



Federal Ministry of Health

# **Annual Performance Report of HSDP-III**

**EFY 2000  
(2007/2008)**

**October 2008**

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# Acronyms

AAU	Addis Ababa University
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARM	Annual Review Meeting
ART	Antiretroviral Therapy
ATM	Automatic Teller Machine
AWD	Acute Watery Diarrhea
BCG	Bacille Calmette Guerin
BEOC	Basic Emergency Obstetric Care
BPR	Business Process Re-engineering
BSC	Balanced Score Card
CDC	Center for Disease Control (USA)
CEO	Chief Executive Officer
CEOC	Comprehensive Emergency Obstetric Care
CPR	Contraceptive Prevalence Rate
CSA	Central Statistics Authority
CSRP	Civil Service Reform Program
DACA	Drug Administration and Control Authority
DHS	(Ethiopia) Demographic Health Survey
DOTS	Directly Observed Treatment – Short course
DPT	Diphtheria, Pertussis, and Tetanus vaccine
EFY	Ethiopian Fiscal Year
EHNRI	Ethiopian Health and Nutrition Research Institute
EOS	Expanded Outreach Service
EQA	External Quality Assurance
EPI	Expanded Program on Immunization
ETB	Ethiopian Birr
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
FP	Family Planning
HC	Health Center
HCF	Health Care Financing
HEP	Health Extension Program
HEW	Health Extension Worker
HHM	HSDP Harmonization Manual
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health Officer
HP	Health Post
HPN	Health, Population and Nutrition Donor Group
HRD	Human Resource Development
HRH	Human Resource for Health
HS	Health Station

HSDP	Health Sector Development Program
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
IUD	Intrauterine Device
LMP	Logistic Master Plan
LMIS	Logistics Management Information System
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
MOI	Ministry of Information
MOWR	Ministry of Water Resources
NGO	Non-Governmental Organization
NHA	National Health Account
OPD	Outpatient Department
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PBS	Protection of Basic Services
PFSA	Pharmaceutical Fund and Supply Agency
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PMICT	Prevention of Maternal to Child Transmission of HIV
PNC	Postnatal Care
POA	Plan of Action
PPH	Postpartum Hemorrhage
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
ROPA	Result Oriented Performance Appraisal
SD	Skilled Delivery
SNNPR	Southern Nations, Nationalities and Peoples Region
SSA	Sub Saharan Africa
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TOT	Training of Trainers
TVET	Technical and Vocational Education and Training Center
USD	United States Dollar
VCT	Voluntary Counseling and Testing



# **EXECUTIVE SUMMARY**



This report gives an overview of the performance of the health sector based on selected indicators during EFY 2000, the challenges encountered in the implementation process; and the next steps to be taken to address the challenges. The major achievements and challenges of the sector during EFY 2000 are summarized as follows.

1. A sector-wide woreda-based Core Plan for EFY 2000 has been prepared through an approach that balances top-down and bottom-up processes, this plan was approved and performance contract was signed between FMOH and RHBs at ARM 2007. Balanced Score Card, which is a strategic planning and measurement tool, has been applied to cascade the core activities of the Core Plan to the level of the individual and monitor its implementation at FMOH. In the same manner, the Woreda Based Core Plan of 2001 has been developed through participation of all woredas in the country.
2. In order to deepen the performance based contract to the grass roots level, Performance Based Contracting Manual has been prepared and is ready for consultation at ARM 2008.
3. Currently, the seven core processes selected for BPR include: Health Care Delivery (former name was Access and Quality of Health Services), Public Health Emergency Management (Reduction of Epidemics), Research and Technology Transfer (New Core Process), Pharmaceutical Supply (Health Commodity Supply and Management System), Resource Mobilization and Health Insurance (Financial Resource Mobilization and Utilization), Health and Health Related Services and Product Regulatory Core Process (new core process) and Health Facility Construction/Renovation/Infrastructure Core Process (new core process).
4. The BPR studies have been completed and are in the final process of incorporating corrections. An Agreement has been signed in August 2008 between the FMOH, RHBs and the Ministry of Capacity Building (MOCB) to define the roles of the different institutions in refining and rolling out the BPR.
5. The pilot test of the new HMIS has been evaluated and lessons have been incorporated. Subsequently, micro planning has been conducted with all RHBs in order to roll it out nationwide. The plan is fully costed and the roles of FMOH and RHBs have been well defined. Training is conducted on all the forms, registers and reporting formats as well as on information use for decision making at the local level. Currently, implementation has begun in Dire Dawa, Harari, Gambella, Afar and Benishangul - Gumuz Regions. Health facilities, after the training of their workers, are being provided with supplies (individual folders, patient cards, master patient index, tracer card, service identification cards, and appointment cards). All other regions are at different levels of fulfilling their requirements for scaling up. In addition, curriculum for the training of HMIS technicians has been designed and the position classification of these technicians has been approved. Integrated supportive supervision, performance review and operational research have been added to the HMIS design to complete the picture of M&E.
6. Based on the logistics master plan endorsed in 2005, a proclamation was issued by the House of


Peoples' Representatives for the establishment of Pharmaceutical Fund and Supply Agency (PFSA). A Business Process Re-engineering study focusing on Pharmaceuticals Supply Core Process; Fund Management Support Processes, MIS Support Processes and Human and General Services Support Processes have been completed. Besides, manuals for Procurement, Finance and Costing have been completed. Major international and local procurements of essential pharmaceuticals and medical supplies worth 310 million Birr have been effected and distribution of 330 million Birr worth of drugs and medical supplies as well as 400 million Birr worth of HIV/AIDS drugs, chemicals and supplies have been distributed through the Agency.

7. As per the EFY 2000 Core Plan to introduce health insurance scheme, a final strategic document, proclamation and explanatory notes thereon have been prepared. In addition, implementation POA for the scheme as well as for its piloting has been prepared. A study on unit cost of health services has been conducted.
8. Public Health Emergency Management Core Process focusing on preparedness, alert, rapid detection and prompt response; capacity enhancement, information and communications systems, structures and jobs needed to handle health hazards which are issues of national importance has also been designed in order to effectively respond to emergencies.
9. Following the signing of the Global Compact in London on 5 September 2007, Ethiopia became the first country to conclude (in August 2008) a national IHP+ Compact with its development partners with the aim of scaling up the Country's efforts to achieve the Health MDGs by accelerating the implementation of HSDP. A joint appraisal of the Federal Ministry of Health MDG Fund is being conducted by a multi-disciplinary team of independent consultants. The appraisal includes the design of specific measures to move towards a joint financing agreement between donors and FMOH, and harmonization of all federal-level funding for the health sector in terms of planning, budgeting and reporting.
10. The national target for EFY 2000 was to deploy a total of 23,987 HEWs. A total of 6918 HEWs have been trained and deployed in EFY 2000. Together with the 17,653 HEWs deployed prior to EFY 2000, the total number of HEWs deployed so far has reached 24,571 accounting for 81.9% of the total national requirement of 30,000 HEWs. Additional 786 HEWs are currently under training, raising the overall planned target for HSDP III to 30,786.
11. The total number of rural kebeles implementing the HEP is 16,731, while the number of rural kebeles with two HEWs is 11,834. In EFY 1999, the national average was 51% whereas in EFY 2000 it is 70%. During EFY 2000, the plan was to train 1,756,082 model families, but 886,208 (50%) have graduated and 133,876 are being trained. When those under training (133,876) are added to the number of those that graduated (886,208), the performance rate will reach 58.1 % (1,020,084).
12. Out of 4047 health posts planned to be constructed during the fiscal year, 818 have been completed, while 2100 are under construction. When this construction is completed, there will be 11,446 (76.3% of the HSDP III target) health posts at national level. To meet the overall target of 15,000 health posts, 3554 additional health posts have to be built.

13. To achieve the planned universal primary health care coverage, the target of HSDP III is to put in place 3,200 health centers by 2009/10. To meet this target, the FMOH and RHBs have concluded an agreement in 2007 whereby for every health center to be constructed/health station to be upgraded/ by each RHB, one matching health center will be constructed by FMOH; and FMOH will also equip both health centers. As per this commitment, the construction of 473 health centers has been contracted out; out of which a site hand over for 368 health centers has been effected. Out of the 368 health centers the construction work of 355 has began, while the construction of 53 health centers has been completed. Preparation has also been completed to commence the construction/upgrading of additional 891 health centers FMOH support
14. On the part of RHBs, the plan for EFY 2000 was to construct 1166 matching health centers. Accordingly, the construction of 499 health centers has already started; and they have committed and secured budget for 645 health centers. If we add the existing health centers with the 500 to be constructed through the contractual agreement entered into with the GTZ and the 891 by the FMOH, there will be 2,064 health centers. The addition of the 1,166 health centers to be built by regions brings the total to 3230.
15. Problems in hospital management were studied in seven regional hospitals (Tigray, Amhara, Oromia, SNNP, Somali and Dire Dawa) and in seven hospitals in Addis Ababa. After the preparation of the Blueprint, which addresses 8 system innovations in detail, pilot implementation was started in these 14 hospitals. At national level, 40 hospitals were selected to implement the Blueprint; but it is now under implementation in 37 hospitals.
16. As a part of the effort to promote technological support to training and tele-diagnosis, a study to assess the possibility and feasibility of starting telemedicine and video-conferencing services in 21 selected hospitals involved in the training of health and medical professionals has been conducted. As a way of showcasing the possibilities of these technologies in support of the training of professionals as well as enhancing health care delivery at the rural level, the implementation of telemedicine and tele-education has been commenced in the Jimma Network (consisting of the Jimma Hospital, Nekempe, Wolliso and Mettu).
17. In line with the plan to strengthen the partnership of professional associations with the Government through intensive discussions held every three months, memorandum of understanding has been signed with the Association of Ethiopian Surgeons, Association of Ethiopian Pediatricians and with the Ethiopian Medical Association. These associations have started to undertake various activities, based on their joint Plan of Action such as improving quality of health services, undertaking various studies, ensuring implementation of the Code of Ethics for health workers etc. These associations are also engaged in providing surgical treatment for cataract, hernia, etc. through campaigns done in collaboration with Government Health Services.
18. During EFY 2000, 10.7 million children aged 6-59 months were given vitamin A supplementation; while 7.7 million children aged 24-59 months were given Albendazole tablets. These figures show that the coverage for Vitamin A supplementation has increased from 91% in EFY 1999 to 94% in EFY



2000. Similarly, the de-worming coverage has increased from 80% to 99% surpassing the target of 90% in EFY 2000.

19. The number of HCT sites has increased from 1005 in EFY 1999 to 1336 in EFY 2000. As a result of the Millennium AIDS Campaign there has been a dramatic increase in the number of people using the HCT service which grew from 1,898,191 in EFY 1999 to 4,559,954 in EFY 2000. The number of facilities providing PMTCT has increased from 408 in EFY 1999 to 719 in EFY 2000. In EFY 2000 PMTCT service was planned to be given to 15,000 pregnant women. However, the number of women who received PMTCT prophylaxis was only 4478. The number of facilities providing ART services increased from 271 in EFY 1999 to 353 in EFY 2000. Compared to the number of planned facilities (640), this amounts to a performance rate of 55.2%. The number of PLHA ever started on ART has increased substantially from 97,299 in EFY 1999 to 150,136 in EFY 2000.
  20. The distribution of 20.5 million ITNs in malarious areas has been a remarkable achievement in the prevention and control of malaria. The 100% coverage with ITNs has contributed to a substantial reduction in morbidity and mortality caused by malaria. On the whole, due to the integrated prevention and control measures taken so far, no major malaria epidemic has occurred during the reporting period.
  21. The TB treatment success rate currently stands at 84% which is near to the international standard (85%). Of note is the fact that around 1400 registered cases were missed and not evaluated. The national TB case detection rate has increased from 32% in EFY 1999 to 33.9% in EFY 2000. TB cure rate has shown a slight decline (67.4%) with respect to the EFY 1999 level of 69%.
  22. Maternal health indicators showed improvement compared to EFY 1999. ANC coverage increased from 52% in EFY 1999 to 59% in EFY 2000 and postnatal coverage from 19% to 25%. The proportion of supervised deliveries rose from 16.4% in EFY 1999 to 20.3% in EFY 2000. However, the national targets set for EFY 2000 were not achieved. The contraceptive acceptance rate increased from 33% in EFY 1999 to 51% in EFY 2000, slightly short of the target (55%) for the reporting period.
  23. The coverage for Pentavalent, Measles and fully immunized children showed consistent increase from 73%, 65%, and 53%, in EFY 1999 to 81%, 72% and 63% in EFY 2000, respectively. Despite this increase in 2000, the target was not met (ie, 85% for Pentavalent coverage).
  24. In EFY 2000, the OPD attendance per capita declined to 0.24 from 0.32 in EFY 1999. Under-reporting could be one the reasons for poor health service utilization level. It appears that achievement of the HSDP III national target for OPD attendance per capita of 0.66 needs greater attention and effort.
  25. There was general increase of the per capita expenditure for health from EFY 1994 to 2000. It had grown from 11.3 ETB to 23.1 ETB. The percentage of total regional budget allocated to the health sector ranged from 3.3% in Addis Ababa to 14.4% in SNNPR, with a national average of 9.1%.
  26. The comparison between commitment and disbursement of donors' funds shows that 81.5 % of the amount committed was disbursed in EFY 2000 with a wide variation across donors.
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27. Some of the major challenges faced during implementation of the EFY 2000 Core Plan were:

- Inadequate ownership by some RHBs and woreda health offices of the innovative woreda based planning exercise. Poor synchronization of planning by some development partners and vertical programmes undermining the principle of harmonization and alignment.
- Some development partners failed to provide budget information during the woreda planning exercise hampering the annual resource gap analysis.
- Long time elapsed to harmonize the core processes at the federal and regional levels and delay in completing the BPR process.
- Inadequate action by some regions to put in place the necessary preconditions to scale up the new HMIS and delay in finalization of curriculum and occupational standard with the Ministry of Education.
- Huge financing gap to finance hubs and revolving drug fund as per the Logistic Master Plan.
- Shortage and rising cost of construction materials, shortage of contractors and inadequate capacity of GTZ to coordinate construction of health centers. Inadequacy of funds secured by some RHBs for matching health centers. Delays in procurement and delivery of medical equipment.
- Very high cost of telecommunication hampering the implementation of e-health including expansion of the new HMIS, tele-education and tele-medicine.
- Shortage of trained personnel and failure of regions to transmit reports on time.
- Poor liquidation of funds by RHBs hampering transfer of additional funds and delay in release of funds by some development partners.
- Low per capita spending for health and difficulty in getting timely financial data.
- Poor predictability of funding and unwillingness of some development partners to provide financial information.



1

# Introduction

The Health Sector Development Programme (HSDP) is now ten years old; and the end of EFY 2000 marks the conclusion of the third year of HSDP III. In the course of these years, the programme has been continually reviewed through such joint exercises as Mid-Term Reviews (MTRs), Final Evaluations and Annual Reviews Meetings (ARMs).

The Annual Review Meeting (ARM) is an important event that brings together a wide range of stakeholders that include federal and regional government agencies, selected woreda health offices, HPN Donors Group, NGOs, professional associations, institutions of higher learning, the private sector and international organizations.

According to the approved TOR, the objectives of the Tenth Annual Review Meeting are to:-

1. Take stock of the progress made and problems encountered in the implementation of the EFY2000 Plan and recommend actions to improve implementation;
2. Deliberate on the report of the Mid-Term Review of HSDP III;
3. Look forward into the activities of the coming year by reviewing and endorsing the sector's Core Plan for EFY 2001; and also to sign a performance agreement to ensure the implementation of the plan.

The major inputs to the review exercise are, therefore, the EFY 2000 Performance Report, the report of the recently concluded Mid-Term Review and the Core Plan for EFY 2001. This year's Performance Report is the second report prepared in the wake of the sector's HMIS reform, which has begun to address the chronic weaknesses of the health system.

Since the beginning of the reform, the reporting coverage from regions to FMOH has grown to 100%; there is now a unified reporting format based on a set of core sector-wide indicators common across regions and standardized in their procedures of data collection and analysis. The indicators, selected through a broad consultative process, reflect sector policy priorities based on PASDEP, MDGs and other international commitments as well as the different levels of responsibility, namely, the national, regional and woreda levels.

However, there are still a number of challenges to overcome. The new HMIS has to be scaled up; gains achieved so far have to be consolidated and utmost attention given to data quality. This is a process that takes time to mature.

Nonetheless, the EFY 2000 Performance Report signifies a further step in the progress towards the development of evidence-based Monitoring and Evaluation.

The health sector has set the harmonization vision of operating through one-plan, one-budget and one-report. The efforts being to prepare a sector-wide annual performance report based on standardized set of indicators and the development of sector-wide annual core plan are major steps of progress towards this harmonization vision.

In the preparation of this report, effort has been made to:-

- Assess the EFY 2000 performance of the sector against the set of around twenty selected indicators.
- Present highlights of performance against the Core Plan with the application of the national and regional level indicators.

- Maintain focus on performance at the regional level and make comparisons among the regions.
- Present highlights of the health sector support system
- Provide a health sector financial report for the period under review.

In terms of data sources, the compilation of this report has relied heavily on the HMIS, which draws its data from routine service and administrative records. In other words, the report uses routine sources of information incorporated within the monitoring and evaluation framework of the HSDP. Other sources of information include:-

- Surveys and studies undertaken by various stakeholder institutions like the CSA (e.g. The Ethiopia Demographic and Health Survey (EDHS) , Population Census *etc*)
- Reports by FMOH programs and other central level institutions.

The report is made up of 20 sections and contains 19 tables and 47 figures used to illustrate progress, decline, comparison and trends. To the extent possible, effort has been made to follow uniform structure of presentation indicating background, plan, performance and challenges.







2

**Health System  
Development & Capacity  
Building**

The major goal of this program is to build capacity in order to provide cost-effective, result-oriented, equitable and customer-focused services through effective institutional transformation. The major areas of focus under this goal include the Civil Service Reform Program (CSRP), Business Process Re-engineering (BPR) and Result Oriented Performance Appraisal (ROPA). The performance of the sector in EFY 2000 with respect to this major goal has been as follows.

## **Civil Service Reform Program Activities**

### **2.1 Top Management Leadership Performance Improvement**

Within the framework of the five sub-components of the Civil Service Reform Program the target was to achieve strengthened implementation capacity by developing management skills and establishing a monitoring system. The major activities planned in terms of achieving the target included: - the provision of training on the system of competence check list for top management; conducting the training of all workers on development strategies, the Core Plan; monitor and the proper utilization of the budget. The revision of the health sector policy and strategy and strengthening of the joint management forum of the FMOH and RHBs were among the planned activities.

A major planning activity undertaken during the period under review was the preparation of a sector-wide, woreda-based Core Plan for EFY 2000, the approval of this plan at the Ninth Annual Review Meeting of HSDP in Bahar Dar, and the launching of its implementation in EFY 2000.

To ensure the effective implementation of the Core Plan, the Federal Ministry of Health had signed a Contract Agreement with Regional Health Bureaus.

The progress of implementation of the Core Plan was being monitored through the joint meeting of the FMOH and the RHBs held every two months and their joint bi-annual review meetings based on the core plan indicators.

In addition, an Action Plan to Implement the Recommendations of the ARM 2007, with implementation timeframe and responsible bodies, has been distributed to all implementing bodies including development partners to serve as a reference for implementation of their respective plans.

Draft Implementation Manual on Performance-based Contracting has been developed. The Balanced Score Card (BSC), which is a strategic planning and measurement tool, and the standard theory of which has been customized to the FMOH context, has been under implementation in the FMOH during EFY 2000.

A planning system whereby all heads of sections, team leaders and experts prepare weekly plans based on the annual plan, and implement the plan upon approval by their respective department heads has been introduced. A guideline to assist this process has been printed and distributed for use by all health facilities.

The study of seven core and two sub BPR process have been underway during EFY 2000. These studies were made to bring about institutional transformation through the full-fledged implementation of the Civil Service Reform Program; and to increase customer satisfaction by making fundamental improvements in access to and utilization of health services.

An Agreement on Health Sector Business Process Reengineering (BPR) has been signed

in August 2008 between the FMOH, RHBs and the Ministry of Capacity Building (MOCB). The Agreement focuses on seven core and seven other support processes and delineates the respective responsibilities of the FMOH and MOCB. Out of the processes that were selected earlier the study of the Pharmaceutical Logistics Master Plan has been completed and Pharmaceutical Fund and Supply Agency (PFSA) has been established. The HMIS study has been finalized and pilot-tested. Implementation manuals and guidelines for two core processes and two sub-processes have been prepared. The results of the study on Procurement, Finance and General Service Support Processes are being implemented. Similarly, the study on Health Human Resource Development/ Management Support Process are being finalized.

Other BPR studies that were undertaken by federal institutions and agencies and the Ministry of Health have been completed in June of EFY 2000 and are in the final process of incorporating corrections and revisions.

The main challenges faced in the process of implementation include:-

- Failure on the part of leaders at various levels to follow-up and implement agreed upon decisions.
- Inadequate staff to design and finalize the BPR processes.
- Migration of experienced professional staff at all levels.

### **2.1.1 Human Resource Development Reform**

The existence of adequate number of skilled, motivated and well-supported health workers is essential for the delivery of efficient health services as well as for the achievement of health related Millennium Development Goals (MDGs). Development of human resources with emphasis on frontline and middle level professionals is one

of the eight priority areas identified in the Health Policy of Ethiopia as well as in the successive phases of HSDP. Accordingly, HRH is one of the major strategic issues that the FMOH has been working to address since the first phase of HSDP.

During the first two phases of HSDP, significant progress has been made in the training and deployment of lower and medium level health professionals notably, Health Officers, Nurses and Health Extension Workers. The number of Health Officers and HEWs has reached 3,500 and 24,000 respectively, while there are currently enough nurses to meet a nurse to population ratio of 1: 5,000 recommended by WHO.

The Federal Ministry of Health with active involvement of the RHBs, has been working in the development of a comprehensive Human Resource for Health Development Strategy (HRH strategy) for over a year. The study, which is the first of its kind, is nearly completed. The new HRH strategy addresses both the supply and demand side of the HRH issues. The strategic direction illustrates the FMOH's intension to follow two mutually reinforcing strategies: substantial increase in the number of trained key health professionals (all types of medical doctors including specialists, midwives, and anesthetist professionals) and putting in place systems of financial and non-financial incentive packages to retain health workers in service.

Human Resources for Health is being studied as one of the Core BPR processes in order to substantially improve the supply and quality of health services professionals and design new system of human resources development and retention. This study is expected to bring about fundamental changes in terms of the supply and retention process of health personnel in the sector.

As part of the measure to implement the BPR study, internal guidelines on deployment of workers and procedures for the submission and handling of complaints arising from deployment have been

prepared.

In order to fill existing vacancies, 101 new graduates with better school performance have been employed by the Federal Ministry of Health. Prior to their deployment, the new recruits were given a two- and- half months orientation on Government development strategies, general features of the Ministry, the health sector strategic plan and various health programs.

To ensure the effective implementation of the result-oriented plan at the level of the FMOH, the work plans of 423 workers for the second half of EFY 1999 have been evaluated. On the basis of this evaluation, the work of 22(5.2%) and 399 staff members(94.3%) was rated as high and satisfactory respectively, while that of 2 workers (0.5%) was found to be poor. The EFY 2000 result-oriented plan has been prepared and implemented based on the “Balanced Score Card (BSC) planning principle.

Some of challenges/problems encountered during plan implementation include:

- the slow progress of the HRD study,
- the long time taken to prepare the BSC plan and M and E

To address these problems, professionals drawn from renowned universities and partner organizations have been deployed to assist the team working on the human resource reform process.

### **2.1.2 Service Provision Performance Improvement**

The goal of this sub-program is to promote client satisfaction by providing efficient and cost-effective services; and by making timely data and information about health facilities available to the general public.

Some of the activities indicated in the Core Plan include: reviewing complaints by establishing a complaints management system, provide up –to- date information to the public and clients by designing strategy for dissemination of information on service delivery, undertaking two assessment studies to identify and resolve problems encountered in service delivery, and providing various types of training to governmental and non-governmental media networks. The performance of the sector in EFY 2000 was as follows:

At the FMOH, 603 suggestions/messages have been received during a period of nine months. Out of these, 462 were complaints, while 241 were expressions of customer satisfaction. Following the review of these feedbacks, measures were taken to have the complaints addressed by the concerned sections and workers of the Ministry.

The FMOH website that was set up to raise public and client awareness about the mission and activities of the Ministry, as well as to receive questions and suggestions, has been improved and timely data and information is being provided to the public and clients.

Information on the activities of the sector such as major communicable diseases and the Health Extension Program were transmitted through different media located at the center and in the regions to increase public knowledge about the health sector.

Failure to respond promptly to complaints made by customers, defensive reaction by some workers to complaints targeted at them, denying authenticity of complaints, and occasionally resistance to change or to the reformed work process are some of the challenges encountered during implementation. In this connection, necessary measures are being taken to alleviate these problems.



### 2.1.3 Financial Management Performance Improvement

The goal of this sub-program is to establish and implement efficient and cost-effective resource management system. Some of the key activities of this sub-program incorporated in the Core Plan include: undertaking performance audit on the implementation of the annual plans of malaria, HIV/AIDS and MCH programs; performing surprise audit on the internal control system of institutions; and putting in place a system that enables monitoring of financial flows as well as liquidation of funds transmitted for procurement purposes to various facilities and to RHBs. The performance of the sub-program in EFY 2000 was as follows:

Based on the study results, implementation manuals to improve the supply and utilization of financial inputs have been developed. To implement the system at regional level, training has been given to the RHBs of Dire Dawa, Harari and Amhara.

The Abyssinia Card System on fuel utilization has been put into use. This step has helped to remove the lengthy work process and red tape associated with the acquisition of transport fuel and also to ensure effective control over its utilization.

To save working time by avoiding the piece-meal procurement of stationary, and also to benefit from economies of scale, the FMOH has entered into an agreement with short-listed suppliers for the procurement of two-years supply of stationeries at one go.

With the view to make vehicle maintenance effective, vehicles that could be maintained by importing companies and partner organizations are selected and repaired by these organizations.

For those that can not be maintained by these organizations, preparatory arrangements are being finalized to out source the maintenance service to short listed garages that have adequate capacity. In order to decrease the work load arising from payment of salary and to avoid the red tape and loss of working hours to pay those workers who cannot take their pay on fixed dates due to field work and various other causes, arrangements have been made, since October EFY 2000, for the payment of the salaries of FMOH workers through banks using Automatic Teller Machine (ATM).

In order to return the unutilized budget of EFY 1999 to the Treasury at the closing of the financial year, inventory has been carried out by the Head Office of the FMOH and by the Drug Administration and Control Authority. Surprise audit has been performed and the audit report is being prepared to verify the proper operation of the cash administration system.

Inability to fully utilize budget allocated for implementation of planned activities on time and failure of sections to give proper feedback on the financial report sent to them weekly are some of the challenges encountered during implementation that are worth mentioning.

### 2.1.4 Ethical Performance Improvement

The target of this sub-program was to prepare and implement an Ethics Guideline incorporating basic ethical principles that are suited to the institution.

The five-year accounts of St. Peter Tuberculosis Specialized Hospital have been audited and it was found that Birr 1,744,709 had been spent in contravention to Government laws and regulations. Proper corrective measures have been taken on the culprits and further investigation is being made by the Ethics and Anti-Corruption Commission. In connection with the discovery of ITNs for

prevention of malaria in the hands of traders, the Regional Health Bureaus of Oromia and SNNPR are being audited. The preliminary report confirmed that 7534 ITNs were missing from Abe Dengoro health center in Eastern Oromia and the case is being investigated by the Federal Police.

## 2.2 Business Process Reengineering (BPR)

After extensive consultations between the FMOH, RHBs and the Ministry of Capacity Building, some core processes have been changed, and in other cases certain aspects of some core processes have been taken to other core processes. As a result, there are new core processes and some core processes have become support processes. HMIS and Harmonization and Alignment have been included under Planning, Monitoring and Evaluation Support process; while HRD has become a support process on its own.

Currently, the seven core processes selected for BPR include:- Health Care Delivery (Former name was Access and Quality of Health Services), Public Health Emergency Management (Reduction of Epidemics), Research and Technology Transfer (New Core Process), Pharmaceutical Supply (Health Commodity Supply and Management System), Resource Mobilization and Health Insurance (Financial Resource Mobilization and Utilization), Health and Health Related Services and Product Regulatory Core Process (New Core Process) and Health Facility Construction/Renovation/Infrastructure Core Process (New Core Process)

Except the HRD Support Process discussed earlier, the status of the remaining core processes is presented as follows:-

### 2.2.1 Health Care Delivery Core Process

The Health Care Delivery Core Process (formerly

known as Health Service Access and Quality Core Process) is now in its final stage of re-designing. This Core process has two sub-processes: 1) Promotive and Preventive Sub-process 2) Curative and Rehabilitative Services Sub-process. The Promotive and Preventive Sub-process deals with all major health promotion and disease prevention activities. On the other hand, the curative and rehabilitative services sub-process addresses all facility-based curative and rehabilitative services.

Analysis of the existing health care delivery system revealed several process-related problems. Major problems identified include: dysfunctional referral system, client-unfriendly environment, delay in management of emergency cases, neglected mental and rehabilitative services, 'one-size fits all' type health service, long and unjustified waiting time, centralized and compartmentalized intra-facility services, vertically oriented service delivery approach, and supply-driven technical support. The new health care delivery process has been designed in a way that addresses the above mentioned problems in a radical way. If implemented properly, it is expected that dramatic improvements will be seen in the Ethiopian health care delivery system. For instance, waiting time for cold admissions would decrease from 6 months to 2 weeks, all emergency cases will receive the necessary care within 5 minutes of arrival (there will be separate gate for emergency), and processing time for outpatient clients would be reduced from 16 to 2 hours.

This core process was discussed at several rounds of plenary sessions in the presence of various MOH agencies and partners. More recently, the report was discussed at a consensus building workshop held at Adama with heads of RHBs in the presence of BPR experts from the Ministry of Capacity Building. Consensus was reached at the meeting. The design team is now in the process of incorporating the comments forwarded at the meeting, and it is expected that the new design will



*Business Process Re-Engineering  
Consensus Building Workshop  
Between FMOH, RHBs, MOCB in  
session in Adama.*



be ready for pilot-testing soon.

In order to bring about all round improvement at national level of the medical care services provided by hospitals, a blue print has been prepared after giving first-round training to 80 Chief Executive Officers (CEOs) drawn from 40 hospitals. This blue print is being implemented in 37 of these hospitals.

As components of the operational system, the organization of health services namely the functions of health post, health center and primary hospital, have been revised. The experience of various countries on the organization of the health service structure has been reviewed. In addition, to adopt and implement the National Health Service Model of Great Britain in Ethiopia, a high level professional invited from abroad, has given orientation to members of the design team as well as to members of the Management Committee; subsequently the job description of service providers and supervisory bodies is being developed.

An improved guideline on procedures governing

the provision of medical documents (sick leave, health certificate, medical referral abroad, *etc*) by health institutions has been prepared. It was decided that medical documents formerly given only by government health institutions should be given also by private health facilities.

### **2.2.2 Health Management Information System (HMIS)**

HMIS has been a Core process selected for Business Process Re-engineering. The objective of this core process is to design a system that will improve decision making at all levels of the health system through the utilization of complete, timely and accurate health information. The design of the HMIS BPR Core Process was launched with the objective to review and strengthen the existing HMIS at federal, regional, woreda, and health facility levels to produce timely information for planning, management and efficient decision-making. Its objective was also to standardize (common definitions of indicators, data collection instruments, and data processing and analysis



procedures), integrate (integrating data from different sources into an integrated channel from which all derive their information) and simplify (collecting, analyzing, and interpreting only the information that is immediately relevant to performance improvement).

To address these, the Federal Ministry of Health established a National Advisory Committee (NAC), chaired by PPD/FMOH, USAID as secretary and with representation from stakeholders, with a view to facilitating the development of a national strategy and implementation plan for a unified HMIS and M & E. The Federal Ministry of Health, based on the recommendation of the National Advisory Committee (NAC) procured HMIS consultancy service to review, design and develop a national HMIS system. For this purpose, a one-year contract was awarded to John Snow Inc. (JSI) in January 2006 in order to facilitate the development of the National HMIS. Subsequently, a Technical Advisory Group (TAG) was established by FMOH, with members from CDC, Tulane and WHO to monitor the implementation of the activities and to assist JSI in the review of and the development of a comprehensive HMIS.

The design of the HMIS was a consultative process with active participation of programs, Regions and all stakeholders. Multiple consultations were conducted on the selection of core set of indicators, the design and standardization of recording and reporting formats and human resource requirements. The indicator selection process took

longer than anticipated as it was necessary that the need of the health sector and all stakeholders was addressed and fulfilled.

The HMIS reform introduces radical changes in the way patient records are handled and health information is managed. Some of the significant changes include the introduction of an integrated patient/client folder. The use of integrated folders is one of the innovations in reducing the accumulation of numerous records for the same patient. Such fragmented record keeping have led providers to make errors during diagnosis and treatment and hampered patient care. The new integrated folder will ensure that the provider will have the full information at hand to make the appropriate decision. Moreover, the introduction by the HMIS of an alphabetized master patient index makes locating revisiting patients' folders easy with improved access to patient's medical records.

One of the primary goals of the HMIS is to ensure that data is used for decision-making at the point of collection. The HMIS introduces not only the procedure but also the structure for performance improvement. At all health institutions, a performance monitoring team will be created that will review service achievements and addresses constraints monthly at facility level and quarterly at the administrative structures based on selected indicators and making adjustments in operations as necessary. The HMIS has introduced an inbuilt mechanism by which reports are checked for accuracy, completeness and timeliness which facilities will assess and report on each quarter.



With the oversight of the NAC and with the technical input from the TAG, pilot testing of the national HMIS and M and E system was conducted from Sene through Nehassie 2000 in 7 Regions, 11 woredas, 6 hospitals, 22 health centers and 30 health posts. Training materials were prepared and training for TOT was conducted by FMOH and Tulane University. Table 1 shows the percentage of HMIS staff hired in EFY 2000 with respect to the plan by region.

*Table 1: Percentage of HMIS Staff Hired in EFY 2000 by Region Compared to the Plan, Ethiopia*

Regions	Planned	Hired	Percentage	Notes
Tigray	229	0	0.0	No activity has been observed
Afar	68	0	0.0	The RHB claimed not to have authority over the Woredas
Amhara	643	0	0.0	Negotiations are happening between RHB and Capacity building
Oromia	1198	0	0.0	Discussion on 1357 HMIS staff to be hired is ongoing with CPA for approval
BG	36	16	44.4	Hired
SNNP	831	0	0.0	Negotiations are happening between RHB and Capacity building
Gambella	32	20	62.5	Hired
Harari	31	7	22.6	Hired
Addis Ababa	59	0	0.0	Negotiations are happening between RHB and Capacity building
Dire Dawa	18	18	100.0	Hired
Total Gap	3145	61	1.9%	

Using different fora, promotional work has been done for stakeholders, partner organizations and donors aimed at speeding up the reform of the information system. A team comprising of members of higher management has made multiple visits to health facilities implementing the pilot test. Additionally, continuous follow-up as well as provision of support and orientation training was provided by FMOH to ensure the successful implementation.

A mid-term review, and at the end of the pilot test, an evaluation was conducted by an independent body to find out whether the new system was able to bring about the expected fundamental changes. Based on the inputs acquired from the evaluation, corrections and revisions have been made on the HMIS.

As a result of their involvement in the design, piloting and training of the New HMIS, Tulane University/PEPFAR was chosen as the FMOH's lead partner in the scale up of the HMIS. Scale up planning was collectively and individually conducted with RHB's by MOH. This planning included the training of health professionals, standardization of medical record rooms (card rooms) which includes renovation of existing facilities and procurement of furniture and equipment, quantification of forms and registers and determining the need and hiring of prospective health information technicians.

Multiple meetings were held between RHB heads and FMOH management to determine the roles and responsibilities for the scale up of the National HMIS. Implementing of the HMIS reform needs active involvement of all stakeholders. To this end, FMOH and RHBs have agreed on shared responsibilities and a comprehensive costing of the scaling up of the HMIS was done and shared with Regions. Accordingly, a coordinating committee composed of five members has been formed in each region and a national implementation plan has been prepared. Based on this plan, a consensus was reached so that RHB's will take the responsibility of bringing the medical record rooms up to standard, hire health information technicians and facilitate the training of all staff within the Region. FMOH will print all necessary forms and registers and will provide all the required technical assistance. Checklist on the requirements to be met by regions has been prepared and distributed.

Bidding for printing of all forms and registers necessary for the scale up is completed and awarded. Printing was initiated and is currently in the process of completion. As this has proven to be an expensive endeavor, FMOH is considering upgrading its printing facility.

One of the gaps seen during the initial HR assessment was lack of HMIS units and focal person at all levels of the health system. In order to address this, FMOH in collaboration with Tulane University has established the occupational classification and occupational standards for these cadres according to Ministry of Education standards. This was a protracted process as the discussions with the Ministry of Education to set off the pre-service training of HMIS technicians took a long time. Curriculum design has been completed and currently preparation is underway to enroll the first batch of students.

Once preparations for the scale up are completed, the FMOH with Tulane University supports RHB's in conducting training. Training is conducted not only on all the forms, registers and reporting formats but focuses on information use for decision making at the local level. Currently training has been completed and implementation has begun for Dire Dawa, Harari, Gambella, Afar and Benishangul-Gumuz Regions. 1740 health professionals, 388 health extension workers and 143 card room clerks have been trained on the New HMIS to date.

It was observed that health facilities, after being trained, being provided with adequate supplies

*Hands on training of "card room" clerks is one of the modalities for the integration and handling of patient records in the medical record unit*



*Facility level distribution of patient folders, registers and forms during HMIS implementation, Dire Dawa*

(individual folders, patient cards, master patient index, tracer card, service identification cards, and appointment cards) had no difficulty in implementing the New HMIS. However, major challenges during the implementation of the new HMIS were observed. It is noted that there is poor commitment of certain Regional Health Bureaus to the HMIS reform. RHBs that identified the HMIS implementation as their priority and owners of the HMIS reform had less challenges. Pre-conditions for the scale-up were distributed to the regions and, based on these, Dire Dawa, Harari and Benishangul-Gumuz fulfilled the requirements for the scale-up. Other major challenges include: resistance to change; poor progress in the renovation of medical record rooms; delayed hiring or placement of the necessary human resource for the New HMIS; and resistance to integration of medical records.

To address some of these challenges the FMOH has drafted a regulation that will enforce the implementation of the HMIS. This “draft for discussion” document addresses all the legal implications of recording, storage and security, right of access, use and disclosure and data reporting mechanisms by establishing legislative duties and rights in respect of patients, health professionals, health institutions and administrative offices. Furthermore, a consultative workshop including all relevant stakeholders is planned to finalize these documents and a legislative agenda has been sent to the Council of Ministers to be considered in the coming year.

Meanwhile, integrated supportive supervision, performance review, quality improvement and operational research have been added to the HMIS design to complete the picture of M&E.

### **Geographic Information Systems for Health**

The Federal Ministry of Health in collaboration with Tulane University has initiated the process

of establishing a Geographical Information Systems (GIS) for health. This tool will enable the collection, storage, management, analysis, retrieval, modeling and visualization of spatially referenced information. This will build the capacity of the health sector to undertake the spatial tasks needed to improve monitoring of the spread of disease, modeling the future diffusion of the disease and planning of timely allocation of resources to improve health conditions of the public. The Central Statistical Agency (CSA) has captured required spatial data (such as health facilities, service centers, infrastructure, etc.) and the FMOH has provided CSA with technical assistance and the necessary resources to finalize and obtain spatial data. This GIS data will be linked to the HMIS in order to improve the quality of information for decision making. The major challenge encountered in implementing GIS is the lengthy bureaucracy of the Central Statistics Authority to provide relevant data to the health sector.

### **Electronic Health Record (e-Health)**

An electronic health record (EHR) system that will enable better patient care and makes the reporting system effective from health facilities to the level of the Federal Ministry of Health has been designed. This software is being pilot tested in Dire Dawa. This EHR system will enable and empower the health care system to acquire accurate and timely patient information and enhance health information exchange. The system will improve patient care and further provide accurate data for informed decision making at all levels. The EHR has been adapted from CDC/Zambia by Tulane University/CDC to include modules covering major patient health information. Following the currently ongoing pilot phase, an implementation of the EMR system covering all hospitals and health centers in the country will be phased within the next five years.

## Health Net

To foster connectivity a Local Area Network (LAN) has been installed at the Head Office and all sections of the FMOH are now beneficiaries and the required equipment for video conference has been installed at the Head Office and is fully operational. Furthermore, negotiations are underway to reduce the rate for broadband for health facilities. This will enable fast and accurate information exchange and efficient resource sharing. Establishing the LAN and reducing connectivity cost are the first steps in the broader vision of the FMOH to facilitate inter-connections of all health institutions in the health sector. This infrastructure can be used to enhance data flow and information sharing. The FMOH envisage that the HealthNet will improve services areas in accurate, quality and timely flow of health information as well as effectively support the existing and future systems such as HMIS, HR, Finance, Decision Support Systems and others.

### 2.2.3 Harmonization and Alignment

Some of the important milestones in the area of harmonization and alignment witnessed during EFY 2000 and in which Ethiopia was involved, were the launching of the International Health Partnership and the signing of the Global Compact on scaling up for the achievement of the Health MDGs.

As part of the global campaign for the attainment of the Health MDGs, the International Health Partnership (IHP) was launched on the 5th of September 2007. The purpose of the IHP is to commit all signatories to strengthened partnerships in line with the Paris Declaration and in a way that reflects the unique situation in each country; and to channel support into country owned health plans as well as to ensure fair and sustainable financing of health systems.

The Global Compact for achieving the Health MDGs was signed by ministers from developing countries (Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal, Zambia and Mali), eight international organizations (WHO, World Bank, GAVI Alliance, UNFPA, UNAIDS, UNICEF, UNDP, EC), seven bilateral donors (UK, Norway, Germany, France, Italy, Portugal and the Netherlands) and other donors such as Bill and Melinda Gates Foundation and the African Development Bank.

The common goal of all these initiatives is to accelerate the achievement of the health MDGs. IHP and related initiatives have created a process, called IHP+. The main objectives of this process are to:-

1. Enable countries identify health systems constraints, to plan and address the problems and to improve health related outcomes in a sustainable, equitable and effective manner;
2. Generate and disseminate knowledge, guidance and tools in specific technical areas;
3. Enhance coordination and efficiency in aid delivery; and
4. Ensure accountability and monitoring performance.

In 2007, in line with these objectives, Ethiopia has prepared a road map that provides estimates of resource requirement and projected financing gap for the next three years of HSDP III. The road map is intended to serve as the basis for discussion, development and signing of country level compact.

Following the signing of the Global Compact in London on 5 September 2007, Ethiopia became the first country to conclude (in August 2008) a national Compact with its development partners within the framework of the IHP+ with the aim of scaling up the Country's efforts to achieve the Health MDGs by accelerating the implementation of HSDP.

The main objective of the Compact is to set out



a framework for increased and more effective aid, in order to enable Ethiopia to make faster progress towards the Health MDGs. The Compact also establishes, among other things, the guiding principles and management arrangements that will be observed by Government and development partners, sets collective target for the level of total aid for health (particularly of pooled aid) that the signatories will endeavor to provide to Ethiopia each year for the period of 2009-2015.

The Compact also serves as an overarching framework for aid coordination in Ethiopia and complements more specific agreements relating to the Aid Policy of the GoE, the Harmonization Code of Conduct signed between the FMOH and HPN development partners in September 2005, and the HSDP Harmonization Manual issued in 2007.

Ethiopia has revised the costing of HSDP III and indicated that to implement its scale up strategy it will require approximately 3.334 billion USD under Scenario One; 4.117 billion USD under Scenario Two; and 4.613 billion USD under Scenario Three (Table 2).

Table 2: Estimated Cost of HSDP III for 2007/08-2009/10 (in Million USD)

Programmatic Areas	Baseline Spending	Total Funding Need Under HSDP III		
	2005/06	Scenario 1	Scenario 2	Scenario 3
Health Systems (incl. HEP)	219.42	1507.10	2026.49	2394.42
Child Health (EPI, IMNCI)	44.10	253.28	277.64	278.77
Malaria	149.57	561.51	604.17	653.90
HIV/AIDS and TB	235.88	742.13	786.44	784.12
Maternal Health	20.46	174.88	276.66	340.39
Nutrition	11.24	56.35	80.62	96.23
Water and Sanitation	3.66	39.29	65.82	65.20
TOTAL	684.33	3,334.54	4117.85	4613.04
Per Capita Per Year	8.80	14.30	17.60	19.70
Total Gap		1,561	2,344	2,840

As shown in table 2, there is a huge financing gap for the implementation of HSDP which needs to be filled through additional resource mobilization.

A joint appraisal of the Federal Ministry of Health MDG Fund is being conducted by a multi-disciplinary team of consultants. The appraisal includes the design of specific measures to move towards a joint financing agreement between donors and FMOH, and harmonization of all federal-level funding for the health sector in terms of planning, budgeting and reporting.

In addition to the activities undertaken in line with the above mentioned global initiatives, efforts have also been made to implement some activities as a follow up of the Health Harmonization Action Plan adopted in 2005. These activities include the launching of the MDG Fund Appraisal, the dissemination and popularization of the Health Harmonization Manual, the refining and consolidating the experience in sector-

*In August 2008, Ethiopia became the first country to conclude a compact with its development partners within the framework of the International Health Partnership.*



wide planning by preparing the second (EFY2001) woreda-based Core Plan, the strengthening of the FMOH-HPN Donors consultations through the regular meeting of the JCCC, the broader consultative forum that meets every two months as well as the meetings of the Central Joint Steering Committee. In addition, in line with vision of “one plan, one budget and one report” and as part of the effort to lay the ground work for comprehensive and evidence-based planning, a Training Manual for Resource Mapping has been developed. On the basis of this Manual, TOT has been given for 138 mentors who, in turn, have given training to 3,945 workers drawn from RHBs and woredas.

#### **2.2.4 Pharmaceutical Supply and Management Core Process**

The target for the year under consideration is to establish an agency that can procure and supply drugs and medical supplies based on the principle of revolving fund scheme. The key activities set out in the Core Plan were to: establish a board for the agency, study the human resources requirement of the agency and build its capacity based on the needs specified in the Master Plan. In addition, it was planned to provide training on the implementation of the Master Plan, to design operating system for the revolving fund and to develop transport

capacity.

Based on the logistics master plan endorsed in 2005, a proclamation was issued by the House of Peoples’ Representatives for the establishment of Pharmaceutical Fund and Supply Agency (PFSA) in September 2007. Directors and Management Board members have also been appointed in December 2007.

**Business Process Re-engineering:** a business process re-engineering study focusing on Pharmaceuticals Supply Core Process; Fund Management Support Processes, MIS Support Processes and Human and General Services Support Processes have been completed. As the critical path for objective achievement, the Pharmaceuticals Supply Core Process captures activities starting from quantification to product and service delivery, and includes the sub processes of forecasting and capacity building, procurement and custom clearance, storage and distribution, and capacity building for pharmaceutical and inventory management at facility level.

The Fund Management Support Process deals with the RDF and the overall financial disbursement mechanisms in the new Agency. The MIS design deals with the networking of the central warehouse with branch hubs and between branch warehouses

and with health facilities. The sub process includes automated warehouse, financial and transportation/fleet management systems to facilitate inventory management, and timely distribution. The systems will also enable gathering of data on consumption and stock level from hubs for use in forecasting, demand planning and procurement. Moreover, information will be available at central level through the central data depository system to share with all customers and stakeholders, including Hospitals, Health Centers, private and government organizations and partners. The BPR study has passed through a consultative process with RHBs and final approval by the Ministry of Capacity Building.

**Procurement systems:** Manuals for procurement, finance and costing have been completed. The procurement manual of the Agency aims at harmonizing the Agency's procurement guidelines with those of PPA, World Bank and ADB procurement procedures. Standard Operation Procedures are designed for procurement, storage, distribution and transport fleet management for use at all levels.

Major international and local procurements of essential pharmaceuticals and medical supplies worth 310 million Birr has been effected and distribution of 330 million Birr worth of drugs and medical supplies as well as 400 million Birr worth of HIV/AIDS drugs, chemicals and supplies have been distributed through the Agency.

**Storage and warehousing capacity:** Plans are underway to construct six new major branch warehouses, seven new secondary hubs and to the expand five existing major warehouses. Architectural and engineering design work for all locations and warehouses is expected to be completed by October 2008. Site plans have already been received from Afar, Adama, Nekemt, Dessie, and those for Benishangul Gumuz, Somali, Gonder and Kebredehar are under process.

Selection of sites for new warehouse construction was determined taking into consideration factors such as new development corridors, increasing accessibility to all existing public health facilities, location of new health center construction sites, recommendations made in the national Logistics Master Plan and the Ethiopian Road Sector Five Years Strategic Plan.

While the preparation for the construction is underway, temporarily leasing and operating pharmaceutical warehouses has been done in some sites. Installation of movable adjustable pallet racking is planned to double available space for storage. Matching this pallet-based warehousing, double-reach forklift trucks are also being procured. In addition, seven senior pharmacists are hired to support regional operations. Investments are also being made to increase the cold chain storage capacity of PFSA, with installation of a state-of-the-art cold room in the central warehouse. When this unit starts operation, it will have more than doubled the national cold room storage capacity.

**Transport and distribution:** Significant investments have been made to upgrade and expand PFSA's fleet and distribution capacity. Ten trucks have been received and procurement of additional fleet of distribution vehicles is under process. Cold boxes have been procured and are being used to deliver heat sensitive products; deep freezers have also been made available to each existing warehouses to support production of ice packs for use in cold boxes in the short term.

PFSA is preparing to implement a delivery-based strategy for supplying products to health facilities across the country, including delivery of consignments from central to branch warehouses, and from each warehouses to all public health facilities on a regular schedule. This strategy is already being used by PFSA to manage HIV/AIDS commodities. A staff of 24 regional logistics



and distribution officers, supported by 3 logistics officers and a senior Distribution Advisor, are deployed to support this direct delivery to over 600 sites currently involved in ART and PMTCT services, with over 200 commodities. An ordering system has been designed and is being used to support this distribution system to sites with commodities that they need.

**MIS:** With a plan to synchronize an automation strategy with modern, customer-focused warehouse operations, activity introduce computerized MIS supported by state-of-the-art software technologies for Warehouse Management Systems is already underway. A solution integrating the use of Portable Data Assistants (PDAs) or “hand-held mini computers” are also being tested to capture commodity data directly from health facilities, for HIV/AIDS commodities.

**The Revolving Drug Fund:** The capitalization of the RDF to secure a long term sustainable supply of essential commodities will be one of the major challenges for PFSA in the short term. With available funding of procurement of commodities from all sources, a significant funding gap exists to make the RDF functional.

**Building capacity of health facilities in commodity management:** PFSA is committed to providing capacity building support to health facilities in areas of inventory management, good storage practice, demand based planning, rational prescribing, dispensing and use. This support will cover training arrangements on inventory and store management to front line workers at the stores and at dispensaries.

**Engaging Private Sector:** PFSA has conducted a meeting with local manufacturers, importers and distributors and discussion was made on how to closely work in the pharmaceutical supply system. Roles and responsibilities have been clarified and consensus was reached to continue discussion on

joint working modalities.

**Partnership:** PFSA uses the strong support of funding partners such as PEPFAR, PBS, GAVI, to leverage technical and financial resources to achieve its defined goals. Accordingly, PFSA has signed a memorandum of understanding with its leading partner Supply Chain Management System (SCMS) covering various technical areas of support. Other partners include RPM Plus/SPS, USAID|DELIVER, and UNICEF. Crown Agents is contracted to provide procurement capacity development support under PBS.

The challenge in implementing the Master Plan is lack of adequate funds for warehouse construction and revolving drug fund. These need enhanced collaboration between the Government and Development Partners to fill the gaps.

### 2.2.5 Public Health Emergency Management (PHEM)

Epidemic-prone diseases pose serious public health threats in many parts of the country. The prevailing problems associated with climate change like epidemics of Meningitis, Malaria, Rift Valley Fever and those associated with other natural and human made disasters like diarrhoeal diseases, measles, and food intoxication/contamination are among the major challenges the country is facing. On top of communicable diseases outbreaks, nutritional emergencies due to recurrent drought and the vulnerability of Ethiopia to the threats of pandemic Avian Influenza are major priorities for the health sector. Rural populations suffering from chronic malnutrition are particularly vulnerable to any fluctuation in food security or food price. Currently, the country is not adequately prepared to respond efficiently to these threats.

A strong Public Health Emergency Management System is required to improve the effectiveness of the health sector response and to comply with



Ethiopia's obligations under existing regulations of the new International Health Regulations (IHR-2005) that came into force as of June 15, 2007. This requires pulling together resources from different stakeholders and to be able to use it efficiently in order to build a sustainable capacity.

In line with the above mentioned requirements, the PHEM Core Process of the BPR focuses on preparedness, alert, rapid detection and prompt response; capacity enhancement, information and communications systems, structures and jobs needed to handle health hazards which are issues of national importance.

Specific objectives of the PHEM are to:-

- Establish robust early warning system
- Detect and respond to public health emergencies on time
- Strengthen communication/information exchange capacity at all levels
- Integrate risk reduction strategies into sustainable development programs
- Build capacity at all levels, especially at Woreda level to prepare, prevent, detect, verify, respond and contain epidemics/other public health emergencies (PHEs) at local level and recover quickly from their impacts;
- Enhance community participation/involvement in EPR activities;
- Strengthen M & E capacity at all levels.

To support the knowledge base of the redesigning work, steps have been taken to benchmark the best practices of various countries that have renowned public health emergency management systems. Accordingly, visits were made to Pennsylvania State Health Department and Centre for Disease Prevention and Control (CDC) of USA.

In addition, desk top reviews about the Public Health Agency of Canada, Health Protection Agency of UK, European CDC and Department of Public Health of Malaysia have been conducted.

This was supplemented by further desk top reviews about the experiences of such countries as Brazil, Australia, India, South Africa, Kenya, Zimbabwe and Uganda.

The major aspects of the new design include :-

- Functional Early Warning System - expansion of coverage/information base; The new system is designed to collect information on diseases (information base which expands to the periphery/community level and collects data/information from private, NGO and other health facilities as well), nutrition, various events from other sectors and from around the world.
- Epidemic Intelligence Service – competent professionals to handle emergencies at the source, which would facilitate local action and yield a high return;
- Health Alert Network and Epidemic Information Exchange (EpiX) are considered to disseminate valuable information at the right time to stakeholders; Robust communication and IT support are also considered in the new design.
- A system that receives report on a 24/7/365 basis to ensure 100% timely and complete data flow. This in turn facilitates early detection of any unusual health events and institutionalization of appropriate counter measures.
- Legal framework for coordination and collaboration as well as mandatory notification of priority diseases have been worked out.
- Flat structure, whereby workers are empowered and can make decision has been prepared,

Since a decentralized early warning of and response to public health emergencies is the key for effective and timely management; public health emergency management structures will be set up within the health system at national, regional and woreda levels. A new National Center for Public Health Emergency Management will be established under

the forthcoming Public Health Agency (PHA). The mandate for this center will encompass the entire cycle of emergency management from the assessment and mapping of health risks, to contingency planning, capacity building of the sector, issuance of early warning and rapid response/recovery.

The new design document is completed and is waiting final endorsement.

### **2.2.6 Financial Resource Mobilization and Utilization**

This section of the report highlights the implementation status of the Financial Resource Mobilization Core Process (FRMCR) of the BPR.

The selection of the Financial Resource Mobilization Core Process as one of the seven core business processes is a response to address the critical and chronic problem of financial resources in the health sector.

The objective of Financial Resource Mobilization Core Process is to establish a system that enables the country to mobilize adequate and sustainable financial resources for the implementation of the health sector development programme.

Systematic mobilization of resources requires, among other things, short, medium and long-term comprehensive and costed plans, regular mapping of resources and gap analysis, a systematic approach to identify and ensure flow of funds to the sector in a more harmonized manner.

Accordingly, one of the activities undertaken in EFY 2000 was conducting of the situational analysis of financial resource mobilization in the sector. Based on this analysis the critical and major problems, old assumptions, working modalities, rules, and breakers for the old assumptions were

identified.

The sub processes which have been selected for detail redesigning under this process were:-

1. Strategic Resource Mapping and Gap Analysis and
2. Source Identification and Soliciting of Financial Resources.

The new design has looked into all possible sources of proactive financial resource mobilization i.e. domestic revenue such as introduction of social and community health insurance, increasing the government allocation to the sector, retention of user fees by health facilities, as well as resource mobilization from international health partnership such as new global health initiatives, philanthropies (selling ready made proposal), bilateral donors, multilateral donors, NGO's etc.

In the redesigning of the new process, the structure and human resource requirement, preparation of working manuals and implementation guidelines have been finalized and are awaiting endorsement.

As per the EFY 2000 Core Plan of the FMOH to introduce health insurance scheme, a final strategic document, proclamation and explanatory notes thereon have been prepared. These documents have been discussed thoroughly by the FMOH Management Committee and later on with the heads of Regional Health Bureaus. Moreover, feedbacks on the documents have been obtained from the Social Security Agency. The legal framework is expected to be endorsed within the first quarter of EFY 2001.

In the mean time, as envisaged in the health insurance strategy and the corresponding legal framework, preparatory work is underway to facilitate the implementation of Health Insurance scheme. Accordingly, a plan of action for a full-fledged implementation of social health insurance; and for piloting community-based health insurance



has been prepared. In addition, a study on unit cost of health services has been conducted to assist in the estimation of the premium that needs to be set from the supply side ; while preparation is underway to estimate how much can be raised from the demand side.

### **2.3 Result Oriented Performance Appraisal (ROPA)**

Performance appraisal is an important component of the health system management and monitoring. An important activity undertaken in line with the development of ROPA in EFY 2000 is the introduction of the Balanced Score Card (BSC) and the effort made to create linkage with ROPA. The Balanced Score Card is a strategic planning, measurement and communication tool while ROPA is its measurement aspect. BSC is a management tool that helps to cascade strategic objectives of an organization down the structures to the of the individual worker. It also helps to make the plans of individual workers more flexible; and as such problems related with division of tasks and measures will be solved.

The BSC was implemented at the FMOH level in EFY 2000. The standard BSC theory and tool have been customized. Different types of local and international trainings have been provided for employees. As the BSC is a new concept, its implementation had initially encountered some resistance. However, the problem was gradually addressed in the course of continuous awareness raising trainings given to all staff members.

In EFY 2001, it is planned to scale up the implementation of the BSC at all levels of the health sector. To this end, an implementation manual will be prepared and distributed to all regions.

### **2.4 National Laboratory System Strengthening and Programmatic Support**

A responsive public health laboratory system is critical for effective disease control prevention, case management and more generally, to a functional health care delivery system. Early detection and management of outbreaks, proper treatment decisions, effective disease surveillance programs and institution of appropriate response strategies can only be achieved if responsive laboratory systems are in place. Since the development of the first laboratory Master Plan in 2005, which focused on ART laboratory support, significant progress has been made in strengthening the capacity of the national laboratory system in addition to expanding the HIV/AIDS diagnostic and monitoring services to health facilities throughout the country.

Capacity building in terms of laboratory equipment and instruments is an essential component of the National Laboratory Master Plan. In 2007/2008, six regional laboratories (Adama, Mekele, Dessie, Harrar, Nekemt and Awassa) have been fully equipped. Three Regional Referral Hospital laboratories have been equipped with ART laboratory monitoring equipment (FACS count, Hematology and clinical chemistry).The instruments are to be used for referral testing services and regional training roll-outs.

Central Training-of the-Trainers (TOT) and Regional training roll out are the strategic approach to in-service laboratory training program. National TOTs and logistic support were provided to the regional laboratories in their effort to expand the program through regional training roll out. Accordingly, in the reporting period, TOT in Clinical Chemistry, Hematology and CD4 has been conducted. A total of 40 laboratory professionals drawn from regional labs, regional referral hospital labs, federal hospital labs and schools of medical laboratory technology attended the training course. The certified trainers will join the regional training teams and support regional training roll out in the above mentioned lab disciplines. Moreover, TOT was also given to thirty professionals on the new National Algorithm for HIV Rapid Testing.

Based on the National Laboratory Master Plan (2005-2010) for operational plan laboratory quality system was developed and is being implemented. In accordance with this plan, 20 laboratories (six regional labs, seven federal hospital labs and eight other ART hospital labs) have been enrolled in a pilot National and International External Quality Assessment Scheme (NEQAS/IEQAS) conducted in May 2007. Proficiency Testing Panels for NEQAS for HIV Rapid Testing were prepared. IEQAS was a collaborative scheme between QASI Canada and UK NEQAS. As part of this program, all the 20 sites were visited and assessed for their quality assurance programs using a standard checklist. The result of both the panel testing and the on-site supervisory assessment were reviewed at national level at which quality improvement plan was developed for immediate implementation. Furthermore, 52 laboratories and 290 HIV testing points have participated in the second round of these programs.

Moreover, in EFY 1999 pilot implementation of Regional External Quality Assessment Scheme (REQAS) for HIV rapid testing was conducted successfully at 135 VCT sites nationwide. Currently, REQAS is being implemented at 500 VCT sites across all regions.

Laboratory equipment maintenance services is also being provided to all major equipment labs throughout the country. A total of 244 automated analyzers including FASCS count, chemistry and hematology machines were maintained for major failures. A one - month intensive training for 24 maintenance engineers drawn from all regions has also been provided. All trainers were from major manufacturers of equipment platforms in the country.

To alleviate the current problems related to the maintenance of medical equipment, and to ensure the continuity of the already started training of

biomedical technicians; additional textbooks and teaching aids have been provided. Furthermore, partners have provided the budget for training that is sufficient for two and half years.

A national database for lab equipment was also developed and put into practice. This system captures essential information on specific lab equipment such as failure rate, maintenance history and overall performance over time. It is an important tool for the post - market surveillance of different lab equipment platforms in the country.

The establishment of the Regional WHO Reference Center for laboratory-based quality control testing of malaria rapid diagnostic tests (RDTs) at EHNRI was another major project that commenced during the reporting period. The testing center is fully functional and samples have started to arrive from other African countries for carrying out quality testing. The center will function as one of the three global testing centers for RDTs.

To strengthen the TB detection and diagnosis, a plan for establishing five TB culture laboratories in 5 regions (Amhara, SNNPR, Tigray, Oromia and Addis Ababa) has been developed. Accordingly, design for the renovation has been completed and the procurement of lab equipment and supplies is in progress.

In Ethiopia the major laboratory challenges are related to poor laboratory infrastructure, human resource constraints, irregular supply of laboratory commodities, weak laboratory quality system programs, and lack of effective system for equipment service and maintenance, absence of systems for monitoring and evaluation and laboratory information management. These challenges are expected to be solved with the full implementation of the Health Care Delivery core process.



**3**

**Health Extension Program**

The Health Extension Program (HEP) is a package of basic and essential promotive, preventive health interventions with selective high impact curative health services, targeting households in a community, based on the principles of Primary Health Care aimed at improving the health status of families, with their full participation, using local technologies and the skill and wisdom of the communities. The main objective of HEP is to improve access and equity in the delivery of essential health services at village and household levels. HEP also serves as an effective mechanism for ensuring that health care resources, which are predominantly urban, shift to rural areas where the majority of the population resides. HEP is therefore considered to be currently the most important institutional framework for achieving the health-related Millennium Development Goals.

The package includes the following interventions: prevention of HIV/AIDS, STIs and TB; malaria prevention and control; first aid emergency measures; maternal, new born and child health; family planning; immunization, nutrition, adolescent reproductive health; excreta disposal; solid and liquid waste disposal water supply; food hygiene and safety measures; healthy home environment; control of insects and rodents; personal hygiene; health education and communication. The following section summarizes the progress that has been made in the implementation of the HEP in EFY 2000.

### 3.1 Training and Deployment of Health Extension Workers

HSDP III (2005/6 - 2009/10) aims at the accelerated training and deployment of 30,000 HEWs. The plan for EFY 2000 was to enroll 6334 trainees and to deploy 7095 trained HEWs. Out of the 7095 trainees enrolled in EFY 1999, 6918 have completed their training in EFY 2000 and have been deployed at health posts (Table 4).

As shown in Table 3, the regional performance with respect to the total trained and deployed HEWs versus the planned target varies among the regions. For example, Afar (67%), Oromia (64.9%), Somali (55.5%), Benishangul Gumuz (41.9%) and Gambella (22.9%) have shown a relatively low performance rate compared to the planned training intake and deployment up to EFY2000. This implies that these regions have to plan and execute the training for more HEWs in the remaining plan period.

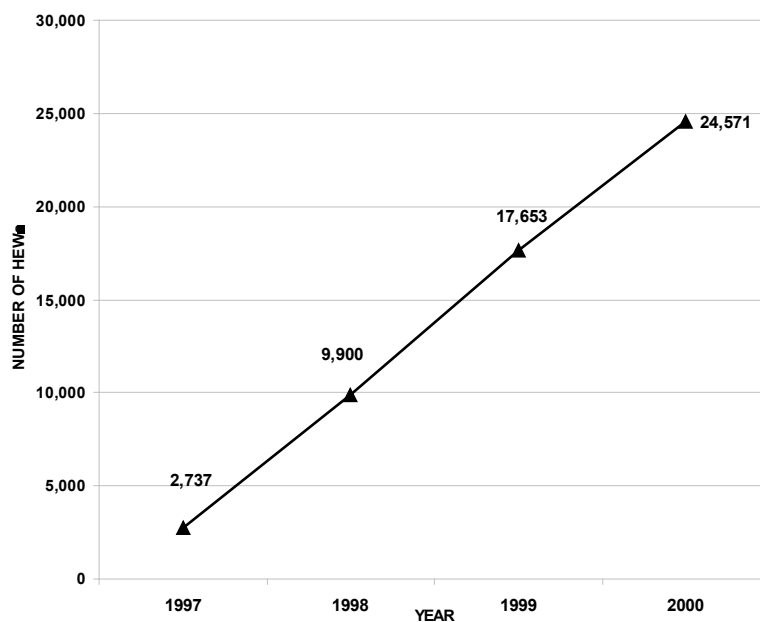


Table 3: Training and Deployment of HEWs by Region, Ethiopia, EFY 2000

Region	Planned Target	Number trained & deployed in 1999 EFY	Number trained & deployed in 2000 EFY	HEWs in EFY 2000			Total trained & deployed	Overall Performance (%)
				Plan	Under training	%		
Tigray	1,235	1,235	-	100	112	112	1,235	100
Afar	336	64	164	150	150	100	228	67
Amhara	6,650	5,950	680	600	382	63.7	6,630	99
Oromia	13,000	5,553	2,884	4,526	4,526	100	8,437	64.9
Somali	1,000	135	420	500	406	81.2	555	55.5
SNNP	7,750	4,465	2,650	0	750	-	7,115	91.8
Benishangul	492	86	120	300	310	103.3	206	41.9
Gambella	205	47	0	158	156	98.7	47	22.9
Harari	39	39	0	0	0	-	39	100
Dire Dawa	79	79	0	0	0	0	79	100
<b>Total</b>	<b>30,000</b>	<b>17,653</b>	<b>6,918</b>	<b>6,334</b>	<b>6,792</b>	<b>107</b>	<b>24,571</b>	<b>81.9</b>

The national target for EFY 2000 has been to deploy a total of 23,987 HEWs in the country. A total of 6918 HEWs have been trained and deployed in EFY 2000. Together with the 17,653 HEWs deployed prior to EFY 2000, the total number of HEWs deployed so far has reached 24,571 accounting for 81.9% of the total national requirement of 30,000 HEWs (Figure 1). An additional 786 HEWs are currently under training, increasing the overall planned target for HSDP III to 30,786.

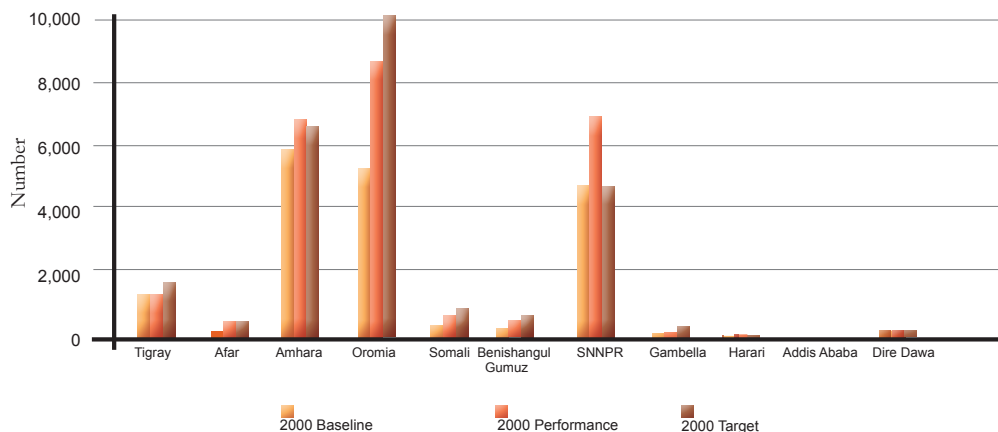
Figure 1: Trends in Number of Health Extension Workers Deployed in Health Posts (Ethiopia, EFY 1997-2000).





Comparison of the total trained and deployed *i.e.* the performance for 2000 with the HSDP III target shows that Tigray, Harari and Dire Dawa have met the target set in HSDP III. Amhara Region reached 99% of the target, while SNNPR reached 92%. The achievement of the remaining regions falls short of the cumulative target by a larger extent.

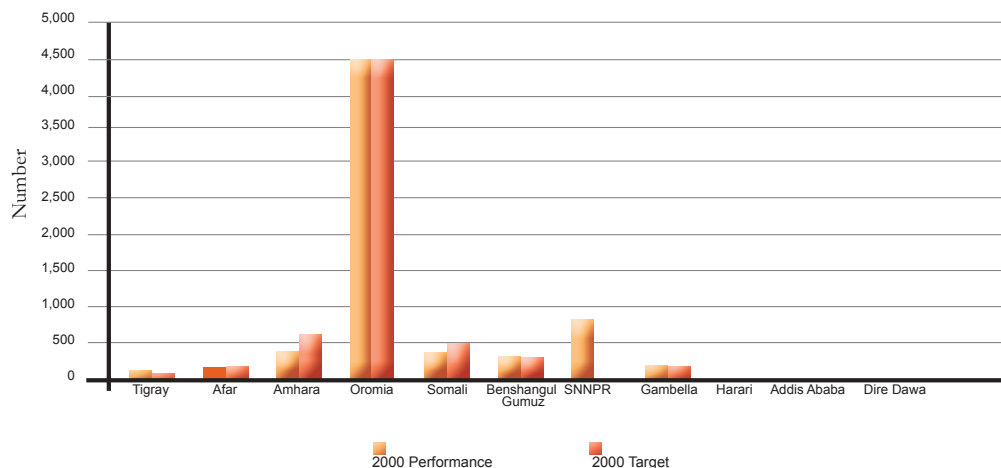
Figure 2: Distribution of the Number of HEW's Deployed by Region (Ethiopia, EFY 2000 baseline, EFY 2000 performance and EFY 2000 target).



Comparison of the regional performance with the 2000 target shows that Harari and Dire Dawa have met the target set for EFY 2000 in the Core Plan, with Afar, Amhara and SNNPR surpassing the target for EFY 2000, and Tigray nearly achieving its target. The performance of Oromia, Somali, Gambella and Benishangul-Gumuz is below the target for EFY 2000 (Figure 2).

Although the plan was to train 6,334 HEW's during EFY 2000 at national level, the actual number of HEW's that have started class at the TVETs was 6,792 (a performance rate of 107%). When the training and deployment of the remaining HEW's in EFY 2001 is completed the national requirement of 30,000 HEW's will be reaching the targeted 100%.

Figure 3: Distribution of the Number of HEW's Recruited for Training by Region (Ethiopia, EFY 2000 performance and EFY 2000 target)

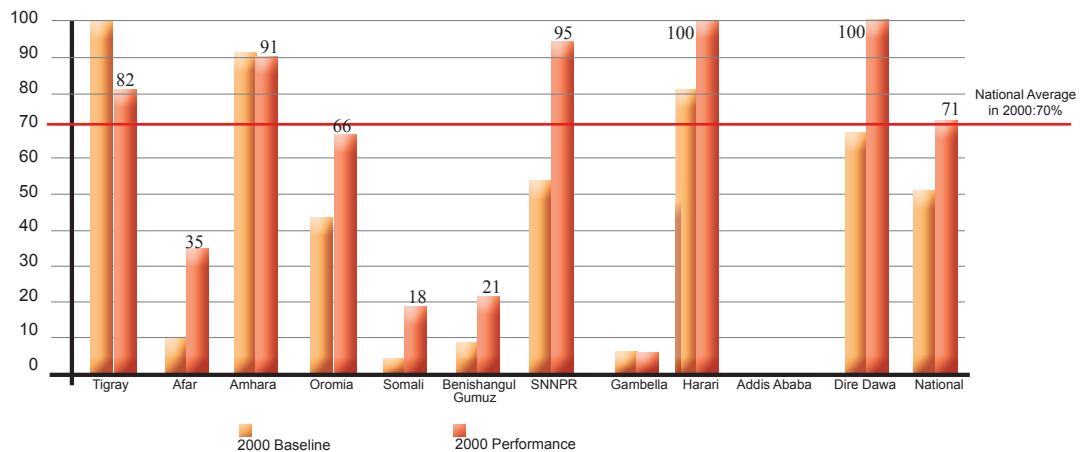


As shown in Figure 3, Tigray, Afar, Oromia, Benishangul-Gumuz, and SNNPR have achieved their target for the EFY 2000. Harari and Dire Dawa have already achieved 100% of their training needs. However, Amhara and Somali have not achieved their own target for EFY 2000, with Gambella almost reaching its target.

### Rural Kebeles Implementing the HEP by Region

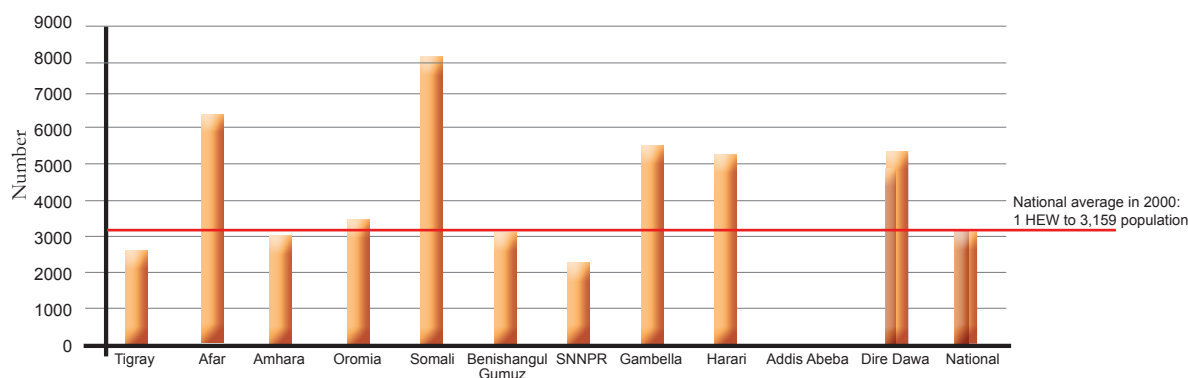
The total number of rural kebeles implementing the HEP is 16,731, while the number of rural kebeles with two HEWs is 11,834. In EFY 1999, the national average was 51% whereas in EFY 2000 it is 70%. Figure 4 shows that the proportion of rural kebeles implementing HEP is higher than the national average of 70% in Dire Dawa, Harari, Tigray, SNNPR and Amhara. In Oromia the proportion of rural kebeles implementing the HEP is 66%. Somali, Benishangul-Gumuz, Afar and Gambella have the lowest proportion with 18%, 21%, 35% and 6%, respectively.

Figure 4: Distribution of the Proportion of Rural Kebeles Implementing HEP by Region (Ethiopia, EFY 2000 baseline and EFY 2000 performance)



HEW to population ratio showed significant improvement over the period 1999 – EFY 2000. In EFY 1999, the national HEW to population ratio was 1:4374, whereas in EFY 2000 it is 1:3159 (Figure 5). Three regions have attained relatively better HEW to population ratio (Tigray, SNNPR, and Amhara) than the remaining regions (6,355 for Afar, 3,327 for Oromia, 8,216 for Somali, 3,184 for Benishangul-Gumuz, 5,511 for Gambella, 5,359 for Harari and 5,418 for Dire Dawa).

Figure 5: Distribution of HEW's to Population Ratio by Region, Ethiopia, EFY 2000



### Provision of Training Materials and Guidelines

In EFY 2000, it was planned to distribute 16 packages to 7500 HEW trainees in 31 training centers. However, the actual performance in terms of the distribution of the packages was to 2,682 HEW graduates in SNNPR and Oromia regions; which gives a success rate of only 35.8%.

In addition to the 30,000 copies of the HEP Implementation Guidelines printed and distributed to regions, health facilities, HEWs and NGOs in EFY 1999, 7,000 copies of the guideline have been printed and distributed to 3586 new graduates in EFY 2000. In addition, 28,510 Health Extension Newsletters were distributed to HEWs in all regions.

Furthermore, for purposes of assisting their practical training, funds have been mobilized from partner organizations and were dispatched to graduating trainees in all regions.

### Implementing the Model Family Package

This is a strategy in which female and male household heads are selected from each household and trained for 96 hours based on the 16 HEP packages. HEWs identify and train Model Families. The health extension model family's package is based on the diffusion theory, the process by which an innovation is communicated through certain channels over time among members of a social system because not all people in a social system adopt an innovation at the same time. According to this model, diffusion of the innovation proceeds by steps in the community. The first few about 2.5% are innovators, about 13.5% are early adopters, the third category are early majority and the final group is the laggards, those who are very traditional and do not want to change.

During EFY 2000, the plan was to train 1,756,082 model families, but 886,208 (50.5%) have graduated and 133,876 are being trained (Table 4). When those under training (133,876) are added to the number of Model Families that graduated (886,208), the performance rate reaches almost 58.1 % (1,020,084).

Table 4: Training of Model Families by Region, EFY 2000, Ethiopia

Region	Target	No. Trained & deployed in EFY 1999	Plan	EFY 2000		Total trained	Performance %
				No. graduated	Under training		
Tigray	734,600	25,164	300,000	100,744	-	125,908	17.14
Afar	262,400	-	-	-	-	-	-
Amhara	3,545,600	39,802	512,700	80,454	-	120,256	3.39
Oromia	4,840,400	-	333,180	123,284	-	-	2.55
Somali	751,200	-	-	-	-	-	-
B.Gumuz	117,800	1,626	6,240	7,850	-	9,476	8.05
SNNPR	2,868,800	-	602,773	571,969	133,696	571,969	19.94
Gambella	41,600	-	-	-	-	-	-
Harari	15,600	-	1,189	1,907	-	1,907	12.2
Dire Dawa	21,200	240	-	-	180	240	1.13
<b>Total</b>	<b>13,199,200</b>	<b>66,832</b>	<b>1,756,082</b>	<b>886,208</b>	<b>133,876</b>	<b>953,040</b>	<b>7.22</b>

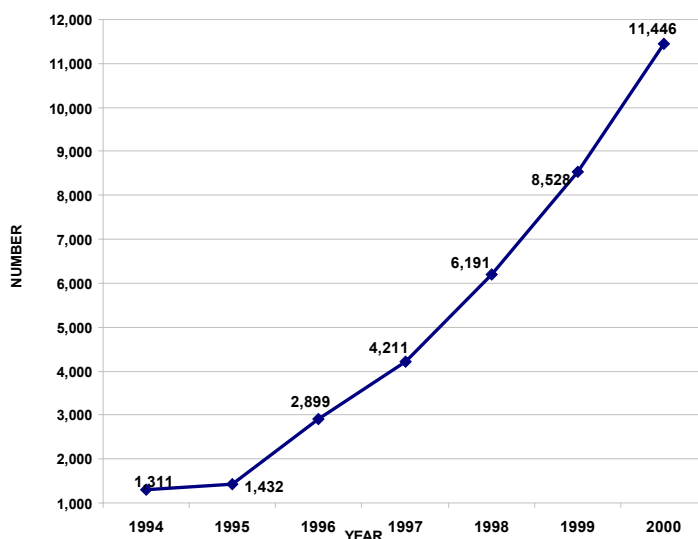
No model families have been trained in three regions (Afar, Somali, Gambella). The performance of two regions is above the planned target (Harari, Benishangul-Gumuz) while the performance of Amhara and Oromia regions is relatively very low. The total number of model families who graduated up to the end of EFY 2000 is 953,040; and compared to the planned target of 13.2 million families country wide, the performance rate of 7.2% indicates the importance of sustained efforts in the next couple of years. The gap in number of model families to be trained is over 12 million. This clearly indicates the need for concerted efforts at regional level to considerably improve their performance.

## 3.2 Construction and Equipping of Community Health Posts

### 3.2.1 Construction of Health Posts

The plan has been to construct and make operational 15,000 health posts in 15,000 kebeles by 2001 EFY. To meet this target, out of 4,047 health posts planned to be constructed during the fiscal year, 818 health posts have been completed, while 2,100 are under construction. When this construction is completed, there will be 11,446 (76.3%) health posts at national level and to meet the overall target of 15,000 health posts, 3,554 additional health posts have to be built (Table 5 and Figure 6).

Figure 6: Trends in number of Health Posts constructed (Ethiopia, 1994-EFY 2000).

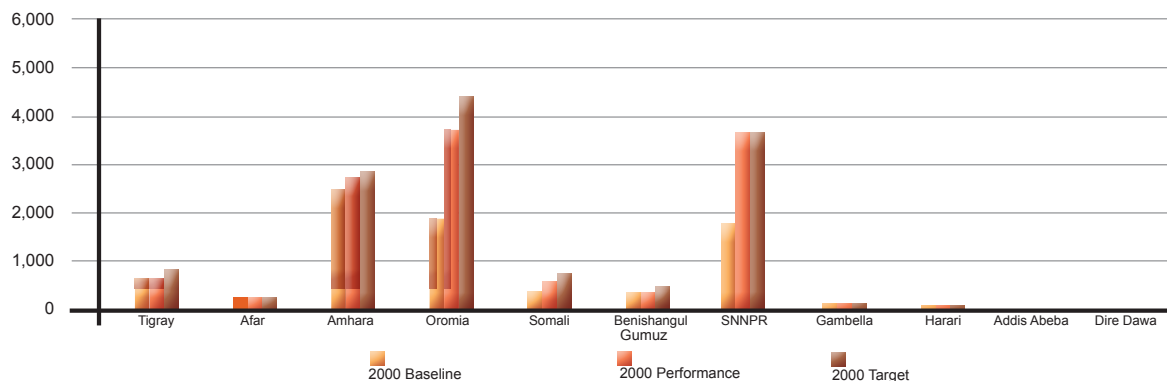


As shown in Table 5 below, during EFY 2000 the completion of the ongoing construction of 1,758 health posts in Oromia and 204 Health Posts in SNNPR will greatly increase the coverage of health posts in these regions. Compared to the HSDP III target, the percentage of health posts completed and under construction is very low in Somali (39%), Gambella (41%), and Afar region (44%). The coverage is above the national average of 76% only in four regions (i.e. Tigray, SNNP, Harari and Dire Dawa). Therefore, to meet the target set for the plan period and to accelerate the pace of construction of health posts, due attention should be given to emerging regions and Amhara region as well.

Table 5: Construction of Health Posts, Ethiopia, EFY 2000

Region	HSDP III Target (A)	Available in EFY 1999 (B)	Status of Construction in EFY 2000					Total of B, D, E (G)	Performance in %
			Planned (C)	Completed (D)	Under Construction (E)	Not Started (F)			
Tigray	786	614	100	0	0	100	614	78.12	
Afar	256	102	10	0	10	---	112	43.75	
Amhara	3,853	2,558	308	18	88	202	2,664	69.14	
Oromia	5,227	1,907	2,563	93	1,758	712	3,758	71.90	
Somali	740	260	100	0	30	70	290	39.19	
SNNP	3,729	2,818	911	707	204	337	3,729	99.9	
B.Gumuz	240	166	41	0	0	41	166	69.17	
Gambella	124	41	11	0	10	1	51	41.13	
Harari	25	23	0	0	0	---	23	92.0	
D.Dawa	42	39	3	0	0	3	39	100.0	
<b>Total</b>	<b>15,022</b>	<b>8,528</b>	<b>4,047</b>	<b>818</b>	<b>2,100</b>	<b>1,466</b>	<b>11,446</b>	<b>76.3</b>	

Figure 7: Distribution of the Number of Health Posts Constructed by Region (Ethiopia, EFY 2000 baseline, EFY 2000 performance and EFY 2000 target).



As far as the regional performance and their own targets are concerned, with the exception of Afar, SNNPR and Harari, the other regions have not met their targets for the year (Figure 7).

### 3.2.2 Equipping of Health Posts

The plan for EFY 2000 includes fulfilling the medical equipment requirement for 10,773 health posts. During EFY 2000, medical kits have been distributed to 2,664 health posts. The number of health posts that have been provided with medical kits up to EFY Sene, 1999 were 2,451 health posts. All in all, up to EFY 2000, a total of 5,115 health posts have been provided with medical kits. Thus compared to the planned target (15,022) the coverage is only 34%. The distribution of medical kits by region is shown in Table 6.

Table 6: Distribution of Medical Kits to Health Posts by Region, Ethiopia, EFY 2000

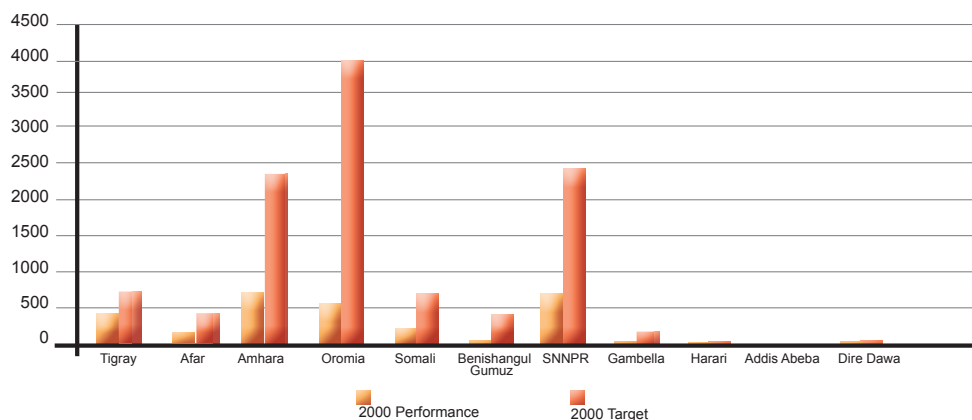
Regions	Plan	Distributed in EFY 1999	EFY 2000		Total Distributed	Coverage (%)
			Planned	Distributed		
Tigray	786	244	686	406	650	82.7
Afar	256	36	256	96	132	51.6
Amhara	3,853	702	2,337	696	1,398	36.3
Oromia	5,227	809	3,987	612	1,412	27.2
Somali	740	60	740	115	175	23.6
Ben-Gumuz	240	-	240	22	22	9.2
SNNPR	3,729	600	2,336	675	1,275	34.2
Gambella	124	-	124	4	4	3.2
Harari	25	-	25	15	15	60.0
Dire Dawa	42	-	42	23	23	54.8
<b>Total</b>	<b>15,022</b>	<b>2,451</b>	<b>10,773</b>	<b>2,664</b>	<b>5,115</b>	<b>34.1</b>

The services of the HEP consist of sustained promotive and preventive health actions and increased health awareness. Since the HEWs work with model families and with communities to communicate health messages; effective implementation of such activities will require the provision of inputs like bags and bicycles.

With this in view, 13,052 bags have been distributed to health extension workers in all regions. This will bring the number of bags distributed so far to 23,636. In EFY 1999, 1100 bicycles were distributed only in Amhara region; whereas during EFY 2000 1,714 bicycles have been distributed for HEWs in Oromia (1,600), Harari (28) and Dire Dawa (86). All in all, a total of 2,814 bicycles have been distributed during EFY 1999 and 2000

In terms of equipping health posts, none of the regions has reached the target set for EFY 2000 (Figure 8). One of the challenges in equipping health posts is related with weak procurement capacity of the Ministry. The procedures take a long time to finalize. Currently, the procurement of equipment for 7000 health posts is being processed. Another challenge is in connection with the procurement by UNICEF. There have been delays in getting cost estimates from UNICEF. The packaging and distribution schedule to health facilities is also made by UNICEF. The equipment stays stranded at the warehouse of UNICEF. These problems need to be resolved soon so that health posts will be equipped on time.

Figure 8: Distribution of the Number of Health Posts Equipped by Region (Ethiopia, EFY 2000 baseline and EFY 2000 performance)



### 3.3 Health Extension Program for Pastoral and Semi-Pastoral Areas

The HEP Implementation Manual for Pastoral and Semi-Pastoral Areas has been prepared and is being refined by the concerned regions.

In accordance with the plan to prepare, print and distribute reference materials for HEWs based on the 16 packages, the preparation of four types of reference materials has been completed and the printing of the materials in 30,000 copies is underway.

### **3.4 Health Extension Program for Urban Areas**

A task force for the preparation of HEP for urban areas has been established; and work on a new design has commenced by taking the experience of different countries into consideration. The draft Implementation Guideline and the 24 HEP packages have been finalized and will be operational in EFY 2001.

### **3.5 Information, Education and Communication**

In EFY 2000, as part of the plan to procure and distribute audiovisual equipment for 3,200 health posts, 1,565 tape recorders, 1,276 megaphones, 69 video teaching aids and 5,167 audiocassettes have been procured and distributed to health posts. When the volume of this distribution is compared with the number of completed health posts, the coverage with tape recorders and megaphones is 10.4% and 8.5%, respectively. Since such equipment are used as teaching aids, their distribution should be given priority attention.

In line with the plan to transmit health messages in different languages that could bring sustained behavioral changes, messages focused on programs of HIV/AIDS, TB, Malaria, Acute Watery Diarrhea (AWD), Hygiene and Environmental Health, Reproductive Health, Regional Level Mobilization and Health Related Issues, have been transmitted using federal and regional mass media as well as other means of communication. In addition, through the use of mobile vans, educational films on AWD and related topics were screened at 70 kebeles in 69 woredas.

### **3.6 Strengthening Organizational Structure**

Inadequate institutionalization of HEP in the organizational structure of RHBs, Zonal Health Departments and Woreda Health Offices has been observed during supportive supervisory visits and evaluations; and FMOH and RHBs have recognized the need to give due attention to the manpower requirements and organizational structure of the program. To this end, based on the joint decisions that were made by the FMOH and RHBs, HEPs are organized as departments at the regional level and as teams at zonal and woreda levels. Most RHBs have implemented this decision taking the concrete condition in their respective region into consideration.

Supportive supervision is required to address quality of service, technical and other constraints faced by Health Extension Workers during the implementation of their plans. Building on the experiences and knowledge generated since the country-wide implementation of HEP, the Ministry of Health is currently training 3200 supervisors for deployment in the HEP. So far, 1290 supervisors who met the admission criteria have been trained during the fourth quarter of EFY 2000; while 842 are still attending the training program. HEP supervisors will be staff of Woreda Health Offices assigned to the different health centers of the Primary Health Care Units.

### **3.7 Environmental Sanitation**

Under environmental sanitation, the plan for EFY 2000 was to increase latrine coverage from 32% to 70% in areas where HEP is fully functional. The following major activities were performed during the year under review:

The performance in the fiscal year showed that at household level, the national latrine coverage



has reached 54%. Data from regions shows that the latrine coverage is over 50% in Addis Ababa and SNNPR. The coverage is below 50% in the remaining regions. For example, it is 40.4% in Tigray and 35.4% in Oromia. In other regions it ranged from 2.7% in Gambella to 33.8% in Dire Dawa.

To create a healthy environment within health facilities, training on collection and disposal of biomedical wastes has been given to health workers drawn from 5 hospitals under the Addis Ababa City Council Health Bureau and from 10 regional referral hospitals. In order to strengthen the HEP, hygiene and sanitation training module has been prepared and training has been given to professionals who will in turn train supervisors. Two hundred HEWs and coordinators drawn from the four emerging regions have made experience sharing visits to Shebedino Woreda in SNNPR and Tiro Afeta and Kersa Woredas in Oromia where the HEP is implemented in a satisfactory manner. A document on the National Millennium Hygiene and Sanitation Mobilization Campaign has been prepared in Amharic and English and distributed to regions. Consultation and evaluation on annual water, sanitation and hygiene activities has been conducted by 200 persons drawn from parliament, pastoral organizations, donors, civil society organizations, and universities. IEC materials have been prepared and are being printed in Afar and Somali languages and in Amharic for Gambella and Benishangul Gumuz regions.

To strengthen and monitor water sanitation and hygiene activities, a steering committee chaired by the Minister of Water Resources and comprising of the State Ministers of Education and Health has been established and has started to function. A technical committee and coordinating office has been set up with members drawn from the above noted institutions. Similar committees have been set up and have started work in all regions.

To improve the quality of water, sanitation and hygiene in elementary schools, guideline on utilization of sanitation facilities has been prepared and awaits approval.

Laboratory examination has been made at entry and exit points to certify food safety; and revenue amounting one million Birr has been collected from 2,015 customers. Fifteen food and beverage factories have been inspected; and after laboratory examination of 25 samples, the factories have been given certificates on food safety. Necessary food safety examination has been made on 650,000 tons of cereals to be exported abroad and certificates of compliance have been given to the exporters.

### 3.8 Strengthening Quarantine Services

The construction of buildings for quarantine centers at Moyale, Dewele and Dire Dawa, which were started in 1999 EFY, has continued in EFY 2000. The construction of the building of Moyale Quarantine Center is completed (100%). However, since additional works like compound work, fence and sanitary works have not been included in the contract, the project is not yet ready for commissioning.

At Dewele Quarantine center 65% of the building is completed; but like Moyale it lacks compound, fence and sanitary facilities. Since the contractor has disappeared, the construction activity is at a standstill. At Dire Dawa, 60% of the building has been completed; but the remaining construction cannot proceed since the landscape requires additional work mainly retaining wall and compound work. In this connection, the measures to provide the remaining as well as additional works are under discussion. As in EFY 1999, the construction of Metema Quarantine site could not start due to the difficulty to secure a suitable site for construction of the building.



In EFY 2000, food inspection and control was done on 49,363 tons of exported and 82,810 tons of imported food and drinks. Compared to EFY 1999, the volume of inspection and control service on imported food and drinks is very low in EFY 2000 indicating the decline in the volume of imported foods and drinks. In addition to this, insecticide spraying and inspection of aircrafts was done 4929 times.

The Internationally Certified Vaccination Centers (Black Lion, Paulos, Petros and Dire Dawa) gave Yellow Fever and Meningitis Vaccine for a total of 39,521 and 33,773 people, respectively.

### **Summary of Achievements and Challenges in the Implementation of the HEP**

In conclusion, the following major achievements have been registered during EFY 2000:-

- Training and deployment of HEWs has progressed as planned and all regions except Amhara, Oromia, Somali and Benishangul Gumuz have achieved a performance rate of over 81.9%.
- The construction of health posts is also proceeding as planned and 76.3% of the target has been achieved.
- The HEP has been given due attention in terms of preparation of an HEP implementation manual for pastoral and semi-pastoral areas and the work on a new design for urban centers.

However, performances were less satisfactory with respect to the training of model families, the very low number of health posts that were provided with IEC materials and equipment and also the low (34.1%) performance in the distribution of medical kits and equipment to health posts.

### **Challenges**

Some of the constraints encountered during implementation of the HEP have been addressed by the FMOH and RHBs after the ninth ARM. However, the following challenges are still affecting the smooth progress of implementation:-

- Delay in the construction of health posts especially in the emerging regions,
- Delay in the provision of medical equipment and supplies for health posts.
- Low performance in the training and deployment of Model Families.

A lot of effort has to be made by the sector to address the root causes accounting for the delay in construction of health post buildings, the distribution of medical equipment and supplies and training of model families.





Immunization diploma is given to children for successful completion of their vaccination schedule before their first birthday.



**4**

**EXPANSION & EQUIPPING  
OF HEALTH CENTERS**

#### 4.1 Construction of Health Centers

Health centers mainly provide basic curative health care services but also support HEP by acting as referral and technical assistance centers for HEWs. In the Ethiopian context, even though a health center is needed for every 25,000 people, there were only 673 health centers at the end of 1999 EFY. To achieve the planned universal primary health care coverage, the target of HSDP III is to put in place 3,200 health centers by 2009/10.

To achieve this target, the FMOH and RHBs had concluded an agreement at ARM 2007, whereby for every health center to be constructed by a RHB, the FMOH will construct one matching health center and supply the equipment for both health center. This agreement is expected to accelerate the plan of putting 3,200 health centers in place by the end of HSDP-III.

Table 7: Status of Health Center Construction, Ethiopia, EFY 2000

HSDP III Target	Available in EFY 1999	Under Construction in EFY 1999 (FMOH / GTZ)	Planned in EFY 2000		To be started in EFY 2000 (FMOH)	To be completed in EFY 2000 (FMOH)	Agreement signed (FMOH)	Status in EFY 2000 (FMOH)		Completed FMOH
			FMOH	RHBs				Site handover	Const. started	
3,200	673	500	891	1166	1408	180	473	368	355	53

#### Construction of Health Centers by FMOH

In this regard, to fill the gap within a short period and meet the national target, the strategy to accelerate expansion of Health Centers was designed and an agreement entered with the GTZ to manage on behalf of the FMOH, the construction of 500 Health centers during 1999 EFY (Tables 7 and 8).

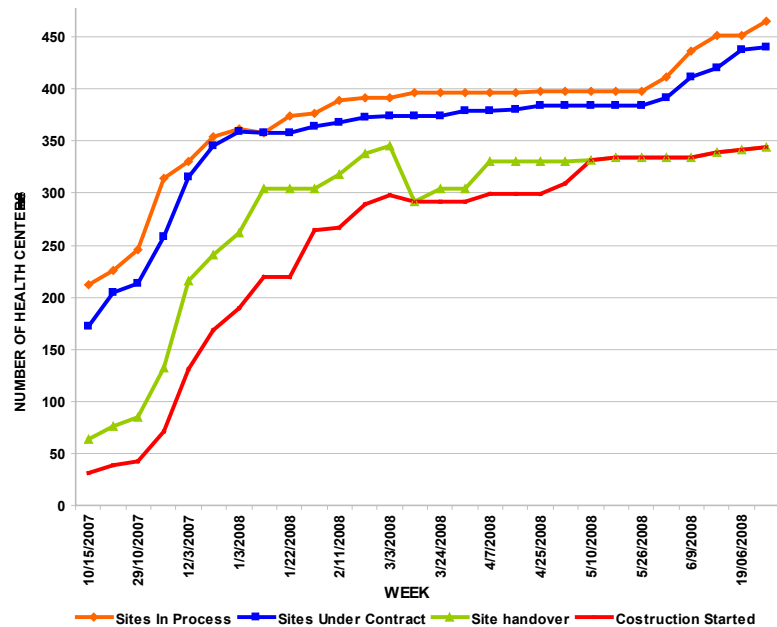
Table 8: Status of the 500 Health Centers Construction Project by FMOH by Region, Ethiopia, EFY 2000

Federal Region	Total no of sites	No of sites in process	No of sites contracted out	% of sites contracted out	Site handover effected	Construction started	% of construction started	Provisional Acceptance (Ready for Service)
Tigray	36	36	36	100%	32	25	69%	8
Afar	15	15	15	100%	14	9	60%	0
Amhara	119	114	114	96%	88	88	74%	11
Oromia	168	168	168	100%	139	136	81%	24
Somali	36	26	25	96%	9	10	38%	0
Benishangul	11	11	11	100%	9	10	91%	0
SNNPR	94	95	87	93%	64	66	70%	8
Gambella	7	4	4	57%	0	0	0%	0
Harar	5	5	5	100%	5	5	100%	1
Dire Dawa	9	8	8	89%	8	6	67%	1
<b>Total</b>	<b>500</b>	<b>482</b>	<b>473</b>	<b>95%</b>	<b>368</b>	<b>355</b>	<b>72%</b>	<b>53</b>

Accordingly the number of sites under contract is 473, site handover has taken place for 368 health centers; while the construction of 355 health center buildings has commenced with support of the FMOH (Figure 9), i.e. 25 in Tigray, 88 in Amhara, 136 in Oromia, 66 in SNNP, 10 in Somali, 9 in Afar, 10 in Benishangul Gumuz, 6 in Dire Dawa and 5 in Harari (Table 8).

FMOH has also committed to construct additional 891 HCs. With respect to the current status of the 891 health centers, the fixed price approach has been approved by MOFED. To facilitate the construction work, a central Project Monitoring Unit (PMU) is being set up and the establishment of regional level PMUs is also underway. Recruitment of staff has started at RHBs, and some regions (Gambella, Benishangul and Oromia) have already completed the recruitment process. A Memorandum of Understanding between the FMOH and MoWUD has been finalized. It was signed by the FMOH and is waiting to be signed by MoWUD. Detailed activities on logistics like contract agreement to get cement, transport contract with a Transporter company etc. have been performed. A project implementation document has been approved and sent to RHBs for implementation.

Figure 9: Trend in Health Centers construction (Ethiopia, EFY 2000)



### Construction of Matching Health Centers

As part of the implementation of the HSDP, the plan for EFY 2000 was to construct 1166 matching health centers by regions. Regions have reported that the construction of 499 health centers has already started; and they have committed and secured budget for 645 health centers.

Table 9: Construction Status of the 1,166 Matching Health Centers by Region, Ethiopia, EFY 2000

Region	Regional share	Fund secured EFY 2000	Planned to Secure Fund in EFY 2001	Balance to start on 2002	No of sites contracted out	Site handover effected	Construction started	Completed in EFY 2000
Tigray	72	40	34	-2	40	13	7	0
Afar	39	0	5	34	0	0	0	0
Amhara	288	195	0	93	195	176	170	25
Oromia	442	226	62	154	226	226	147	79
Somali	80	7	12	61	7	6	6	0
Benishangul	10	2	4	4	2	2	2	2
SNNPR	221	167	54	0	167	162	162	0
Gambella	12	7	5	0	7	6	4	0
Harar	1	0	1	0	0	0	0	0
Dire Dawa	1	1	0	0	1	1	1	1
<b>Total</b>	<b>1166</b>	<b>645</b>	<b>177</b>	<b>344</b>	<b>645</b>	<b>592</b>	<b>499</b>	<b>107</b>

As shown in Tables 7, 8 and 9, if we add the existing health centers with the 500 to be constructed through the contractual agreement entered into with the GTZ and the 891 by the FMOH, there will be 2,064 health centers. The addition of the 1,166 health centers to be built by regions brings the total to 3,230. Currently there are 673 health centers; and if we add those that are under construction by the FMOH and RHBs including the 53 health centers that are completed, there will be 1,703 health centers (53.2%). To reach the HSDP III target, 1,497 health centers have to be built within the remaining plan period.

The following were the main challenges faced during the implementation with respect to the construction of health centers:-

- Continuous price escalation of construction materials and the difficulty to get contractors to bid according to the quoted cost estimate which was calculated on the basis of cost-efficient construction model
- The long time taken to collect data from building sites for the purposes of bid preparation and cost analysis and the inability of regions to present complete data on time.
- General shortage of contractors due to the construction boom in the country, and

- Weak construction management and coordination capacity of GTZ; and
- Inadequate budget secured by regions as per the plan.

In order to meet the challenges to implementation, some actions have been taken by the FMOH and RHBs. Project management unit has been established at federal and regional levels. The price of construction materials has been revised; and for the construction of health centers which did not get contractors, it was decided to circumvent the bid process and use direct offer to contractors who have participated in earlier bids. Evaluation on health center construction is conducted monthly by regions, GTZ and FMOH. It was also jointly decided that professional staff assigned by GTZ in every region should work together with the engineering teams of RHBs and that GTZ project teams should monitor construction activities at every site and solve problems on time.

Furthermore, in collaboration with the implementing agency and the Ministry of Works and Urban Development detailed arrangements are being made with respect to the wholesale procurement and distribution of construction materials for contractors; creating conditions conducive for

acquisition of construction materials on a priority basis; to organize the project administration in a way that would ensure the efficiency and quality of the construction process; and to work in an integrated manner with the Regional Health Bureaus.

## **7.2 Equipments for Health Centers**

In order to strengthen services provided at health centers, the plan in EFY 2000 was to procure and distribute medical equipment for 1733 health centers. To date, medical equipment has been procured and is being distributed for 353 health centers and funds adequate for provision of medical equipment for 1405 centers has been acquired. Preparations are being made for the procurement and distribution of this equipment by next year. Concurrently, pre-feasibility study on equipment needs of health centers is being made. In addition medical equipment has been procured for 33 health centers located in Oromia region and the procurement of generators for 80 health centers is underway.

The procurement of medical equipment for health centers has been delayed due to the time-consuming procurement procedures of partner organizations that are delegated to handle the procurement on behalf of the FMOH. It is expected that the work being done to strengthen the recently established Pharmaceutical Fund and Supply Agency will solve this problem.







5

**STRENGTHENING AND  
EXPANSION OF HOSPITAL  
SERVICES**

## 5.1 Hospital Management

The Ethiopian Hospital Management Initiative (EHMI) began as part of efforts to meet Ethiopia's health needs by the William Jefferson Clinton Foundation's Initiative (CHAI) in partnership with Yale University. The goal of EHMI is to enhance the management capacity of hospitals in Ethiopia using a systems-based approach. This was to be achieved by replicating improved management systems that potentially advance patient care and outcomes in hospitals throughout the country.

Using the 8 Steps of Scientific Method of Problem Solving along with the skills and concepts of leadership, the EHMI program has developed a set of guidelines for key areas of hospital management. Together, these comprise the Blueprint for Hospital Management in Ethiopia, which addresses 8 system innovations in detail. The 8 standards include: Human Resources Management, Governing Boards, Patient Flow, Medical Records Management, Nursing Standards and Practice, Infection Prevention Policies, Pharmacy Inventory and Warehouse Management, and Global Budgeting and Financial Management.

At the outset, problems in hospital management were studied in seven regional hospitals (Tigray, Amhara, Oromia, SNNP, Somali and Diredawa) and in seven hospitals in Addis Ababa. After the preparation of the Blueprint, pilot implementation was started in these 14 hospitals. At national level 40 hospitals were selected to implement the Blueprint; but it is now under implementation in 37 hospitals. In these hospitals, technical assistance is provided by 14 professional staff employed by the Clinton Foundation.

Performance-based evaluation (PBE) is one component of the Blueprint. It is the practice of periodic review and evaluation of an individual's or team's performance. PBE is used to improve the hospital's performance by evaluating those responsible for achieving desired results. PBE provides a hospital with a method for systematically measuring if its goals are being met. The goals of PBE are: (i) to assess how well an employee's performance supports the hospital's goals and, if necessary, determine how to improve it; (ii) to align employee incentives with the hospital's mission; (iii) to chart progress from initiation to completion for an individual or team project by creating "benchmark" measures of comparison and (iv) to review and assess the performance of employees: reinforce or reward positive performance, while utilizing performance improvement procedures for poor performance.

Monitoring and evaluation tools have been prepared and one of the tools is related to patient and staff satisfaction. This is done quarterly. Implementation plan has been prepared for each standard. Each standard has a certain number of activities. So, the evaluation considers how much of the activity has been initiated and how much has been completed.

Measured in terms of initiated and completed activities, the rate of implementation varies slightly by hospitals and overtime. For example, the rate of Implementation of the Blue print during the third and fourth quarters of EFY 2000 is shown in Table 10.

Table 10: Rate of Implementation of the Blue Print in 10 Selected Hospitals in Addis Ababa, EFY 2000

Ser. No.	Name of Hospital	Percent of activities initiated	Percent activities completed
1	Gandhi	100	71.16
2	Ammanuel Mental Specialized General Hospital	73	49
3	Black Lion	88	36
4	ALERT	93	30
5	St. Peter TB Specialized General Hospital	97	28
6	Yekatit 12	91	25
7	Ras Desta	98	19
8	St. Paul's Specialized General Hospital	81	16
9	Zewditu	65	12
10	Menelik	63	8

The average scores achieved by the hospitals vary slightly from one quarter to another. But as shown in Table 11, during November 2007 and June 2008, Zewditu and Menelik hospitals had relatively lower achievement scores.

Table 11: Staff Satisfaction Scores in 10 Selected Hospitals in Addis Ababa, During 3rd &amp; 4th Quarter of EFY 2000

Ranking No.	Hospital	November 2007	Ranking No.	Hospital	June 2008
1	Gandhi	3.67	1	Emanuel	4.71
2	Yekatit	3.06	2	Gandhi	4.55
3	Ras Desta	3.01	3	Ras Desta	3.94
4	St. Pauls	2.94	4	Black Lion	3.90
5	Black Lion	2.83	5	St. Peter's	3.81
6	ALERT	2.79	6	Yekatit	3.76
7	Emanuel	2.77	7	Menelik	3.72
8	St. Peter's	2.68	8	ALERT	3.66
9	Menelik	2.67	9	St. Pauls	3.51
10	Zewditu	2.49	10	Zewditu	3.50

The Assessment study on satisfaction of service providers showed that professionals at Emanuel and Gandhi Hospitals got better satisfaction, while the lowest score was achieved by Zewditu Hospital.

Other important activities performed in EFY 2000 include training that would enable implementation of 13 guidelines included in the Blue Print for various committees at hospitals. Furthermore, led by the Minister of Health, evaluation of the implementation process is undertaken every two weeks in the presence of hospital management, Addis Ababa Regional Health Bureau and professionals employed by the Clinton Foundation. Implementation of the hospital standard in other regions is discussed at the Joint

FMOH-RHB meeting held every two months. Supportive supervision is being made in every hospital to monitor progresses and to identify problems encountered during implementation. To assist in making the implementation process as effective as possible, Chief Executive Officers (CEOs) have been assigned in four Federal and 40 Regional Hospitals. These CEOs were given the opportunity to join the Masters Degree training program in Hospital Administration offered by Jimma University in collaboration with Yale University of USA.

In addition, various guidelines are being prepared to ensure the quality and sustainability of the new system. Hospital Management Boards have been established and have started to function in selected hospitals in Amhara, Tigray and SNNPR where the standard has begun to be implemented.

The main problems faced during implementation of the blue print were:

- Lack of ownership of the implementation process of the new hospital standard, and
- Inability to allocate a budget for the purpose of executing the standard in hospitals under the Addis Ababa Health Bureau.

## 5.2 Establishment of Private Wings in Public Hospitals

A private wing has been defined as a service rendering wing established within or adjacent to an existing public hospital whereby services are provided at a higher fee with some quality improvements.

A private wing is initiated for the following reasons: It can mobilize additional resources; improve quality of service in the non-private wing sections; increase motivation and reduce attrition of health workers; and it can provide an alternative choice of care.

In order to help start private wings in St. Paul's, ALERT and Black Lion Hospitals, the experience of other countries has been reviewed and based on such reviews, draft regulation governing the commencement and operation of this service has been prepared.

## 5.3 Construction, Rehabilitation and Expansion of Hospitals

The design of Emmanuel Specialized Hospital has been completed and the final design is being reviewed by the Ministry of Works and Urban Development (MoWUD).

On the whole 94.2% of the rehabilitation and expansion work at ALERT Hospital has been completed. The rehabilitation of existing wards, construction of one new ward and OPD building at ALERT Hospital have been fully completed. Moreover, the construction of a library and office building has commenced, contract agreement for the rehabilitation and expansion of the HMIS Training Center has been signed and over 50 % of the construction of a Trial ward has been completed.

Building for the examination and treatment of HIV/AIDS has been completed 100% at St. Peter's Hospital and provisional acceptance of the building has been made at the end of this fiscal year.

The design work for the Millennium Medical School and MCH Center at St. Paul's specialized Hospital has been delayed and has not been completed as per the schedule due to changes in the ToR and the needs of the hospital. However, it is now ready for review by the MoWUD. With respect to the construction of additional emergency block at St. Paul's Hospital, only 65% has been completed due to delay in the supply of construction materials.

The interior design and room service arrangements



of the FMOH head office building were being prepared but have been suspended since BPR exercise was not finalized. Currently 65% of the building has been completed excluding the compound work and if wall blocks are provided by the MoWUD on time, it is expected to be completed by the end of December 2008.

At regional level in EFY 2000, the construction of 6 new hospitals, the rehabilitation of 7, expansion of 15, and the upgrading of one hospital were started. There is an ongoing construction of 21 hospitals in three regions (Oromia, Tigray and Afar). The distribution of these hospitals is shown in Table 12.

Table 12: Status of Hospital Construction/Upgrading by Region, Ethiopia, EFY 2000

Region	New	Ongoing	Rehabilitation	Expansion	Upgrading
Tigray	-	1	-	2	1
Afar	1	1	-	1	-
Amhara	3	0	4	6	0
Oromia	1	19	-	5	0
Somali	1	0	2	0	0
Ben-Gumuz	0	0	0	0	0
SNNPR	0	0	0	0	0
Gambella	0	0	0	0	0
Harari	0	0	0	0	0
Dire Dawa	0	0	0	0	0
Addis Ababa	0	0	1	1	0
Total	6	21	7	15	1

## 5.4 Construction of Blood Banks

The purpose of establishing a blood bank facility is to ensure the supply of safe blood for transfusion and to prevent blood-borne diseases including HIV/AIDS.

55% of the construction work of 16 Blood Banks has been completed in six regions. In order to strengthen existing blood banks eight vehicles have been procured and distributed to regions. Furthermore, to strengthen blood banks at both central and regional levels, 54 professional and support staff have been assigned and medical equipment and tools worth USD 1,539,153 have been procured and distributed to regions.

Challenges faced in the construction work of blood banks were:

- Shortage of construction materials, and continuous price escalation.
- Delay in settling payment obligations for the executed construction works.

## 5.5 Tele-Medicine and Tele-Education

In order to enhance the training of physicians and facilitate access to Continuing Medical Education (CME),

the Ministry is exploring the use of telemedicine and tele-education technologies to support pre-service training as well as CME. Telemedicine is concerned with the application of technology in medical services such as tele-diagnosis and tele-consultation, in which tools are used to bridge the distance between skilled professionals and remote locations. In tele-education we use information communication infrastructure to enhance education so that professionals in remote location could have access to training resources and educational facilities.

Telemedicine holds a lot of promises for confronting the health challenges in Ethiopia, especially in facilitating access to skilled professionals who may be located in remote locations, and ensuring that patients in rural and remote areas can have access to the skills and resources of health professionals and experts in the urban centers. As a part of the implementation of the technological support to training and tele-diagnosis, an assessment study on the feasibility and assessment of telemedicine implementation was conducted to evaluate the possibility of starting telemedicine and video-conferencing services in 21 selected hospitals involved in the training of health and medical professionals.

As a way of showcasing the possibilities of these technologies in support of the training of professionals as well as enhancing health care delivery at the rural level, the implementation of telemedicine and tele-education has been commenced in the Jimma Network (consisting of the Jimma Hospital, Nekempte, Wolliso and Mettu). It is believed that this network will become a model health information system for primary care as well as a veritable source for professionals. The overall goals of the application of the tele-education and telemedicine technologies include: 1) providing quality health care through ICT supports; 2) ensuring prompt access to specialist care, 3) supporting the teaching and learning processes with appropriate

technologies, and 4) enhancing the creation of a knowledge infrastructure that would contribute to formulation and the continuing professional development of the staff of the ministry.

The key challenges to full implementation of the telemedicine and tele-education programs include paucity of required telecommunication infrastructure in health facilities and the huge cost of telecommunication services. As a way of solving these problems, and to ensure the establishment of the necessary infrastructure, the FMOH has carried out a number of activities including: 1) Consultative meetings on tele-education and telemedicine with participating health institutions to discuss on and agree on the implementation; 2) High-level consultation meeting with the Ministry of Capacity Building and the Ethiopian Information Communications Technology Agency (EICTDA) on establishment of the telecommunications infrastructure and reduction of telecommunication cost to the health institution since health is a fundamental social service to a very large extent. It is believed that the success of ensuring the use of tele-education and telemedicine technologies at the health facilities level to support the enhancement of the health service delivery depends, to a very large extent, on efforts to ensure connectivity to health centers and to eliminate telecommunication cost for health related services. In addition, the increased awareness and commitment of the stakeholders and enhanced ownership of the project, specifically in covering of local running costs and ensuring sustainability, must be emphasized.

## 5.6 Traditional Medicine

The Core Plan envisaged the establishment of a strengthened system that allows the provision of traditional medical services side by side with modern health services. To this end, a committee has been formed and detailed action plan prepared



to revise the regulation on traditional medical services and to identify and address the observed gaps. The final draft of the regulation has been prepared and is ready for submission to the Council of Ministers.

### **5.7 Role of Professional Associations**

Code of Ethics for health professionals has been prepared with the participation of representatives of Medical, Nursing, Laboratory, Pharmacy and Public Health associations and members drawn from the Legal and Medico-Legal Services at the FMOH. Draft guideline on licensing of private clinics has been prepared in the same manner.

In line with the plan to strengthen the partnership of professional associations with the Government through intensive discussions held every three months, memorandum of understanding has been signed with the Association of Ethiopian Surgeons, Association of Ethiopian Pediatricians and with the Ethiopian Medical Association. These associations have started to undertake various activities, based on their joint Plan of Action such as improving quality of health services, undertaking various studies, ensuring implementation of the Code of Ethics for health workers etc. These associations are also engaged in providing surgical treatment for cataract, hernia, etc. through campaigns done in collaboration with Government Health Services.

Similarly, to improve the quality of health services by strengthening the role and capacity of professional associations, memorandum of understanding has been signed with the following associations namely:-Association of Ethiopian Laboratory Technicians, Association of Ethiopian Physiotherapy Technicians, Ethiopian Nurse's Association, Association of Ethiopian Obstetricians and Gynecologists and Association of Ethiopian Midwives. These associations have also started the process of identifying their areas

of action and preparing a joint action plan.

In collaboration with the Association of Ethiopian Pediatricians, TOT and facilitation skills training on IMNCI have been given to professionals drawn from six regions. Since the trained workers have to continue to give the training in every region by incorporating essential data, the material has been prepared in the form of a book and distributed to regions.

In collaboration with the Association of Obstetricians and Gynecologists, "Standard of Care" has been prepared to enable higher clinics to provide Emergency Obstetric Services.

### **5.8 Role of Private Health Facilities**

Based on the suggestion forwarded by a five-member Implementation Task Force, drawn from owners of private hospitals in Addis Ababa, a document that facilitates the formation of an "Association of Private Hospitals and Clinics" has been prepared.

The Private Clinic Licensing Guideline has been reviewed in six regions including Addis Ababa; but the review results were not sufficient for revision of the guideline.





6

**NATIONAL NUTRITION  
PROGRAM**

The targets of the National Nutrition Program in EFY 2000 were to:-

- Increase provision of vitamin A from 91% to 95% and expand de-worming coverage from 80 to 90% and
- Increase coverage with iodized salt from 4.2% to 25%.

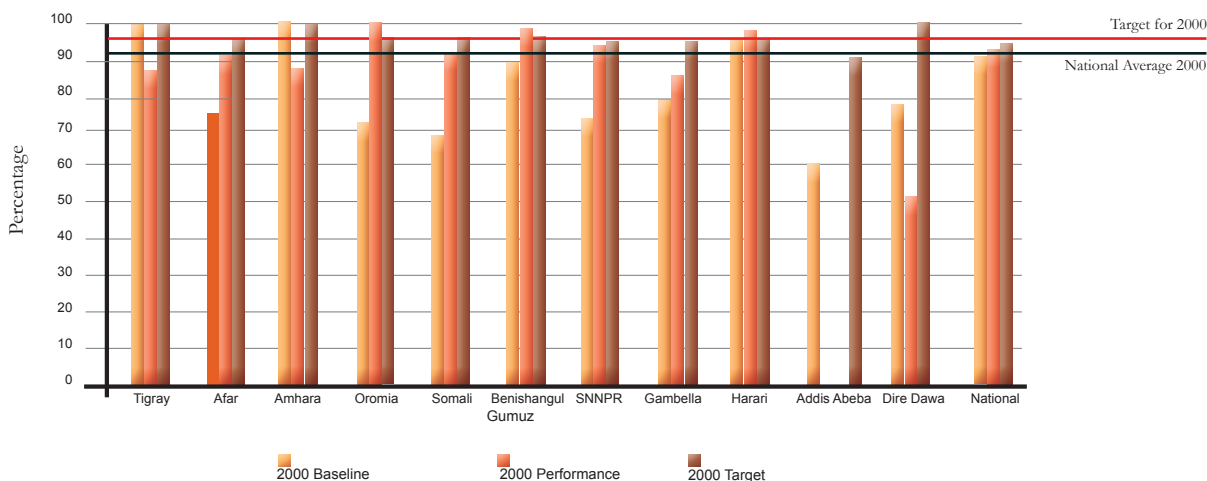
In EFY 2000, the National target has been 95% for VAS and 90% for de-worming.

### Vitamin A Supplementation

The performances of the sector during EFY 2000 shows that 10.7 million children aged 6-59 months were given vitamin A supplementation, with a coverage for Vitamin A increasing from 91% in EFY 1999 to 94% in EFY 2000.

Figure 10 shows the baseline (EFY 1999), the achievements in EFY 2000 and the EFY 2000 target of the coverage of under 5 children receiving Vitamin A supplementation.

Figure 10: Coverage of Under 5 Children Receiving Vitamin A Supplementation by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target)



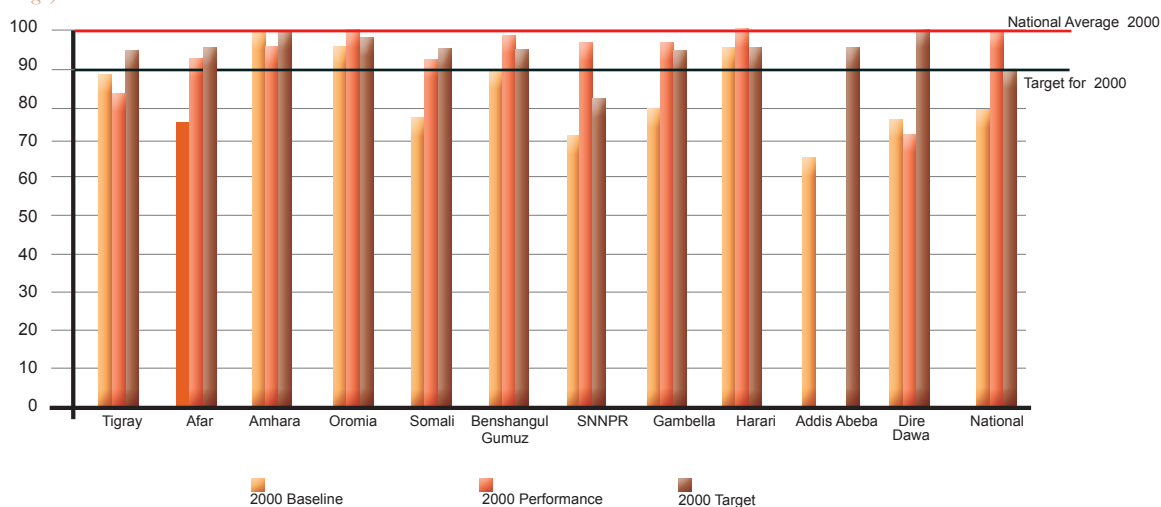
If we compare the performance of each region in EFY 2000 with the national target for EFY 2000, Oromia, Benishangul-Gumuz, and Harari are above the national target, while the rest of the regions are below the national target ranging from 61.0% in Dire Dawa to 92.8% for SNNPR. On the other hand, if we compare the performance of regions in 2000 with their own targets for EFY 2000; Oromia, Benishangul-Gumuz, SNNPR and Harari are above the target for EFY 2000, while Tigray, Afar, Amhara, Somali, Gambella and Dire Dawa are below the 2000 target shown in the Core Plan.

## De-Worming

A total of 7.7 million children aged 24-59 months were given Albendazole tablets. The de-worming coverage has increased from 80% in EFY 1999 to 99% in EFY 2000.

If we compare the achievements for 2000 with the targets set by regions for 2000, we find that, except Dire Dawa (73%) and Tigray (83.1%) which are below the 90% national target for 2000, all of the remaining regions are above the national target in 2000; ranging from 92% for Afar to 110 % for Oromia (Figure 11).

Figure 11: Distribution of the Coverage of Under 5 children De-wormed by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target).



Based on the joint interests of the government and its partners, a National Nutrition Program covering the period 2008 to 2013 has been prepared. A project agreement on implementation of the program has been signed with the World Bank. A Nutrition Strategy has been officially adopted in the presence of the MOH, Regions, other sector institutions as well as partners. As the main tool for implementation of the National Nutrition Program, the strategy has been distributed to relevant bodies for implementation.

Detailed mapping and profiling study has been conducted in Afdera and Dobia the main salt producing areas in Afar Region. Action plan on implementation of the study results has been prepared with the participation of relevant sector institutions and the salt producers.

Nine iodization machines and eight generators have been handed over to Afdera woreda Council and agreement has been reached to start production of iodized salt using these machines. Twelve medium capacity mobile machines have been procured and of these, six were received by Afar RHB, while the remaining six are in the process of being transported into the country.

A National Micro-Nutrient Survey has been conducted in collaboration with the Ethiopian Health and Nutrition Research Institute and Regions and partners have been oriented about the results of the survey.

In accordance with the plan to develop the skills and strengthen the implementation capacity at the regional level, training on Essential Nutrition Action has been given to 64 program coordinators and professional workers in pastoralist areas (Benishangul Gumuz, Somali, Afar and Gambella) that need special attention. Master Trainer Training on Community Based Nutrition has been given to 70 professional staff drawn from 40 selected woredas located in four regions (Tigray, Amhara, SNNP and Oromia). These woredas were selected in order to implement the Community Based Nutrition Program at their localities during the year. In addition, training on HIV/AIDS and nutrition has been given at Adama and Bahir Dar, for 55 professional staff drawn from all regions.

Planned activities that did not materialize during the year include; inadequate supervision of regions, inability to promulgate the regulation that could help in the implementation of the salt iodization program and the non-performance of the Action Plan on Salt Iodization within the time frame set by the Federal and Regional levels.

Lack of uniform working relations, due to non-existence of nutrition structures in health facilities at Regional, Zonal and Woreda levels, and despite the presence of a joint Action Plan on salt iodization, inability to implement the plan at the required pace were the major problems encountered during plan implementation.

The way forward is to enhance the implementation of the National program especially the salt iodization program.



7

**PREVENTION & CONTROL  
OF COMMUNICABLE  
DISEASES**

### **7.1 HIV AIDS Prevention and Control**

It is to be recalled that on 2 June 2006, Ethiopia joined other UN member states at the UN General Assembly to approve resolution 60/262, popularly known as the Political Declaration on HIV/AIDS. The declaration includes a commitment by UN Member States to move towards the goal of universal access to HIV prevention, treatment, care and support services by 2010 and to work with partners at country level in order to overcome barriers that block access to prevention, care and treatment.

In response to this commitment, leadership has been provided for the development of a Multi-sectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia 2007-2010. The Universal Access Plan of Action was costed and consisted of specific targets and detailed activities categorized under 16 major program areas. Its development has been guided by the SPM- Ethiopia's universal access commitment and the "Three Ones" principles. Since then Ethiopia has updated its planning framework with ambitious targets to achieve universal access and it has launched a "Millennium AIDS Campaign" that has catalyzed more rapid scale up of key prevention and treatment programs.

As far as the status of the epidemic is concerned, a careful assessment of data gathered over the last four years suggest that the epidemic in Ethiopia has stabilized with adult HIV prevalence estimated at 2.2% in 2003/04 and 2.1% in 2006/07 and 2007/08. The urban and rural prevalence rates are estimated at 7.7% and 0.9% respectively. The rural epidemic appears to be relatively widespread but heterogeneous, with most regions having a relatively low prevalence of HIV, but a few demonstrating adult prevalence rate of over 5%. Gender wise, the prevalence rates were 1.7% for males and 2.6% for females. The higher rate for women shows that women are more vulnerable than men to HIV infection. Recent studies suggest that, the prevalence of HIV/AIDS is stabilizing in urban areas and increasing gradually in rural areas. In general, HIV incidence is leveling off after declining over the last few years.

There are around one million PLHAs and of these about 258,000 need ART. There are around 125,000 new infections every year. The total number of HIV positive pregnant women and annual HIV positive births are 75,000 and 14,000, respectively. At present, 65,000 children below the age of 14 years live with the virus.

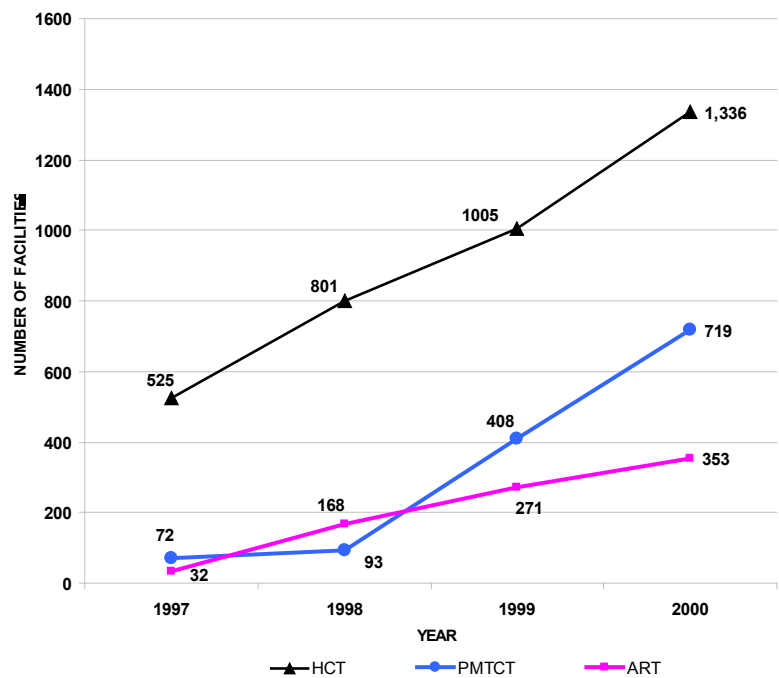
Regional distribution of prevalence showed that Addis Ababa has the highest HIV prevalence rate of 7.5% followed by Dire Dawa and Harari with 4.2% and 3.2%, respectively. Somali Region has the lowest prevalence rate (0.8%), whereas the prevalence in SNNP, Tigray, Amhara, and Oromia Regions is 1.4%, 2.7%, 2.7% and 1.5%, respectively.

The multi-sectoral response to HIV/AIDS has been guided by strategic plans, and, based on these plans, a number of activities have been accomplished during the last five years. The progress being made to date in HIV testing, care, support and treatment, and ART and PMTCT programs, is summarized in the following sections.

## HIV Counseling and Testing (HCT)

During EFY 2000, though the plan was to expand HCT centers in 293 sites, the service has been made available in 331 health facilities, with an achievement above the target. One thousand three hundred and thirty six health facilities were providing HCT service in EFY 2000. As shown in Figure 12, there has been a marked increase in the number of sites providing HCT from 525 in EFY 1997 to 801 in EFY 1998, to 1005 in EFY 1999 to 1336 in EFY 2000, with an increase by 33% over the EFY 1999.

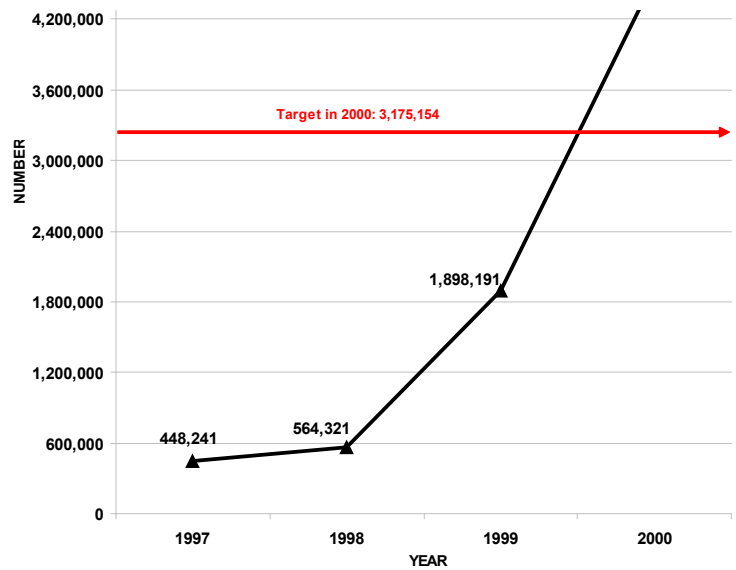
Figure 12: Trend in the Number of Facilities Providing HCT, PMTCT and ART Services (Ethiopia, EFY 1997-2000).



Concerning the trend in the number of clients using HCT services, the number of users has more than doubled in EFY 2000 (4,559,954) compared to EFY 1999 (1,898,191). The target for EFY 2000 was to provide HCT services to 3.1 million people, with an achievement (over 4.5 million) above the target (Figure 13). This large increase was brought about by the social mobilization made through the Millennium AIDS Campaign. The campaign has thus contributed substantially in increasing the number of HCT users. From EFY 1997 up to the end of this fiscal year, a total of 7.47 million people have been tested for HIV. Out of these, 1,030,000 are people living with HIV/AIDS, 436,572 have tested positive and 264,454 have been registered for ART.

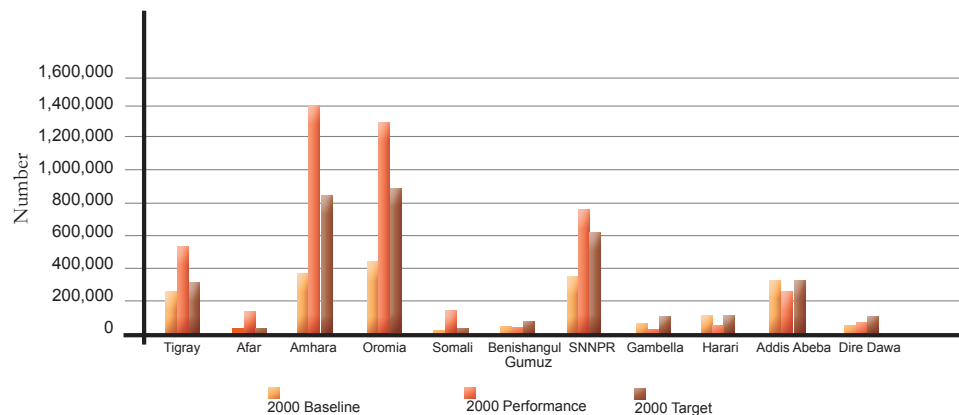


Figure 13: Trend in the Number of Clients Using HCT (Ethiopia, EFY 1997- 2000).



Wide variations in the number of clients using HCT were observed across regions, with 6 regions (Tigray, Afar, Amhara, Oromia, Somali and SNNPR) showing a performance above the target set in the EFY 2000 (Figure 14). In particular, there were 562,004 HCT users in Tigray during the year (target: 295,205), 91,626 in Afar (target: 19,330), 1,401,241 in Amhara (target: 821,699), 1,274,640 in Oromia (target: 847,592), 77,266 in Somali (target: 10,635), and 757,103 in SNNPR (target: 602,093).

Figure 14: Distribution of the Number of Clients Using HCT by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target).



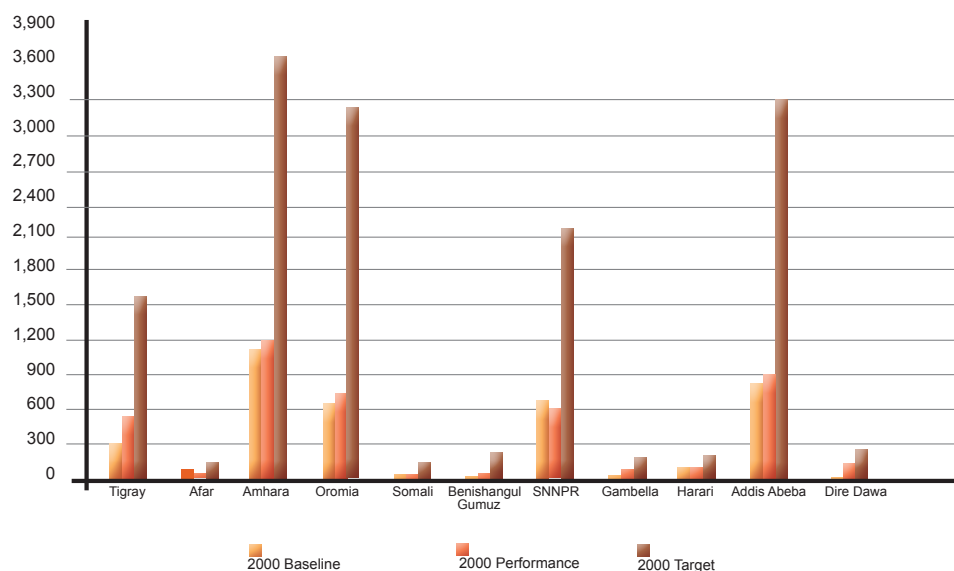
## Prevention of Mother to Child Transmission (PMTCT) of HIV

With regard to PMTCT, the number of facilities providing the service has increased from 72 in EFY 1997, 93 in EFY 1998, 408 in EFY 1999 to 719 in EFY 2000 (Figure 12), exceeding the planned target of 603 health facilities.

According to current estimates, there are 75,420 HIV infected pregnant mothers and 14,148 HIV infected births within a year. In EFY 2000, 4478 mothers received antiretroviral treatment and this amounted to only 5.9% of those eligible for treatment. Out of the HIV infected infants only 25% received PMTCT prophylaxis. The performance in the provision of PMTCT service has been very low. The ANC coverage in the country is far lower than national targets and in most settings ANC and PMTCT are not strongly linked. The major gaps and challenges identified in the implementation of PMTCT in the country include: (i) the limited expansion of the service, (ii) the small number of users even in areas where the service is available, (iii) poor integration of PMTCT into ANC services, (iv) low rates of skilled attendant deliveries, (v) limited number of skilled and motivated human resources, and (vi) a weak M&E system. The integration of counseling, testing and PMTCT in antenatal clinics is of utmost importance for increasing the uptake of the service.

In EFY 2000, even though PMTCT service was planned to be given to 15,000 pregnant women, the number of women who received PMTCT prophylaxis was 4478. Hence only 30% of the target has been achieved. Figure 15 shows the distribution of HIV-positive mothers provided with PMTCT prophylaxis by region, highlighting that no region achieved the target set in the EFY 2000. The highest number of HIV-positive mothers provided with PMTCT prophylaxis was achieved in Amhara (1205), Addis Ababa (939), and Oromia (811).

Figure 15: Distribution of HIV-Positive Mothers Provided with PMTCT Prophylaxis by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target).



## Antiretroviral Treatment

With respect to ART, the number of health facilities (hospitals, health centers and private clinics) providing ART services have increased from 32 in 1997 EFY to 168 in 1998 EFY to 271 in 1999 EFY to 353 in EFY 2000. The number of health centers providing ART has increased from 154 in EFY 1999 to 234 in EFY 2000, while the number of hospitals has increased by only one digit during the same period because almost all public hospitals are already providing ART services. Thus 119 hospitals and 234 health centers are currently providing the service. Of note is the fact that 87 new health facilities, not yet included in the above mentioned total number, will start to provide the service as of the end of June EFY 2000, increasing soon the total number of facilities providing ART to 440. Fourteen private hospitals have started to provide the service. Thus 98% of the hospitals and only 34% of the health centers are providing the service as of the current reporting year.

The number of PLHA ever enrolled in chronic HIV care has increased significantly over the years from 13,773 in EFY 1997 to 266,507 in EFY 2000. As shown in Figure 16, the number of PLHA ever started on ART has increased from 8276 in EFY 1997 to 24,236 in EFY 1998, 97,299 in EFY 1999 to 150,136 in EFY 2000. Out of the 150,136 ever started on ART, 51% are women, 44% are men and 5% are children. A total of 109,930 PLHAs were currently on ART at the end of EFY 2000.

The target for EFY 2000 was to reach a cumulative number of ever-starting PLHA of 174,000, with an achievement rate of 86% during the year, but with only 58% of coverage of those eligible for treatment. ART is given free of charge in all regions.

Wide variations in number of people living with HIV/AIDS ever starting ART were observed across regions, with Amhara, Addis Ababa and Oromia accounting for the highest number of PLHA ever starting ART (38,389, 37,130 and 28,185, respectively); only Dire Dawa achieved the 2000 target (2000 performance: 2,801; 2000 target: 2,717) (Figure 17).

Figure 16: Trend in Number of People Living with HIV/AIDS who Accessed Chronic HIV Care and ART (Ethiopia, EFY 1997–2000)

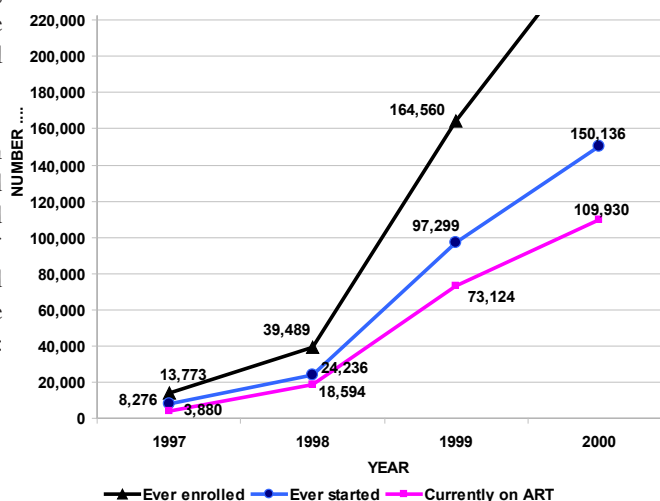
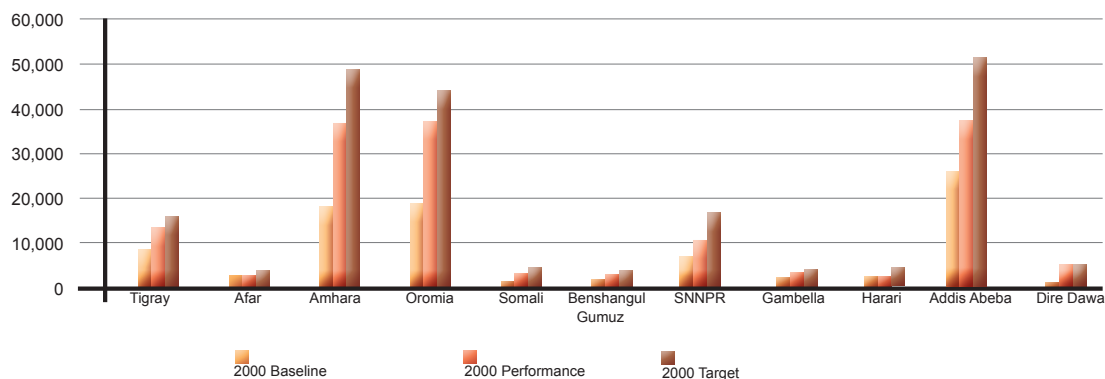


Figure 17: Distribution of PLHA Ever-Starting ART by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target)



## 7.2 Malaria Prevention and Control

The malaria prevention and control program in Ethiopia is guided by five-year strategic Plans. The first has been completed in 2005, and the program is currently implementing the Second Five Year Strategic Plan covering the period 2006-2010.

The objective of the program is to strengthen malaria prevention and control activities in 13,425 kebeles located in 489 malarious woredas. The targets for EFY 2000 include the following:

- Achieve 100% ITN coverage by distributing a cumulative number of 20 million ITNs;
- Spray 2 million houses in malarious areas; and
- Provide treatment for 6 million malaria cases and fever cases with symptoms of malaria in 13,425 kebeles.

The prevention and control of malaria follows three implementation approaches, namely:

- Selective vector control including the use of long lasting insecticide treated nets, indoor residual spraying with insecticides (DDT) and environmental management;
- Early diagnosis and treatment of cases; and
- Epidemic prevention and control.

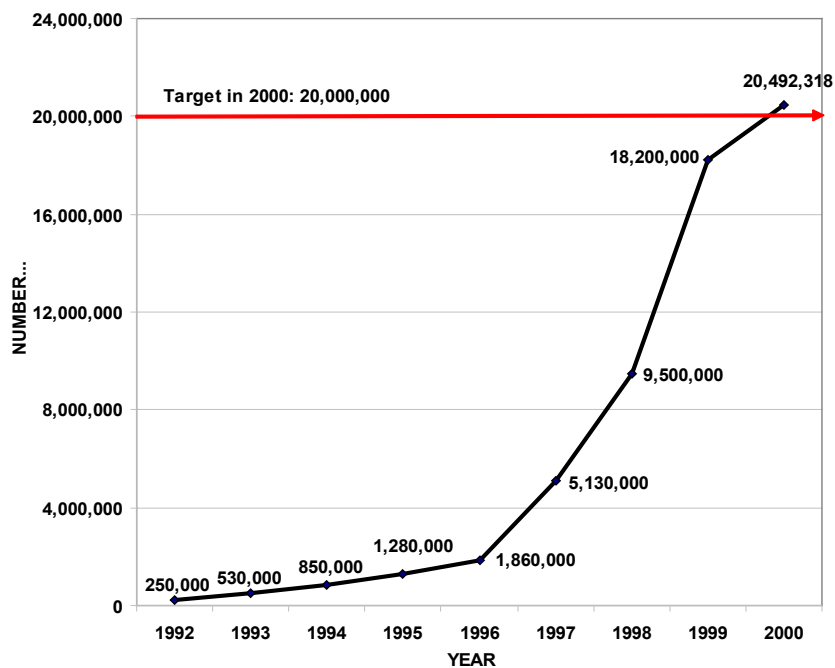
The performance with respect to each approach is summarized as follows.

To meet the target of spraying 2 million houses, one key activity was to procure and distribute 972 tons of insecticides. For this purpose, TOT training on prevention and control of malaria was provided to a total of 50 health workers drawn from woredas where spraying was to be made; similar training was given for two months to 50 health workers drawn from each region.

The procurement of 1600 tons of insecticides has been started and, out of this total, 1334.4 tons (83%) has been distributed to regions. Compared to the planned amount of insecticides (972) the achievement rate is over 100%.

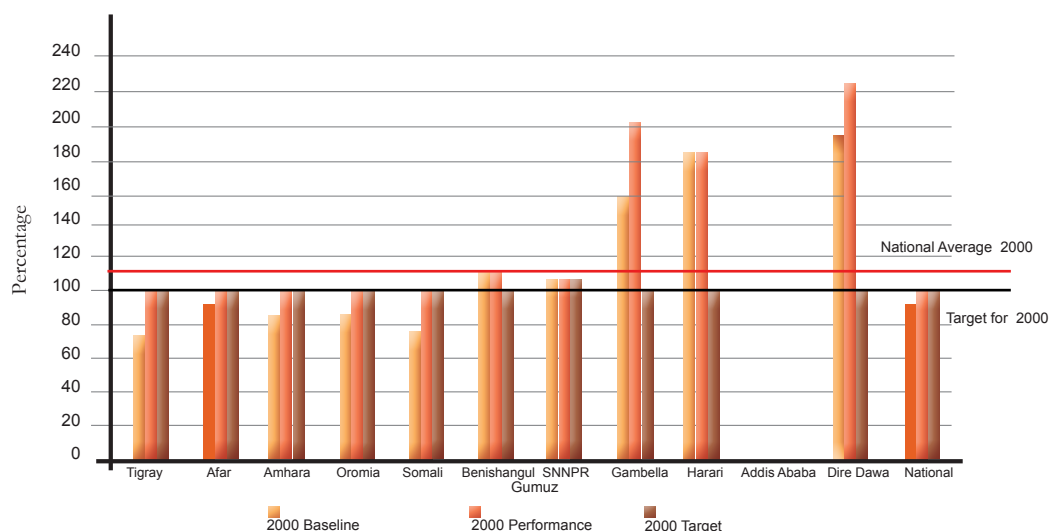
The second approach in vector control is the use of ITNs. In this connection, the plan has been to achieve 100% coverage. Up to the end of 1999 EFY 18.2 million ITNs were procured and distributed, while in EFY 2000 the cumulative number of ITNs distributed reached 20,492,318, with a national coverage of 102% (Figure 18).

Figure 18: Trend in Number of Insecticide-Treated Nets (ITNs) Distributed by Region (Ethiopia, EFY 1992-2000)



If we compare the ITN distribution by region, the target has been met in all regions and the number distributed was above the planned target in five regions: Benishangul-Gumuz (105%), SNNPR (103%), Gambella (206%), Harari (182%), and Dire Dawa (224%) (Figure 19).

Figure 19: Distribution of Insecticide-Treated Nets (ITNs) Coverage by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target)



A cross-sectional national Malaria Indicators Survey (MIS) was conducted during the major malaria transmission season (October-December 2007) to assess intervention coverage and malaria and anemia prevalence.

The results indicated that household ownership of nets increased from 6% in 2005 to 56% in 2007. For households in areas of altitude <2000 meters, ownership was 69% and for the highly malarious regions (Afar, Benishangul-Gumuz and Gambella) it ranged from 73 to 88%. Net use by children under five years was 2% in 2005; according to MIS, among children under age five years, 43.8% reported sleeping under a net the previous night in household below 2000m, and 34.7% nationally. Among pregnant women living in households below 2000m, 44.8% reported sleeping under a net the previous night, 36.7% nationally. In households owning at least one ITN, 60.1% of the children under age five years and 65.7% of pregnant women slept under a net the previous night.

Moreover, Indoor Residual Spraying (IRS) has been conducted in 20.0% of households below 2000 meters in the 12 months preceding the survey, and 14.2% of households nationally.

In terms of the implementation of early diagnosis and treatment of cases, Coartem adequate for the treatment of six million malaria cases has been distributed to regions as planned. Furthermore, in order to enhance the control of malaria, 4.1 million Malaria Rapid Diagnostic Tests have been procured, and a distribution plan is being prepared.

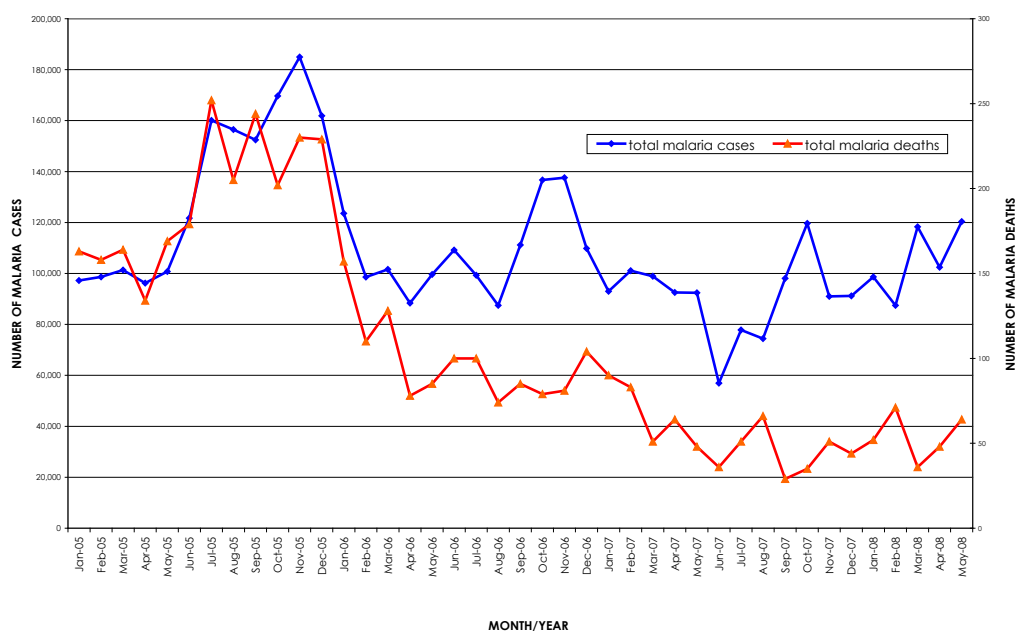
The Millennium Anti-malaria Campaign is going well and out of 3.5 million fever cases, 2.1 million (60%) have been treated for malaria.

With respect to epidemic prevention and control, no major malaria epidemic has been reported during the year under consideration.

The main result in the prevention and control of malaria has been the distribution of 20.5 million ITNs to 10 million households in malarious areas with the achievement of the target set in EFY 2000. This was confirmed by a survey of households in Boset Woreda of East Shoa Zone of Oromia Region, where the coverage rate of ITNs was 117%. At the national level, the 100% coverage rate of ITNs has contributed to a substantial reduction in morbidity and mortality caused by malaria.

In general, the implementation of the three-pronged approach consisting of early diagnosis and effective treatment, selective vector control and epidemic prevention and control has resulted in a downward trend in malaria cases and deaths (Figure 20).

Figure 20: Trend of Malaria Cases and Deaths (Ethiopia, January 2005 – May 2008)



A recent study conducted by the World Health Organization, showed that the morbidity due to malaria declined by 48%, hospital admissions by 54% and mortality by 55%. As shown by this study, due to the decrease in number of cases and subsequent reduction in workload of the staff, the additional time gained by the health facilities is being used for improving the quality of service.

Shortage of trained manpower, lack of adequate awareness about the campaign on the part of zones, woredas and health facilities, and failure of regions to transmit reports on time were the key challenges affecting implementation of the control program.

As part of the measure taken to address these problems, joint consultation meetings have been made with regions and vigorous actions including the revision plans have been agreed upon in order to enhance the momentum of the Millennium Anti-malaria campaign.

### **7.3 Tuberculosis and Leprosy Prevention and Control**

According to TB notification data for 2006 reported by 202 (out of 212) countries and territories to the WHO in 2007, at global level, there were an estimated 9.2 million new cases of TB in 2006 (139 per 1000000 population), including 4.1 million new smear positive cases (44% of the total) and 0.7 million HIV-positive cases (8% of the total). The African region has the highest incidence rate per capita (363 per 10000 population).

Targets for TB control have been set within the framework of the MDGs. MDG 6 target 6.c is to halt and reverse incidence by 2015. The Stop TB Partnership has set two additional impact targets which are to halve prevalence and death rates by 2015, compared with their level in 1990. The outcome targets first set by the World Health Assembly in 1991 are to detect at least 70% of new smear-positive cases in DOTS programs and to successfully treat at least 85% of detected cases. All five targets have been adopted by the Stop TB Partnership, and in 2007 were recognized by the World Health Assembly resolution -WHA 60.19.

The Stop TB Strategy launched by WHO in 2006 is designed to achieve the 2015 impact targets as well as the targets for case detection and treatment success. The Stop TB Strategy has six major components: (i) DOTS expansion and enhancement, (ii) addressing TB/HIV, MDR-TB and other challenges; (iii) contributing to health system strengthening; (iv) engaging all care providers, (v) empowering patients and communities; and (vi) enabling and promoting research.

Point estimates of case detection and treatment success indicate that the world as a whole failed to meet the targets for both indicators. However, measurement uncertainty allows the possibility that case detection exceeded 70% in 2006, and treatment success was only 0.3% below the target of 85% in the 2005 cohort.

The magnitude of the TB burden within countries can also be expressed as the number of incident cases per 100 000 population. Among the 15 countries with the highest estimated TB incidence rates, 12 are in Africa. The high incidence rates range from 2% to 15%. The incidence rate estimated for Ethiopia is 3%.

Concerning Ethiopia the FMOH has declared the ambitious target of increasing case detection to 60% in 2007. The expansion of primary health care facilities will help with this goal, as will plans to increase the involvement of HEWs in identification and referral of TB suspects, and to continue the scale up of collaboration with private health clinics. Intensified case- finding among HIV patients would also contribute.

The objective of the TB Control program is to reduce morbidity, disability and death caused by TB. The target for EFY 2000 was to increase TB case detection rate from 32% to 60%. To meet this target a number of key activities have been planned for implementation. These comprise of: (i) provision of





laboratory equipment and reagents adequate for 685,820 suspected TB cases; (ii) provision of medicine and equipment adequate for 153,450 patients; (iii) revision and dissemination of printed copies of the “Diagnostic Algorithm” to health facilities; (iv) provision of TOT training to workers drawn from central and regional levels; and (v) expansion of TB/HIV integrated prevention and control activities in additional 340 health facilities. In this respect the achievements of the TB and Leprosy Program are presented as follows.

In accordance with the targets set in the Core Plan for EFY 2000, reagents adequate for an estimated 685,820 suspected TB cases, and drugs adequate for the treatment of 153,450 TB cases, have been procured and are being distributed. This represents a performance rate of 100% compared to the planned targets.

The diagnostic algorithm has been revised along with the TB manual in order to ensure adherence; the manual has been printed. TOT has been given for 25 health workers to make TB and Leprosy program coordinators drawn from regions and zones to adhere to the program manual in all health facilities. In addition to strengthen the quality assurance of laboratories, TOT has been given to 30 health workers drawn from all regions.

To expand integrated TB/HIV Prevention and Control activities in 340 health facilities, training on TB and Leprosy has been given in 22 rounds for a total of 850 (55%) health workers at SNNP, Benishangul-Gumuz, Afar, Amhara, Dire Dawa, Tigray, Gambella, Harari, Oromia and Somali Regions.

Integrated prevention and control work has been started in 177 health facilities during the fiscal year, and the number of facilities which provided the service has grown from 300 to 477.

Quality Assurance Protocol that shows the role, process of data exchange and provision of support of the Federal MOH and Regional Laboratories, has been prepared and distributed to regions and partner organizations.

In order to start PPM-DOTs in 495 private health facilities, the plan to give TOT training for 33 health workers drawn from regions failed to materialize during the plan period, the reason being inadequate manpower at central level and low capacity of private health facilities to undertake this task.

### **TB Case Detection Rate**

One of the indicators used to monitor and assess the TB prevention and control program is the TB case detection rate which is defined as the percentage of new sputum smear positive TB cases detected out of the estimated number of new sputum smear positive TB cases. In EFY 2000, a total of 40,794 new sputum smear positive TB cases were detected. The national target has been to achieve a 60% TB case detection rate. However, since the current rate stands at 33.9%, the performance is far below the planned target. The TB case detection rate has remained stagnant for a long time showing upward fluctuations only in the last two years (Figure 21).



Figure 21: Trends in TB Case Detection, Treatment Success and Cure Rates, Ethiopia, EFY 1995-2000.

As shown in Figure 22, TB case detection rate varies from one region to another. At 20.3% and 21.0%, Somali and Amhara Regions have the lowest case detection rates; followed by Tigray (28.6%), Oromia (35.8%), and Benishangul-Gumuz (38.8%). Gambella, Harari, Afar and Addis Ababa have relatively higher rates than the other regions with 76.9%, 71.4%, 70.0% and 68.3%, respectively.

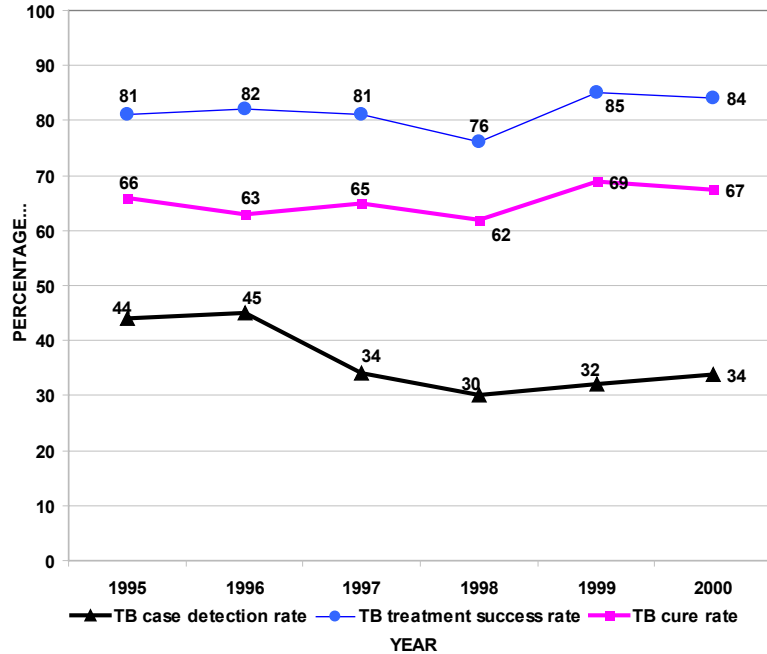
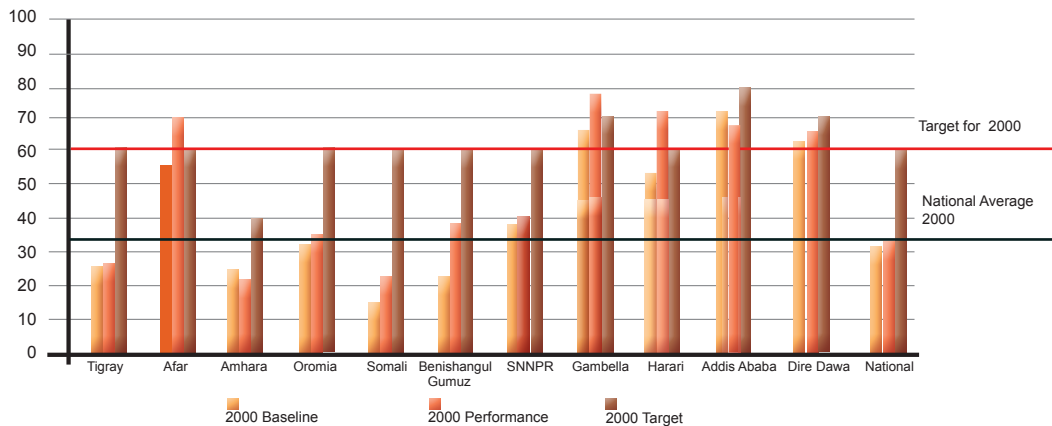


Figure 22: Distribution of TB Case Detection Rate by Region (Ethiopia, EFY 2000 baseline, EFY 2000 performance and EFY 2000 target).



The variation is mainly due to insufficient utilization of Health Extension Workers (in terms of educating the public and making them to undertake timely sputum examinations) and inadequate laboratory capacity.

In order to raise the case detection rate, future strategy should consider consultation with regions on how to strengthen the human resources and structure at regional level, increase the use of HEWs in case

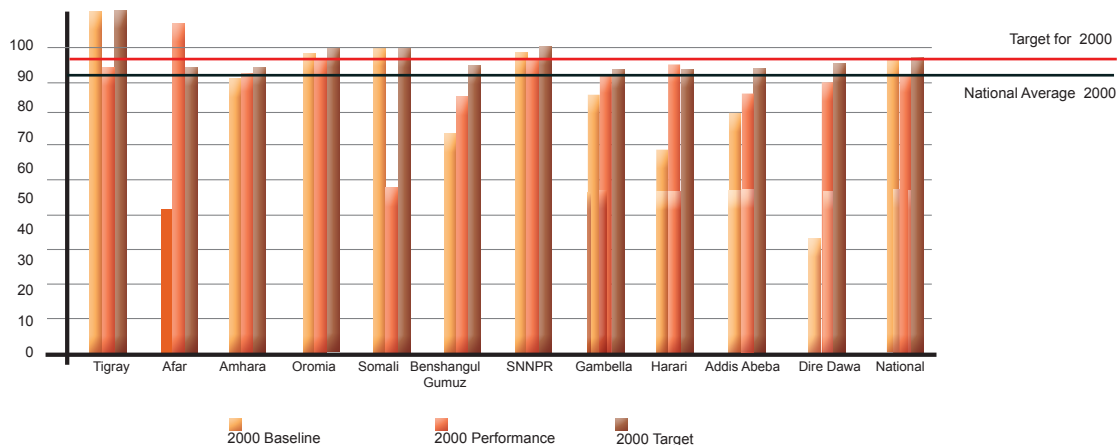
detection work and apply various educational means to raise the awareness of the community.

## TB Treatment Success Rate

As shown in Figure 23, the trend for TB treatment success and cure rates has shown fluctuations over time around 80-85% and 65-70%, respectively. In EFY 2000, the TB treatment success rate was 84.0% which is near to the international standard (85%). Of note is the fact that around 1400 registered cases were missed and not evaluated.

As shown in Figure 23, treatment success rate is good in most of the regions except in Somali Region (58.8%); in addition to Somali, it is below 80% in three other regions: Benishangul-Gumuz (76.2%), Addis Ababa (77.1%), and Dire Dawa (79.9%). The highest rate was found in Afar Region (96.5%).

Figure 23: Distribution of TB Treatment Success Rate by Region (Ethiopia, EFY 2000 Baseline, EFY 2000 Performance and EFY 2000 Target).

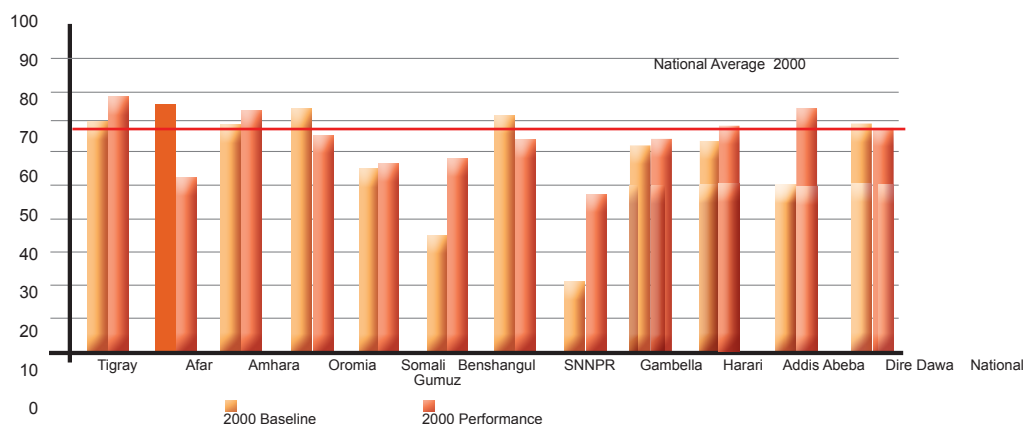


## TB Cure Rate

In EFY 2000, TB cure rate has shown downward fluctuation (67.4%) with respect to the EFY 1999 level of 69%. The lack of improvement signifies the existence of problems related to the lack of capacity at the grassroots level. This issue requires extensive review and the taking of appropriate measures based on the results of the review. Tigray, Dire Dawa, and Amhara showed the highest cure rate (78.9%, 74.0%, and 73.2%, respectively), whereas Gambella showed the lowest one (39.2%) (Figure 24).

The low participation of regions with respect to the expansion of the service, turnover of trained health workers, the inability to give fully integrated TB and HIV prevention and control service, and the lack of complete and timely reports were the major problems faced during the implementation process.

Figure 24: Distribution of TB Cure Rate by Region (Ethiopia, EFY 2000 baseline and EFY 2000 performance).



#### 7.4 Onchocerciasis Prevention and Control

The plan for EFY 2000 was to treat with Mectizan 5 million people affected by Onchocerciasis. Accordingly, 11,916,574 Mectizan doses adequate for 4.5 million cases were acquired from a partner organization and along with 2,684,526 Mectizan doses available in store, preparations are being made to distribute the drug to people who are in need of such treatment.

#### 7.5 Trachoma Prevention and Control

The plan for EFY 2000 was to expand the Trachoma Control Program from 57 to 82 woredas and to provide treatment for 8.4 million trachoma cases. However, the number of Zithromax doses distributed to regions exceeded the planned amount considerably and it was adequate for 10.25 million people.

The planned printing and distribution of a National Guideline for mass antibiotic distribution in Ethiopia did not materialize, since translation of the guideline into Amharic and collection of feedback took a longer time than anticipated. The guideline when implemented will be useful for monitoring and evaluation of the program.

Although the planned preparation of a leaflet on SAFE strategy to be implemented by the Health Extension Program has been completed, its printing and distribution did not materialize due to inadequate capacity in terms of human resources.

Drugs and medical equipment necessary for the surgical treatment of cataract and other eye diseases were distributed to regions that need support. A total of 369 medical instruments for the surgical treatment of trachoma provided by a health sector partner organization was distributed to regions where trachoma is a major disease.

## 7.6 Kalazar Prevention and Control

The plan for EFY 2000 was to provide drugs for the treatment of 8000 Kalazar (Visceral Leishmaniasis) cases and to give TOT training for 30 health workers drawn from regions affected by the disease.

On this basis, 4000 doses of the drug were procured and distributed to affected regions. The procurement of 606 doses is underway and, when they will be distributed, the performance rate of the program will be 57.6% compared to the plan.

In addition, TOT on detection and treatment of the disease was given for 30 health workers. Since the target has been fully achieved, regions will give similar training to lower levels of the health care delivery system.

As shown by field reports, unlike previous periods, the current number of Kalazar cases is small. One problem faced during implementation is that these cases are widely distributed across regions. In order to tackle this challenge, efforts should be made to raise the level of awareness of health workers, including health extension workers.

## 7.7 Epidemic Prevention and Control

The status of activities performed in EFY 2000, in connection with the prevention and control of Acute Watery Diarrhea, Meningitis, Measles, Polio, Rift Valley Fever, and Avian Influenza is summarized as follows.

### Acute Watery Diarrhea (AWD)

Epidemic of Acute Watery Diarrhea (AWD) initially occurred in Gambella in 1998 EFY, and since then it spread to various regions and city administrations. In 1999 EFY the epidemic spread to 8 regions and 2 city councils. 79,831 persons were treated free-of-charge and, of these, 941 have died.

In EFY 2000 the epidemic affected 188 woredas in 7 regions and 3 city councils. There were 20,006 cases and 287 deaths (Case Fatality Rate = 1.4%). This rate is slightly above the international standard (1%).

As incoming reports show, though it has been controlled in all regions for a duration of three months, the disease is once again appearing, especially in Amhara, Oromia and Tigray Regions (Figure 25). To fully control the spread of the disease, the main approach should focus on provision of integrated prevention activities. To this end, training was given for 54 health workers with the aim of establishing Rapid Woreda Response Teams in all regions.

The trend of Acute Watery Diarrhea cases and deaths in EFY 2000 is shown in Figure 26.



Figure 25: Distribution of Number of Acute Watery Diarrhoea Cases and Deaths by Region (Ethiopia, EFY 2000).

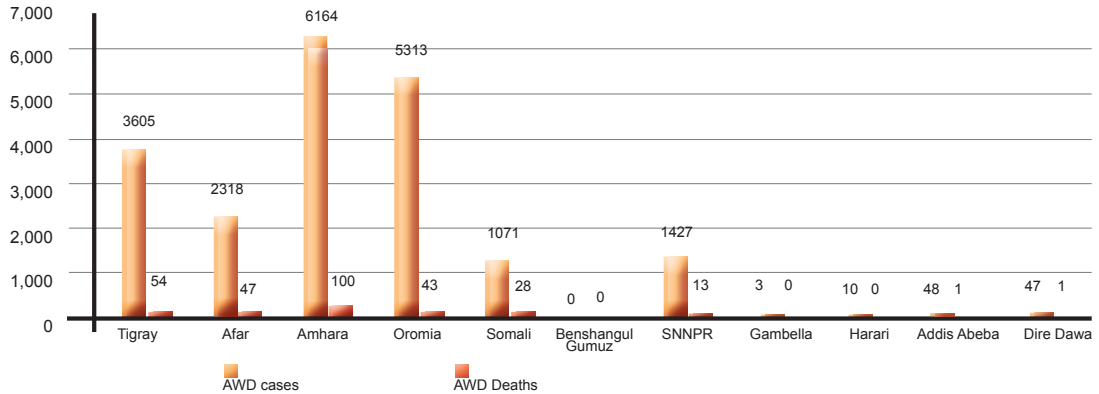
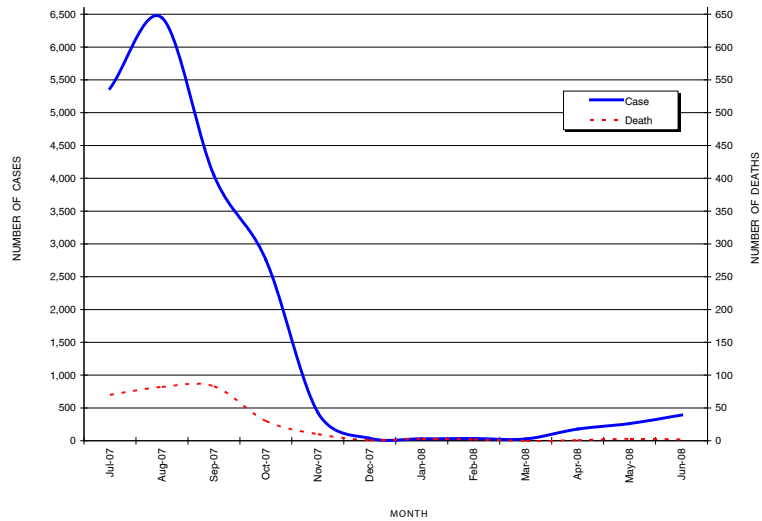


Figure 26: Trend of Acute Watery Diarrhoea Cases and Deaths (Ethiopia, July 2007-June 2008).



The strategy adopted to control the epidemic included:

- Raising the level of awareness of the society;
- Maintaining personal and environmental sanitation;
- Providing rapid medical care;
- Ensuring availability of drugs and medical equipment; and
- Providing technical assistance and making follow-up on activities.

Accordingly, an AWD Epidemic Coordinating Committee was established at FMOH and was engaged in coordination tasks. Ministries directly concerned with the prevention and control of the epidemic (MOE,

MOH, MOWR, MOI and Privatization Agency) established a joint ministerial committee which prepared a Joint Action plan and conducted monitoring activities. As a result of the coordination, drugs and medical equipment were distributed to Oromia, SNNP, Afar, Somali, Harari and Amhara Regions.

In order to develop the awareness level of the society, educational messages were transmitted using various means of communication. Technical assistance was given in areas affected by the disease. Necessary support was provided in the collection of data for disease surveillance.

Problems encountered during the implementation included: (i) the high demand placed on human resources and supplies due to the occurrence of the epidemic regularly and over a number of months; (ii) flow of untimely and incomplete data from regions affected by the epidemic and (iii) inadequate cooperation from concerned institutions. In order to solve the above mentioned problems, a joint committee drawn from five ministries was set up and started to implement joint activities.

### **Meningitis Outbreak**

Ethiopia is located in the meningitis belt, which makes it vulnerable to an epidemic every year. Monitoring the disease is conducted through gathering epidemiological data from regions on a weekly basis.

During the EFY 2000, the epidemic occurred in a number of regions and 612 cases and 18 deaths were reported. Since the forecast of the World Health Organization envisaged the possibility of a severe epidemic during the year, a National Fund Raising Proposal and Implementation Guideline were submitted to Donor Agencies, to prevent and control the epidemic without delay.

At the national level, 689,500 doses of vaccine were used in seven regions (SNNPR, Oromia, Amhara, Tigray, Addis Ababa, Gambella and Benishangul-Gumuz) as well as in the Prison Administration, and 679,556 persons aged 2 to 30 years were vaccinated.

Early warning forms and guideline were distributed to regions and training on preparedness and response has been given to 30 health workers drawn from all regions.

Figure 27 shows the regional distribution of meningitis cases and deaths, while their trend in EFY 2000 is shown in Figure 28.



Figure 27: Distribution of the Number of Meningitis Cases and Deaths by Region (Ethiopia, EFY 2000)

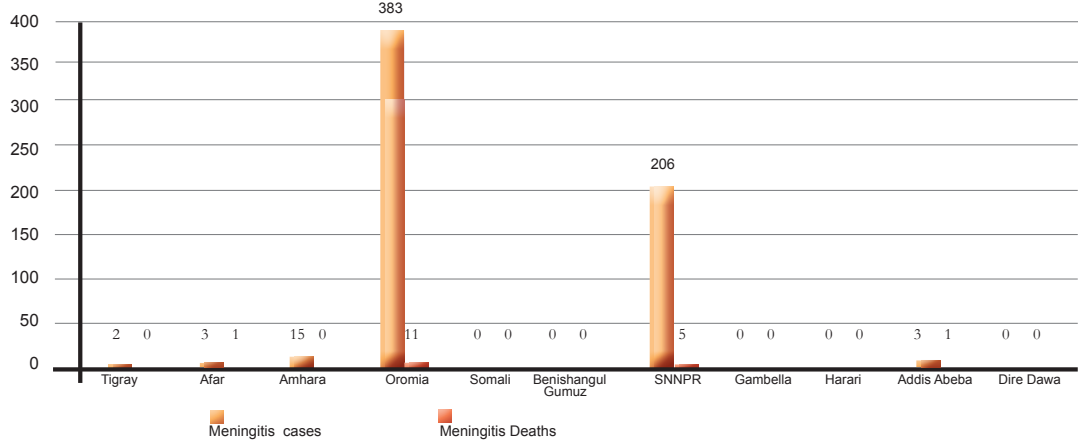
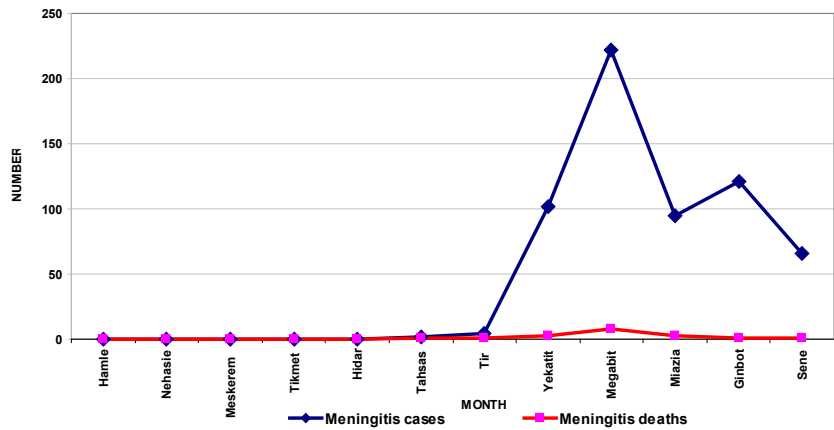


Figure 28: Trend in the Number of Meningitis Cases and Deaths by Month (Ethiopia, EFY 2000).





## Measles Outbreak

In EFY 2000, epidemic of measles occurred in some regions and accounted for 7,285 cases and 19 deaths. The epidemic occurred in some drought affected zones of the country. Because of the untimely and incomplete data flow from regions affected by the epidemic, it was impossible to take action on time. Hence, to strengthen the data collection and timely action on the part of regions, regular support and follow up was provided to regions.

Figure 29 shows the regional distribution of measles cases and deaths, while their trend in EFY 2000 is shown in Figure 30.

Figure 29: Distribution of Number of Measles Cases and Deaths by Region (Ethiopia, EFY 2000)

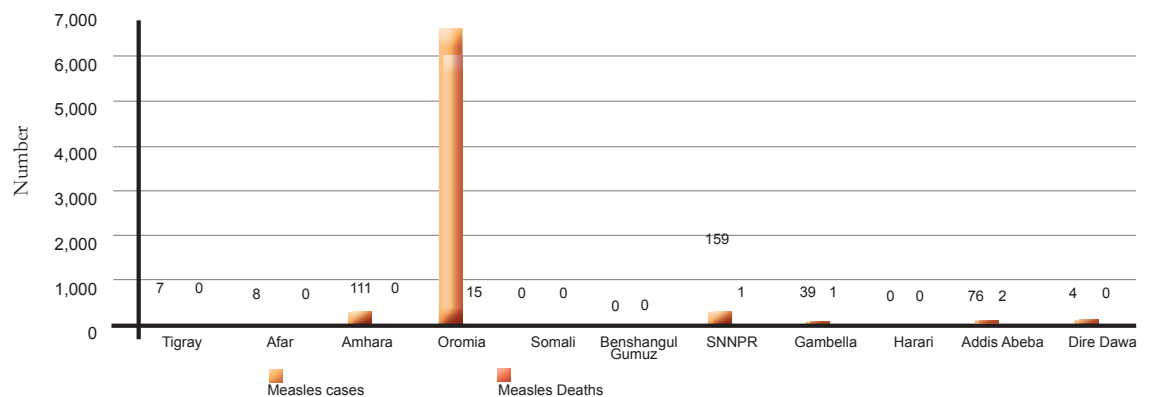
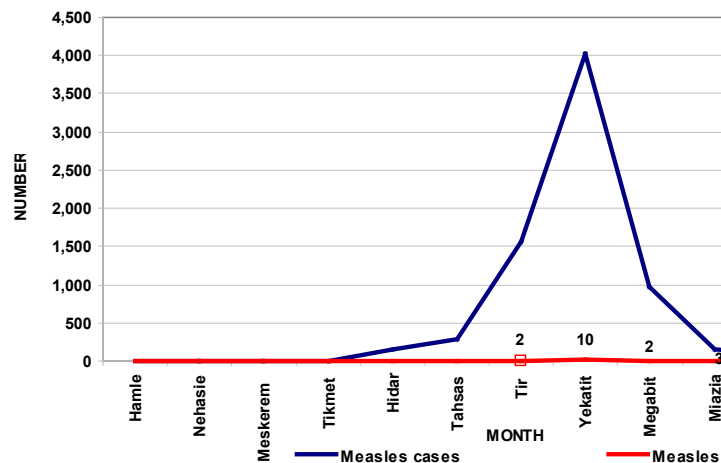


Figure 30: Trends in the Number of Measles Cases and Deaths by Month (Ethiopia, EFY 2000)



In order to control the epidemic fully, it is essential to strengthen and expand the vaccination program against measles.

### **Poliomyelitis**

With respect to Polio, the existence of two polio cases in Gambella was confirmed and polio vaccine was given in two rounds.

### **Relapsing Fever**

In EFY 2000, Relapsing Fever Epidemic appeared in Adama prison in Oromia region and 237 cases were reported. As a result, prevention and control activities were undertaken by a team dispatched to Adama by Oromia Regional Health Bureau.

### **Rift Valley Fever**

With respect to Rift Valley Fever (RVF), Ethiopia is monitoring the disease which appeared repeatedly in neighboring Sudan and Kenya. Monitoring is being conducted by a Health Committee led by the Ministry of Agriculture and the Ministry of Health. Training on RVF was given to health workers in SNNP and Somali Regions. Guidelines, fact sheets and posters on RVF were prepared. Early warning was made for regions to conduct surveillance and monitoring of the disease, and strategic plan was developed and is being finalized.

### **Avian Influenza**

No Avian like influenza was reported through the weekly reports so far. However, vigorous surveillance was conducted during EFY 2000.

Twenty eight health workers drawn from the center and five regions were trained on Avian Flu, and Birr 744,277.00 were released to six regions (Addis Ababa, SNNP, Oromia, Tigray, Benishangul-Gumuz, and Dire Dawa Administrative Council). Sensitization training was given to 60 coordinating committees in Oromia and Amhara Regions.

## **7.8 Prevention and Control of Emergencies**

Out of the estimated 4.6 million people affected by drought, children with severe and acute malnutrition are estimated at 75,000. Various integrated activities within the framework of Health Extension Programme have been performed to mitigate the impact of the consequent acute malnutrition. After identifying some gaps in the Nutrition Surveillance and Response, FMOH decided that the response to Severe and Acute Malnutrition management should be at the health post level whereby cases that need medical care are referred to Stabilization Centers in the health facilities.

Consultative meeting has also been organized with regions and weekly reporting of Severe and Acute Malnutrition management has been initiated. Besides, training on Severe and Acute Malnutrition management was conducted in SNNPR and Oromia.

23,200 and 43,048 Severe and Acute Malnutrition cases were managed in Oromia and SNNPR,

subsequently, from May to August. In this response, partners working on the Nutrition program had significant contribution.

Recent natural disasters highlighted the need for integrated and coordinated emergency management among sectors through strengthening the federal and regional multisectoral preparedness and response bodies. Accordingly, FMOH is working in coordination with relevant sectors. In the past couple of years, different Health Emergencies were supported through Humanitarian Response Fund and Central Emergency Relief Fund which were accessed by UN organizations and NGO's as well. Furthermore, fund raising proposal for year 2008 has been prepared and submitted to the Disaster Prevention and Preparedness Commission to raise more resources.

In response to the possibility of occurrence of health and nutrition problems in Somali region, action plan has been prepared and coordination activities have been performed by assigning professionals. Nine mobile emergency teams have also been assigned in nine woredas. Furthermore, medicine and medical equipment has also been provided. A total of 445,768 persons have benefited from the service.

Challenges encountered include inability of relevant bodies to work in an integrated and sustained manner with the health sector, delayed and incomplete reports and shortage of finance and drugs. Implementation of the Public Health Emergency and Management Core Business Process is expected to solve most of the challenges encountered in this regard.



# 8

## **PREVENTION & CONTROL OF NON-COMMUNICABLE DISEASES**

A strategy that would enable the expansion of mental health services throughout the country is being finalized. This task was previously handled by Emanuel Hospital but is now underway by including the concerned units from the FMOH.

The draft three-year strategic plan on issues related with accidents and medical emergencies was refined at a workshop attended by concerned stakeholders and Regional Health Bureaus. Preparation was made to print and distribute the final version of the strategic plan.

In EFY 2000, it was planned to undertake situational analysis that would help to identify non-communicable diseases and their etiology. However, the study did not materialize as planned, due to the heavy workload on the part of experts selected to undertake the study.

9

**MATERNAL HEALTH  
SERVICES**

Worldwide, every minute a woman dies from pregnancy and childbirth related complications. This amounts to more than half a million maternal deaths every year. The great majority of these deaths take place in developing countries. In addition, for every woman who dies from childbirth complications, 20 or more suffer injury, infections or other diseases. Reducing the number of women dying in childbirth by three-quarters by 2015 is one of the goals of the Millennium Declaration.

The maternal mortality ratio of Ethiopia has declined from 871/100000 live births in 2000 to 673/100000 in 2005 (EDHS 2005), but it is still unacceptably high.

Maternal deaths can be prevented if women have access to and make use of skilled care during pregnancy, child birth and in the first 6 weeks after delivery and receive quality family planning and post abortion care services.

The status of the most common maternal health service indicators and the targets of HSDP III (EFY 2002) and EFY 2000 are presented in Table 13. More effort would be needed to achieve the HSDP targets of antenatal care, delivery by skilled attendant and postnatal care. On the other hand, the new targets set for EFY 2000 for ANC coverage, proportion of deliveries attended by skilled health personnel and contraceptive acceptance rate were not met, falling short by 4% for contraceptive acceptance rates and 12% for skilled attendance at birth.

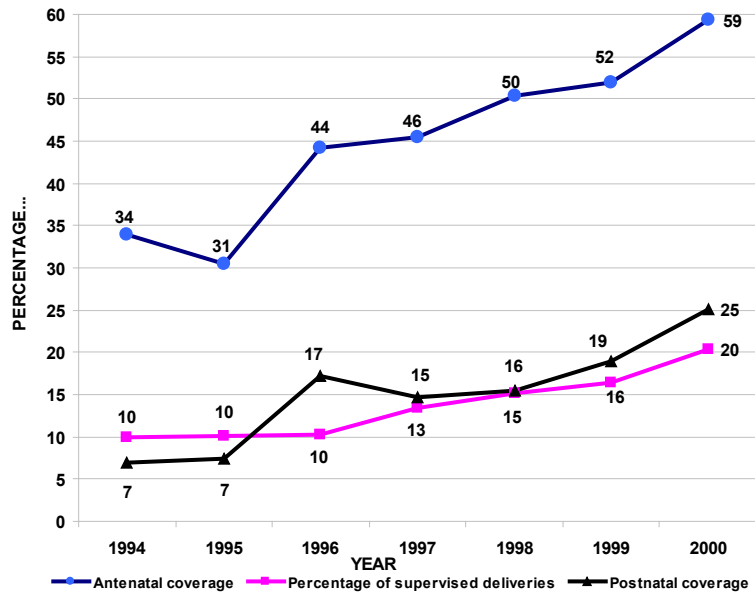
Table 13: Targets and achievements of Maternal Health Service indicators, Ethiopia, EFY 2000

Indicators	EFY 1999 Coverage	EFY 2000 Coverage	EFY 2000 Target	HSDP III Target (for EFY 2002)
Antenatal Care Coverage	52%	59.4%	67%	80%
Proportion of Deliveries Attended by Skilled Health Personnel	16.4%	20.3%	32%	32%
Postnatal Care Coverage	19%	25.1%		31%
Contraceptive Acceptance Rate	33%	50.9%	55%	

## 9.1 National Antenatal Care, Delivery and Postnatal Care Trends

As shown in Figure 31, there has been an increasing trend in the coverage of all the three indicators at the national level.

Figure 31: Trend in Antenatal Care, Supervised Delivery and Postnatal Care Coverage, Ethiopia, EFY 1994-2000



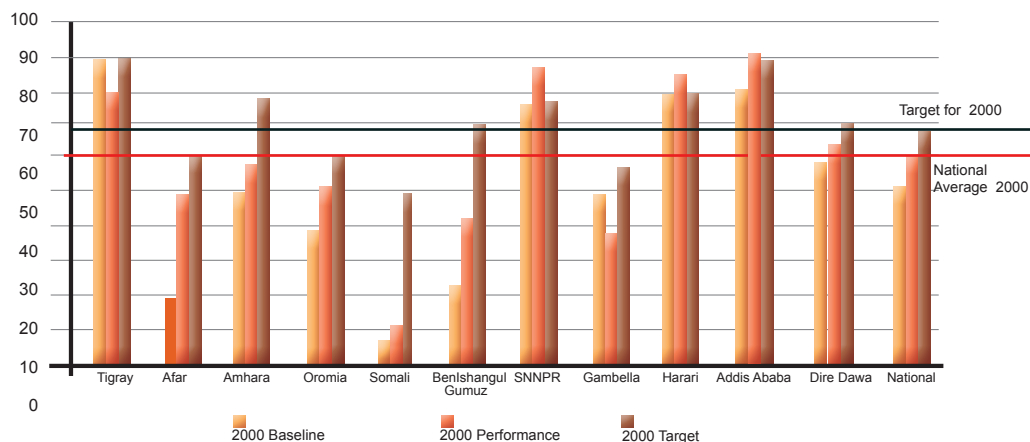
## 9.2 Antenatal Care coverage distribution by region

Figure 32 shows the distribution of ANC coverage by regions and compares performance with the target set for the fiscal year. There is a wide variation among regions in ANC coverage, with Somali having the lowest (10.9%) and Addis Ababa the highest coverage of 91.0%, followed by Harari, SNNPR and Tigray. The coverage of Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, and Gambella was lower than the national coverage. A notable increase was observed in Afar Region where the coverage rose from 19.2% in EFY 1999 (2000 baseline) to 49% in EFY 2000. Similarly, twice the coverage of last year was reported in Benishangul- Gumuz Region. Decline in ANC coverage was observed in Tigray compared to the baseline, although the coverage remains one of the highest in the country. Decline was also noted for Gambella

Region. On the other hand, only SNNPR, Addis Ababa and Harari achieved greater than the target of ANC coverage set for EFY 2000.



Figure 32: Comparison of Baseline, Target and Achievement of ANC Coverage by Region, Ethiopia, EFY 2000

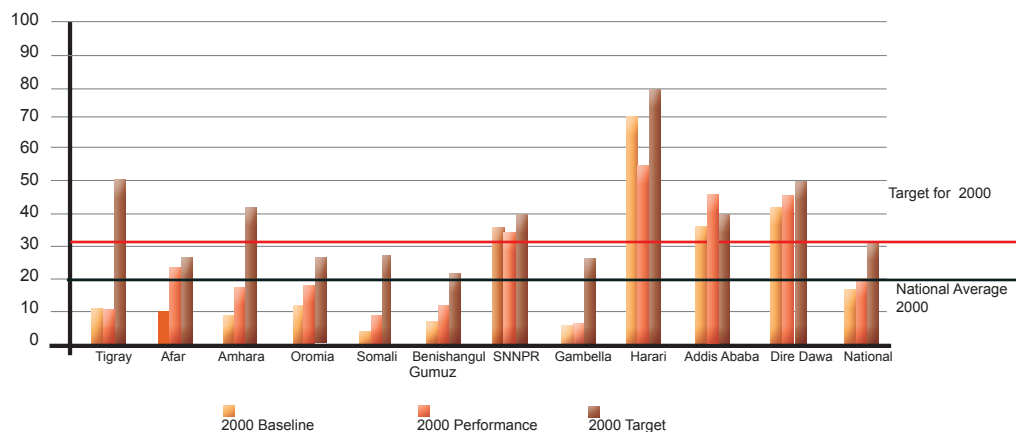


### 9.3 Regional distribution of skilled attendance at birth/ Supervised Delivery

The highest coverage of delivery attended by skilled health personnel (Figure 33) is reported from Harari (63%) followed by Dire Dawa (44.4%), Addis Ababa (43.6%). Afar and Amhara have doubled the coverage of the baseline. The lowest coverage of skilled attendance at birth is reported by Gambella Region (6.1%). Other regions that had lower than the national average performance are Somali (8.1%), Tigray (11.7%) and Benishangul-Gumuz (12.1%), Amhara (16.7%), and Oromia (16.7%).

Comparing performance with the targets, only Addis Ababa achieved the targets set for EFY 2000. Afar Region was very close to the target while Tigray reported the biggest gap between plan and achievement (around 40% lower than the target).

Figure 33: Comparison of Baseline, Target and Achievement of Percentage of Deliveries Attended by Skilled Health Personnel by Region, Ethiopia, EFY 2000



### Basic and Comprehensive Emergency Obstetric Care

It is estimated that about 15% of pregnancies end up in life threatening complications. Hence, improving access and utilization of Basic and Comprehensive Emergency Obstetric Care is one of the most essential strategies to improve maternal health. The elements of BEOC include provision of intravenous or injectable antibiotics, oxytocic drugs, anticonvulsants, manual removal of placenta, removal of retained placental products and assisted vaginal delivery. CEOC include the above services and blood transfusion and surgery (Cesarean Section).

Equipment for CEOC has been purchased for 10 of the 50 hospitals selected for the service in the fiscal year.

Table 14 shows targets and achievements with respect to training of professionals in Basic and Comprehensive EOC by region. Only about 51% of the BEOC and 49% of the CEOC planned number of professionals were trained. Unavailability of obstetricians and low per diem rates were the reasons given for low performance.

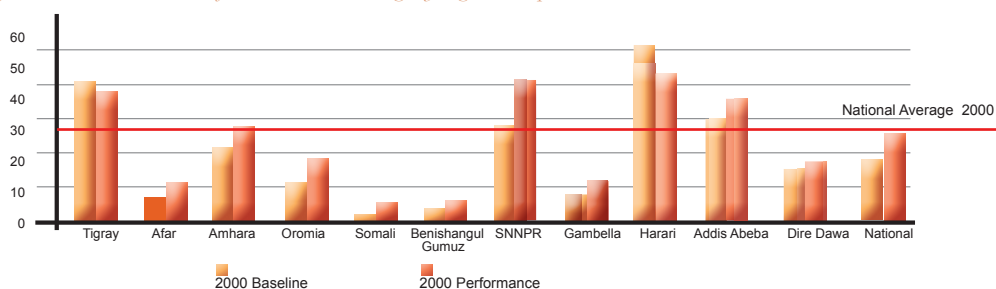
Table 14: Plan and Achievement of Training of Health Professionals on Basic and Comprehensive EOC by Region, Ethiopia, EFY 2000

Region	BEOC		CEOC	
	Planned	Achieved	Planned	Achieved
Tigray	95	106	0	0
Afar	30	0	12	0
Amhara	80	64	24	24 (8 teams)
Oromia	120	22	42	9 (3 teams)
Somali	16	15	24	0
Benishangul- Gumuz	20	0	8	8 (3 teams)
SNNPR	68	18	24	24 (8 teams)
Gambella	20	0	8	8 (3 teams)
Harari	12	0	6	0
Addis Ababa	50	30	0	0
Dire Dawa	14	15	0	0
<b>Total</b>	<b>525</b>	<b>270 (51.4%)</b>	<b>148</b>	<b>73 (49.3%)</b>

## 9.5 Postnatal Care coverage distribution by region

The postnatal care coverage for EFY 2000 ranged from 3.2% in Somali Region to 42.6% in Harari (Figure 34). Lower than the national average was reported in Afar, Oromia, Somali, Benishangul-Gumuz, Gambella, and Dire Dawa.

Figure 34: Comparison of Baseline and Achievement of Postnatal Care Coverage by Region, Ethiopia, EFY 2000.



## Contraceptive Acceptance

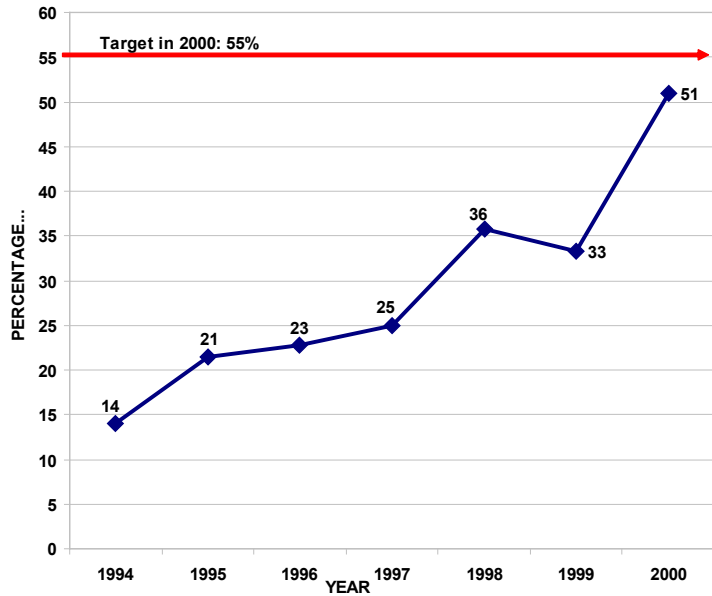
Contraceptive acceptance rate is the proportion of women of reproductive age (15-49 years) who are not pregnant who are accepting a modern contraceptive method (new and repeat acceptors). Each acceptor is counted only once, the first time s/he receives contraceptive services in the calendar year. Appropriate supervision is needed to ensure that the number of acceptors (not the number of consultations) is included in the numerator of CAR.

As shown in Figure 35, contraceptive acceptance rate increased from 14% in EFY 1994 to 51% in EFY 2000. The highest increase is observed between EFY 1999 and EFY 2000. Thus, although the newly set target of 55% for the current fiscal year has not been met, substantial progress has been made at the national level.

Figure 35: Trends in Contraceptive Acceptance Rate, Ethiopia, EFY 1994-2000

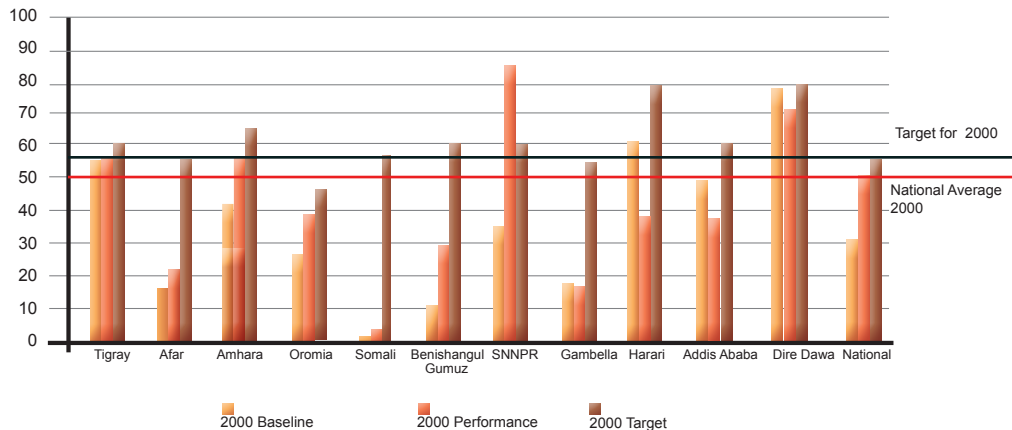
There were wide variations of the contraceptive acceptance rates among regions (Figure 38). The lowest coverage of 3.4% was reported from Somali Region while the highest coverage of 85.2% was reported from SNNPR, where there was a dramatic increase of CAR compared to baseline (EFY 1999 CAR= 34.6%).

A substantial increase was also observed for Benishangul-Gumuz, although the coverage is lower than the national average. Performance in CAR was also below the national average for Afar, Oromia, Somali, Gambella, Harari and Addis Ababa. Harari showed considerable decline compared to last fiscal year.



Comparison between plan and achievement reveals only SNNPR had achieved the target set for contraceptive acceptance rate for the EFY 2000 (Figure 36). Tigray performance was closest to the target (about 5% lower) and relatively closer to the target were Oromia (6% lower) and Amhara (8% lower). Other regions showed a much lower coverage compared to their plans.

Figure 36: Comparison of Baseline, Target and Achievement of Contraceptive Acceptance Rate by Region, Ethiopia, EFY 2000



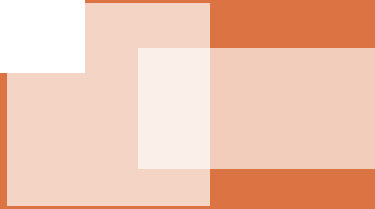
In summary, there has been an improvement of coverage of contraceptive acceptance rate, ANC, delivery and postnatal care by most regions compared to previous years. However, there is a large difference between the coverage of the different maternal health service indicators. ANC coverage is relatively higher than delivery by skilled attendant and postnatal care coverage while the latter two (skilled attendance at birth and postnatal care coverage) have a greater and more direct effect on maternal morbidity and mortality as most complications occur during delivery and the immediate postnatal period.

Delays have also been noted in training professionals in emergency obstetric care and equipping facilities for BEOC and CEOC and the resulting relative low coverage of BEOC and CEOC services.



10

**CHILD HEALTH SERVICES**



Every year about 10 million children die globally before the age of five. About 40% of these deaths occur in Africa, which has only 10% of the world's under-five population. Almost all under-five deaths occur due to preventable diseases (Pneumonia, Diarrhoea, Malaria, Measles and HIV/AIDS) and malnutrition is the underlying cause of death in about 54% of the cases. One of the eight Millennium Development Goals is to ensure a two-thirds reduction in under-five mortality by 2015 from the base year of 1990. Although still high, Ethiopia has made encouraging progress in reducing child mortality and currently infant mortality rates is about 77/1000 live births. Improving child health is also one of the priorities of HSDP III. It sets an explicit target of the reduction of under-five mortality rate from 123 to 85 per 1000 live births and the infant mortality rate from 77 to 45 per 1000 live births.

The report in this section highlights the implementation of child immunization and IMCI services.

## 10.1 Immunization

One of the indicators used to monitor progress towards reduction of under-five and infant mortality is coverage of immunization. The goal of the immunization program is to reduce the incidence of vaccine preventable diseases in children through high coverage of immunization with potent vaccines.

Table 15 compares immunization coverage of EFY 1999 and EFY 2000 against HSDP III target (EFY 2002). The EFY 2000 national Pentavalent immunization coverage is 81% which is about 8% higher than the coverage of the last fiscal year. A similar rise in coverage was achieved in measles coverage and proportion of fully immunized children. HSDP III target has already been achieved for fully immunized children coverage.

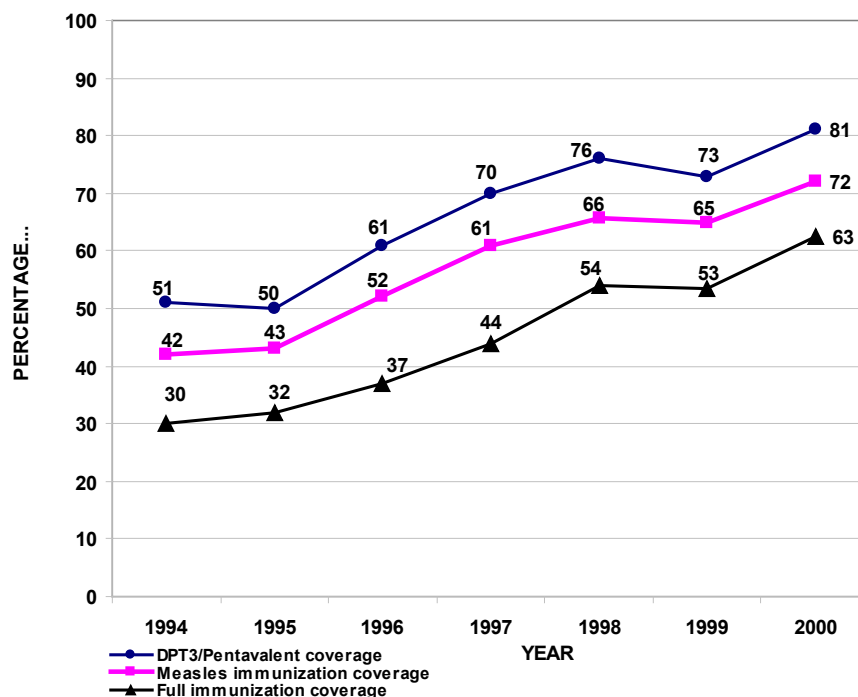
Some of the problems encountered in the implementation of the program include delay in receiving vaccines, particularly those that were sent through the Ethiopian Airlines, delay in receiving reports from the regions and lack of capacity to timely maintain the cold rooms both at the central and regional levels.

Table 15: Immunization Coverage Indicators, Ethiopia, EFY 1999-2000

Indicators	EFY 1999	EFY 2000 Target	EFY 2000 Achievement	HSDP III Target (for EFY 2002)
DPT3/Pentavalent Coverage	73%	85%	81%	85%
Measles Coverage	65%		72%	75%
Proportion of Fully Immunized Coverage	53%		63%	54%

Figure 37 shows an increasing trend in immunization coverage for all the three indicators in the years EFY 1994-2000 with a slight decline in the last fiscal year.

Figure 37: Trend in DPT3/Pentavalent, Measles and Fully Immunization Coverage, Ethiopia, EFY 1994-2000



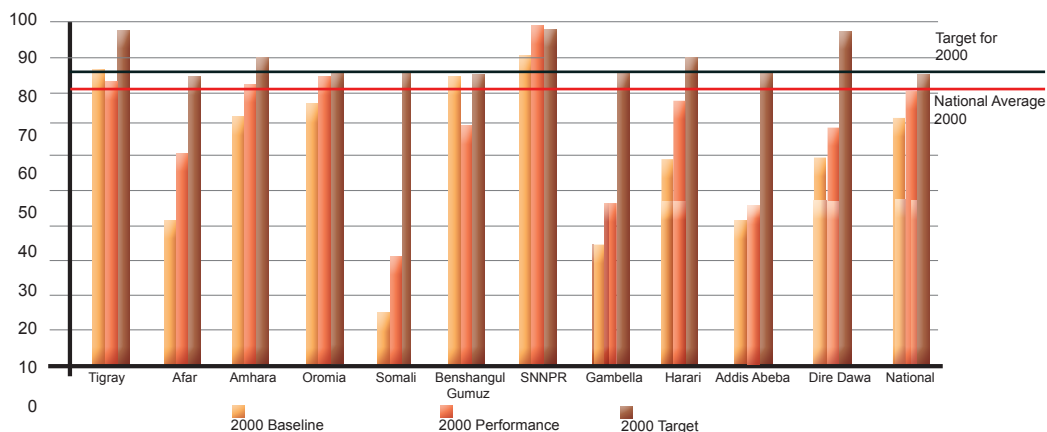
Vaccination (DPT3/Pentavalent) coverage as well as change in coverage between EFY 1999 and 2000 varied widely among the regions (Figure 40). The lowest coverage was reported by Somali Region (31.1%), while the highest was reported by SNNPR (96.7%), which has greatly contributed to the increase in the national average. Afar, Somali, Benishangul-Gumuz, Gambella, Addis Ababa, Harari and Dire Dawa had lower than the national average Pentavalent coverage rates in this fiscal year, although Afar Region has made a considerable increase from 42.6% to 61.7%.

All regions reported increased Pentavalent coverage compared to EFY 1999 (baseline), except Benishangul-Gumuz, Tigray and Dire Dawa. The decline in Benishangul-Gumuz was relatively high amounting to about 15%.

On the other hand, only SNNPR achieved the target for Pentavalent coverage for EFY 2000, with Oromia almost achieving it. Large discrepancies between the targets and the plan for Pentavalent coverage were noted for Somali, Afar, Gambella, Addis Ababa and Dire Dawa (Figure 38).



Figure 38: Comparison of Baseline, Target and Achievement of Pentavalent Coverage by Region, Ethiopia, EFY 2000



## 10.2 The Integrated Management Neonatal and Childhood Illnesses

The Integrated Management of Maternal, Neonatal and Childhood Illnesses (IMNCI) is a strategy adopted by Ethiopia to improve the quality of the management of childhood illnesses. It has three components i.e. improving the skills of health workers, health systems, family and community practices. It links preventive and curative services. Programmes such as immunization, nutrition, malaria and infectious diseases are implemented in an integrated manner. The main activities under IMNCI are prevention and control of ARI, diarrhea, malaria, malnutrition, measles and HIV/AIDS.

At the beginning of EFY 2000, the number of health centers providing IMNCI in the country was 303 and the national target was to cover 635 health centers by the end of the fiscal year. Table 16 shows the baseline, planned and actual number of health centers that provided IMCI by region. Tigray, Afar, Benishangul-Gumuz, Harari, Addis Ababa and Dire Dawa have achieved the target set for EFY 2000. Larger regions such as Oromia, Amhara and SNNPR have achieved more than 80% of the target.

Most of the government hospitals in Tigray, Amhara and Oromia provided IMNCI while none of the hospitals in Addis Ababa provided the service. Hospitals in Afar, Benishangul rendered IMNCI services while those in Gambella and Somali did not. In Harari and Dire Dawa, 2 hospitals and 1 hospital, respectively, out of 4 in each region, implemented IMNCI.

*Table 16: Baseline, Planned and Actual Number of Health Centers Providing IMNCI by Region, Ethiopia, EFY 2000*

Region	Baseline (Beginning of EFY 2000)	Total number planned EFY 2000	Health centers* that provided IMNCI in EFY 2000
Tigray	10	40	40
Afar	6	14	14
Amhara	113	155	125
Oromia	96	192	166
Somali	0	14	9
Ben-gul G.	0	14	14
SNNPR	42	161	140
Gambella	0	8	3
Harari	1	2	2
Addis Ababa	29	29	29
Dire Dawa	6	6	6
Total	303	635	548 (86.3%)

Community IMNCI (C-IMNCI) interventions are well underway in 185 woredas in 10 regional states (except Somali). Of these 40 woredas initiated the program in EFY 2000.

In conclusion, it is important to identify the reasons for the discrepancy between targets set for immunization and achievement and improve the planning and monitoring process. Similarly, solutions should be sought to handle problems related to reporting, vaccine delivery and maintenance of cold rooms. Due attention should also be given to proper tracking of facilities providing IMNCI.



11

**UTILIZATION OF HEALTH SERVICES**

This report considers OPD attendance per capita, Bed Occupancy Rate (BOR), Average Length of Stay (ALOS) and Admission Rate to show utilization of health services.

Figure 39 shows the trend of OPD attendance per capita in the years 1994-2000. OPD attendance rate has generally remained low over the years (range 0.24-0.36). The highest rate (0.36) was reported in EFY 1996 and the lowest OPD attendance rate of 0.24 in EFY 2000. It appears that achievement of the HSDP III national target for OPD attendance per capita of 0.66 needs greater attention and effort.

Figure 39: Trend in OPD Attendance Per Capita, Ethiopia, EFY 1994- 2000

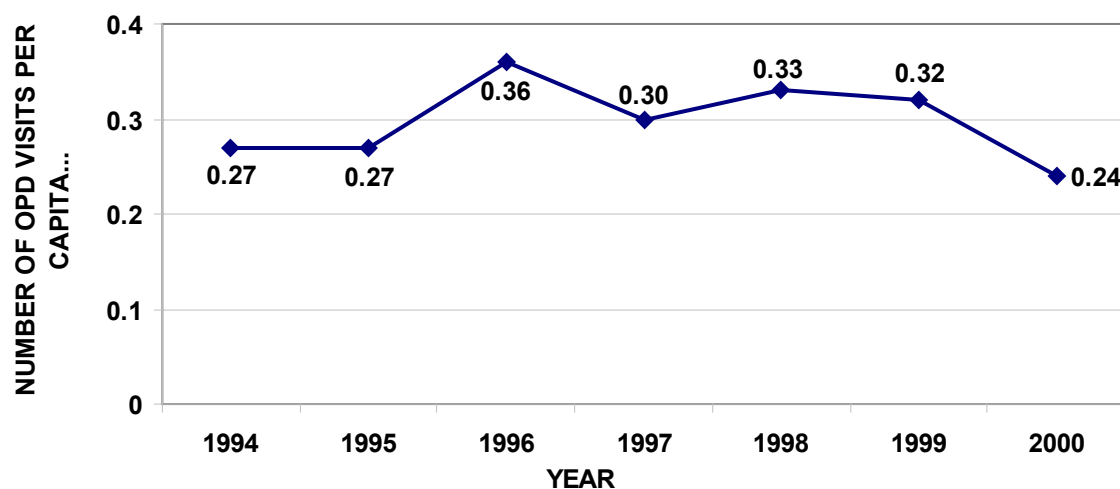
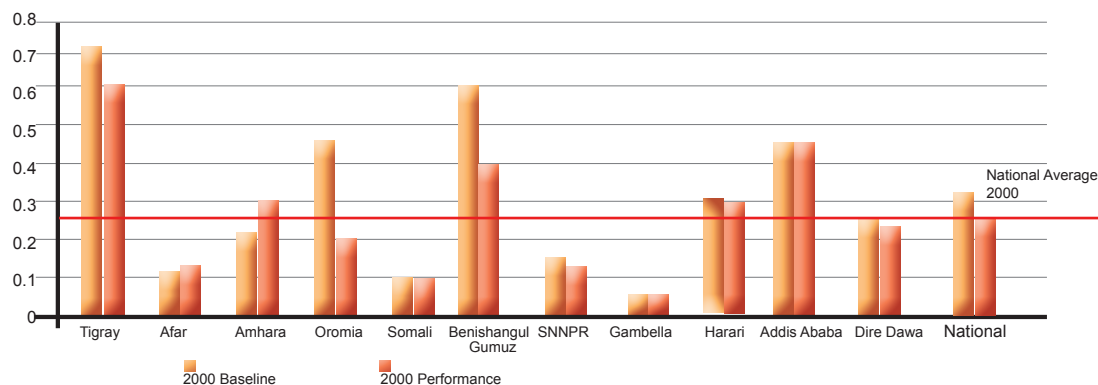


Figure 40 demonstrates OPD attendance per capita by region in EFY 1999 and 2000. The highest per capita OPD attendance in EFY 2000 was reported from Tigray (0.60 visit per capita per year), whereas the lowest one was observed in Gambella (0.04). Relatively lower coverages were also reported by Somali (0.10) and SNNPR (0.12). The biggest decline from the baseline was observed in Oromia (from 0.44 to 0.20) and Benishangul-Gumuz (from 0.60 to 0.40). Identical attendances per capita were reported for EFY 1999 and 2000 for three regions (Somali, Gambella and Addis Ababa).

One of the gaps identified during the pilot testing of the HMIS was that most of the health facilities reported on only 25-30% of their performance. This is mainly due to the fragmented record keeping system in almost all institutions. The new HMIS has brought the concept of “integrated folder” whereby all medical records of an individual patient are kept in a single folder and in one medical record room. This allows the health facilities to fully capture all service utilization data thereby facilitating proper planning and monitoring.

Figure 40: Distribution of OPD Attendance Per Capita by Region, Ethiopia, EFY 1999-2000



The Bed Occupancy Rate (BOR) is the average percentage of occupied beds during the year. It is calculated as the total length of stay (in days) divided by the product of the number of beds and the number of days in the year. BOR reflects the level of utilization of inpatient services and the efficiency in hospital resources use. In principle, health facilities are designed to operate most efficiently at a level of about 80-90% occupancy; however, BOR at the national level was much lower (about 35.0%). It ranged from 17% in Amhara to 44% in Harari.

The average length of stay (ALOS) is calculated as the total length of stay (in days) during the year divided by the number of discharges. The national ALOS was about 4.4 days in 2000. It is to be noted that a relatively short duration of hospital stay with high bed occupancy enables turnover rates to increase and thus allows hospital benefits to be extended to a greater number of people.

The national inpatient admission rate (number of inpatient admissions per 1000 population) for EFY 2000 was about 4.8 per 1000, ranging from 1.5/1000 in Afar and Amhara to 53.3/1000 in Harari. Following Harari, DireDawa (17.4/1000) and Benishagul-Gumuz (13.5/1000) had relatively higher rates. Relatively lower rates were reported from Gambella (2.9/1000) and Somali (2.5/1000). This year's national rate appears to be lower than that of last fiscal year (7.6/1000).

Utilization of health services as presented by the indicators used in this report is generally low and health facility resources do not appear to be used efficiently. Perhaps, there are also problems of registering and calculating the indicators and reporting hospital statistics, as was noted during the last fiscal year's report.

Training and supervisory support on service data collection, analysis, interpretation of service utilization statistics as part of the implementation of the HMIS Reform would enable to minimize the problem of analyzing and using the information.



12

**STRENGTHENING  
OPERATIONS RESEARCH  
AND RELATED ACTIVITIES**



Operations research in health aims at identifying priority problems and producing evidence that would help to improve the services. In EFY 2000, operations research were conducted in the areas of Maternal and Child Health, Nutrition, Malaria, HIV/AIDS, costing of health services and surveillance of major public health problems such as HIV/AIDS, malaria and TB.

## **12.1 Maternal and Child Health**

Improving the unacceptably low maternal and child health status of the country requires evidence-based interventions using operations research. Accordingly, research has been conducted on important issues including:

### **12.1.1 Assessment of the Causes of Maternal Mortality (Maternal Death Audit)**

This study is conducted in collaboration with Addis Ababa University in four selected hospitals (Shire, Assela, Dila and Dessie). The general objective of the study is to reduce maternal mortality through service quality improvement by institutionalizing maternal death review to identify causes and solutions. The project did not progress as expected. A recommendation has been made to revisit the project document to enhance project activities.

### **12.1.2 Piloted Misoprostol Intervention Evaluation**

The purpose of this assessment was to document the experiences of a Misoprostol community-level intervention trial at the MPS pilot areas and provide recommendations for expansion of the program. The assessment was conducted from January 28 to February 8, 2008 and involved a total of 17 health centers and 64 health posts. In total, 103 of the 128 HEWs initially trained under the project and 72 health center providers were involved in the assessment. Both quantitative and qualitative approaches were used to collect information from various sources.

### **12.1.3 Assessment on Choices of Family Planning**

The main objective of this project is to assess the determinants for clients' preference for specific family planning method among non-user married women of reproductive age. The study is postponed to EFY 2001 due to time constraint.

### **12.1.4 National Prevalence of Cervical Cancer/ Cervical Cancer Screening**

This is a joint collaborative study between the FOMH and AAU. The general objective of the study is to compare the test characteristics of Pap smear, VIA and VILI for cervical cancer screening and determine the prevalence and associated historical risk factors for cervical cancer in Ethiopia. The results and experiences of the study will be used to set up and expand cervical cancer services in selected sites.

The project is expected to have a duration of 4 years in two phases. The plan was to start in selected seven hospitals and expand the service to other hospitals in the country. Unfortunately screening without managing the cases was uncovered to be a bottle neck for further implementation and expansion. Also, weak follow up and limited financial support were among the constraints that hindered the progress of the study.

Other studies that have been conducted in the current fiscal year, and the results of which have been used to improve service delivery, are: (i) “Process Evaluation of MPS pilot project in Gedeo zone”, and (ii) “Assessment of quality of care on child health referral care in eight hospitals”.

### **12.1.5 EPI Cluster Sampling Coverage Survey in Ethiopia**

The study aimed at determining the coverage of child and TT immunization and the reasons for not utilizing immunization services. The survey confirmed the increment of EPI coverage compared with a previous survey and identified factors that affect utilization of the EPI services in the regions. The results of the study have been used for planning and improving the quality of EPI service delivery in Ethiopia.

## **12.2 Nutrition**

### **12.2.1 EOS Coverage Validation Survey**

This objective of this study is to validate the EOS coverage. Data collection and write up are underway.

### **12.2.2 National Nutrition Baseline Survey**

This survey is planned to be conducted by the Nutrition Unit of the FHD and EHNRI. It aims at providing key baseline nutrition data for the implementation of the National Nutrition Program. Preparations are underway to start data collection.

A National Micro-nutrient Survey has been conducted in collaboration with EHNRI and the Regions.



### 12.3 Operations Research on Malaria and HIV/AIDS

Effectiveness of Coartem (antimalaria drug currently used in the country) was assessed in Wondogenet and Serbo health centers. Data have been entered and analyzed and preliminary results show that effectiveness of Coartem is 96% in Wondogenet and 96.3% in Serbo.

A study on the effectiveness of residential residual spray using DDT in annihilating malaria mosquitoes is underway. The study also includes assessment of the resistance to antimalaria drugs. Data have been collected from six malarious areas and entered into computer. Analysis and report write up will be completed during the next fiscal year.

Another study that assesses the contribution of the Global Fund and other partner organizations to the reduction of morbidity and mortality due to HIV/AIDS, TB and Malaria is underway. Accordingly, data have been collected from 8533 houses and 163 health institutions. Data have been entered into computer and analysis is underway. A report will be submitted to stakeholders during the first quarter of EFY 2001.

A cross sectional national Malaria Indicator Survey was conducted during the major malaria transmission season (October- December, 2007) to assess intervention coverage and malaria and anemia prevalence.

### 12.4 Cost of Health Services

In order to address the problem of under financing, poor quality, low access and utilization of services in the health sector, the FMOH is in the process of developing various insurance schemes one of which is social health insurance (SHI). A unit cost study was undertaken with the aim of assessing the existing situation with regard to availability of services which are proposed to be covered by SHI and unit cost of providing these services with the existing service delivery mechanism. This cost analysis has two main objectives as it relates to the SHI. One is to come up with a cost benchmark on which to set insurance premium for enrollees and the second objective is to identify cost of services in order to make reimbursement decisions to health care providers.

The unit cost of services was estimated with and without considering the capital cost. The unit costs are presented for the final cost centers i.e. outpatient visit and inpatient stay. The cost for outpatient visit is inclusive of consultation, diagnosis and any other OPD related costs. Inpatient cost on the other hand includes amenities such as food, bed, nursing care, drugs and treatment as well as cost of surgical procedures if any. The cost estimates have been organized as low, average and high cost scenarios. For selected interventions, which have clear treatment protocols, the unit cost of providing these services according to standard operating procedures (SOP) was estimated. Also, the study has calculated the unit cost of commonly prescribed laboratory test, x-ray procedures and surgical interventions.

The unit cost information from the costing study has been combined with the expected utilization pattern to make a preliminary estimation of the financial requirement of running SHI scheme and the level of contribution that should be made by insurance subsidiaries in order to cover health related costs



for themselves and their dependants. Premium estimation has been made by taking into consideration different scenarios.

### **12.5 Surveillance of Major Public Health Problems**

Surveillance of HIV/AIDS among pregnant women was conducted as planned. Out of the 108 sites planned for HIV surveillance, data collection in 100 sites was completed. Concerning the laboratory work, four rounds of training were conducted that enabled better performance in laboratory investigations in the regions. Quality control samples have been sent to EHNRI.

A project that was designed to build capacity in the monitoring of quality of rapid malaria tests is being implemented. An agreement has been reached on the work plan and budget with WHO and FIND that provide financial support for the study. SOP has also been prepared to undertake the project to achieve the expected quality work.

It was noted that there were delays in the conduct of some studies thereby hampering the utilization of their results.





13

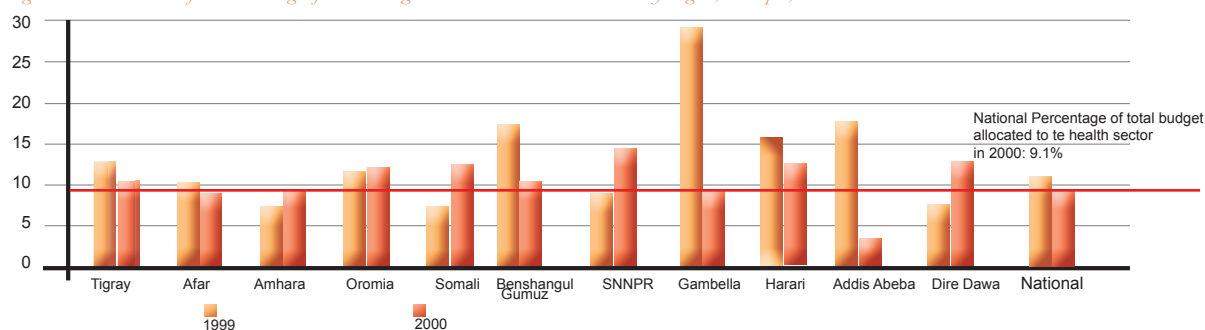
**PUBLIC BUDGET  
ALLOCATION AND  
EXPENDITURE**

Increasing the proportion of budget from public funds and enhancing its utilization are among the major principles underpinning the Health Care Financing Strategy of the Government of Ethiopia. Accordingly, performance in relation to public budget allocation and expenditure on health are presented below.

### 13.1 Percentage Share of Health Budget from Total Budget

As shown in Figure 41, percentage of total regional block grant budget allocated to the health sector ranged from 3.3 % in Addis Ababa to 14.4 % in SNNPR. The national average was 9.1%. A large decrease in the share of the health budget is noted in Gambella and Addis Ababa. The percentage of the total budget allocated to the health sector was 11.6% in EFY 1999; despite the decline in percentage terms, the total amount of the budget allocated to the health sector increased by 77% from ETB 1,277,725,729 in EFY 1999 to ETB 2,257,778,899 in EFY 2000. The allocation on health per capita is ETB 28.5 in EFY 2000. This figure was 21.6 Birr in EFY 1999.

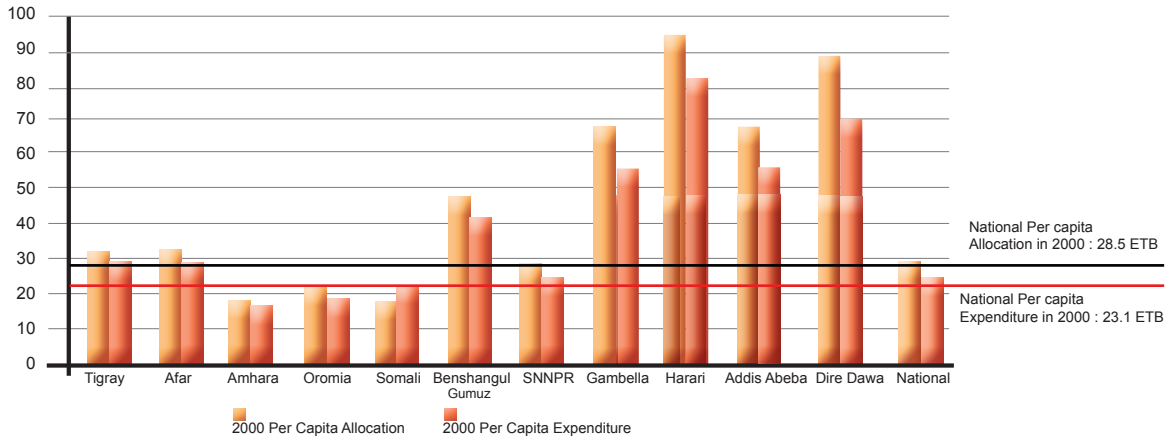
Figure 41: Distribution of the Percentage of Total Budget Allocated to the Health Sector by Region, Ethiopia, EFY 1999 and 2000.



The total and per capita allocation on health remains below the sectors need for delivery of accessible and quality health care services in the country. Getting timely financial data appears another constraint which shows the need to continue to advocate for better budget allocation to the health sector, strengthen implementation of the on-going HCF reform such as facility level revenue retention and use and individual social and community based insurance

Figure 42 compares per capita allocation with per capita expenditure on health by region. At the national level, the per capita allocation was ETB 28.5, about ETB 5 higher than the expenditure. Regions with higher allocations per capita had a slightly lower expenditure rate (Harari, Dire Dawa, Addis Ababa, and Gambella), while those with lower allocation show higher rates of budget utilization (Amhara, Oromia, SNNPR).

Figure 42: Comparison of Per Capita Allocation and Per Capita Expenditure on Health (ETB), Ethiopia, EFY 2000



### 13.2 Per Capita Public Expenditure on Health

Per Capita expenditure on health is an important indicator reflecting both governments’ commitment for delivering quality health care as well as resource availability for the sector.

As shown in Figure 43, there was a general rise in the per capita expenditure for health over the last six years. Per capita expenditure for health has grown from ETB 11.3 in EFY 1994 to 23.1 ETB in 2000.

Figure 43: Per Capita Expenditure on Health (ETB), Ethiopia, 1995-2000

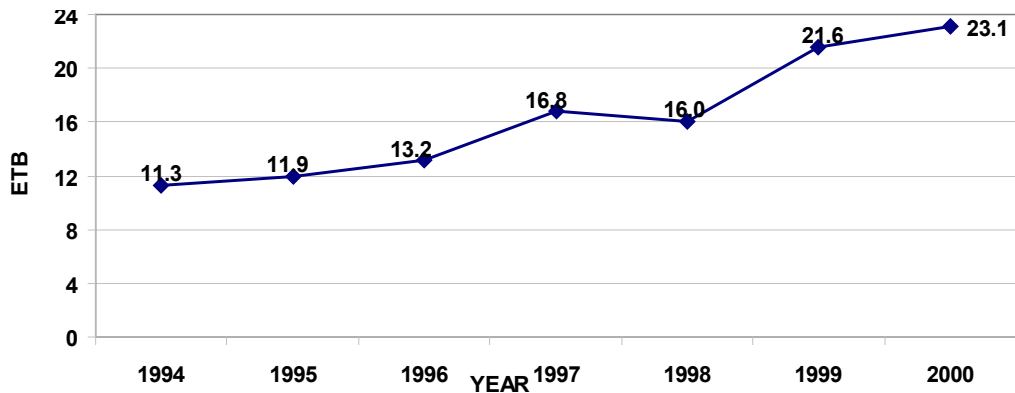
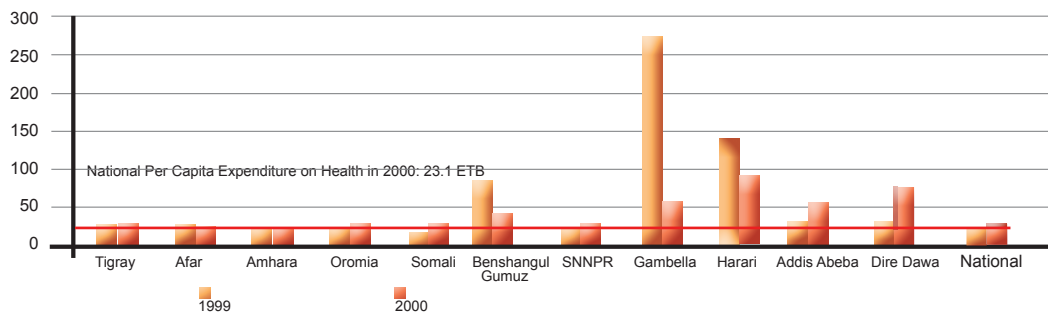




Figure 44 shows the level of per capita public expenditure of regions in EFY 2000 and compares it with EFY 1999. Per capita public expenditure for health varied widely among the regions from that of ETB 15.2 in Amhara to ETB 55.8 in Gambella and ETB 82 in Harrari. The two largest region (Oromia and Amhara) had lower than the national average per capita expenditure for health.

Figure 44: Comparison of Per Capita Allocation and Per Capita Expenditure on Health (ETB), Ethiopia, EFY 2000



It should be noted that this comparison does not include resources flowing to the health sector from other sources such as out of pocket spending by individuals, expenditure from private for profit and private not for profit (NGOs) and from donors particularly channels 2 and 3 are not included in this estimation.

14

**DEVELOPMENT  
PARTNERS'  
CONTRIBUTION TO THE  
HEALTH SECTOR**

At this juncture it is important to rehighlight that the prevailing resource gap in the health sector till the end of HSDP-III is estimated at 2.8 Billion USD.

Table 17: Commitment and Disbursement of Funds by Development Partner, Ethiopia, EFY 2000.

Source of Fund	Commitment in ETB	Disbursement in ETB	Percentage of Disbursement
<b>AECID (Spanish Cooperation)</b>	5,984,589.00	5,984,589.00	100.00
<b>ADB</b>	119,052,000.00	42,500,000.00	35.70
<b>CDC</b>	27,407,500.00	17,485,000.00	63.80
<b>Clinton Foundation</b>	52,646,767.30	52,646,767.30	100.00
<b>GAVI</b>	305,007,000.00	428,519,350.00	140.50
<b>Global Fund</b>			
<b>Malaria</b>	237,492,675.50	195,878,932.50	82.50
<b>TB</b>	145,712,406.00	81,889,715.00	56.20
<b>HIV/AIDS</b>	1,662,500,000.00	1,154,626,200.00	69.50
<b>Italian Cooperation</b>	33,582,750.00	6,375,000.00	19.00
<b>Irish aid</b>	565,250.00	565,250.00	100.00
<b>JICA</b>	11,875,000.00	6,045,455.00	50.90
<b>Protective Basic Service component 2 /PBS-C2</b>			
<i>WB</i>	275,500,000.00	275,500,000.00	100.00
<i>DFID</i>	9,500,000.00	0.00	0.00
<i>EC</i>	69,702,450.00	66,217,327.50	95.00
<i>CIDA</i>	183,540,000.00	183,540,000.00	100.00
<i>Total PBS-C2</i>	538,242,450.00	525,257,327.50	97.60
<b>PEPFAR</b>	71,119,616.50	29,217,086.00	41.10
<b>Technical Assistance Health Pool Fund</b>			
<i>RNE</i>	2,449,600.00	5,277,765.00	215.50
<i>IA</i>	3,062,000.00	3,110,771.00	101.60
<i>DFID</i>	2,711,400.00	2,758,525.80	101.70
<i>SIDA</i>	2,600,000.00	0.00	0.00
<i>IC</i>	1,225,412.00	0.00	0.00
<i>ADC</i>	2,449,600.00	4,786,469.80	195.40
<i>UNICEF</i>	914,000.00	2,064,015.20	225.80
<b>Total TA HPP II</b>	16,265,650.00	17,997,546.70	110.60
<b>UNDAF</b>	8,152,900.00	5,787,400.00	71.00
<b>UNFPA</b>	74,703,582.50	49,149,531.00	65.80
<b>UNICEF</b>	410,892,874.30	404,328,655.50	98.40
<b>USAID</b>	17,113,085.00	16,846,179.00	98.40
<b>WHO</b>	236,540,000.00	215,707,900.00	95.60
<b>World Bank</b>	95,000,000.00	60,566,300.00	63.80
<b>Total</b>	4,069,856,096.20	3,317,374,184.50	81.50

Amongst the programmes, the gap is worst on health systems, maternal health and child health interventions. In the following paragraphs, the commitment of development partners is compared with their disbursement for EFY 2000. But it is important to note that the 2.8 billion USD gap takes into account 100% disbursement of the commitments, hence, any less disbursement adds an extra gap to it.

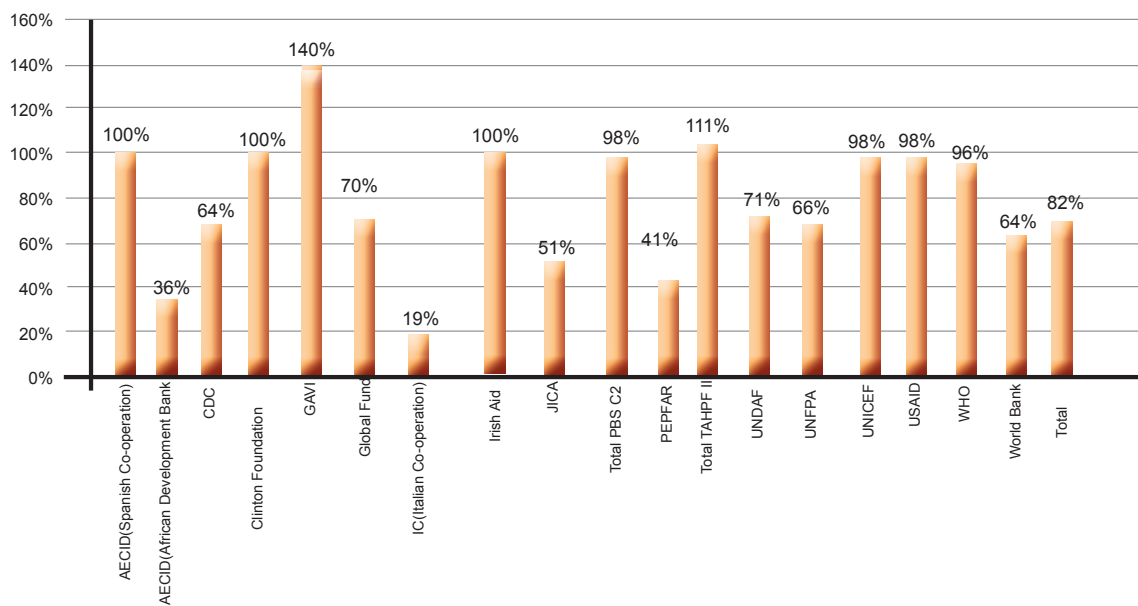
As per the Annual Core Plan of FMOH, around 4.1 billion ETB was committed by development partners as shown in the table below (Table 17).

The total percentage of disbursement of financial resources to health in EFY 2000 is 81.5% which indicates that there is 19.5% disbursement gap from the total committed amount by development partners. (Figure 45). When we take a closer look at individual development partners' disbursement behavior, there is a wide variation. For instance, 22% of the development partners disbursed less than or equal to 50% of their commitment, 50% of the development partners disbursed more than 50% of their commitments, while 16.6% disbursed full amount of their commitment and 2% of the development partners actually disbursed more than 110% of their commitment. It can also be seen that the development partners who actually disbursed more than their commitment are GAVI and UNICEF. The same situation is true for TA assistance health pool fund. Although the total disbursement is over 100% for HPF, there are two development partners (IC and SIDA) who did not disburse any financial resource to the health pool fund in EFY 2000.

About 19% disbursement gap is a significant shortage of disbursement that can seriously affect the implementation of health program activities. In addition, even if the current situation of some development partners disbursing more than their commitment continues, some of these development partners disbursement procedures do not allow flexibility to cover for the disbursement gaps created by other development partners. Hence, some of the programs or activities remain under funded affecting the implementation process of health program to a large extent.



Figure 45: Percentage Distribution of Disbursed Funds by Development Partner, Ethiopia, EFY 2000



In conclusion, there are already significant resource gaps to meet the targets of HSDP-III. These resource gaps are further aggravated if the committed amounts are not disbursed according to the agreed time frame. Hence, FMOH and development partners need to work hand in hand in addressing major bottlenecks and in creating better procedures or channels to facilitate the timely disbursement of financial resources to the health sector.

The major bottlenecks for capturing the actual resource commitment and disbursement information for health and HIV/AIDS programs are mainly: i) the use of various calendar years and procedures for committing and disbursing funds by various donors, ii) reluctance on the part of some donors to provide commitment and disbursement information on time; iii) absence of consistent commitment and disbursement information when data are obtained from various sources and iv) difficulty to obtain documents relating to agreement and financial reports.

The way forward is: 1) development partners need to improve the predictability of resources and also improve their willingness to provide information and 2) development partners need to align their financial disbursement plan with the Government's Financial Calendar.

15

**STRENGTHENING  
MONITORING &  
EVALUATION AND  
COORDINATION**

An important activity undertaken in the area of monitoring and evaluation during the period under review is the conducting of the Midterm Review (MTR) of HSDP III. The report of the MTR will be presented for discussion at ARM 2008.

At the level of the sector, the status of plan implementation has been closely monitored thorough Joint Steering Committee meetings of the FMOH and RHBS held every two months.

Similarly, the RHBS have been conducting steering committee meetings at which the extent of achievement of the major objectives and targets and key system issues of the HSDP are presented and discussed.

At the level of FMOH, monthly meetings have been conducted to assess the implementation of the main activities where each department presents physical and financial report and the Management Committee discusses and evaluates the performance at the FMOH level.

Guidelines have been prepared on preparation of weekly plans and implementation with the view to link routine daily activities to the main objectives/targets. The guidelines have been printed and distributed for use by central and regional health facilities and other sectors.

As per the plan to conduct working visits by the central and regional management committee members, visits have been made to three health institutions in Oromia and three health posts in Amhara regions as well as in some areas where the AWD epidemics occurred.

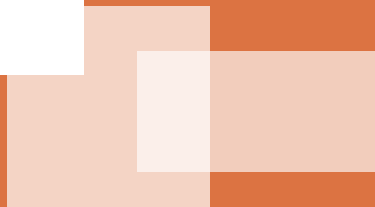
Similarly, supervisory visits were also conducted to health posts in Tigray, Amhara, Oromia and SNNP regions according to the plan to monitor and strengthen the HEP. Based on this supervision, strengths and weaknesses were identified concerning issues related to supportive supervision, resource mobilization, integrated approach, community mobilization, training and expansion of model families.

In addition, analysis of performance of the special support program and supportive supervision was conducted in four pastoral and semi pastoral regions. As a follow-up, a team of experts from departments of different sector ministries together with these regions have prepared special support plans for EFY 2001.

In terms of coordination with development partners, the Joint Core Coordination Committee, which is a technical ARM of the Central Joint Steering Committee, has met almost on weekly basis throughout the year. This was due to the major harmonization, financing and monitoring and evaluation issues addressed during the fiscal year. These include the IHP+, resource mapping exercise, the MDG Performance Fund Appraisal, Midterm Review of HSDP-III and the Annual Review Meeting (ARM). The Joint FMOH-HPN Donors Group Consultative Forum and the Central Joint Steering Committee need to further strengthen the monitoring activities in the next fiscal year.

16

**CONCLUSION**





The report of EFY 2000 has presented performance of the sector in which many achievements have been made in various areas or health programs. It has also indicated areas in which performance has not been satisfactory or below the targets set in the plan.

The major activities regarding system strengthening include undertaking relevant studies, preparation of guidelines and pilot testing of implementation of the seven BPR core processes, and preparation of a sector-wide woreda-based Core Plan for EFY 2000 and its implementation.

A high achievement was observed in training and deployment of health extension workers where 81.9% of the total national requirement of 30,000 HEWs was met. However, the performance on staffing and equipping of health posts was relatively lower than planned in some regions. Health post construction is slow in emerging regions. Remarkable improvement has been observed in latrine construction, even though the target set has not been achieved. Preparation to implement HEP in urban areas and enhance the program in pastoral and semi-pastoral areas is underway.

With respect to construction and equipping of health centers, important preparatory measures such as establishing a project monitoring unit, contractual agreements and site hand over have been undertaken. The number of health centers to be constructed is lower than the targets, the reasons being cost revisions and price hikes of construction materials, and delay in bid preparation and cost analysis.

A major achievement regarding strengthening and expansion of hospitals was the implementation of the hospital reform “Blue Print” in 37 hospitals. Extensive training has been given to hospital staff and several guidelines have been prepared to ensure quality and sustainability of the new hospital system.

There was a substantial increase in the number of HCT users in EFY 2000 and, similarly, the number of sites for the delivery of HCT, PMTCT and ART services have increased, although improvement in infrastructure and human resources remain challenges particularly to improve PMTCT services.

The achievement in the reduction in malaria morbidity and mortality was remarkable, the 100% coverage of ITN being one of the contributory factors. Slight improvement was observed in TB case detection, whereas TB treatment success and cure rates showed slight declines compared to last year.

There was a general improving trend of maternal and child health indicators. Challenges in MCH services include lower performance compared to targets set for the year in several indicators and low coverage in skilled attendance at birth.

It is hoped that this report will shed light on the overall performance of the sector and also serve as a useful review document during the deliberations of ARM 2008.