY 2008)

2.4.2.1.3. TB Treatment Outcomes

2.4.2.1.3.1.TB Treatment Success Rate

TB TSR had almost similar performance in EFY 2007 (92.1%) and in EFY 2008(92.2%); however, it was below the target set for the year 2008 (94%). Disparities were observed across regions, with the highest performance being observed in Harari region (95.4%) and the lowest performance was observed in Gambella region (70.1%). Three regions (Afar, Somali, and Gambella) showed a low performance while the remaining eight regions have relatively high performance in EFY2008.

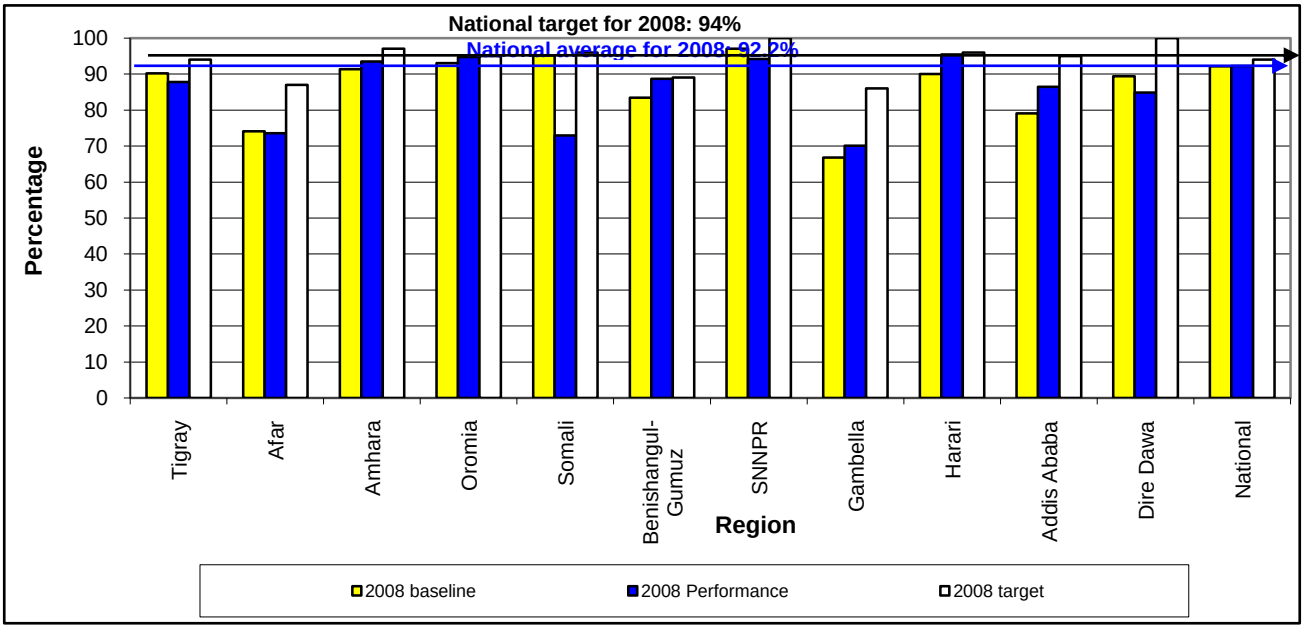


Figure 25: Comparison of Baseline, Performance and Target of the TB Treatment Success Rate by Region (EFY 2008)

2.4.2.1.3.2.TB Cure Rate

TB cure rate increased from 77.9% in EFY 2007 to 81.2% in EFY 2008; however, it was below the target set for the year (84%) (Figure 26). The best performance was seen in Harari region (92.1%) and Oromia region (89.9%), while the lowest performance was observed in Afar region (38.1%). Two regions (Somali, and Gambella) decreased their performance in EFY 2008 from the previous year.

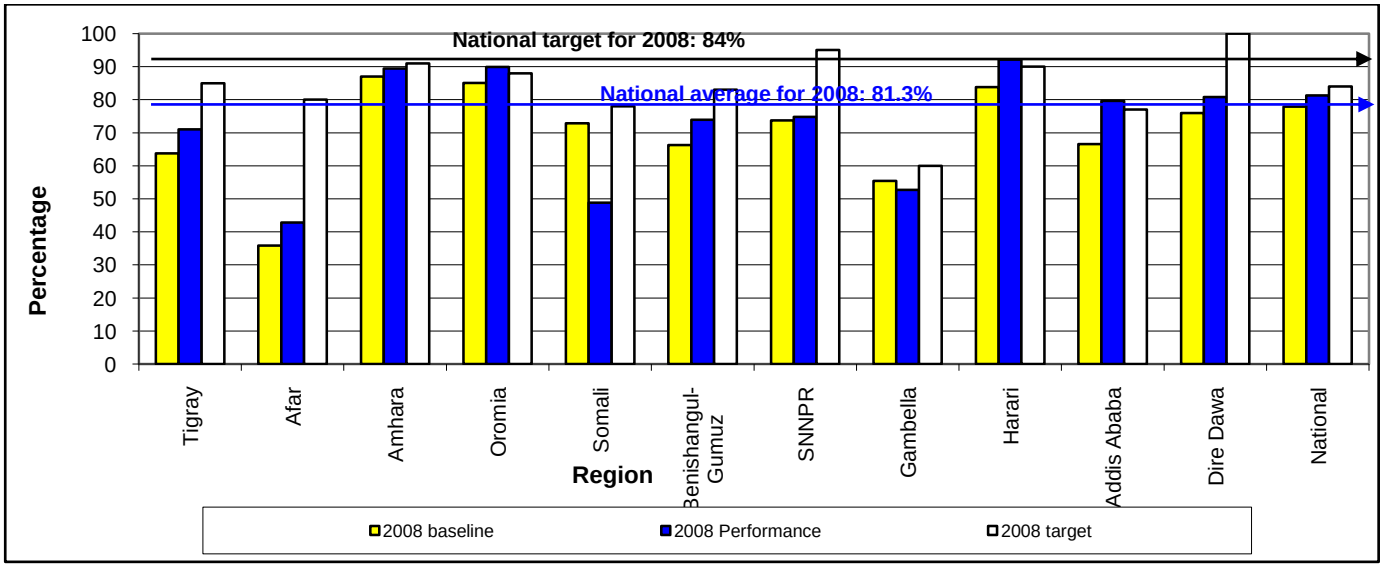


Figure 26: Comparison of Baseline, Performance, and Target of the TB Cure Rate by Region (EFY 2008)

2.4.2.1.4. MDR TB

Regarding MDR TB, 733 patients were identified and initiated second line anti TB drug; the treatment success rate of MDR TB reached 69.5%. 110 health facilities have been providing TB and MDR TB diagnostic service by using Genexpert machine and, additionally, 23 gene expert machines and 70 LED microscope procurements and distributions were made. Technical support for health facilities which provide TB laboratory services in order to conduct regular external quality assessment serviceswere made. To improve access of TB culture and DST service, strengthening and expansion of sputum sample referral system were made in collaboration with the postal office.
So far, a cumulative total of 3,053 MDR TB patients were enrolled in second line drug (SLD) treatment and 733 MDR TB patients were enrolled in SLD treatment in EFY 2008.

When looking at regional disaggregation, five regions account for 85% of the MDR cases reported in EFY2008 with Oromia at 27%, Addis Ababa at 25%, Amhara at 20%, Tigray at 15%, and of the remaining 15%, SNNPR is at 8%, Afar at 2%, Dire Dawa at 5%, and Harari at 0.3%.

Table 5: Rifampicin Resistance /MDR-TB Pts put on SLD by Region, EFY 2008

Regions	EFY 2008 RR/MDR-TB Pts put on SLD
Tigray	107

Afar	12
Amhara	143
Oromia	196
Somali	0
Benishangul-Gumuz	0
SNNPR	55
Gambela	0
Harari	2
Addis Ababa	180
Dire Dawa	38
National	733

In EFY 2008, there were a total of 45 health facilities providing MDR TB treatment services and an additional fourhealth facilities are in process to start the service in the coming year. GenXpert MTB/RIF detection of TB cases was provided to 110 health facilities and a total of 285 laboratory professionals were trained on GenXpert machines.

To expedite the process of referral linkage on TB case detection, the Ethiopia Postal Service transfers samples from health facilities. Furthermore, to widen FNA cytology service for extra pulmonary tuberculosis in health facilities, different procedural documents were prepared.

To strengthen and expand community-based TB prevention and control programs, reference materials and brochures were prepared and distributed to regions. Registration tools and follow-up cards were designed using local languages and distributed to respective regions.

For those MDR TB patients who fail to treat on second line anti-TB drugs, new anti DR TB drug implementation guidelines were prepared. A national-level DR TB clinical review committee was formed to provide advisory and decision-making services on proper anti DR TB drug utilization. Currently, a total of 7 patients are on new and repurposed anti TB treatment at Bishoftu Hospital and mapping of patients to enroll in this treatment is underway. Additionally, two federal hospitals will start providing the treatment in EFY 2009.

A national childhood TB roadmap was designed in collaboration with the maternal and child health directorate and also communicated to stakeholders and other implementing bodies who contribute to improve TB case detection and diagnostic capacity among children. Training materials were prepared and training on childhood TB case detection was given for health professionals coming from all regions working at IMNCI and TB clinic, intwo rounds.

2.4.2.2.Leprosy Prevention and Control

2.4.2.2.1. Leprosy Case Detection

In EFY 2008, a total of 3,076 new leprosy cases were detected which was lower than EFY 2007 (3,817), the majority of whom were detected in Oromia and Amhara regions (Figure 27).

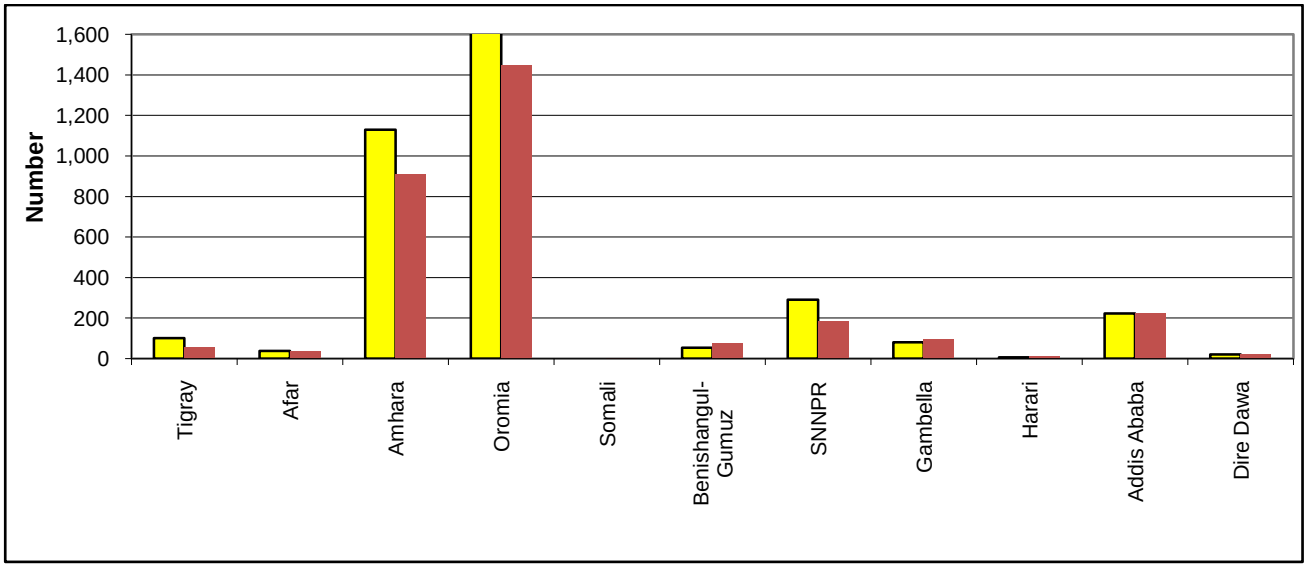


Figure 27: Comparison of Baseline and Performance of Leprosy Cases Detected by Region (EFY 2008)

2.4.2.2.2. Proportion of Grade II Disability among New Leprosy Cases

Regarding grade II disability, the national performance was 14% and showed improvement from EFY 2008 baseline, which is 18%, but doesn't meet the 12% national target. Except Benishangul-Gumuz and Afar region 30%and 3%, respectively, all regions have shown progress in reducing grade II leprosy disability compared with 2008 baseline, but the problem remains prevailing in Addis Ababa at 31%,Gambelaat 27%, Tigray at 19%,SNNPR at 18%, and Dire Dawa at 13%.

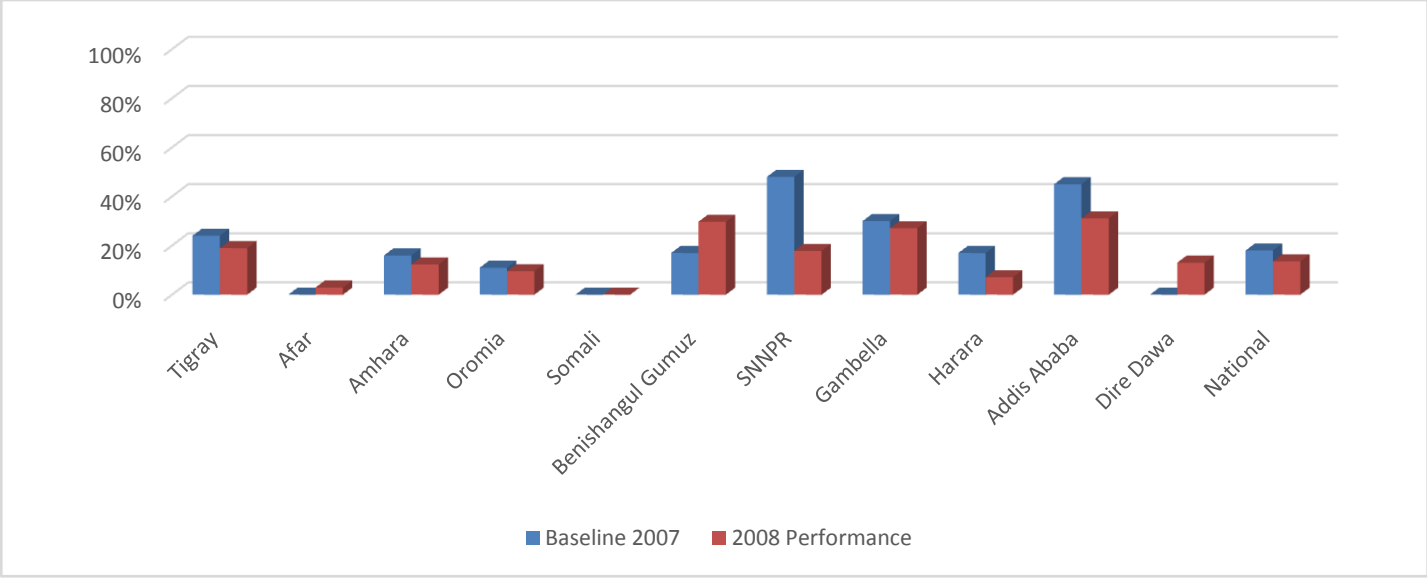


Figure 28: Comparison of Baseline and Performance of Leprosy Grade II Disability by Region (EFY 2008)

Challenges

- Progress in the implementation of community TB care;
- Gene Xpert service utilization and reporting system is far below optimal,monitoring system is not satisfactory;

- Weak samplereferral system for presumptive MDR suspected cases;
- MDR case finding is far below target and data quality problem at lower level;
- TICs expansion inpastoral regions;and
- Dallianceutilization and liquidation of grant.

Way forward

- Enhance community participation and engagement in TB service;
- Strengthen TB/DR-TB diagnostic services and M&E;
- Strengthen sample referral network;
- Improve TB program management capacity at all levels; and
- Liquidation enhancement.

2.4.3. Malaria Prevention and Control

For EFY 2008, as with previous years, the major activities planned for malaria prevention and control focused on expanding vector control and strengthening malaria case detection and treatment. In particular, increasing the availability and use of Long-Lasting Insecticidal Nets (LLINs) as well as implementing Indoor Residual Spraying (IRS) are powerful vector control tools for reducing malaria transmission. Furthermore, access to care for suspected malaria cases and appropriate diagnostic testing and therapeutic management at all places of care are needed to ensure that all patients with malaria receive prompt and effective treatment.

2.4.3.1.Number of Confirmed Malaria Cases and Deaths

In EFY 2008, the total number of laboratory confirmed plus clinical malaria cases was2,320,135. In particular, the monthly pattern showed an increase in the first five months of the fiscal year reaching the highest peak in November, followed by a decrease in Feburary and April.A total of 510 deaths were recorded in the same period, with a Case Fatality Rate (CFR) of 0.02%.

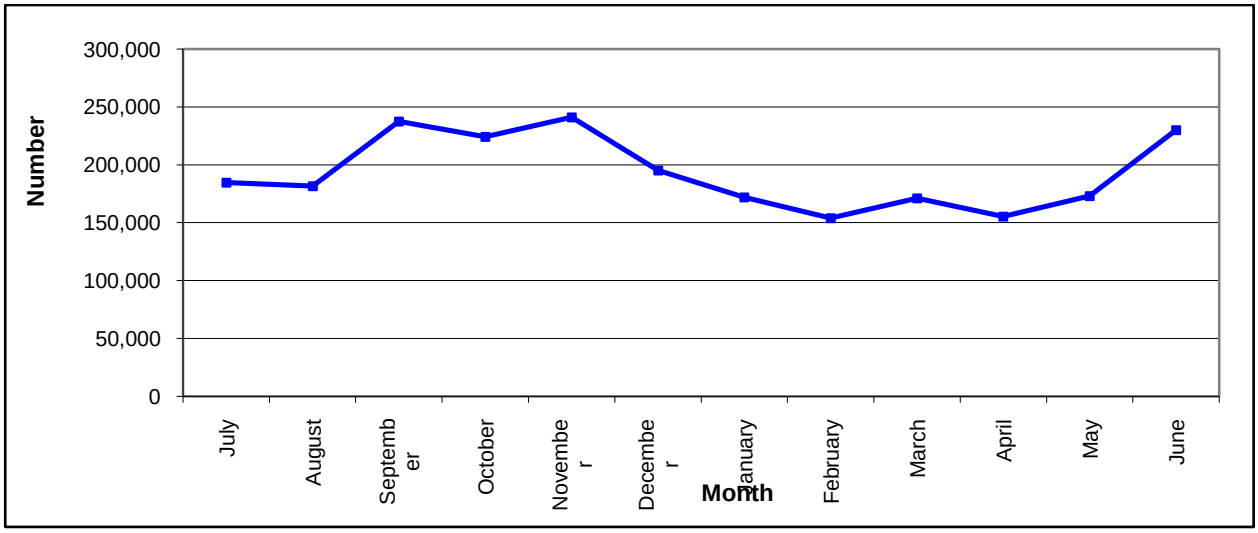


Figure 29: Trend in Laboratory Confirmed Plus Clinical Malaria Cases by Month (EFY 2008)

Out of the total 2,320,135 malaria cases reported in the fiscal year, 2,033,310(87.6%) were confirmed by either microscopy or rapid diagnostic tests (RDT), out of which 1,325,409(65.2%) were Plasmodium falciparum (PF) and 707,901 (34.8%) were Plasmodium vivax (PV). The monthly pattern showed an increase in the first five months of the fiscal year reaching the highest peak in November, followed by a decrease in Feburary and April.

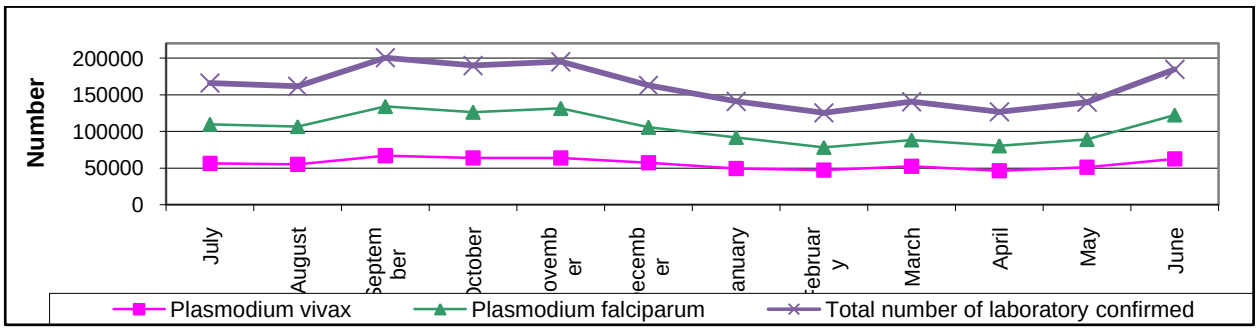


Figure 30: Trend in Laboratory Confirmed Malaria Cases, Plasmodium falciparum Malaria Cases, and Plasmodium vivaxMalaria Cases by Month (EFY 2008)

In EFY 2008, the highest number of laboratory confirmed plus clinical malaria cases was reported from SNNP (713,532), followed by Amhara (583,988cases), and Tigray (252,173cases) (Table 6).

Table 6: Distribution of Laboratory Confirmed plus Clinical Malaria Cases by Region (EFY 2008)

Region	Population at risk	Cases			Death		
		Number	Percent	Incidence per 100,000 at risk population	Number	Percent	CFR (%)
Tigray	3,763,267	252,173	11.0%	6,701	56	11.0%	0.02%
Afar	1,863,902	81,619	3.6%	4,379	15	2.9%	0.02%
Amhara	15,790,154	583,988	25.5%	3,698	31	6.1%	0.01%
Oromia	23,161,304	208,542	9.1%	900	48	9.4%	0.02%

Somali	4,912,248	106,061	4.6%	2,159	170	33.3%	0.16%
Benishangul Gumuz	815,589	248,192	10.8%	30,431	10	2.0%	0.004%
SNNPR	12,238,426	713,532	31.1%	5,830	137	26.9%	0.02%
Gambella	419,955	76,800	3.3%	18,288	23	4.5%	0.03%
Harari	186,963	10,116	0.4%	5,411	2	0.4%	0.02%
Addis Ababa	324,430	11,533	0.5%	3,555	16	3.1%	0.14%
Dire Dawa	210,298	2,012	0.1%	957	2	0.4%	0.10%
National	61,429,786	2,320,135	100.0%	3,735	510	100.0%	0.02%

A total of 7.3 million doses of artemisinin-based combination therapy (ACT), 40,000 vials of Artesunate injection, 1.17 million doses of chloroquine, and 8.4 million RDTs were distributed to respective regions for malaria prevention and control.

2.4.3.2.Households Covered with Indoor Residual Spray (IRS)

With regards to vector control, 5.4 unit structures were sprayed in the budget year; this makes total coverage 91.8% which is an increase from last year at 89.05%.

2.4.3.3.Long-Lasting Insecticidal Net Distribution

In EFY 2008, a total of 29.8 million LLINs were distributed which was more than the amount distributed in EFY 2007 (17.2 million).This makes the LLIN coverage 100%. On top of this distribution, an additional 459,600 LLIN were distributed for specific woredas affected by the El Nino disaster.

2.4.3.4.Other Activities

- Malaria elimination strategy was prepared in line with world malaria elimination technical document and Africa Malaria elimination strategy.
- From 18 zones, 209 woredas with low malaria burden were selected for malaria elimination and implementation guidelines, community advocacy, and vector control, and other complimenting manuals were prepared.
- Site selection was done for insecticide resistance study and insecticide resistance management strategy was prepared and cascaded to regions for implementation.

Challenges

- Budget constraints at woreda level to conduct IRS activities;
- Gap on site selection (targeting households for IRS) and skill gap to conduct IRS in some woredas;
- LLIN utilization; and
- Malaria prevention and control in migrant worker and development corridors.

Way forward

- Ensure woreda level budget allocation for IRS activities;

- Promote proper utilization of LLIN; and
- Improve targeting areas for IRS activity.

2.4.4. Prevention and Control of Neglected Tropical Diseases

Eight neglected tropical diseases (NTDs) require serious attention since they are among the main impediments for poverty reduction and some are targeted for elimination by 2020. A national task force for NTDs, involving FMOH and partners, oversees coordination of the strategies. Moreover, a fast track strategy is instituted so as to enable the elimination of blinding trachoma before the global target of 2020, the Ethiopian Onchocerciasis Elimination Expert Advisory Committee is also established that would provide state-of-the art technical guidance so that the country achieves onchocerciasis elimination by 2025 with technical working groups for each of the diseases.

In the reporting fiscal year 2008, over 10.5 million people took drugs for the prevention of onchocerciasis. To prevent blindness caused by Trachoma, Trachomatous Trichiasis surgery was conducted for119,197 patients and 55,409,469people living in endemic woredas took drugs for the prevention of the disease. A total of 13 million children received deworming service for Soil Transmitted Helminthiasis in 450 woredas and schistosomiasis treatment was provided for 6.5 million people in the first round of the year.

Lymphatic Filariasis treatment was given for 3.6 million people and integrated hydrocele and lymphedema prevention and control service for LF and Podoconiosis was expanded to health centers in four endemic regions (Amhara, Benishangul Gumuz, SNNPR, and Oromia) through training of 234 health workers in addition to conducting burden assessment for detection and registration of lymphedema patients in 20 highly endemic woredas (6 Amhara, 1 Tigray, 14 SNNPR, 12 Benishangul Gumuz, and 27 Oromia).

To initiate the new short-term (17 days) treatment regimen for Leishmaniosis, training was given for 128 health workers from Tigray, Amhara, Somali, and SNNP regions and the service was initiated in all Leishmania treatment facilities.

Challenges

- Incomplete mapping for some NTDs resulting in gaps for comprehensive planning and action;
- Inadequate coordination and co-implementation of interventions impeding efficient use of limited resources;
- Inadequate surveillance system for effective monitoring of progress;
- Limited community mobilization; and
- Inadequate partnership and resources.

Way forward

- Complete the mapping of NTDs;
- Strengthen coordination and co-implementation of interventions at federal and regional levels;
- Strengthen the surveillance system nationwide;
- Advocate for multi-sector engagement and promote community mobilization; and
- Promote partnership and resource mobilization.

2.5.Prevention and Control of Non-Communicable Diseases

Available evidences showed that the burden of Non-Communicable Diseases (NCDs) is growing fast in Ethiopia. Obesity, harmful consumption of alcohol and tobacco, narcotic drugs, and environmental pollution are among the major risk factors attributed to the rise of the problem. Considering the vast amount of financial resources required to treat NCDs and the limited capacity that the country has, emphasis has to be put on strengthening prevention and control of NCDs from the very onset.

Cycling for health event was celebrated at Hawasa town and awareness creation efforts were carried out to increase awareness on NCDs and risk factors. A total of 15,000 city residents and 5,000 students attended the event at which 70 health workers provided weight and BMI screening service for 2,415 adults. Additionally,international and national health days related to NCD (World DM, Hypertension, Kidney, Heart, World Health, and World No Tobacco Day) were observed and the NCD team facilitated and participated in the events; panel discussions were conducted and over 17,000 different IEC materials were distributed.

DM and hypertension prevention care and treatment service integration to primary health care was launched in the presence of State Minister of FMOH, RHB representatives, and partners. To facilitate the integration process, 12 Hospitals and 36 Health centers were selected for demonstrating integrated DM and HTN services. A baseline assessment of these selected sites was done and findings were shared with workshop participants. The finding from the baseline assessment showed that the quality of care being delivered at hospitals is unacceptably low and the health centers are not giving any meaningful DM and HTN services. To address this gap, Major NCDs Guideline was prepared and printed and training manual for HTN and DM prevention and control was developed. Training of trainers workshop was conducted and 29 health workers from 12 hospitals and 7 regional health bureaus were trained.

Additionally,a training module on NCDs for urban health extension workers was drafted to involve the HEWs and HDA in increasing awareness on prevention and control of NCDs and their risk factors.

To address the neglected burden of rheumatic heart disease, a concept note on rheumatic heart disease and a draft training material is developedin collaboration with in Addis Ababa University.

To address the huge burden of cancer, the NCD team, in collaboration with the ministry of women and child affairs and other governmental organizations, conductedtraining on cervical and breast cancer prevention, providing screening and treatment for 700 participants. IEC materials were distributed to health facilities that start the program.

Cancer chemotherapy was availed at subsidized cost at Black Lion hospital and patients are accessing the service in the same facility. To improve access to chemotherapy of cancer service,FMOH renovated Woreda 8 health center in Lideta sub-city and inaugurated the center after fully equipping it with the necessary equipment, furniture, and medicines. This helped decrease the waiting time of patients to get treatment from six months to one month.

The FMOH is working to establish four additional radiotherapy centers in the country in addition to TikurAnbessa Hospital. The construction of these centers is progressing very well and it is hoped that it will be finalized by the end of EFY 2009.

To facilitate screening and treatment of cervical cancer, 118 cryotherapy machines were procured and distributed to 118 health facilities and health care providers were trained; of which, 64 sites have started the service. Among this, 15 machines were given to special support regions. To increase access to high quality surgical services, procurement of 10 LEEP (Loop Electro Excision Procedure) machines is underway.

Hepatitis B and C are major causes of morbidity and mortality in Ethiopia. They are major causes of chronic liver disease and liver cancer. FMOH is keen in the prevention and treatment of these infections. To that effect, the FMOH has prepared training material on Hepatitis management and developed a five year strategic action plan. The service is launched in Addis Ababa in selected public and private health facilities. Medicines are procured at subsidized prices in collaboration with Julfar and Kenema pharmacy.Work is under way to supply Hepatitis B treatment with affordably priced

preparatory activities completed on provision of Hepatitis B virus vaccine to all health workers.

A range of important strategic documents on NCDs were developed:

- A guideline on prevention and control of major NCDs developed and sent for printing;
- National cancer control plan launched;
- A national strategy on prevention and control of viral hepatitis finalized and launched;
- A guideline on prevention and control of viral hepatitis developed; and
- National mental health strategy task force formed and draft TOR developed.

Mental health problems are also a major cause of suffering, loss of productivity, and death. The FMOH has been implementing the mhGAP Program for the past three years. Implementation of this initiative was continuing this year. For the mhGAP implementing sites, 13 types of mental health medicines were procured and a distribution plan is being rolled out.

FMOH, Emmanuel Specialized Mental Health Hospital, and AARHB worked collaboratively to increase awareness of the public on mental health in the 10 sub-cities of Addis Ababa. HC andhospital staff were trained on mhGAP and mentoring was provided by Emmanuel Hospital. Through this approach, 456 abandoned psychiatric patients were collected from the streets, 275 of whom were provided inpatient treatment at 79 health centers and hospitals.

The same year, a national mental health symposium was conducted in Mekele to start mental health service at the PHCU level. Different research papers were presented and mental rehabilitation centers were visited.

National Epilepsy week was celebrated, with more than 17,000 IEC materials prepared in different language and distributed to participants. A press conference was also conducted.

Eye health problems which are causes of blindness or severe visual impairment are a major public health problem in the country, as shown by an eye health survey conducted few years ago.

A five year eye health strategy plan was drafted, and costing works are under way. To strengthen the NCD case team, an eye health technical advisor was recruited and has started work. A cataract surgery campaign is planned for six sites and has been achieved in two sites. Clearance for a budget for procurement of supplies for a backlog of 60,000 cataract surgerieswas approved and procurement is in process. A concept note was prepared for school children refractive errors screening and a fund for was transferred to AA RHB. The national TWG is revitalized and is working to harmonize work plans by the different stakeholders.

Challenges

- Poor priority given to NCDs at all levels of the health system and in the community;
- Low awareness of the HCWs on NCDs and risk factors;
- Low awareness of the community on NCDs;
- Lack of NCD focal points in FMOH and RHBs;
- Absence of expertise and regional centers on cancer , heart disease, and other NCDs management;
- Difficulty in quantification and procurement of NCD supplies;
- Poor data capturing system;
- Weak or non-existentmultisectoral collaboration to address NCD risk factors;
- Weak supportive supervisionat regional level; and

- Limited number of national and international partners working on NCDs.

Way forward

- Develop multisector NCD Strategic Plan 2017-2020;
- Conduct trainings on Major NCDs;
- Develop national cancer treatment protocols and decentralize service;
- Conduct national quantification exercise on NCDs;
- Facilitate procurement of drugs for the initiatives;
- Develop RHD implementation plan;
- Ensure technical and financial support to NCD plan;
- Conduct intensive awareness campaign on NCDs and their risk factors nationwide; and
- Carry out high level advocacy to increase the number of national and international partners working on NCDs.

2.6.Public Health Emergency Preparedness and Response

Public Health Emergency Management (PHEM) aims to improve how the health system deal with with existing and evolving disease epidemics, malnutrition, and natural disasters of national and international concern. At this stage, HSTP assumes to improve health risk identification, early warning, response and recovery from the disasters. Therefore, the strategies were set towards an effective early warning, preparedness, response, recovery and rehabilitation system.

2.6.1. Epidemic Prevention and Control

Measles

In EFY 2008, a total of 12,477 laboratory confirmed and epidemiologically linked measles cases were reported nationally with 78 deaths that for a CFR of 0.6%. When compared to last EFY 2007 (32,469 cases), there is a sharp decrease by 19,992 (160%) in EFY 2008 but the CFR remains the same. From the total cases reported, Oromia accounts for the highest number of cases with 61%, followed by Somali at 12.1%, SNNPR at 11.4%, and Amhara at 8.1%. The CFR was high in Dire Dawa (23.5%) and Harari (15.3%). Looking at the incidence rate, the highest annual incidence rate per 100,000 under five children was reported from Addis Ababa (322), Harari (242), Somali (184), Oromia (150), Benishangul Gumuz (147), and Afar (129).

Table 7: Distribution of Suspected Measles Cases and Deaths by Region, EFY 2008

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000	Number	Perce	CFR

			U5 Children)		nt	
Tigray	52	0.4%	6.92	0	0.0%	0.00%
Afar	334	2.7%	129.40	1	1.3%	0.30%
Amhara	1014	8.1%	33.46	3	3.8%	0.30%
Oromia	7568	60.7%	150.02	32	41.0%	0.42%
Somali	1508	12.1%	184.62	21	26.9%	1.39%
Benishangul Gumuz	223	1.8%	147.81	0	0.0%	0.00%
SNNPR	1425	11.4%	52.17	2	2.6%	0.14%
Gambela	38	0.3%	61.71	0	0.0%	0.00%
Harari	85	0.7%	242.73	13	16.7%	15.29 %
Addis Ababa	213	1.7%	322.26	2	2.6%	0.94%
Dire Dawa	17	0.1%	3.48	4	5.1%	23.53 %
National	12477	100.00%	92.74	78	100.0 %	0.63%

In EFY 2008, the monthly trend of laboratory and epidemiologically confirmed measles cases show a similar trend to EFY 2007 from July to February and a sharp decrease month of June.

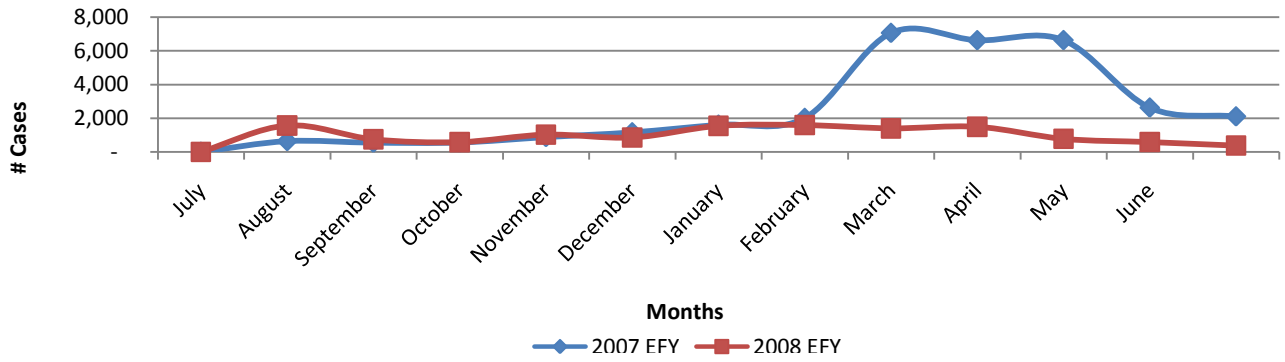


Figure 31: Trend in Suspected Measles Cases by Month (EFY 2007 and 2008)

Dysentry

In EFY 2008, a total of 306,594 dysentery cases were reported from all regions, an increment by 39,105(12.7%) from EFY 2007. The majority of the cases were reported from Amhara (28.5%) and Oromia (28.2%), followed by Tigray (12.2%) and SNNPR (10.4%), while Harari (0.33%) accounts for the lowest case report. The incidence rate per 100,000 population is high in Addis Ababa (4,537), Benishangul Gumuz (1,480), and Tigray (723).

Table 8: Distribution of Suspected Dysentery Cases and Deaths by Region, EFY 2008

Region	**Cases**			**Deaths**		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	37,265	12.15%	723	0	0%	0.0%
Afar	11,756	3.83%	665	0	0%	0.0%
Amhara	87,240	28.45%	420	2	13%	0.0%
Oromia	86,346	28.16%	250	11	73%	0.0%
Somali	11,740	3.83%	210	0	0%	0.0%
Benishangul Gumuz	15,306	4.99%	1480	0	0%	0.0%
SNNPR	31,934	10.42%	171	0	0%	0.0%
Gambela	2,013	0.66%	477	2	13%	0.1%
Harari	1,010	0.33%	421	0	0%	0.0%

Addis Ababa	20,554	6.70%	4537	0	0%	0.0%
Dire Dawa	1,430	0.47%	43	0	0%	0.0%
National	306,594	100.00%	333	15	100%	0.0%

The monthly trend of dysentery case shows a slight increase from EFY 2007 with peaks in July and March and a declinein May.

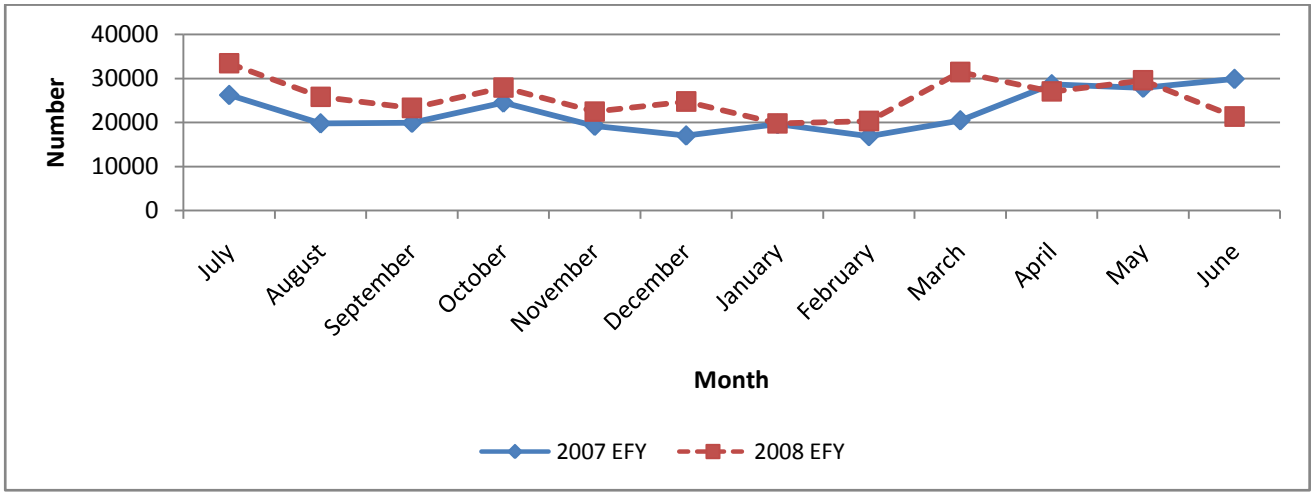


Figure 32: Trend in Suspected Dysentery Cases by Month (EFY 2007 and 2008)

Meningococal Meningitis

A total of 1,571 suspected meningococcal meningitis cases were reported in 2008 EFY 2008, which is a decrement from the same period last year by 304(16%) with higher case reports from SNNPR (43%), Oromia (24%), and Amhara (13%). A total of 27 deaths were reported with a CFR of 1.7%, which was decreased by half compared to EFY 2007. The higher CFR reports from Afar 4.72% Benishangul 4.55%,Addis Ababa 3.13% respectively. On other hand, the incidence rate per 100,000 population is 2/100,000 at national level with the highest reports from Gambela (15.2/100,000) followed by Afar (7.2/100,000), Addis Ababa (7.1/100,000), SNNPR (3.6 /100,000), and Benishangul Gumuz (2.1/100,000).

Table 9: Distribution of Suspected Meningococcal Cases and Deaths by Region, EFY 2008

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	29	1.8%	0.6	0	0.00%	0.00%
Afar	127	8.1%	7.2	6	22.22%	4.72%

Amhara	200	12.7%	1.0	6	22.22%	3.00%
Oromia	376	23.9%	1.1	2	7.41%	0.53%
Somali	38	2.4%	0.7	1	3.70%	2.63%
Benishangul Gumuz	22	1.4%	2.1	1	3.70%	4.55%
SNNPR	681	43.3%	3.6	9	33.33%	1.32%
Gambela	64	4.1%	15.2	1	3.70%	1.56%
Harari	2	0.1%	0.8	0	0.00%	0.00%
Addis Ababa	32	2.0%	7.1	1	3.70%	3.13%
Dire Dawa	0	0.0%	0.0	0	0.00%	0.00%
National	1571	100.0%	1.7	27	100.00%	1.72%

The monthly trend of meningococcal meningitis show an increment in July to December and March, compared to EFY 2007; there is a decrement from January to April and June.

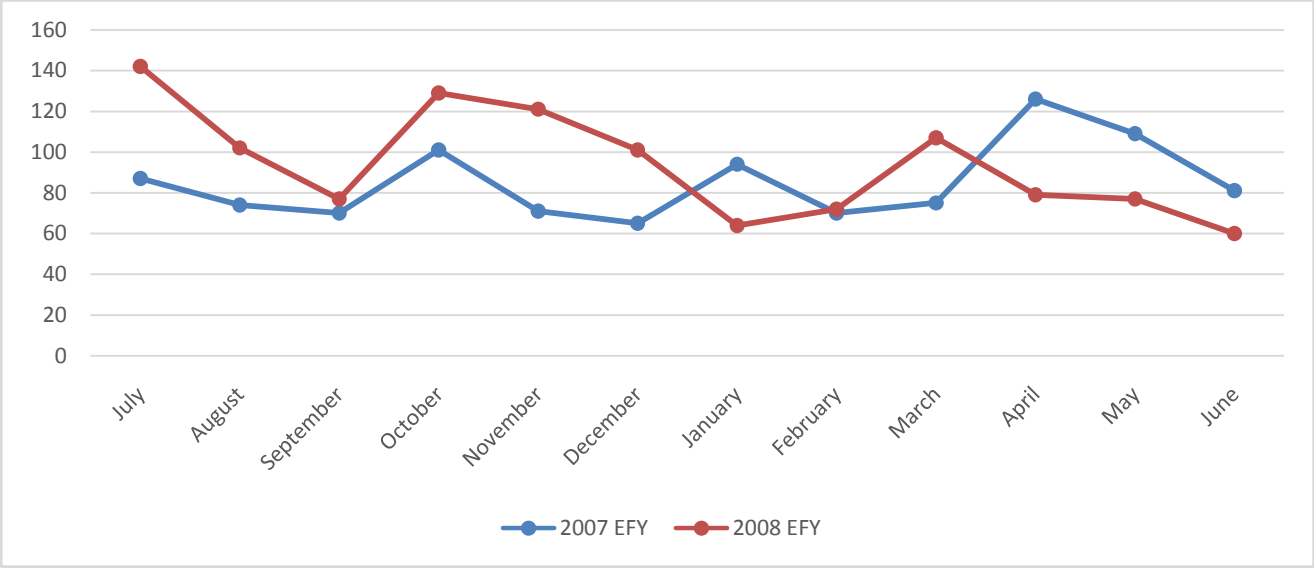


Figure 33: Trend in suspected Meningococcal cases by month (EFY 2007 and 2008)

Anthrax

In EFY 2008, a total of 575 anthrax cases were reported with CFR of 1.2% which is a significant decrement (32%) from EFY 2007 with 848 cases. The highest proportion of cases was reported from Amhara (73%) and Tigray (18%), while highest CFR is from Oromia (5.6%) and Amhara (1.4%). The incidence rate of 0.62 per 100,000 population has showed slight decrement from last year's report which is 1 per 100,000 population.

Table 10: Distribution of Suspected Anthrax Cases and Deaths by Region (EFY 2008)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	103	18%	2.00	0	0%	0.0%

Afar	0	0%	0.00	0	0%	0.0%
Amhara	421	73%	2.03	6	86%	1.4%
Oromia	18	3%	0.05	1	14%	5.6%
Somali	0	0%	0.00	0	0%	0.0%
Benishangul Gumuz	0	0%	0.00	0	0%	0.0%
SNNPR	33	6%	0.18	0	0%	0.0%
Gambella	0	0%	0.00	0	0%	0.0%
Harari	0	0%	0.00	0	0%	0.0%
Addis Ababa	0	0%	0.00	0	0%	0.0%
Dire Dawa	0	0%	0.00	0	0%	0.0%
National	575	100%	0.62	7	100%	1.2%

The monthly trend has slightly similar trend from July to March and has a sharp decrement in April and May when compared with EFY 2007.

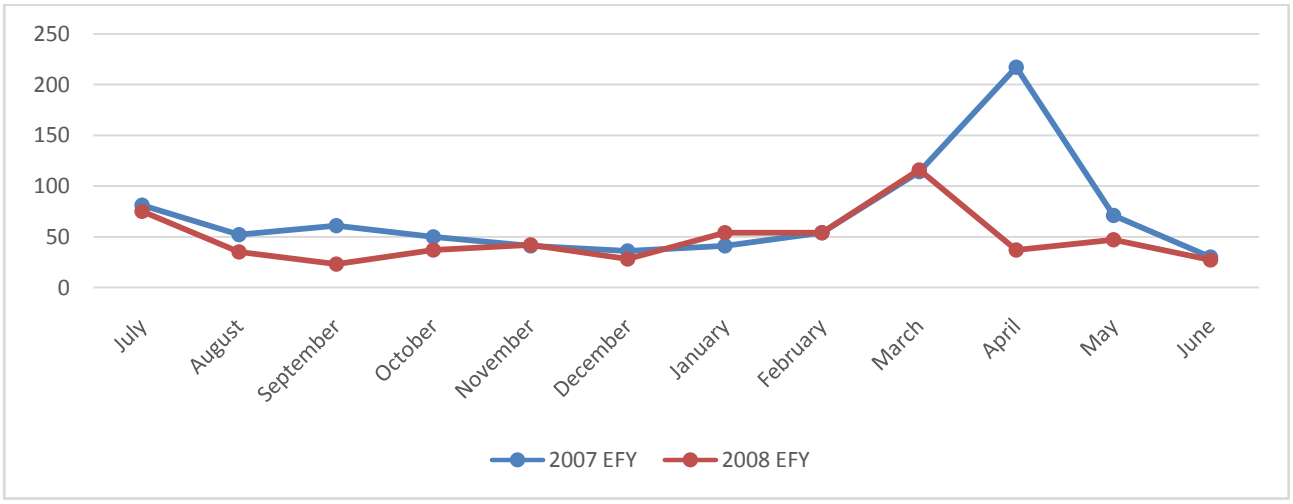


Figure 34: Trend in Suspected Anthrax Cases by Month (EFY 2007 and 2008)

Rabies

A total of 2,518 suspected rabies case were reported with 36 deaths, which has showed a decrease from EFY 2007 with 2,684 cases and 53 deaths by 6% and 32%, respectively. The highest proportion of cases was reported from Amhara (40.2%), Tigray (30.9%), and Oromia (19.5%). The incidence rate at national level is 2.7 per 100,000 population with the highest incidence rate in Benishangul Gumuz (17.9/100,000 population) and Tigray (15.1/100,000 population). The highest CFR came from Oromia (36.1%), Amhara (22.2%), and Benishangul Gumuz (22.2%).

Table 11: Distribution of Suspected Rabies Cases and Deaths by Region (EFY 2008)

Region	Cases			Deaths		
	Number	Percent	Incidence Rate (per 100,000 population)	Number	Percent	CFR
Tigray	777	30.9%	15.1	1	2.8%	0.1%

Afar	0	0.0%	0.0	0	0.0%	0.0%
Amhara	1013	40.2%	4.9	8	22.2%	0.8%
Oromia	490	19.5%	1.4	13	36.1%	2.7%
Somali	6	0.2%	0.1	0	0.0%	0.0%
Benishangul Gumuz	185	7.3%	17.9	8	22.2%	0.0%
SNNPR	40	1.6%	0.2	3	8.3%	7.5%
Gambela	5	0.2%	1.2	3	8.3%	0.0%
Harari	0	0.0%	0.0	0	0.0%	0.0%
Addis Ababa	2	0.1%	0.4	0	0.0%	0.0%
Dire Dawa	0	0.0%	0.0	0	0.0%	0.0%
National	2518	100.0%	2.7	36	100.0%	1.4%

The monthly trend is similar to EFY 2007 with the exception of peak cases in the month of September, October, and January EFY 2008.

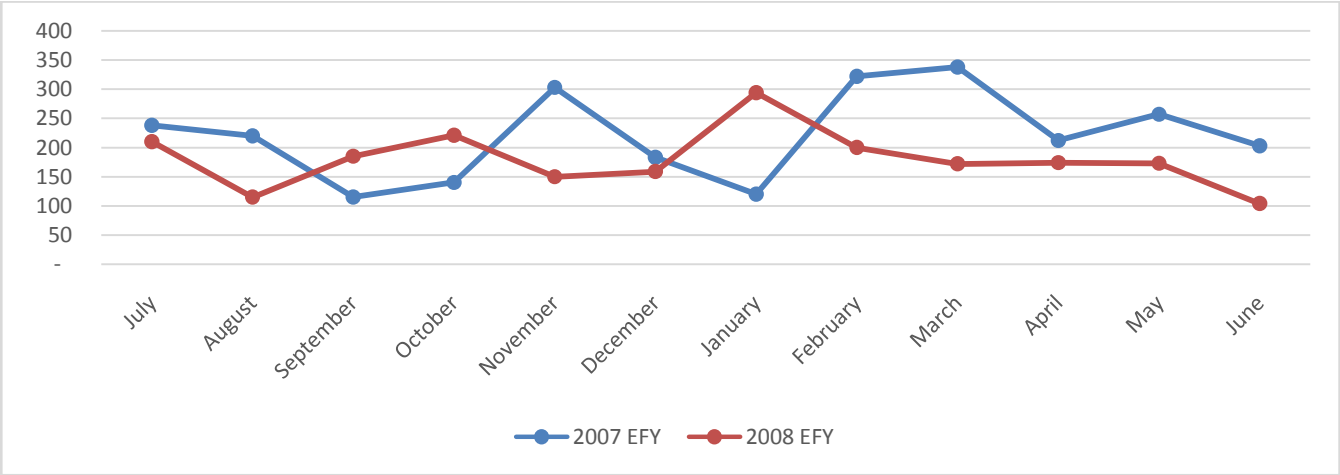


Figure 35: Trend in Suspected Rabies Cases by Month (EFY 2007 and 2008)

Challenges

- Low completeness and timeliness of reporting from some regions;
- Inadequate data utilization, especially at lower levels;
- Limited capacity of laboratory for timely confirmation of outbreaks; and
- Staff turnover, especially at national and regional levels.

Way forward

- Implementation of electronic surveillance system and regular supportive supervision;
- Strengthen data documentation through training of PHEM officers and data managers; and
- Provide training on data analysis and reporting.

CHAPTER THREE

QUALITY IMPROVEMENT AND ASSURANCE

3.1.Quality Improvement

Health Service Transformation in Quality (HSTQ) Manual Development

In an effort to institutionalize quality in the Ethiopian healthcare system, the Health Services Quality Directorate has developed and launched the National Healthcare Quality Strategy, which is a road map for the coming five years. The strategy has four focus areas integrating quality planning, improvement, and assurance. In order to operationalize the strategy, the Health Services Quality Directorate has developed a quality improvement tool on selected high priority healthcare services in hospitals. It is a clinical audit tool called the Health Services Transformation in Quality (HSTQ) manual. It includes standards that were developed for selected service areas on premises, processes, and professionals to which facilities and healthcare professionals are expected to comply. For better implementation of the manual and to avoid conflicts, the standards in the manual are made to be aligned with the regulatory standards of FMHACA.

To carry out development of the clinical audit tool, a technical working group was established anddivided into different subgroups based on the prioritized services. The document's preparatory phase began in February 2016. The groups were composed of experts and professionals from different disciplines. Initially, a draft document was prepared and commented on by directorate staff. Once the group had agreed on the draft document, it was arranged in a format that was easy to use and suitable for users. The different service areas included in the clinical audit tool are:

- Communicable diseases (TB, HIV, Malaria);
- Nursing and midwifery services;
- Maternal healthcare services
- Neonatal and child health care services;
- Non-communicable diseases;
- Standard treatment guideline (STG) adherence;
- Surgical services;
- CRC and patient centered care;
- Patient safety; and
- Healthcare data quality.

Hospitals are expected to conduct a regular clinical audit on the selected service areas and implement quality improvement projects on identified gaps.

Ethiopian Hospitals Alliance for Quality (EHAQ) Initiative

The Ethiopian Hospitals Alliance for Quality (EHAQ) program was initiated to improve the quality of health service delivery in hospitals through establishing institutional networks and collaborations. Nationally, there is a technical working group established toprovide continuous technical and occasionally financial support for the program. The group also facilitates and leads supportive supervisions, technical onsite supports, and development of change packages. In EFY 2008, as the second cycle of the EHAQ program was near completion, hospitals were selected using a defined set of criteria for onsite validation and recognition. A total of 74 hospitals were chosen during the preliminary screening based on key performance indicators. Later, based on the Regional Health Bureau's ranking, the number of hospitals to be validated was reduced to 52. These hospitals were evaluated based on four major initiatives of the directorate: Maternal and Child Health Services, Hospital Reform Implementation, Clean and Safe Hospital Initiative, and EHAQ Cluster activities. Evaluation teams were deployed to different regions for assessment and validation. After the validation process, the collected data was analyzed and best performing hospitals were identified.

Later, after one month of preparation, an EHAQ recognition ceremony was held at the African Union conference hall to recognize the best performing hospitals. More than 2,600 participants from Regional Health Bureaus, Woreda Health Offices, hospitals, health centers and different partners took part. A total of 32 hospitals were given recognition and awarded money for their best performance. The categories of recognition were:Best performing hospital, best CASH implementing hospital, best university hospital, and best cluster. Bisidmo General Hospital,AlemKetema General Hospital, and BoruMeda General Hospital were recognized as best performing hospitals. BoruMeda Hospital was again recognized for best CASH implementing category. Hawassa University Hospital was recognized for the best performing university hospital category.

Ethiopian Hospital Reform Implementation Guidelines (EHRIG) Revision

The Ethiopian Hospital Reform Implementation Guideline (EHRIG) was revised based on recommendations from regional health bureaus, hospitals, and implementing partners. After conducting a national evaluation on its implementation, the first activity completed by the directorate was to develop a framework. A first draft of the revised guideline was developed using the framework through the establishment of revision teams for each chapter; it was refined in three separate workshops. In the first workshop, which was attended by more than 100

professionals (revision teams), a draft document was developed and appraised for three consecutive days. A second workshop was conducted in Addis Ababa to comment on the zero draft of the revised guideline. About 50 professionals from different departments of the ministry and partners were involved. The revised chapters were presented by each and for comments. Later, comments were incorporated by each team and a first draft guideline was developed. A third and final workshop was also conducted in which about 40 professionals participated.Chapters that received comments in the second workshop were presented to the participants and thorough discussions were had on selected chapters. Finally, an editorial committee was established to refine the chapters and prepare it for printing. The revised hospital document has two volumes and 20 chapters and it is called the Ethiopian Hospital Services Transformation Guideline.

Saving Life through Safe Surgery (SaLTS)

The SaLTS initiative is a new initiative launched by the Federal Ministry of Health to address the apparently country-wide long waiting time for surgery. It is a large initiative in which basic and emergency surgical services will be launched in all hospitals of the country and it includes task-shifting to middle-level healthcare professionals through short or medium term competency based trainings. It will be a flagship initiative of the health sector. The ministry has set aside budget to achieve the goals of the initiative in the coming five years.

A national technical working group was established and has held consecutive meetings for the development of the national SaLTS five-year strategic plan. This includes a pharmaceutical and consumables list for implementation, different surgical procedures list, and the human resources needed for five years to meet the surgical and anesthesia man power gap. Different stakeholders and staffs from the directorate participated in the development of the SaLTS package.

The SaLTS baseline assessment tool was also developed and hospital readiness for the implementation of safe surgery was assessed using the tool. Identified gaps in hospitals will be addressed before the initiative is launched. The SaLTS initiative will be the primary focus area for the current cycle of EHAQ.

Clean and Safe Hospitals (CASH) Initiative

In the process of making health facilities convenient, clean, and safe both for the patient and healthcare professionals, a CASH initiative was launched in EFY 2007. A nationally developed audit tool was employed for regular auditing and improvement of cleanliness and safety in all public hospitals across the country. The same activity continued this year and, additionally, hospitals regularly conducted awareness and cleaning campaigns and procurement of the necessary equipment and supplies for CASH. This has resulted in significant improvement with

regard to the overall cleanliness of hospitals although there were challenges especially in areas where clinical services are provided to patients. Additionally, different trainings were conducted on infection prevention and patient safety. Training of trainees was also given for health professionals from different hospitals and selected regional health bureaus (Tigray, Amhara, Oromia, Dire Dawa, Harari,and Addis Ababa) in two rounds. About 30 healthcare workers in CASH/IPPS have been provided with the training of trainers. After all these activities, documentation of best practices of hospitals was also conducted. Television programs were developed and broadcast to show the impact of the initiative for the public. As the success story of the initiative had attracted the public, different organizations including the WHO have visited Ethiopia to see the activities of hospitals in relation to CASH. Currently, a national assessment is being done to understand the impact of the initiative on the overall service delivery process and patient satisfaction.

Improving Nursing Services Initiative

It is known that generally there is a deteriorating quality of nursing services in hospitals across the country. It is also repeatedly noted that nurses' motivation has deteriorated in the past several years. In order to address this issue, the Federal Ministry of Health has conducted different activities including implementation of nursing services standards, and development and introduction of the nursing leadership manual.Several subsequent trainings were provided on nursing leadership and management. Trainings on the nursing process were also provided to nurses from across all public hospitals in the country. During these trainings, discussions were held on existing problems regarding nursing services to help identify and act on the identifiedproblems. In addition, national nursing mobilization activities were conducted in which discussions took place between hospital senior management and the nursing staff. To help capitalize on the mobilization process, ambassador nurses were assigned to motivate nurses in hospitals across the country. A national dressing code guideline was also launched and almost all regions have followed suit so that all hospitals across the country will have a uniform dressing code.

3.2.Emergency Service in Addis Ababa

Improving Addis Ababa's Emergency Medical Services Coordination

It is mandatory to create an integrated and harmonized system to establish functional and strong emergency medical services. Accordingly, to improve the emergency services in Addis Ababa, mainly in hospitals, the Federal Ministry of Health organized a team to coordinate Addis Ababa emergency services. In EFY 2008, a total of 5,032 emergency calls were received by the team and among these 4,889(97%) of the clients received service. From those who received service,

732(15%) were mothers, 412 (8.4%) neonate and infant, and 3,745(76.6%) were patients with different age and different illnesses.

Ambulance Service

There are 1,269 ambulances in Ethiopia; among these, 1,087(85.6%) are providing service. The remaining 182(14.4%) ambulances are not functional due to damage and lack of regular and periodic maintenance. Generally, in EFY 2008, 692,007 community members got ambulance services, 65.07% were mothers that needed ambulance for delivery services, and the remaining 34.93% were clients with other emergency conditions.

Health Facilities Emergency Medical Services

To strengthen the emergency services provided at health facilities, supportive supervision was conducted in selected hospitals in Harari, Dire Dawa, Oromia, Amhara, Addis Ababa, Gambella, Afar, SNNP, and Tigray regions and feedback was provided for the hospitals and regional health bureau. Gap-identified training was provided for 178 health professionals from 46 different hospitals. To strengthen the implementation of triage format, an evaluation checklist was prepared and disseminated to regional health bureaus to be used for assessment of hospitals in their catchment area. The result of the triage implementation assessment was obtained from 85 hospitals and the result feedback was provided to each region.

For better organization and development of the emergency units, the necessary equipment and supplies list was distributed to regional health bureaus. The final draft of the EmergencyMedicine Treatment Protocol was prepared and improved through workshops and is ready for print.

Intensive Care Medical Services

- In EFY 2008, 10 hospitals has opened adult multidisplinary ICUs and started to provide service this makes total functional ICUs 20 at the end of EFY 2008.
- To strengthen intensive care services supportive supervision was conducted, for 20 selected hospitals (Harari, Dire Dawa, Oromia, Amhara, Addis Ababa, and Tigray) region and feedback was given for the hospitals and regional health bureau
- Burn care management training is given for 88 health professionals those are selected from different hospitals.
- ICU Implementation, poison control center guidelines and poison treatment protocol have been developed.
- Base line assessment was done on the occurrence and management of poisoning to establish poison information center.

- ICU 3 months training curriculum developed.
- First draft of ICU implementation guideline has been developed.

Trauma Center Performance

For trauma centers established in Addis Ababa, St Paul specialized hospital AaBET and under Alert hospital in 2008 service was provided for over 8525 trauma patients. Among these 1,631(19%) were neurological patients and 2,378(28%) were orthopedic patients, and car accidents account for 27.5%. Similarly, in Black Lion hospital, 2,369 trauma patients received service.

Improving Referral Services

- To strengthenthe patient referral system, liaison officer training was provided for 42 participants from Addis Ababa hospitals and regional health bureaus.
- Baseline assessment was done on the bed management and referral system for the purpose of establishing web-based data management system at Black Lion, Zewditu, Minilik, and St. Paul hospitals.
- Prepared and distributed 11,000 referral service brochures and 500 liaison manuals to all regions.
- National service directory was released on FMOH website and 350 copies of CDs were distributed to all regional hospitals.

Blood Safety

To eliminate deaths due to lack of safe blood and to contribute to the quality of health care service delivery, one of the major activities in in EFY 2008 was availing safe and adequate blood and blood products to all patients who need blood transfusion.

In the fiscal year, a total of 139,409 units of blood were collected and there was 9% increment from the previous year (Figure 36).

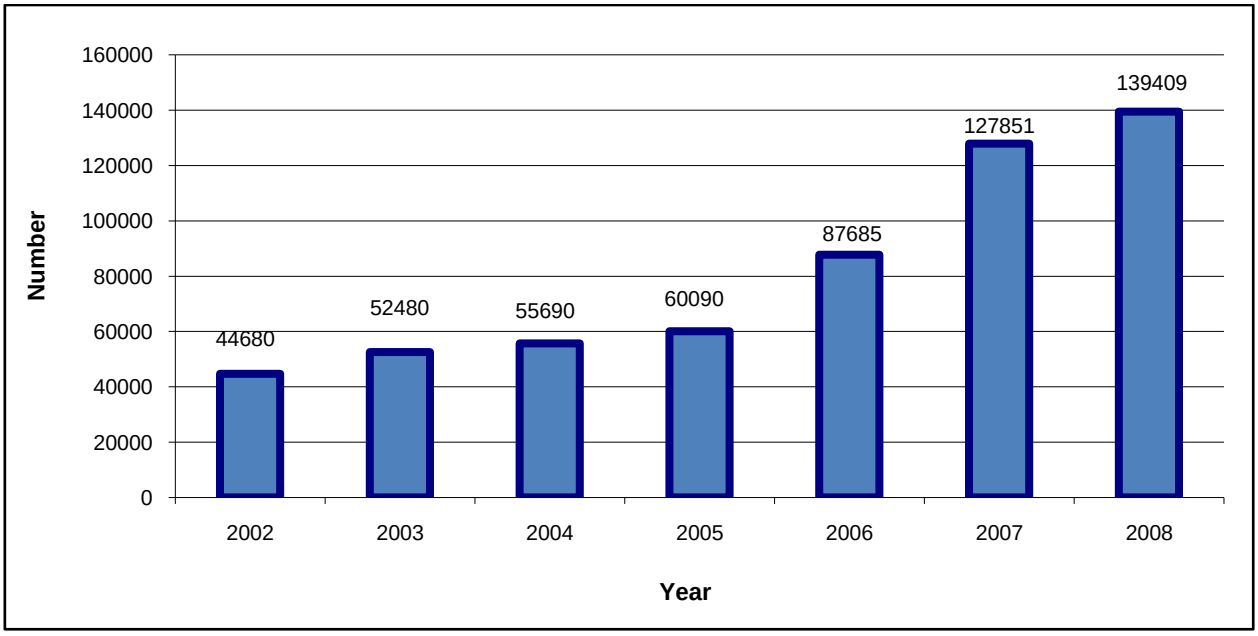


Figure 36: Trend in Number of Units of Blood Collected (EFY 2002 - 2008)

There was an increase in the proportion of voluntary blood donors from 95% in EFY 2007 to 97% in EFY 2008. As the same time, there was also declineon the proportion of replacement blood donors from 5% to 3% in the same period (Figure 37).

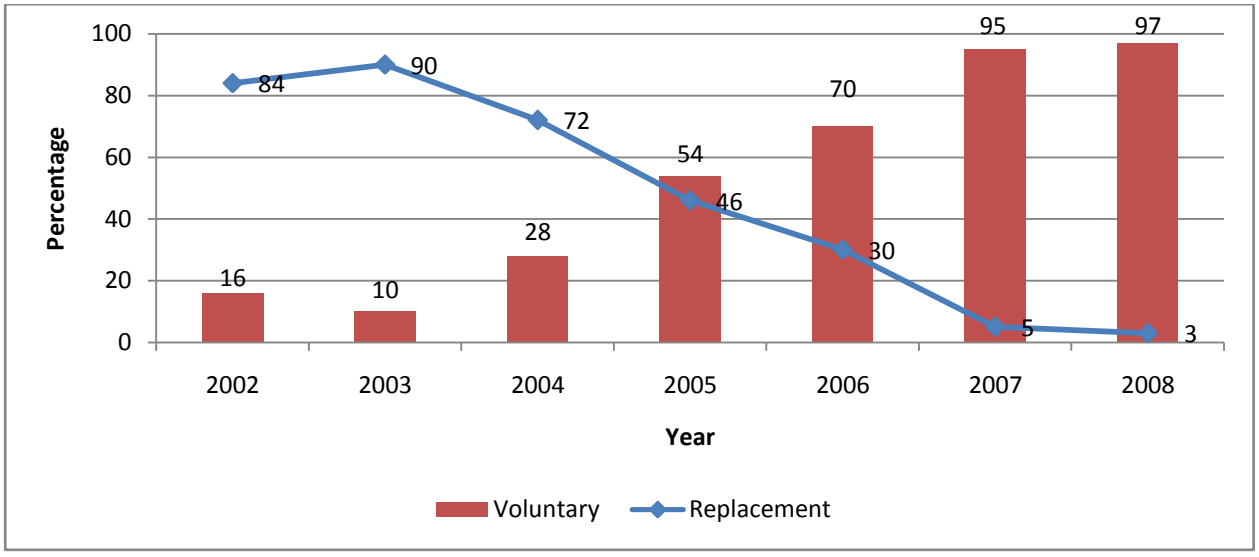


Figure 37: Trend in Percentage of Voluntary and Replacement Blood Donors (EFY 2002-2008)

3.3.Auditable Pharmaceutical Transaction and Service (APTS)

With the objective of creating a transparent and accountable drug management system,the Ministry has been conducting several activities to ensure continuous availability of medicines to the community and to ease the drug auditing processes. Previously, it had been difficult to manage and audit hospitals' income and expenditures from drugs. It was also difficult to improve client satisfaction through making the drug service provision integrated and systematic.

Two years ago, Amhara Regional Health Bureau, in collaboration with development partners, launched Auditable Pharmaceuticals Transaction Service (APTS). It aimed to improve the pharmacy service and pharmaceuticals auditing processes through detail analysis of pharmaceuticals in terms of items used and in stock, cash balance, and budget deficit.

APTS took lessons from a successful pilot project implementation at Debre Markos Referral Hospital. The implementation helped to make the health facility's pharmacy service suitable to the community, to improve availability of drugs at hospitals, and to achieve national and global pharmacy goals. Misuse of drugs has decreased significantly in facilities that have implemented the initiative as transparency and accountability have improved.

Implementation of the Initiative

In EFY 2008, the federal level plan was to implement APTS in ten selected hospitals. Among these, Dilla and HiwotFana Specialized University hospitals have started the implementation. In Black Lion Hospital, the preparatory work has been finalized and trainings have been given for all pharmacy professionals; and thus will begin the initiative immediately. The majority of hospitals have finalized the preparatory work and are awaiting trainingto start the implementation. In terms of hospital reform guidelines, the first draft revision of the Pharmacy Chapter is complete, taking into consideration the APTS, national, and international strategies.

Integration of vaccines management into the Integrated Pharmaceuticals Logistics System has been started in additional Pharmaceuticals Fund and Supply Agency hubs based on the experience obtained from the first phase of integration in selected hubs.

Based on this,Desse, Shire, Dire Dawa, Gonder, Hawasa, and Gambela PFSA hubs have started to implement partial integration and, in the near future, it is expected that the remaining hubs will implement the transition. To ensure smooth transition of vaccine management to PFSA hubs, and based on the national inventory previously done by Pharmaceuticals Fund and Supply Agency, procurement of cold chain equipment began in March 2016 and some of the equipment has started arriving into the country.

In the last few years, many efforts have been made to build capacity and modernize the pharmaceuticals supply and medical equipment store, including improved distribution and management to supply essential drugs to the community with minimum cost. Successful results have been achieved. Different capacity building efforts have been completed to build self-reliance as a country on pharmaceuticals supply purchasing and distribution.

3.4.National Laboratory System

A total of 70 laboratories were assessed to qualify for WHO/AFRO qualification, ranging from STAR Zero to STAR 5. Out of the assessedlaboratories, twoqualified as 4 STAR; seven qualified as

3 STAR; 16qualified as 2 STAR, 20qualified as 1 STAR, and 25qualified as Zero STAR. One laboratory (at EPHI) has applied for ENAO to get ISO accreditation.

A total of 1,755 laboratory professionals from all regions of the country enrolled in skill development and quality improvement training in the following areas:-

- 30 laboratory professionals on biosafety and biosecurity;
- 234 laboratory professionals on malaria diagnosis and quality control;
- 22 laboratory professionals on laboratory quality audit;
- 285 laboratory professionals on external laboratory quality control implementation;
- 208 laboratory professionals on fast diagnostic results communication/delivery;
- 38 laboratory professionals on Gene-Xpert diagnosis;
- 26 laboratory professionals on HIV diagnosis and quality control;
- 24 laboratory professionals on TB diagnosis and quality control;
- 16 laboratory professionals on microbiological diagnosis and quality control;
- 33 laboratory professionals on Strengthening Laboratory Management Towards Accreditation (SLMTA);
- 27 laboratory professionals on laboratory quality control, EID, equipment maintenance, and data base implementation; and
- 20 laboratory professionals on dangerous pathogen handling and control.

External quality assessment (EQA) had been done to enhance laboratory quality by introducing proficiency test samples from abroad and distributing them to different laboratories.

- Oneworld Accuracy samples had been distributed for 255 laboratories;
- UKNEQAS (chemistry and hematology) samples had been distributed for 120 laboratories;
- HIV (DNA-PCR) samples had been distributed for 10 laboratories; and
- HIV viraload samples had been distributed for 10 laboratories.

Ethiopian Public Health Institute (EPHI) had provided back-up laboratory services in EFY 2008 for specimens received from 14 government hospitals in Addis Ababa, with which EPHI has already signed MOU.

A total of 89,494 tests had been done by EPHI laboratories (in different disciplines):

1. Through back-up testing services:

- Clinical chemistry: 31,768
- HIV Viral load/EID: 3,085
- TB drug resistant: 2,337
- Different bacteria and fungi: 11,825

2. Through referral testing services:

- TB drug resistant: 3,659
- Rabies disease clinical diagnosis: 1,284 cases
- Different bacteria and fungi: 1,575
- Parasitology: 331
- Foods and drinks safety and microbiology: 21,319
- Non-communicable diseases diagnostics and analytical(physico-chemical): 905
- Food contents and contamination: 11,406

Improvement of laboratory services at federal and Addis Ababa Hospitals

- Recent demand assessment and prices determination hasbeen done for 26 hospitals. The required budget has been approved and the purchasing process has been run by drug fund agency.
- A selected federal and Addis Ababa hospitals laboratory service has supported two times a year. The supervision was done at Minilik hospital and Yekatit 12 hospital medical College, BLSH, St. Paul Hospital millennium medical College, ALERT, Amanuel, and Gefersa Mental Rehabilitation Center, with a structured checklist. To strengthen back-up laboratory services, a common committee was established from federal hospitals and Ethiopian public health institutions. The committees met frequently and decisions have been made.
- Standard mentoring checklist was prepared at a center and sent to hospitals implementing back-up laboratory. An assessment was done to check the available laboratory services in five federal hospitals. Based on this, a discussion was held on the identified results to bring solutions for unavailable services. These discussions included the management of federal hospitals implementing back-up laboratory services.
- Medical Gas Services draft guideline was developed. Eight hospitals in Addis Ababa implemented a pain management initiative, and an additional 11 hospitals have selected to start intensive pain management initiative in the future. Advocacy work on the pain management initiative was done with seniorhospital management members.

3.5.Clinical Service

3.5.1. OPD Attendant Per Capita

A total of 58,213,532 OPD visits were offered with an average of 0.63 OPD visit per person per year in EFY 2008; this achievement was more than the performance in EFY 2007 (0.48 OPD visit per person per year) but below the target set for the year (0.86 OPD visit per person per year).

Wide variations were observed across regions, ranging between 0.24 visits per person per year in Somali Region and 1.76 visits per person per year in Addis Ababa (Figure 38).

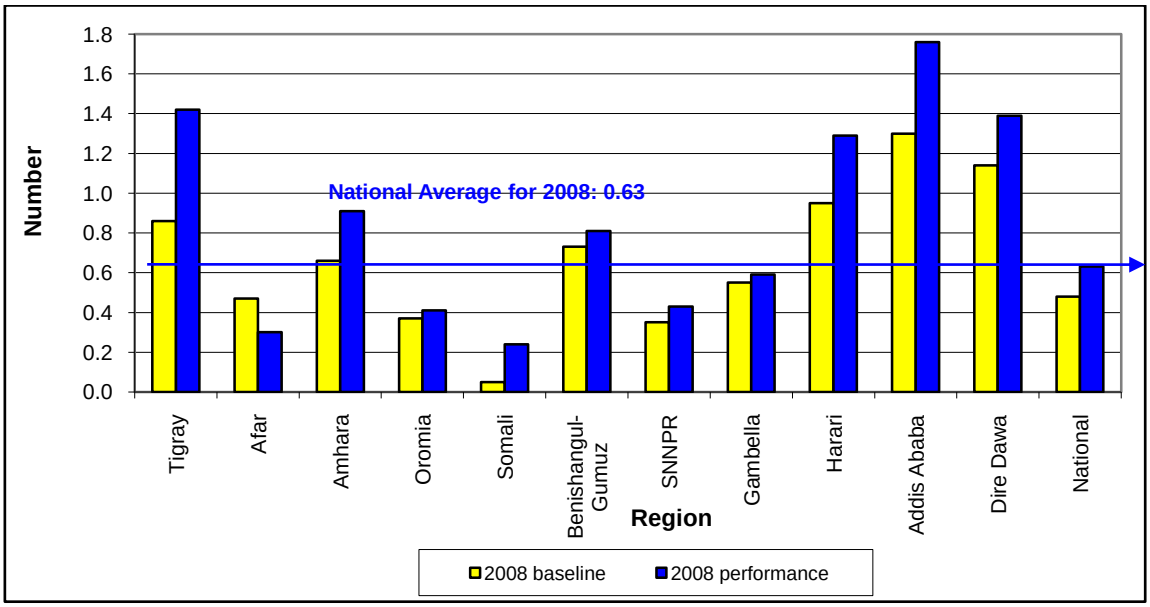


Figure 38: Comparison of Baseline and Performance of OPD Attendance Per Capita by Region (EFY 2008)

3.5.2. Average Length of Stay

In EFY 2008, there were a total of 973,408 inpatient discharges with an average length of stay (ALOS) of 4.5 days. Variations were observed across regions, between 2.7 days ALOS in somali region and 5.5 days ALOS in Addis Ababa (Figure 39).

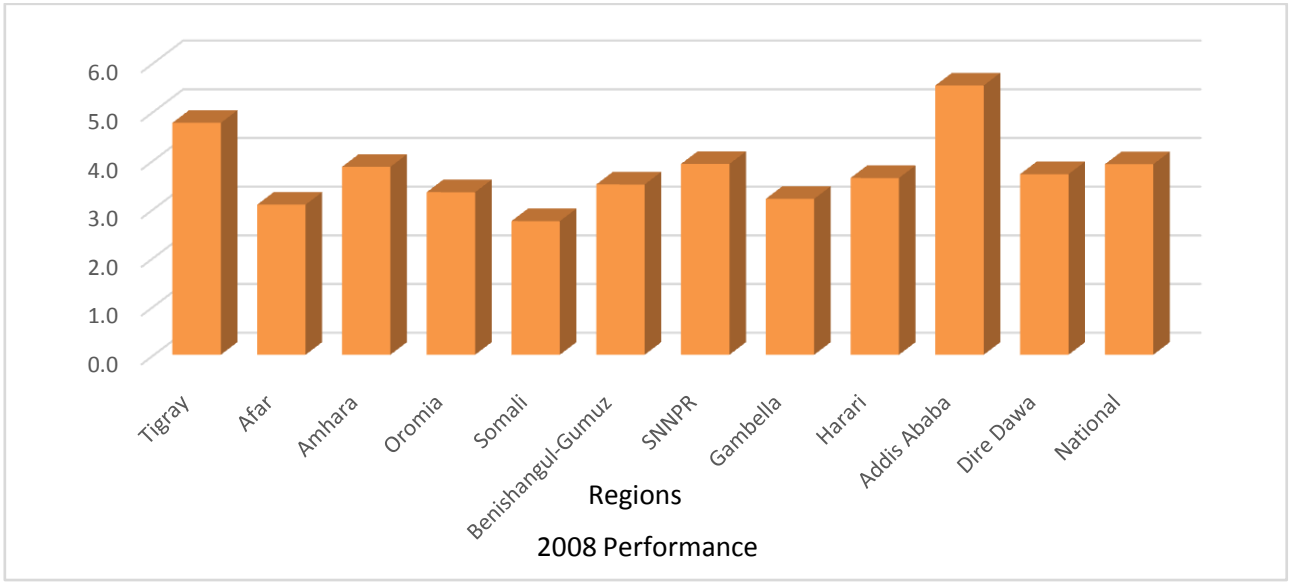


Figure 39: Average Length of Stay by Region, EFY 2008

3.5.3. Bed Occupancy Rate

In EFY 2008, the Bed Occupancy Rate (BOR) was 37%, much below the 80% annual target set for the year. Variations were observed across regions, between 13% in Afar region and 46% in Harari (Figure 40).

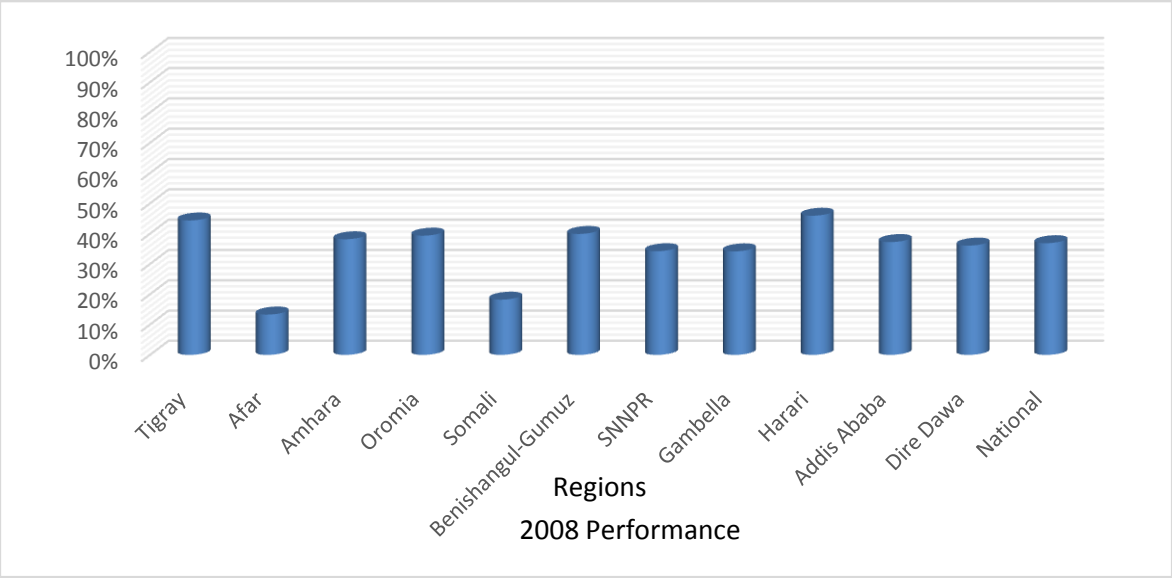


Figure 40: Bed Occupancy Rate by Region, EFY 2008

CHAPTER FOUR

LEADERSHIP AND GOVERNANCE

4.1.Evidence-Based Decision Making by Enhanced Harmonization and Alignment

A comprehensive plan was prepared and reconciled with regions and partners to avoid overlap and to promote efficient and effective implementation of the transformation plan. To ensuresuccessful implementation of the transformation plan, particularly to strengthen evidence-based decision making, the EFY 2008 annual plan was prepared withan aim to: sustain the percentage of woredas with a comprehensive and integrated plan at 100%, increase the completeness and timelines of the report to 100%, and increase the percentage of health facilities implementing health data quality indictor (LQAS) to 100%. Based on this, the performance of the EFY 2008 is presented as follows.

4.1.1. Planning

Finalization of the Health Sector Transformation Plan:

The Health Sector Transformation Plan (HSTP) was finalized with feedback from JANS bodies and the community. In addition,HSTP training was given to relevant bodies to create awareness and clear understanding at all levels during the implementationprocess. The participants were:

- High and mid-level leaders,all experts, and staffof the Ministry;
- High and mid-level leaders fromregional health bureau;
- High and mid-level leaders and main expertsfrom agencies and hospitals; and
- Main implementing professionals fromuniversities.

Moreover, the training wascascaded down to lower level health sector structures. Thereby, health sector administrators, implementers, and health extension workersfrom regional health bureaus, zonal health departments, and woreda health offices, as well as hospitals, health Centers and health posts participated in the training.

The transformation plan is printed in both English and Amharic languages.Explanation of the plan wasshared with 41 Forum members attending the Ethiopian Civil Societies Health Forum. . Awareness creation activities on health policy and the transformation plan hasalso beenshared with new graduates before deployment.Follow-up was also done in regions to prepare the Woreda Based Plan

Annual Plan Preparation

A comprehensive EFY 2008 Health Sector Woreda Based Plan wasprepared by consolidating plans received from each woreda and r4egion. The plan was discussed and agreed upon byall stakeholders. Thebudget gap for implementation was analyzed by programs and regions and disseminated to all stakeholders.

The annual plan for EFY 2009 was developed after the national indicative plan was approved. National level orientation on the planning process and the tools was given to 30 participants of regional health bureau planners. Following the training, it was cascaded to zones and woredas by RHBs. The woreda plan was conducted at the woreda level, except for emerging regions, and many WoHO experts and PHCU heads participated. This planning process entails ease of access to information and demonstrated improvement in regional ownership during the planning process. Woreda plan reconciliation and aggregation was also done at all levels.

Balanced Score Card Implementation

There was support to harmonize the prepared transformation plan to strengthen the balanced score card implementation in the sector, particularly at the regional level.Support forthe implementation of the balanced score card at federal hospitals and preparatory workin the four special support requiring regions wascompleted duringthe fiscal year. Discussion was held and a proposal was prepared to support the process of balanced score card implementation at regions requiring special support. To enhance and standardize the implementation of BSC at the federal level, needs-based capacity building was done for PFSA, St. Paul, and Gefersa hospitals. An experience-sharing visitwas conducted onbalanced score cardautomationto learn best practices on how to upgrade the score card to automated level assessment.

4.1.2. Routine Data Collection and Aggregation

Strengthening of Health Information System and Ensuring Quality

Although improvements have been made on the use of health dataduring decision making processes, more must be done to bring data use culture and practice to a required level.With this understanding, implementation of the Information Revolution plan has been started and initiatives that will bring drastic change havebegun.

Expansion of Community Health information System

- Preparatory work to implementan electronic urban community health information system has begun, including a monitoring and evaluation framework, registers, reporting formats, tally sheet, and other types of formats. Concerning the methods of data handling, the family register was selected as a means of data collection. Incorporating suggestions and comments, finalized work hasbeen done.In addition,system user requirements to inform software design and development for urban and agrarian settingswere prepared.

Printing Material Distribution for the Implementation of Health Information Systems

In the budget year, 2,914,674 Registers, 1,333,475 integrated individual folders,and 16,709 tally sheets were printed and distributed. In addition, 9,647,272 cards, 1,357 Registers and 508,110 tally sheets, which are available at Birana printing and the FMOH store,are being distributed to

regionsthat need special support. Among this 1,467,617 integrated individual folders and 157,800 Registers were sent to Ethiopian Somali Region and 1,419,091 folders and 258,275 registers were sent to Afar region.

Electronic Health Information System

The electronicHealth Information Management Systemhasa significant role in strengtheningHMISthroughensuring the quality of data andsupporting evidence based decision-makingat all levels. Cognizant of this, internal assessment of the existingHMIS systems as well as DHIS2 have been conducted. In addition,DHIS2 was piloted to evaluate suitability fora local context. Accordingly, all HMIS reporting formats and indictors were customizedin thesoftware. After software cleaning and customization work, it was piloted in four woredas and 19 health facilitiesin four regions. Prior to pilot implementation, DHIS2 training was also provided to health information technicians selected from project piloting sites.

Disease List Update (ICD Update)

The existing ICD list was revised ina workshop conducted in the presence of health professionals from selected hospitals and stakeholders. The three updated sets of disease listsare targeted to serve health centers, general hospitals, and specialized hospital. The disease lists are approved to be tested through pilot implementation. Accordingly, development of operational guidelines, and revision of registers, tally sheets, and reporting formats were conducted.

Capacity Building

TOT level HMIS training was given for health professionalsfrom Somali and Afar regions based on gapsidentified. Accordingly, the training was cascaded to the facility level. In addition, all preparatory works have been completed to conduct the training in Gambela and Benishangul-Gumuz regions.

Health System Data Quality Assessment (RDQA)

Based on the identified gap on the quality of data in Afar region,a data quality assessment was conducted. The assessment was done in two randomly selected hospitals, ten Woredas, 20 all catchment heath centers, and 16 health posts selected from each health center. Based on the checklist,the EFY 2008 first quarter data was collected and analyzed and the report has been submitted to relevant bodies.

4.1.3. Performance Monitoring and Coordination

Strengthening of Health Services Monitoring System

Quarterly, bi-annual, annual, and strategic transformation plans,a performance evaluation, and health equity reportswereprepared. The following reports are distributed to all relevant stakeholders.

- Quarterly health sector report was prepared and disseminated to all stakeholders.

- The EFY 2007 Annual Performance report was prepared in Amharic and English languages and shared with participants during an annual review meeting. Similarly, the five-yearhealth sector transformation plan report was prepared and communicated to the National Plan Commission.
- The EFY 2008 annual finance utilization report and theEFY 2009 finance utilization action plan were prepared and submitted.

Accountability Score Card

- Woreda performances on selected RMNCH and disease indicators were reviewed and feedback was given to regional health bureaus and regional state offices, on a quarterly basis. On the report, the performance of each woreda was indicated with three different colors for easy interpretation.
- To implement the community accountability score card,an appropriate system was being designed based on the results obtained from the pilot project in some woredas.

Supportive Supervision

In the nine regions and in the two city administrations, supportive supervision was conducted by a team including members from FMOH, agencies, and regional health bureaus. Assessments made duringthe supervision included the status of Health Development Armyin achieving the stated goal, health services quality and equity, health sector governance, and evidence-based decision making at all levels. Technical support on the identified gaps was provided atall levels (from kebele command post to regional health bureau) toachieve better implementation in the future.

Challenges

- Delay in implementation of eCHIS in all settings;
- Lack of integration of HMIS with pharmaceutical, regulatory, human resource, and other information systems;
- Delay in ratification of health information deflation;
- Low level of implementation of HMIS at private facility;
- Poor data quality at the lower administrative levels;
- Low level of data use for decision making; and
- Limited human resource.

Way Forward

- Implementation of information revolution flagship initiatives;
- Speed up the implementation of eCHIS in all settings;
- Promote integration and interoperability of all health information systems;
- Support information use capacity at national and regional levels; and

- Scale-up implementation of HMIS in private facilities.

4.2.Operational Research

Operational research is performed in the health sector to identify and study priority problems of public health importance and produce evidence that would help decision-makers improveservices and develop realistic health sector policies and strategies. The following operational surveillance and researche focusing on infectious and noninfectious diseases and nutrition were conducted and completed by EPHI in EFY 2008.

- Treated HIV patients case-based surveillance;
- 2015/2016 HIVDR early warning surveillance;
- Drug resistance surveillance on HIV second drug treated patients;
- XDR-TB survey;
- Laboratory based first-lineTB drug multiple resistance (MDR-TB)surveillance;
- 2015 Malaria Indicator Survey (MIS);
- Lymphatic FlariasisSentinel surveillance;
- Lymphatic Flariasisenvironmental distribution re-mapping;
- Malaria rapid diagnostic test (RDT)kits evaluation;
- Evaluation of chemical treated new long lasting insect nets (LLINs) for effectiveness against malaria mosquitoes;
- Evaluation of Bendocarp residual influence on malaria mosquitoes;
- Non-communicable diseases (NCD) national survey has been conducted;
- 2015/2016 health facilities service provision and readiness assessment (SARA); and
- National nutrition program (NNP) end-line evaluation.

4.3.Regulatory System

This strategic objective refers to improving the regulatory system to a level that is truly functional. The functional regulatory system enablesthe implementation of effective, transparent, and accountable systems that ensureadherence by all state and non-state actors to the standards set by the country's rules and regulations. The objective is to ensure safety and quality in the delivery of services, products, and practice.

The strategic initiatives to strengthen pharmaceutical supply in EFY 2008 included: (a) Improve efficiency of regulatory systemon regulating health service inputs;(b) Provide/review license for health professionals;(c)Provision of pre-import permit for medicines and medical equipment; (d) Conduct inspection on food, medicine, and medical equipment manufacturers;(e) Improve product quality assurance system of domestic food manufacturers; (f)Import authorization for products (foods, medicines, medical supplies, cosmetics); (g) Conduct surveillance and inspection on high-

risk foods and cosmetics produced domestically;(h) Licensing of health facilities as per the health institutions requirement; and (i) Banning of smoking in public areas.

The following section describes the performance of the sector in implementing strategic initiatives to improve the regulatory system in EFY 2008.

Enhancing the Control of Food Quality and Safety

Registration and licensing of foods is one of the activities toward enhancing the control of food quality and safety. Hence, 36 food supplements, two infant formulas, and two child formulas that make 41 food items were evaluated and registered, which corresponds to 63% performance. Dossiers for two special need foods, 103 food supplements, four infant formulas, and 21 child formulas were also evaluated.

Concerning licensing and inspection of food establishments andthe issuance of new licenses for food establishments that met requirements; more than 100% was accomplished by issuing 568 licenses for manufacturers, exporters, importers, and distributors. 7,864 licenses were issued for retail establishments. The reported high performance is because of increased applications and quick response.

Similarly, post-licensing inspection was conducted on 935 (77%) food manufacturers, importers, and distributors as well as 74,334 (68%) food retailers. The observed underperformance in both cases was due to shifting of priority for the pre-licensing inspection. The performance of the newly implemented internal quality system on food manufacturers, importers, and distributors was not satisfactory; execution at the federal level was 62%.

Furthermore, it was planned to conduct quality control of food. Two (50%) post marketing tests were performed out of the planned target of four; a report was completed for edible oil whereas for juices, the test is close to being finalized. Of the 240 oil samples, 179 were found to comply with the standard while 61 failed to comply. Concerning the consignment test, all planned nine targets (100%) were done by the food laboratory and conformity assessment laboratory.

Volume of import authorization; 1,565,419 tons of food and 71,369 tons of food raw materials were given import permit after checking their quality and safety.

Enhancing the Control of Health Service Inputs

Medicine registration and licensing is well established as this activity was initiated and has been functional for a number of years. By employing a new initiative, 1,500 new medicines for evaluation and registration were planed and 1,009 were performed. Moreover, it was planned to issue 925 market authorization certificates for those complying with the requirements; 285 were done. The “zero backlogs” strategy is also under implementation.

Medicine quality control includes physicochemical, microbiology, and condoms tests for premarket, post-market, and consignment purposes. In connection with premarket, the performance for condom tests was 110% while for physicochemical and microbiology it was 49.8% and 52.5%, respectively. The low performance was due to the low number of samples submitted to the lab. Although all the condom and physicochemical consignment samples submitted for the lab were done, the performance was low. The performance for the post-market test was better as it was performed on 46 types of medicines out of the planned 50. This includes; medicines for mothers and children, antimalarial, antineoplastic, and medicines for opportunistic infections. Highperformance was achieved because focus was given as a flagship and the task was supported by branch laboratories after building their capacities.

Concerning inspection and licensing of the health input establishments: eleven (23.4%) health input manufacturers and 94 (more than 100%) import and distribution licenses were issued, with all applications entertained. 575 (77%) new licenses for medicine retail outlets have been issued. GMP inspection is 42 (76.4%) for local manufacturers and 59 for foreign manufacturers. Inspection of 282 (97.6%) importers and distributors and 7,089 retail outlets was completed. Though the performance of the newly implemented internal quality system on manufacturers, importers, and distributors was not satisfactory, the execution at the federal level was 57.7%.

The value of imported medicine, medical supplies, raw materials, and lab reagents was 8.78 billion Birr, 2.36 billion Birr, 831 million Birr and 551.4 million Birr, respectively.

Concerning narcotic drugs, psychotropic substances, and precursor chemicals, performance on import permit was 73.3% and the value of imported products was 2.5 billion Birr, while proper use control was 62%.

Ensuring Health Professional Competence and Ethics

Countrywide, 17,023 new health professionals were registered and licensed to practice their respective profession, all applicants were entertained. There was good performance in renewal of professional license that amounts to 13,127 as a nation. At federal level, there is still a significant gap between those who were supposed to renew their license vis-à-vis those who renewed, because those who are practicing in the public sector are not forced to renew.

Atotal of 103 public complaints, including those which were carried forward from previous year, were received nationwide and 36 cases received adecision while the remaining cases are under investigation.

Ensuring Health Service Quality

One activity to ensurehealth service quality is the issuanceof a certificate of competence for health facilities. Issuance of certificate of competence was found to be 61.7% with sevencertificates for

specialty centers and 14 certificates for comprehensive specialized hospitals. This is because the performance is dependent up on the number of applicants. 2,446 facilities including public health facilities were licensed by regional level.

The performance of post-licensing inspection for the federal level was found to be 55.4% by inspecting 19 specialty centers and 17 comprehensive specialized hospitals. The performance was low because more attention was given to pre-licensing inspection. On the other hand, regions inspected 29,046 facilities in post licensing that makes performance >100% Health facilities auditing was conducted in 24 private and 29 public facilities (total 53). 58 health facilities were made to establish internal quality system. This better performance was attained because the work was under follow-up as one of the flagship initiatives.

Hygiene, Environmental Health, and Control of Communicable diseases

Regulatory activity at the federal level for health related facilities was good. Performance on the proper allocation and control of tobacco-free areas was 94.5%. Aggregated performance in the regions on the control of health related facilities was 57,294 facilities or 76%.

Strengthening Development and Implementation of Legal Instruments

With regard to development and revision of directives and requirements, 12 directives and requirements were developed. This includes: Good manufacturing practices directives for medicine manufacturers, regulatory requirements for ambulance service, inspection manual, regulatory requirements for ophthalmic medium clinic, regulatory requirements for mobile clinic, regulatory requirements for VCT clinics, regulatory requirements for health consultancy service, regulatory requirements for family guidance, regulatory requirements for ENT specialty center, regulatory requirements for hearing aid regulatory requirements for Fistula center, and regulatory requirements for health facility operating in an organization/institution. Revision of directives for food supplements, infant formula import, export, wholesale distributers,as well as cosmetics has been done.

Prevention and Control of Illegal Food and Medicine

It was planned to intervene in all regions and city administrations including a survey to identify hot spots. Accordingly, a 20-days assessment in 18 selected towns was conducted in the nine regions and one city administration. Based on the findings of the survey, special task force was established and operations were conducted in 21 places followed by regulatory measures. This includesnine places of Addis Ababa, six areas of Gondar, four points of Chagni, Dire Dawa, Adama, WolayitaSodo, and other areas.

Strengthening Good Governance

To support growing regions, joint inspection was conducted with regional regulators of Gambella, Ethiopian Somali, and Benshangul Gumuz in selected health facilities, food manufacturers, food distributors, and health related establishments. Joint inspection with Afar regional regulators was conducted in public health facilities and private clinics found at Semera, Asyta, and Dufti. Supportive supervision on the plan and report was conducted in the four growing regions.

Improving Community Ownership for the Regulatory Sector

The regulatory sector is performing many planned activities to attaincommunity ownership. Online and recorded messages were broadcasted through EBC, Zami, Bisrat, Sheger, and Fana Radios as well as Amhara and other regional FM Radios. Topicsincluded universal salt iodization, tobacco, bottled water, edible oil, circulation and control of illegal medicines, and health professional ethics. Consequently, 18 live discussions were made, over performance of the plan.

Strengthening the Participation and Partnership of Community and Stakeholders

Though the Health Development Army (HDA), was planned to strengthen community participation only some regions such as Tigray, Amhara, and Oromia were executed partially, corresponding to 30% performance for the year. The reason for the underperformance is that more time is needed for a preparatory phase, as it is a new endeavor that requires consensus on the plan.

Planning and performance review of the regulatory sector with the public wing was fully accomplished. Accordingly, review and discussion was conducted with regional regulatory bodies, a media forum, and public wings on the performance of EFY 2007 and the strategic plan for 2008 EFY. A joint plan was prepared with Regional Regulatory Bodies, and EFY 2008 performance was reviewed with public wings and Regional Regulatory Bodies.Awareness creation for a total of about 3.1 million people was given through mass mobilization in four sub-cities of Addis Ababa, all Ethiopian Sport Festival at Hawassa, and in collaboration with the Ministry of Youth and Sport at Afar region and Awash Sebat Kilo about illegal food and medicine trade, health services, tobacco, and NPS.

Challenges

- Weak collaboration/integration with stakeholders especially atlower level;
- Problems of handling information in more integrated and organized way, weak regulatory information system;
- Limited capacity;
- Disparity among regions on structural setup;
- Shortage of human resourcesin terms of number, capacity, and professional mix;
- Weak supportive supervision and monitoring at each level; and
- Low incentive mechanism and motivation.

Way forward

- Strengthening HDA;
- Strengthening community regulatory ownership activities;
- Applying uniform structure among regions;
- Aligned and integrated health regulatory system from top to bottom level;
- Improve motivation system at all levels;
- Strengthening the health regulatory sectordata base and information communication system usingadvanced technology;
- Building the health regulatory sector utilizing competent and ethical professionals qualified with regulatory science; and
- Strengtheningresource mobilization for health regulatory sector.

4.4.Gender Mainstreaming

Gender mainstreaming within the health sector has been implemented with the objective of promoting gender equality and the empowerment of women on the utilization of health services. To ensure efficient implementation, the Ministry of health adopted a Health Sector Gender Mainstreaming manual and this manual is used as the working document at the federal, regional and lower level structures within the health sector.

So far, promising activities have been done to enhance the capacity and level of understanding on gender mainstreaming so as to increase women's involvement and beneficiaries of health services. Being the results and experiences that has been achieved on EFY 2007, the gender mainstreaming of the health sector transformation plan was designed and the plan for EFY 2008to confirm through the participation of women. Particular emphasis was given in the transformation plan on gender based awareness rising, women's empowerment, participation and beneficence from health sector.

In this report, the women and youth affairs directorate had been embarked on several core activities that are aimed at addressing the needs of women, youth and people with disabilities. Core activities, that improved women and youth participation and benefit from health services, were identified and successfully dealt with. Activities that enhanced equitable access to health services by mainstreaming issues of women, youth and people with disability, were prioritized and given considerable attentions. Efforts were also made to improve the resource base of the directorate especially on financial resource and its effective utilization. Moreover, the directorate strengthened its adherence to the good governance process, its coordination capacity, and monitoring processes, so as to satisfy clients served directly and support regional bodies, federal agencies and hospitals to accomplish their level best. Finally, the directorate played a significant role within this report to

ensure the implementation of health policies, proclamations, frameworks and procedures pertaining to women/Gender, youth and disability, at federal and regional structures. Therefore, in EFY 2008, first year health sector transformations plan implementation activities presented in detail as follows.

Institutionalizing Issues of women's, youth and People with disability : In collaboration with public relation and communication directorate, weekly "TENACHEN" TV program and different TV Spots are interpreted and broadcasted by sign language to create accessible health services and health related information for persons with hearing impairment. In partnership with Integrate Family Health Program (IFHP) gender mainstreaming pocket manual, that enables the successful implementation of woreda transformation plan, was prepared. Sign language training need assessment was conducted at Addis Ababa, Oromya, Amhara and SNNPR regions, thus regional health bureau women's and youth affairs are willing to cascade the training but so far cascading process was materialized only in Addis Ababa. Addis Ababa health bureau provided sign language training for 130 health professionals drawn from health center and hospitals under its supervisions, in collaboration with Ethiopian National Association for the Deaf (ENAD). WYAD provided refresher sign language training for 83 health professionals from federal hospitals. Moreover, standard sign language training was delivered for 41 health professionals, security and information desk officers, of federal agencies. The directorate is working hard to make sure women's, youth and persons with disabilities are benefited from different strategies, guidelines, and manuals that have been prepared by different directorates within the ministry. Adolescent Health Strategy, national nutrition strategy, and health sector CEDAW report, were among the document reviewed. In collaboration with the health infrastructure directorate, new health service building designs were assessed and feedback were given for designs to take in to consideration the issue of women's and persons with disabilities. Support was also given to federal hospitals to include the CRC principles in their plan and implementation during the routine supportive supervision process.

Enhance Coordination and Partnership; the directorate is closely working with implementers of RIF project so as to ensure RMNCH and empowerment activities in Afar, Ethiopian Somali, pastoralist zones of Oromia, and SNNP regions are effectively implemented and pastoralist women and youth are benefited the best out of the project. Based on regional technical assistant request from SNNP, Harari, Gambella, Somali and Benishangul Gumuz health bureaus, 414 participants dawn from different zones, woredas, hospitals, women and youth affairs structures, regional members of regional parliaments, religious leaders etc attended the gender mainstreaming manual familiarization workshop facilitated by the technical assistance of the directorate. In addition, familiarization workshop was provided for 280 participants from public hospitals in Addis Ababa,

and 389 management bodies and line staffs from Amhara, Oromia and Addis Ababa regional bureaus, on standard operating procedure for the response and prevention of sexual violence in Ethiopia. Plan alignment was made between WYAD and within eleven directorates of ministry of health as well as with federal agencies, federal hospitals and regional health bureau women's and youth affairs office. Furthermore, awareness raising training was provided for federal micro and small scale enterprise agency on cervical cancer and safe motherhood in collaboration with MCH directorate. International women's day (March 8) was celebrated jointly with finance and procurement as well as public relation and communication directorates. In collaboration with legal affairs directorate awareness rising training sessions were held on strategies and policies that were effected to increase the participation and benefits of women. Ethiopian national association for the deaf, Addis Ababa women's federation, and Ethiopian Youth federation were the public wings that are working closely with the directorate.

Mobilization and Awareness Creation Activities: International youth day was commemorated by promoting the core theme of the year. Moreover, 231 attendees participated in the global anti-gender based violence campaign weeks that were celebrated with different activities in presence of the ministry's higher officials. This campaign was also commemorated at federal level within agencies, hospitals and in regional health bureaus and a total of 2155 people take part in the campaign. At this campaign voluntary blood donation was facilitated from 52 volunteers from the ministry and 13 participants from Alert Hospital. Similarly, 76 unit of blood was donated by volunteers from Addis Ababa Health bureau.

International women's day (March 8) was celebrated and model female workers and the directorate which creates enabling environment this success were acknowledged on the event. In connection with the awareness raising process, ToT on gender mainstreaming was provided for 153 participants drawn from regions women and youth affairs structures. Moreover, gender mainstreaming training was provided for about 132 medical doctors from HAYAT medical college and Arbaminch university graduates. The directorate provided budget and technical assistance for the HTP awareness rising training provided to 122 participants from Benshangul Gumuz region health bureau. Based on the technical assistance request from federal agencies and hospitals training on gender mainstreaming and related topics were provided for 202 participants. Federal agencies, hospitals and regional women and youth structures provided different awareness rising trainings on gender mainstreaming, burst cancer, cervical cancer, drug use, breast feeding, HIV/AIDS, gender and law, gender and nutrition, water sanitation and gender, corruption, good governance, and other different related topics for 976 participants.

Gender and media communication training was provided in collaboration with IFHP for 48 public relation and communication officers from regional health bureaus, federal hospitals and agencies.. As the same time, the training was provided for management of different media houses for three consecutive days. Familiarization work shop was conducted for 137 from MOH, federal agencies and hospitals to introduce policies, guidelines and manuals that enable to mainstream disability, gender and youth issues. Different activities that are conducted by the directorate were promoted to the general public using various social media outlets and the ministry's own quarterly magazine.

Follow up on health policies, proclamations, frameworks and procedures Implementations: Women's and youth affairs directorate has been striving to make sure affirmative action's stated in the policies, strategies and guidelines pertaining to women, youth and people with disabilities are put into practice. Accordingly, the directorate in collaboration with the human resource development directorate implemented affirmative action while recruiting, training and educational opportunities for 24 women from FMOH and 51 women from federal agencies and regional health bureaus.

Enhance empowerment of women in the health sector: There are a various activities that are implemented to promote women to leadership position within MOH. The key factor that promotes this initiative is to conduct strong advocacy and communication activities. As the result the participation of women in the leadership position increased within the ministry. At regional level, in order to strengthen the leadership capacity of women's training was provided for 85 leaders on leadership and decision making skills. Moreover, as vital empowerment processes for 209 female employees from MOH, federal agencies and hospitals mainly those who serve as administration and support were provided training on self-confidence, team building and the revised family law. 90 female experts also sensitized with the new family law. In addition to the trainings, educational empowerment support was provided for 84 female and 37 male employees at degree, and TEVET level ranging from full tuition fee coverage to partial sponsorship.

Strengthen Monitoring and Evaluation:

Supportive supervision was made to regional health bureaus, federal agencies and hospitals on regular basis. Accordingly, quarterly, bi-annual and annual review meeting was conducted as per the agreed plan. Joint activities were accomplished in collaboration with the policy plan directorate to enable data collection disaggregated by age and sex. Different data collection and reporting formats were developed and shared to women and youth structures at federal and regional level. Six month onsite/on job monitoring and follow up was made for all regional and city administration

women's and youth structures. In addition to this, nine (9) month plan vs report achievement evaluation was made, gap identified and directions were given on the health sector women and youth annual review meeting. Based on the evaluation result best performing regions, agencies, and hospitals women and youth affairs structures were identified and recognized. In the annual review meeting 2009 E.C joint plan on women and youth issues within the health sectors were developed and shared.

Challenges

- Lack of assigned budget to the directorate to implement different activities as per the plan;
- There was a shortage of man power in the directorate to work constantly and effectively as per the plan;
- Absence of best practice documentation; and
- Low level of commitment, ownership and support from to women and youth affairs structures at all level.

Way Forward

- Promote and strengthen frequent supportive supervision;
- Capacitate the woman and youth structures on documentation, capturing best practices and lessons learned; and
- Bridge the gaps in understanding and attitudes for women empowerment initiatives.

CHAPTER FIVE

HEALTH SYSTEM CAPACITY

This strategic theme refers to the enhancement of resources for health, which includes human and financial resources, health infrastructure, and supplies that are accessible to communities. In general, this chapter focuses on development and retention of skilled human resources for health with the right mix of professionals. It also refers to professional development to promote respectful and compassionate care. It includes health infrastructure covering the construction of new facilities, the rehabilitation and equipping of health facilities, the availability of adequate utilities (water, sanitation facilities, and power), and the development and use of basic ICT infrastructure and innovations. Furthermore, this chapter focuses on ensuring commodity security and delivery of safe, effective, and affordable essential medicines at all levels of the health system. The progress made in EFY 2008 highlighted below.

5.1. Health infrastructure Development, Rehabilitation, and Maintenance

Health infrastructure Development

This strategic objective encompasses the expansion and standardization of health and health related facilities. It involves (a) Development of standard design of health infrastructures; (b) Construction, maintenance, renovation,andrehabilitation of health facilities; (c) Equipping and furnishing of health facilities; (d) Availability of adequate utilities (water, sanitation facilities, and power installations); (e)Enhancing medical equipment management and maintenance; and (f)Developing basic ICT infrastructure, use, and innovations.

Construction, Maintenance, Renovation, and Rehabilitation of Health Facilities

5.1.1. Construction of Health Posts

The first year of the HSTP planned to maintain a linear increase in the construction of health posts. In view of that, 33 new HPs were constructed throughout the country. The cumulative number of functional health posts increased to 16,480 in EFY 2008 (Table 12).

Table 12: Cumulative number of Functional Health Posts by Region,EFY 2008

Region	Cumulative Number of HPs Functional in EFY 2008
Tigray	712
Afar	325
Amhara	3392
Oromia	6519
Somali	1096
Benishangul Gumuz	391
SNNPR	3849
Gambella	133
Harari	30
Dire Dawa	33
National	**16,480**

5.1.2. Expansion of Health Centers

The cumulative number of functional health centers increased to 3,562 in EFY 2008from that of 3547 in EFY 2007. In the year under review, a total of 165 HCs were Under Construction and Completed but not Functional.

With regards to regional distribution, Oromia, Amhara, and SNNPR accounted for 1,363 (38%), 840 (24%), and 696 (20%), respectively (Table 13). In EFY 2008, PV solar installations were made for 116 health centers and 457 HPs.

Table 13:Number of Functional andUnder Construction Health Centers by Region,EFY 2008

Regions	***Functional***	***Under Construction and completed but not Functional***
Tigray	202	3
Afar	90	6
Amhara	840	17
Oromia	1,363	48
Somali	183	20
Benishangul Gumuz	37	14
SNNPR	696	52
Gambella	32	1
Harari	8	0
Addis Ababa	96	4
Dire Dawa	15	0
National	***3562***	***165***

5.1.3. Construction, Rehabilitation, and Expansion of Hospitals

5.1.3.1. Federal Hospitals

Emmanuel General Hospital and Mental Health Research Institute

The project has been carried out in two phases: The construction of the new Emanuel General Hospital (phase one of the construction) which includes an inpatient department with 161 bed capacity, has reached 90.31% (108.47% including additional works) of physical progress and partial pre-provisional acceptance was done while finishing works were in progress.

The physical construction of the building has reached 8%, as its design and bid process was completed for the construction of the Research Institute and administration buildings with offices and housing to accommodate approximately: (i) offices for 50 administration staff; (ii) training rooms for 50 to 100 students; and (iii) 20 family guest rooms.

The physical construction of the building of St. Peter 2B+ G+1 Buildinghas reached 67%. With regards to St. Peter's Hospital workshop, fence, and guard house construction**,** 98% of the construction process has been completed and partial provisional acceptance was done.

St. Peter Hospital G+6 Apartment Building**:** The progress of construction of one block with 36 flats with two bed rooms and four flats with three bed rooms has reached 84%.

Alert Hospital G+2 Directorate Residences: The construction of the building is fully completed and provision acceptance was done.

Alert Hospital G+6 Apartment Building: More than 85% of the construction of two blocks with 36 flats with two bed rooms and four flats with three bed rooms is completed and finishing works are in progress.

Urban Typology General Hospital Standard Design: The final standard design of urban General Hospital with eight floors that can accommodate more than 450 beds is completedin every engineering disciplineand dispersed to regional health Bureaus. It was made not only in an environmentally friendly manner but also with priority consideration of disabled patients.

5.1.3.2. Regional Hospitals

As illustrated in Table 14 below, a total of 241functional hospitals were available in EFY 2008.In EFY 2007 a total number of functional hospitals were 189. On the other hand, it was reported from regions that a total of 153 hospitals has been under construction and completed but not functional.

Table 14: **Number of Functionaland Under Construction Hospitals by Region (EFY 2008)**

Regions	*Functional*	*Under Construction and completed but not Functional*
Tigray	38	9
Afar	6	1
Amhara	57	34
Oromia	65	50
Somali	9	2
Benishangul Gumuz	2	4
SNNPR	47	50
Gambella	2	2
Harari	2	0
Addis Ababa	11	0
Dire Dawa	2	1
National	***241***	***153***

Other Projects

Blood Bank Buildings: Construction of Gondar and Arba-minch regional blood bank offices had reached more than 31% and 95% performance levels, respectively. For the construction of five additional regional blood banks and six mini blood banks, the bid process has been on process.

PFSA office, warehouses, and cold rooms: From a total of 17 projects of the agency constructions, two of them (NegeleBorena and Kebridehar warehouses) each have a progress performance of 95%. On the other hand, the Addis Ababa G+1 warehouse construction reached about 56% performance level and the administration office construction progress was at 25% performance level.

Adama G+7 Anti-Malaria Center: The process of construction has been underway and the progress has reached about 40%.

Challenges

- Limited capacity of contractors and RHB contract administration;
- Dalliance in health facility construction due to shortage of professionals as well as important engineering software; and
- Poor follow-up on regional health facility projects.

Way forward

- Strengthen the capacity of contractors and/or mobilization of qualified contractors; and
- Strengthen collaboration with RHB on contract management.

5.2. Human Capital and Leadership

This strategic objective includes: (a) human resource planningand (b) human resource development and management.Human resource management focuses on recruitment, deployment of staffs, performance management, and motivation. It also includes leadership development, promoting women in leadership positions, and community capacity development.The main focuses of this strategic objective for EFY 2008 is to promote patient-centered, respectful, and compassionate care by all professionals, and to increase the intake of physicians and integrated emergency surgery and obstetrics officers

In EFY 2008 it was planned to (a) Develop national minimum competency for public health training; (b) Enroll 650 new medical students; (c)Train forensic medicine, gyn/obs, general surgery, and family medicine specialists; (d)Support the provision of educational materials and instructors to medical schools; (e)Prepare family medicine curriculum;(f) Enroll 318 gyn/obs and general surgery residents;(g) Enroll 500 trainees in the accelerated midwifery program and 1,000 trainees in the regular program;(h)Provide mentorship support to 200 midwives;(i) Develop curriculum for the training of urban health extension professionals;(j) Enroll 280 students in emergency and ambulance service training;(k) Identify and document health professionals' public health competencies;(l) Establish licensing examination system at five assessment centers;(m) Implement licensing examination for firstdegree medical, health officers program, nursing, medical laboratory, radiography, anesthesia and midwifery graduates and standardize and institutionalize service trainings. The implementation of each activity is presented in detailbelow.

5.2.1. Training

In EFY 2008, 3,256 new students were enrolled in 29 medical schools. Annual enrollment in medical schools has increased to 16,389 (Table15) in EFY 2008 from its baseline level of 14,940 in EFY 2007.

In the year under review a total of 1,275 physicians were deployed to the health sector, making the total number of physicians deployed 6,570.In EFY 2008, physician population ratio increased to one physician per 14,045 population compared to EFY 2007 (1:17,160).According to the WHO standard for developing countries, the physician to population ratio is 1 physician to 10,000 populations.

Table 15: Number of Medical Students by Year of Study and University (EFY 2008)

University	1st year	2nd year	3rd year	4th year	5th year	6th year	Total
Addis Ababa	357	322	299	332	272	229	1811

Arba Minch	144	108	174	104	88	55	673
Arsi	171	98	134	118	76	85	682
Bahirdar	215	155	125	222	146	73	936
Defense					15	22	37
Gondar	289	366	393	224	236	165	1673
Haromaya	164	249	305	200	192	141	1251
Hawassa	217	295	369	283	157	128	1449
Jimma	371	310	361	310	286	141	1779
Mekelle	222	242	289	195	210	157	1315
St.Paul	148	128	169	111	93	65	714
Adigrat	133	93	92	34	0	0	352
Wachamo	94	58	57	39	0	0	248
Debre Tabor	62	57	46	0	0	0	165
Axum	58	49	23	61	39		230
Wollo	50	40	41	71	53		255
Debre Markos	49	67	41	73	50		280
Debre Birhan	37	48	50	62	46		243
Ambo	23	46	29	78	70		246
Wollega	24	14	41	60	60		199
Wolayita sodo	45	52	35	95	65		292
Medawolabu	22	28	17	62	45		174
Dilla	22	30	25	57	46		180
Dire Dawa	24	24	39	56	45		188
Adama Hospital	55	50	45	64	28		242
Yekatit 12 Hospital	64	72	52	76	56		320
Yirgalem Hospital	34	52	46	56	50		238
Wolkite	70	0	0	0	0	0	70
Jigjiga	92	55	0	0	0	0	147
Total	**3,256**	**3,108**	**3,297**	**3,043**	**2,424**	**1,261**	**16,389**

To strengthen teaching capacity, buses and mini buses, desktop computers, and video conference equipment (plasma screens) have been distributed to Ambo, Dilla, Medawolabu, and Wollega universities.As a move to improve the quality of training programs and to ease access to trainings,

all medical education schools have created direct link to woreda net. Training was given to staff from quality assurance units of 13 newly established medical schools as a move to strengthen HSDC centers and improve the quality of training programs. In addition, training curriculum was developed by joint technical teams established from all newly established medical schools.

Integrated Emergency Surgery and Obstetrics Training

A three year master's program for health officers that has been started in five universities aimed at improving the provision of emergency obstetric care and surgical services at primary hospital level has been in progress in the year under review. In EFY 2008, 67health professionals completed the trainingprogram and deployed, and 112 health professionals were enrolled in eleven existing and new training institutions. As part of the capacity building, supportive supervision was conducted in ten universities and 28 hospitals. Assessment was conducted to identify knowledge gaps, and training was provided for graduates accordingly.Educational materials, teaching aids, and medical equipment were being procured for medical schools.

Anesthesia Training

Level "V" Anesthesia Training

FMOH initiated post basic anesthesia training program in EFY 2006 to increase access to the services of nurse anesthetist, a critical role in the provision of emergency surgery at primary hospitals and health centers..At the end of EFY 2008, a total of 381 level V nurse anesthetists have been trained and deployed.

Post Basic (BSC) Anesthesia Training

In EFY 2008, 96 anesthesia trainees were graduated and deployed in the BSC program, making the total number of BSC graduates 247. In the same year, 447 professionals were enrolled in BSC programs in 18 existing and new training institutions, making a total of 1,010professionalsunder training in BSC (Table 16).

Table 16: Anesthesia Training in BSC Program by University and Year of Study (EFY 2008)

S/No	University/College	Numberof students on training				Number of students graduated in EFY 2008
		Year I	Year II	Year III	Total	
1	Addis Ababa	30	50	30	110	22
2	Gondar	65	33	30	128	24
3	Jimma	31	28	30	89	18
4	Dilla	32	15	15	62	15

5	Wolayita Sodo	16	12	16	44	17 (sponsored by SNNPR RHB)
6	Mekelle	25 +12(PB)	41	25	103	
7	Debre Tabor	20	20	15	55	
8	Dire Dawa	20	32	31	83	
9	Hawassa	20	20	21	61	
10	Axum	22	20	15	57	
11	Arba Minch	25	22		47	
12	Menilik II HSC		30		30	
13	Arsi	22	12		34	
14	Debre Birhan	15			15	
15	Wachamo	30			30	
16	Wollo	25			25	
17	Ambo	12			12	
18	HarerHSC	25			25	
	Total	447	335	228	1010	96

Health Extension Workers

A critical component of the program is enhancing the knowledge and skills of health extension workers to deliver quality health service to the community by providing in-service training and career development education.The aim of HEW upgrading program is to improve the quality of health extension services at community and household level.

In 2008, 4,642 level III HEWs were enrolled to be upgraded to level IV.Level III replacement training has been continuing in line with the upgrading program in all regions. Accordingly, a total of 5,005 HEWs enrolled in EFY 2008. To support the education process, teaching modules were distributed to training centers. 26 newly recruited HEW trainers from training centers of four regions(Afar, Somali,Benishangul Gumuz, and Gambella) were trained on teaching skill, occupational standard, and assessment methods in the same period. Furthermore, a total of ETB 44,274,384 transferred to region to support the training programs.

Table 17: Regional Distribution of HEWs Enrolled for the Replacement and Upgrading Program (EFY 2008)

Region	No. of TrainingCenters	No of Level III replacement HEWs Enrolled in EFY 2007	No oflevel IV upgrading HEWs Enrolled in EFY 2008

Oromia	4	1,500	1,504
Amhara	5	1,055	1,000
SNNPR	4	1,600	1,200
Tigray	2	0	278
Somalia	2	400	400
Harari +Dire Dawa	1	0	72
Gambella	1	0	0
Benishangul Gumuz	1	150	100
Afar	1	300	0
Addis Ababa	1	0	88
Total	**22**	**5,005**	**4,642**

Emergency Medical Technicians / Paramedics Training

FMOH initiated the pre-service Emergency Medical Technicians /Paramedic Training program with the aim of improving pre-hospital emergency care in managing all emergencies. In EFY 2008, 265 students were enrolled in six training institutions. The performance has reached 94.6% of the planned target of 280 set for the year.

Health Information Technicians Training

The training program essentially focuses on addressing the critical shortage of skilled human resources in data recording, analysis, and reporting as well as in use of information for evidence-based decision makingboth at the point of data collection and also at the various levels of the national health care system. In EFY 2008, a total of 1,356 HIT students were enrolled for the training program.

Table 18: **Training Program of Health Information Technicians by Region (EFY 2008)**

Region	Number of Health Science College/ TVET	Student Enrolled in EFY 2008
Tigray	2	0
Afar	1	80
Amhara	5	260
Oromia	4	559
Somali	1	89
Benishangul Gumuz	1	33
SNNPR	4	160

Gambella		
Harari	1	75 (Harari, DD,Gambela)
Addis Ababa	2	100
Dire Dawa		
Total	**19**	**1,356**

Biomedical Technician Training

The biomedical technician level 4 training program was started in collaboration with Debre Markos University and Human Bridge College in EFY 2007 by enrolling 250 students (200 in Debre Markos and 50 in AA Tegbare EID). In EFY 2008, an additional 180 new students were enrolled (155 in Debre Markos and 25 in AA Tegbare EID), making the total number of students in training 430 in EFY 2008(Table 19).

Table 19: Enrolment of Biomedical Technician Level IV (EFY 2008)

Region/ Institution	2007Enrollemnt		2008Enrollment		
	Enrolled in Debre Markos	Enrolled in AA TegbareEid	Debre Markos	AA TegbareEid	Total
Tigray	44		18		62
Afar	10		7		17
Amhara	32		32		64
Oromia	46		36		82
Somali	5		17		22
Benishangul Gumuz	4		6		10
Gambella	5		6		11
SNNPR	31		25		56
Harari	1		1		2
Addis Ababa	6	50	2	25	84
Dire Dawa	4		0		4
Federal Hospitals (Alert, St.Paul, St. Peter, Amanuel)	4		2		6

Gondar University Hospital	3		3		6
Federal Prison Police	3		0		3
Human Bridge College	2		0		2
Grand total	**200**	**50**	**155**	**25**	**430**

Nursing Specialty Initiatives

The new nursing specialty training initiative focuses on Nursing Specialty Training with the specialty of neonatal nursing, emergency and critical care, operating theatre, pediatrics, and surgical nursing. The –training approach aimed at responding to the current human resources gap and current and future demand by the country.

Nursing Specialty Enrolment

Training of 441 trainees who were enrolled in EFY 2007 in emergency clinical care, neonatal care and operating is in progress. In EFY 2008, a total of 974 new trainees were enrolled in 19 training centers.Surgical and pediatric nursing specialty trainings were also included during the year .

In EFY 2007 and EFY 2008, a total of 1,415 nursing specialty students were enrolled in 19 training centers (Table 20).

Table 20: Total Enrolment of Nursing Specialty (EFY 2007 and 2008)

S/no	Region	Enrolled in EFY (2007				Enrolled in EFY 2008					Total
			ECCN	N,N	OTN	ECCN	N,N	OTN	Surg	Ped	
1	Tigray	Mekele	11	12	18	15	15	15	20	15	121
		Axsum									0
2	Amhara	Baherdar				20			30	30	80
		Wollo	18	16	15	15	15	15	20	20	134
		Gondar	17	12	15	15	15	15	15	15	119
		D/Tabor		21			15			20	56
		D/Birhan							15	15	30
3	SNNRP	Dilla					10				10

		Hawassa	11			15			15		41
		Wollayta Sodo	22	22		10	10	10			74
3	Addis Ababa	St Paul	25	15	31	27	21	29	22	25	195
		AAU				8	7		15	20	50
		Menelek II	20	20	20	20	20	20	20	20	160
4	Oromiya	Arsi		10	7		10	10			37
		Ambo				15				25	40
		Haromya	13	10		15	15			20	73
		Wollega				15	15	15	15	15	75
		Jimma		40	20						60
5	Harar	Harar H/s/c				20				25	45
6	Somali	Jigjiga					15				15
	Total		**137**	**178**	**126**	**210**	**183**	**129**	**187**	**265**	**1415**

To strengthen the teaching and learning process and ensure success, various supports were given to universities and health science colleges. Practical training materials were distributed to 17 universities and three health science colleges, and 14 trucks were distributed for Addis Ababa and Gondar universities and ArbaminchHealth Science College. To further enhance teaching, 17 instructors were trained on basic life support/advanced life support skills. Based on the gap identified through supportive supervision at training institutions in nursing specialty training programs, 40 teachers were hired from India. Among them, 32 were already deployed to training institutions, the remaining eight will soon arrive and start the teaching program.

Field Epidemiology Training

The Ethiopia Field Epidemiology Training Program (EFETP) is a comprehensive two-year competency-based post-graduate training and service program designed to build sustainable public health expertise and capacity. The program was inaugurated in February 2009.

With the goal of deploying one epidemiologist to 200,000 population in EFY 2007, FMOH expanded the MPH-level FETP program to seven additional universities. In EFY 2008, 199 trainees were enrolled and started training programs. As part of the capacity building for training institutions, 40 pickups were distributed, budget support was given to eight universities and 38 field based training centres, and 100 trainers from universities and regional health bureaus received skill

enhancement trainings. In the same year, the national field epidemiology training program was jointly evaluated by national and international experts.

Table 21: Number of Field Epidemiology Trainees in MPH Program by University and Year of Study (EFY 2008)

University/College	Number of Residents on training			No ofResidents Graduated						
	Year I	Year II	Total	1st batch	2nd batch	3rd batch	4th batch	5th batch	6th batch (EFY 2008)	Total
Mekelle	10		10							
Jimma	11		11							
Hawassa	70		70							
Haromaya	10	10	20							
Gondar	10	18	28							
St. Paul's HMMC	26	42	68							
Addis Ababa	17	0	17	13	21	16	15	16	17	98
Bahir Dar	45		45							
Total	199	70	270	13	21	16	15	16	17	98

Midwifery Training program

To provide prompt response to problems arising during pregnancy and child birth, and to reduce maternal and neonatal mortality, the FMOH accelerated midwifery training program including a plan to staff each HC with two midwives.

To strengthen the teaching and learning process and ensure success, various supports were given to training institutions. Demonstration materials were distributed to 13 universities, six teaching modules were revised and printed. To fill the skill gap of instructors, 50 instructors were given skill enhancement trainings.

In EFY 2008, it was planned to train 1,400 midwives in regular and in service/BSC program and 200 trainees in accelerated midwifery training in level IV, in 50 training institutions. Accordingly 1,736 trainees (124% above the planned target) were enrolled in regular and in service/ BSC

program and 200 (100% of planned target) were enrolled in accelerated midwifery training program. In EFY 2008, 789 midwives from the diploma program were graduated. (Table 22)

Table 22: Midwife Degree Graduates by Universities,EFY 2008

Sno.	University	Total Number of graduates
1	Addis Ababa	46
2	Ambo	34
3	Jimma	38
4	Arsii	47
5	Jigjiga	33
6	Wachemo	29
7	MizanTepi	40
8	Wollega	49
9	Hawassa	37
10	Axum	50
11	Arba Minch	32
12	Adigrat	26
13	Debre Birhan	40
14	Gondar	106
15	Debremarkos	47
16	Horomaya	38
21	Mekelle	19
22	Wollo	52
23	Semera	26
	Total	789

5.2.2. In-service Training

In-service Training Standardization and Institutionalization

FMOH has been working to provide need-based, standardized, and institutionalized In-Service Trainings (IST) to ensure sustainability and ownership of health program trainings as part of the human capital developmentin the health sector. Standardizing in-service training ensures the quality of the trainings; institutionalizing them ensures the sustainability in the country by linking training to the local facility. In line with this, the following key achievements were carried out in EFY 2008.

- Based on the new IST directive and implementation guideline, the standardization and institutionalization of IST has been strengthened.
- National IST database developed and hosted on the FMOH website. Trainings on IST database have been given for 78 IST providersin which they started to fill training data using the data base.
- Standard IST information form developed for trainer, trainee, and events to capture the training data.
- Capacity building trainings on IST program management for regional HR staffand IST management on clinical facilitation and instructional design skill has been provided for IST centers coordinator.
- TwentyIST packages were reviewed as per the IST courses standardization checklist of the FMOH and five training materials, namely: IMNCI, essential care for every baby,obstetric fistula and pelvic organ prolapse training resource, integrated emergency medicine, and STI; all approved in 2008.
- The partnership between regional health bureaus and IST centers has improved and RHBs have started to transfer funds for IST courses by the respective IST centers.
- Most RHBsare able to conduct most of the CDC funded trainings in IST centers.
- Fifteen additional IST centers have been selected and assessed based on the region demand and the total IST center number increased to 50.
- All IST centers have organized and conducted in-service training courses for 14,336 health professionals in the fiscal year.

5.2.3. National Licensing Examination

The goal of the National Licensing Examination is to protect the public through standardized assessment of all health professionals irrespective of where they are trained. It serves as a powerful quality assurance tool by providing structured and informative feedback on curricula. It ensures that only competent health care professionals are granted a license to practice in the health sector. It was launched in EFY 2007 and started with four major health care cadres, namely; anesthesia, public health, midwifery, and medicine. This year, for the first time, the exam has been administered for nursing graduates. So far, the exam has reached the above mentioned five professions with a plan to include two more professions (pharmacy and laboratory) and skill assessment for selected cadres in the 2009 fiscal year. In EFY 2008, a total of 8,784 graduates from five cadres have taken the National Licensing Examination both from public and private institutions (Table 23).

Table 23: Number of Graduates who sat for Licensure Examination in EFY 2008

S.N	Profession	Number of examinees	
		Public institutions	Private institutions
1.	Anesthesia	212	**
2.	Midwifery	1878	77
3.	Public Health Officer	3115	1055
4.	Nursing	1134	***
5.	Medicine	1237	76
Total		***7576***	***1208***

** Anesthesia program not allowed in PRIVATE institutions.

***Nursing Private took the exam in August (EFY 2009)

Specialty Initiatives in Hospital-Based Surgery and Obstetrics and Gynecology (OBGY) Training

Based on the HRH development of the country, it was planned to use the underutilized resources of hospitals and community demand especially for interventional services to pave the foundation for clinical postgraduate training. The objective is to scale up and transform this low rate of specialist physicians to the regional and district hospitals in the country for residency training in surgery and OBGY. In EFY 2008, 113 physicians were enrolled in both the surgery and OBGY training program (61 in surgery and 52 in OBGY). The total number of trainees in both fields increased to 224.

Table 24: Enrolment of Specialty Programs (EFY 2008)

Institutions	Surgery				GYN/OBS			Total
	1st year	2nd year	3rd year	4th year	1st year	2nd year	3rd year	
Adama Hospital Medical College	9	4	-	-	9	6	-	28
St. Paul MMC	35	9	7		33	15	13	112
Wollo University	8	9	7	-	6	5	-	28
Bahir Dar University	9	14		5	4	13	4	56
Total	61	36	14	5	52	39	17	**224**

5.2.4. Deployment

The FMOH has been engaged in establishing a human resources database to carry out equitable deployment of health manpower, especially those that are in short supply. Accordingly, 1,275, general practitioners, 1,128 health officers, 72 anesthetists, 67 IESOs, 1,029 BSC nurses, and 734 midwives and other health professionals have been deployed during EFY 2008 (Table 25).

To ensure the quality of training on medicine, pharmacy, midwifery, nursing, and anesthesia, implementation guideline and health sector standard policy documents were developed and some exercises have been started.

Table 25: Number of Health Personnel Deployed by Occupation (EFY 2008)

Occupation	Number of Health Professionals Deployed
General Practitioner	1275
Health Officers	1128
Optometrists	27
Anesthetists	72
Biomedical Engineering	50
IESOs	67
BSC Nurse	1029
Midwives	734
Pharmacy	303
Radiology Technology	43
Psychiatry	78
Total	**4,806**

Challenges

- Low utilization rate of IST centers;
- Lack of attention for IST institutionalization andstandardizationof IST materials;
- Poor quality of education;
- Irregular implementation of health science education development center;
- Incomplete HRH data anddata driven decision making capacity, evidence based planning;
- Weak plan alignmentat regionaland woreda level;
- Mismatch between fast HR development versus infrastructure expansion (artificial saturations);
- “Brain drain” overseas flight and internal mobility;
- Poor motivation and retention strategy; and
- Organizational and structural problems.

Way forward

- Improve utilization of the local IST centers;

- Standardize all IST materials to be accredited CPD activity;
- Strengthen quality assurance mechanism for higher education training centers;
- Focus on roll-out and strengthening of HRIS at regional, zonal, and woreda level;
- Strengthen coordination and curriculum development;
- Focus on critical shortage and scale-up training;
- Establish and strengthen skill lab/ simulation center;
- Twinning of training institutions
- Improve quality of health professional's education by implementing program level accreditation and competency-based pre-licensure system for all health workers;
- Movement towards compassionate, respectful, and caring health professionals;
- Work on health worker retention and motivation packages; and
- Resolve the existing organizational/structural problem.

5.3. Pharmaceutical Supply and Services

This strategic objective entails: (a) Ensured access to quality assured, safe, effective, and affordable essential medicines (b) Significant reduction in pharmaceutical wastage; (c) Improved rational drug use;and (d) Strong pharmaceutical supply chain supported by an effective logistic management system. The expected outcome is ensuring adequate availability of the right pharmaceuticals at the right place and at the right time in the right condition, being also properly used by clients.

The strategic initiatives to strengthen pharmaceutical supply in EFY 2008 included: Strengthening forecasting and quantification of pharmaceuticals, procurement and distribution of essential pharmaceuticals and health program commodities, strengthen the production capacity of local pharmaceuticals and medical supplies manufacturers, strengthen and enhance systems for advanced pharmaceuticals and medical supplies and warehouse management system, promote rational drug use, build capacity and good governance, implement integrated pharmaceuticals fund and supply management information system; and strengthen monitoring and evaluation. The performance of the planned activities in EFY 2008 is described as follows.

Forecasting, Quantification, and Essential Drugs Availability

The effective procurement and distribution of pharmaceuticals and medical supplies plays a key role in the proper functioning of health systems. Timely forecasting and quantification is a cornerstone for effective and timely procurement and distribution.

In EFY 2008, a list of vital and essential drugs and medical supplies was prepared and distributed to health facilities to facilitate pharmaceutical and medical supply forecast for EFY 2009. Stock status of identified vital and essential pharmaceuticals was followed closely, and stock status reports were prepared regularly and used for distribution purposes.

In EFY 2008, the national vital and essential pharmaceuticals stock status on average reached 86%. The stock difference of essential drugs between the center and branch warehouses has been lowered to 4.1%, below the planned target of 5%.

A of previously identified 350 essential pharmaceuticals was revised to accommodate an additional list of drugs included in the national CBHI scheme. Accordingly,the national vital and essential drug list increased to 713.

To facilitate timely forecasting and quantification, procurement, distribution, and stock management, a vital and essential stock status monitoring template was developed and implemented.

In EFY 2008, 84% of pharmaceuticals and medical supplies were identified for CBHI scheme. The stock status of drugs identified for CBHI scheme was followed up closely on a weekly basis.

To further enhance and strengthen forecasting, quantification, procurement, distribution, stock management, and rational drug use, a technical working group was established and started working at a central level.

Procurement and Distribution of Pharmaceuticals and Medical Supplies

In EFY 2008, it was planned to procure ETB 8.87 billion worth of pharmaceuticals and medical supplies. Out of the planned target, the agency procured a total amount of ETB 6.4 billion worth of pharmaceuticals and medical supplies (ETB 2.4 billion revolving drug fund and ETB 4.0 billion health program), 72% of the planned procurementin the year. In addition, the agency has received pharmaceuticals and medical supplies worth ETB 7.6 billion procured by development partners. Overall, the agency has availed pharmaceuticals and medical supplies worth a total amount of ETB 14.04 billion.

With regard to pharmaceuticals and medical supplies distribution, in EFY 2008, pharmaceuticals and medical supplies worth a total amount of ETB 18.87 billion(2.4 billion revolving drug fund and 16.4 billion health program) has been distributed to health facilities (123% of the planned target of ETB 15.31 billion (4.26 billion revolving drug fund and 11.05 billion health program).

In EFY 2008, direct deliveries of pharmaceuticals and medical supplies were done every two months to the following government health facilities: 292 hospitals, 1,473 health centers, 644 woreda health offices, and 49 zone health offices countrywide, following the predetermined delivery schedule in an integrated manner.

Strengthen the Production Capacity of Local Pharmaceuticals and Medical Supplies Manufacturers

This calls for improving and strengthening the availability of the pharmaceuticals and medical supplies system by supporting and strengthening local manufacturers engaged in the sector among priority areas. It is believed that these priority areas contribute to socioeconomic development in Ethiopia and for which strategic direction has been laid down and is being implemented.

In EFY 2008, it was planned to procure ETB 1,015,750,714.42 worth of pharmaceuticals and medical supplies from local pharmaceuticals and medical supplies manufacturers, and a contract agreement was signed. Out of this total amount, the local manufacturers were able to produce and supply ETB 779,669,010.79 worth of pharmaceuticals and medical supplies, which is 77% of the planned target.

Strengthen and Enhance Systems for Advanced Pharmaceuticals and Medical Supplies and Warehouse Management System

Inventory of pharmaceuticals and medical supplies was conducted at the end of EFY 2007, to have an estimated cost on stock level at hand for 2008 and to further strengthen and enhance stock management. Distribution of malaria pharmaceuticals and medical supplies was done in an integrated manner with other pharmaceuticals and medical supplies through an integrated pharmaceuticals logistics system. A task force was established that will assess the current situation and come up with workable solutions to minimize the wastage rate with a focus on pharmaceuticals and medical supplies with short life spans. In the year under review, efforts were made to minimize wastage rate and enhance proper utilization of pharmaceuticals and medical supplies by redistributing pharmaceuticals and medical supplies with the highest stock level and slow moving items based on the reports received from branches. Accordingly,transfer process has been initiated andutilizedETB 21.8 million worth of pharmaceuticals and medical supplies.

Promote Rational Drug Use

To promote the rational use of drugs, various activities including advocacy, training, and public education on rational drug use (including drug storage, handling, use, prescribing, adverse effects) was conducted using print media (published and distributed bulletins such as "Zena Pharmacy Service" 3rd Edition and brochures with short messages). In addition, "Zena Pharmacy Service" 4th Edition was prepared for printing.

In EFY 2008, to strengthen drug and therapeutic committees at health facility level, a detail service implementation guideline/operating procedure was prepared and 3,000 copies were printed and distributed.

Supportive supervision was conducted jointly with development partners on300 health facilities mainly focusing on supply of pharmaceuticals and medical supplies for maternal and child health

and 922 health facilities (423 hospitals and health centers, 117 Woreda Health Offices, 370 health posts, and 12 PFSA branches) focusing on supply of pharmaceuticals and medical supplies for child health services, specifically on diarrhea and pneumonia. Similarly, an assessment was conducted focusing on handling and utilization of vital pharmaceuticals and medical supplies for pediatrics.

In line with the plan to further expand and strengthen clinical pharmacy service, the national assessment was conducted on the implementation status of clinical pharmacy service in 43 selected hospitals.

5.4. Health Information Technology

FMOH has prioritized the introduction and scale up of new innovations and technologies in the health sector with the aim of transforming the data collection, management, and data use processes to support evidence-based decision making as well as to improve the quality and efficiency of health service delivery. Digitization of information management in the health system is one of the two pillars of the Information Revolution. In EFY 2008, it was planned to start electronic medical record systems in ten hospitals, eHMIS in 1,001 health facilities, mobile health in 820 selected woredas, tele-education in 13 newly opened universities, tele-radiology in 53 hospitals, and tele-dermatology in 52 health facilities. The implementation status of the above initiatives is summarized below.

5.4.1. Electronic Health Management Information System

Implementation of HMIS was one of the flagship activities in EFY 2008. Internal and external evaluations of the two systems developed and implemented by partners (Tulane and JSI) as well as the widely-used international platform (DHIS2) were conducted based on a checklist developed by the FMOH. Accordingly, the following activities were accomplished in the budget year.

- Based on the needs of FMOH, data collection tools and reporting formats are identified on DHIS2.
- Completed DHIS2 validation and customization based on national reporting schedule.
- DHIS2 installed on FMOH server and it is accessible via internet.
- Completed piloting at the FMOH and selected sites. Test reports prepared and submitted.
- Training provided on DHIS2 for more than 60 participants selected from three regions and one city administration, 33 hospitals and health centers, and four woredas and zones.
- User acceptance testing completed and report submitted to higher officials for approval of next steps.
- Evaluation of the pilot implementation conducted.

- Detailed roll out plan and budget prepared for implementation in Addis Ababa and other regions.

5.4.2. Mobile Health (mHealth)

FMOH has planned to improve the usage of mobile health data in all woredas. Accordingly, capacity has been built at all levels in the health system on usage and management of the interactive voice response (IVR) system. Continuous discussions have also been conducted with regional health bureaus to identify challenges that hamper the implementation and use of the IVR at all woredas. Additional network lines have been subscribed and the required hardware for the expansion project has been acquired. Development of the mHealth dashboard is underway and all the required inputs including hiring programmers and procurement of computers and servers have been completed.

Table 26: IVR Implementation Status by Region (EFY 2008)

Region	IVR Implementation percentage
Tigray	99
Afar	10
Amhara	94
Oromia	20
Somali	-
BenishangulGumuz	-
SNNPR	10
Gambela	-
Harari	100
Addis Ababa	-
Dire Dawa	-

5.4.3. Tele-education

FMOH has provided technical and material support to strengthen and expand tele-education at medical schools in all regions. FMOH has procured and distributed 20,000 tablets to medical students to enable access to electronic course content, textbooks, and other health and health-related references. A digital library system has been developed to organize and provide students easy access to electronic books and journals collected by FMOH. In addition, ten universities have received support to establish infrastructure and connectivity to delivery biomedical science courses using videoconference links. An additional two universities have started delivering selected clinical courses using tele-education.

5.4.4. Tele-medicine

Tele-radiology and tele-dermatology services strengthened at 42 regional hospitals and the services have been started in an additional seven hospitals. A total of 388 tele-consultation services have been provided. A payment scheme for tele-consultation services and a National Tele-medicine Image Center for establishing documents has been prepared.

5.4.5. Electronic Medical Records (EMR)

Full EMR system is implemented at Ghandi Memorial and Tirunesh Beijing Hospitals in the 2008 EC. The required hardware to implement and administer the system was purchased and the network infrastructure was expanded into new buildings. A total of 235 clinical and administrative staff from the two hospitals weretrained on how to use the EMR system.

5.4.6. Other activities

- eSPA+ web application has been installed in a local server and technical support provided for different directorates to use the SPA+ data.
- Infrastructure assessment conducted at six federal agencies under FMOH to expand IFMIS to the agencies.
- User and performance evaluation of the newly developed Electronic Human Resource Information System (eHRIS) conducted.
- Master facility registry (MFR) software developed and the public portal design is underway.
- A data dictionary and terminology management service developed to serve as a gold standard for designing and revising data collection tools, understanding and comparing disparate data sets, and aligning data reporting to international standards.

Challenges

- Shortage of skilled health information technology human resources; and
- Problems of efficiency in planning and implementation of heath information systems.

Way forward

- Connect all health centers, hospitals, and health offices to a government-supported multiprotocol label switching (MPLS) virtual private network (VPN);
- Development, pilot, and rollout of eCHIS in Addis Ababa, Harar, and Dire Dawa;
- Transitioning to DHIS2 as a national HMIS platform;
- Rollout of eHRIS;and
- Build capacity on systems administration, health information systems design and development, and IT project management.

5.5. Resource Mobilization and Utilization

In EFY 2008, several activitieswere planned and implemented accordingly, comprised of: Mobilizing resources from different partners; implementing innovative health financing strategies; strengthening the health care financing programs; strengthening health partnership and coordination;establishing health economics and financial analysis case team; and,institutionalizing and conducting the sixth round NHA study.

The following section addresses major outputs and achievements registered during the fiscal year.

5.5.1. Health Care Financing

Health services in Ethiopia are largely financed through financial resources secured from (i) the Federal and Regional governments' budget, (ii) grants and loans from bilateral and multilateral donors, NGOs, and also from the private sectors. Even though the flow of financial resources required for the health sector has been improving over the years, the prevailing gap still remains as a major challenge.

Therefore, in EFY 2008, several tasks were carried out, which mainly focus on:Mobilizing and ensuring the proper allocation; distribution and utilization of resources; proactively mobilizing additional resources from domestic and international sources; and strengthening partnership with different stakeholders.

Accordingly, to estimate the flow of partner resources and to ensure its proper allocation and utilization, necessary resource mapping activities were performed.Several innovative health financing sources (including using SIN TAX from alcohol and tobacco sales and tourism levy) have been identified and necessary concept notes were designed and submitted to MOFEC and other relevant institutions.

Considering the potential contribution of domestic resources, several business organizations (hotel owners, construction companies, banks, and other local philanthropists) were communicated and have reflected their willingness to contribute financial, material, and human resources to make eleven public hospitals clean and safe in the fiscal year.

On the other hand, public health facilities across the country are heavily engaged in implementing the health care financing reform program components including:(i) Establishment of health facility governing boards; (ii) Revenue retention and utilization by health facilities for quality improvement; (iii) Implementation of fee waiver system for enhanced equity; (iv) Establishment of private wings; and (v) Outsourcing of non-clinical services for better efficiency.

As several field level assessmentsclearly reveal, the reform program is not onlyvalued for its substantial contribution in augmenting the financial resource base of the health facilities but also for its strategic importance in realizing the transformation agenda ofensuring the equity and quality of

the health services.Cognizant of this fact, in the fiscal year, several activities were carried out accordingly.

5.5.1.1. Revenue Retention for Quality Improvement

As it is documented in the health care financing strategy, revenue retention is an addition to the budget allocated from treasury, and it is only used for quality improvement activities. In EFY 2008, a total number of 3,417 health facilities (225 hospitals and 3,192 HCs) (Table xx) have started retaining and utilizing their internal revenue.

Table 27: Number of Health Facilities Retaining and Utilizing, EFY 2008

	Number of Health Facilities Retaining and utilizing		
	Number of Hospitals	**Number of Health Centers**	**Total Number of Health Facilities**
Tigray	36	215	251
Afar	6	28	34
Amhara	54	799	853
Oromia	58	1,300	1,358
Somali	4	0	4
B-Gumuz	2	36	38
SNNP	44	694	738
Gambella	1	9	10
Harari	1	8	9
Addis Ababa	6	88	94
Dire Dawa	2	15	17
Federal	11		11
Total	**225**	**3,192**	**3,417**

In addition, as theassessment conductedacross all regions reveals , most of the health facilitiesutilized the retained revenues to: (i) Purchase drugs; (ii) Improve laboratory services (i.e. purchase of microscopes, hematology complete blood count machines, centrifuges, hematology diagnostic products, chemicals and reagents, etc.); (iii) Improve medical equipment (i.e. purchase ofDoppler 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, and 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.).

5.5.1.2. Fee Waiver System for Enhanced Equity of Access to Health Services

A fee waiver scheme is being implemented as a mechanism to ensure the equity of health services to those segments of the society who are not able to pay for their health care needs. Citizens who cannot afford to pay for their medical expenses are entitled to the fee waiver scheme, and the authority providing the waiver certificate shall cover costs incurred for the service

provided.Accordingly, in EFY 2008, a totalof budget of ETB 62,363,564.00was allocated for fee waiver beneficiaries and out of the identified beneficiaries, 1,508,587 received the health services.

Table 28: Fee Waiver (Screened and Served Beneficiaries, Budget Allocated), EFY 2008

	Fee Waiver System	
	Budget allocated for Fee Waiver service	**Number of served beneficiaries**
Tigray	1,276,561.00	70,080
Afar	100,000.00	180
Amhara	4,324,825.00	589,515
Oromia	41,902,515.00	559,328
Somali	-	-
B-Gumuz	538,000.00	-
SNNP	7,257,844.00	114,721
Gambella	150,000.00	308
Harari	150,000.00	270
Addis Ababa	5,345,777.00	164,836
Dire Dawa	1,318,042.00	9,349
Total	**62,363,564.00**	**1,508,587**

5.5.1.3. Strengthen Health Facility Governance and Management

A health facility has been governed through a joint managing body established from the community, health institution staff, and representatives from other government offices.

Accordingly, in EFY 2008, capacity building was provided to a total of 224 board members (157 from Oromia, 47 from SNNPR, and 40 from Addis Ababa City Administration). Furthermore, a total of 285 individuals (104 from Oromia, 84 from SNNPR, 46 from Tigray, 25 from Addis Ababa City Administration, and 26 from Benishangul Gumuz) were also trained on HCFR finance collection and execution processes to strengthen health facility governance and management.

5.5.1.4. Private Wing and Outsourcing

A private wing has been designed to increase health workers' motivation and reduce attrition of highly qualified medical doctors. 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 2008, four public hospitals have opened private wing services and increased the number ofhealth facilities with a private wing to 54.A total number of 71 hospitals outsourced non-clinical services to other institutesfor better quality of services.

Table 29: Number of Hospitals Opened Private Wing and Outsourcing Non Clinical Services

	Private Wing and Outsourcing	
	Number of hospitals opened private wing	**Number of hospitals outsourcing Non Clinical Services**
Tigray	10	5
Afar	-	-
Amhara	4	18

Oromia	25	22
Somali	1	
B-Gumuz	2	2
SNNP	-	9
Gambella	-	1
Harari	1	1
Addis Ababa	5	6
Dire Dawa	1	1
Federal	5	6
Total	**54**	**71**

5.5.2. Health Partnership Coordination

To widen the spectrum of the resource bases of the health sector, health partnership coordination mechanisms (including public-private partnership (PPP), bilateral cooperation, NGO coordination, and diaspora coordination) were implemented during EFY 2008.

5.5.2.1. Public Private Partnership

Recognizing the potential of the private sector in expediting health development,FMOH has been collaboratively working with the sector by (i) Engaging them in the provision of secondary and tertiary level health services; (ii) Manufacturing indigenous health products; (iii)Alleviating human resource constraints; and (iv) Nurturing the existing public private partnerships (PPP) in the health system.

In EFY 2008, FMOH has initiated and coordinated the development of PPP in the health guideline, operational manual, and users guide for implementing priority projects. These documents are aligned with the guiding principles and values stipulated in the strategic framework for PPPin the health sector. Furthermore, these documents provide essential information for both public project promoters and private parties who want to engage in tertiary and secondary health services, pharmaceutical production,or HRH development.

A total of 100 participants from government andthe private sectorparticipated in a consultative forum and drafted out a joint TOR thatshows respective duties and responsibilities.

5.5.2.2. Bilateral Agreement

In EFY 2008, according to the agreement reached with neighboring countries on addressing common health-related issues:

- The 22nd Ethio-Djibouti, the 30th Ethio-Kenya, and the 17th Ethio-Sudan JointCommission Meetings were held by reviewing the previous agreements and approving the future joint plan.
- HSTP was briefed to South Koreandelegates within the framework of county partnership strategy.

- A database for 28 bilateral agreements was also built in the fiscal year.

5.5.2.3. NGO Coordination

To strengthen the monitoring and evaluation tasks of FMOH, in EFY 2008, FMOH has delegated the mid-term and terminal monitoring and evaluation tasks of 44 NGOs to RHBs. The NGO project implementation manual and TOR were being developed and presented to MOH-ChSOs joint health forum. Similarly, a new project agreement was signed with three NGOs and terminal evaluation was conducted on a total of five NGOs in the fiscal year.

5.5.2.4. Diaspora Coordination

To encourage the diaspora to be part of health system strengthening in the areas of knowledge, skill, and technology transfer, a total of 5,000 brochures were distributed on the National Diaspora Festival in EFY 2008. Furthermore, different diaspora promotional materials including 1,000 DVD documentary films, 25,000 brochures,and 10,000 booklets were prepared and submitted to Ministry of Foreign Affairs for distribution through their diplomatic channels.

5.5.3. Establishing Health Economics and Financing Analysis Case Team

Cognizant of the importance of efficiently and effectively utilizing scares resources, the health economics and financial analysis case team was established to shoulder the major objectives of economics evaluations, comprised of:Cost-effectiveness; cost-benefit analysis; cost-utility analysis; ensuring the efficient allocation and utilization of resources; institutionalizing health expenditure tracking process/NHA; evidence generation; and follow-up on the properimplementation of health care financing strategy.In EFY 2008, the team was engaged in identifying operational efficiency of the activities for which the ministry invests huge resources, analyzing the efficiency of health centers, and preparingallocative efficiency matrix on resource allocation for the coming fiscal year.

5.5.4. Institutionalizing NHA andConducting the SixthRound Study

Regularly tracking the resources spent on health is critical for informed decision making. Cognizant of this, five rounds of NHA studies were conducted and in the EFY 2008, the FMOHis on the verge of finalizing the sixthround study .The overall objective of this study is to update empirical evidence on the overall Ethiopian health care financing system. Specific objectives are to identify financing trends, know sources of health financing, fund management responsibilities, and understand which providers of health care are getting how much funding for which services. The task of conducting household surveysto collect the necessary health expenditure from 10,000 households has been completed, as hasinstitutional survey expenditure data from640institutions comprising government, donors, NGOs, employers (peristalsis and private enterprises), and insurance companies, and data analysis has been started.

Institutionalizing NHA was also among the core agendas of the budget year.Accordingly,the sixth round NHA was performed with the lead role of FMOH particularly in reaching out to organizations that provide data inputs for NHA production, validating and ensuring quality of the data, analyzing , report writing, anddisseminating findings.

5.5.5. Health Insurance

Health insurance is one of the health care financing strategies being implemented in Ethiopia with the aim of protecting citizens from health- related financial risk and mobilizing additional resources to the health sector. The government of Ethiopia has designed two types of health insurance: Community based health insurance (CBHI) targets those engaged in the informal sector while social health insurance focuses on formal sector employees including pensioners.

In EFY 2008, the agency has accomplished various activities in scaling up and implementing CBHI in the country. In addition, it has also done the necessary preparatory activities to roll out social health insurance. Accordingly, the following section describes major accomplishments during the fiscal year.

5.5.5.1. Community-Based Health Insurance

Community based health insurance is one of the woreda transformation agendas identified in the HSTP. Toward meeting the objective, a new directive and scale up strategy was prepared and approved by FMOH in consultation with regional health bureaus. To enable the smooth implementation of the directive, a CBHI implementation manual, data management and reporting manual, and clinical audit manual are being developed and printed for dissemination to CBHI implementing woredas and RHBs.

Membership

In order to ensure sustainability of the health insurance scheme, expanding the membership base and improving contribution collection are important activities. Accordingly, in EFY 2008, member recruitment as well as contribution collection was strengthened in old pilot woredas and expansion woredas. Currently, the number of woredas nominated for CBHI implementation reached 320 and a total of 191 woredas has started provision of health services to beneficiaries.

The total number of eligible households in 205 woredas were 6,650,150. Of this, 2,372,736 (35.7%) households joined CBHI. Out of these households,430,591 (18%) wereindigents and1,942,145 (82%) were paying members (Table 32). The average enrollment rate in the four regions has reached 36% with the highest being inTigray at 50 % and the smallest being in Oromia with 26%.

Table 30: CBHI Membership in EFY 2008

Regions	Total	Woreda	Eligible	New	Total Number of Members	Number of	Enrol

	CBHI wored as	that started service provisio n	Population	members in 2008	Paying Members	Indigent s	Total	Beneficiarie s	lment rate
Amhara	91	77	2,783,345	411,748	1,043,508	125,090	1,168,598	5,796,326	42%
Or Omiya	134	68	1,998,755	40,361	315,256	197,491	512,747	2,461,186	26%
Tigray	18	7	484,141	132,798	187,807	52,361	240,168	1,056,739	50%
SNNP	77	39	1,383,909	374,923	395,574	55,649	451,223	2,210,992	33%
Total	**320**	**191**	**6,650,150**	**959,830**	**1,942,145**	**430,591**	**2,372,736**	**11,525,243**	**36%**

So far, out of 81% of the eligible population for CBHI,only 15% are covered through the scheme with some encouraging results. However, this is showing that great effort must be in place to achieve the target set in HSTP.

Contribution from paying members

The contribution collected from paying members since the roll out of CBHI has reached ETB 378,951,250. Out of this, 198,655,247 (52%) was collected during EFY 2008. On the other hand, payment for health facilities since the roll out of CBHI was ETB 191,970,615. Out of this, ETB 88,835,740 (46 %)was paid during EFY 2008.

CBHI contribution

Table 31: CBHI Contribution in EFY 2008

Regions	Contribution by Paying members		Percentage
	2008	Since roll out of CBHI	
Amhara	123,026,235	234,600,194	62%
Oromiya	13,852,525	69,446,593	18%
Tigray	22,283,124	30,811,100	8%
SNNP	39,493,363	44,093,961	12%
Total	**198,655,247**	**378,951,848**	100%

5.5.5.2. Social Health Insurance

The Health Insurance Agency has been building its capacity to carry out the responsibilities vested upon it by the government. In EFY 2008, it opened four additional branch offices to bring the total number of its branches to 24. During the same period, it recruited 245 employees for all branches including the head office which made the total number of employees 724.

During the fiscal year, the agency has prepared and approved different directives, manuals, and documents which were necessary for the roll out and implementation of social health insurance. Different types of training were provided to employees of the agency to enhance their knowledge and skill, which help them in discharging their duties and responsibilities.

Training and communication activities

Awareness and capacity building trainings to different stakeholders

Awareness raising and ToT trainings were provided to stakeholders selected from federal and regional institutions. Accordingly, it was possible to reach to 30,655 trainees through all branch offices of the agency. The trainings helped to raise awareness of stakeholders on social health insurance.

Provision of training to health professionals and health sector employees

Health care providers are a major stakeholders for the success of social health insurance in the country. To this end, training was provided for 10,743 health professionals with a view to enhance their awareness on social health insurance and its implementation. This has helped to clear confusion raised on the issue of health insurance by health care providers.

Discussion with employers

Discussion forums have been held with government development enterprises, private companies, and civic organizations on the implementation of social health insurance and issues raised by the respective institutions. This includes: Ethio-telecom, Commercial Bank of Ethiopia, Electric Power Authority, Sugar Corporation, Ethiopian Airlines, employers and employees' federations, teachers associations, chemical industry cooperation, Sheraton Addis, Coca Cola, BGI Ethiopia, and more.

Communication and mobilization

During the fiscal year the agency has used electronic and print media to disseminate information on health insurance and enhance awareness. Accordingly, television and radio spots have been prepared in Amharic, Oromiffa, and Tigrigna and broadcast for two months. In addition,a radio spot has been broadcast through local media in Somali, Afar, Sidama, Sheka, and Bench languages throughout the year.

With regard to print media and products, an annual magazine, brochures, information booklet, agenda, calendar, and notebook carrying the logo and objectives of the agency has been prepared and distributed to different stakeholders.

Membership Registration

Different types of registration forms for social health insurance have been printed and distributed to all branch offices of the agency. Software has been developed that can help to produce IDs of members and beneficiaries. Employees of the agency both at head office and branch offices have received necessary training to usethe software.

Assessment and Signing of Agreement with Health Service Providers

Another important preparatory activity for social health insurance is selection of health service providers. Accordingly, the agency has made an assessment on 949 health facilities. Training has

been provided to staff of the newly opened branch offices to enable them to carry out the assessment. So far, the agency has signed contractual agreement with 963 health facilities in order to provide service to social health insurance beneficiaries. These health facilities have established health insurance preparedness committees and assigned focal persons to ensure readiness and address challenges that may occur during implementation.

Challenges

- Lack of ownership towards CBHI for some regional, zonal, and woreda officials;
- Lack of awareness about social health insurance among the society;
- The impact of drought due to El Nino has negatively affected membership and contribution performance of CBHI in some woredas;
- Lack of adequate subsidy allocation to indigents by some regional and woreda governments;
- Difficulty in securing staff with the necessary educational background, expertise, and experience;
- Shortage of vehicles at branch office level compared to the scope of work undertaken and the catchment area they cover; and
- Lack of adequate office space in most of the branch offices.

Way forward

- Strengthening Health Development Army performance;
- Internal capacity building (human resource and institutional);
- Strengthening member registration and contribution collection for SHI;
- Coordination with health service providers;
- Develop the health insurance communication strategy;
- Strengthen awareness of health insurance through trainings, discussion forums, print, and electronic media;
- Expansion of CBHI scheme in all regions;
- Strengthen partnership with different stakeholders;
- Mainstream the issue of women, youth, and the disabled; and
- Establish women's forum at head office and branch level.

5.5.6. Financial/Expenditure Management and Control

With the aim of ensuring efficient and effective utilization of financial resources entrusted to FMOH, and to better support the implementation of HSTP, strong and reliable systems have been in place through the EFY 2008. There are two financing streams, namely:government budget and donor grants funds. ETB 240.5 million has been allocated from government for capital and

operating budget out of which ETB 235 million (98%) has been utilized. In terms of grants management, FMOH has exerted its maximum effort in trying to collect all the agreed upon donor funds, utilizing and liquidating all grants revenues with the target of zero level efficiency loss.

In effect, ETB 6.99 billion (91.08%) was collected from donors, and ETB 5.05 billion (93%)was utilizedand liquidated including the carried forward left over balance from EFY 2007. To this end, the FMOH has been closely working with and supporting all the implementing regions/city administrations, federal agencies, and other federal level health institutions to strengthen grant management systems and practices. Fifty-four new grant management personnel have been recruited and deployed to regions and zones to leverage the grant management systems and practices.

All the required audit and assurance services have been obtained for both financing streams to ensure accountability for proper utilization of financial resources in compliance with the prevailing financial management proclamations, regulations, directives, policies, and procedures.

The clean audit opinion has been achieved for all audits for both government and donor grants. FMOH has also been using the quarterly internal audit to ensure the health of internal control systems and practices with the objective to have strong, reliable, and transparent systems in place.

5.5.6.1. Integrated Financial Management Information System

Following a strong desire to have an effectual and efficient financial management system, the government of Ethiopia, through MoFEC, has already endorsed the implementation of Enterprise Resource Planning said to be Integrated Financial Management System (IFMIS). IFMIS is an oracle-based financial application currently deployed on 21selected sites throughout the country for a powerful financial management system. The project is owned and managed by MoFEC, leapfrogging from piloting to roll out, with the help of a pool of staff with diversified skills housed within the project office.

FMOH was one of the organizations chosen for pilot implementation of IFMIS, representing the health sector. A team composed of seven individuals have been fully involved in supporting the day-to-day operations of the Ministry's Directorates in utilizing the system for their regular activities. The Ministry has successfully implemented all nine modules, involving General Ledger, Account Payables, Account Receivables, Cash Management, Public Sector Budgeting, Procurement and Inventory (Supply chain Management), Fixed Assets, and Payroll (Human Resource Management). Currently, all the directorates of FMOH are using the system for their daily operations(especially inventory and fixed asset).

Meanwhile, the best practices and lessons learned from the implementation of IFMIS at the FMOHis very helpful in putting the IFMIS system into action for organizations that have a

relationship with FMOH. Activities have already started to bring these efforts together in order to implement the system in collaboration with MoFECat the six organizations, namely: Blood Bank, HAPCO, EPHI, PFSA, FMHACA, and Health Insurance.

IFMIS implementation requires basic information technology infrastructure, such as the Local Area Network (LAN), WorldNet connectivity, IT personnel for support, basic IT skill among staff, appropriate assets management, and proper reporting procedures. A detailed assessment has been made along with MoFEC IFMIS focal personnel at the aforementioned organizations mainly in order to complement the requirements if there are gaps and to follow up the implementation process for those already fulfilling the requirements. If approval is obtained from MoFEC to implement the system at the said organizations, the site implementation will take place, ranging from data cleansing to provision of class-based and on-job training with supporting until the system is owned.

Expectedly, within the coming budget year, IFMIS will be implemented on organizations which have already been equipped with the necessary infrastructure required. .

Challenges

- Infrastructure related problems at the subordinate organizations, mainly the absence ofWoredaNet infrastructure;
- High employee turnover;
- For the reason that the overall project is led by MoFEC, unable to align MoH requirement of implementation with project plan;
- Skilled human resources to work on the system; and
- Resistance to change with the new system.

Way forward

- Based on the assessment obtained, enabling the organizations to fulfill preliminary requirements for the implementation of the system;
- Putting the WoredaNet infrastructure into place for the six organizations;
- Providing awareness creation for the staff to fully migrate to the new system; and
- Implementing the IFMIS system at the six organizations and one RHB in collaboration with MoFEC.

5.5.7. Public Budget Allocation

This section explains budget allocation to the health sector including the regional level out of the total public budget in EFY 2008 by the government. The source of data is MoFEC.

5.5.7.1. Percentage Share of the Public Health Budget Allocation from the Total Budget

In EFY 2008, the percentage of total budget allocated in the health sector at regional level was 11.3%, which was slightly higher than in EFY 2007 (11.1%) (Figure 45). In this fiscal year, there wasaincrement on the per capita health allocation from ETB 122.78 in the previous fiscal yearto ETB 156.31.The regional block grant budget allocated to the health sector ranged from 7.4% in Addis Ababa to 14.0% in Dire Dawa in the same year. Except the decrease in the percentage share of health budget from last year in SNNP and Gambella Regions, there was an increase in the eightregions and remained the same in one region (Amhara Region).

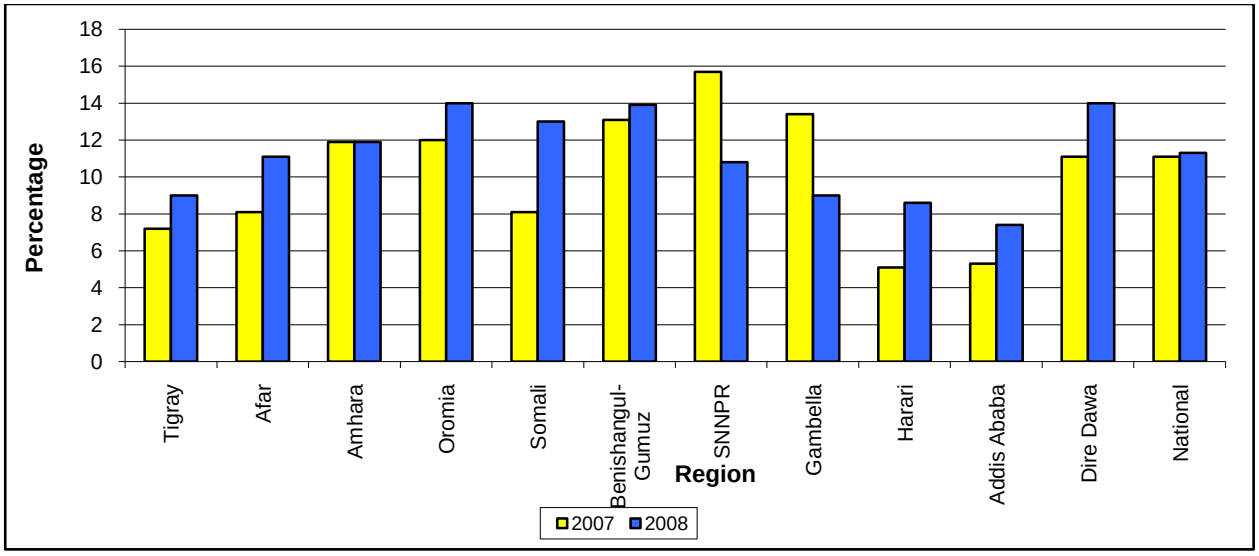


Figure 41: Distribution of the Percentage of Total Budget Allocated in the Health Sector by Region (EFY 2007 and 2008)

5.5.8. Development Partners' Contribution to the Health Sector

The major source of funding for the Ethiopian health sector is financial contribution from development partners. The following section shows how much was contributed and disbursed by DPs to the health sector in EFY 2008.

5.5.8.1. Proportion of Each Donor's Contribution as Compared to the Total DP Disbursement

In EFY 2008, a total amount of USD 285.43 million was committed and a total amount of USD 238.54 million (83.6%) was disbursed using channel two modality to the health sector. This was still lower thanthe previous two years commitment and disbursement.

Table 32: Commitment and Disbursement of Funds by Development (EFY 2008)

S. N	Source of Fund	Commitment (in USD) inEFY 2008	Disbursement in USD in EFY 2008	Percentage of Disbursement
1	**SDG Performance Fund**			
	DFID	48,304,131.00	45,344,460.00	93.87%
	World Bank	10,000,000.00	3,667,317.36	36.67%
	Netherland Embassy	15,891,429.00	15,874,899.00	99.90%

	Irish Aid	8,051,530.00	6,911,116.00	85.84%
	Spanish Aid	1,200,000.00	-	0.00%
	UNICEF	500,000.00	453,867.36	90.77%
	Italian Cooperation	3,354,804.00	2,724,004.53	81.20%
	GAVI	20,000,000.00	20,742,868.00	103.71%
	EU	9,487,386.00	7,650,273.22	80.64%
	Total	**116,789,280.00**	**103,368,805.47**	**88.51%**
2	Technical assistance pool fund			
	HPF	2,462,025.85	2,083,256.06	84.6%
	Total	**2,462,025.85**	**2,083,256.06**	**84.6%**
3	Bilateral Partner			
	DFID (RIF)	8,194,660.73	8,194,660.73	100.00%
	CDC	3,952,014.00	3,872,973.72	98.00%
	Total	**12,146,674.73**	**12,067,634.45**	**99.35%**
4	UN Organization			
	UNICEF	1,996,419.71	1,996,419.71	100.00%
	UNFPA	71,994.55	71,994.55	100.00%
	WHO	21,647,616.00	21,647,616.00	100.00%
	Total	**23,716,030.26**	**23,716,030.26**	**100.00%**
5	**Global Fund**			
	Malaria	65,215,524.00	42,312,126.00	64.88%
	TB	21,725,945.00	20,819,323.00	95.83%
	HSS	23,620,598.00	18,360,918.00	77.73%
	Total	**110,562,067.00**	**81,492,367.00**	**73.71%**
6	GAVI			
	GAVI- VIG-IPV	2,536,500.00	2,536,500.00	100.00%
	GAVI- DEMO-HPV	195,000.00	170,000.00	87.18%
	GAVI- MENAIII-OPC	9,768,488.00	5,847,421.00	59.86%
	GAVI-HSS2-CSOs	2,060,000.00	2,060,000.00	100.00%
	Global Sanitation	1,113,450.00	1,113,450.00	100.00%
	Total	**15,673,438.00**	**11,727,371.00**	**74.82%**
7	Foundation			
	CIFF	4,083,083.86	4,083,083.86	100.00%
	Total	4,083,083.86	4,083,083.86	100.00%
	Grand Total	**285,432,599.70**	**238,538,548.10**	**83.60%**

In EFY 2008, Global Fund committed the amount of USD 110.56 million and disbursed an amount of USD 81.49 million which was the largest contributor to the health sector followed by DFID and GAVI.

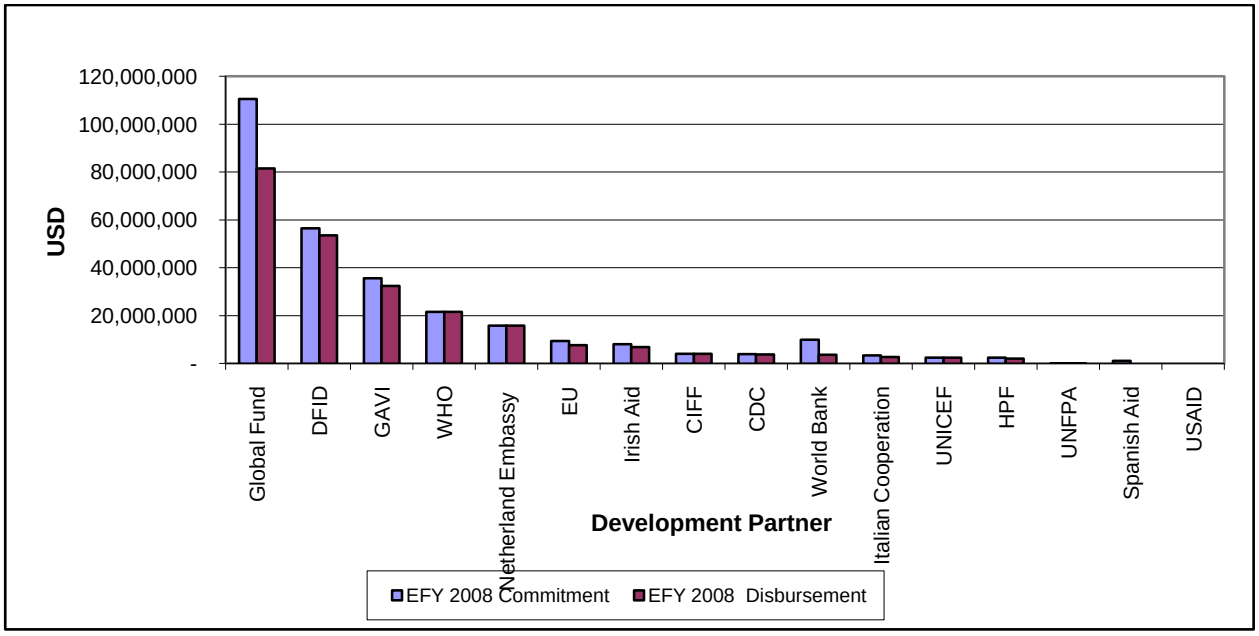


Figure 42: Distribution of Amount Committed and Disbursed by Development Partner (EFY 2008)

As share of disbursement by DP, Global Fund (34.2%) of the total, followed byDFID accounted 22.4%, GAVI (13.6%), WHO (9.1%), Netherland Embassy (6.7%), European Union (3.2%), Irish Aid (2.9%), CIFF (1.7%), CDC (1.6%), World Bank (1.5%), Italian Cooperation (1.1%), UNICEF (1.0%),HPN (0.9%), and UNFPA (0.03%).

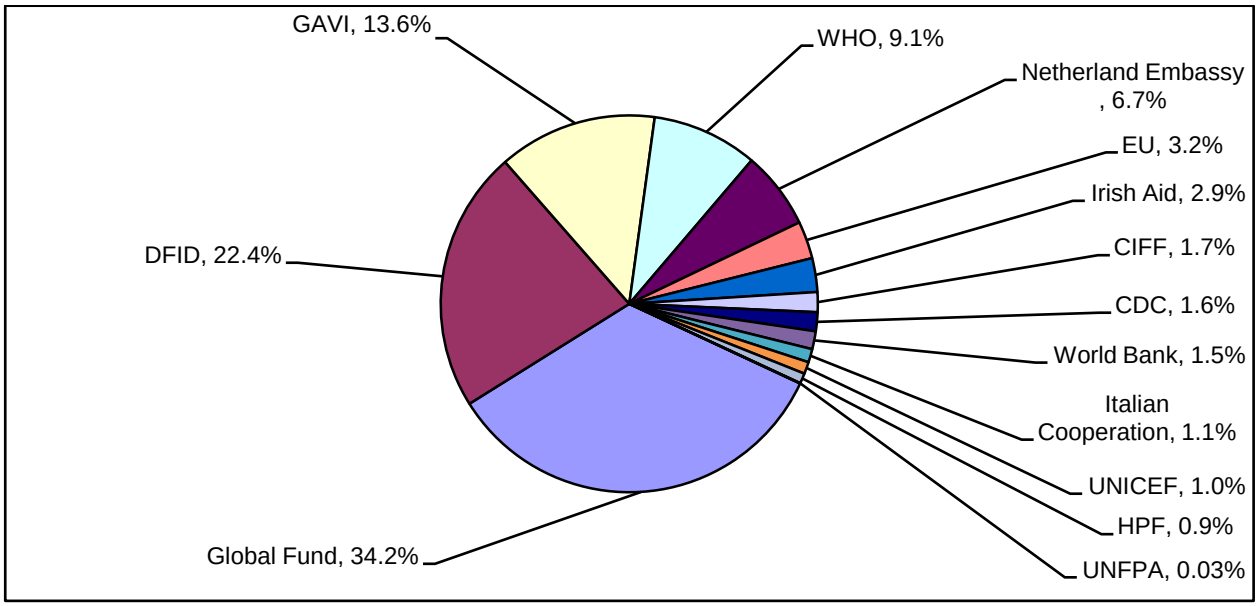


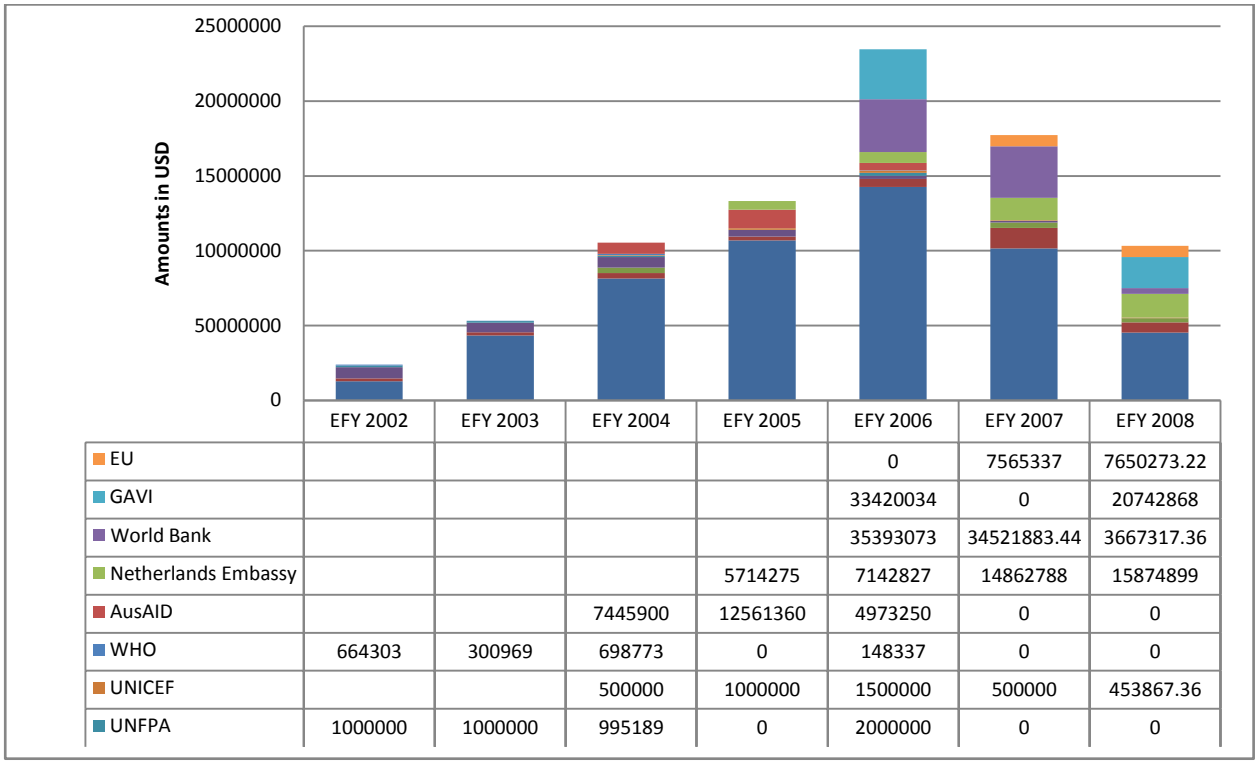
Figure 43: Percentage Distribution of Disbursement by Development Partner (Out of Total Disbursed) (EFY 2008)

As it was documented in the previous years, channel three contributors are not accounted in the above financial contribution by DP's. It is known that there is also a considerable amount of resources provided by U.S. partners through channel three modality which is not directly monitored by FMOH.

5.5.8.2. SDG Performance Fund

In EFY 2008, the budget commitment to SDG PF by contributors was USD 116.79 million and, a total amount of USD 103.37 million was disbursed to SDG PF in the same period. This accounted for 88.5% DP's disbursement in the fiscal year which shows DP pooling resources to the preferred channel that FMOH can manage by applying GOE financial procedures. However, there was a decrement by 41.7% from the previous fiscal year (USD 177.37 million).

As it was documented last year, DFID was the major contributor to SDG PF, accounting 43.9% of the total amount disbursedby DPs to SDG PF; followed by GAVI (20.1%), Netherlands Embassy (15.4%),EU (7.4%),Irish Aid (6.7%), World Bank (3.6%), Italian Cooperation (2.6%), and UNICEF (0.4%). However, Spanish AID, AusAID, WHO, and UNFPA were not disbursed to SDG PF in EFY 2008.



	EFY 2002	EFY 2003	EFY 2004	EFY 2005	EFY 2006	EFY 2007	EFY 2008
EU					0	7565337	7650273.22
GAVI					33420034	0	20742868
World Bank					35393073	34521883.44	3667317.36
Netherlands Embassy				5714275	7142827	14862788	15874899
AusAID			7445900	12561360	4973250	0	0
WHO	664303	300969	698773	0	148337	0	0
UNICEF			500000	1000000	1500000	500000	453867.36
UNFPA	1000000	1000000	995189	0	2000000	0	0

Figure 44: MDG/SDG Performance Fund Disbursement (EFY 2002 - 2008)

5.5.8.2.1. Implementation Progress of the SDG Performance Fund

In the Joint Finance Arrangement of Sustainable Development Goals Performance Fund, it is stated that SDG Fund is a pooled funding mechanism managed by the FMOH using the Government of Ethiopia procedures. In the framework of the Ethiopia IHP compact, it provides flexible resources, consistent with the 'one plan, one budget, and one report' concept, to secure additional finance to the Health Sector Transformation Plan. It is one of the GoE's preferred modalities for scaling up Development Partners assistance in support of HSTP.

In EFY2008, there were identified gaps which are financed by SDG PF based on the annual comprehensive plan and in line with eligible expenditure stated on JFA. Like the previous period, in EFY 2008, the major funding areas are presented below, together with the budget.

Table 33: Areas of Support Funded by SDG Perfromance Fund (EFY 2008)

Area of focus	**Budget allocated for 2008 in USD**	**Budget allocated in percentage**
Public Health Commodity Procurement	64,600,000.00	31%
Health System Strengthening	52,916,350.00	26%
Health Service Delivery	2,565,000.00	1%
Maternal Newborn Health and Nutrition	12,000,000.00	6%
Child Health	46,809,570.00	23%
Prevention, Control of Communicable and Non Communicable Diseases	18,000,000.00	9%
Health Extension Program	7,750,000.00	4%
Miscellaneous	900,000.00	0.4%
Total	**205,540,920.00**	**100%**

As depicted in the above table, the highest budget is allocated to Public Health Commodity Procurement (31%) under which medical equipment and pharmaceuticals are procured. Health System Strengthening follows in amount taking 26% of the budget and Maternal Newborn Health and Nutrition is the third largest program area receiving the 23% of the annual budget of SDG PF.

5.5.8.2.2. Implementation Status of the SDG Performance Fund

SDG PF is used to fill the financial gap in most underfunded priorities of the health sector. In EFY2008, following the Joint Financing Arrangement guidelines, the underfunded priority areas are financed using the SDG PF to strengthen the overall health system and provision of public health goods, for the improvement of maternal and child health and prevention and control of communicable and non-communicable diseases. The highlights of the achievements are described in the paragraphs below.

Health Extension Program

During the year, the Health Development Army was strengthened in all regions and city administration. Required supplies and consumables have been procured and provided for health posts to strengthen the service. In addition, the transformation agenda of the HSTP for Health Extension Workers in all regions and training on HSTP was provided. In addition, high performing woredas were identified for recognition.

Maternal and Newborn Health and Nutrition

Under this program,EmNOC equipment and drugs has been procured and distributed to health facilities during the year to strengthen the delivery service. In addition, health facilities that provide free delivery services are being reimbursed for the service. Furthermore, there is a project initiatedto upgrade NICU in selected hospitals thought the country and the procurement of the required equipment is under progress to strengthen the newborn service.

Child Health Services

Child health service is supported by the SDG PF by procuring vaccines, provision of syringes, and safety box and procurement of child health pharmaceuticals in the year. In addition, to strengthen the cold chain in health centers and health posts, facilities that have been completed are being identified and located, and there is an undergoing initiative to equip health centers and health posts with Solar Direct Drive refrigerators.

Prevention andControl of Communicable and Non Communicable Diseases

SDG PF supported TT surgery in regions during the year and professionals have received training on conducting the surgery. From the fund, procurement and distribution of prophoxure was done for malaria prevention and NCD drug was procured to subsidize the cost for the end users.

Health System Strengthening

There were continued and new trainings of HEWs in the period including level three and four paramedics, bio technicians, and anesthesia level five. There was also expatriate recruitment from overseas to develop faculties in university hospitals for nursing specialty and OBGYN tosupport NMIE and IESO. Under the construction of infrastructure, the already started and new Operations Theater blocksprogressed significantly. There were also major construction of blood banks, biomedical workshops, and finalization of health centers in emerging regions. The installation of solar PV in the selected health centers and health posts is also finalized in the year. There were also

major medical equipment procurements initiated in the year to strengthen the health system by distribution to primary hospitals.

CHAPTER SIX

THE HEALTH SECTOR TRANSFORMATION AGENDAS

6.1.Quality and Equity in Health Care

Equity and quality of care has been set as a transformation agenda in the Health Sector Transformation Plan (HSTP). Equity in health care refers to ensuring availability of the best care to all, whereby the quality of care provided does not differ by any personal characteristics. Quality health care refers to care which is safe, reliable, patient-centered, efficient, and provided to all in need in an equitable and timely manner. The Federal Ministry of Health has been engaged in improving equity and quality of care across the spectrum of the health care system from prevention to palliative care during this fiscal year.

In this regard, the following major activities were accomplished to improve health service quality.

- The national health care quality strategy which reflects commitment to safer, more effective, more accessible, and more equitable care for every Ethiopian by 2020 has been prepared and national quality summits were held to share the strategies for quality.
- National health care quality committee has been established to monitor implementation of the national strategy and provide directives.
- Situational assessment in regions requiring special support was conducted and appropriate strategy for addressing geographic inequity in those regions was developed.
- Health care service improvement guidelines and audit tools were prepared in consultation with relevant stakeholders.
- Training on quality health care service provision models was provided to regional health bureaus and hospitals. Moreover, a description of the health care service quality improvement models was prepared and disseminated.
- Through the Ethiopian hospitals association for quality initiative, high performing hospitals were identified and recognized by the ministry.
- The hospital reform standards were revised so as to make hospitals responsive to the growing need of quality health care services. Health serviceslike blood transfusion which was not included in the former standards has been incorporated.
- National operation service quality improvement guidelines and a list of basic operation services have been prepared in consultation with relevant stakeholders.
- Different capacity building trainings such as quality improvement leadership methods were provided to build leadership in improving quality health care provision across all levels.

Regarding equity,

- The national health Equity strategy which reflects Equal access to essential health services for equal need ,Equal utilization for equal need and Equal Quality of Care for all Ethiopian by 2020 has been prepared and regional level launching was held to share the strategies for all stake holders in the four emerging regions and seven suboptimal performance zones in the Agrarian Regions.
- A leadership skill development training was Conducted for 370 health managers.
- An Advocacy was conduct on Equity plan of Action to the regional and sub-regional political leadership at all level to ensure health Equity is taken as political priority.
- TOR is prepared and recruitment of 59 high level Technical Assistance for the regional health bureau head, and zones health management team.
- A Design was prepared for Construction of staff residential in health centers found in the periphery/hard to reach area for staff retention and motivation.
- Selection of 47 Health centers for initiation of pharmaceutical revolving fund was done.

6.2.Information Revolution

The Information Revolution is one of the four transformation agendas of the HSTP. The objective of the Information Revolution is to maximize the availability, accessibility, quality, and use of health information for decision making processes through the appropriate use of ICTs to positively impact the access, quality, and equity of healthcare delivery at all levels. In the first year of HSTP, most of the focus was on planning and preparations for implementation in both data use and digitization pillars of theInformation Revolution.The following are some of the major accomplishments of FMOH in the first year of implementation.

- FMOH has developed a national Information Revolution (IR) Roadmap, which consists of the National Health Information Enterprise Architecture, the interventions and focus areas in the two pillars of the IR, governance of the IR, performance measures, and the action plan and budget required for the full implementation of initiatives of the IR. The IR Roadmap was launched in a meeting in which all stakeholders from the FMOH, regional health offices, and partners participated.
- FMOH has established a governance structure to coordinate the development of the digitalization aspects of the Information Revolution and to direct its implementation in alignment with the 2016 to 2020 Health Sector Transformation Plan.
- The Information Revolution plan is cascaded down to the regional level to allow the initiative to be implemented throughout all levels of the health sector. Each Regional Health

Bureau (RHB) has developed a plan for implementation of the Information Revolution at the regional level, ensuring alignment with the framework of the national strategy.

- The Connected Woreda program implementation roadmap has been developed. The Connected Woreda program arises from the IR Roadmap, which calls for strengthening data use via enhancements in “Data Culture” and “Digitalization of HIS systems”. The Connected Woreda strategy covers the tiered pathway for facilities and woredas as a whole to achieve the highest standards in data quality and use, the criteria for assessing facilities and administrative units, the interventions at all levels in a tiered system, and the M&E framework.
- A health data dictionary has been developed to capture the definitions of data elements, indicators, and the relationships between these elements to improve the FMOH’s ability to manage data recording and reporting guidelines and to harmonize data across many stakeholders. As part of this initial phase of data dictionary development, all HMIS and HSTP indicators and clinical concepts from PHEM, the Family Folder, and a prioritized set of HMIS registers are modeled, harmonized, and mapped to international reference vocabularies (where applicable). Ethiopia’s revised ICD-10 codes have also been included to improve accessibility, define linkages to the modeled indicators, and provide standardized distribution mechanisms. A cloud-based terminology management service is developed to support access to and systematic management of the data dictionary.
- A Master Facility Registry (MFR) has been developed to collect, store, and distribute an up-to-date and standardized set of facility data to all health system stakeholders and to facilitate governance. So far, data from SPA+ and eHMIS have been cleaned and uploaded in the MFR software and a public access portal has been developed.
- FMOHconducted internal and independent assessment of HMIS systems with the view of improving its ability to collect and use routine health system data through the introduction of a single, open-source, government-led HMIS platform.

6.3.Woreda Transformation

The HSTP has set very ambitious goals and aspires to transform the health system to deliver equitable and quality health care. To realize this,the woreda health office should be transformed to a high- performing entity that translates the national aspirations and the desire of the public into a reality. The woreda transformation maintains high coverage with a focus on bringinghigh quality service in an equitable manner. The transformed woreda is expected to have an accountable and transparent governance system that nurtures meaningful community participation; strives to meet

the needs of the people; makes data-informed decisions;applies evidence-based frameworks to systematically identify bottlenecks and scale up best practices to address them; and, achieves universal health. The agenda hasthree key goals (1) developing high performing primary health care units, (2) graduation of model Kebeles, and (3) achievement of universal health coverage with financial risk protection. The ministry made efforts to lay down ground work in the existing conducive environment for the successful implementation of the transformation agenda. The activities carried out in EFY 2008 are described below.

- Woreda transformation agenda implementation guideline developed and distributed to regions.
- National dissemination workshop conducted.
- Model Kebele selection criteria and verification guide developed.
- Orientation provided to HEWs except in some regions.
- Resource mobilization and financial support provided to regions during regional level launching.
- 26 High performing woredas were selected and ready for recognition.
- 36 woredas identified for the transformation agenda.
- In 191 woreda 2,372,736 (35.7%) household joined CBHI and 198,655,247 (52%) was collected during EFY 2008.

6.4.Caring, Respectful, and Compassionate Health Professionals

It is beyond much argument that compassion, empathy, respect, and kindness, are increasingly being acknowledged as the foundation and an indispensable dimension of quality of health care.

The health workforce is the core of the health system. Without health workers, there is no health care. Medical care without caring, respectful, and compassionate health professionals cannot be truly patient centered.

Despite significant improvements in health care delivery in recent years, clients of the Ethiopian health care system are not receiving consistent, reliable,and high quality care that is truly patient and family centered, caring, compassionate, and respectful. Addressing challenges observed in delivering healthcare of this caliber is among the priorities of HSTP.

The ambitious targets set by theHSTP will only be achieved if dramatic improvements are made to strengthen the health workforce. Having caring, respectful, and compassionate (CRC) health professionals is a critical requirement to ensure equity and achieve high quality health service. Cognizant of the prevailing situation, and to help achieve the target set, FMOH has identified“Compassionate, patient-centered care as a top priority to improve quality and equity in service delivery” as one of the transformation agendas. In EFY 2008, efforts were made to lay the

groundwork that will serve as a springboard for successful implementation of theCRC transformation agenda during. Progress to date is describedas follows.

- CRC transformation agenda implementation guideline were finalized and endorsed.
- CRC launched at federal and regional level.
- Consultation forums were organized with stakeholders to enrich the implementation guideline.
- Consensus building and advocacy campaigns were undertaken.
- Draft regional level CRC counseland center of excellence establishing guideline/manual prepared.
- Training module preparation at final stage.
- CRC incorporated into hospital quality audit tool.
- Draft CRC training course designed.
- CRC training need assessment conducted in selected health facilities in AddisAbaba and assessment report prepared.

CHAPTER SEVEN

CONCLUSION

FMOH through HSTP envisions all of its citizens enjoying equitable and affordable access to all types of health services. Improving quality and addressing inequalities are the unifying guiding principles are key pillars of the transformation plan. Therefore, this report shows what has been achieved and major challenges in the first year of HSTP towards universal health coverage. The inclusion of universal health coverage as part of the health-related SDG agenda puts equity at the forefront of a major global movement. The theme of the previous meeting was "Transforming the Ethiopian Health Sector: Realizing Equitable and Quality Health Service"and accordingly in the concluded fiscal year a lot of activities were carried out in line with the four strategic themes.

Furthermore, to achieve the ambitious targets set during the HSTP period, the sector has identified transformation agendas: (i) transformation in equity and quality of health care; (ii) information revolution; (iii) woreda transformation; and (iv) develop caring, respectful and compassionate health work forces. Similarly, detailed implementation guides/manuals has been developed and preparatory phases of the implementation has been successfully started.

With the efforts made together with stakeholders and development partners, we have demonstrated encouraging strides and a leap forward in priority areas such as maternal and child health, nutrition program, communicable and chronic diseases, infrastructure, human resource development and pharmaceutical supply services.

According to estimates by the UN Inter-Agency Group (UN-IAG), MMR had declined from 1,400 to 353 maternal deaths per 100,000 live births between 1990 and 2015. Child mortality has also declined significantly, from 205 per 1,000 live births in 1990 to 59 per 1,000 live births in 2015.

An increase in service coverage has also mainlined during the first year of HSTP. Consequently, there was an increment on CAR from 69.9% in EFY 2007 to 70.8%, ANC coverage (at least one and at least four visits) from 96.9% and 67.9% in EFY 2007 to 98.4% and 75.9% in EFY 2008, respectively. Similarly, the percentage of deliveries attended by skilled health personnel increased from 60.7% to 72.4 in the same period. On the other hand, the proportion of pregnant women counseled and tested for the prevention of mother to child transmission (PMTCT) of HIV increased from 92.6% to 94.8% in EFY 2008. With regards to child health services, pentavalent 3, measles and fully immunized children coverage reached 97%, 93.7% and 90.9%, respectively.

With regards to strengthen the national nutrition program in EFY 2008,the first draft Food and nutrition policy developed, the NNP II (2016-2020) has been developed and implementation started. Furthermore, micronutrient prevention and control acute malnutrition management, maternal, adolescent, infant and young children nutrition and multi-sectoral nutrition implementation guidelines were prepared. Government of Ethiopia has demonstrated its commitment to end nutrition related problems by launching an initiative known as "The Seqota Declaration", a declaration to End Child under-nutrition in Ethiopia by 2030 through improvements in nutrition to propel sustainable development; and in turn sustainable development can bring malnutrition reduction.

Remarkable achievements registered since the start of HSDP I in prevention and control of HIV/AIDS, TB and Malaria. This has also been maintained in the first year of HSTP. In EFY 2008, a total of 394,566 clients are on ART of which 20,899 were children.

Health workforce, are the core of health systems, without health worker force there is no health care. Medical care without caring, respectful and compassionate health professionals cannot be truly patient centered. In EFY 2008, 3,256 new students were enrolled in 29 medical schools. Annual enrollment in medical schools has increased to 16,389 in EFY 2008. Similarly, a total of 1,275 physicians were deployed to the health sector, making total number of physicians deployed 6,570 and increased the ratio to 1physician per 14,045 population.

Expansion of HCs plays a pivotal role for the achievement of universal health coverage. Expanding, equipping, furnishing, maintaining, and managing health facilities are one of the priorities of HSTP. In EFY 2008, total cumulative number of available health centers reached to 3,579 witha ratio of 1 health center to 25,705 population. However, despite remarkable achievements with regards to improving access to the population compared with the standard, challenges still exists that need to be addressed to make them functional.

In the fiscal year, encouraging progress was made with regards to strengthening the pharmaceutical service, the national vital and essential pharmaceuticals stock status on average reached 86%. The stock difference of essential drugs between the center and branch warehouses has brought down to 4.1% below the planned target of 5%. Besides, list of previously identified

350 essential pharmaceuticals was revised to accommodate additional list of drugs included in the national CBHI scheme. Accordingly, national vital and essential drug list increased to 713.

In spite of, significant improvements in health care delivery in recent years, clients of our health care system are not receiving consistent and reliable high quality care. Our care is not truly patient and family centered, caring, compassionate and respectful.

Therefore, in the years to come, the observed encouraging progress must accelerate in order to achieve the goals laid out in the HSTP of significantly improving the health outcomes in the next five years and meeting the expectations of the Ethiopian people.

To this end, there will be a commitment of the FMOH to mobilize and allocate increased share of public financial resources through CBHI and SHI to bring sustainable development, and SDG agendas will also be effectively mainstreamed into sub regional development strategies and programs. Furthermore, platforms will be established to enable sharing experiences and scaling-up of best practices. There must be collaboration and coordination among various partners to harmonize interventions. Finally, a robust monitoring and evaluation framework that tracks progress; identifies areas of concern; and monitors financial resources allocated to the set priorities, and assesses the overall impact of the key policies, is crucial to the attainment of HSTP.

At this juncture, participants at ARM 2016 are expected to review the report in depth and come up with important suggestions and recommendations that will further enrich the process of HSTP for equitable and quality health service delivery in the coming years of implementation.